



African Christian Health Associations: Joining Forces for Improving Human Resources for Health

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We also wish to thank the members of the Technical Working Group on Human Resources for Health (see Annex) for their insights, feedback and comments on the workings, accomplishments and challenges of the group.

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Abbreviations and Acronyms

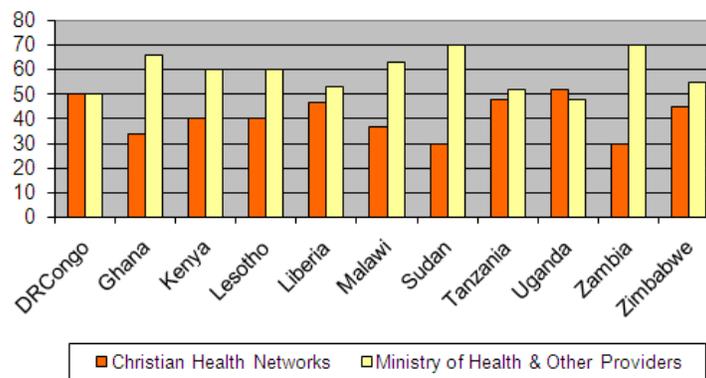
ACHA	Africa Christian Health Association
CHA	Christian Health Association
CHAG	Christian Health Association of Ghana
CHAK	Christian Health Association of Kenya
CHAM	Christian Health Association of Malawi
CHAZ	Christian Health Association of Zambia
CMC	Christian Medical Commission
FBO	Faith-Based Organization
HR	Human Resources
HRH	Human Resources for Health
IMA	IMA World Health
KEC	Kenya Episcopal Conference
PEPFAR	President's Emergency Plan for AIDS Relief
TWG	Technical Working Group
UCMB	Uganda Catholic Medical Bureau
VLDP	Virtual Leadership Development Program
WCC	World Council of Churches
WHO	World Health Organization

Executive Summary

Africa is the second largest continent both in area and population. With 800 million people living in 54 countries, it holds one-seventh of the world's population (BBC World Service, 2009); yet there is only an average of 2.3 health workers per 1,000 people. According to the African Religious Health Assets Program (ARHAP), in sub-Saharan Africa faith-based facilities provide 30%-70% of the region's health care services (2006).

Table I illustrates the contributions of Christian Health Association (CHA) networks in select countries. It should be noted that in statistics and when discussing resource allocation, faith-based health care provision is often grouped with private providers or in the category of private not-for-profit.

Table I. CHA Networks' Contributions in Selected African Countries



Recognizing that the human resources (HR) shortage must be addressed in order to strengthen sub-Saharan Africa's national health sectors, the CHAs sought to mitigate the HR crisis. In 2004, 14 CHAs in Africa organized a Technical Working Group (TWG) on Human Resources for Health (HRH). The goal was twofold; i) to share experiences and build a knowledge base; and ii) to give a voice through advocacy to the crucial role faith-based health networks play in national health sectors on the African continent.

In February 2006, the Capacity Project and the World Council of Churches hosted a mini-forum in Nairobi to develop a framework and terms of reference (known as the Nairobi Declaration), outline objectives and define ways of collaborating among members of the CHA TWG on HRH. At the General Assembly of the Africa CHAs' 4th Biennial Conference, held in February 2009, participants decided to integrate the TWG on HRH and its work into the larger CHA group, now called the Africa Christian Health Association (ACHA) Platform based at the Christian Health Association of Kenya (CHAK). In March 2009, IMA began the process of transitioning the secretariat functions to CHAK. Although focused on the overall status of the CHAs, the ACHA Platform has the ability to provide greater networking and communication among CHAs and other HR organizations.

By forming the TWG, African CHAs gained an extensive network of organizations with similar historical backgrounds and current concerns. In addition, the TWG has improved the collection of and access to faith-based organizations' reports and documents. Together member organizations are moving forward in developing recruitment and retention strategies by learning from one another, and advocating with one voice to governments, donors and stakeholders.

Introduction

Recognizing that part of strengthening the national health sectors of sub-Saharan Africa required a response to the human resources for health (HRH) crisis, the Christian Health Associations (CHAs) decided to act. In 2004, 14 African CHAs organized a Technical Working Group on HRH. The goal was twofold; i) to share experiences and build a knowledge base; and ii) to give a voice through advocacy to the crucial role faith-based health networks play in national health sectors on the African continent.

History of the CHAs' International Collaboration

Member facilities of the African CHAs have a long history of providing health care in their countries, often dating back to colonial times. For over a hundred years, medical work was one of the main focuses for North American and European church missionaries. In 1968, the World Council of Churches (WCC) established the Christian Medical Commission (CMC) following several WCC studies showing that church health facilities had little impact and made limited sustainable improvements on the health of the populations they were serving. The WCC found that “95% of church-related work was curative and at least half of the hospital admissions were for easily preventable health conditions” (Listosis, 2004). The WCC concluded that organizations needed to focus more on prevention and behavior change work at the community level, and established the CMC to oversee this expansion of services.

The WCC charged the CMC “to enhance the quest for Christian understanding of holistic health” by promoting innovative approaches to health care and experience-sharing by networking within and between countries (Kaseje, 2006). The CMC was one of the pioneers of what is now known universally as community-based primary health care¹. During the 1970s and 1980s, as the focus of mission activity changed, North American and European churches turned over the management of African hospitals, health centers and dispensaries to national church bodies, leading to the creation of umbrella organizations called CHAs. Although CHAs continued to participate in CMC meetings and discussions, increasingly they came together more informally as a group at various international fora and venues such as WCC meetings and the Decade for Women conferences to discuss common challenges, issues, strategies and solutions. Today, CHAs provide 30%-70% of health care in their countries; therefore, they are critical for sustaining the national health sectors of their nations (ARHAP, 2006).

Creating the Technical Working Group

Since 2000, many CHAs have become increasingly concerned that there are not enough qualified professional health staff at all levels of health provision. CHAs' member facilities face out-migration of health workers, either from the faith-based organization (FBO) health care facilities to public or private facilities within the country, or to better opportunities abroad. With the increase in major donor funding and forgiveness of national debts, governments now have additional resources to change the personnel incentive packages in the public sector. FBO facilities cannot match these incentive packages because their traditional partners have changed their focus and no longer provide the level of financial and personnel (missionary) support as in the past. Therefore, the CHAs have been working to develop and implement alternative retention strategies to minimize out-migration.

¹ See the reports in the Christian Medical Commission journal, *Contact*.

Several CHAs initiated discussions on HR-related issues for several years on a bilateral basis. During the 2004 CHA meeting hosted by the CHA of Malawi (CHAM), the extent and similarity of the HR crisis facing all CHAs became apparent. The groups passed a resolution to form a Technical Working Group (TWG) on HRH. All CHAs face similar HR issues, such as staff recruitment, retention, out-migration to public facilities and strategies for dialogue and negotiated service agreements with their respective governments. By sharing and working together on common issues, the once informal networks learned from each other's experiences and sought tools and approaches to address the HRH crisis more meaningfully.

2004 marked the first time that CHAs joined in solidarity to confront the HRH challenge. The CHAs felt that the TWG could become a forum for the faith-based health care community and provide a platform to share issues, knowledge and successful models for solving problems. The working group assists its members by addressing their organizational HRH issues more effectively and creatively, and by discussing experiences and solutions across the wide geographic spectrum of CHAs. In addition, the TWG enhances the visibility of FBOs and enlarges their shared voice on HR issues within the national and international arenas.

The Africa Christian Health Association (ACHA) held the HRH Mini-Forum in Nairobi in March 2006, sponsored by the Capacity Project and Medicus Mundi (Capacity Project, 2006). The Mini-Forum created a framework, outlined objectives, developed collaboration activities and defined the responsibilities of each member. The CHAs approved the results of the forum and signed into existence the document known as the Nairobi Declaration. The framework also served as a call to action to address HRH issues within the faith-based context. The TWG formally launched in Zambia on World Health Day (April 7, 2006), organized by WHO and the WCC.

TWG Objectives and Activities

The TWG on HRH has four main *objectives*:

1. Strengthen partnerships and relationships among the CHAs, the respective governments and other partners
2. Increase retention of health personnel for facilities within the CHA networks
3. Advance human resource management systems of CHA secretariats and their institutions
4. Improve human resources financing, training opportunities and practices.

Broadly, TWG *strategies* and *activities* are as follows:

- Advisory work—The TWG will function as an expert group to analyze how CHA networks are confronting HRH issues and advise individual CHAs
- Knowledge-sharing—Serve as a clearing house for sharing information and experience about CHAs' HRH practices
- Advocacy—Advocate both nationally and internationally for policies and resources to support the CHA networks' ability to improve health services.

It is envisioned that the TWG will enable the CHAs to lift a unified voice, raising awareness nationally and internationally about the role FBOs play in the national health sector, how health care is affected by the HR issues faced by FBOs and that both public and faith-based facilities need to be supported in order to strengthen the national health sector of any African country.

Running the TWG

Membership

The 14 signatory organizations of the Nairobi Declaration are the CHAs of Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria and Sudan as well as the Churches Association of Zambia, the Christian Social Services Commission (Tanzania), the Churches Forum on HIV/AIDS (Swaziland), the Kenya Episcopal Conference—Catholic Secretariat, the Protestant Church of Congo (Democratic Republic of Congo), the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau. Each organization serves an umbrella capacity, representing a cross-section of faith-based health facilities in their respective countries.

Currently, the TWG membership is predominately made up of organizations based in the English-speaking African countries. The sole exception is the Protestant Church of Congo². The stated aim is to embrace the French and Portuguese-speaking CHAs through dialogue and engagement, although linguistic constraints continue to hinder this expansion.

Functioning

The member organizations each agreed to appoint a focal person from within their structure who would liaise with the TWG. By agreement, this person devotes 10% of his/her time to TWG activities.

However, in many cases the leadership of the member CHA continues to liaise with the TWG directly and has not designated a focal person for the organization. In other cases, individuals are asked to participate on an *ad hoc* basis (with little expectation of level of effort), which affects continuity and consistency. The reason for this is not a lack of commitment on the part of the associations; rather, it is that many of the CHAs face longstanding staffing constraints. As a result, almost all personnel fulfill multiple roles within the organization. Regularly, staff must set priorities and are forced to abandon activities or projects as more urgent matters take precedence. This has often been the case for TWG-related activities as these tend to be perceived as more flexible and less time- and finance-bound. However, this in turn created additional challenges to the smooth functioning of the TWG. For example, regular participation in longstanding planned teleconferences is difficult to arrange, as is receiving feedback in a timely manner.

Secretariat

The TWG secretariat was temporarily hosted at IMA, as it was able to provide staffing and technical assistance. The members decided that the secretariat should rotate every two years among the participating CHAs. The first rotation will occur in July 2009, when the secretariat will transition to CHAK. At the 2007 CHA meeting in Tanzania, participants agreed that a secretariat based in Africa will facilitate smoother networking and communication among the CHAs and associated organizations (Christian Social Services Commission, 2007).

The secretariat performs a number of essential tasks. It coordinates meetings, teleconferences and sharing of information, and assists members with specific requests to circulate essential notices and data. In addition, the secretariat acts as a clearinghouse for sharing HR documents through a portal on the IMA website. The publication and dissemination of the monthly e-mail newsletter *Hotline HRH* provides essential information on workshops, seminars, meetings and articles that may be of interest to the membership.

² This organization has a historical link to IMA, and has English-speaking leadership.

Communication

Early in the development of the TWG, members and organizers understood that TWG meetings would take place annually, concurrently with other workshops or conferences, attended by a large plurality of TWG members. These meetings have proven essential to keep the members engaged in the TWG. The TWG members lack the resources, without outside funding, to organize HRH-specific meetings. This makes it difficult to organize face-to-face training and learning events for members; however, a few hours can, with good planning, be set aside within the framework of other meetings to gather the TWG for important discussions.

Predominantly, we communicate through electronic means because of the difference in location and time zones between North America and Africa. In addition, the members of the TWG felt it was important to plan quarterly teleconferences. However, these have been difficult to organize and implement as they are potentially costly for organizations with limited resources. In April 2008 the TWG decided to try other methods of communication, such as Skype, that might be less costly.

Funding

The Capacity Project provided the financial assistance to initiate the TWG. In addition, Cordaid, Medicus Mundi and the Capacity Project have assisted with the organization of CHA-wide conferences in Kenya (2006), Tanzania (2007) and Uganda (2009).

Currently, the TWG relies on funding from the Capacity Project that will end in June 2009. The network's future funding is far from secure, and discussions are underway with a number of potential funding sources. However, donors can be wary of working groups and loosely-established networks whose benefits or results are only apparent after many years of intense labor.

As one of its top priorities, the TWG needs to develop a strategy for ensuring sustainable funding. Resource mobilization should include funding for CHA networking activities, internally and externally, such as participation in international conferences, meetings and multinational policy strategy sessions.

TWG Achievements

The TWG's main targeted objectives are to increase health worker retention, advance HR management systems and improve HR financing and training. The TWG also seeks to strengthen partnerships between CHAs and their respective governments as well as other essential stakeholders.

What has the TWG achieved so far? To answer this question, IMA developed a survey to gauge members' perceptions of the group's strengths and weaknesses, their understanding of the TWG's challenges and achievements and what benefits have accrued to members as a result of this collaboration. The survey was sent to 14 members and nine responded in the spring of 2008³.

The feedback was largely concerned with the activities undertaken by the TWG. The following table includes a sampling of the CHAs' replies. The TWG is generally perceived as a positive

³ Survey respondents are the CHAs of Kenya, Lesotho, Ghana, Malawi, Zambia, the Kenya Episcopal Conference—Catholic Secretariat, Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau and Protestant Church of Congo.

step toward greater exchange of information and experiences among CHAs. Members of the TWG feel that they have become better informed on HR issues and options for addressing them, through networking and information-sharing. Members expressed a greater realization that they all face similar problems with respect to HR and that joining forces in solidarity makes perfect sense.

Table 2. Sample Survey Results on TWG Activities

	Yes	No	Don't know
Participated in TWG activities	8	1	-
Received useful information through the TWG	9	-	-
TWG contributed to collaboration among CHAs and exchange of lessons learned, documentation, etc.	6	1	2
TWG is fulfilling its objectives	5	1	3

The next sections will summarize members' detailed responses as to the key achievements of the three main activities of the TWG: advisory services, knowledge-sharing and advocacy.

Advisory Services

The TWG has promoted exchanges among members on specific issues either by e-mail or by exchange visits on specific topics. Some exchange visits were then organized by the associations themselves and not the TWG. CHAK had the opportunity to share its use of information and communication technology in enhancing communication and motivation of health workers with the CHAs of Zambia (CHAZ) and Ghana (CHAG). In addition, the CHAK health management information system officer traveled to CHAG to participate in an HR information systems assessment. Another achievement in this area was CHAM's request to TWG members for feedback on its proposed survey of the top-up allowances in its facilities; the survey was amended and improved accordingly.

Encouraged by the TWG's collaborative spirit, HR staff from member CHAs shared their experiences through exchange visits between CHAM, CHAZ, CHAK and the CHA of Liberia. In 2007 a team from CHAK visited its counterparts in Uganda, Tanzania, Ghana, Malawi and Zambia—a remarkable example of cross-country collaboration in a learning exchange that would not have taken place without impetus from the TWG. These visits were specifically designed to create awareness and gather tools on FBO health systems strengthening through formal contractual relationships with host governments, as HR management and retention strategies. In addition, CHAM visited CHAK to gather information on strategies and implementation methodologies utilized by the Kenyan network to interact successfully with government, donors and other partners.

In Uganda, the TWG inspired increased in-country collaboration whereby the Catholic and Protestant medical bureaus made a strategic decision to harmonize their HR information systems. This includes sharing and streamlining formats, tools and guidelines, with the ultimate goal of collecting identical and easily-shared data from their respective health facilities. This demonstrates a remarkable step forward in reducing competitiveness and emphasizing the value of collaboration at the national level.

Knowledge-Sharing

The TWG has worked to increase skills and knowledge relating to HR issues within the faith-based community. Prior to its formation, many health development professionals perceived that FBOs accomplished little in the health sector, based on the absence of collected data or

published information. In order to address this misconception, the TWG secretariat collected, organized and made available FBO-related reports and documents concerning HRH via the clearinghouse portal on the IMA website.

This clearinghouse has successfully provided access to documents that organizations may not have known about. These documents provide an array of information and lessons learned, including practical tools such as forms and procedures for drafting CHA constitutions, memoranda of understanding, service agreements, ministerial contracts and many others. The *Hotline HRH* is distributed to about 200 subscribers throughout the CHA community as well as to partners, donor agencies and stakeholders⁴.

In 2008, the Capacity Project recruited and seconded an HR professional to CHAK and KEC to develop HR policies and strategies for both organizations. As a result, technical staff are now adapting detailed HR manuals for local use by CHAK and KEC members. In addition, these manuals and policy strategies completed by the HR professional were shared with other CHAs.

The Virtual Leadership Development Program (VLDP) on HR management, established by Management Sciences for Health with support from the Capacity Project, launched in 2006. The VLDP linked Capacity Project-supported programs or recipients, such as CHAG, with an increased knowledge base. Philibert Kankye, executive director for CHAG, was pleased that the 16-week online course enabled CHAG to “develop [a] team focus on our HRH issues and [...] an action plan to address our HRH information system.” The success of this course paved the way for more online training in other member countries. For example, in 2008, the Uganda Catholic Medical Bureau (UCMB) personnel and tutors from affiliated nursing training schools participated in online family planning training.

Advocacy

CHAs now have improved access to one another’s methods for gaining support from their governments, such as memoranda of understanding with service providers and governments. This strengthens their strategic position in advocacy around HRH as well as health services delivery. Isaac Mpoza, HR management advisor for UCMB, remarked, “We have used the lessons learnt from Zambia and Tanzania CHAs and how they managed to get support from their governments as precedence for us to advocate for support from our own government.”

The TWG is working toward a unified voice on HR issues and increased international visibility of the work of FBOs. It has advocated the position that for the purposes of health service delivery definition, FBOs are a separate sector and should not be included with private or private not-for-profit operators, which happened in Uganda with the Kampala Declaration of the Global Forum on HRH in 2008. Unfortunately, this categorization misconception was supported by WHO’s Global Health Workforce Alliance (GHWA) office. The TWG wrote a letter to GHWA in August 2008 addressing the misconception that was created by including FBOs within the private sector. To its credit, GHWA responded and agreed that in the future it would distinguish FBOs from the private sector. In addition, the GHWA provided substantial funding support for the ACHA biannual meeting held in Kampala, Uganda in February 2009.

The TWG secretariat has the capacity to respond quickly to calls for input for advocacy campaigns, as it has collected extensive information about its members. Recently, when the

⁴ As of September 2008 there were approximately 200 individuals representing numerous FBOs, development partners and donors receiving the *Hotline HRH*.

HWAI Network⁵ needed information on existing health professional training capacity in Africa for its advocacy concerning the PEPFAR reauthorization bill, the secretariat was able to provide valuable and timely information.

TWG members who are invited to international conferences increasingly voice the needs of other FBOs as their awareness of the commonality of their problems and the importance of joining forces has grown. This is a major achievement that speaks eloquently to the value of collaboration and communication. At the Capacity Project-sponsored HRH Action Workshop held in Accra, Ghana in 2007, six FBO representatives made significant contributions to the discussions and held an *ad hoc* meeting on lessons learned. Once again, the TWG provided the spark toward greater cooperation and solidarity.

Some members expressed the need to further strengthen advocacy efforts. “I am yet to acknowledge the visibility of [the] TWG on the advocacy aspect of its function,” said a representative of CHAG. This is a fine example of the expectations raised by many within the TWG—it is not enough to collaborate and cooperate with one another; there must also be a clear set of achievable priorities and objectives.

The TWG needs to implement a strategy for intentional outreach to other CHAs to expand its membership and network. Across sub-Saharan Africa many of the CHAs face similar challenges, and it makes sense to utilize solutions from other CHAs. Through membership in the TWG, a health association gains access to hundreds of foundational documents and other resources that were expensive and time-consuming when first created.

Follow-Up

Following the completion of the previously cited chapter (Adjei et al., 2009) for Cordaid, ACHA held a General Assembly meeting in Kampala, Uganda in February 2009. At this meeting, participants decided to fold the TWG and its work into the larger CHA group. This will allow for integration of the TWG’s work with the larger ACHA Platform, thereby streamlining communication, networking and resource mobilization and utilization.

Conclusion

By forming the TWG, African CHAs gained an extensive network of organizations with similar historical backgrounds and current concerns. In addition, the TWG has improved the collection of and access to FBO reports and documents. Together member organizations are moving forward in developing recruitment and retention strategies by learning from one another, and advocating with one voice to governments, donors and stakeholders. CHAs share lessons learned on the enabling environment for HRH, and HRH policies are put forward with greater clarity. In addition, the membership strives to speak with a unified voice in the international arena on how HR issues have financial and nonfinancial implications for FBOs, what this implies for service delivery and what additional support is needed. The future of the TWG depends almost entirely on its ability to develop more efficient and effective ways of networking, communicating and coordinating.

⁵ E-mail listserv of the Health Workforce Advocacy Initiative, which is the civil society-led network of the Global Health Workforce Alliance.

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Annex A: Technical Working Group Participants

Signatories of the 2006 “Nairobi Declaration” (Nairobi, Kenya)

1. Christian Health Association of Ghana
2. Christian Health Association of Kenya
3. Christian Health Association of Lesotho
4. Christian Health Association of Malawi
5. Christian Health Association of Sudan
6. Christian Social Services Commission, Tanzania
7. Churches Health Association of Zambia
8. Kenya Episcopal Conference
9. Uganda Catholic Medical Bureau
10. Uganda Protestant Medical Bureau

Participants in the 2007 HRH Meeting (Bagamoyo, Tanzania)

1. Christian Health Association of Ghana
2. Christian Health Association of Kenya
3. Christian Health Association of Malawi
4. Christian Health Association of Nigeria
5. Christian Health Association of Sudan
6. Christian Social Services Commission, Tanzania
7. Churches Health Association of Zambia
8. IMA World Health
9. Kenya Episcopal Conference
10. Maua Methodist Hospital
11. PC (USA)
12. Protestant Church of Congo
13. Uganda Catholic Medical Bureau

CHA Participants in the 2009 TWG Meeting (Kampala, Uganda)

1. Christian Health Association of Ghana
Philibert Kankye
2. Christian Health Association of Kenya
Samuel Mwenda
Mike Mugweru
3. Christian Health Association of Lesotho
Rosinah Lebina
4. Christian Health Association of Liberia
Jenkins Jorgbor
5. Christian Health Association of Malawi
Francis Gondwe
Potiphar Kumzinda
6. Christian Health Association of Sudan
Joy Mukaire

7. Christian Social Services Commission, Tanzania
Godwin Ndamugoba
8. Churches Forum on HIV/AIDS, Swaziland
Hlobisile Nxumalo
9. Churches Health Association of Zambia
Stenford Zulu
10. Kenya Episcopal Conference
Robert Ayisi
11. Protestant Church of Congo
Jacques Katele
12. Uganda Catholic Medical Bureau
Sam Orach
Isaac Mpoza Kagimu
13. Uganda Protestant Medical Bureau
Lorna Muhirwe
Henry Katamba

Others at 2009 TWG Meeting

1. Baptist Community Center for Africa (Democratic Republic of Congo)
Olivier Musongya
2. Christian Assembly of Chad
Ndilta Djekadoum
3. Cordaid (The Netherlands)
Johan van Rixtel
Jose Utrera
4. Difaem (Germany)
Albert Petersen
5. Global Health Workforce Alliance
Dr. Sandra Kiapi (Uganda)
6. ICCO (The Netherlands)
Wilma Rozenga
7. IMA World Health
Erika Pearl
Sarla Chand
Craig Hafner
8. International Aid
Milton Amuyan
9. Medicus Mundi International (The Netherlands)/Miserior (Germany)
Nina Urwanzoff
10. PC (USA)
Frank Dimmock

The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

The Capacity Project Partnership



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