

CHRISTIAN HEALTH ASSOCIATION OF GHANA

Programme of Work

2008 – 2012



Dated October 2007

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Background Information

The Christian Health Association of Ghana (CHAG) is an umbrella organization that coordinates the activities of sixteen (16) Christian Health Institutions and Health Programmes in Ghana that broadly fall under the Ghana Catholic Bishops Conference, the Christian Council of Ghana and the Ghana Pentecostal Council, It is a body through which all or most of the Christian Church related health facilities/programmes liaise with the Ministry of Health to ensure proper collaboration and complementation of government efforts at providing for the health needs of Ghanaians.

The Goal of CHAG is to improve the health status of people living in Ghana, especially the marginalized and the poorest of the poor, in fulfilment of Christ healing ministry.

CHAG's membership grew from 25 health institutions in 1967 to 160 institutions in 2006. These institutions are made up of 60 hospitals, 83 primary health care bodies and 8 health manpower-training centres in the country.

CHAG's member institutions located strategically with the aim of reaching the marginalized and poorest of the poor who are predominantly located in the rural area. A few can now be found in some of the big cities serving the health needs of the poor and vulnerable populations in the slums that have been created by urbanization.

1. Organizational Structure & Functions

The organizational structure of CHAG as spelt out in the constitution comprises:

- The Trustees/Owners
- The Council
- The Board
- Steering Committee
- Other Sub-Committees and
- Office of the Executive Secretary

The Trustees or legal owners of CHAG are the Christian Council of Ghana and the Ghana Catholic Bishops Conference. The Council is the highest governing body and is made up of representatives of the churches and institutions that make up the association. The Council is responsible for top appointments at the secretariat, major disciplinary issues and financial investment policies. It meets once a year.

The Board is the Executive arm of the Council with a composition similar to the Council but is smaller. The Board formulates policy including technical policy for approval by the Council and monitors the implementation of policies by the Secretariat and members. It meets three times a year.

The Steering Committee is a sub-committee of the CHAG Board created to take urgent decisions. Other sub-committees of the CHAG board are those of Finance, Development, Public Relations, and the Advocacy sub-committee (the latter is not in CHAG's constitution).

There is a CHAG Secretariat based in Accra, the national capital and comprises the Executive Secretary who is the leader, five other senior managers and other supporting staff. The office of the Executive Secretary is subordinate to the CHAG board and is responsible for the day to day running of the affairs of the Association.

2. Organisational Presence of CHAG

The organizational presence of CHAG can be categorized into three groups, namely, the Secretariat (which serves as the executive arm of CHAG), the Church (represented by the Church Health Coordinating Units and the Member Institutions). The major roles of CHAG include:

- *Advocacy*
- *Co-ordination*
- *A link (Between the Mission Health Services and Government)*
- *Provides (Operational) support to the Health Institutions*
- *Translation of Government policies to Churches and their respective Health Institutions*
- *Lobbying for resources*

Additional Roles include

- *Development of partnerships (Internal and External)*
- *Networking and Public Relations*
- *Monitoring and Evaluation (Peer and Participatory Health Appraisal and Action)*
- *Networking*
- *Supervision and monitoring and*
- *Information Management*
- *Human Resource Development*

3. Introduction

The Health Sector of Ghana led by the Ministry of Health and its Agencies in 2006 develop a programme of that gives direction to a paradigm shift in the National Health Policy. A five year Programme of Work (POW) spanning the years 2007-2011 to guide the health sector was therefore developed to guide all players in the health sector in playing their roles well to help the help the ministry in delivering on its mandate.

The “new paradigm shift” places healthy lifestyles within the context of the physical and social environments where people live, school and work emphasising potable water, sanitation, and safe food, housing and roads, as a means to promote good health and prevent diseases and injury. It lays emphasis on the promotion of healthy lifestyles such as good nutrition, regular exercises, recreation and personal hygiene.

The Christian Health Association of Ghana CHAG in line her policy of complementing the efforts of the Ministry by operating within the policies and framework of the Ministry of Health in providing for the health needs of people living in Ghana has drawn from these policies and priorities to provide the forgoing POW for fostering her collaboration with the Ministry.

Other key documents that influence the direction of this strategic plan include:

- the Ghana Poverty Reduction Strategy (GPRS II)
- the Millennium Development Goals
- Global Health Partnerships, the NEPAD health strategy, the African Union (AU) health strategy and the Ghana Macroeconomics and Health Initiative.

CHAG Strategies for the next five years take root and are aligned to all these documents.

4. The Health Sector Vision, Mission, Objectives and Priorities

5.1 The National Vision for Health

Create wealth through health and contribute to the national vision of attaining middle income status by 2015.

5.2The Ministry of Health’s Mission Statement

“The mission is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry.”

5.3 Strategic Objectives of MOH 5YrPOW:

1. Promoting an **individual lifestyle and behavioural model** for improving health and vitality by addressing risk factors and by **strengthening multi-sectoral advocacy and actions**
2. Rapid **scaling up** within the existing capacity, **high impact interventions** and services **targeting the poor, disadvantaged** and vulnerable groups
3. Investing in **strengthening health system capacity** to sustain high coverage and expand access to quality of health services
4. Promoting **governance, partnership** and sustainable financing

5.4 Priorities for the health sector:

- Ensuring **healthier mothers and children** through scaling up implementation of high impact and rapid delivery health interventions
- Promoting **good nutrition** across the life span, **food security** and **food safety**
- Combating **communicable diseases** such as HIV/AIDS, Malaria, Tuberculosis, epidemic prone diseases and diseases that almost exclusively affect the poor etc
- Effectively **collaborating with** relevant MDAs and stakeholders to improve **housing, personal hygiene, environmental sanitation and access to potable water**
- **Reducing risk factors associated with non communicable diseases** such as tobacco and alcohol use, lack of exercise, poor eating habits, unsafe driving and stress
- Strengthening **clinical management** of diseases as well as prevention and management of blindness and promotion of mental health
- Strengthening **surveillance and response to epidemics and emergencies**
- Strengthening the **regulatory framework** within the health sector
- Forging stronger, integrated, effective, equitable and accountable **health systems** including strengthening financing, human resources management, information management and private sector

5. Vision of CHAG

“A healthy nation, Christ Healing Ministry Fulfilled”

6. The Mission Statement

CHAG is a non-governmental Organisation bringing together Churches involved in the provision of Health Services to provide support to members (Church Leaders, Church Health Co-ordinating Units and Member Institutions). CHAG serves as a link between government and other development partners on the one part and members on the other through capacity strengthening, co-ordination of activities,

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lobbying and advocacy, public relations and translation of government policies; using professionals and well motivated staff who are honest, accountable, transparent and committed. In all these CHAG respects the diverse nature of members and individual church's philosophy'.

7. Situational Analysis

8.1 Achievements

CHAG has over the years played a complementary role to the Ministry of health in the provision of significant proportion of health services in Ghana. CHAG's working relations with the Ministry of Health/Ghana Health Services (MOH/GHS) has therefore improved, MOH/GHS therefore now give full recognition to CHAG facilities, as very important providers of health care in the country and as valued partners in the development of the health sector.

CHAG is included in each of the five-year programs of work, the annual planning cycle of the Ministry as well as the monitoring and evaluations of the MOH. The MOH facilitates the work of CHAG **Member Institutions and the secretariat by absorbing a significant proportion of the salaries of the staff** and often providing some additional financial support.

CHAG has a **memorandum of understanding (MOU)** with the MOH to formalize the relationship between the two. The MOU between the MOH and CHAG and its Administrative Instructions provide a good mechanism for addressing these issues and further strengthening the collaboration of CHAG and the government, especially with the agreement to establish a **Partnership Steering Committee (PSC)**.

The benefits flow both ways however. The government in turn sees the boosting of its National Health Service outputs by CHAG member institutions and services, especially in areas not covered by government health services.

CHAG members have also been bringing more resources for health care into the country from outside— although this has been dwindling in recent years.

On **quality of services** the main activities were:

- An assessment of the quality of patient care and the satisfaction of patients and communities with the care they received for all the hospitals through the **PPRHAA** process
- Some MIs made it a priority to address problems identified in the assessment and as a result achieved some significant improvements, but

coordinated regional monitoring and follow-up would have been valuable.

- A CHAG consultant trained a team of trainers, who organised zone **training workshops on Quality Assurance (QA)**. This covered a QA process that GHS is using. Again there has not been follow up to the workshops and it is difficult to gauge the impact and the extent to which the QA process has been established.

CHAG's work to improve financial access for the poor consisted mainly of some **limited support for strengthening the deferral and exemption schemes at MIs** and later in contributing to the discussions and planning around the issue of financial access during the design of the NHIS.

CHAG has over the years done well in increasing its partnership with other funding agencies besides their traditional missionary donors, both Catholic and Protestant, who continue to provide ongoing funding to sustain the Secretariat's functions. It is just completing a five year, 4.5 billion Cedi programme of support from DANIDA and has been implementing a youth awareness program with UNFPA for a number of years that was recently extended. CHAG is also a grant manager of the Global Fund for malaria, HIV/AIDS and tuberculosis. As well, talks are ongoing for engagement with the European Union.

8.2 Financial Governance and Management

CHAG has adopted the procedures of central government for its financial management. The legal framework for financial management in CHAG therefore includes the Financial Administration Act, 2003 (Act 654), the Internal Audit Agency Act, 2003 (Act 658) and the Public Procurement Act, 2003 (Act 663). At the CHAG Secretariat, primary responsibility for financial management resides with the Executive Secretary who reports to the CHAG Board. The Executive Secretary is assisted in the discharge of this duty by a Finance Manager.

CHAG Secretariat's capacity for effective financial management is currently limited. The skills and experience required to manage and report on the financial resources of the Secretariat are limited.

8.3 Planning

CHAG institutions use the Government of Ghana (GOG) Medium Term Expenditure Framework (MTEF) process for planning and budgeting in line with the MOU signed with MOH. Member Institutions have been trained to use the MTEF planning and budgeting approach.

The annual planning process is supplemented by specific programme planning when earmarked funds become available during the course of the year. The CHAG Secretariat has been playing this particular role in respect of funds that are channelled through them for Member Institutions.

The Secretariat uses annual Participatory Peer Rapid Hospital Appraisal and Action (PPRHAA) to undertake annual monitoring and evaluation of the member Institutions.

8.4 Human Resource

For a long time CHAG has had an agreement with the Government under which the salaries of CHAG staff are paid by Government through the mechanised national payroll. This arrangement has allowed CHAG institutions to recruit professional staff that would have otherwise been difficult to recruit to man their facilities.

Ceilings are placed on the categories and number of staff that can be recruited (mechanised) in any year. It has been observed from the PPHRAA reviews that there is disproportionately more auxiliary staff than professional staff in the CHAG institutions compared with GHS institutions.

Difficulties also arise when CHAG institutions recruit staff and start paying them from their User Fees, pending an opportunity to place these staff on the mechanised Government payroll.

8.5 Monitoring and Evaluation

Peer and Participatory Rapid Health Appraisal for Action (PPRHAA) is the main approach CHAG introduced under its Strategic Plan and which is used to monitor and evaluate the performance of CHAG member institutions. PPHRAA is undertaken once in a year. During the course of the year CHAG member institutions could benefit from structured, targeted monitoring by CHAG. While some of this is done by Church Coordinators that have monitoring capacity, a good number of member institutions will benefit from monitoring and evaluation visits from the CHAG Secretariat. The CHAG Secretariat is planning to set up a monitoring and evaluation system that would enable it to undertake routine monitoring and evaluation.

8. Challenges

There are however aspects of the relationship that need improvement. CHAG members feel the MOH/GHS treat CHAG like a poor relative and do not see CHAG as having equal footing with them. Resource allocation from the Ministry to government and CHAG facilities and services is clearly not yet equitable.

The MOH in turn complains CHAG is mainly interested these days in advocating for additional resources from the government and does not give sufficient attention to helping the MOH promote the goals and targets of better health care especially for the poor, for which both MOH and CHAG are supposedly committed.

The MOH also has a legitimate case in their call for CHAG to increase its involvement in preventive health programs, where the Ministry will be devoting a larger and larger proportion of its funding in the medium term.

The implementation of the MOU has been rather uneven and patchy however. For instance the PSC is not yet meeting regularly, there are a number of other measures of cooperation that have not yet been enacted and the MOU is being implemented better in some regions and districts than others.

There is also a wide variation in CHAG GHS relationship from region to region and district to district. While in some the relationships between CHAG institutions and the Regional or District Health Management Teams are very cordial and mutually supportive, this is still not true of others. The nature of this relationship still depends mostly on the approach and attitude of the head of the regional or district health team. Regions and districts with a healthy relationship include CHAG facilities in their quarterly and yearly performance review meetings and in-service training. They also share equipment and allocations for recurrent budgets with CHAG MIs. In these districts and regions, the GHS has a lot of influence over the plans and programs of CHAG.

A major CHAG's HR challenge now is the difficulty in working with the CHCUs to help MI's to deal with their HR constraints in a structured way.

The annual plans and budgets of CHAG institutions are currently not combined or consolidated in anyway. There is no system in place for co-coordinating these plans and budgets at regional and national level. They are maintained at the individual institutions. National level data on the consolidated financial data (budget, actual revenue and expenditure) on all sources of funds will greatly enhance CHAG's advocacy for additional resources.

Another major challenge is resource mobilisation at the MI level is that some Regional Health Administrations do not include CHAG institutions in their list of institutions when planning and budgeting their allocation of resources. CHAG institutions in these Regions do not receive non-salary budgets from Government (apart from the DPF that is disbursed specifically to CHAG institutions from the MOH), whereas MIs in other Regions are included in the budget.

Lack of and inadequate support from the national level to the regional and district levels through support and supervisory visits leading to lowered morale of lower level managers.

9. Strategic Objectives Outputs and Activities for the CHAG Secretariat

Objective 1: Capacity Of CHAG Secretariat In Coordination, Lobbying, Advocacy And M & E Strengthened By 2012.

Output 1. A Comprehensive HMIS Set up by December 2008

ACTIVITIES

- 1 Test the completeness of the Pilot system
- 2 Build consensus on rolling out with health coordinators
- 3 Procure funds for rolling out
- 4 Disburse funds for rolling out
- 5 Develop monitoring and evaluation systems
- 6 Monitor and support implementing Member Institution
- 7 Conduct Annual evaluations

10 Professional Staff with Relevant Expertise in Finance, Public Health Policy Analyst and Health Researcher Recruited by end of 2009

Output 2.

ACTIVITIES

- 1 Develop Job requirement/specification in the respective areas of expertise
- 2 Open file and start documentation on applicants' information
- 3 Shortlist applicants
- 4 Constitute an interview panel
- 5 Invite applicants for interview
- 6 Interview and short-list interviewees
- 7 Develop Job Description and conditions of Service
- 8 Research into the background of 2nd shortlist
- 9 Invite 2nd shortlist applicants for final selection interview
- 10 Write to successful candidates to inform them of their selection and request for medical examination.
- 11 Prepare and furnish offices for the new appointees
- 12 Issue appointment letters to successful candidates
- 13 Give orientation to the newly recruited staff

Output 3. Technical Adviser in Institutional Management and Organisational Development Recruited by December 2008

ACTIVITIES

- 1 Develop terms of reference for procurement of Technical Assistance in Institutional Management and Organisational Development
- 2 Write a letter of request for technical Assistance to DANIDA
- 3 Sign Common Management Agreement with DANIDA in respect of Technical Advice Support to CHAG
- 4 Prepare and furnish for the Technical Advisor
- 5 Receive and give orientation to TA
- 6 Introduce TA to major stakeholders of CHAG

Outmoded/Obsolete Office Equipment and Furniture Replaced and 2 New Vehicles Procured by December 2009

Output 4 ACTIVITIES

- 1 Identify and list outmoded, obsolete office equipment furniture and types of new vehicles to be acquired
- 2 Request for funds for replacement of obsolete outmoded, office equipment, furniture and new vehicles
- 3 Go through procurement procedures for acquisition of office equipment, furniture and new vehicles
- 4 Order equipment, office furniture and new vehicles
- 5 Receive, document and mark the items received
- 6 Allocate items to the various offices and users
- 7 Initiate and go through legally required assets disposal process
- 8 Dispose of the outmoded and obsolete equipment and furniture

Capacity of CHAG Secretariat in Coordination, Lobbying, Advocacy and M & E Strengthened by December 2012

Output 5 ACTIVITIES

- 1 Undertake staff capacity assessment to identify training needs
- 2 Identify appropriate training programmes and facilities/institutions to undertake training programmes for the identified needs
- 3 Procure funds for training
- 4 Terms of reference for training programmes/receive applications from staff-candidates
- 5 Sign contract with training organisation/approve application for qualified staff-candidates
- 6 Organise training workshops/sponsor approved staff-candidates
- 7 Assess staff after training to determine the impact of the training of their performance
- 8 Develop monitoring and evaluation guidelines for the CHAG Secretariat
- 9 Undertake quarterly monitoring activities to member institutions
- 10 Organise quarterly health coordinators meetings
- 11 Support regional peer review programmes

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Output 6
ACTIVITIES

Lobbying and Advocacy Plan Developed and Implemented by December 2012

- 1 Identify consultants in the development of a lobbying and advocacy plan for CHAG
- 2 Source funding for the development of a lobbying and advocacy plan
- 3 Complete terms of reference for the development a lobbying and advocacy plan
- 4 Write out and sign contract with consultants
- 5 Organise workshop for the development of a lobbying and advocacy plan
- 6 Produce a zero draft of CHAG lobbying and advocacy plan
- 7 Meet with key stakeholders to discuss and review zero draft advocacy plan
- 8 Finalise and produce a lobbying and advocacy plan document
- 9 Pre-test lobbying and advocacy plan
- 10 Undertake a final review
- 11 Produce final lobbying and advocacy plan document
- 12 Disseminate information of document to owner member churches and key stakeholders
- 13 Use document to undertake advocacy

Output 7
ACTIVITIES

Network Systems Updated by December 2012

- 1 Undertake assessment of the existing local network at the CHAG secretariat to identify the gaps in the current system
- 2 Secure funding
- 3 Procure technical assistance
- 4 Procure and install soft and hardware required to update the system
- 5 Train staff on the use of new equipments

OBJECTIVE 2: Technical And Financial Support Through The Management And Development Of Partnerships Increased By December 2012.

5 New Partners Identified and Contacted for Technical and Financial Support to CHAG by 2012

Output 1
ACTIVITIES

- 1 Identify and list potential new partners for collaboration
- 2 Seek information about them through internet and other sources
- 3 Short list potential new partners
- 4 Book appointment with the short listed partners
- 5 Meet them, introduce CHAG to them and discuss possible ways of collaboration and partnering with them
- 6 Take responses from them

7 Seek board approval to partner with identified partner/s
***Programmes And Projects Relevant To CHAG And Partners
Developed And Implemented By December 2012***

**Output 2
ACTIVITIES**

- 1 Develop proposal in consultations with the health coordinators
- 2 Seek Board's approval and submit proposal to development partner/s
- 3 Agree and review proposals with partner/s
- 4 Submit final proposal to partner/s for approval
- 5 Agree on common management terms
- 6 Get Board's final approval
- 7 Sign contract with development partner/s
- 8 Procure funding
- 9 Implement programme.

**10. Strategic Objectives, Outputs and Activities for Church
Health Coordinating Units**

**Objective 1: Capacity of Sixteen (16) National Health Coordinating Units
Developed in Monitoring and Evaluation, MIS, Financial and Administrative
Systems With Technical Support From Local And External Partners In Five
Years**

Output 1 *Funding for M & E, MIS, Financial and Administrative Systems
Capacity Building Secured by Quarter 1 2008.*

Output 2 *Capacity of 16 NCHCU's in M & E, MIS, Financial and
Administrative Systems Determined by Quarter 2 2008*

ACTIVITY

- 1 Recruit consultant to carry out systems assessment on M&E, MIS,
financial and administrative systems of the NCHCU's.

Output 3 *Standards & Tools of M & E, MIS, Financial and Administrative
Systems Developed by Quarter 4 2008*

ACTIVITIES

- 1 Meeting of NCHCU coordinators and internal technical resource persons
with consultant to discuss findings and recommend best practices.
- 2 Consultant develops draft guidelines
- 3 Consultative meeting to discuss and agree on draft guidelines for piloting
- 4 Consultant to develop resource needs for implementing of the guidelines
***Programme to Build Capacity of 16 NCHCU's in M & E, MIS,
Financial and Administrative Systems Developed by Quarter 4
2008***

**Output 4
ACTIVITIES**

- 1 Implement a pilot programme

2 Implement a scale up programme
16 NCHCU's Trained in the Implementation and use of M & E, MIS, Financial and Administrative Systems Standards and Tools Developed by Quarter 2 2009

Output 5
ACTIVITIES

- 1 Train pilot programme institutions
- 2 Pilot programme institutions implement systems
- 3 Train scale up programme institutions
- 4 Scale up institutions implement systems

Objective 2: Clarity in Roles and Coordination of Activities between CHAG and the National Church Health Coordinating Units resolved by Church Leaders In One Year

Output 1 *Funding to Develop Guidelines Secured by Quarter 1, 2008*
ACTIVITIES

Guidelines Defining the Roles, Responsibilities and Coordinating Arrangements between CHAG Secretariat and NCHCU Developed by Quarter 1, 2008

Output 2
ACTIVITIES

- 1 Recruit a consultant to manage the process of development of the guideline.
Consultant facilitates meeting of NCHCU coordinators and Exec. Secretary of CHAG to discuss and define boundaries of relationships by January 2008
- 2
- 3 Consultant prepares draft guideline by February 2008.

Approval for Guidelines Secured from Church Leaders by Quarter 2, 2008.

Output 3
ACTIVITY

Coordinators submit and receive feedback from church leaders on draft guideline by March 2008.

Output 4 *Guidelines Implemented by Quarter 2, 2008*
ACTIVITIES

- 1 Consultant facilitates a meeting of the coordinators and CHAG Exec. Secretary to discuss feedback from church leaders for finalization of guideline.
- 2 Consultant will finalize and submit to CHAG Exec. Sec. the final guideline for publication and dissemination to all levels of CHAG.

Objective 3: Adequate skills and mix of Staff at The National Church Health Coordinating Units Developed through technical and financial support from local and external Partners in two (2) Years

Funding to Develop Adequate Skills and Mix of Staff at the National Church Health Coordinating Units Secured by Quarter 1 2008
Output 1

Output 2
ACTIVITIES

Required Skills And Mix Of Staff At The National Church Health Coordinating Units Determined By Quarter 2, 2008

1 Recruit a consultant to support the NCHCU coordinators in defining the appropriate mix and skills of staff for their units.

Output 3
ACTIVITIES

Short and Long-Term Training Programmes Identified and Developed by Quarter 3 2008

1 Request consultant to identify and recommend the training needs and appropriate programmes both locally and internationally and submit to CHAG secretariat.

2 CHAG secretariat prepares detailed budget for training requirements.

Output 4
ACTIVITIES

Training Programmes Implemented by 2012

1 NCHCUs select and submit list of appropriate staff for skills development to CHAG secretariat

2 CHAG secretariat releases funds for training.

Output 5
ACTIVITY

Impact of Training Reviewed by 2012

1 Assess the performance of NCHCUs in 2011

Objective 4: Favourable National, Political and Legal Framework supported through the continuous articulation, translation and relay of Policies and issues to and from Church Health Services over the next Five (5) years.

Output 1
ACTIVITY

Funding to Support the NCHCU's Articulate, Translate and Relay Policies and Issues Secured by Q1,2008

Output 2
ACTIVITY

Capacity of 16 NCHCUS to Articulate, Translate and Relay Policies and Issues to and from Church Health Services Approved by 2009

1 Recruit a consultant to conduct training for 16 NCHCUs on Policy analysis, advocacy and lobbying skills by July 2008.

2 Conduct training for 16 NCHCUs on Policy Analysis, advocacy and lobbying skills by September 2008

Output 3
ACTIVITY

16 NCHCU's Knowledge on National, Political and Legal Frameworks, Policies and Issues in Health Annually Updated by 2012.

1 CHAG Secretariat to put together a set of all relevant documents (policies and legal frameworks in Health) for NCHCUs and their respective institutions by March 2008

2 The quarterly NCHCU coordinators meeting includes policy updates on the agenda all the time
3 CHAG secretariat prepares periodic briefs on policy and other issues for dissemination to NCHCU coordinators and their respective member institutions.

Continuous Inputs from 16 NCHCUs made into National, Political and Legal Frameworks, Policies and Issues in Health and Disseminated to Member Institutions by 2012.

Output 4
ACTIVITY

1 NCHCUs discuss and disseminate relevant documents to their respective institutions at least twice a year till 2012.
2 NCHCUs receive and collate inputs from respective members to CHAG secretariat for input into discussions on national policy and legal frameworks.
3 The quarterly NCHCU coordinators meeting includes policy updates on the agenda all the time

Objective 5: The Capacity of Institutional Managers to manage relationships between Health Institutions and NHIS improved with Support from NCHCUS by 2012

Funding to Build the Capacity of Institutional Managers to Manage Relationships Between Health Institutions and NHIS Secured by Quarter 2 2008.

Output 1
ACTIVITIES

1 Five days training for institutional managers on NHIS and other related issues by December 2008
2 Request for funds with accompanying budget to CHAG Secretariat by January 2008
3 Receive Funds from CHAG Secretariat by February 2008

Knowledge and Skills of Institutional Managers to Effectively Manage the Relationships with the NHIS is Continuously Improved and Developed by 2012.

Output 2
ACTIVITIES

1 Prepare a questionnaire for member institutions to identify operational challenges and best practices by January 2008
2 NCHCUs request respective institutions to complete and submit questionnaires by January 2008.
3 Receive responses from Member institutions by February 2008
4 NCHCUs meet to discuss responses from Member institutions and suggest interventions by March 2008
5 Recruit Consultant to facilitate NCHCUs meeting, collate, analyse responses and submit reports by April 2008.

- 6 Develop interventions informed by consultants' report by May 2008.
- 7 Implement interventions developed by September 2009.

11. Strategic Objectives, Outputs and Activities for Member Institutions

Objective 1: 200 Clinical and Paramedical staff recruited by end of December 2012

Output .1 *200 Existing Vacancies in all Health Institutions Identified by the end of 2008*
ACTIVITIES

- 1 Copies of MOH staffing Norms acquired and distributed to all Member Institutions (MIS) by March 2008.
- .2 Appropriate software for building HR database for Member institutions acquired by March 2008.
- .3 MIS requested through NCHCUs to submit staffing levels, guided by staffing norms and indicating gaps, by June 2008.
- 4 Staffing levels of MIS received and a comprehensive database on HR built by September 2008
- 5 Existing vacancies for clinical paramedical and other technical grades in all MIS compiled December 2008.

Output 1.2 *Job Analysis for Identified Vacancies Conducted by June 2009*
ACTIVITIES:

- 1 List of reputable HR consultants made by January 2008
- .2 A capable HR Consultant selected by February 2008.
- .3 HR consultant contracted to build capacity of MIS on recruitment, especially, conducting job analysis by March 2009
- 4 Job analysis conducted by MIS on existing vacancies by April 2009.
- 5 A revised list of vacancies in MIS submitted to secretariat by May 2009.
- .6 Existing vacancies in all MIS revised by Secretariat in line with the MOH staffing norms by June 2009.

Output 1.3 *Advertisement for Identified Positions Placed in Appropriate Print Media by the end of 2009*
ACTIVITIES:

- 1 A meeting between CHAG and HR Directorate of MOH held to discuss existing vacancies by Q1 2009.
- 2 Employment guidelines discussed at NCHCs meeting by first quarter 2009.

3 Employment guidelines communicated to MIs by Q2 2009
 4 Advertisement of vacancies in the various church health services
 appropriately placed by the respective NCHCs by the close of 2009
**Applications Received and Interviews Conducted by December
 2010**

Output 1.4
 ACTIVITIES:

.1 Applications received by MIS by 2010
 Interviews conducted for applicants throughout the various MIS by the
 2 end of 1st quarter 2010.
 3 Successful candidates selected by June 2010

Output 1.5
Successful Candidates Placed by March 2011

ACTIVITIES:

1 Inputs on new staff prepared and to submitted secretariat from MIS
 by September 2010
 2 Inputs on new staff from MIS collated by secretariat by November
 2010
 3 Inputs on new staff from MIS submitted to appropriate government
 ministries for clearance by March 2011

**Objective 2: 300 Non-professional Staff upgraded to professional levels over a
 five (5) year period**

**Various Categories of Non-Professional Staff and their Training
 Needs Identified by December 2008**

Output 1
 ACTIVITIES:

1 MIS requested to submit list of categories of non-professional staff
 through NCHCs by 1st quarter 2008.
 2 Comprehensive list of non-professional staff of all MIs compiled by the
 Secretariat by the end of 2nd quarter 2008
 3 List of non-professional staff discussed by NCHCs at a meeting before
 the end of 2nd quarter 2008
 4 Individual non-professional staff marched to training needs based on
 MIs' requests in consultation with NCHCs by September 2008
 Feedback communicated to MIs by October 2008.

Output 2
 ACTIVITIES:

1 Stake holders meeting involving Secretariat, NCHUs and HRD of MOH
 held to discuss content of training by January 2008.
 2 Consultants engaged to develop training modules by March 2008
 3 Training sites identified by CHAG/NCHCUs by December 2008.
 4 Training modules piloted in selected sites by June 2009

Output 3
300 Non-Professional Staff Trained at Appropriate sites by end

of 2011

ACTIVITIES:

- 1 MIS organized into zones under the various training sites and training schedules drawn by Q4 2009
- 2 Training schedules and zones communicated to respective MIS by Q1 2010
- 3 Training of non professional staff started at all sites by Q2 2010
- 4 Training of non professional staff ended at all sites by Q4 2011

Output 4 **300 Upgraded Staff Placed by 2012**

ACTIVITIES:

- 1 Mass graduation/ certification organized for upgraded staff by Q1 2012
- 2 Status of upgraded staff redefined by MIS by Q2 2012
- 3 Upgraded staff appropriately placed by Q3 2012

Objective 3: 10 CHPS compounds constructed in selected remote areas to increase PHC coverage by 20% by the end of 2010

Output 1 **Chps Sites Identified by December 2008**

ACTIVITIES:

- 1 Allocation of 10 CHPS agreed upon between Secretariat and NCHCs at a meeting by 1st quarter 2008
- 2 Survey of potential CHPS zones carried out by member churches accepting to operate CHPS compounds by June 2008
- 3 Member churches accepting to operate CHPS compounds and selecting preferred CHPS sites
- 4 List of preferred CHPS sites submitted to Secretariat by October 2008

Funding for Construction of 10 CHPS Compounds Sourced by the end of 2009

Output 2

ACTIVITIES:

- 1 Proposal for sourcing funding developed by March,2009
- 2 List of potential donors compiled by June,2009
- 3 Ten potential donors contacted by June,2009
- 4 Funding secured from interested donors by end of 2009.

Output 3 **1 10 CHPS Compounds Constructed by 2011**

ACTIVITIES:

- 1 Land for the construction of CHPS compound acquired by 1st quarter 2010
- 2 Plan for building CHPS compounds developed by 1st quarter 2010
- 3 Invitation for bids and selection of contractors completed by June 2010
- 4 Contract awarded for the construction of CHPS compounds by October 2010
- 5 CHPS compound constructed by October 2011

6 Constructed CHPS compounds inspected and taken over by December 2011

10 Constructed CHPS Compounds Furnished and Staffed by December 2012

Output 4

ACTIVITIES:

1 Necessary items for furnishing CHPS compound identified by 1st quarter 2012

2 Funding sourced for purchasing basic items CHPS compound by 2nd quarter 2012

3 Necessary items for CHPS compound purchased and installed by 3rd quarter 2012

4 Staff posted to CHPS compounds by 4th quarter 2012

5 CHPS compounds commissioned by December 2012

Objective 4: Aggregate Service coverage increased by 30% over a three-year period

Output 1

Clinical Management Systems Improved by end of 2009

ACTIVITIES:

1 Training on Quality Assurance (Q.A.) organized for all MIS by Q1 2008

2 Guiding document for implementing Q.A. developed for all MIS Q4 2008

3 Functional QA teams formed in all MIS by Q1 2009

4 Quarterly monitoring activities instituted in all MIS by Q1 2009

5 TOT workshop on clinical care organized for all MIS by end of Q4 2008

6 700 Traditional Birth Attendants (TBAs) trained by Q4 2008

PHC Outreach and Static Services Strengthened by December 2009

Output 2

ACTIVITIES:

1 500 new outreach points opened by Q2 2009

2 Number of PHC visit increased by 30% by Q4 2009

3 Quarterly Community durbars for education on PHC activities instituted by Q2 2009

4 138 school health coordinators trained on basic hygiene by Q3 2009

5 Weekly radio talk shows on health promotion instituted in all ten administrative regions by Q4 2009

Output 3

HMIS in Member Institutions Improved by 2010

ACTIVITIES:

1 HMIS Guidebook with common indicators developed for all MIS by Q1 2009

2 Common HMIS Software (CHMISS) acquired for all MIS by Q1 2009

3 TOT Workshop on HMIS organized for all MIS by Q2 2009

- 4 MIS without computers for HMIS supported to acquire computers and accessories by Q3 2009
- 5 Permanent Regional/Zone HMIS offices set up in identified MIS to facilitate information flow between Secretariat and MIS by Q4 2009
- 6 Internal Network System (INS) established in 50% of MIS by 2012
- 7 Proportion of Middle/Senior Level Managers using computers increased by 100%
- 8 Web domain of 50% of MIS on CHAG website activated by 2010

**Output 4
National Health Insurance Coverage in CHAG Operational Areas Increased by 40% by 2012**

ACTIVITIES:

- 1 National Health Insurance Desk established in all MIS by Q4 2008
- 2 Weekly Health Insurance education instituted in all MIS Q1 Q4 2008

**Output 5
Management Capacity of MIS Strengthened by 2010**

ACTIVITIES:

- 1 One week Annual Management Orientation Workshop (AMOW) for all newly appointed middle/senior managers instituted by Q4 2008
- 2 Quarterly Continuous Management Education (CME) instituted for middle and senior level managers from all MIS Q3 2008
- 3 Annual Financial Management and Budgeting Workshop (AFMBW) instituted for senior managers from all MIS Q3 2009
- 4 20 senior managers sponsored to GIMPA to pursue the Post-graduate Diploma in Management and Administration Q4 2010
- 5 20 Middle Level Managers sponsored to GIMPA/ MDPI to acquire skills in management and administration by Q4 2010

Skills of 60 Staff Improved Under Donor Sponsored Fellowships by 2010

ACTIVITIES:

- 1 Fellowship Board instituted by Q2 2008
- 2 Criteria for selecting Candidates for fellowships developed Q3 2008
- 3 15 clinical staff sponsored (3 each year), for further studies Q4 2012
- 4 15 paramedical staff sponsored (3 each year), for further studies Q4 2012
- 5 15 support service staff sponsored (3 each year), for further studies Q4 2012
- 6 5 PHC coordinators sponsored (1 each year) for further studies Q4 2012
- 7 10 Tutors sponsored (2 each year) for further studies Q4 2012

**Output 7
Staff Capacity of MIS Improved Through In-service Training Over a Five Year Period**

ACTIVITIES:

- 1 Staff Capacity Improvement Units (SCIU) commonly referred to as In-service Training Units established in all major MIS by Q2 2008
- 2 Staff Capacity Improvement Coordinators (SCICs) appointed in all major MIS by Q3 2008
- 3 SCICs from major MIS trained by Q4 2008
- 4 Staff Capacity Improvement Plan (SCIP) drawn and followed in all MIs by Q4 2008
- 5 Continuous Clinical Care Education (CCCE) instituted for all MIS by Q4 2008

Objective 5: Comprehensive revamp of service facilities undertaken by the end of December 2012

Output 1
300 Units New Clinical, Diagnostic and Surgical Equipment Purchased by the end Of 2012

ACTIVITIES:

- 1 Workshop on Hospital Equipment and Equipment Management organized for all MIS Q4 2008
- 2 Equipment needs of MIS compiled and submitted to secretariat by Q1 2009
- 3 Equipment needs of all MIS compiled by secretariat by Q2 2009
- 4 Funding sourced for the purchase of equipment by Q4 2009
- 5 Needed equipment purchased by Q4 2010
- 6 Purchased equipment Distributed to MIS Q4 2010
- 7 User Training organized for Beneficiary MIS Q1 2011
- 8 Planned Preventive Maintenance Instituted for beneficiary institutions Q1 2011

Output 2
10 New Wards Constructed in Selected Facilities Over a Five Year Period

ACTIVITIES:

- 1 4 Hospitals in dire need of Hospital wards identified Q2 2008
- 2 Design and drawings for Ward blocks completed by Q4 2008
- 3 Funding sourced for construction of ward blocks Q4 2009
- 4 Advertisement placed inviting bids for the construction of 10 wards Q1 2010
- 5 Qualified contractors selected for the construction of wards by Q2 2010
- 6 Contract awarded for construction of wards by Q3 2010
- 7 Construction of wards completed by Q4 2011
- 8 Wards furnished and commissioned by Q2 2012

Output 3
4 Operating Theatres Constructed and Furnished in Selected Facilities by the end of 2012

ACTIVITIES:

- 1 4 Hospitals in dire need of operating theatre identified Q2 2008
- 2 Design and drawings for theatre blocks completed by Q4 2008
- 3 Funding sourced for construction of theatre blocks Q4 2009
- 4 Advertisement placed inviting bids for the construction of 4 operating theatres Q1 2010
- 5 Qualified contractors selected for the construction of operating theatres by Q2 2010
- 6 Contract awarded by Q3 2010
- 7 Construction of operating theatres completed by Q4 2011
- 8 Operating theatres furnished and commissioned by Q2 2012

30 Brand New 4x4 Toyota Hilux Vehicles Purchased Over Five Year Period

Output 4

ACTIVITIES:

- 1 Suppliers for 30 4X4 Toyota Hilux Vehicles Identified by Q4 2008
- 2 Funding sourced for purchase of vehicles Q4 2009
- 3 Contract awarded for the supply of 30 Toyota Hilux 4X4 vehicles by Q2 2010
- 4 30 brand new vehicles purchased by Q4 2010
- 5 Distribution criteria agreed between Secretariat and NCHCs by Q4 2010
- 6 Vehicles distributed to selected MIS by Q1 2011

Output 5

30 Selected Facilities Renovated by the end of 2012

ACTIVITIES:

- 1 Independent facilities' inspection committee formed by Q4 2008
- 2 Member institutions toured and structured inspected by Q3 2009
- 3 Secretariat and NCHCs discuss inspection report Q4 2009
- 4 30 facilities selected for renovation Q4 2009
- 5 Qualified contractors selected by Q2 2010
- 6 Contract for renovation awarded by Q3 2010
- 7 Renovation of 30 facilities completed by Q4 2011

Performance Monitoring & Evaluation Mechanism Flow Chart

