REPORT ON THE 6TH BIENNIAL AFRICA CHRISTIAN HEALTH ASSOCIATIONS CONFERENCE
FEBRUARY 25-28, 2013, LUSAKA ZAMBIA

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TABLE OF CONTENTS

1. BACKGROUND 4
2. CONFERENCE OBJECTIVES 5
3. OUTCOMES OF THE CONFERENCE 6
4. CONFERENCE OBJECTIVES 6
5. OPENING SESSION 7
6. KEYNOTE ADDRESS 7
7. WELCOME REMARKS AND INTRODUCTION OF GUEST OF HONOUR 9
8. COUNTRY EXPERIENCES WITH ADDRESSING THE INCREASING BURDEN OF NON-COMMUNICABLE DISEASES; SUCCESSES AND CHALLENGES- UPMB 11
9. PREVALENCE OF DIABETES IN DEVELOPING COUNTRIES- NOVONORDISK 12
10. RECOMMENDATIONS FOR COUNTRY EXPERIENCES FOR SUCCESSFUL PARTNERSHIPS 13
11. PANEL ON APPROPRIATE STRUCTURES FOR IMPROVED PRIVATE PUBLIC PARTNERSHIPS AT COUNTRY LEVEL; 13
12. MALAWI EXPERIENCE 13
13. LESOTHO EXPERIENCE 15
14. CHALLENGES TO THE MOU: 15
15. ZIMBABWE EXPERIENCE 16
16. ENGAGING FBO'S IN THE IMPLEMENTATION OF THE GLOBAL PLAN FOR THE ELIMINATION OF MOTHER TO CHILD TRANSMISSION. 17
17. PANEL SESSION; HEALTH SYSTEMS STRENGTHENING FOR INTEGRATED HEALTH SERVICES INCLUDING NON-COMMUNICABLE DISEASES. 19
18. ACCESS TO ESSENTIAL HEALTH COMMODITIES- MEDS 20
19. CANCER CARE; HEALTH, SAFETY, AND ENVIRONMENT- EPN 20
20. PARTNERSHIPS FOR EFFECTIVE SERVICE DELIVERY FOR NON-COMMUNICABLE DISEASES-NOVONORDISK. 21
21. LESSONS FROM INTERVENTIONS TO ADDRESS NON-COMMUNICABLE DISEASES. 22
22. LESSONS LEARNT 23
23. CERVICAL CANCER SCREENING & TREATMENT PROGRAM- IMA 23
24. REACTIONS TO PRESENTATIONS 25
25. ENGAGING WITH DEVELOPMENT PARTNERS; PROGRAMS AND PARTNERSHIP OPPORTUNITIES 25
26. OPPORTUNITIES FOR MEDICAL SURPLUS RECOVERY ORGANIZATIONS IN THE US; -CRS .. 26

27. REFLECTIONS ON SUCCESSFUL PARTNERSHIPS FOR IMPROVED ACCESS TO QUALITY HEALTH CARE SERVICES 27
28. RECOMMENDATIONS 27
29. COCKTAIL CELEBRATION OF OFFICIAL REGISTRATION OF ACHAPLATFORM 27
30. GENERAL ASSEMBLY 29
31. FUNDING: 29
32. REACTIONS 30
33. FINANCIAL STATUS 30
34. MEMBERSHIP: 30
35. BOARD MEMBERS 31
36. ACKNOWLEDGEMENTS 31
37. APPENDICES 32
38. LINKS TO PRESENTATIONS 34
39. CONFERENCE PROGRAM 34

BACKGROUND

The Africa CHA Platform (ACHAP) is a registered faith based international NGO with a mandate in Africa which provides information and knowledge sharing platform that facilitates learning and joint advocacy for Christian Health Associations [CHA] and Christian Health Networks [CHN] from Sub-Saharan Africa and their Development Partners. ACHAP currently has 31 member organizations from 26 countries of Africa who provide a significant proportion of health services which range between 20-50% of the national health services. Every two years ACHAP and partner organizations convene for a Biennial Conference to reflect on regional and global health issues and priorities which have an impact on countries and communities served by faith based health services.

In the 2010 WHO Global Status Report on Non-Communicable Diseases, NCDs are the leading global causes of death, causing more deaths than all other causes combined and they strike hardest at the worlds low and middle income population. These diseases have reached epidemic proportions, yet they could be significantly reduced, with millions of lives saved and untold suffering avoided through reduction of their risk factors, early detection and timely treatment.

Mortality and morbidity data reveal the growing and disproportionate impact of the epidemic in lower resource settings; over 80% of cardiovascular and diabetes deaths and almost 90% of deaths from chronic obstructive pulmonary diseases occur in low and middle income countries. More than two-thirds of all cancer deaths occur in low and middle income countries. The WHO estimated percentage increase in cancer incidence by 2030 is projected to be greater in low income countries. A large proportion of NCDs are preventable through the reduction of their 4 main behavioral risk factors; tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet.

According to Dr Margaret Chan, Director General WHO "current evidence unequivocally demonstrates that Non-Communicable Diseases are largely preventable. The diseases can be effectively treated and controlled. We can turn the tide, but we have a long way to go. The epidemic already extends far beyond the capacity of the lower income countries to cope"

The vision and framework for reversing the epidemic is contained in the "Global Strategy for the Prevention and Control of Non-Communicable Diseases" which was endorsed by the World Health Assembly in 2000. The United Nations General Assembly of 2010 adopted a resolution on the prevention and control of non-communicable diseases. An Action Plan 2008 -2013 was developed by WHO and member states to translate the Global Strategy into concrete action. It highlights the following 6 objectives;

i. To raise the priority accorded to NCDs in development work at global and national level and to integrate prevention and control of such diseases into policies across government departments
ii. Establish and strengthen national policies and plans for the prevention and control of NCDs
iii. To promote interventions to reduce the main shared modifiable risk factors; tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol
iv. To promote research for the prevention and control of NCDs
v. To promote partnerships for the prevention and control of NCDs
vi. To monitor NCDs and their determinants and evaluate progress at national, regional and global level

In response to this call, ACHAP members, acknowledging their unique dual role of advocacy and service delivery towards improving access to quality health care in general including prevention and control of non-communicable diseases (NCDs), dedicated their 6th Biennial Conference and General Assembly meeting held in Lusaka in February 2013 to discussing the increasing burden of non-communicable diseases in Africa and health systems strengthening towards scaling up FBOs response. FBOS have a unique position that gives them an advantage in provision of health education, advocacy for behavior and lifestyle change, and provision of health services through their large network of health facilities covering both urban and rural areas of the country. The conference created an opportunity for CHAs to take stock of where they were with regard to their contribution to the prevention and control of non-communicable diseases as well as to discuss opportunities for strengthening capacity, partnerships and health systems for quality, accessible, integrated and sustainable health services through the faith based health networks in Africa.

The conference drew attendance from 21 countries from Europe, the U.S and Africa. It was attended by 17 member Christian health associations, including and drug distribution agencies from 15 countries. In total, the conference attracted 93 participants.

The conference was hosted in Lusaka, Zambia by the Churches Health Association of Zambia (CHAZ) in collaboration with ACHAP Secretariat/CHAK and various partners.

CONFERENCE OBJECTIVES

The Conference objectives were:

1. To reflect on the burden of non-communicable diseases in the Africa continent
2. To share information and experiences on efforts to reduce the burden of non-communicable diseases by member CHAs and CHNs in Africa.
3. To identify issues for joint advocacy with and for the CHAs and CHNs in Africa that will lead to improvements in the prevention and management of Non-Communicable Diseases
4. To take stock of lessons learnt from the responses to HIV&AIDS that can be engaged in the response to Non-Communicable diseases.
5. To identify the health systems capacity development needs of CHAs and CHNs that will enable them improve upon their service delivery.
6. To review, identify and initiate continental and international partnerships that will enable ACHAP and its members increase programs that respond to Non-Communicable Diseases.
7. To create opportunity for capacity building, knowledge exchange and sharing of tools in health systems strengthening and public-private-partnerships towards enhancing health service delivery through the faith based health network.

There were three pre-conference workshops held on the February 25th, one was hosted by Novo Nordisk and addressed measures to tackle diabetes in the healthcare system in Sub-Saharan Africa. IMA/Capacity plus sponsored a Human Resource in Health workshop focusing on the impact that non-communicable diseases on the health workforce while the Christian Connections for International Health- CCIH sponsored a Family Planning workshop that discussed developing a contraceptive security strategy within faith based organizations.

UNAIDS hosted a post-conference workshop on the 1st of March which looked at the Global Plan

to eliminate new infections in children and keep mothers alive. The reports of the pre and post conference workshops are available on the ACHAP website.

OUTCOMES OF THE CONFERENCE

It was expected that at the end of the conference and General Assembly, participating members of ACHAP will have**;**

- Increased knowledge and skills on health systems strengthening, non-communicable diseases, RH/FP, HIV and public-private-partnerships from workshops, conference sessions and networking.
- Improved understanding of the status and challenges of non-communicable diseases in Africa .
- Recommendations on strategies for enhancing FBOs contribution to the prevention and management of non-communicable diseases
- Enhanced partnerships for scaling up sustainable FBO health services.
- Consensus on a Commitment to Action statement for scaling up FBO services in addressing non-communicable diseases and an Action Plan for joint advocacy through ACHAP.
- Consensus on a roadmap for ACHAP Institutional strengthening and strategic plan development within the framework of its Constitution.
- Knowledge on the Global Plan for the elimination of mother-to-child transmission of HIV and commitment to action in scaling up FBO services in HIV prevention and treatment.

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4. To take stock of lessons learnt from the responses to HIV&AIDS that can be engaged in the response to Non-Communicable diseases and
5. To disseminate the Global Plan for the Elimination of Mother-to-Child Transmission of HIV (EMTCT)
6. To identify the health systems capacity development needs of CHAs and CHNs that will enable them improve upon their service delivery
7. To review, identify and initiate continental and international partnerships that will enable ACHAP and its members increase programs that respond to Non-Communicable Diseases
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OPENING SESSION

Day TWO: 25th February

The opening session started with devotion conducted by Mr. Gordon Hanna, the CHAZ Board treasurer. Quoting Ephesians Chapter 4 verse 15 which reads “Speaking the truth in love,” Mr. Hanna encouraged the delegates to use the lessons from the conference to make a difference in the lives of those they serve. He said the five words “Speaking the truth in love” can make a tremendous change in lives of the communities. Mr. Hanna said speaking the truth should be at the core of every Christian and that it should flow naturally. He bemoaned the trend in some people who had the great ability to speak but their actions were not backed up by the words they spoke. He said it was a pity that truth had become a rare commodity and gave an example of a court situation where people giving evidence on oath are required to swear to “speak the truth and nothing else but the truth” and yet just after speaking those words everything else that they speak is not the truth. Mr. Hanna asked the delegates to emulate God who gave away his son without expecting anything in return. “For God gives without demanding anything from us,” he said and quoted from a bible verse that states that “For God so loved the world that he gave out his only begotten son…” Mr. Hanna said Christians should always be consistent in “speaking the truth in love” because as human beings there were times when people “spoke the truth but without love and some other times when they spoke in love but without the truth.”

1. KEYNOTE ADDRESS

The key note address on the theme of the conference “***increasing burden of non-communicable diseases (NCDs) in Africa; the challenge of sustainability in scaling up FBOs response***” was delivered by the Zambia country representative of the World Health Organization (WHO), Dr. Olusegun Babaniyi.

Disease burden and trends

In his address Dr. Babaniyi said currently NCDs, mainly cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, represented the leading threat to human health and development. He said the four NCDs mentioned above were the world’s biggest killers, causing an estimated 35 million deaths each year – 60% of all deaths globally – with 80% in low and middle income countries.

Dr. Babaniyi said that WHO had projected that globally, NCDs deaths would increase by 17% by 2010 with the greatest increase expected in Africa (27%) and the Eastern Mediterranean region (25%). He said many NCDs share some behavioural, environmental and genetic risk factors adding that the major risk factors include smoking, obesity, high alcohol consumption, tobacco and insufficient physical activity.

He stated that tobacco was responsible for 6 million deaths annually, physical inactivity accounted for 3.2 million, the harmful use of alcohol was responsible for 2.3 million, high blood pressure 7.5 million, overweight and obese 2.8 million, cancer 2 million with most of the deaths occurring in sub-Saharan Africa.

Socio-economic impact

Dr. Babaniyi said though many NCDs developed slowly, lifestyle changes were taking place with speed and that NCDs had a huge negative economic impact, representing a significant impediment to human development. He said many governments were now overwhelmed and were finding it difficult to cope

with the ever expanding needs for policies, legislation, service delivery and infrastructure that could protect their citizens from NCDs.

He said vulnerable and socially disadvantaged people get sicker and die sooner as a result of NCDs than people of higher social class adding that the costs of chronic care could be catastrophic for patients as well as health systems, driving many millions of households below the poverty line each year. Dr. Babaniyi said health care costs for NCDs create significant strain on household budgets, particularly for low income families.

The burden of NCDs in the African Region

Dr. Babaniyi said studies show that the proportion of the adult population with high blood pressure was as high as 40% in some localities on the African continent. He said high blood pressure was more common in the African region compared to anywhere else in the world and yet nearly 90% of those affected were not aware of their situation because of lack of regular checks.

He said available data shows that 35 million people in Africa had cardiovascular diseases, causing about one million deaths annually while more than 10 million had diabetes in 2010 a figure that is likely to double by 2030. Dr. Babaniyi said people were not checking their sugar levels and only discovered when the disease had reached a stage of complications such as problems of vision, renal insufficiency, disorders of blood circulation in the veins, leading to amputation of the lower limbs.

Dr. Babaniyi said projections indicate that the number of cancer cases may double by 2030, increasing from about 700,000 to 1,600,000 cases annually at a mortality rate of over 80%. He said the commonest cancers in the African region were cancers of the cervix, the breast, the prostate and cancers of infectious origin such as Kaposis sarcoma, liver cancer and bladder cancer.

He said road traffic accidents claimed 235,000 lives each year in the African region accounting for 20% of global deaths although the region has only 2% of registered vehicles in the world. Dr. Babaniyi said current figures for mental health diseases and neurological disorders showed that 1% to 3% of the population was affected, a sign that mental health should be given priority.

Dr. Babaniyi said sickle-cell, linked to hemoglobin anomaly, was a very common genetic disease in several African countries adding that the prevalence of the disease could be up to 40% of the population in certain communities.

Lessons learnt

Dr. Babaniyi said progress made in developing successful ways of managing chronic infections, including community based support, such as tuberculosis and HIV infection indicates that effective response is feasible.

He said much could be learnt from the last decades’ struggle to improve access to HIV treatment and care especially the need to balance treatment and prevention instead of pitting one against the other. Dr. Babaniyi told the delegates that they could also draw lesson from previous UN summits on HIV about the importance of agreeing on priority actions for prevention and care and cited the meeting of the needs of the people with NCDs as a prerequisite to enhancing the impact of prevention policies as an example.

Conclusion

In conclusion, Dr. Babaniyi said the WHO Global Plan provides a clear framework for effectively addressing NCDs such as multi-sectoral approach to NCDs, establishing policies and plans on NCDs, addressing risk factors on NCDs and promoting research for prevention and control of NCDs.

He said the NCDs were high on the global development agenda and this was reflected at the high level meeting of the UN General Assembly on the prevention of NCDs and the adoption of the political declaration.

He pointed out that addressing the high burden of NCDs would require countries to develop relevant policies, plans and strengthen health systems in order to deliver sustainable, coordinated, cost-effective, evidence based, equitable, and integrated essential services.

2. WELCOME REMARKS AND INTRODUCTION OF GUEST OF HONOUR

CHAZ Executive Director, Mrs. Karen Sichinga, as host organizer of the conference welcomed the delegates and the guest of honour, Dr. Joseph Kasonde, the Zambia Minister of Health.

Mrs. Sichinga paid glowing tribute to Dr. Kasonde for accepting to officially open the 6th Biennial Conference stating that the gesture was a clear demonstration of the importance the Zambian government placed on the contribution of the church in the delivery of health services in Zambia.

She described the minister as an all-weather friend of CHAZ who in the mid-1980s signed the first memorandum of understanding between CHAZ (then known as the Churches Medical Association of Zambia) and the Government of the Republic of Zambia.

Mrs. Sichinga informed Dr. Kasonde that the conference had been organized by ACHAP whose member countries are drawn from Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of Congo, Ghana, Kenya, Lesotho, Liberia, Malawi, Mali, Nigeria, Rwanda, Sierra Leone, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

She said the conference had learnt that Zambia had done very well in reproductive health and family planning but was optimistic that the country could perform even much better if the family planning related commodities reached the health centres and appealed to the minister to influence the increase of the budget for this distribution purposes.

Mrs. Sichinga said there was no doubt that NCDs were an emerging problem in Zambia. She said that she was happy that Government was aware of this threat and had introduced NCDs technical working group in 2012 of which CHAZ was a member.

She said the problem of NCDs was not peculiar to Zambia but to other countries as well and that that was why ACHAP had organized the conference to provide a unique chance for the Church Health Associations to share and learn best practices and increase the FBOs response.

Mrs. Sichinga offered to share the resolutions of the conference with the minister and assured him that CHAZ would support the government's initiatives in scaling up the national response to NCDs. She was optimistic that ACHAP members would also do the same in supporting their government policies on NCDs.

Quoting Luke 9:2 which reads thus “He sent them out to preach the Kingdom of God and to heal the sick,” Mrs. Sichinga implored the delegates to facilitate healing to the sick including those suffering from NCDs.

The Guest of Honour

The Guest of Honour was the Minister of Health of the Government of the Republic of Zambia, Dr. Joseph Kasonde and in his speech to officially open the conference, he recommended the Church for their role in service delivery.

Dr. Kasonde welcomed the delegates to Lusaka in particular and Zambia in general and invited them to visit Zambia’s numerous tourist attractions such as the Victoria Falls in Livingstone.

He thanked ACHAP Secretariat based in Nairobi, Kenya for choosing Zambia to be the host country for the conference on NCDs and described its theme titled “increasing burden of NCDs; the challenge of sustainability in scaling up FBOs response” as appropriate and relevant.

Dr. Kasonde said it was important to recognize that Churches have a unique and highly respected place in healthcare systems. He praised the church for the pioneering spirit for the poor and gave an example of now Zambia where the churches were the first to work in rural areas.

He said according to the report of the Commission of Inquiry into the health and medical services of Zambia (then the Federation of Rhodesia) and Malawi (then Nyasaland) presented to the Federal Assembly that in 1958 church health institutions provided 2,310 beds to Africans, with outpatient attendances of nearly 2,000,000. He said this was in contrast to 549 beds available for non-Africans and 3,746 available for Africans, with African outpatient attendants of 5.5 million in all Government institutions.

Dr. Kasonde explained that the church hospitals had 21 resident medical staff and 107 trained nurses.

He commended the church for their devoted and caring attitude which had continued to endear and patients and their relatives saying this was an attribute that Governments wanted to see in all health institutions.

Dr. Kasonde praised CHAZ for the proactive stance the Association had taken in raising awareness of the NCDs in Zambia and working closely with the parliamentary select committee on health in formulating policy on NCDs.

Zambia's Ministry of health, Dr. Kasonde presents during the opening session

3. COUNTRY EXPERIENCES WITH ADDRESSING THE INCREASING BURDEN OF NON-COMMUNICABLE DISEASES; SUCCESSES AND CHALLENGES- UPMB

The Uganda Protestant Medical Bureau gave a presentation on the background of NCD's in Uganda focusing on the NCD control program which was launched in 2007. It was said that Regional referral hospitals have reported an increasing number of diabetes and chronic obstructive pulmonary disease patients in Uganda.

It was said that The Uganda Heart Institute has had a 500% increase in outpatient attendance due to heart related conditions over the past 7 years (2002-2009).

The Uganda Cancer Institute has also reported an upward trend in cancer incidence over the past four years (2005-2009), particularly among HIV infection related cancers.

It was said that the increase in NCDs is attributed to factors such as adoption of unhealthy lifestyles, increasing ageing population, metabolic side effects resulting from lifelong antiretroviral treatment. A brief survey done in 5 out of the 17 UPMB Hospitals to assess compliance with NCD service provision standards showed that on average compliance was 69.9% with the least scoring 47.4% and highest 94.7%

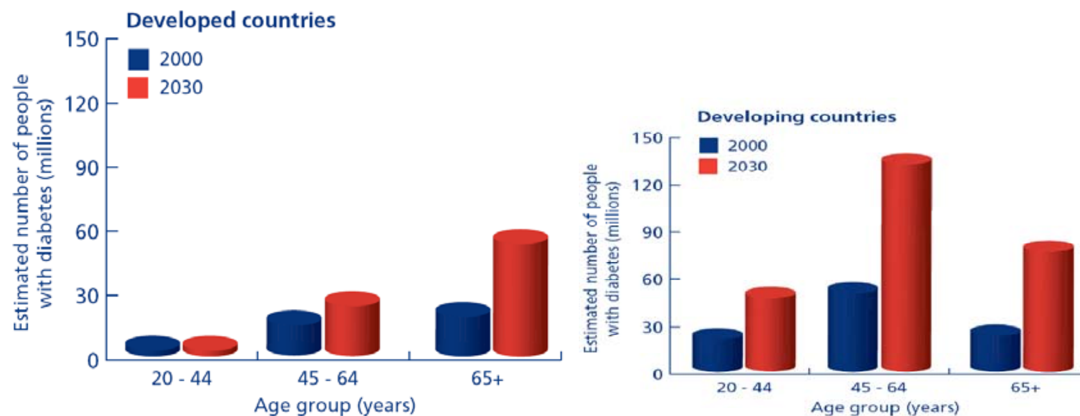
Poor scores were attributed to inadequate capacity to provide Cancer and Chronic Obstructive Pulmonary Disease treatment,

In its recommendations, UPMB called for strengthening health facilities capacities to effectively provide NCD services in terms of adequate staffing, skills building and equipment as well as

prevention programs to include health education to reduce on incidence levels of NCDs in communities.

4. PREVALENCE OF DIABETES IN DEVELOPING COUNTRIES- NOVONORDISK

Novo Nordisk gave a presentation on the prevalence of diabetes in developing countries via the situation in developed countries.



It was said that 7million people were newly diagnosed every year and that while the statistics were alarming, 80% of the cases were preventable. It was said that 50% of people with type 2 diabetes were unaware that they suffered from it.

They also presented on a range of insulin and non-insulin based treatment regimes as well as their advantages and disadvantages.

Reactions

Participants sought to know the history of cancers in Uganda, it was said that due to high prevalence of HIV/AIDS in 2005, mission hospitals saw a significant increase in cases of cancers and the government took the step to address the issue.

Participants also sought to know what role the Catholic Missions Medical Board played in NCD management in Zimbabwe. It was said that their role was to ensure that the clients on cervical cancer lists in health facilities were attended to.

In Kenya, it was said that there is a policy on NCD management as well as a government cancer diagnostic centre.

It was also noted that there was little information flowing regarding NCD's to the general population and a lot of myths flying around and this put the population at a disadvantage.

5. RECOMMENDATIONS FOR COUNTRY EXPERIENCES FOR SUCCESSFUL PARTNERSHIPS

- **Data collection**: Have statistics on service delivery by member health units and push for MOUs as well as advocate with partners and government while armed with data .
- **Accountability**. CHAs must be accountable to all stakeholders to create trust.
- **Sharing values** instead of positions – once values are shared, it is easy to get an understanding towards achieving a common goal.
- **Align strategic plans** to the national strategic framework
- **Autonomy** – CHAs must be autonomous as not to be swayed from their core values and mandates regarding medical service delivery
- **MOUs** should be all encompassing i.e. covering entire service delivery
- **Lobby for reduced prices** of NCD's when engaging medical and pharmaceutical companies.
- **Produce information,** education and communication material based on collected data that carries clear messages on health education and awareness on NCD's, both for prevention and management.
- **Take the lead** in promoting health days as advocacy windows for awareness and prevention of NCD's.
- **Promote referral systems** with member CHA health facilities for complicated cases.
- **Support ACHAP** in lobbying government of respective countries to sign memoranda of understanding between respective country CHA and Ministries of health.
- **Promote creation** of support groups within member health units for survivors of cancers and other NCD's.
- **Support pooling** of resources for acquisition of medical supplies.
- **Encourage standardization** of M&E tools for collection of quality data and documentation of best practices.

6. PANEL ON APPROPRIATE STRUCTURES FOR IMPROVED PRIVATE PUBLIC PARTNERSHIPS AT COUNTRY LEVEL;

MALAWI EXPERIENCE

Malawi; Lessons from Service Level Agreements between CHAM Hospitals and the Ministry of Health in Malawi

The Christian Health Association of Malawi CHAM, which is the second largest health care provider in Malawi and which contributes 37% of health care service delivery in that country gave a presentation on its service level agreement with the government of Malawi.

CHAM has a Memorandum of Understanding (MOU) with the Malawi Government through the Ministry of Health which was signed in 2002.

The MOU covers a number of areas including:

- Government support towards Health workers salaries (100%)

- Secondment of tutors in CHAM training Colleges
- Provision of essential medicines to CHAM health facilities
- Student scholarships for middle level health workers(Nurse Midwife Technicians , clinical Officers, Medical Assistants etc)

The context of the service level agreement is as follows; it is based on a fee for services provided by a CHAM facility, the fees are priced and paid separately and it is done at district level. 75 out of 172 (36%) of CHAM health facilities have SLAs with government through District Health Offices.

Lessons learnt from Service Level Agreements contractual arrangements

(a) **Budget allocation for SLAs affects implementation-** A commitment to service level agreements needs a budget to back it up in order to see real results.

(b) **Policy and implementation guidelines on SLAs -** When launching a programme ensure policy implementation guidelines and procedures are very clear.

(c) **Pricing of services not evidence based;** There was no proper mechanism for reviewing the pricing framework to guide implementation

(d) Performance monitoring mechanisms resulted in delayed renewals of contracts

(e) **Inclusion of Preventive Services:** Health care to be looked at as holistic. Preventive services were not included in SLAs thereby putting pressure on curative services.

7. LESOTHO EXPERIENCE

The Christian Health Association of Lesotho shared its experience with the government of Lesotho under a MoU. CHAL operates with a number of governance structures at different levels of policy and strategy directions as well as the levels of implementation. CHAL's mandate is to facilitate the participation of the Christian Churches in ensuring that the right of all members of the community to the highest quality health services is upheld.

Purchase-partner agreement

Under this agreement, the Government purchases essential services (Essential services package agreed upon) plus certain specialized services stipulated under the letter of Intent. Family Planning services are provided by all member churches, except the catholic run facilities which advocate for Natural Family Planning.

CHAL and GoL through their implementing agencies have to ensure that health care services are delivered within the specified framework and that the below mentioned terms and conditions are met by all parties concerned.

- Essential Service package;
- Standard Equipment List;
- Minimum Staffing requirements;
- Health Facility Typology;
- Essential Medicines List;
- Standard Treatment Guidelines;
- Certification System
- Funding Formula
- Decentralization Framework

8. CHALLENGES TO THE MOU:

- Lack of national legislative and policy framework on PPPs.
- The rigidity of the agreement:
  - Environment and systems changes not provided for.
  - No allowance for the review of standardized user fees
  - The funding formula is fixed
- Lack of clarity of the MoU and the inherent obligations and responsibilities

Way forward

- A need for a national legislative and policy framework on PPPs.
- To strengthen the participation of all the other stakeholders such as Ministry of Finance and the Ministry of Planning etc (apart from CHAL and GoL)

- Improved commitment from all the partners.

- Involvement of PM and Heads of Member Churches in advocacy for efforts.

9. ZIMBABWE EXPERIENCE

The Zimbabwe Association of Church related hospitals (ZACH) has 14 designated district hospitals. In Zimbabwe, mission hospitals cater for 70% of the national population which lives in the rural areas.

The government pays salaries for authorized post only and provides for recurrent expenditure and capital investment in designated hospitals. ZACH signed an MOU with the Ministry of Health and Child Welfare(MOHCW) which has been in operation for 2 years now. In the MoU, ZACH is recognized as a major health partner, ZACH also;

- Is exempted from duty tax.
- Is the Principal Recipient HIV/AIDs, TB /Sub Recipient Malaria- Global Fund.
- Is a major partner in the Vital Health Services Supply II program, in building the capacity of Health workers,
- Contributes to the MOHCW policy development and discussant in Parliament Pre-budget presentation by Minister
- Sits in the Parliament Portfolio Committee in Health
- Seats on a number of Boards –MDPC, HPA, Private Sector Board Health Advisor, etc

Lessons learnt

- PPP works well when systems are strengthened and in a situation where the economy is stable for sustainability.
- PPP helps improves service delivery.
- Needs clearly defined operational parameter which are clearly understood by all concerned
- PPP needs close monitoring by preferably an independent body and if executed well- will generate more funding.

Recommendations for Scale up of NCDs; response by Church Health Service providers

- Set up a permanent dialogue structure with the government with the government before signing of any MoU. In addition, formalized partnerships are always preferable over a gentleman's agreement.

- CHA's maybe seen as "poor partners" by the government and in order to gain credibility, they need to strengthen their evidence collecting mechanisms as well as have proper structures for resource and personnel management.

- Set up evaluation committees made up of representation from both sides so as to ensure that the MoU is well implemented.

- Vertical funding – advocate for integrated funding open for NCDs related illness unlike other emerging diseases such as HIV/AIDS.

- CHA's should create partnerships with community verifiers/advocacy groups which will help them speak with the government.
- Define clear accountability frameworks, this means, clear deadlines, clear performance measuring matrixes, clear financial reporting mechanisms and clear modes of how to get financial support from the government. Also define clear quantity and quality indicators.
- Train health workers to promote demand for training on NCD's, support creation of support groups and counseling groups for cancers for post-clinical survivors.
- Pool the procurement of drugs/medicines for Church Health Institutions to enjoy economies of scale. At the same time, lobby for reduced prices by engaging directly with pharmaceuticals and medical supplies companies.
- Church Health Institutions should prioritize awareness creation by systematically carrying out research and collecting primary data on NCD's. They should use this information in periodically producing Information Education and Communication materials carrying clear messages for alternative lifestyles and health education as well as awareness on NCD prevention and management.
- They shall promote the standardization and sharing of M&E tools for quality data collection and documentation of good practices.
- Public Private Partnership- Church Health Institutions should intentionally pursue partners including government to initiate the signing of memorandums of understanding. The ACHAP secretariat is ready to support with technical expertise and sharing models of partnerships from among its member institutions. In the MoU's CHI's should prioritize resource allocation and awareness raising for prevention, care and treatment for NCDs.
- CHAs shall seek to build an information, consultancy and referral system within their membership for practitioners for the purposes of promoting inter-country idea-sharing for complicated cases.

10. ENGAGING FBO'S IN THE IMPLEMENTATION OF THE GLOBAL PLAN FOR THE ELIMINATION OF MOTHER TO CHILD TRANSMISSION.

(a) Presentation from the UNAIDS Global Plan for EMCT/Ecumenical Advocacy Alliance

UNAIDS presented on the creation of the Global Plan towards elimination of new HIV infections among children by 2015 as well as keeping their mothers alive. The plan aims to help meet global targets of reducing by 90 percent the number of new HIV infections among children by 2015 and reducing AIDS-related maternal deaths by half. The Plan has four prongs: (a) Prevent HIV among women of reproductive age, (b) Prevent unintended pregnancies in women living with HIV,(c) Prevent HIV transmission through antiretroviral treatment during pregnancy and breastfeeding, and, (d)Treatment care and support for mothers living with HIV, their children, partners and their families.

It was said that The Global Plan prioritizes 22 countries.[1] In 2011, these countries accounted for 89 per cent of all HIV-positive pregnant women in low- and middle-income countries. All except India are in sub-

[1] The Global Plan focus countries are : Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, DR Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe

Saharan Africa. Of these countries, South Africa has the greatest number of HIV-positive pregnant women, and Nigeria has the greatest unmet need for antiretroviral treatment and prophylaxis for HIV-positive pregnant women to prevent new HIV infections among children. Indeed, there is a large distribution gap in all low- and middle-income countries in providing antiretroviral medication to HIV-positive pregnant women to prevent new HIV infections among children. The total gap in 2011 was 630,000 women.

Dr Muraguri who presented for UNAIDS recommended four actions to achieve the goal of zero new infections in children:

a. Strengthen efforts to reduce the unmet need for family planning. In particular, it is vital to collect better data on the unmet need among women living with HIV;
b. Increase coverage of prophylaxis during breastfeeding. Statistics show that prophylaxis coverage falls sharply during breastfeeding when compared with coverage during pregnancy, and therefore this increases the risk period for mother-to-child transmission;
c. Ensure that eligible children receive ART; early infant diagnosis remains very low at 35% across 21 countries. It is vital that this increases to improve ART uptake among children;
d. Integrate PMTCT into maternal and child health services. Achieving no new HIV infections in children can only be done in the context of a functioning maternal and child health system, where services are fully integrated and virtually all pregnant women come to antenatal care and deliver in a health care facility. These actions are particularly dependent on a strong sexual and reproductive health program, to enable significant reduction of new HIV infections among women of reproductive age.

(b) Community engagement

UNAIDS also presented on the Community Engagement in activities of the Global Plan. The community engagement strategy hinges on four action points, namely:

(a) Sensitize leaders at all levels to support evidence-informed decision-making.
(b) Hold governments and others accountable through constructive advocacy and partnerships.
(c) Provide leadership and innovation in programme delivery, for example through task shifting and task sharing.
(d) Strengthen the engagement of women living with HIV, men and couples in HIV prevention and treatment programmes for women and children and ensure that programmatic approaches do not unduly burden women or inadvertently exclude children.

(c) Involvement of women living with HIV

UNAIDS also highlighted the work of four civil society representatives who sit on the Global Steering Group of the Global Plan. The organizations are the International Community of Women living with AIDS (ICW), Mothers2mothers, NEPHAK and Caritas Internationalis

Activities have so far included global advocacy for increased engagement of communities, in particular the involvement of women living with HIV, mapping of community engagement in national policy making

and planning, the development of advocacy materials to highlight the role of communities and women living with HIV in the Global plan, research into the experiences of women living with HIV and the development of tools to support community engagement.

Wednesday February 2013

DAY THREE

1. PANEL SESSION; HEALTH SYSTEMS STRENGTHENING FOR INTEGRATED HEALTH SERVICES INCLUDING NON-COMMUNICABLE DISEASES.

(a) Resources for strengthening Human Resource in Health support and development

IMA presented on the tools and resources for strengthening Human Resource in Health development. Among their key areas of focus include:

- Fostering stakeholder leadership groups
- Strengthening FBO & MOH linkages
- Strengthening HRM systems
- Scaling-up pre-service education
- Reforming health professional schools
- Professionalizing supply-chain management

(b) Health workforce tools include:

- Rapid Retention Survey Toolkit (for designing evidence based incentives for HWs)
- iHRIS (Health Workforce Information Software); iHRIS:manage, iHRIS:qualify, iHRIS:plan and iHRIS:retain (piloted in Uganda)
- Pre-Service Education Costing Tool
- HR Management Assessment Tool (piloted with CHAG)

(c) Achievements reported by Christian Health Associations as a result:

- Improved Human Resource Management (HRM) systems at health facility level
- Increased knowledge and articulation of HRH challenges
- Introduction of shared/peer learning cycles for facility based HR teams
- Increased advocacy base for HWs in FBO facilities
- Improved integration of HRM systems with other health system building blocks

- Development of advocacy messages on HRH targeting Church leadership and other stakeholders
- Increased awareness and interest in HRH by CHAs

2. ACCESS TO ESSENTIAL HEALTH COMMODITIES- MEDS

The Mission for Essential Drugs and Supplies- MEDS from Kenya presented on access to essential health commodities. MEDS is a supply chain system that enhances access to good quality healthcare in Kenya and other countries in Africa.

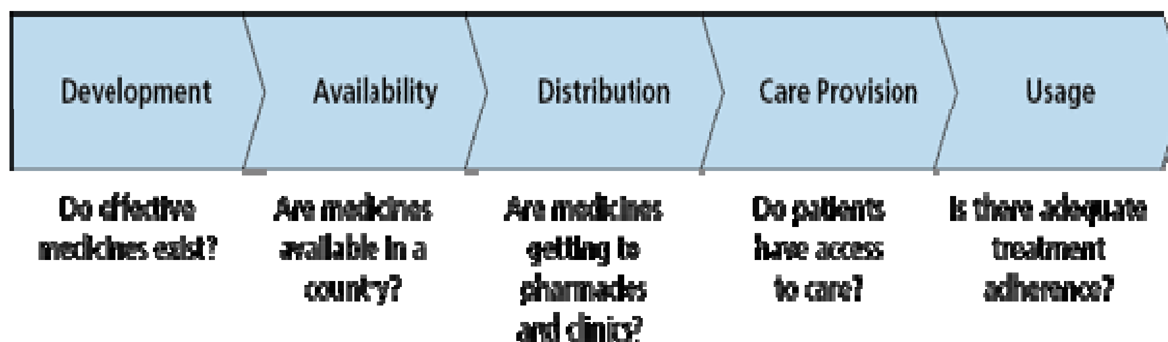
It was said that for access to medicines to be reliable and affordable, three things need to be in place:

1. A reliable ssupply Chain
2. Pharmaceutical Quality Control Laboratory Services
3. Capacity Building of health personnel

In terms of a reliable supply chain, MEDS has a good inventory control that ensures a 99.5% stock availability. It also has adequate buffer stock & well-defined supplier delivery schedule as well as a new 10,000 m^2 warehouse to cater for a large clientele base in other African countries.

In terms of quality control, MEDS has in place a WHO certified lab which checks for counterfeit medicines. It also works closely with the Pharmacy & Poisons Board to identify pharmaceutical products in the market that are not of good quality, they also conduct suppliers and manufacturers audits to ensure that manufacturers adhere to good manufacturing practices an they also help in securing importation and exportation permits.

In terms of capacity building of health personnel, MEDS offers residential courses to members, it also offers facility based interventions, consultancy services, mentorship programmes and exchange visits to other DSOs



3.CANCER CARE; HEALTH, SAFETY, AND ENVIRONMENT- EPN

The Ecumenical Pharmaceutical Network presented on the examples of supportive care offered for chemotherapy patients as well as exposure, risks and preventive measures. They started with a presentation of types of drugs used to treat cancer with a special emphasis on cytotoxic drugs. These

were described as drugs that stopped or interfered with the growth of cancer and other fast growing cells in the body

Adverse Drug Effects to patients include;

- Mucositis
- Hair loss
- Immune suppressive effect
- Nausea and vomiting

Modes of exposure to healthy people include;

- During preparation and administration of the drugs
- Handling of body fluids from patients receiving cytotoxic drugs
- Handling and disposal of cytotoxic wastes and related trace contaminated
- Material and transportation of cytotoxic drugs.

The primary focus of safety during the use of cytotoxic drugs was recommended as follows:

- Control of the working environment
- Safe work practices
- Education and training of personnel
- Detailed, written procedures and safe work practices for all aspects of handling cytotoxic drugs
- Adequate education and training procedures
- Periodic evaluation and validation of the training
- The provision and correct use of protective equipment

Waste management in cancer treatment was discussed as follows:

- Use of properly labelled, sealed, and covered containers, handled only by trained and protected personnel
- Gowns, gloves, aprons etc
- Solid waste should be double bagged
- “Sharps” including contaminated glass vials and plastic syringes should be placed in an impenetrable container specified for the purpose
- Incineration.

4. PARTNERSHIPS FOR EFFECTIVE SERVICE DELIVERY FOR NON-COMMUNICABLE DISEASES- NOVONORDISK.

Novo Nordisk presented on its partnership with FBO’s in Kenya to ensure that its project that provides diabetes treatment to the low income people takes off.

The role of the FBO’s in the supply chain were summarized as follows:

- Ensure that insulin is available and sold at (approx. US$ 6) or Kshs 500 in health facilities.
- Achieve commitment from its membership facilities within the pilot areas
- Ensure that health care professionals participate in educational activities provided by the MoH
- Provide educational material on diabetes to the patients
- Ensure monthly capture and reporting on diabetic related data
- Sensitize Hospital Boards & Health Facility Committees on the purpose of the project and the need to support it.

(a) Lessons learnt from the collaboration with FBO’s:

- To have the right partners on board has been crucial for the success of the project
- After the first pilot phase in two counties, the project is now scaling up to another 14 counties
- Patient health improvements and a reduction in insulin price have been observed in phase I
- Many health care providers have been trained in phase II and feedback from the facilities on training is very positive.

5. LESSONS FROM INTERVENTIONS TO ADDRESS NON-COMMUNICABLE DISEASES.

The IMA Capacity project presented its work on Non-communicable disease initiatives in Tanzania. They presented on how they offered training to health workers in identifying Burkit Lymphoma (BL), a type of cancerous tumor that grows on a child’s jaw, face or abdomen. The training involves diagnosis, case management and laboratory investigations. It was noted that Community and family sensitization were needed to create awareness and promote observance and ensure recovery in patients. So far the IMA supported training had achieved considerable success namely;

- Treating over 4,400 children from 38 health facilities in 12 regions
- Training approximately 2,000 health professionals in Burkitt Lymphoma diagnosis and treatment
- Developing and distributing training manuals, treatment guidelines and outreach materials approved by the Ministry of Health and Social Welfare (MOHSW)

In 2009, IMA facilitated development of the *Burkitt's Lymphoma National Treatment Guidelines* - the first document for cancer diagnosis and case management.

6. LESSONS LEARNT

- Lack of knowledge and awareness of the symptoms and early signs of BL among health professionals and families is still lacking, especially those in rural regions, resulting in delayed treatment due to misdiagnosis or families choosing traditional healers instead of opting to go to a medical facility.
- Inadequate knowledge by health care providers for proper diagnosis and case management.
- Not all health care providers use standardized treatment protocols
- The drugs used to treat BL are expensive and health care facilities need financial subsidies or assistance to purchase them.
- Challenges in maintaining a working referral system for children requiring specialized treatment needs remain.

7. CERVICAL CANCER SCREENING & TREATMENT PROGRAM- IMA

IMA launched a cervical cancer screening and treatment program in August 2011 and upto to January 2013, 3,224 women had been screened for cervical cancer. Patients who had advanced cancer were referral to Bugando Medical Center in Mwanza.

IMA collaborated with the Ministry of Health and Social Welfare to develop Information, Education, and Communication (IEC) materials to raise community awareness in the Mara Region found in the North East of the country about cervical cancer risks and successful treatment results. This was aimed at promoting cervical cancer screenings and early treatment.

Due to the strong relationship between HIV and cervical cancer there is an increased demand for HIV Test Kits as women are screened for both HIV and cervical cancer through the screening program

Challenges

- Competing health needs (i.e. Malaria, HIV) leading to Inadequate resources for cervical cancer prevention activities.
- Few screening sites resulting in a need for rapid scale up
- Lack of recognition and prioritization of cervical cancer treatment by Ministry of Health.
- Long distance for clients to travel for screening services; few available screening health facilities.

Sustainability

- It was recommended to incorporate cervical cancer counseling and screening into daily hospital operations.
- It was recommended that nurses and clinicians from Care and Treatment Center (CTC) and Reproductive and Child Health (RCH) services at both Shirati and Musoma Hospitals be trained on cervical and breast cancer screening procedures.
- Link cervical cancer program with Care and Treatment Center (CTC) services

(a) Community Mobilization lessons from the HIV/AIDS Response

CHAZ presented on their efforts on community mobilization, describing community mobilization as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, making decisions about factors that affect their lives, formulating and Implementing policies, Planning, Developing and delivering services, and taking Action to achieve change.

Benefits of community mobilization efforts include:

- Combating Exclusion and Stigma
- Empowering People
- Mobilizing Resources and Energy
- Developing Holistic and Integrated Approaches
- Achieving better Decisions and more Effective Services
- Ensuring the Ownership and Sustainability of Programmes

CHAZ Community mobilization blue-print

Lessons learnt from community mobilization initiatives:

- Tapping the Community's Potential and Resources helped CHAZ integrate their HIV/AIDS Community Based Interventions in the social fabric of the community.
- Developing community participation and increasing its influence requires facilitating the development of Community and Health Works' infrastructures.
- Community development ensures that local communities are able and willing to respond to the Views, Ideas and Needs expressed by themselves and HIV/AIDS services users.

8. REACTIONS TO PRESENTATIONS

Assumptions made by CHAZ in implementing the community mobilization model:

1. That patients, family and the government would be involved and facilitate the program, that there would be funds available and that there would be an M&E system in place. One set back to the assumption was the lack of funding.

Monitoring and Evaluation: In terms of monitoring and evaluation, CHAZ deploys M & E staff to identify bottlenecks to program implementation; they also review the programs on an annual basis.

Collaboration with religious leaders: In terms of collaboration with religious leaders, CHAZ utilizes partnership network via an MoU that it has with the government to lobby the government for trainings at community level.

Types of insulin available: Novo Nordisk supplies 3 types of insulin available to most countries in Africa actrafid (rapid acting), insulatard (long acting) and mixtrad (premixed combinations of the two). This is in response to the types of diabetes available ie type 1 and type 2 diabetes and also juvenile diabetes.

Malpractices within the medical fraternity: In Zimbabwe there are medical oversight councils where patients can report malpractices. However this is not a standard procedure throughout Africa and countries need to review their own systems and strengthen their oversight structures.

In-kind contribution: It was said that some health centers in poor communities accepted in-kind contribution, like goats and sheep in lieu of hard-cash payment

9. ENGAGING WITH DEVELOPMENT PARTNERS; PROGRAMS AND PARTNERSHIP OPPORTUNITIES

USAID presented on its engagement with FBO's which revolved around four areas of focus:

- Partnership
- Innovation
- Results
- Implementation Reform

Under its grants and cooperative agreements to NGO's, USAID said that it looks at the following organizational structures to determine partnership suitability: Legal Structure and Status, Financial

Management and Internal Controls, Procurement Systems, Human Resource Systems, Project Performance Management and Organizational Sustainability.

Every year, it issues, annual program statements which in essence are opportunities to support creative approaches to development challenges. Some of the current annual program statements include:Family Planning and Reproductive Health Methods (open until 2023)and Microbicide Research and Development (open until 3rd March 2013).

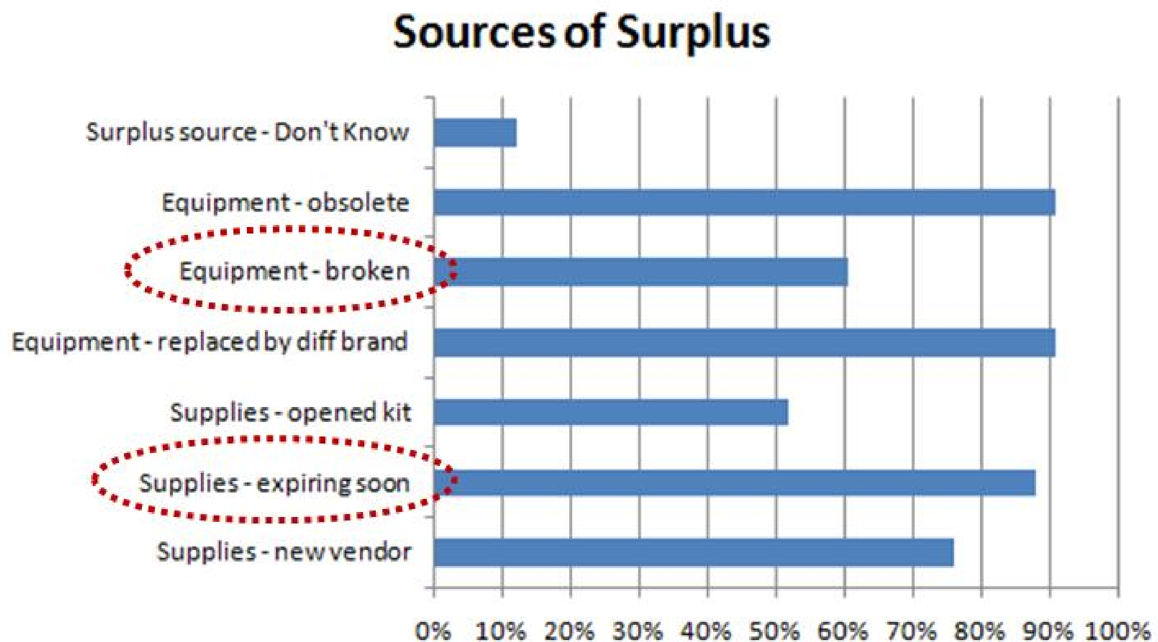
Within Zambia, USAID is running two projects, one on stopping gender-based violence that cost US$ 8.3million and another on protection of orphans and vulnerable children that is supported to the tune of US$ 7million.

The U.S embassy small grants are available on the following websites: **PEPFAR Annual Small Grants Program** http://zambia.usembassy.gov/ and http://zambiausembassy.gov/

10. OPPORTUNITIES FOR MEDICAL SURPLUS RECOVERY ORGANIZATIONS IN THE US; -CRS

Three organizations, the Catholic Relief Services (CRS), the Catholic Health Association of the U.S (CHAUS) and the Partnership for Quality Medical Donations (PQMD) presented on the collaborative and innovative ways that organizations in the west can donate equipment in alignment with the needs of FBO's in Africa and in a way that takes into consideration quality assurance standards.

Gaps in the current donation attempts



It was said that identification of surplus was the most cited improvement opportunity by hospitals.

It was also noted that 9 out of 10 hospitals donate expired supplies and that 6 out of 10 hospitals donate broken equipment and such donations may not be appropriate or useful. Only 8% of hospitals work with a high-quality surplus recovery organization.

11. REFLECTIONS ON SUCCESSFUL PARTNERSHIPS FOR IMPROVED ACCESS TO QUALITY HEALTH CARE SERVICES

Trust between government and CHA

Governments and CHA's are yet to reach a plateau of mutual trust between them especially in terms of financial accountability and disclosing existing partnerships, CHA's felt threatened by revealing their core support base and financial status to the government.

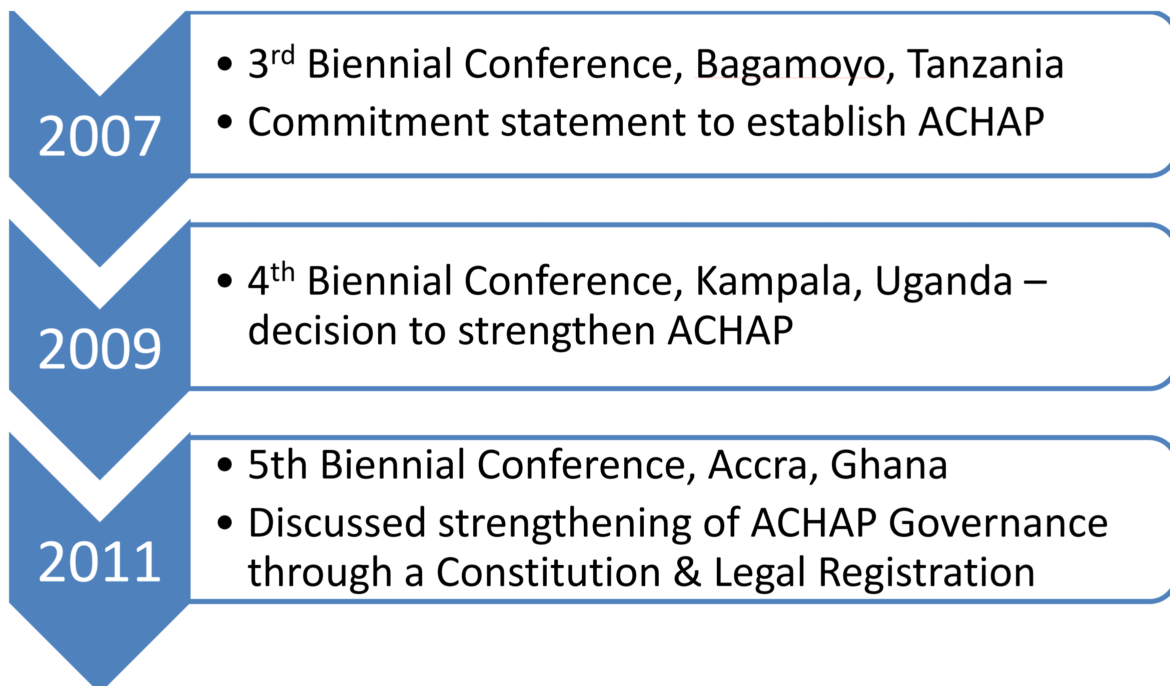
It was suggested that a good way of handling CHA-Government relationships was through having an MOU.

RECOMMENDATIONS

- CHA' s that need copies of MoU's or that need to start off the process of building an MoU should contact the ACHAP secretariat both for material and personnel support. Developing an MoU is a multi-layered process involving multiple levels of stakeholder engagement.
- CHA's need to learn lessons from other countries that have working MOU's. Accountability is a key component on both sides as well as spelling out of obligations.

12. COCKTAIL CELEBRATION OF OFFICIAL REGISTRATION OF ACHAPLATFORM

The journey of ACHAP's registration



A brief history on the birth and formation of the ACHAP secretariat was given. A recap of the events of that led to the registration of ACHAP as an international NGO was presented starting with the taskforce meeting that was held in October 2011 in Mombasa which finalized the ACHAP constitution, to the registration under the NGOs Coordination Act in Kenya on May 4th 2012 as an International NGO and culminating with the election of the new board on February 2013. The core values and objectives of the Platform were re-stated and a toast was given to the new legal entity.

Participants pose for a photo during the cocktail to commemorate the registration of ACHAP

ABT associates who were the sponsors of the cocktail gave a short presentation of their work. ABT associates. ABT associates are a global leader in research and program implementation in the fields of health, social and environmental policy, and international development. They also showcased a metrics based tool that measures the long term capacity and sustainability of an NGO. The tool, they said had been used in key intervention areas with CHAM such as:

- Finance and Business Management Training
- Strategic Planning Workshop and Facilitation with Senior Management
- Governance Workshop and Facilitation with Hospital Boards
- Enterprise Development and Business Planning
- Fundraising and Grant Writing
- Clinical Efficiency using Lean Management and Six Sigma Methodologies

DAY FOUR FEBRUARY 28TH

GENERAL ASSEMBLY

A roll-call was made for members of the ACHAP network and 17 Christian Health Associations were present forming an adequate quorum .

Highlights on the developments from 2011 – 2013 including presentation of the ACHAP Constitution were made by Dr. Samuel Mwenda who is the ACHAP coordinator. Key institutional developments included the consensus of the country of registration by the interim board, review and adoption of the communication strategy and finalization of the constitution. The committee also suggested a staffing structure that includes an Executive Director, a Communications and advocacy officer, a Monitoring and Evaluation Officer and an Accounts person.

The taskforce had suggested terms of reference for various Technical Working Groups building on the lessons from the ACHAP Human Resource in Health Technical Working Group. The following were the recommended Technical Working Groups;

- Maternal & Child Health
- Advocacy & Communication
- Health Financing & Sustainability
- HMIS
- Essential Medical Commodities – to be headed by EPN

FUNDING:

It was noted that funding ACHAP had become a critical challenge as we were no longer receiving funding from traditional ecumenical donors for Secretariat. The administrative & financial support by CHAK was acknowledged and appreciated. The Task Force discussed some budget projections for sustaining the Secretariat .Various financing options were discussed and recommendations made for Interim Board follow-up, strategic partnerships and proposal development were emphasized.

(a) **Membership obligation in funding ACHAP** and supporting ACHAP TWGs and activities was emphasized.

Members reviewed part of the draft ACHAP institutional assessment and strategic plan 2013-2016 with the newly elected board, being mandated to review it further and complete the strategic plan..

Key progress and achievements from 2011 were enumerated with the highlights being the official registration of ACHAP, the human resources for health technical working group and funding from IMA/Capcity*Plus* to support technical assistance in human resources for health to ACHAP member CHAs over the last two years. CHAK continued to provide support towards the operations and running of the Secretariat including support to salaries of the Communications Officer..The Secretariat also reported on a joint family planning project between CHAK and UPMB that whose fundraising was supported by the ACHAP Secretariat by the Packard Foundation (500,000 usd). The ACHAP Coordinator; also reported on various advocacy opportunities that had been supported through various partners such as CCIH, IMA where ACHAP was represented and actively participated in high level engagements and key forums. .

REACTIONS

- Staff transitioning from member CHA secretariats need to orient new staff on the importance of the ACHAPlatform.
- ACHAP needs to be focused on its principal role towards member CHA's, which is that of facilitation and not implementation.
- CHAs need to take responsibility concerning making ACHAP visible in their fields of operation. Advocacy and visibility of ACHAP is mutually beneficial when ACHAP profiles the work of CHA's as well as when CHA's profile the role of ACHAP.
- During the 5th biennial conference in Ghana, Terms of Reference for TWGs were developed, CHA's were asked to familiarize themselves with these TOR's and use them to contribute toward the body of knowledge in the network. CHAs must familiarize themselves with these and also take stock of experiences available within the CHAs in order contribute effectively to the various TWGs.
- CHA's need to look at the entire Health Delivery System other than just NCD's.
- ACHAP needs to update the database of TWG members and their experiences for the sake of experiential and exchange learning among CHAs.

FINANCIAL STATUS

An appeal was made to membership to contribute to fundraising strategies to the secretariat as a way of assisting in resource mobilization.

CHAs were asked to be the first to provide support to their own secretariat through being faithful to pay membership fees, contributing to TWG's, before asking potential partners for support.

There is need to put in place a mechanism of ensuring that CHAs are invoiced in time for them to honor their membership financial commitments.

ACHAP will need to engage in proposal writing as a source for funds mobilization

ACHAP secretariat was asked to ensure that it circulates the financial report to CHAs before the conference so that they can make comments. Members requested for a more detailed financial report on ACHAP's status and it was agreed that this would be shared with all members before June 2013. (This will include in kind support provided by some partners and that had not been reflected in the financial report)

Nominations for new board members were made based on region and then elections were carried out through a secret ballot system for the post of Chair and Vice Chair.

MEMBERSHIP: It was said that members who could not immediately pay the membership fee of US$ 200 would be allowed member status, however if they failed to pay for 2 consecutive years then they would cease to members.

The ACHAP constitution is accessible on the ACHAP website. www.africachap.org . Click on ACHAP constitution. Alternatively click here:
http://www.africachap.org/x5/index.php?option=com_content&task=view&id=40&Itemid=71

BOARD MEMBERS

2 extra board members were elected, these being:

- Rev. Dr. Paul Ngando Mbene (CEPCA)representing Francophone CHA's
- Rev. Baraka Kabudi representing pharmaceutical DSO

The new board as voted by secret ballot was as follows:

- Karen Sichinga (CHAZ)- Chair
- Dr. Samuel Mwenda (CHAK)- V/Chair
- Rose Kumwenda (CHAM)- Member
- Rev. Baraka Kabudi (EPN) – Member
- Dr. Daniel Gobgab (CHAN)- Member
- Paul Ngando (CEPCA) represented at the meeting by Leonard Onana - Member
- Dr. Sam Orach-(UCMB) represented at the meeting by Mr. Peter Asiimwe- member

ACHAP board members from L-R: Michael Mugweru (Ex-Officio member), Baraka Kabudi (member) Karen Sichinga (Chair), Peter Asiimwe (member), Daniel Gobgab(member), Rose Kumwenda (member),Dr. Samuel Mwenda(vice-chair) and Peter Onana(member).

ACKNOWLEDGEMENTS

The ACHAP secretariat would like to extend its heartfelt appreciation to the following partners without whom the conference would not have happened.

- Novo Nordisk
- IMA World Health
- Abt Associates
- UNAIDS
- Catholic Health Association of the U.S.A

- Evidence to Action- E2A
- Nicholas Shaiyen- CHANigeria
- Catholic Relief Services

APPENDICES

- Participants list
- Link to Power point presentations
- Time table

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LINKS TO PRESENTATIONS

Links to all the presentations can be found on the ACHAP website www.africachap.org. Click on ACHAP 2013 Lusaka Conference

CONFERENCE PROGRAM

AFRICA CHRISTIAN HEALTH ASSOCIATIONS (ACHA) PLATFORM – 6TH BIENNIAL CONFERENCE;

FEBRUARY 25 – MARCH 1, 2013; LUSAKA ZAMBIA;

CONFERENCE PROGRAM - Draft

Theme:

Increasing burden of non-communicable diseases in Africa; health systems strengthening towards scaling up FBOs response

Venue – Cresta Golf View Hotel , Location - Lusaka, Zambia

TIME	SESSION TITLE AND DESCRIPTION	PRESENTER/FACILITATOR
	Sunday, February 24th , 2012	
2:00 -6:00pm	**Arrival & Registration at Hotel**	ACHAP Secretariat & CHAZ Representative
Day One	**Monday, February 25th, 2013**	
7:30 – 8:00am	**Late Registration**	ACHAP Secretariat & CHAZ Representative
8:00 am	**Introductions and Welcome** • Introductions and Administrative Issues (15 mins) • Over-view of Pre-Conference Objectives & Agenda (15 mins)	Master of Ceremony Dr Mwenda(ACHAP Secretariat)
8:30am	**Pre-Conference Workshops** Overview of Pre-Conference Workshops Room 1: Tackling Diabetes in the health systems of Sub-Saharan Africa Room 2: ACHAP HRH-TWG; Country experiences in the management of health worker workloads in the light of increasing burden of non-communicable diseases Room 3: Post-conference workshop on Reproductive Health and Family Planning	Master of Ceremony Novo Nordisk IMA / Capacity Plus Project ACHAP/USAID/CCIH/E2A/JSI
9:00am	**Pre-Conference Workshop Sessions**	
10:30am	**Tea Break**	
11:00am	**Pre-Conference Workshop Sessions**	
1:00pm	**Lunch Break**	
2:00pm	**Pre-Conference Workshop Sessions**	

4:00pm	**Tea Break**	
4:30pm – 5:30pm	**Pre-Conference Workshop Sessions**	
5:30 – 6:00pm	**Moderators & Facilitators Meeting**	Dr Mwenda & Mike Mugweru
Day Two	**Tuesday, February 26th, 2013**	
8:00am	**Biennial Conference Welcome Remarks** • Introductions & Administrative Issues (10 mins) • Welcome Remarks (20 mins)	Master of Ceremony Karen Sichinga; CHAZ
8:30am	**Official opening session** **Key note address** • Introduction of Keynote Speakers (5 mins) • Increasing burden of non-communicable diseases; a global perspective by WHO (40 mins)	Master of Ceremony; CHAZ WHO Representative
9:15am	**Official Opening address** • Introduction of Chief Guest (5 mins) • Opening Remarks by Chief Guest (40 mins)	Karen Sichinga; CHAZ Senior Government Representative; Zambia
10:30am	**Group Photo & Tea Break with Chief Guest**	

11:00am	**Panel on Country Experiences with Addressing the Increasing Burden of Non-Communicable Diseases; Successes and Challenges** **Panel Moderator: Introduction of session & panelists (10 mins)** • Ghana Experience (30 mins) • Uganda; UPMB & UCMB Experiences (30 mins) • DR Congo (30 mins)	Ray Martin; CCIH Ghana Representative UPMB/UCMB Represenatives CBCA; Jerome Muvunga
12:40pm	**Question & Answers (20 mins)**	Moderator: Ray Martin; CCIH
1:00pm	**Lunch Break**	
2:00pm	**Panel on: Appropriate Structures for improved PPPs at country level; Experiences from CHA MOUs & Service Level Agreements with Government** **Panel Moderator Dr Nelson Gitonga: Introduction of session & panelists (10mins)** CSSC; Tanzania Experience (15 mins) Malawi Experience (15 mins) Zimbabwe (15 mins) Lesotho Experience (15 mins) **Questions & Answers (20 mins)**	Session Chair Dr Nelson Gitonga; SHOPS Peter Maduki; CSSC Rose Kumwenda; CHAM Vyuwela Chitimbire; ZACH Lebo Mothae; CHALe

		Dr Nelson Gitonga; SHOPS
3:30pm	**Reflections on Successes and Challenges for Church Health Services in the context of increasing burden of non-communicable diseases in Africa** **Recommendations for Scale up of Non-Communicable Diseases response by Church Health Services** **Session Chair (TBD): Instructions on Group Task (5 mins)** (30 mins for group discussions) Room 1: Group 1 (Moderator; Baraka Kabudi; EPN) Room 2: Group 2 (Moderator; Craig Hafner; Capacity Plus Project) Room 3: Group 3 (Moderator; Amy Metzger; CCIH)	Session Chair Dr Nelson Gitonga, SHOPS
3:40pm	**Plenary presentation - Question & Answer Session (20 mins)**	Session Chair; Dr Nelson Gitonga
4:00pm	**Tea Break**	
4:30pm	**Panel session on: Engaging FBOs in the implementation of the Global Plan for the Elimination of Mother-to-Child Transmission of HIV (EMCT)** UNICEF Presentation (20 mins) UNAIDS Presentation (20 mins) EAA Presentation (20 mins) Question & Answers (20 mins)	Session Moderator; Peter; EAA UNICEF Representative Sally Smith; UNAIDS Representative Fr. Bob Vitilo Global Plan Dr Nicholas Muraguri, Global Plan Secretariat
5:50pm	**Closure of Day Two**	Master of Ceremony
	Wednesday, February 27th 2013	

Day Three		
8:00am	Recap & Administrative Issues (10 mins) **Panel Session on; Health Systems Strengthening for integrated health services including Non-Communicable Diseases** **Panel Moderator:** Introduction to session and panelists (10 mins) • Experiences from ACHAP member CHAs, Tools and Resources for strengthening HRH support and development (20 mins) • Access to essential health commodities; MEDS (20 mins) • Pain management and cancer therapy within the EPN network and possible steps forward (20 mins) • Electronic Medical Records System for Hospitals; opportunity for collaboration with CHAs (20 mins)	Master of Ceremony Panel Moderator; Vyuwela Chitimbire; ZACH Doris Mwarey; IMA/CapacityPlus Project Jonathan Kiliko; MEDS Andreas Weigand; EPN Rev Mark Lancaster, Electronic Health Records International
9:30am	**Question & Answers (30 mins)**	Panel Moderator; Vyuwela Chitimbire; ZACH
10:00am	**Tea Break**	
10:45am	**Panel Session on Partnerships for Effective Service Delivery for Non-Communicable Diseases;** **Panel Moderator: Introduction of session & panelists (10 mins)** • Case Study on FBO-MOH-Novo Nordisk-DANIDA partnership for Diabetes management in Kenya (30 mins)	Nick Shaiyen; CHAN-Medipharm

	• IMA World Health; Lessons from interventions to address non-communicable diseases (NCD) (30 mins) • Community mobilization lessons from the HIV/AIDS response (30 mins) CHAZ	CHAK/Novo Nordisk Representatives Erika Pearl; IMA Representative from CHAZ/MOH; Zambia
12:20pm	**Question & Answer Session (30 mins)**	Session Chair; Nick Shaiyen; CHAN – Medipharm
12:50pm	**Lunch Break**	
1:45 pm	**Engaging with Development Partners; panel session for partners to share their programs and partnership opportunities** USAID - Zambia Representative (20 mins) UNAIDS (20 mins) Global Plan on EMCT (20 mins) Question & Answers (15 mins)	Session moderator – Rick Santos; IMA World Health Susan Brems Sally Smith
3:00pm	**Opportunities for Medical Surplus Recovery Organizations (MSROs) in the US linkages with CHAs in Africa for medical equipment and supplies support** **CRS (20 mins)** **Catholic Health Association of USA (20 mins)**	Michele Broemmelsiek, CRS & Bruce Compton, Catholic Health Association of USA

3:40 pm	**Tea Break**	
4:00pm	**Reflections on Successful Partnerships for improved access to quality health care services for non- communicable diseases by FBOs in Africa** **Session Chair : Introduction of topic and instructions on Group Task (5mins)** (25 mins for group discussions) Room 1: Group 1 Moderator; Erika Pearl; IMA Room 2: Group 2 Moderator; Douglas Huber; CCIH Room 3: Group 3 Moderator; Mona Bormet; CCIH	Session Chair; Ndilta Djekadoum; BAC - Tchad
4:30pm	**Plenary Presentations by Group leads (10 mins each)**	Session Chair; Ndilta Djekadoum; BAC- Tchad
5:00pm	Recap, administrative issues and closure of day three	Master of Ceremony
6:30pm	**Special Cocktail: Celebration of the Official Registration of Africa CHAs Platform**	ACHAP &CHAZ; Yorum Siame
Day Four	**Thursday, February 28th 2013 – General Assembly Meeting (CHA representatives)**	
8:00am	Administrative Issues & Introduction of Devotional Speaker (5 mins) Devotion (25 mins) Speaker:	Master of Ceremony CHAZ Representative
8:30 am	Welcome & Remarks by the ACHA Platform interim Board Chairman	Dr Gilbert Buckle; CHAG
9:00am	Issues from the last biennial conference meeting (Ghana, 2009) and Secretariat Report (30 mins)	Dr Samuel Mwenda; CHAK
10:00am	ACHAP Institutional Assessment and Strategic Plan 2013 - 2016 (30 mins)	Charles Gerhardt; ACHAP Consultant
10:30am	**Tea Break**	
11:00am	Membership Issues & other ACHA Constitutional issues (30 mins)	Dr Gilbert Buckle; CHAG

11:30am	Election of Board members (30 mins)	Dr Gilbert Buckle; CHAG
12:00noon	Comments and input to Strategic Plan 2013 - 2016 (30 mins)	Elected Board Chair
12:30pm	AOB & Official Closing Remarks	Elected Board Chair
1:00pm	**Lunch**	
2:00pm	Group Tour of selected sites in Lusaka	CHAZ; Yorum Siame
6:00pm	Return from Tour & evening departures	