CANADIAN NETWORK FOR INTERNATIONAL SURGERY

STRATEGIC PLAN

2007 – 2012

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Section 1: Introduction

1.1 Executive Summary:

Since 1995, the Canadian Network for International Surgery (CNIS) has focused on surgical and obstetrical needs and the injury pandemic in Africa. The health infrastructure and human capital in place at the independence of African nations was designed only to serve a limited portion of the population. In the post-independence years, ill conceived attempts to extend this infrastructure with inadequate financial support in the context of rapidly growing populations resulted in institutional decay of such an extent that surgical and obstetrical care came to a point of collapse. In this negative environment with its legacy of elitism in surgical and obstetrical care, and minimal to non-existent injury control, the CNIS has laid the groundwork for a dramatic change in surgical, obstetrical, injury prevention and safety promotion capacity in Africa. The CNIS has chosen countries, partners, and program strategies to result in long-term positive impact: with specific emphasis on needs of women, the poor, and the marginalized.

The Canadian Network for International Surgery (CNIS) is a non-profit, charitable organization dedicated to reducing or preventing death and disability from surgical disorders. Its vision is to empower low income countries to create an environment where risk from injury is minimal and all people receive adequate surgical care. Since its origins in 1995, CNIS has done this through four program areas: Surgical Skills, Injury Prevention, Surgical Education/Information, and Public Engagement.

CNIS is a network of Canadian surgery-related professionals, committed individuals and organizations that facilitate, promote, and support surgical and development programs in low income countries, particularly focusing in Africa.

CNIS chooses to engage in partnering relationships with African based institutions, organizations, and professionals. Programs are designed to effectively increase the logistical and human capacity in Africa. As a means of supporting partners in Africa, CNIS is relocating its International Director from Canada to Africa. Certain CNIS organizational members focus their collaborative efforts with specific African Institutions to promote partnership.

The work of CNIS is unique and distinctive. Its innovative programming is grounded in both theory and best practices.

CNIS recognizes the challenges it faces in engaging Canadians and attracting resources. To that end, strategic planning becomes both an analytical and visioning tool which helps focus and guide the organization. Innovative strategies to expand the work in Africa will be addressed.

1.2 Background:

This Strategic Plan builds upon the previous three year plan (November 2001 to October 2004) and the experiences of CNIS from 2001 to 2006. CNIS has made strides in moving from project to program based funding from CIDA. However, current three year CIDA funding requires CNIS to plan for various future funding scenarios, as well as recovering from the 2006 six month lack of CIDA funding. This suggests that the new strategic plan be over five years instead of three.

The current plan is guided by three strategic principles: surgical development, partnerships, and capacity building.

This plan is the result of CNIS' critical thinking, analysis, and visioning in the following key challenge areas:

1. Program focus—the need to review program depth and breadth;
2. The nature of partnerships—in particular moving from African management to African leadership and African institution building.; and, in Canada, optimizing collaborative partnerships; with surgical and obstetrical departments.
3. The organization's human resources (staff, board members, committees, volunteers, African partners)—the need to increase these due to the larger mandate under program based mode, in particular, the need to diversity and separate the administrative and programming roles; and
4. Financial support—in particular, the need to diversify funding beyond CIDA support, even while having moved to program funding from CIDA. Also, to encourage other high income countries to develop Networks for International Surgery to support the African Institutions we have developed.

Section 2: The Current Context

2.1 The internal context:

Incorporated in 1995, CNIS has a 12-year track record of work to reduce or prevent death and disability from surgical disorders in Africa. It has done this through four program areas: Surgical Skills, including Essential Surgical Skills (ESS™); Injury Prevention; Surgical Education/Information; and Public Engagement. CNIS continues to strengthen its existing programming while also looking for ways in which successes can be replicated in new areas. The organization's programming is results-based, with achievements of outputs, outcomes, and impacts measured and monitored regularly.

New programming is developed by both staff and board, with input from African partners. Those partners are putting forward ideas for new surgical skills courses as well as ideas on strengthening our leadership. Programming needs define any required changes in or additions to the leadership/board or staffing configuration.

The current president / international director has been in place since the formation of the organization. The CNIS Board, at its meeting in Montreal in October 2005, evaluated the structure and at that time decided that it should not be changed. Another surgeon educator was employed part-time to reduce the workload of current president.

The continuing growth of CNIS, in particular the shift to program status, suggests that a new leadership model which will separate the president and international director functions is now required, the first based in Canada, the other one in Africa. A new leadership model will address the current expansion of the CNIS but a fundamental change in the organizational structure may be required to facilitate further expansion of international surgery.

In Vancouver, administration and financial systems have been enhanced through re-definition of office roles, the addition of a bookkeeper and a public engagement associate, and the hiring of a reports consultant, as well as information technology and language specialists.

The board and its committees have moved from a surgeon-based to an interdisciplinary composition. Continued movement to include a wide range of medical professionals will be beneficial in expanding expertise and in increasing the scope of contacts.

Given the mandate, mission, and area of CNIS operations, an increase in number of African-Canadians involved in CNIS leadership and governance will help foster a sense of ownership by that segment of CNIS' constituency and demonstrate that the concept of partnership has been internalized and mainstreamed by CNIS. The systems in place are at a level of sophistication that CNIS could easily expand its Canadian operations and support increased African activity without any major changes in administrative processes.

CNIS is an innovative organization. Some of its innovations are the ESS course, technical skills laboratories, the trauma team concept, a multidisciplinary approach to programming, injury prevention registries in an African context, the establishment of the first two Injury Control Centers in Africa, twinning of established hospitals with new hospital partners, and surgical departments with new surgical capacity in Ethiopia. CNIS continues to look for new innovative approaches and opportunities. One of these approaches that will be considered is for its operational activities to be moved to Africa. This would be run by the CNIS international director with succession planning to include Africans. The formation of a US Network for International Surgery (USNIS) and a UK Network for International Surgery (UKNIS) would be the basis for a Global Network for International Surgery (GNIS). The Injury Prevention Initiative for Africa (IPIFA) and the Africa Canadian Committee for Essential Surgical Skills (ACCESS)

would be the basis for such changes. Being based in Africa will result in additional international funding opportunities.

Funding remains a challenge for the organization. CNIS has moved from almost total reliance on CIDA for project funding to a mix of support from CIDA and various Foundations and Surgical partners. CIDA support will continue to be important, assuming no change in the tax structure in Canada. However, other sources of funding will continue to be sought vigorously. As well, lobbying of the Canadian Government to provide tax credits for international organizations will continue. The CNIS joining the Canadian Council for International Co-operation (CCIC) may be one strategy for that purpose. New technologies will both require additional funding sources and support additional funding opportunities. Although there is room for expansion of CNIS activities and anticipated additional CIDA funding within the program unit of Canadian Partnership Branch, to consider coverage of all of Africa will require support from other countries. The strategy of developing other Networks for International Surgery is therefore a key strategy for continuing the current momentum.

Success in Canada will be the template upon which networks in other countries can be modeled and helped to come to fruition. Events such as the Bethune Round Table, an international surgery gathering, to be held in Vancouver in 2008, can be used to help mobilize these embryonic networks.

The CNIS membership support base is drawn primarily from surgery-related professionals and from segments of the African-Canadian community. A strategy for increasing the CNIS support base, in particular among nurses, includes a membership drive, campaigns, and group-specific initiatives. More attention will be given to marketing strategies, including the preparation and dissemination of success stories.

2.2 The External Context:

The work of CNIS reflects the mandate and commitment of the organization and its constituency to develop and implement programming that responds to external forces and fits within external contexts.

CNIS responses to the need for building health capacity in Africa and addressing the injury pandemic are placed in the context of various frameworks, from Canadian Government policy to the UN Millennium Development Goals.

In the Canadian debate on health care, the Romanow 2002 Commission on the Future of Health Care in Canada delineates Canada's role in improving health in developing countries: The federal government should play a more active leadership role in international efforts to assist developing nations in strengthening their health care systems through foreign aid and development programs. Particular emphasis should be placed on training health care providers

and on public health initiatives (Chapter 11: Health Care and Globalization, Recommendation 46, p. 243). The Commission states that Canada should also work with other countries to assist developing countries in strengthening their own health care systems – especially in the areas of public health and health information – so that expensively trained health care providers will want to stay in their own countries' health care systems (p. 244).

Canada was instrumental in bringing the focus of Africa to a world audience through the Kananaskis G8 summit in 2002 by endorsing NEPAD (New Partnership for Africa's Development). Initiated by the Organisation of African Unity (OAU), and mandated in 2001 as an integrated socio-economic development framework for Africa, NEPAD addresses underdevelopment and continued marginalization of Africa. Within NEPAD's human development priority areas, health sector approaches include both addressing the burden of preventable disease, disability and death in Africa and building capacity of local health systems and services.

The Human Resource Crisis in Health Services in Sub-Saharan Africa, a 2003 World Bank working paper by Liese, Blanchet, and Dussault, highlights the critical situation of the health workforce in that region. The paper reviews the availability of human resources, focusing on workforce motivation, the serious brain drain of health professionals, and the increasing impact of HIV/AIDS. The paper suggests that without renewed emphasis on the health workforce crisis, it will be hard for African countries to attain the health-related Millennium Development Goals.

Those of the Millennium Development Goals (MDGs) which focus on health care in Africa specifically address improving maternal health (highest pregnancy and childbirth-related death rate is in Africa) and under 5 mortality. The 2003 World Bank MDG update on sub-Saharan Africa notes that Uganda is one of the countries achieving progress in poverty reduction and other MDGs. However,

> while other regions of the world are expecting better health services and outcomes over the next 20 years, sub-Saharan Africa alone is anticipating further deterioration in its health services and stagnation or worsening of health outcomes, especially among the poor. The World Bank states that the few successes in disease control (vitamin A deficiency, river blindness), fertility reduction, or health policy (new WTO rules on pharmaceutical patents) are insufficient to meet the unique challenges facing Africa: severe shortages in health workers; an over-reliance on donor support; chronic poor nutrition and reproductive health; the unprecedented burden of HIV/AIDS; and the resurgence of malaria and tuberculosis.

The health systems in Africa have suffered from neglect. However, decentralization, quality assurance, cost-sharing and partnerships with the private and non-governmental sector have led to improvements in CNIS partner countries. CNIS works with African professionals to improve these systems.

African colleagues are enthusiastic about the work and the results have been morale builders. The barriers to surgical care are serious for the poor and dispossessed populations which disproportionately include women and children. Increasing the capacity for surgery improves access, particularly for these marginalized populations. In support of increased surgery capacity, more information resources are needed to improve health care.

CIDA states that the injury pandemic leads to 5.1 million deaths annually which is as much as the mortality from AIDS, Malaria and TB combined. The importance of the Injury pandemic and the need for policy makers and funders to understand this are important areas for Canadian Public Engagement. Obstetrical and injury mortality are high priority issues addressed by CNIS activities. Female genital mutilation is a common intentional injury in Ethiopia, and women are physically abused in at least 50% of Uganda households (CNIS data).

The work of the CNIS fits within individual country and regional plans of governments and donors. Specifically, the CNIS program work aligns with three of the five CIDA focus areas in sub-Saharan Africa: governance, health and pandemic control (including HIV/AIDS prevention and control), and basic education. CNIS programming addresses both capacity building and health infrastructure.

Injury is a major cause of disability and death globally. A 2004 Wilson Odero paper, Africa's Epidemic of Road Traffic Injuries: Trends, Risk Factors and Strategies for Improvement, highlights the critical issues of injury in Africa, reflected in disability adjusted life years (DALYs) lost.

In this context of an increased Canadian focus on international health issues, renewed Canadian support for African development, and deteriorating health indicators in Africa, CNIS directly addresses needs in Africa through matching available resources with those demonstrated needs.

In the light of Canadian Government emphasis of its support to bilateral and multilateral UN interventions, CNIS remains a valid and viable partner for CIDA funding, as demonstrated by the successes of CNIS' programming. The CNIS will continue to build on its successful relationship with CIDA and will submit additional funding requests to expand and replicate current programming.

Section 3: Organizational Framework

The CNIS vision, mission, values, general objectives, and core strategies reflect the organization's continuing mandate. These are summarized below.

3.1 Vision:

Empower low income countries to create an environment where the risk from injuries is minimal and all people receive adequate surgical care.

3.2 Mission:

To improve maternal health, increase safety, and promote local capacity through Surgical & Obstetrical Skills training and transfer, Injury Prevention & Safety Promotion initiatives and infrastructure, and Surgical Information systems and technology in low income countries.

3.3 Values:

CNIS values are grounded in the belief that health and safety are a human right, as brought forward in seven United Nations declarations and elaborated in the SPHERE project. Specifically, CNIS values:

1. integrity – ensuring an ethical, honest and forthright approach to all CNIS initiatives;
2. cultural sensitivity – respecting and valuing the knowledge and cultural diversity of all peoples and communities;
3. transparency – providing an honest, accountable and transparent approach to programming and financial management;
4. participation – a client-driven approach that involves stakeholders, partners, and communities in decision-making and program delivery;
5. accountability – being fiscally responsible and accountable and clearly defining the outcomes provided through the CNIS' programming;
6. responsibility – being able to respond effectively and efficiently to meeting beneficiaries' needs; and
7. apolitical and non-sectarian activity – open to everyone while not compromising our work by taking a political stance.

3.4 General Objectives:

1. To reduce the incidence and severity of injury; and
2. To promote sustaining of surgical and obstetrical capacity

3.5 Core Strategies:

1. Sustainability and self-sufficiency – creating new or enhanced programming and/or local entities able to function successfully beyond reliance upon CNIS financial support;
2. Partnership – seeking mutually beneficial relationships with individuals and organizations in North America and overseas. A new dimension would be promoting partnership with other high income country surgeons.
3. Local capacity building for program delivery – facilitating the emergence and enhancement of local capacity in individuals or organizations;

4. Gender equity – supporting equitable access and inclusion of responses to address the specific needs of women;
5. Inter-sectoral action – working with those in and outside of the medical field;
6. Peacebuilding – supporting initiatives that build a culture of peace in conflict and post-conflict settings;
7. Surgical development – promoting surgical care through training and equipping people and assisting in building infrastructure; and
8. Clinical or contextual evaluation – analyzing results through evidence.

Section 4: Program Areas

4.1 Core Programs:

Key past programming areas have been surgical skills, injury prevention, educational support, surgical information, and public engagement. Surgical Education is now described as Surgical Information.

Public Engagement describes a range of initiatives and activities which inform, educate, and mobilize Canadians to engage with the issues at the heart of CNIS and to become involved. Public Engagement focuses on specific current or potential constituent groups of people whose interests, skills, and support are needed by CNIS, e.g. surgical and medical professionals, medical students, youth, African-Canadian groups. Some specific areas that help focus CNIS' Public Engagement work are obstetrics and injury.

While program areas can run independently, the links between program areas provide leverage with donors, create an understanding within its constituency of the inter-relationships between various aspects of health, and help create consistent messages of hope.

Therefore, CNIS' core programs are:

1. The Surgical and Obstetrical Skills Program (SS)

The surgical and obstetrical skills program is the center from which all other CNIS programs have developed. ESS (essential surgical skills) is the flagship project in this area. It has been conducted in nine departments of surgery in five African countries by CNIS and 150 African ESS instructors with more than 6,000 learners benefiting. This course has expanded to three more centers in Ethiopia and one more each in Uganda and Tanzania. In addition to the ESS program, a structured hernia course and a structured caesarian section course are being taught and additional courses being planned and developed. The development of dedicated surgical teaching laboratories is the latest innovation in this program.

2. The Injury Prevention and Safety Promotion Program (IP)

The injury prevention and safety promotion program is based on the public health approach to injury. The injury control center Uganda was established to conduct surveillance, risk analysis and interventions. The injury control center Tanzania has been started using the model of ICCU. A peace building project in war-torn Northern Uganda which includes teaching children non-violent conflict resolution has been conducted since 1998, with plans for replication in northern Ethiopia. In addition, trauma team training courses and first aid courses are being conducted. New surgical skills training of primary care practitioners is being done. Through its injury prevention activities, CNIS has influenced government priorities and introduced effective interventions, in particular the areas of traffic safety and violence among war affected children.

3. The Injury, Safety, Surgical and Obstetrical Information Program (SI)

Information systems are both supported by and to some extent dependent on technological infrastructure and capacity. Systems improvements at CNIS support systems enhancements at partner locations in Africa.

In line with historical support, Books and Journals are sent to the libraries of Departments of surgery. A container of new surgical books was sent to 6 departments of surgery in Ethiopia and additional shipments for Africa are planned. Students are sent on Scholarship to ICCU and the CNIS supports the editorial board of the East and Central African Journal of Surgery.

4. The Public Engagement Program (PE)

The Canadian surgical public is engaged through workshops on the place of surgery in development, surviving and succeeding in surgery in development and by presentation at scientific meetings. BC school children are engaged in the peace building project. The Afro-Canadian community, in particular the Ethiopian North American Health professionals, are engaged in our education workshops, including new initiatives with nurses.

There are other issues of Canadian public engagement that are crucial to the development of the CNIS. One is that CIDA has now agreed that within the context of some of the Millennium Development Goals the injury pandemic is important. However, CIDA has not given injury the prominence that the actual data would indicate. Effective public engagement by CNIS can help pressure CIDA to re-examine their policy responses to injury.

Canadian Tax law does not encourage Canadians to donate nor Canadian Foundations to promote international work. Again, effective public engagement will result in CNIS having positive impact regarding this issue.

4.2 Program Modality:

CIDA funding for CNIS work was historically accessed on a project by project basis. This began as a one year arrangement and then expanded to a longer timeframe. Over time, CNIS developed a more program-based approach to its work. This was seen in integrated approaches to programming, piloting and replication of activities within a single country or several, cross-project learning, and long-term planning exercises. CNIS also developed a program-based relationship with several private funding bodies. In late 2006, CIDA accepted the CNIS program proposal, although reducing it to three years from the five years requested by CNIS. The CNIS does not believe that three years is an appropriate length and continues to seek to influence CIDA to extend funding for the original proposal to five years. The change in the administrative model and the change in the structure needs five years of programming in order to ensure sustainability.

4.3 Partnerships:

CNIS has demonstrated the key importance of partnerships as a means to successful program work. This is seen in its relationships with supporting or collaborating agencies in Canada. We now have agreements with the Office of International Surgery at the University of Toronto, the Canadian Association of General Surgeons, Children's and Women's Health Centre of British Columbia, the University of California San Francisco, and ongoing relationships with surgical departments at the following universities: Calgary, Ottawa, McGill, Montreal and Sherbrooke (for Mali), which we are in the process of formalizing. The Canadian partnerships are a substantive source of funding as all Canadian agreements are put in the context of the CIDA 1:1 matching requirement. The importance of partnerships can also be seen in Africa through the CNIS facilitation of partnering situations between African agencies.

A major constraint to continued growth of the work of CNIS is the lack of long-term funding commitments. Success in developing long-term funding relationships is enhanced by having a program-based track record. The current work of CNIS is the basis for this track record. CIDA program funding over the next three years will be a springboard for subsequent longer-term agreements. Initially, the CNIS wishes its current three-year CIDA agreement to be extended to five years. This, and subsequent longer term funding on a regular basis, is needed for the purposes of both succession planning and programming implementation.

A program-based approach requires selection and nurturing of new partners and sustaining existing partnerships. It requires intentional focus on potential key partnerships and on institution building. Key to partnership development in Africa is a commitment to building local capacity and transferring skills in appropriate and sustainable ways. This is demonstrated by the CNIS work with the Africa

Canadian Committee for Essential Surgical Skills (ACCESS) and its members and with the Injury Prevention Initiative for Africa (IPIFA) and its members.

For example, in Ethiopia, a partnership with six universities has been developed based on three with established surgical units and three with newly emerging surgical units. Past learning is distributed to new situations and existing skills and capacity are transferred.

Partnership discussion includes both needs assessment and an exit strategy. Exit strategies are positive and intentional means of focusing activities and resources on capacity development that results in healthy local organizations. Adequately formulated exit strategies guide and nurture local partners towards self-reliance, resulting in sustainable organizations under African direction. CNIS intends that Ethiopia and Uganda become self sufficient partners by the end of 2009 and that there will be a focus on developing the programs in Tanzania to the level of Ethiopia and Uganda by 2010.

The CNIS had expected that ICCU would take advantage of its non-Canadian status to obtain other funds from other countries. This has not been as successful as we would have liked but the model still seems to be correct. If ACCESS and IPIFA become Africa-based NGOs with support from multiple Networks for International Surgery in multiple countries, then these entities can become more self-sustaining.

The CNIS seeks to enable African organizations to grow and flourish. A partnership goal is the establishment of a multi-disciplinary African network for international surgery.

In Canada, the CNIS will evaluate its existing network memberships and will add the Canadian Council for International Cooperation (CCIC) and the Canadian Society for International Health (CSIH). As a unique and distinct organization, the CNIS is willing to share expertise with other high income country (HIC) networks. Some of CNIS' partnerships are listed in Appendix A.

4.4 Innovation:

Program-based approaches linked with long-term partnerships provide a receptive space for innovative thinking. Part of strategic intention is to identify how strengths can be combined and leveraged to explore and test innovative techniques, methodologies, and approaches in order to increase program impact.

Some examples of innovative programming at CNIS have been surgical teaching laboratories and centers dedicated to injury control (these centers are the first in low income Africa). Both the skills labs themselves and the structure of teaching are innovative. The injury control centers (new in Africa in 1995), data management and data construction are all reflective of a new robust approach to

injury data. This fulfilling of WHO mandates, e.g. through road traffic safety programs, has resulted in a number of CNIS partner organization employees moving on to WHO employment.

The CNIS has developed innovative curriculum and teaching models for surgical skills transfer. In fact, the strength of CNIS has been its embracing of innovation. This has resulted in new courses in obstetrics and other disciplines and has also allowed for replication in new countries.

Innovation should be seen as a springboard from which new programming can be developed and new capacity encouraged to grow and flourish. CNIS will intentionally continue to fund research that is innovative and that supports innovation.

New technology capacity is resulting in second generation internet applications such as Wiki editing, telehealth workshops, online injury research, and social utility group connectivity.

Also, Structured Nursing skills courses should be developed for nurses as companion courses to the medical courses for surgical skills. Implementation by Canadian nurses would be a positive strategic direction for the CNIS.

4.5 Evaluation:

All projects and programs of CNIS undergo evaluations. Planned inputs are provided and scheduled activities take place. Using both quantitative and qualitative indicators, outputs are measured, and end of project outcomes are evaluated. To the extent possible, impacts of projects and programs are analyzed and evaluated against long-term plans and goals of the Organization. Impact is seen within the context of external factors beyond CNIS' control. The goal of evaluations is to identify success in achieving objectives, to build a portfolio of best practices, to enhance CNIS' capacity to address needs, and to project CNIS' future programming directions.

The CNIS is committed to continually assess the most relevant health needs of communities and to evaluate its own and other models of local healthcare.

CNIS had an evaluation mission performed by CIDA in 2000 which helped the CNIS become a much stronger organization. It will request CIDA to repeat this process in 2006.

In Tanzania, research activities on ESS will inform and help to build best practices documentation.

CNIS has requested that the institutional review to be undertaken by CIDA be done this year. CNIS sees this as a healthy exercise which will help to solidify gains in its relationship with CIDA as well as being a benefit to CNIS itself.

Section 5: The Future

5.1 Organizational Challenges:

CNIS has reached a high level of expertise and capacity. Without changing its structure or systems, CNIS addresses its human capacity as needs arise. For example, a recently hired part-time surgical associate educator could have more time assigned as warranted by workload. CNIS will continue to rely on volunteer surgeons. Hiring a part-time Vice President to assist with administration would allow for a move to the Presidency in the near future. An Information project person will help develop technological systems capacity at CNIS. All aspects of CNIS work will benefit by continued use of volunteers.

A key challenge is how to "grow" the organization. This requires strategies in place for mobilizing people and for raising funds. Additional funding is needed to meet the CIDA 1:1 matching requirement. Considerations of medicine and instrument donations are part of long-term strategic planning.

The CNIS move to reduce its organizational carbon footprint is a strategically focused effort to be an environmentally conscious good citizen. CNIS corporate social responsibility good practices are a means of encouraging its constituency, individual and corporate, to also be responsible citizens.

5.2 Fundraising:

The Board of CNIS has made significant efforts in addressing the fundraising needs of the organization. At the heart of fundraising is telling the story of people in Africa. Stories and photos help people in Canada connect with people in Africa. With marketing expertise on the Board, as marketing opportunities are identified by the CNIS Staff and Board, initiatives will be taken forward. Commercial opportunities on the web are one area of expected activity in the future. Some of the ways that CNIS will fundraise is through selling its courses and through providing internet services.

In addition to individuals, CNIS facilitates connections with Africa for foundations, medical companies, drug companies, other corporations, and philanthropists. The CNIS has a strategy of balanced budgets with all partners.

The CNIS recognizes the important contribution made by Canadian partners through MOUs and by volunteer surgeons.

CNIS separates the roles of public engagement and fundraising. However, CNIS encourages a holistic approach to the participation of Canadians in the issues of African health care. Fundraising is foundational to the long-term health and sustainability of CNIS' influence and impact.

5.3 Strategic Opportunities:

A number of favourable precursors are in place for CNIS to continue to fulfill its mandate in a meaningful way.

First, CNIS has a loyal support base. These people are assets to the organization and can be mobilized to a greater extent to pass on the vision of CNIS. Board members meet quarterly and include others for focus review.

Second, CNIS has strategic partnerships in place, e.g. IPIFA, College of Surgeons of East Central and Southern Africa (COSECSA), ICCU, ICCT, ACCESS. CNIS participates in annual meetings with all these organizations, and regularly analyzes the evolution of these partnerships and determines next steps. Discussions take place together with the partners, with decisions informed by the input of those partners. A recruitment strategy will see CNIS focus meetings with new groups of medical practitioners (e.g. nurses, obstetricians, anesthesiologists, physiotherapists), thus providing potential for expanded programming opportunities.

Third, Africa is a CIDA priority area. CNIS will continue to diversify its sources of funding so as to reduce its dependency on CIDA. However, there is benefit in continuing to build on existing relationships that CNIS has established with those in CIDA who believe in the work of CNIS and who advocate on its behalf within the funding bureaucracy. CNIS will leverage its expertise to a greater extent as CIDA increases its emphasis on development in Africa. The CNIS will shift the location of its International Director from Canada to Africa to better support the work of its partners and to facilitate expansion in programming.

MERX, the federal government bidding service through which all CIDA requests for proposal are listed will be accessed regularly for opportunities. Non-CIDA funding opportunities in Canada may be enhanced by CNIS establishing chapters in various Provinces. Initially, this could be in Saskatchewan and Manitoba, then Ontario and Quebec.

5.4 Prioritization:

CNIS does not have the resources to do everything it might want or choose to do. Therefore, prioritization is essential.

CNIS prioritization will be guided by the CNIS "core" programs and countries of focus.

In 2002, CIDA established a priority group of 9 countries, 6 of which were in Africa: Ethiopia, Ghana, Mali, Mozambique, Senegal, and Tanzania. In 2005, CIDA redirected its focus to 25 priority countries, 14 of which are in Africa: Benin, Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, Tanzania, and Zambia.

CNIS will emphasize program growth in Ethiopia and Tanzania. In 2006, CNIS selected Rwanda, which is an IPIFA member, for increased programming to begin in 2007. CNIS also intends to establish work in Mali, a francophone country in Africa.

5.5 Planning for Success:

CNIS envisions growth in its programming. As part of long-term planning for successful growth transitions, CNIS will establish mechanisms to help define and facilitate those transition points, while ensuring organizational cohesion and health. Benchmarks will be established for funding, staffing, and programming.

The initial step was to move from project to program-based funding with CIDA. Based on this successful engagement with CIDA, CNIS can now focus on solidifying its programming in Africa, strengthening its partnerships in North America and Africa, ensuring the optimum staffing mix, and identifying new opportunities.

In the future, the CNIS would be one of several country-based NGO's which supports the activities of one or two Africa-based NGO's which develop from IPIFA and ACCESS. Each of these Africa umbrella groups would be supported by University-based surgical skills organizations and nationally based. The new CNIS President would take the lead in helping other high income countries (HIC) develop National networks for international surgery (NIS). The International Director would assist the Africans develop a new international NGO which would benefit from and implement activities supported by their HIC partners.

The current five year plan envisions the following:

2007 - adapt to program status and recover from interruption of funding (programming extension)
2008 - administrative staffing re-assignments in Africa to solidify program development
2009 - development of African institutions (solidify Canadian and African organizations)
2010-11 continued development of African institutions with Global NIS's (as a means of leveraging expertise and resources)

Appendix A

CNIS Partners:

Africa Canadian Committee for Essential Surgical Skills (ACCESS)
Association of Surgeons of East Africa (ASEA)
Canadian Association of General Surgeons (CAGS)
Canadian Society for International Health (CSIH)
Children's and Women's Health Centre of British Columbia (C&W)
College of Surgeons of East Central and Southern Africa (COSECSA)
Ethiopian North American Health Professionals Association (ENAHPA)
Injury Control Centre – Tanzania (ICCT)
Injury Control Centre – Uganda (ICCU)
Injury Prevention Initiative for Africa (IPIFA) – pan-Africa
Office of International Surgery, University of Toronto (OIS)
University of California, San Francisco (UCSF)
University departments of surgery in:

- Ethiopia (Addis Ababa, Alemaya, Awassa, Gondor, Jimma, Mekele)
- Uganda (Gulu, Mbarara, Makerere)
- Tanzania (Muhimbili, Kilimanjaro)
- Malawi (Malawi)
- Mozambique (Eduardo Mondlane)
- Canada (University of Calgary, McGill University, University of Montreal, University of Ottawa, University of Sherbrooke, University of Toronto, University of British Columbia)

Appendix B

SWOT Analysis
CNIS
August 11, 2007

Strengths	*Weaknesses*
• Proven programs with good tools • Solid core operations • Solid funding • Established local, international and African partnerships • Strong Board and Staff • Good clarity, focus and direction • Strong vision and mission and understanding of needs	• Weak brand recognition • Limited capacity • Limited revenue sources • Intermediate term CIDA funding (3 years) instead of longer term (5 years) • CNIS leadership confirmed succession plan needed • Small number of partners • African partner organizations not yet self-sustaining • Narrow membership base • Human resources • Reactive marketing program
Opportunities	*Threats*
• Expansion of programming to other countries and continents • Replication of network in other countries and globally • Addition of pharmaceutical initiative • Expansion to other health professional groups, e.g. nurses, physiotherapists, orthopaedic technicians • Expansion of injury control programming • Increased global awareness of injury as a pandemic • Promotion of surgical skills labs • Using advocacy expertise • Expansion of peacebuilding into other countries	• Limited volunteer resources to deliver programming • Insufficient second party funding • Insufficient human resources administrative support • Fracturing, i.e. lack of collaboration as more partners become involved • Technology constraints • Canadian tax law and community foundation tax structure constraining charitable giving