Contribution of Civil Society Organisations to Health in Africa
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Cover photo: Nurse Martha Anyangu treats a child during an open-air clinic in Turkana Region, Northern Kenya. Courtesy of AMREF.
# List of Acronyms

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<th>Acronym</th>
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<tr>
<td>AHP</td>
<td>African Health Placements</td>
</tr>
<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral Drug</td>
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<td>AU</td>
<td>African Union</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>CCRDA</td>
<td>Consortium of Christian Relief and Development Association</td>
</tr>
<tr>
<td>CFW</td>
<td>Child Family Wellness Stores</td>
</tr>
<tr>
<td>CHAK</td>
<td>Christian Health Association of Kenya</td>
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<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>CHRAIC</td>
<td>Connections Health Research in Africa and Ireland Consortium</td>
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<td>CONGAD</td>
<td>Conseil des Organisations Non Gouvernementales (National Civil Society Consortium)</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
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<td>CSS</td>
<td>Community Systems Strengthening</td>
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<tr>
<td>DHIS</td>
<td>District Health Information System</td>
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<tr>
<td>ECM</td>
<td>Episcopal Churches of Malawi</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based Organisation</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccine Initiative</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>HENNET</td>
<td>Health NGOs Network (Kenya)</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
</tr>
<tr>
<td>HSCC</td>
<td>Health Sector Coordinating Committee</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>ICC</td>
<td>Inter-Agency Coordinating units</td>
</tr>
<tr>
<td>IHP+</td>
<td>International Health Partnership</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organisation</td>
</tr>
<tr>
<td>KEC</td>
<td>Kenya Episcopal Conference</td>
</tr>
<tr>
<td>MCC</td>
<td>Malawi Council of Churches</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MEDS</td>
<td>Mission for Essential Drugs and Supplies</td>
</tr>
<tr>
<td>MOTECH</td>
<td>Mobile Technology for Community Health</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
</tr>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>REPAOC</td>
<td>Réseau des Plates-Formes d’ONG d’Afrique de l’ouest et du Centre (REPAOC)</td>
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<tr>
<td>RESSIP</td>
<td>Réseau Santé Sida et Population</td>
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<tr>
<td>PDA</td>
<td>Personal Digital Assistant</td>
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<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<tr>
<td>PMCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PNA</td>
<td>Pharmacy Nationale d’Approvisinnement</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
<td>SAP</td>
<td>Structural Adjustment Programmes</td>
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<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<tr>
<td>SWAA</td>
<td>Society for Women and AIDS in Africa/Senegal</td>
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<tr>
<td>SWAP</td>
<td>Sector-Wide Approach</td>
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<tr>
<td>TAC</td>
<td>Treatment Action Campaign</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children's Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Sub-Saharan Africa (SSA) has made tremendous gains in improving its health outcomes with several countries on track to meet the health Millennium Development Goals (MDGs). The overall health improvements have increased life expectancy, reduced child mortality and reduced maternal deaths. CSOs have been a key contributor to the improved health outcomes and have been at the forefront in addressing SSA’s health challenges.

CSOs in SSA play a critical and diverse set of roles in the health sector. They have been associated with delivery of health care in rural and marginalised areas and being the voice of the community in articulating their health needs. The reality, though, is that CSOs are involved in all aspects of health care and are bridging the gap in access to equitable health services. They are partners in service delivery of health care, influential financiers and powerful advocates in protecting the rights of the poor in access to health care. The agility and flexibility of CSOs have enabled them to innovate and provide life-saving solutions.

This report accurately captures the contribution of CSOs to health care delivery in SSA. The description of the services they are providing and the positive impact on health outcomes provides justification for the need for governments to collaborate with them in health care planning and delivery. Worthwhile to note is the fact that the contribution of CSOs is largely influenced by the environment within which they operate. Governments are instrumental in creating an enabling environment and other development stakeholders, including donors, are influential in providing resources and determining priority areas.

It is my hope that the information in this publication will contribute to the development of an enabling space for CSOs and the report will continue to serve as the basis for strategic partnerships between health stakeholders. It is only when governments, civil society and the private sector work together in a harmonised manner that we will be able to achieve the MDGs and make real impact in the wellbeing of our communities.

Dr. Noerine Kaleeba

Chair, AMREF International Board
Acknowledgment

The African Medical and Research Foundation (AMREF) and Dalberg Global Development Advisors would like to thank the individuals from various organisations that generously offered their time and expert knowledge towards this report.

The findings and analyses in the pages that follow would not have been possible without the contributions from the following individuals who graciously provided their invaluable insights to aid our study: Dr. Samuel Mwenda, Christian Health Association of Kenya; Andrew Ogombe and Douglas Owino, NGO Bureau; Zaddock Okeno, Health NGOs Network (HENNET); Scott Burnett, Love Life; Leila Akahloun, Broadreach Health care; Saul Kornik, Africa Health Placement; Lynette Mbote and Lawrence Mbalati, AIDS and Rights Alliance for Southern Africa; Dr. Connie Osborne, Boniface Hlabano, Phineas Muchenjekwa, AMREF South Africa; Ann Gitimu, AMREF Kenya; Lieve Vanleeuw, Treatment Action Campaign; Rose Kumwenda, Christian Health Association of Malawi; Timothy Mtambo, Centre for Human Rights and Rehabilitation; Florence Temu and Dawit Seyoum, AMREF Ethiopia; Daouda Diouf, Enda Santé; Dr. Hambarukize Simon, Society for Woman and AIDS in Africa; (Guy) Aho Tete Benissan, Réseau des plates-formes d’ONG d’Afrique de l’Ouest et du Centre REPAOC; Harouna Wassongma, Chercheur dans le domaine de la santé (CRES) ; and Amadou Cissé, Conseil des Organisations Non Gouvernementales (National Civil Society Consortium) COGAD/RESSIP.

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This report was co-authored by Edwin Macharia, Carlijn Nouwen, Kagwiria Koome, Anne-Marie Makhulo, Daniel Ndungu and Modou Fall of Dalberg Global Development Advisors. Design and layout was done by Black Butterfly Limited. The report was edited by Ruth Omondi, Essence Communication, Documentation Centre and Betty Muriuki, AMREF.
Civil society in sub-Saharan Africa (SSA) is an important and vital partner in health care development, with a wide variety of roles ranging from direct service delivery in marginalised communities to advocacy for access to health care by all.

Executive Summary

Civil Society Organisations (CSOs) have been providing health services in SSA for decades, even predating political independence. However, the context within which they work continues to evolve, necessitating a need for continuous shift in role and approach. Most notably, these shifts drive changes in and formation of new partnerships and operating models. In some countries, a convergence of roles between CSOs and the public and private sector can be observed whilst in most settings an approach based on social entrepreneurship is being experimented on to increase sustainability in a time of decreasing funding for the sector.

Across sub-Saharan Africa, CSOs play a crucial role in developing and strengthening the health sector as can be seen by both their sheer numbers and the diversity of roles/contributions. The number of CSOs operating per country differs, driven by disease burden, capacity of government to deliver health services, funding patterns and regulation of the sector. South Africa and Kenya report the strongest environments that support the CSO sector¹ while in Malawi, Senegal and Ethiopia regulatory environments are more restrictive on CSO registration and operations. Per 100,000 inhabitants, there are 150 CSOs registered in South Africa, 19 in Kenya, 4 in Senegal and 3 in Ethiopia (across all sectors)².

CSOs are active across the continuum of health care with a large proportion focused on HIV/AIDS, maternal and reproductive health, malaria, TB and water and sanitation. Most have community at the heart of their work and play a key role in strengthening health systems with strong contributions across each of the elements of the health system defined in the WHO health systems framework (service delivery, health workforce, health financing, leadership and governance, medicines and technologies and health information systems). Of the six WHO health systems building blocks, the strongest contribution by CSOs in SSA has been in service delivery and health

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² Number of CSOs in health is not readily available therefore total number of CSOs used is a proxy.
workforce development. Since colonial times, faith-based organisations (FBOs) have been important providers of direct medical services and trainers of middle level medical staff. In Kenya and Malawi, CSOs offer over 40% of medical services, with this percentage being even higher in rural areas. Further, Christian Health Association of Malawi (CHAM) provides 47% of all health workforce training and specifically equips 70% of all nurses in Malawi. In Kenya, Christian Health Association of Kenya (CHAK) owns 34% of all medical training facilities while CSOs in Tanzania manage 46% of training institutions. Other CSOs including AMREF, Intra-health, African Health Placements (IHP) and various others also play an active role in capacity building for community health workers and middle level medical staff.

Key success factors for CSOs in health care are: a well defined mission, alignment of activities with capabilities, and strategic partnerships with stakeholders in the sector. CSOs have constantly evolved and shifted their roles in response to the various and changing health challenges in SSA. Successful CSOs start from a clearly defined mission and desired impact and continuously calibrate with that. AMREF positioned itself as an African CSO with a mission to strengthen communities; while they have expanded, all its activities and focus areas have stemmed from its mission. Treatment Action Campaign (TAC) in South Africa has been successful in using the law to secure the right to health. It built legitimacy as a mass movement advocating the rights of the poor by building its membership in urban and rural communities, setting up networks and working closely with well-established organisations.

Furthermore, successful CSOs have ensured alignment of their activities with their capabilities and processes with a view to being effective in the roles they choose to play. This has enabled CSOs to shift focus to other roles, geographies and diseases as long as the capabilities are suitable. In other cases, CSOs have had to recruit new staff with particular skills sets in order to respond to the requirements of the changing terrain or work in partnership with others with a view to leveraging on their comparative advantages. For instance, AMREF has staff with varied expertise to adequately respond to the changing context; 30% of its board is made of technical health experts while over 20% of staff are health professionals. On the other hand, TAC, in responding to the xenophobic attacks of 2010 in South Africa, chose to work with partners that had the requisite knowledge and skills to effectively respond to the problem at the time. In the case of CCRDA in Ethiopia which was designed to respond to famine in the Nineties, the increased food security necessitated the organisation to transform into a development-focused umbrella organisation. On its part, Society for Women and AIDS in Africa/Senegal’s (SWAA) close engagement with government as a partner has created legitimacy, enabling them to impact significantly on the health sector.

Partnership with stakeholders in the sector is critical for CSOs seeking to impact health outcomes in the region. The type of partnership largely depends on the role played by the CSO in the sector. For example, as a watchdog, a CSO needs good relationships with the general public, press and donors, whereas as a policy advisor, a CSO needs engagement with government. CHAM in Malawi is a key partner to government, having signed a memorandum of understanding for service delivery in partnership with government. CHAM sits on all the technical working groups instituted by the Ministry of Health in Malawi and acts as a signatory to the Health Sector Wide Approach Programme in Malawi. The Health NGOs Network (HENNET) in Kenya has been able to directly engage with government and therefore influence policy through, for instance, lobbying for amendment of the Public Benefits Organisations Bill passed as an Act in early 2013. Partnership is also essential among CSOs, with the private sector and with development partners for coordination of efforts so as to avoid duplication and fragmentation for greater impact.
Going forward, CSOs need to continuously be nimble and flexible enough to respond to changing needs (e.g. disease trends), opportunities (such as the possibilities of technologies) and their operating environment (funding models, donor shifts and sector regulation). In essence, CSOs need to:

- Diversify sources of funding including identifying income-generating activities aligned with their capabilities;
- Strengthen networks and alliances for more effective advocacy and meaningful engagement as equal partners in health sector policy and strategic development;
- Deepen partnerships with government, especially given the focus on primary health care;
- Focus on strengthening health systems as a whole instead of focusing solely on individual elements of the system;
- Strengthen internal governance and reporting systems so as to enhance accountability and transparency.

The impact of CSOs in the health sector will depend on government’s willingness to provide a conducive environment for CSOs to operate and donors’ recognition of CSOs as partners in development. Governments in the region will need to provide an enabling environment for CSOs to operate. Further, the participation of CSOs in the sector will need to move from ad-hoc interventions to structured engagement, with clear roles and defined outcomes. CSOs on their part will need to meet their obligation of being accountable and transparent and delivering on their mandate. On the other hand, donors need to begin engaging with CSOs as partners in development as opposed to being mere recipients of funds as envisaged in global development partnerships, including the Busan Partnership, which provides space for CSOs to contribute to the broader development agenda.

Partnership with stakeholders in the sector is critical for CSOs seeking to impact the health outcomes in the region.
Introduction

This chapter gives an overview of the development challenges in the health sector in sub-Saharan Africa (SSA), giving a justification for the role of CSOs in improving health outcomes in the region, and provides a definition of the concept of civil society. The chapter outlines the purpose of this publication and the approach used in completing the publication, including the countries of SSA profiled in this publication. It provides the framework used in assessing the role of CSOs and ends with the structure of the publication.

The development challenge in the health sector in sub-Saharan Africa

SSA suffers a disproportionate share of the world’s disease burden, accounting for 25% of the global disease burden, with 1% of global health expenditure and 3% of the health workforce. The African continent is struggling with the HIV/AIDS epidemic with an estimated 22.1 million adults and children living with HIV, which accounts for two-thirds of the global prevalence. SSA also has an estimated 2.8 million new cases of tuberculosis (TB) and 176 million cases of malaria each year. Although the maternal death rate in SSA has reduced over the past 20 years, it still accounts for 56% of global maternal deaths. Infant mortality is slowly declining, but it is the highest globally with a regional average of one in nine children dying before the age of five.

The high disease burden is further exacerbated by poor health infrastructure in the region. Access to health services in the region also remains inequitable, with the urban population having access to more and often better services than rural populations. The poor and indigent are further marginalised as they lack the resources to pay for health care services. In addition to these challenges, governments in the region struggle with inadequate financing for the sector. This is despite the fact that a large proportion of SSA countries have committed to the Abuja Declaration recommending GDP expenditure of 15% to health care; very few countries have complied with the requirements. Some of the countries that have complied include Botswana (17%), Rwanda (20%), Togo (15%), Madagascar (15%), and Zambia (16%). While historically there has been insufficient funding for health care in Africa, the situation was further aggravated by the Structural Adjustment Programmes (SAPs) that required governments to introduce cost sharing to health care, as a way of reducing government expenditure in the social

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3 Transformative Scale up of Health Professional Education. WHO Health Report 2011.
Defining Civil Society Organisation

A CSO is a diverse group that defies generalisation. For the purposes of this report, we use the definition given by the African Union CSO framework which states that:

“A CSO is an association of people that exists to promote economic and social development. Normally speaking, a CSO would be non-profit, non-governmental and non-partisan (i.e. non-party political). Such a definition would include faith-based groups, trade unions, NGOs, village associations, producer groups, professional associations, universities and the like, big and small. From these wide ranging definitions, it can be seen that a CSO will represent all actors who are not connected to the state or private sector for profit motivated players, with a social mission essential in the definition of a CSO”.

Table 1 below provides a typology of CSOs in the region.

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<th>CSO</th>
<th>Definition</th>
<th>Funding</th>
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| Non-Governmental Organisations   | Sometimes used synonymously with CSO, national NGOs are registered in the country of operation and international NGOs (INGOs) are defined as ‘any international organisation that is not founded by an international treaty’. They include many groups and institutions that are entirely or largely independent of government and that have primarily humanitarian or cooperative rather than commercial objectives. Citizen groups, professional associations, cooperatives organised nationally or internationally to raise awareness and influence policy are also NGOs. | • Funded by individuals, corporate, foundations and foreign governments and donors  
• Increasing avenues for funding from country governments |
| (NGOs)                           |                                                                          |                                                                                                                                         |
| Faith-Based Organisations (FBOs) | FBOs are classified based on affiliation, as they have some religious denomination affiliation, with major links to the Catholic, Anglican/Episcopal/Protestant and Muslim congregations in many countries. FBO is used as a catch-all category referring to health programmes designed, conducted, or supported by groups affiliated with or based in a non-secular setting. | • Largely receiving funding from the congregations nationally and internationally  
• Currently a large donor partner and receiving funding from several sources including government |
| Community-Based Organisations    | CBOs are non-profit entities that operate within a single local community. They are essentially a sub-set of the wider group of non-profit organisations. | • They were previously run on a voluntary basis and were largely self-funded  
• Due to inclusion as key partners in community health, they are largely receiving funding from the larger national NGOs to conduct community-based activities  
• Funding shift, with CBOs receiving funding directly from donors and capacity building support to strengthen internal systems. |
| (CBOs)                           |                                                                          |                                                                                                                                         |

7 Commission on Social Determinants of Health, 2007.
The landscape of CSOs in the different countries is not homogeneous and is influenced by the country’s history, political structure, legal and policy environment and disease trends. Countries with a history of British colonisation and largely Christian population will have a large FBO presence. Their established presence in the country of operation will have them as key contributors to health outcomes. Disease trends also influence CSO operation due to increased funding sources. The HIV/AIDS crisis occasioned increased funding and the realisation that several partners were required to address the crisis. Senegal, with a lower than average HIV/AIDS prevalence of 0.7%, has an estimated 500 CSOs registered compared to South Africa with a HIV/AIDS prevalence of 17.3% and an estimated 76,000 CSOs registered.\footnote{Department of Social Welfare, Government of South Africa.} In addition, countries with restrictive legal and policy environments often experience low CSO presence and vice versa. For instance in Ethiopia, the regulations by government over funding sources and activities that CSOs can engage in has influenced the types of CSOs registered; national NGOs can only get 10% of their funding from international sources.\footnote{USAID NGO Sustainability Report for SSA 2011.}

The definition of CSOs is not static and global changes have led to the emergence of new players that has made the term more fluid. There are now an increasing number of social enterprises, for example Micro Ensure, which have a similar mission to CSOs of improving livelihoods but differ in the operating model with a focus on building financially sustainable delivery models, generating their own resources by charging fees for service models.\footnote{Micro Ensure works with groups to provide back office support in the delivery of low cost insurance in agriculture and health. In Africa, they are operating in Kenya, Ghana and Tanzania.} Foundations are also critical actors, playing a dual role of donor and providing direct services. As CSOs continue to focus on operational sustainability, definitions involving terminologies such as not-for-profit are likely to be less helpful, because the differences between CSOs and the private sector blur.
SCOPE AND METHODOLOGY OF THIS PUBLICATION

Purpose and scope of this publication

This publication seeks to explore, analyse and highlight the role of CSOs and their contribution in the development of health care in sub-Saharan Africa. The publication highlights the current contribution of CSOs across the different components of health systems and provides recommendations on ways the sector can be better organised to deliver on improved health outcomes.

Broadly, the geographic scope of this study is sub-Saharan Africa with a focus on case studies from Ethiopia, Kenya, Malawi, Senegal and South Africa. From these countries, success stories from a CSO in each have been profiled, showcasing their contribution in improving health outcomes, challenges faced and the lessons they have learned in the areas in which they operate. These countries were chosen to demonstrate the diverse operating environments of CSOs.

Framework for determining contribution of CSOs in Health

To effectively analyse the roles CSOs are playing in health in SSA, we have used the WHO health systems framework and its six building blocks shown in the figure below.

Figure 1: Health Systems Framework

This framework sets out what constitutes a health system and what health systems strengthening entails. The building blocks are elaborated below:

- **Service delivery**: Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

- **Health workforce**: A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

- **Health information systems**: A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

- **Access to medicines and technology**: A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

- **Health financing**: A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophes or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

- **Leadership and governance**: Involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability.

This publication assesses how CSOs have contributed to the above components of the health systems framework.

**Report Outline**

The report is structured as follows:

1. Chapter One gives the background to the publication, provides the definition of CSOs and introduces the framework within which we review the contribution of CSOs to the health sector in SSA;

2. Chapter Two describes the roles that CSOs are playing, both globally and in sub-Saharan Africa, and delves into their historical evolution and the accompanying driving forces shaping the sector.

3. Chapter Three highlights the contribution, value addition and impact of CSOs in strengthening health systems in SSA;

4. Chapter Four profiles CSOs that have succeeded in improving health outcomes and gives insights into lessons learnt on remaining strategically relevant to disease trends, alignment of capabilities to roles and fostering financial sustainability;

5. Chapter Five explores the future outlook of the driving forces that will reshape the context within which CSOs operate.
Student nurse Keraya Esmael attends to a mother during an antenatal clinic visit at Semera Hospital in Afar Region, Ethiopia. Courtesy of AMREF.
This chapter highlights the role of CSOs in health, providing both a global view as well as the SSA regional perspective. It also delves into the evolution of the role of CSOs based on the shifts in the sector.

**GLOBAL VIEW**

Globally, CSOs have been influential in determining the health agenda and creating a global spotlight on diseases such as malaria, HIV/AIDS and maternal health. This attention has greatly influenced funding patterns and increased funding for CSOs operating in developing countries and their participation in national coordination structures. The creation of international alliances and partnerships has accelerated momentum around certain diseases, creating legitimacy for funding, enabling the sharing of research and knowledge and avoiding duplication of investments and activities. Global alliances such as GAVI have successfully worked with local organisations to ensure vaccines are affordable in low income countries. Their operating model utilises partners from both the public and private sectors and also avoids duplication of services by different partners. The International Health Partnership (IHP+), consisting of 31 developing countries and 25 bilateral and multilateral partners and foundations, successfully engages civil society; CSOs are members of the executive committee of IHP+. In SSA, partnerships in the health sector have been substantial in pooling resources, creating bargaining power and pushing specific health agendas. The FBOs in several countries have created alliances that have enabled them to benefit from affordable medicines, health workers paid for by government, and reimbursements for their health services. However, alliances do not always provide the solution to the risk of fragmentation; for example, in Kenya there are several HIV/AIDS alliances, making it difficult to identify the legitimate alliances and their respective roles, leading to a lot of effort being spent on alignment and potentially a duplication of services.

The important role of CSOs is illustrated by the acknowledgement and institutionalisation of partnerships. Several organisations, including governments, UN agencies and other major health sector players have increasingly acknowledged the critical role that CSOs play in the health sector. As a result, most of the health sector stakeholders,
including WHO, UNAIDS, UNICEF and the Global Fund, among many others, have established formal channels for CSO involvement, developed frameworks for cooperating with CSOs and some have departments that specifically deal with CSO engagement, and conducted research on CSO involvement in health. In South Africa, health CSOs derive funding from a government instituted mechanism, where formally registered non-profit entities can both enjoy tax benefits and draw funds from the Minister of Welfare, who can prescribe benefits and allowances for registered non-profit organisations.16

CSOS IN SUB-SAHARAN AFRICA

In SSA, CSOs are an important partner in health; they are influential in advocating for health systems strengthening as well as a key partner in improving health outcomes. An illustration of their key role is the fact that several governments have formal agreements with CSOs for service delivery, with strong examples from Kenya17, Lesotho18 and Malawi (as profiled in this study through the Christian Health Association of Malawi). The role of CSOs in health care delivery in Africa is not static. It has evolved and continues to expand in response to changing development needs and government capability and responses across the different sub-Saharan African countries. Over time, the role of CSOs has evolved from a primary focus on service delivery (aiming to provide access and quality) to a more sophisticated engagement with government and the highest levels of leadership in order to influence and frame national and international health agenda and spending through advocacy. These roles are increasingly carried out through engagement in partnerships and collaborative frameworks across civil society sector (through alliances, networks etc.) and with stakeholders from business, government and international institutions. In these partnerships, CSOs increasingly play the role of enabler in driving change in collaboration with other stakeholders.19

The transition to becoming an influential player in health policy is dependent on government creating an enabling environment for CSOs to operate and also providing platforms for them to engage in national health policy and strategy. However the transition and acknowledgement by government that CSOs are a legitimate partner is accompanied by responsibilities. CSOs have to be coordinated as a sector, in addition to being transparent and accountable.

EVOLUTION OF THE ROLES OF CIVIL SOCIETY ORGANISATIONS IN THE HEALTH SECTOR

Overview

The role, structure and operations of CSOs are perpetually shifting as a result of changes in underlying health needs (disease development and epidemics), their operating environment (e.g. legal framework, and funding) and new opportunities such as those provided by technological innovations. These forces have defined the CSOs space in the past and will continue to do so into the future.

Epidemics like HIV/AIDS and disasters like drought and famine (e.g., in Ethiopia) change the health needs and therefore strongly impact the number of CSOs, their focus areas, and target groups.

In the operating environment, we can see the impact of government performance as well as of the focus and approach of funders on the CSO landscape and operating models. Weak government reach and a strong network of faith-based organisations doing direct service delivery in East Africa meant significant contribution in that sector compared to, for instance, Senegal or even South Africa.

Driven by the strong funder focus and the large amounts of funding mobilised for HIV/AIDS, the relatively low prevalence of HIV/AIDS in West Africa, compared to Eastern and Southern Africa, has led to divergences in the number, focus areas and overall development of CSOs. Currently, shifts in funding from the CSOs headquartered in the North to local CSOs will lead to an upsurge of national NGOs over international NGOs and compel international NGOs to register local chapters. Furthermore, the reduction in funding following the economic recession has led to greater focus on income generation even among FBOs, with fees for service models introduced in health facilities.

The approach taken by funders has also impacted the operating model and capabilities of CSOs. For example, the Global Fund’s funding requirements and channelling of funds through NGOs altered and strengthened their accountability structures and forced governments to work hand-in-hand with the civil society sector.
Evolution of the Role of CSOs from 1980s to Date

In the 1980s, the CSO sector was predominately faith-based, stemming from missions that had been operating in the continent from colonial times. The famine and hunger in the continent in the Eighties led to the response of several international NGOs to work in peripheral areas where the government was not present. This led to the CSOs setting up permanent offices in some of these areas after the disasters to continue providing services.

The 1990s was a period of increased prominence of the operations of CSOs in the health sector. Bureaucratised government systems and weak systems of accountability led to several donors channelling development funds directly to CSOs in the countries largely working through international NGOs. Increased funding in this sector led to a surge in the registration of local CSOs and CBOs to work as partners with the international NGOs that were the main recipients of funding to implement community projects.

From the year 2000, the HIV/AIDS epidemic in SSA could not be addressed by government alone and required novel approaches. The Global Fund requirements of a country response that was inclusive of all actors was a game changer in the CSO sector in providing increased funding levels and engaging CSOs in decision-making bodies. CSOs were required to work in partnership with governments, while maintaining their role of ‘watchdog’ of government. Working together in health coordination bodies has greatly improved the relationships between CSOs and governments that were previously antagonistic, and CSOs have also played a more prominent role in health strategy and policy development.

While in the years prior to 2008 CSOs were benefitting from increased funding being directed to the health sector, the global financial crisis and emergence of several countries as middle income countries have now restricted the number of donors operating in the sector and the amount of funding available. CSOs are now operating in a contested space in which they compete for funding that has greatly reduced.

The global recession and reductions in The Global Fund and United States President’s Emergency Plan for AIDS Relief (PEPFAR) funds have increased demand for government funding to the health sector. This is expected to change the terrain in the next few years as well as the relationship between CSOs and government.

CSOs are now operating in a contested space in which they compete for funding that has greatly reduced.
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<tr>
<td>• Structural Adjustment Programmes (SAPs) leading to reduced spending by government on the health sector and introduction of fees for service in the health sector to address financial sustainability</td>
<td>• HIV crisis</td>
<td>• Refocus on diseases such as Tuberculosis and maternal deaths and infant mortality</td>
<td>• Increase in non-communicable disease burden</td>
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<td>• Famine and over-population with corresponding high death rates</td>
<td>• Millennium Development Goals designed</td>
<td>• Paris Declaration requiring donors to align to country systems and harmonisation in priority areas</td>
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<td></td>
<td>• Human rights approach to health care</td>
<td>• Moving away from lateral funding for diseases to a health systems strengthening approach</td>
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<td>• Largely faith-based affiliated CSOs</td>
<td>• Emergence of local NGOs and CBOs</td>
<td>• Trend towards building alliances such as International Health Partnership (IHP) and in-country health CSO networks</td>
<td>• Stronger roles for local CSOs as driven by donor focus (e.g., USAID Forward requiring funding channelled through local organisations)</td>
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<td>• International NGOs</td>
<td>• Increasing number of CBOs particularly those working on HIV/AIDS issues</td>
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<td>• Increasing partnerships with the private sector and government for PPP opportunities in the health sector</td>
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<td>• Alliances emerging such as GAVI</td>
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<td>• Networks between south to south coalitions to create increased bargaining power</td>
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<td>• Trend towards building alliances such as International Health Partnership (IHP) and in-country health CSO networks</td>
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<td>• Population</td>
<td>• HIV/AIDS</td>
<td>• HIV/AIDS, TB and Malaria</td>
<td>• Non-communicable diseases (NCDs)</td>
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<td>• Nutrition</td>
<td>• Maternal Health</td>
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<td>• Health financing</td>
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<td>• Convergence of technological solutions for health systems</td>
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<td>• Service Delivery</td>
<td>• Service delivery particularly using community approaches (Home Based Care for HIV/AIDS)</td>
<td>• Service delivery</td>
<td>• Reduced funding may impact on the contribution to service delivery</td>
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<td>• Increased role in advocacy</td>
<td>• Advocacy and policy contribution</td>
<td>• Design of innovative models for health care financing</td>
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<td>• Increased role in training, including for both formal health workers and community health workers</td>
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<td>• Rural and poor communities</td>
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<th>Funding</th>
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<th>2000 - 2005</th>
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<tr>
<td>• Direct support to NGOs by bilateral donors</td>
<td>• Establishment of the Global Fund</td>
<td>• Global financial crisis leading to a reduction in funding availability</td>
<td>• Development of fees for service models to address financial sustainability</td>
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<td>• FBOs receiving funding for programmes from their international networks</td>
<td>• Increased funding for HIV/AIDS with Global Fund and PEPFAR commitment</td>
<td>• New funders, including social impact investors, philanthropists and foundations</td>
<td>• Creation of funding mechanisms by governments to fund CSOs for service delivery</td>
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<td>• Funding in the CSO sector (1990-1999) is estimated at $23BN</td>
<td>• Funding in the CSO sector (2000-05) is estimated at $24.8BN</td>
<td>• Funding in the CSO sector (2006-10) is estimated at $64.6BN</td>
<td>• Development of PPP models for efficient service delivery</td>
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<td>• Funding for the CSO sector (2011) is estimated at $40.6 BN²</td>
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21 Funding figures are retrieved from development aid flows statistics available at www.oecd.org
A nurse carries a child from theatre following reconstructive surgery by AMREF outreach surgeons in Moshi, Tanzania. Courtesy of AMREF
CSO Contribution to Health Systems Strengthening in SSA

This chapter highlights the contribution of CSOs in SSA across the WHO’s six building blocks of health systems framework discussed in Chapter One and assesses their value addition and the level of impact they are having on improving health outcomes.

SERVICE DELIVERY

CSOs have been at the forefront of ensuring equitable access to health care by engaging in direct service delivery, working in collaboration with government and other key partners. As enablers for health access, CSOs are responsible for a large proportion of health care delivery both to the general population and to the special needs population in rural, urban informal and remote areas. The figure below demonstrates the contribution of CSOs in selected SSA countries.

Besides sheer reach, CSOs have a specific focus in service delivery on aspects such as strengthening community health systems, reaching the marginalised, providing specialised services, innovating in service delivery and providing integrated health services.

Figure 2: Service Delivery Contribution by CSOs

CSO Contribution to Health Services through Clinics and Hospitals

Level of service provision by CSOs in comparison to other providers (public and private) in selected African countries

Sources: GAVI website; Stakeholder engagement; PEPFAR report - Firm Foundation: The PEPFAR Consultation on the Role of Faith Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS; Dalberg analysis
Community health systems strengthening (CSS): CSOs have successfully provided leadership in re-orienting health services to promote access, prevention and care at the community level. Focusing on health interventions at the community level has ensured health interventions are relevant to the community’s needs. Working closely in communities has made it possible for CSOs to identify the vulnerable people - including orphans and vulnerable children (OVC), pregnant women and the elderly - who would qualify for social services. The CSS approach has also transformed the delivery of health care to include task shifting to community health workers, easing the burden on other categories of health workers. The Primary Health Care (PHC) movement, which mobilises community involvement in promotion of preventive health care, has been attributed to CSOs and is one of their key successes to date. CSOs like AMREF are advocating for consideration of CSS as an additional building block to the health systems framework.

Reaching marginalised communities: CSOs remain critical in the provision of health services to marginalised communities. In Malawi, CSOs have the widest reach to marginalised populations, with the Christian Health Association of Malawi providing over 60% of health care in rural areas. As health care continues to focus on preventative measures, a grassroots approach of bringing health services closer to communities is required. CSOs are especially well placed to address this shift, have a comparative advantage in already established community networks and can lead innovation to address health challenges at the community level.

Providing specialised services: CSOs have been pioneers in providing specialised health care services. Their agility and flexibility enables them to be responsive to emerging health issues that require increased investments to address health concerns that may affect a smaller population. For instance in Kenya, the Christian Health Association of Kenya (CHAK) currently manages the only physical rehabilitation centre for children. In reproductive health, CSOs have led with promoting access to reproductive health services including family planning services. With the alarming increase in prevalence of NCDs in the region, CSOs are at the forefront of advocating healthy lifestyles and treatment literacy for disease management. However, the high cost of care for some specialised services (such as cancer) has restricted the number of CSOs providing such services.

Innovating service delivery: CSOs have been promoting social franchises to increase access to quality health care in the region. International CSOs such as Marie Stopes and Population Services International (PSI) have several local franchises in the region. The models are creating sustainable delivery models for health care and ensuring access to quality health care in hard-to-reach areas. The health franchise, Profam Healthcare in Cameroon has over 80 family planning clinics in both urban and rural areas. The franchise model has benefits in economies of scale, with pooled procurement and shared training providing lower cost models for quality health care.

Providing integrated health services: In the delivery of health care, CSOs are able to expand their services to address social determinants of health or refer patients to partner organisations to achieve the required health outcomes. Provision of clean water, adequate nutrition and advocacy on healthy behaviour are some of the value additions that CSOs provide in delivery of health care, especially in contexts in which these responsibilities are distributed across different government institutions. AMREF has succeeded in providing a compendium of services that address health needs in the different countries it works in. AMREF works with communities to assist in ensuring access to clean water and also works closely with local government in developing health priorities for communities. In South Africa, the CSO Emmanuel Haven is successfully providing care and treatment services to HIV patients in Port Elizabeth in addition to providing food products from its horticultural farm and life skills that support development of small business initiatives.

24 Social franchising is the application of the principles of commercial franchising to promote social benefit rather than private profit. In health, a social franchise is defined as network of private health providers that is operator owned, payments are made for services provided and services are standardised.
HEALTH FINANCING

CSOs have shaped the international health policy landscape and the broader discourse around global health. They have been able to put the spotlight on and channel funding to neglected areas such as maternal and reproductive health. However, as the funding for this sector is largely donor-driven, several CSOs have had to focus on donor priorities that do not necessarily correspond to the needs of the citizens. Apart from their direct contribution of funding, CSOs have focused on the management of health funds and advocacy for increased funding for the health sector. They have also been pioneers in innovation for health financing, including the promotion of health saving schemes using mobile phones, promotion of health vouchers for reproductive health and development of low-cost health delivery models.

Direct contribution of CSOs to health care expenditure: The CSO sector is a key contributor to health care financing in the region. The expenditure by civil society organisations is growing at a faster rate than government-channelled funds and thus contributing significantly to the development of health care in Africa. In SSA the contribution made by non-profit organisations serving households has increased by almost 50% in the 5-year period from 2006 to 2010. The increased funding in the sector is largely HIV/AIDS-focused. With expected funding reductions, CSO contribution to health expenditure will decrease significantly.

Figure 3: SSA Private Health Composition and Non-Profit Health Expenditure

SSA Private Health Expenditure Composition 2010

OUT OF POCKET 61.6%
INSURANCE 28.5%
NON-PROFIT 7.7%
OTHER 2.2%

SSA Private Health Expenditure 2006 - 2010, in billions of USD PP terms

2006 2007 2008 2009 2010
3.5 4.0 4.5 4.8 5.1
+9.6%

Source: WHO National Health Account Estimates; Dalberg analysis
* included all SSA countries except Zimbabwe and Somalia for which there is no data available

25 http://asenetwork.org/resources/case-studies/emmanuel/#more-1018
The contributions made by CSOs vary across individual SSA countries. The variation is driven by differences in the strength of the country in social service delivery and disease prevalence levels such as HIV/AIDS, which unlocks funding sources for CSOs. The CSO sector has been able to access a wide range of the resources available to the health sector as a whole because of their recognition as a legitimate partner in the health sector.

**Management of health funds:** CSOs are particularly important as a channel of funds for PEPFAR, the Global Fund and large foundations such as the Bill and Melinda Gates Foundation. In Kenya, the CSO sector manages 29.5% of health funds, the government manages an estimated 36.6% of health funds and the remaining 33.9% is managed by the private sector.26 In the management of funds, CSOs are involved in providing direct services and other health promotion activities or disbursement of funds to smaller CSOs for project implementation.

**Advocacy for health financing:** Universal health coverage has become a priority for all governments, despite varying implementation approaches to achieve this goal. The CSO sector has actively campaigned for governments to work towards universal health coverage. The global People’s Health Movement, consisting of grassroots health activists, CSOs and academic institutions, launched a national health insurance civil society coalition in South Africa in 2012, and led the third People’s Health Assembly in Cape Town, bringing together experts from health and political sectors worldwide.

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to campaign for Universal Health Coverage in South Africa. Furthermore, the Budget and Expenditure Forum monitors government spending in health care in South Africa. The Africa Public Health Alliance +15% campaign monitors government health expenditure and campaigns for increased resources for the sector.

However, as governments consider different approaches to achieve universal health coverage, the increase in the proportion of funds managed by CSOs and donors creates parallel channels to government systems. Some of these funds can be diverted into a more sustainable and broad based risk pooling mechanism for universal health coverage that would promote access to equitable health care for all.

**Innovation in health financing:** CSOs have led innovations that aim to reduce out of pocket expenditure. The Ecumenical Church Loan Fund, a micro-finance institution in Kenya, has a health plan pegged on its financial products to promote health insurance coverage. In addition, the promotion of health vouchers for reproductive health has successfully increased attendance of pre-natal care and has promoted safe deliveries. In Uganda, the Safe Motherhood voucher programme distributed over 100,000 vouchers during a two-year period, enabling access to affordable health care. Increasing the scale of the voucher programme by a factor of 10 would mean an additional 1,820 deaths and 2,400 still births averted annually.27

**HEALTH WORKFORCE**

In SSA, the health work force is plagued by severe shortages, inappropriate skills mixes and gaps in service coverage. In 2006, WHO estimated that approximately 1.5 million additional health workers were required in Africa to meet the minimum density of 2.28 health workers per 1,000 people to provide essential care.28 The contribution by CSOs to the health workforce is invaluable. Profiled below are contributions of CSOs on four levels: training, innovation of training delivery models, improving equitable distribution of health workers and advocacy for health workforce.

**Health workforce training:** CSOs play a pivotal role in health workforce training, through involvement in setting up and running of training institutions; developing, implementing and scaling up of new training modules; as well as advocacy for improvement of health training. For instance in Tanzania, CSOs manage about 46% of the training institutions for lower cadre health workers.29 This directly increases the number of graduates in the sector without increasing the burden on government institutions. In South Sudan, AMREF has trained 70% of the country’s clinical officers. Community health workers (CHWs) play an integral role in providing health services in rural areas. It has been estimated that doubling current investments for reproductive, maternal and neonatal programmes to $24.6 billion annually would save the lives of 1.7 million newborns and 251,000 women annually. Civil society has pioneered models of community health worker training and service delivery.30 In Malawi, NGOs’ support to community workers has increased immunisation coverage, reducing disease incidence of meningitis by 50%.

**Innovation in training delivery:** CSOs have led the design of innovative training delivery methods. This has included eLearning and recently mLearning curricula that enhance access to health training particularly for health workers in rural areas. In Kenya, AMREF, in partnership with the government, has enhanced nurses’ education through distance learning, which contributed to a 31% increase in the number of registered nurses.31

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28 AfDB website: This threshold is based on studies done by the Joint Learning Initiative, comprised of global health experts, in which it was found that a density of 2.3 health care workers per 1,000 population was associated with 80% coverage in skilled birth attendance and measles vaccination.
30 Core Group, 2012 How Effective are Community Health Workers.
31 AMREF Website www.amref.org
The design of innovative training delivery has increased the number of health workers with minimal disruption of health services. It is estimated that replicating AMREF’s model could increase the current nursing workforce nine times faster than the current infrastructure in Ghana, Nigeria and Senegal. Providing training in rural areas also encourages health workers to remain in their localities, reducing the urban bias for health workers, enhancing the equity in distribution of health workforce. For CSOs to have the required impact in the sector, close working relationships with government to receive the required approvals for curricula and to use government infrastructure (training centres) is required.

**Distribution of health workers:** CSOs such as African Health Placements (AHP) are addressing the severe shortage of health workers in rural areas in South Africa. Amongst others, AHP is involved in creative recruitment campaigns to attract local and international health workers and managers to work in permanent or volunteer posts in government and NGO facilities. To date, the organisation has placed over 2,500 health workers in rural and underserved areas of South Africa.

**Advocacy for human resources for health:** To respond to the health workforce crisis, CSOs have campaigned for policies and actions to address health worker production and to improve the distribution and performance of existing health workers. This has led to an increase in resources directed towards health personnel development and medical training has quadrupled from USD86m 2000 to USD364m in 2011. At a global level, The Global Health Workforce Alliance (GHWA) is a platform comprising of national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating health workforce solutions. AHP constantly focuses on identifying and helping to solve bottlenecks in any human resources function, such as lengthy accreditation and visa procedures for foreign staff.
LEADERSHIP AND GOVERNANCE

CSOs play a central role in supporting governments, donors, and other global health actors to respond to the needs of communities. CSOs contribute by being the voice of the community, promoting accountability and transparency, monitoring quality and developing policies and regulations.

Being the voice of the community: The representation of CSOs in different government committees and forums enables them to contribute to defining government priorities. The case study of SWAA profiles the CSO’s engagement in policy development in Senegal. Though engagement is necessary, it is important to create a balance on the number of committees that individual CSOs have to be involved in to have a meaningful impact, as this can put a significant strain on their resources, especially when the mandates and roles of the committees are not clearly defined.

Promoting accountability and transparency: CSOs have also fostered more accountability and transparency in the sector. The CSO sector has been active in monitoring health expenditure and putting pressure on governments to honour their commitments to the MDG targets and Abuja health expenditure target of 15% of GDP.

Monitoring quality: Whilst monitoring quality remains a preserve of government, the CSO sector identifies best practices and develops treatment standards that government can easily adopt for implementation, such as in treatment guidelines and protocols for HIV/AIDS management. The South Africa National AIDS Council has benefitted from the inclusion of civil society in the council; CSOs have been able to influence and advise on government treatment protocols.

Developing policies and legislations: Historically, CSOs have played an important role in influencing and shaping health policies, as well as in evaluating their impacts and outcomes. Treatment Action Campaign (TAC), which advocated affordable, universal access to life-saving anti-retroviral drugs in South Africa against a powerful global drug manufacturing industry, is a case in point. TAC was very central in the advocacy for and adoption of the Medicines and Related Substances Control Amendment Act of 1997 that significantly increased access to anti-retrovirals for a majority of South Africa’s People Living with HIV/AIDS (PLWHA), and has been used as a blue print by other countries such as India. AMREF Kenya is currently represented on various government working groups, where it participates in development of policies and legislation for the health sector.

HEALTH INFORMATION SYSTEMS

There has been tremendous activity and innovation in the development of health systems spurred by growth of technology and mobile phone penetration in the region. That said, the support of donors to different programmes and CSOs has led to an uncoordinated approach, with a focus on vertical systems that focus on single diseases or single donor reporting requirements. For example, in Tanzania the Ministry of Health (MOH) has over 20 separate information systems that are not integrated.

The key area that CSOs have contributed to is in capacity building and development of innovative data collection tools, easy to use applications and registers. In Ghana, for instance, the CSO Mobile Technology for Community Health (MOTECH) has developed two interrelated mobile health services, the “Mobile Midwife” application and the “Nurses’ Application”, which help nurses and community health workers to record and track the care delivered to women and newborns in their areas. Mobile technology, including Personal Digital Assistants (PDAs), has been used successfully in Ghana in the collection of health data that feeds into the District Health Information System (DHIS).

The CSO Cell-Life in South Africa has developed open source health data collection and management applications for mobile phones and personal digital assistants that assist in data collection for HIV treatment literacy practitioners, mass messaging around HIV/AIDS, ARV drug dispensing and data collection on aftercare for HIV patients. Their pharmacy management system iDART is currently being used in over 100 district clinics and over 260 ART referral sites. The system deployment has grown, and currently has more than 300 000 patients receiving ARV treatment every month. This has improved the drug supply chain management in the country.

**ACCESS TO MEDICINES, TECHNOLOGY**

Reliable supply of medical commodities promotes effective and equitable health care. CSOs have been involved in quality assurance, warehousing and delivery of essential medicines, particularly with a focus on hard-to-reach areas and marginalised communities. Mission for Essential Drugs and Suppliers (MEDS) in Kenya is a good example of CSO involvement in ensuring access to medicines and technologies. In 2006, MEDS was appointed as one of the distributors for PEPFAR and benefitted from partnerships that have enabled them to have their laboratory pre-qualified by WHO. This has enabled them to offer value added services such as the quality testing of medicines and training on rational medicine use. To date, the organisation is able to supply medicines to Central and Southern Africa. It is noteworthy that the CSO sector, specifically the FBOs, has benefitted from increased drug contributions by the Global Fund and PEPFAR, forcing them to strengthen their systems to benefit from the increased funding and opportunities in the sector.

**Reliable access to medical supplies:** The FBO pharmaceutical network in Kenya, Tanzania, Rwanda and Uganda provides affordable, life-saving medicines to 40% of the people living in those countries. Their participation in this sector is invaluable. A recent survey in Uganda showed that the availability of key essential medicines in mission health facilities was 57% higher than both the public and the private sectors. Other local CSOs actively engaged in this sector include franchises of drug stores that provide access to genuine and affordable medicines in rural areas. The Sustainable Health Foundation runs the franchise Child and Family Wellness (CFW) stores, and to date has over 60 micro-drug stores in Kenya, reaching over 2.5 million patients. The foundation has plans to expand to Rwanda, having recently signed a public private partnership agreement with government.

**Emergency situations:** CSOs also play a key role in procuring medicines and medical supplies for emergency situations. CSOs, in particular the INGOs such as the Red Cross and their local chapters can quickly mobilise resources due to their large networks and dispatch supplies to affected areas.

**PERSPECTIVES OF CURRENT CONTRIBUTION GOING FORWARD**

The level of contribution of CSOs is significant across the six health systems building blocks. However, the focus of intervention is still largely driven by activities addressing the HIV/AIDS epidemic. Several advocates see a clear and complementary role division between CSOs and other actors. In the ideal situation, government focuses on providing an enabling environment, policy and standards development and quality assurance, whilst CSOs provide support in health care delivery using government or own structures. Others view service delivery as a key task of government and see a more important role for CSOs in building capacity of government to deliver and holding them to account through checks and balances.

Whatever the role division, many government systems are currently overburdened and therefore CSOs will continue to contribute significantly to the development and delivery of health care in the region. The challenge will be to ensure alignment and complementarity, both amongst CSOs and between CSOs, government and private sector, whilst continuing to provide checks and balances and holding government to account.

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37 PEPFAR FBO Contribution to Health Care 2012.
38 Sustainable Health Foundation website available at http://www.cfhshops.org/overview.html
Lay Counsellor Rose Tembe speaks with a client at the KwaNdaba Clinic in UMhanyakude, KwaZulu Natal Province, South Africa. Courtesy of AMREF.
In this chapter, we have profiled CSOs from five countries – Kenya, Malawi, South Africa, Senegal and Ethiopia – that have contributed significantly to improved health outcomes in the SSA region.

Country Case Studies

We based our choice of CSOs profiled here firstly on their impact on health outcomes of the respective countries. Secondly, we sought to illustrate the success factors we identified for effective CSOs. Therefore, we have selected CSOs based on (1) their ability to be clear on their mission and definition of success, (2) their ability to align their activities with their capabilities and processes and (3) their ability to form strong partnerships with governments and other stakeholders. As a results, the case studies represent CSOs which have been able to organise themselves to respond to the changing terrain, whilst remaining true to their mission.

In Kenya we have profiled AMREF, which has been successful in building a strong African CSO that has offices in five countries and two regions. We have highlighted their success in being responsive to the environment while remaining strategically aligned to the organisation’s and country’s health goals. In Malawi, we have profiled CHAM, which has been successful in improving access to health care for rural communities by building partnerships with government. In South Africa, we have profiled the Treatment Action Campaign that has successfully lobbied for the right to health for citizens and continues to address the recent challenges in health funding and weak health systems to deliver on the rights they have campaigned for. In Senegal we have profiled SWAA that has been successful in building a local pan-African NGO focused on promoting the right to health for women. We have delved into their innovative models of interacting with community structures to increase engagement. In Ethiopia we have profiled the Consortium of Christian Relief and Development Association (CCRSA) whose history is closely linked to the development of the CSOs in the country and that is currently trying to define its identity as it responds to shifts in the sector.
### Figure 4: Selected case study countries

<table>
<thead>
<tr>
<th></th>
<th>Senegal (People)</th>
<th>Ethiopia (People)</th>
<th>Kenya (People)</th>
<th>Malawi (People)</th>
<th>S.A. (People)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>12.8M</td>
<td>84.7M</td>
<td>41.6M</td>
<td>15.4M</td>
<td>50.5M</td>
</tr>
<tr>
<td>GDP per capita</td>
<td>$1,119</td>
<td>$357</td>
<td>$808</td>
<td>$365</td>
<td>$8,070</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>0.7%</td>
<td>1.4%</td>
<td>6.2%</td>
<td>10%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Health expenditure % of GDP</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Non-profit % of health expenditure</td>
<td>1.6%</td>
<td>7.8%</td>
<td>5.9%</td>
<td>15.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Health workers per 1000 population</td>
<td>0.4</td>
<td>0.2</td>
<td>1.3</td>
<td>0.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Number of CSOs</td>
<td>&gt;500</td>
<td>&gt;2,100</td>
<td>&gt;8,000</td>
<td>N/A*</td>
<td>&gt;76,000</td>
</tr>
<tr>
<td>CSO contribution to health service delivery</td>
<td>1% - 3%</td>
<td>5% – 7%</td>
<td>~65%</td>
<td>~37%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Table sources:
1. World Bank Development Indicators;
2. UNAIDS HIV estimates 2011;
3. WHO estimates for country National Health Accounts
4. Africa Health Workforce Observatory, WHO (ratio includes doctors, nurses and mid-wives, 2004 est.)
5. Various: Kenya – National NGO Coordination Bureau, SA – Department of Social Services, Senegal, Ethiopia, Malawi – USAID 2011 CSO Sustainability index for SSA;
1. **Disease burden:** Crude birth rate of 37.61/1000, under five mortality of 74/1000, maternal mortality of 484/100,000, vaccination rate among children of 77%, delivery in health care facilities of 43%, and HIV Prevalence of 6%.¹

2. **Number of CSOs:** 8,000 total registered CSOs - 3,000 of which are in health care.²

3. **CSO contribution to service delivery:** 8,357 health facilities, with 49% in the public sector, 33% in the private sector and 16% non-profit CSOs. CSOs provide an estimated 60% of health care services in arid and semi-arid areas.³

4. **CSO contribution to health financing:** The CSO sector is currently managing 30% of funds in the health sector. Community-based health financing schemes currently cover 1.2% of the population in Kenya.⁴

5. **CSO contribution to health work force:** FBOs own 32 out of the 79 medical training institutions.⁴ AMREF trains over 10,000 nurses and health workers per annum through their various programmes.⁵ Other CSOs like Intra-Health, with their Capacity Kenya programme and Funzo Kenya project, have also provided training to health workers in rural areas.⁶

6. **CSO contribution to leadership and governance:** CSOs, through HENNET, are represented in the Health Sector Coordinating Committee (HSCC) and each of the 18 health inter-agency coordinating units (ICCs), In addition, HENNET has district focal point persons who attend District Health Stakeholders Forums and report back on key highlights to the network. HENNET is a recognised partner to government, is a signatory to the health sector Code of Conduct and was key in the process of drafting the Public Benefits Organisations Bill; after some concessions, this bill was passed as an Act of Parliament in January 2013.⁷

7. **CSO contribution to health information management systems:** Limited CSO involvement.

8. **CSO contribution to access to medicine and technology:** Mission for Essential Drugs and Supplies (MEDS) is a FBO providing medical supplies. MEDS sales in 2011 totalled $187m. MEDS supplied over 12 countries in SSA with medicines in 2011 and is currently supplying to Southern and Central Africa.⁸

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**Sources:**
1 WHO Health Database
2 NGO Coordination Board
3 Master Facility List; 2011
5 Interview with CHAK
6, 6 Interview with HENNET secretariat
7 Interview with HENNET secretariat
8 MEDS Annual Report
Kenya

Kenya is characterised by a fairly robust CSO sector, with strong contribution of CSOs to the health sector.

COUNTRY CONTEXT AND DEVELOPMENT CHALLENGE

Kenya is faced with a high disease burden, with a high HIV prevalence relative to most of its East African neighbours. Kenya also grapples with fewer numbers and poor quality of health workers – 1.3 doctors, nurses and midwives per 100,000 people compared to WHO minimum prescribed threshold of 2.3. Government spending on health care is low, currently at 4.75%\(^\text{40}\) of GDP, significantly less than the Abuja Declaration target of 15%. Kenya’s dependence on donors to finance the health sector has increased between 2006 and 2010 from 21% to 36%\(^\text{41}\) for total health expenditure. Generally, Kenya is characterised by a fairly robust CSO sector,\(^\text{42}\) with strong contribution of CSOs to the health sector. Across the WHO Health Systems Framework, CSOs in Kenya are trendsetters for the region. FBOs contribute an estimated 65% of total direct health services rendered and own and run approximately 40% of the health training institutions.

This section profiles AMREF, one of leading health CSOs in the continent, headquartered in and with operations originating from Kenya. The profile includes the work of AMREF in other countries beyond Kenya.

40  WHO National Health Accounts estimates 2010.
41  WHO National Health Accounts estimates.
42  Kenya and South Africa achieve top rankings in Africa in the USAID CSO sustainability index 2011.
## AFRICAN MEDICAL AND RESEARCH FOUNDATION

### Organisation Overview

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>AFRICAN MEDICAL AND RESEARCH FOUNDATION (AMREF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding year</td>
<td>1957</td>
</tr>
<tr>
<td>Focus areas</td>
<td>AMREF’s goals focus on health priorities and supporting mechanisms:</td>
</tr>
<tr>
<td></td>
<td>1. Making pregnancy safe and expanding reproductive health</td>
</tr>
<tr>
<td></td>
<td>2. Reducing morbidity and mortality among children</td>
</tr>
<tr>
<td></td>
<td>3. Scaling up HIV, TB and malaria responses</td>
</tr>
<tr>
<td></td>
<td>4. Preventing and controlling diseases related to water, sanitation and hygiene (WASH)</td>
</tr>
<tr>
<td></td>
<td>5. Increasing access, by disadvantaged communities, to quality medical, surgical and diagnostic services</td>
</tr>
<tr>
<td></td>
<td>6. Developing a strong research and innovation base to contribute to health improvement in Africa</td>
</tr>
<tr>
<td></td>
<td>7. Developing a stronger and unified AMREF</td>
</tr>
<tr>
<td>NOTE:</td>
<td>Capacity Building is overarching and cross-cutting in the seven goals.</td>
</tr>
<tr>
<td>Country reach</td>
<td>5 country offices – Kenya, Ethiopia, South Sudan, Uganda and Tanzania and two regional offices in South Africa and Senegal.</td>
</tr>
<tr>
<td></td>
<td>More than 30 African countries reached through training and consulting services.</td>
</tr>
<tr>
<td></td>
<td>Additionally AMREF has 11 offices in Europe and North America.</td>
</tr>
<tr>
<td>Number of staff</td>
<td>1,000 staff in Africa</td>
</tr>
<tr>
<td></td>
<td>(15 nationalities, over 99% African, &gt;200 health professionals – doctors, nurses and other health professionals)</td>
</tr>
<tr>
<td>Governance</td>
<td>International Board made up of 15 members – 5 from country advisory councils in Africa, 5 from the European and North American offices, 5 highly qualified technical experts.</td>
</tr>
<tr>
<td>Programme expenditure</td>
<td>&gt;$ 70m p.a. ($ 73m in 2012, projected $80m in 2013)</td>
</tr>
<tr>
<td>Programme reach</td>
<td>&gt;10 million lives annually (7 million lives covered in the 6 months from March to October 2012).</td>
</tr>
</tbody>
</table>

AMREF has expanded and reached over 7 million people, covering over 35 countries, with country or regional offices in seven countries and a staff of over 1,000.
Background

The African Medical and Research Foundation (AMREF) is one of the leading Africa-based international organisations working in health development, founded in 1957 as the Flying Doctors of East Africa. AMREF has a vision of creating lasting health change in Africa by supporting communities to build the knowledge, skills and means to maintain their good health and to break the cycle of poor health and poverty.

From its origins in Kenya, AMREF has expanded and reached over 7 million people, covering over 35 countries, with country or regional offices in seven countries and a staff of over 1,000. Future plans include expansions into Malawi and Mozambique and additional West Africa countries.

AMREF country programmes differ in size, scope and impact. Kenya’s programme, for instance, is the longest standing; it covers the entire breadth of AMREF’s focus areas and has achieved the largest scale impact. Other East African programmes in Tanzania and Uganda are fairly significant in size as the initial expansion point for AMREF beyond Kenya. AMREF’s focus in these countries is on HIV/AIDS, maternal health, water and sanitation, and capacity building for health workers. In South Sudan, a country emerging from more than 20 years of civil war, AMREF is working directly with the government, through the Ministry of Health, to strengthen health systems through capacity building for health workers. In Ethiopia, AMREF is training health workers in nomadic and pastoralist communities. Country offices in Senegal and South Africa are more recent additions and are growing in size, scope and impact. AMREF’s expenditure patterns indicate the relative size of country programmes and are distributed as follows: Kenya – 35%, Tanzania – 21%, Uganda – 11%, South Sudan – 6%, Ethiopia – 5% and South Africa – 3%.

Successes

Bringing health closer to communities: AMREF’s vision for lasting health change in Africa has communities at the heart of it and success is measured by the real impact and the results arising in the communities. AMREF takes a holistic approach to health by focusing on the different components needed to effectively deliver health care. To this end, AMREF is training health workers, educating communities about preventive measures; improving the management of health services; supporting national, regional and local health authorities in service provision; providing laboratory services across East Africa; training laboratory technicians; and strengthening systems used to gather health information from the community level right up to the national level.

Some examples of the work done by AMREF in its various community-focused programmes are:

- **HIV/AIDS/TB**: AMREF works closely with local communities to stop new infections of HIV and minimise its impact on people already infected. In Tanzania AMREF’s Angaza testing and counselling model was adopted by the government and also influenced modelling of other counselling and testing approaches that have been introduced in the country, i.e. provider-initiated testing and counselling models. When Angaza was introduced, the Government had already begun introducing voluntary counselling and testing (VCT) in a number of regions, but Angaza brought in the quality aspect and client-centred and user-friendly model, increasing confidentiality aspects and quality assurance. Still there were a range of training curricula that needed harmonisation. AMREF (Angaza project) played a significant role in the harmonisation process, with Angaza training materials largely being adopted.

- **The health of mothers and children**: AMREF is committed to addressing the continuing high levels of mortality among mothers and children from preventable causes. Working towards achieving the MDGs, AMREF is focused on building the capacity of front line health services, including the community, to provide services with higher coverage and efficiency, particularly for hard-to-reach communities. Key target services are immunisation, nutrition, newborn care, greater access to skilled delivery and family planning, and integrated management of childhood illnesses, particularly at community level.
• **Pastoral communities:** AMREF has a wealth of experience working in nomadic areas in various health interventions. Due to this experience, in a community that is rarely well understood in which previously tried and tested solutions frequently do not work, AMREF was selected by USAID as the prime recipient of a $45M grant for the *Aphiaplus Kamili Programme* for Arid and Semi-arid Lands in Kenya.

• **AMREF’s clinical and diagnostics programme:** This programme has the dual aim of service delivery for patients who would otherwise have no access to the care they need, and training of local health teams in rural and underserved areas to be able to carry out this work for themselves. From four hospitals in 1967, AMREF’s Specialist Outreach Programme today serves more than 160 hospitals in Kenya, Tanzania, Uganda, Rwanda, DRC, Liberia, Ethiopia, Somalia and South Sudan through 3 to 5 day visits.

• **Equipping health workers with skills and capacity to serve communities:** AMREF is a key partner to governments in close to 40 African countries through its training programmes to strengthen capacity and capability of health and health-related professionals and institutions. Every year, AMREF trains more than 10,000 community health workers located at the grass-roots in marginalised communities. Training is also provided to doctors, nurses, community midwives, clinical officers, laboratory technicians and pharmacists. AMREF is a leader in innovation too, with the notable innovative eLearning and mLearning programmes which are helping to upgrade the skills of more than 20,000 nurses in Kenya.

• **Ensuring access to emergency health care by far-flung communities - AMREF Flying Doctors:** AMREF operates one of the most comprehensive air ambulance services in Africa, and the most expert in the region. The service covers East African countries, including Uganda, Kenya and Tanzania and, when clearance can be obtained, most neighbouring countries, including the Democratic Republic of Congo, Eritrea, Somalia, Ethiopia, Rwanda and Burundi. In 2011, 1,254 patients were evacuated in 35 countries.

• **Setting quality standards for rural laboratories - AMREF laboratory network:** The AMREF laboratory network provides clinical and public health support to several countries in the region. AMREF is also the lead partner in a WHO-supported programme to establish an external quality assessment model for primary level laboratories, which also aims to build capacity throughout East Africa. The overall programme has reached an estimated 5,000 laboratories, with Tanzania covering an impressive 4,000 laboratories due to their mega training programme in rapid HIV testing. Further, more than 450 laboratory staff from 24 countries have been trained under this programme.

• **Achieving international recognition and building a brand:** Partnership is central to AMREF’s strategy; AMREF has proved to be a critical partner to both government and development partners in East Africa and across the continent. Globally, AMREF is in official relations with the World Health Organisation (WHO) and is a member of the Global Health Workforce Alliance and the World Bank CSO Consultative Group on Health, Nutrition and Population. Nationally, within governments, AMREF is represented in approximately 86 committees and technical working groups, whose focus areas include health system support, HIV/AIDS, water and sanitation, and child and reproductive health. In addition, AMREF - both internationally and at a country level - is a member of more than 20 coalitions and networks of CSOs, including the global Health Workforce Advocacy Initiative for which it was selected as secretariat and is still the chair in transition, and locally, HENNET in Kenya.

AMREF has been globally recognised and rewarded for its pioneering work.

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43 USAID programme running from 1 January 2011 to December 2015, APHIA (AIDS, Population and Health Integrated Assistance) aims to ensure improved health outcomes through an approach that is people-led for universal access to services with intrinsic sustainability. Entails support for people and families living with or affected by HIV/AIDS.


45 Breakdown of lab outreach: Tanzania 4,000 labs, Kenya 200, Uganda 132, Outreach 35.
Success Drivers

Community as the centre of engagement: AMREF’s focus on community engagement as the centre of its interventions, coupled with its commitment to collaboration with government and other national and international players, is a key contributor to their organisation’s success. Through this approach, AMREF is able to drive evidence-based advocacy at national level and bring about real change in the communities it serves. This approach builds capacity of communities to not only develop the skills they need to meet their health needs, but also to demand of governments to meet their obligation of health care service provision.

Partnerships as pivotal to impact: Through its continued commitment to building partnerships with community based, national and international players in the health sector, AMREF has been a strong advocate for changes in the health sector, in both the national and global arena - thus contributing to the overall strengthening of health systems. These partnerships have enabled more structured and effective engagement with national governments, representation in government working groups and participation in drafting of health policies to influence the health agenda.

Appropriate governance and a qualified and diverse staff body: Human resource is a vital factor contributing to the success of AMREF’s interventions. AMREF has an international board that consists of health care professionals and experts who drive the strategy and agenda of the organisation in line with both national trends, defined by country offices, as well as global trends. AMREF has over 200 health professionals engaged at the community level, who are able to feed directly into the strategy-setting process of the organisation.

Knowledge sharing: AMREF continuously documents success stories arising from its interventions and shares these with stakeholders with a view to providing evidence for replication and for policy and decision-making, as well as strategy development.

Lessons Learned

Strategic focus: Having a strategic plan that clearly defines the strategic direction of the organisation is key in ensuring that it delivers to its mandate despite the changing terrain, mainly defined by funding, disease trends and policy and legal environment. AMREF’s interventions, prior to its current strategic plan, would be greatly influenced by donations and donor trends, stretching its focus away from its key competencies. AMREF now has a strategic plan that is responsive to the country’s health priorities and needs, succinctly defines the areas of strategic focus, and is reflective of the organisation’s capabilities. Keeping a strategic focus that is not shifted by donor funding trends, but is responsive to the dynamics of the health sector, has enabled the organisation to deliver to its mandate.

Sustainable funding: Financial sustainability provides autonomy in the execution of planned activities and ensures sustainability in interventions. AMREF is in the process of growing the level of internally generated income to create sustainable funding sources to run its programmes, at least partially. The approach adopted by AMREF is to leverage on its existing infrastructure and expertise in health care, and provide goods and services in line with that. In 2011, AMREF Flying Doctors was registered as a non-profit commercial entity fully owned by AMREF, offering evacuation cover on both an annual and short term basis. The Flying Doctors brought in an excess of $800,000 in revenue in 2011. Future plans may include commercialising the laboratory services as well as specially designed training packages.

Accountability: To be a true partner of government, CSOs need to be professionally run, with effective systems in place, and to be transparent in both their programme as well as their financial reporting. CSOs that can be held to a high standard of performance are in a better position to also hold government to account and to be fully recognised as credible partners in the health sector. AMREF has been able to achieve this through its rigorous reporting as evidenced in its multiple partnerships with government and international donors.
FACTSHEET

1. **Disease burden:** Crude birth rate of 21.18/1000, under five mortality of 41/1000, maternal mortality of 410/100,000,
   vaccination rate of 94%, HIV/AIDS prevalence of 17.3%.1

2. **Number of CSOS:** The National Development Agency has 76,415 registered CSOs with 8,723 (11.4%) working in the health sector.2

3. **CSO contribution to service delivery:** CSOs are responsible for 30% of delivery of social services.3

4. **CSO contribution to health financing:** The total public health expenditure in South Africa is 248.6 billion, with the public sector contributing 49.2%, the private sector contributing 48.5%, and donors and NGOs contributing the remaining 2.3%.4

5. **CSO contribution to health workforce:** Government and other private institutions run the primary training institutions while CSOs offer only post-service training.

6. **CSO contribution to leadership and governance:** The CSO sector has successfully advocated for the reform in health policy, including free HIV/AIDS treatment and is currently at the forefront campaigning for universal health care through the proposed National Health Insurance.

7. **CSO contribution to health information management systems:** The CSO sector is represented in the Health Data Advisory and Coordination Committee that revised the health indicators in 2012. The CSO Cell Life has developed several information systems, including drug dispensing for ARV clinics, mobile data capture programmes for Home-Based Care providers that feeds into the District Health Information System.

8. **CSO contribution to access to medicines and technology:** CSOs have been effective whistle-blowers, identifying areas with essential medical stock-outs and ensuring medical supplies are available.

Sources:
1 UNAIDS HIV Estimates 2011
2 WHO Health Database
3 WHO Health Database
4 Department of Social Services South Africa, State of NPO 2011/2012
South Africa

COUNTRY CONTEXT AND DEVELOPMENT CHALLENGE

South African health outcomes remain poor when compared to similar middle income counties. The country is described as having a quadruple disease burden of HIV/AIDS and TB, non-communicable diseases, peri-natal and maternal deaths and injury and violence related disorders. The government currently spends 8.3% of its GDP on health care, which is above the WHO requirement of 5% but below the Abuja Declaration target of 15%. Despite the high spending, there are high inequalities in health expenditure especially between the public and private sectors, with the public sector spending 40% of the total health funds on 80% of the population while the private sector spends 60% of the health funds on 20% of the population. A similar inequality, with a bias towards the private sector, exists in health workforce distribution. This puts a tremendous strain on the public health system, which negatively impacts the quality of health care.

The CSO sector in South Africa has been at the forefront of campaigning for equality in the health care system and championing the rights of rural and marginalised communities.

The CSO sector in South Africa has been at the forefront of campaigning for equality in the health care system and championing the rights of rural and marginalised communities that represent 50% of the country’s population. Below we profile the organisation, Treatment Action Campaign, that has successfully advocated for the right to treatment for HIV/AIDS patients.

46 http://www.southafrica.info/about/health/health.htm#.UPeqqMW-yAmE
TREATMENT ACTION CAMPAIGN

Organisation Overview

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>TREATMENT ACTION CAMPAIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding year</td>
<td>1998</td>
</tr>
<tr>
<td>Focus areas</td>
<td>Prevention and treatment literacy for HIV/AIDS, community health advocacy and policy</td>
</tr>
<tr>
<td></td>
<td>communications and research</td>
</tr>
<tr>
<td>Country reach</td>
<td>Headquarters in Cape Town with 267 branches</td>
</tr>
<tr>
<td>Number of staff</td>
<td>76 full time staff</td>
</tr>
<tr>
<td>Governance</td>
<td>The organisation is governed by six directors of the National Council, which consists of</td>
</tr>
<tr>
<td></td>
<td>the national office-bearers, provincial chairpersons of the seven provinces, and partners</td>
</tr>
<tr>
<td>Programme expenditure</td>
<td>$3.9m for 2013</td>
</tr>
</tbody>
</table>

Background

TAC began as a campaign initiative within the National Association of People Living with HIV/AIDS. It was started by a group of activists who intended to build a mass movement to campaign for access to safe and effective treatment for those infected with HIV and to reduce new infections. The CSO was formed in response to the increasing number of deaths related to HIV/AIDS and the lack of government response to the epidemic. TAC began organising campaigns in the streets to highlight the severity of the issue. The organisation then campaigned for the protection of access to medicine for prevention of mother to child transmission and campaigns for access to anti-retroviral (ARV) treatment through the legal system. Working closely with media, they organised campaigns to promote their cause. The organisation has grown from a mass movement to an entity with over 16,000 advocates for increased access to treatment, care and support services for people living with HIV/AIDS.

Successes

Advocating affordable, universal access to life-saving anti-retroviral drugs: TAC and its partners, Section 27 and Legal Resources Centre, used the legal system to campaign for the right to health care for HIV/AIDS patients. TAC was successful in securing the rights of citizens to ARV treatment. The government to date supports the National Strategic Plan (2007) that has provided ARVs from a base of zero in 1998 to 1.9m in 2012. The campaign that led to access by pregnant mothers with HIV/AIDS to ARVs has resulted in a reduction in mother-to-child HIV transmission in South Africa from 30% to 2.7%. This campaign enabled more recognition of sexual reproductive rights of women living with HIV: the right to have a healthy child, which in the early 1990s was, and still today in some areas is, taken away through forced sterilisations of HIV-positive women.

Addressing the politics and economics of affordable drugs: TAC was very central in the advocacy and adoption of the Medicines and Related Substances Control Amendment Act 90 of 1997 that significantly increased access to ARV therapy for a majority of South Africa’s PLWHA, and has been used as a blue print by other countries like India.

Access to treatment for prisoners: Successful constitutional litigation for the right to access ARV treatment for prisoners at Westville Prison in KwaZulu Natal province. Currently TAC is advocating for improved TB infection control and TB treatment in prisons, where the transmission rate is as high as 90%.
Success Drivers

**The law as a tool:** TAC, working in partnership with leading legal experts, including Section 27 and The Legal Resources Centre, achieved tremendous successes in fighting for the right to health for the citizens of South Africa. This was made possible by utilising the legal system, especially the constitutional provisions that guarantee the rights of citizens to health. Importantly, the understanding of the constitution helped TAC to frame its demands in human rights language and use the law as a tool for progressive social change. TAC also leveraged the intellectual capital of researchers, scientists and academics to provide evidence for the feasibility of their proposals.

**Strong leadership:** TAC benefited from strong leadership provided by reputable activists that were able to provide political and moral authority. The dynamic leadership of Zachie Achmat, who become internationally recognised for refusing to take his ARV treatment in protest against the government’s failure to provide health care, resulted in international recognition of the campaign and the organisation.

**Working closely with communities:** To build the required legitimacy as a mass movement advocating for the rights of the poor, TAC had to build its membership in both urban and rural communities. TAC worked through educational programmes to teach communities about the science of HIV and their right to health care, and to build a network of volunteers in the communities. Setting up networks enabled the organisation to gain the trust of communities and to build its constituency, increasing its capacity to mobilise for campaigns. Working closely with well-established organisations such as trade unions and churches also provided additional legitimacy and power to convene community members for campaigns. TAC also successfully forged alliances with international alliances that organised solidarity events in support of TAC and worked closely with media to shame the government and pharmaceutical companies for the former’s non-responsiveness to the HIV/AIDS pandemic, and the latter’s quest for profits even in the provision of essential, lifesaving and dignifying medicines.

Lessons Learned

**Sustainable funding:** Designing sustainable funding strategies for an organisation at the outset ensures that it can plan effectively and sustainably implement its programmes. Although TAC attracted increased funding with expansive media attention, both locally and internationally, it has remained dependent on contributions from donors, which have been negatively affected by the funding crisis occasioned by the global financial meltdown. This significantly affected its ability to implement its mandate as it was forced to reduce its programme size and staffing in certain areas.

**Working with partners:** In order to effectively protect the rights of the vulnerable to access health care services, it is important to work in partnership with other stakeholders, especially in furthering those rights that fall outside the ambit of an organisation’s mandate. This makes it possible to leverage the strengths of other stakeholders. Notably, with a large ambit of protecting the rights of the poor to access health care, TAC has ventured into advocating against gender violence and had to respond to the victims of the xenophobic clashes. It has been criticised for stepping out of its mandate; however, the protection of the rights of the poor is large and it is important for organisations to work with different partners that can focus on areas that are not within their key competencies.

**A holistic approach to health:** Adopting a holistic approach to advocating for the right to health, in line with the WHO health systems framework, is important in ensuring access to the whole continuum of care by vulnerable groups. It is noteworthy that, although TAC has successfully campaigned for the government to provide HIV/AIDS treatment in South Africa and currently has the largest ARV programme in the world, the next challenge is the limited capacity of the government to deliver effective treatment with a health system facing several challenges, including shortages of essential medicines and health workers, overburdened public health facilities addressing HIV/AIDS, and the increasing prevalence of NCDs. With all the gains in ensuring access, the quality of treatment can only be provided by a strong health system that is adequately financed. Prevention of new HIV infection is also a key feature required.
1. **Disease burden**: Crude birth rate of 37/1000\(^1\), under five mortality of 75/1000 (2010)\(^2\), maternal mortality of 370/100,000 (2010)\(^3\), vaccination rate among children is at 63\%\(^4\), and HIV prevalence of 0.8\%.\(^5\)

2. **Number of CSOs**: In 2011, there were 517 registered CSOs.\(^6\)

3. **CSO contribution to service delivery**: In 2011, there were 72\(^1\) non-profit institutions delivering health care services. Many of these health facilities, e.g. Hôpital Saint Jean de Dieu, are owned and managed by FBOs.

4. **CSO contribution to health financing**: NGOs mobilise between 40 and 50 million dollars annually, 50 percent of which goes to health-related programmes/projects.\(^8\)

5. **CSO contribution to health workforce**: Out of a total of 69 health training institution, there is only one owned and run by a CSO. 25\% are public run institutions, 74\% are private for-profit while 1\% is private not-for-profit.

6. **CSO contribution to leadership and governance**: RESSIP/Congad is advocating to government to ensure that CSOs are involved in development of health strategy and policy. RESSIP/Congad took part in the definition of the National Sectoral Health Plan.

7. **CSO contribution to health information management systems**: CSOs provide input to the National Health Statistics Division, but have so far less influence on the information system and processes. However, the Ministry of Health is working with SWAA, Senegal to refine a tool, "Tableau Lumière", designed by the NGO to monitor prenatal visits of pregnant women in order to use it at national level.

8. **CSO contribution to access to medicines and technology**: The Pharmacy Nationale d'Approvisinnement (The National Supply Pharmacy) is the only authorised drug supplier. CSOs are mainly focused on promoting and distributing health products (e.g. condoms, mosquito nets, water purifying tablets, etc.); and providing training on quality management of the supply chain.

**Sources:**

1, 2, 3 WHO

4 National Statistics Agency (ANSD)

5 WHO

6 Impact des conférences de Dakar et Beijing sur les organisations de la société civile au Sénégal et leurs influences sur les politiques

7 Interview with Amadou Cisse
Senegal

**COUNTRY CONTEXT AND DEVELOPMENT CHALLENGE**

Senegal has a long history of civil society engagement in major development issues, including public health. However, with between 500 – 600 registered CSOs, this level of engagement is relatively low compared to South Africa (with over 76,000 registered CSOs and Kenya with 8,000 registered CSOs). The government provides more than 70% of health care in the country, with the bulk of the balance provided by private for-profit facilities. Some CSOs are active in health service provision, but this constitutes less than 2% of services provided; CSOs run only 72 out of the more than 3,000 facilities in the country. Further evidence of the relatively low contribution of CSOs is in health expenditure, with the non-profit sector contributing only 1.6% of total health expenditure compared to the SSA average of 4.2%.49

Various reasons are given for this relatively low contribution, including Senegal’s restrictive legal environment, which has been cited as a challenge for the development of CSOs. In 2010, the government made modifications to Decree 96 – 103 of 1996 which governs the scope of permitted CSO activities. With these changes, the government could in 2011 suspend host-state agreements with international CSOs, forcing many CSOs to suspend their activities.50 However, the application of this measure has since been suspended in response to intense lobbying from CSOs. Senegal’s low HIV/AIDS prevalence of less than 1% limits the (donor) resources available for CSOs and hence the number of CSOs. As earlier mentioned, HIV/AIDS prevalence plays a central role in the formation of CSOs, with countries with high HIV prevalence like South Africa having many CSOs compared to those with low prevalence like Senegal due to availability of funding.

48 USAID CSO Sustainability Index 2011 – report for SSA.
49 WHO National Health Account Estimates.
50 USAID CSO Sustainability Index 2011 – report for SSA.
The health status of Senegal provides opportunity for further development of CSOs in the health care sector. Notably, Senegal has a large deficit in health workers – 0.4 per 1,000 people compared to the WHO-recommended 2.3. The workforce would need to grow by six times its current size in order to meet this shortfall. The government cannot do this on its own and concerted efforts by government and private for-profit and not-for-profit players are required to bridge this gap. Furthermore, to support the government in achieving its universal health coverage goal, CSOs are planning to work with the health insurance system being designed by government to develop social coverage services that will include health insurance, financing income-generating activities, etc. With a single subscription, all family members will be covered by the insurance and they will benefit from the other social protection services.

**SOCIETY FOR WOMEN AND AIDS IN AFRICA, SENEGAL**

**Organisation Overview**

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>SOCIETY FOR WOMEN AND AIDS IN AFRICA/SENEGAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding year</td>
<td>1989</td>
</tr>
<tr>
<td>Focus areas</td>
<td>Raising awareness of women organisations in HIV/AIDS prevention, delivery of health care to PLWHA, promotion of women's and children's rights</td>
</tr>
<tr>
<td>Country reach</td>
<td>40 country offices</td>
</tr>
<tr>
<td>Number of staff</td>
<td>Staffing of 70</td>
</tr>
<tr>
<td>Governance</td>
<td>SWAA Senegal is a member of SWAA International. The board is composed of 11 members that include representatives from PLWHA. The organisation promotes gender equity, with 60% of its current composition being female. SWAA Senegal currently has over 350 members</td>
</tr>
<tr>
<td>Programme reach</td>
<td>Presence in 8 out of the 14 regions in Senegal</td>
</tr>
<tr>
<td>Programme</td>
<td>SWAA Senegal depends mainly on foreign donations, from $196,816 in 2008 to $444,164 in 2012, to implement their programmes. To foster financial sustainability, the organisation is currently planning on partnerships with the private sector.</td>
</tr>
</tbody>
</table>

**Background**

Society for Women and AIDS in Africa (SWAA) Senegal is a constituent of SWAA International, a pan-African Women's organisation with its headquarters in Senegal. SWAA International was conceptualised at a conference in Stockholm, Sweden, where a few African women came together based on the recognition that in Africa, there was a need to focus on the NGO sector and on women in the fight against HIV/AIDS. SWAA Senegal was established in 1989 and has since then been involved in education and advocacy programmes on HIV/AIDS and committed to reducing the impact of HIV/AIDS on women and children in Senegal.

**Successes**

Raising awareness to reduce the transmission of HIV: SWAA has implemented a combination of activities to inform, educate and communicate with its target groups. Women's organisations and SWAA partners have organised spaces for dialogue, including focus groups, individual interviews, social mobilisation with griots (traditional story tellers), and talks in dahiras (religious associations) in the 12 health districts. SWAA has also successfully managed to encourage the use of condoms amongst the female population, traversing cultural norms. Working with a cross section of community members has provided legitimacy and built community trust that has enabled the organisation to have greater impact.
Leadership and contribution to the public health policy: SWAA has built a reputation from its projects and is recognised by government as a key partner in the delivery of services and development of policy. The SWAA team, that includes leading professionals, was involved in the development of the national strategic plan on prevention of mother to child transmission (PMTCT). To date, the plan is effective and is being implemented by government and its partners. One of the major benefits of the PMTCT plan is the creation of “solidarity circles”, meetings regularly held by pregnant women in order to share experience on pregnancy and childbirth. Through these sessions, the facilitator (a health professional, usually a midwife) provides insights on issues raised during the debates, educates the participants on (avoiding) mother-child transmission of HIV and encourages pregnant women to regularly get prenatal tests.

Success Drivers

Governance set-up that fosters inclusiveness and alignment to government structures: The existence of decentralised units in the regions enables SWAA to share information with the communities and coordinate activities. Having representatives of PLWHA on the board is not just a way to fight stigma, but ensures a certain level of inclusiveness and credibility.

Strong partnerships with CBOs: In the implementation and monitoring of activities, SWAA Senegal works closely with CBOs: women organisations, sports and cultural associations, traditional child caregiver (Bajenu gox) organisations, and traditional communicators. This gets the community engaged, which is critical to the sustainability of the projects. The decentralised structure also ensures that SWAA has dialogue networks with constituents for programme and policy planning.

Promotion of innovations in health care: For the prevention of mother to child transmission project, SWAA has developed a tool, ‘Tableau Lumière’, to monitor prenatal visits of pregnant women regardless of their HIV status and promote maternal health. An evaluation performed on the test phase has given promising results. SWAA Senegal is working with the Ministry of Health to improve and use the tool at national level for monitoring reproductive health.

Lessons Learned

Sustainable funding sources for holistic health care services: Donor funding in the health sector is expected to reduce in Senegal. For SWAA to have the anticipated impact, sustainable funding sources that can finance preventive care, in addition to having resources to fund holistic care interventions, will be required.

Engagement with government creates legitimacy: In a country where the CSO sector is in its nascent stages of increasing contribution and relevance to the health sector, building trusted relationships with government health institutions is key to its success. SWAA Senegal works closely with health workers in the intervention areas in the design, implementation and monitoring of projects, which enables communication between the SWAA Senegal, communities and health officials (heads of health districts and health workers).
1. **Disease burden**: Crude birth rate of 44.3/1000, under five mortality of 85/1000, maternal mortality of 510/100,000, HIV/AIDS prevalence of 10%.¹

2. **Number of CSOs**: Difficult to determine; a CSO can register as a NGO under the NGO Act, a trust under the Trustees Incorporation Act, or a limited company by guarantee under the Company Act among many other forms of registration.³

3. **CSO contribution to service delivery**: CSOs (largely Christian Health Association of Malawi - CHAM) provide about 37% of overall health services. The other major non-governmental, not-for-profit organisation is Banja La Mtsongolo. These are the two majors CSOs that the government of Malawi collaborates with through service level agreements.⁴

4. **CSO contribution to health financing**: The CSO sector currently contributes 9.2% of the total health expenditure.⁵

5. **CSO contribution to health workforce**: CHAM has a wide network of health worker training institutes, providing nursing, teaching and other health technical training. CHAM trains approximately 70% of all nurses in Malawi.⁶

6. **CSO contribution to leadership and governance**: Malawi Health Rights Education Programme successfully lobbied government to allocate 15% of GDP to health for 2010/2011, in line with the Abuja Declaration.⁷ CSO budget tracking is quoted by Oxfam to be among the best in SSA.⁸

7. **CSO contribution to health information management systems**: There is limited involvement of CSOs in HMIS.

8. **CSO contribution to access to medicine and technology**: CHAM is the largest and only identifiable player in the supply chain, which is mainly controlled by the government.⁹

**Sources:**

¹ World Bank 2012 statistics (2010 reported); UNAIDS database
² Republic of Malawi and WHO, Malawi Country Profile, 2005, Connecting Health Research in Africa and Ireland Consortium (ChRAIC), undated; Knowledge Synthesis on Malawi Health System
³ USAID CSO Sustainability Index 2011 – for SSA
⁴ The Alliance Group, 2008 Global Fund
⁵ Year Impact Assessment, Malawi National Health Accounts, Connecting Health Research in Africa and Ireland Consortium (ChRAIC), undated; Knowledge Synthesis on Malawi Health System; ⁶ Malawi National Health Accounts 2005/06
⁷ CHAM statistics
⁸ Health and Rights Education Programme : CSOs in Health Public Policy
¹⁰ USAID/Abt Associate, 2012, Malawi Private Health Sector Assessment, Maryland: Abt. Associates
Malawi

COUNTRY CONTEXT AND DEVELOPMENT CHALLENGE

Malawi has overall poor health indicators, with low life expectancy, high infant and maternal mortality rate, high poverty levels, and a very large disease burden - with a HIV/AIDS prevalence rate of about 10%. Moreover, Malawi has a serious and chronic shortage of health workers - with 62% of positions unfilled.\(^{52}\) In 2010, Malawi’s total spend on health as a percentage of GDP was 6.59\(^{53}\), which is higher than the SSA average and higher than the WHO recommended level at 5%, but significantly below the Abuja Declaration’s recommended 15%. Malawi’s health sector is heavily reliant on donor funding, with 64%\(^{54}\) of total health expenditure in 2010 coming from donors and development partners. The heavy reliance on donor funding has increased the vulnerability of the sector to unpredictable funding patterns, which negatively affects the ability of CSOs to implement their activities. For example, the cancellation of Global Fund round 11 had negative impacts on drug availability, community outreach and planned infrastructure improvements.

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\(^{54}\) WHO National Health Accounts Estimates, 2010.
CHRISTIAN HEALTH ASSOCIATION OF MALAWI

Organisation Overview

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>CHRISTIAN HEALTH ASSOCIATION OF MALAWI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding year</td>
<td>1966</td>
</tr>
<tr>
<td>Focus areas</td>
<td>Health care service delivery, human resources for health</td>
</tr>
<tr>
<td>Country reach</td>
<td>Malawi</td>
</tr>
<tr>
<td>Number of staff</td>
<td>9,000 (32 in secretariat and the balance in member institutions)</td>
</tr>
<tr>
<td>Governance</td>
<td>Board of trustees – 5 members from Malawi Council of Churches (MCC) and Episcopal Council of Malawi (ECM). Oversee fundraising, resource mobilisation and dissolution of CHAM. Board of directors – 11 members, 5 from MCC, 5 from ECM and 1 ex-officio from other church-related organisations. Provides policy oversight and implementation of strategy.</td>
</tr>
<tr>
<td>Programme expenditure</td>
<td>MK4.4 billion in 2012 (Approx. $ 0.85M)</td>
</tr>
<tr>
<td>Programme reach</td>
<td>37% of health care service delivery - 172 facilities serving close to 4 million of the Malawian population annually. 47% of total HRH training in Malawi – 10 training colleges equipping 70% of all nurses in Malawi</td>
</tr>
</tbody>
</table>

Background

The Christian Health Association of Malawi (CHAM) is the major private provider of health services in Malawi and is instrumental in the provision of health care in rural and marginalised areas. CHAM is an ecumenical organisation established in 1966 and owned by the ECM and the MCC. CHAM’s vision is ‘to be a leader in provision of holistic, quality, affordable and sustainable health services to all people in Malawi as inspired by the healing ministry of Jesus Christ’. CHAM seeks to achieve this vision in partnership with and complimentary to government activities through provision of health care services and training of health workers.

Successes

Fostering equitable access to health care to the vulnerable: CHAM has got arguably the largest footprint in terms of service delivery in rural areas of all health care providers in Malawi. CHAM provides health services to 25% of the population through a network of 172 health facilities, 90% of which are located in rural and hard-to-reach areas. Through these facilities, CHAM directly reaches 4 million people with various services such as HIV/AIDS, primary health care, maternal and child health, curative and preventive as well as referral services. CHAM also provides specialised services like gynaecology and obstetrics, surgery, endoscopy, cancer care, ophthalmology and family medicine. In tandem with direct service delivery, CHAM implements a number of projects in communities, including health, water and sanitation, nutrition, HIV/AIDS, maternal and child health community services.

Equipping medical staff and building capacity in the community: CHAM runs 10 training colleges that train 70% of middle level nurses and 47% of human resources for health in Malawi. Sixty percent of the graduates are deployed to government health facilities while 40% are retained within the CHAM health care delivery system.
Government and continental recognition: CHAM stands out for its first-of-a-kind partnership with government to ensure equitable access to quality medical services for rural and marginalised communities. CHAM charges a user fee for their health services and the Public Private Partnership (PPP) is designed to ensure equitable access through government subsidies.

CHAM is a member of various international associations and alliances, and nationally is a member of the Malawian Health Donor Group, a signatory to the Sector Wide Approach Programme to health in Malawi and a member of all the technical working groups constituted by the Ministry of Health.

Success Drivers

Mission driven: Despite challenges with infrastructure, retention of health workers in rural areas and access to basic amenities, CHAM has remained a mission-driven organisation founded on Christian principles and committed to achieving equitable access to health for the vulnerable and unreached. CHAM's board and secretariat ensure alignment of the different facilities with the overall strategy of the organisation. Working with the health coordination desks at each facility ensures a strong grassroots presence and responsiveness to community needs, alignment in strategy execution, quality assurance in service delivery and district-based advocacy and resource mobilisation.

Partnership building: CHAM works closely and cooperates with the Malawi Government and key church partners. The Malawi Government recognises the role that CHAM plays and has ensured that there is a clear memorandum of understanding to support the work that CHAM is carrying out in Malawi. This MoU allows other development partners to indirectly support CHAM's programmes. Partners also offer administrative support to compensate for the lack of capacity in CHAM, which acts as programme management unit, thus enabling the organisation to recruit adequate staff to manage its programmes and ensure adequate representation.

Lessons Learned

Sustainable funding: Consistent funding has ensured the association's operations from 1966 to present, but has made CHAM vulnerable to both government and donor funding fluctuations. With a budget of MK 4.4 billion in 2012 (approx. $0.85 million), CHAM's funding comes primarily from government and donors: 80% government, 15% donors, 4% membership fee and 1% from properties/estates. This heavy reliance on unreliable government and donor funding does constitute a vulnerability, driving CHAM to focus on diversification of funding strategies to support its core business.

Staff retention: Staff turnover in facilities in marginalised and rural areas, in which 90% of CHAM's facilities are located, tends to be high. To this end CHAM's retention strategy is closely linked to its training programme. CHAM identifies trainee health workers from the communities around the health facilities and bonds them to the facility in question so that after they graduate, they work for a period of five years at the given facility. This ensures adequate health workers and low staff turnover in those facilities.

Clarity on partnership design with government: Clarity on roles and obligations in partnership is essential to ensuring that each party complies. A key challenge faced by CHAM in the PPP was in the management of the relationship with government as the funder of health care. The Malawi Government committed to Service Level Agreements (SLAs) with no corresponding budget allocation for District Health Office to support SLA implementation or an allocation for preventive health care - this directly affected implementation on the ground, impacting on quality of services provided.
1. **Disease burden:** Crude birth rate of 31.43/1000, under five mortality of 105.9/1000, maternal mortality of 676/100,000, HIV/AIDS prevalence of 1.4%.¹

2. **Number of CSOs:** There are 2,117 registered charities and societies, among which 80.4% are Ethiopian or resident charities, while the rest are foreign charities/international NGOs.²

3. **CSO contribution to service delivery:** CSOs managed 6 of the 194 hospitals in 2011; and 322 primary health facilities out of the total 4,641, limiting their scope of service delivery.³

4. **CSO contribution to health financing:** Financing comes from a variety of sources, with figures from the 2004/05 National Health Accounts indicating 31% from government, 37% from donors and NGOs, 31% out of pocket expenditure by households and 2% from other private employers/funds.⁴

5. **CSO contribution to health workforce:** There are 11 public universities and 24 Regional Health Science Colleges; 19 accredited private for-profit training institutions and 3 CSO-operated training institutions.

6. **CSO contribution to leadership and governance:** CSOs are represented in the Country Coordinating Mechanism and Joint Review Team for the health sector development plan.

7. **CSO contribution to health information management systems:** There is limited involvement of CSOs in HMIS.

8. **CSO contribution to access to medicines and technology:** USAID-supported Supply Chain Management Systems project works with several CSO partners and Pharmaceutical Fund and Supply Agency, responsible agency for storing and distributing all health commodities to public facilities, by supporting the implementation of the Pharmaceutical Logistics Master Plan.

**Sources:**


⁴ Wamai Richard G. Reviewing Ethiopia’s Health System Development. International Medical Community, 52(4) 279-286, 2009)
Ethiopia

COUNTRY CONTEXT AND DEVELOPMENT CHALLENGE

In Ethiopia, communicable and infectious diseases account for 60-80% of the health problems. The health of women and children remains a key concern, with maternal and child mortality remaining considerably high despite the efforts towards improvement.

The health sector remains generally under-resourced. In 2010, Ethiopia’s total spend on health as a percentage of GDP was 4.9%56, which is below the WHO recommended level of 5%, and significantly lower than the Abuja Declaration’s recommended 15%. Financing for health care by government has significantly decreased over time, only supplemented by increased funding from donors. The health system infrastructure is also weak, being about a third of Kenya’s in terms of infrastructure and personnel even though the population of Ethiopia is twice that of Kenya. Direct CSO involvement in health service delivery is limited, despite a nationally under-resourced health system. Almost all health facilities have historically been government-owned, with less than 10% owned by CSOs. Ethiopia has the lowest number of health facilities in the region despite being the largest country in size and population.

Civil society engagement in Ethiopia emerged as a response to the famine disasters in the 1970s and to date is still largely focused on relief and service delivery in marginalised areas.57 The end of the socialist era created space for CSO engagement and led to the registration of several CSOs, enabling them to contribute to the development of the country. However, the operating environment remains restrictive, with regulations introduced in 2009 limiting activities that CSOs can engage in based on registration. Only Ethiopian charities or societies can work on rights-related issues such as human rights, access to justice and conflict resolution. Additionally, for locally registered Ethiopian charities or societies, 90% of their incomes must come from domestic sources. This has restricted the number of CSOs

57 USAID, CSO Sustainability Index 2011.
registered as local, with the majority opting to register as international CSOs so as to source for funding both locally and internationally.

In addition to constraints in CSO registration, government directives on the administration of project and administrative cost utilisation restrict the participation of networks and consortiums in project implementation. It also restricts the local CSO networks from receiving international funds. This restriction prevents the establishment of a single national organisation representing the interests of the entire civil society sector. The following profile of a network organisation illustrates the difficulty in operations and shows how, despite the challenges, the organisation has succeeded in creating meaningful impact.

**CONSORTIUM OF CHRISTIAN RELIEF DEVELOPMENT ORGANISATIONS (CCRDA)**

**Organisation Overview**

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>CCRDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding year</td>
<td>Founded in 1973/4 by 13 CSOs</td>
</tr>
<tr>
<td>Focus areas</td>
<td>Umbrella organisation working in capacity building, developmental advocacy, protection and promotion of human rights</td>
</tr>
<tr>
<td>Country reach</td>
<td>Head offices in Addis Ababa and six regional offices</td>
</tr>
<tr>
<td>Number of staff</td>
<td>42</td>
</tr>
<tr>
<td>Governance</td>
<td>The board comprises of nine members with a varied skills-set in the development sector</td>
</tr>
<tr>
<td>Programme expenditure</td>
<td>Between 2008 – 2012, the organisation managed projects worth over $30m</td>
</tr>
<tr>
<td>Programme reach</td>
<td>Membership of over 360 Civil Society Organisations</td>
</tr>
</tbody>
</table>

**Background**

The Consortium of Christian Relief and Development Association (CCRDA) is a local non-profit umbrella organisation of CSOs in Ethiopia. CCRDA's history is synonymous with the growth of the CSO sector in Ethiopia. It was formed in 1974 by 13 CSOs to coordinate relief and humanitarian activities of its member organisations during the famine in the Seventies. The continued famine crisis in the Eighties led to unprecedented donations that required CCRDA to be involved in coordination, in addition to operational activities including managing relief centres and providing medical assistance. The active involvement in the famines created international recognition and government acceptance of the organisation as a partner and CCRDA emerged as the voice of CSOs in the sector. The organisation has since expanded its membership base to over 360 CSOs and services to include capacity building, developmental lobby work, water and sanitation, youth and children affairs, gender advocacy, health, rural and urban development engagements.
Successes

Coordination of the health sector: CCRDA currently coordinates the CSO health sector forum to ensure coordination, harmonisation and alignment of services required in the health sector. The forum acts as a platform for planning, networking and knowledge-sharing and the model is replicated in the regional offices. The participatory planning has reduced duplication of efforts in the sector, enabling CSOs to identify areas for prioritisation. The platform also creates a forum for resource mobilisation for the health sector and has been the recipient of funds intended for disbursement to CBOs.

Building sustainable institutions: CCRDA provides training services to CSOs to strengthen their capacity in different areas. The training services focus on institutional strengthening and also cover technical areas that they work in. The network currently provides scheduled training services annually.

Policy and advocacy: Ethiopia’s CSO sector operates in a restrictive environment, limiting participation in all areas of the health sector. Despite this, there have been gains in CSO inclusion in policy and advocacy. CCRDA was involved in the development of a Poverty Reduction Strategy Paper and several other policies in the health sector. The CSO currently holds the position of deputy chair in the country coordinating mechanism (CCM) and is a member of the Health Policy Advisory group to the Minister for Health.

Success Drivers

Building legitimacy as a trusted partner: The large number of CSOs in its membership base has created legitimacy as a representative organisation of the sector. This has positioned the organisation to be involved in several committees, including the Donor Assistance Working Group and several government policy-level committees. In a restricted operating environment, CCRDA is well positioned to negotiate with government to advocate for policy reforms. In working with donors, the network’s forums on coordination position it to prioritise areas of intervention based on community needs. However the current dual role of funder (channel for sub-grants) and coordinator has created complexities in how the network interacts with different CSOs.

CSOs have to be responsive to the health trends and operating environment: CCRDA in its design phase was organised to respond to the famine disasters of the Seventies and Eighties. With growing food security in the country, the organisation transformed into a development focused organisation, coordinating CSOs in the different sectors. However, the emergence of several umbrella organisations that are more specialised in specific areas and are more agile and responsive to the health environment presents a challenge to the organisation. The CSO, as it has in the past, needs to redefine its mission and focus on areas where it has the expertise and capacity to deliver.
Future Outlook

Future Outlook

Going forward, CSOs need to continuously be nimble and flexible enough to adjust to shifts in needs (e.g., disease trends), opportunities (such as the possibilities of technologies) and their operating environment, (funding models, donor shifts, technology and sector regulation). In doing so, they will continue to be influential in addressing the region’s health challenges.

The health terrain is dynamic and several shifts are expected that will create opportunities which will impact the strategy of CSOs and their operating models. This section explores the driving forces that will reshape the context within which CSOs operate. Perspectives on how CSOs should be responsive to shifting roles, funding, relationships, and technology are also discussed with a view to enabling CSOs to continue providing the required input in the health sector.

DRIVING FORCES FOR FUTURE TRENDS

Shifts in health needs, driven by disease and demographic trends

Current projections indicate that by 2030 deaths arising from non-communicable diseases (NCDs) will exceed the combined deaths arising from communicable and nutritional diseases and maternal and peri-natal deaths. The management of NCDs requires a re-orientation of health systems, with a focus on taking health care to communities to strengthen prevention, through promotion of healthy lifestyle as well as early detection and timely treatment that requires a more long-term and holistic approach. CSOs are strategically positioned to take an active role on this, given their community networks, enabling them to be a key partner in delivery of health services in communities by building on their HIV/AIDS care and treatment models.

New opportunities – the power of technology

Revolution in technology and communication has created groups of networked and more informed citizenry. This has enabled citizens to engage across geographic and social divides, increasing the numbers that can rapidly mobilise around a cause, attracting media attention that was previously

Key questions CSOs should be asking to respond to the changing environment
1. What new trends in health needs, opportunities and enabling environment affect us?
2. How are the trends affecting or aligned with our current mission?
3. How do we need to change to respond to these trends?
4. Does our organisation have the capacity (staffing, infrastructure, experience) to respond to the trends?

59 WHO Statistics.
not possible. This creates new avenues for CSOs to engage in social change and in doing so, they can benefit from harnessing the power of technology and communication.

**Shift in the operating environment – changing funding streams**

Funding will significantly reshape the environment in which CSOs operate in several countries. Whilst donor funding has significantly reduced, there are new (emerging) sources of funding, including the corporate sector and governments. In South Africa, 25% of the funding for the non-profit sector is from the corporate sector. Apart from the conventional corporate social responsibility (CSR) funds, there is an increasing availability of social funds and impact investors that CSOs can tap into. The new sources of funding create complex multi-stakeholder relationships that will have to be managed using different approaches. The private sector that is focused on creating sustainable models will require CSOs to start developing models on how they can deliver services in a cost-efficient and sustainable manner.

As several countries in SSA progress towards middle income status, their eligibility for funding from conventional donors will diminish. Government will be a key funder for the CSO sector, creating a myriad of challenges in balancing relationships to maintain independence. This is dependent on the willingness of government to support the sector. Notably, some governments in SSA continue to have antagonistic relationships with CSOs where they are viewed as a competitor for health funds. Working closely with government is key to creating an enabling environment for CSOs to operate in and be recognised as a key partner contributing not only to service delivery but also to national policy/strategy development and technical assistance within the sector. Having MoUs or other legal instruments in place that govern these partnerships will ensure that the CSOs’ participation is not dependent on incumbent government leaders and that the partnership is legally recognised as binding.

**Shift in the operating environment – changing funder focus**

Funder focus has always been an important driver of the formation and operation of CSOs, as can be seen in the sharp growth in the number of CSOs focused on HIV/AIDS when donor funding focused strongly on HIV/AIDS. Going forward, we see two key trends in funder focus which impact CSOs: a focus on local partners and a focus on an integrated systems approach.

Leading donors such as USAID are focused on building strong local CSOs and have several funds for CSOs to build their capacity in addition to regulations for funds to be channelled through local institutions. This creates an opportunity for strong local CSOs to actively participate in bidding for work that was previously executed by leading INGOs based in the USA.

A shift by donors from lateral disease funding to a systems approach creates a space where not one CSO is competent to address all health aspects efficiently. Partnerships between CSOs to build their competencies are encouraged to avoid competition and create an enabling environment for them to deliver on improving health outcomes.

Despite the numerous demands for harmonisation in health funding, CSOs remain at the whim of donor funding trends. National governments, through the Paris Declaration on Aid Effectiveness, have achieved commitment for harmonisation and alignment of aid to national priorities. The Busan Partnership promises new global development partnerships; it moves from the aid effectiveness agenda that was largely donor-driven to a broader development effectiveness agenda. In addition, Busan encompasses all forms of cooperation policies and actors that are focused on development, including CSOs. The inclusion of CSOs as a development partner provides a platform for them to campaign for funding alignment and consistency. This requires effective coordination in the CSO sector and corresponding commitment from CSOs on transparency and accountability and clearly defined mandates.

This commitment would also improve their recognition in the sector as important and equal players and aid in the planning and design of sustainable health outcomes.
Expected implications for CSOs

Going forward, CSOs are likely to continue to play a central role in improving health outcomes in SSA. Some of the drivers identified above necessitate the need for specific skills-sets and hence the contribution of CSOs for improved health outcomes. That said, the changes in the health sector landscape as observed also have implications for how CSOs can best organise themselves and operate to be most effective. In particular, they call for an increase in partnerships (both with other CSOs and with government and private sector), strong and adaptive talent with ability to lead and drive change and an increased focus on transparency and accountability.

Partnerships to promote health outcomes

As described above, a variety of changes call for increased partnerships. Be it an increase in corporate funding or co-delivery in the context of CSR or Corporate Social Investment (CSI), cooperation in PPPs to tackle health system changes rather than single disease focus or a close cooperation with and development of local CSOs to meet the shifting funder focus, all these drivers call for the ability to engage in effective partnerships, mutually complementing skills and knowledge whilst retaining the CSOs’ identity and voice. Partnerships to develop the capacity of the sector are also important. Capacity building of CSOs is a responsibility of the sector itself, which can – amongst others – be addressed by the larger CSOs supporting smaller CSOs in ensuring capacity to deliver.

The need for strong and adaptive talent

Civil society has to adapt to the shifting landscape, emerging roles, challenging trends and new strategic concerns in order for them and others to be as effective as possible in solving societal challenges. This requires strong leadership that can inculcate a culture of innovation and an organisation that is nimble to respond to the changes. This will require the CSO sector to compete for leading and possibly expensive talent with other sectors. With limited funding and an increased scrutiny on salaries in the CSO sector, this also calls for the need to develop and strengthen an employee value proposition which hinges on other factors beyond financial remuneration.

Transparency and Accountability

CSOs have previously been negligent to compliance requirements with statutory bodies, with a compliance rate of 60% in South Africa and 67% in Kenya.\(^{60,61}\) In the past, citizens and funders have also let the sector get away with good intentions and plans rather than measurable results, partially driven by the complexity of establishing and proving (causal) relationships and attribution. The shift in government relationships from regulator to funder, increased access to information enabled by technology and increased engagement with the private sector that is focused on results requires higher levels of accountability and transparency. CSOs have to be cognisant that doing good is not enough. They must recognise the need to demonstrate effectiveness and results to attract investments and remain legitimate. This pressure will come from their funders and partners as much as it will come from their beneficiaries; the power of technology increases the democratic space, exposing CSOs to increased scrutiny and the requirement for them to be increasingly more accountable to citizens.

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