Community Health Australia is the national peak body for community health in Australia, and a founding member of the International Federation of Community Health Centres (IFCHC).

The IFCHC evolved from a 2011 memorandum of understanding between the National Association for Community Health Centers (USA), the Canadian Association of Community Health Centers and the European Forum for Primary Care. The IFCHC aims to:

- increase the awareness and visibility of community health centres (CHCs) around the world
- advance the understanding and alignment of the CHC model with the World Health Organization's definition and vision of primary care
- increase the adoption of the CHC model of care in contemporary health system design around the world, which includes establishing new CHCs as state-of-the-art healthcare facilities
- increase the research and evidence base that underscores the value of CHCs
- increase the scope of governance and operational tools available to CHCs to advance safety and quality in their provision of services
- support individual CHCs in their respective processes of continuous quality improvement
- facilitate advocacy in support of CHCs directed at local, state and national governments, and at private sources and the general public

The IFCHC website can be accessed here: www.ifchc2013.org.
The IFCHC constitution is attached as an appendix and can be accessed here: http://www.ifchc2013.org/?page_id=22

Community Health Australia will facilitate Australia's representation on the IFCHC, and provide a nation-wide peak body for CHCs. Our membership criteria, governance structure and activity focus have yet to be determined. Membership criteria similar to those of the IFCHC are likely to be applied. The following characteristics are listed as minimum requirements for IFCHC membership:

- CHCs deliver integrated, comprehensive, people-centred primary health care, through an inter-professional team that addresses aspects of both health and wellbeing
- clinical primary care services at CHCs address aspects of health promotion and illness prevention, curative care and rehabilitation, using a holistic frame of reference and are oriented towards the needs of individuals, families, populations and communities
- the CHC primary care team integrates into its daily activities, attention to the broader causes of illness, and looks at the social determinants of health, addressing them through intersectoral cooperation
- CHCs develop a community-oriented primary care strategy, blending skills for individual health care with approaches focused on public health

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- CHCs have a commitment to equity and social inclusion and put emphasis on access to healthcare with special attention given to the most vulnerable, and on respect for fundamental human rights
- CHCs place a strong emphasis on community engagement and civic participation in health and healthcare which may, but does not necessarily, include participation of clients/patients and other community members in governance of the healthcare organisation
- CHCs contribute to universal coverage and are strongly committed to being accessible for individuals and families, irrespective of race, religion, social status and other factors, including ability to pay for care
- CHCs engage in processes of continuous quality improvement, starting from the needs of individuals and patients that they are serving
- CHCs take responsibility for a defined population that can be geographically-determined or defined by population group(s)

For further information please email: info@communityhealth.org.au

International Federation of Community Health Centres (IFCHC) Constitution

PREAMBLE

Pursuant to the Memorandum of Understanding signed in October 2011 by the National Association of Community Health Centres (NACHC), the European Forum for Primary Care (EFPC) and the Canadian Association of Community Health Centres (CACHC – formerly CACHCA), the following constitution is presented for the purpose of enacting and mobilizing an "International Federation of Community Health Centres (IFCHC)". This IFCHC and the objectives, structures and protocol outlined in this constitution have emerged consequent to dialogue arising from the 2011 Memorandum of Understanding.

SECTION 1: NAME OR ORGANIZATION

1.1 The organization will be known as the International Federation of Community Health Centres, hereafter referred to as IFCHC.

1.2 Translation of the organization's name into other languages will be undertaken in consultation with the IFCHC's Directing Council members, with a goal of ensuring cultural and linguistic relevancy across countries and regions.

SECTION 2: AIMS AND OBJECTIVES OF THE ORGANIZATION

Through knowledge exchange, resource-sharing and cross-jurisdictional partnership-building (e.g. "CHC twinning") and the development/use of tools to carry forward these processes, the IFCHC exists to achieve the following objectives:

2.1 To increase awareness and visibility of Community Health Centres around the world (as defined in Section 4). Examples of tools that may be developed and used to achieve this include such things as:

2.1.1 Inventories and mappings of Community Health Centres, regionally and globally;

2.1.2 An IFCHC website and member/collaboration portals;

2.1.3 Health 2.0 tools such as webinar platforms, tele-health, social media and other platforms;

2.1.4 Relevant promotional materials, both in hard-copy and electronic formats;

2.1.5 Annual "Community Health Centre Week" events as organized in the individual countries.

2.2 To advance understanding of the alignment of the Community Health Centre model with the World Health Organization's definition and vision for primary health care.

2.3 To increase the adoption of the Community Health Centre model of care within contemporary health system design around the globe, including establishment of new Community Health Centres as state-of-the-art primary health care practice.

2.4 To increase the research and evidence base that underscores the value of Community Health Centres:

2.4.1 To individual clients;

2.4.2 To population groups and communities;

2.4.3 To secondary and tertiary care organizations, and to health systems as a whole;

2.4.4 To partners from other social service sectors;

2.4.5 To policy makers and decision-makers in government and the private sector.

2.5 To increase the scope of operational and governance tools that are used by CHCs to advance safety and quality in the provision of community health services.

2.6 To support individual Community Health Centres in their respective processes of continuous quality improvement through:

2.6.1 Dissemination and sharing of tools and resources, as described in Sections 2.1 – 2.5, above;

2.6.2 Facilitation and coordination of centre-to-centre and peer-to-peer knowledge exchange and collaboration opportunities;

2.6.3 The offering of education and training services aimed at improving the operations of health centres individually and collectively;

2.6.4 Other opportunities as they may arise.

2.7 To facilitate advocacy in support of Community Health Centres directed at national, state/provincial, and local governments and at private sources of support and the general public.

SECTION 3: POWERS OF THE ORGANIZATION

In accordance with the rules, roles and responsibilities of the organization's governance body, outlined below in Section 5, the IFCHC will have the power to:

3.1 Set and require dues from all "certified" country-level CHC associations in order to support the IFCHC's operational activities.

3.2 Manage all revenues and expenses of the organization, in keeping with any limitations imposed by the organization's governing body, and for the specific purpose of pursuing the aims and objectives of the organization, as outlined in Section 2.

3.3 Solicit contributions and donations from external partners, via philanthropic donations, research grants and other opportunities, in order to pursue the aims and objectives of the organization, as outlined in Section 2.

SECTION 4: MEMBERSHIP

4.1 Definition of Community Health Centre

We define "Community Health Centre (CHC)" as a model of care that can take a variety of formal names depending on the jurisdiction in which they are situated. The following

characteristics are fundamental and define the “Community Health Centre “. This list defines minimum criteria, but in certain jurisdictions additional criteria may be in place.

4.1a Community Health Centres deliver integrated, comprehensive, people-centered primary health care, through an interprofessional team that addresses aspects of both health and wellbeing.

4.1b Clinical primary care services at Community Health Centres address aspects of health promotion and illness prevention, curative care and rehabilitation, using a holistic frame of reference and are orientated towards the needs of individuals, families, populations and communities.

4.1c The Community Health Centre care team integrates into its daily activities, attention to the broader causes of illness, and looks at the social determinants of health, addressing them through intersectoral cooperation.

4.1d Community Health Centres develop a community-oriented primary care strategy, blending skills for individual health care with approaches focused on public health.

4.1e Community Health Centres have a commitment to equity and social inclusion and put emphasis on access to health care (with special attention given to the most vulnerable), and on respect for fundamental human rights.

4.1f Community Health Centres place a strong emphasis on community engagement and civic participation in health and health care, which may, but does not necessarily include participation of clients/patients and other community members in governance of the healthcare organization.

4.1g Community Health Centres contribute to universal coverage and are strongly committed to being accessible for individuals and families, irrespective of race, religion, social status and other factors, including ability to pay for care.

4.1h Community Health Centres engage in processes of continuous quality improvement, starting from the needs of individuals and patients that they are serving.

4.1i Community Health Centres take responsibility for a defined population that can be geographically-determined or defined by population group(s).

4.2 Full Members

4.2.1 Eligibility for “full membership” in the IFCHC will be limited to Community Health Centre (CHC) organizations that satisfy the operational definition of “Community Health Centre”, as described in Section 4.1, above.

4.2.2 Membership by individual CHC organizations will be administered via their CHC associations at the national, state/provincial or municipal level. These associations are all described hereafter as “country-level CHC associations”.

4.2.3 In order to be eligible to confer Full Membership status upon its member CHCs, a country-level CHC association must first be certified by the IFCHC Directing Council, as described in Section 4.3, below.

4.2.4 Full membership in the IFCHC will be extended to individual CHC organizations through the "highest" country-level CHC association that exists within a particular country. In other words, from national-level, then to provincial/state-level, and then to municipal-level.

4.2.4a In keeping with the IFCHC's priority of fostering national CHC associations and movements throughout the world, individual CHC associations will not be eligible for full membership in the IFCHC via any other level of CHC association (state/provincial or municipal) in cases where a national-level CHC association exists.

4.2.5 Administration and extension of full membership to individual CHC organizations at country-level will be the jurisdiction of the respective association, at country level. This includes the levying of any dues or contributions that the association deems necessary and appropriate to foster participation in the IFCHC and to support the IFCHC's operations.

4.2.6 In the absence of any country-level CHC associations, full membership may be granted directly to an individual CHC organization by the IFCHC. In such cases, an individual CHC organization will be required to submit a standard membership application form to the Directing Council of the IFCHC.

4.2.7 Membership of a world-regional partner such as the European Forum for Primary Care (EFPC) for the European region does not preclude membership from national, state/provincial and municipal CHC associations within that region (e.g. European region countries, states or municipalities). In such cases, the conditions and dues for membership in the IFCHC by CHCs and their associations at national, state/provincial or municipal levels will be determined by the IFCHC Directing Council.

4.2.8 The benefits and rights of Full Membership in the IFCHC (i.e., for individual CHCs) will be defined by the IFCHC Directing Council, as described in Section 5.

4.3 Certification of country-level CHC Associations

4.3.1 In order to be eligible to confer full membership on individual CHC organizations within their country, all country-level CHC associations (whether national, provincial/state, or municipal) must be "certified" by the Directing Council of the IFCHC.

4.3.2 Certification is required as a mechanism to support the country-level administration of membership in the IFCHC, while ensuring an acceptable level of quality control and adherence by CHCs at country-level to the IFCHC's minimum definition of Community Health Centre, as outlined in Section 4, above.

4.3.3 Certification of country-level CHC associations will be conducted by the IFCHC Directing Council, or one of its designated committees.

4.3.4 Certification will take the form of a review of a given country-level CHC association's local definition of "Community Health Centre" and its criteria for CHCs to participate as a member of that country-level association.

4.3.5 This certification process and the administration/ extension of membership to individual CHC organizations in the IFCHC will be guided by a code of ethics, principles and good practices to be developed as an appendix to this draft constitution.

4.4 Associate Members

In recognition of the valuable contributions to primary health care by diverse stakeholders from within health systems and across other sectors, the IFCHC may offer Associate Membership in the federation to organizations that do not meet the minimum definition of Community Health Centre, as described in Section 4.1. The criteria for associate membership, along with application process, fees and membership benefits will be discussed and negotiated by the IFCHC Directing Council. Amendments to this constitution may be made accordingly.

SECTION 5: GOVERNANCE AND MANAGEMENT

5.1 The IFCHC will be governed by a Directing Council comprised of one representative from each certified country-level CHC association. The founding Directing Council will be constituted by one representative from each of the founding national and state CHC association members of the IFCHC, which are:

5.1.1 Canadian Association of Community Health Centres;

5.1.2 Community Health Australia;

5.1.3 European Forum for Primary Care (for additional reference, see Section 5.2, below);

5.1.4 National Association of Community Health Centres (United States of America).

5.2 Although it is a regional partner, a Directing Council seat will be reserved for the European Forum for Primary Care in recognition of: a) its strategic role as a regional block organization for CHC partners throughout Europe; b) EFPC having been a signatory to the 2011 IFCHC partners MOU; c) the proposal of EFPC to act as founding Secretariat for the IFCHC. The EFPC's seat on the Directing Council does not preclude representatives from national, state/provincial and municipal CHC associations within the European Region from occupying additional Directing Council seats, in accordance with Section 4.2.7, above.

5.3 Additional Directing Council seats will be allocated to national, state/provincial or municipal CHC associations at the discretion of the existing Directing Council members. Directing Council seats will only be extended to country-level CHC associations that have been certified by the existing Directing Council, as described in Section 4.3.

5.4 The total number of Directing Council seats will not exceed 15.

5.5 The Directing Council will have a rotating Chairperson, whose election and terms of reference will be developed by the Directing Council.

5.6 At such time where there is potential for Directing Council membership to exceed 15 qualifying, country-level CHC association seats, the Directing Council will be required to undertake a review of the Directing Council composition, and to negotiate a revised constituency structure. At that time, a review of Directing Council term limits and other relevant governance criteria and limits will be undertaken.

5.7 All Directing Council members will receive one vote on all matters where voting is deemed necessary to guide IFCHC decisions.

5.8 On all matters that require voting to occur, support by at least two-thirds of Directing Council members is required for a motion to carry.

5.9 The IFCHC will carry forward operational activities via a rotating Secretariat.

5.9.1 The term of each rotation will be determined by the Directing Council.

5.9.2 A founding Secretariat will be agreed upon by the IFCHC Directing Council.

5.9.3 A review of the rotating Secretariat structure is required for discussion after no more than two years following initial implementation of the IFCHC constitution.

SECTION 6: MEETINGS

6.1 The Directing Council shall meet at least quarterly, subject to the call of the Chairperson

6.1.1 Meetings of the Council may be held by conference call or via the Internet, provided that all members can simultaneously hear and communicate with one another.

6.1.2 A quorum of at least a majority of the members of the Directing Council shall be required in order to conduct the business of a meeting of the Council.

6.1.3 Special meetings of the Council may be called by the Chairperson, or by a majority of the members of the Council.

6.1.4 A calendar of meetings will be developed in order to provide sufficient advance notice to Directing Council Members. All Council members shall be notified of any special meeting at least 7 days in advance of the meeting. The notice of any special meeting shall include a statement of the purpose or purposes of such meeting, and the matters to be voted upon.

6.1.5 Any action required or permitted to be taken by the Council may be taken without a meeting if all members of the Council individually and collectively consent in writing, including email transmission, to such action. Such written consent shall have the same effect as a unanimous vote of the Council, and shall be filed with the minutes of the proceedings of the Council.

SECTION 7: COMMITTEES

7.1 The Directing Council may appoint one or more committees at its pleasure, and may delegate to any committee the authority as required to conduct its business, except that such authority may not include any action requiring a vote of the Directing Council.

SECTION 8: FINANCE

8.1 To be determined at the discretion of the Directing Council.

SECTION 9: INDEMNIFICATION / PERSONAL LIABILITY

9.1 No member, officer, or director of this organisation shall be personally held liable for the debts or obligations of the organisation of any nature whatsoever; nor shall any of the property of any member, officer, or director be subject to the payment of debts or obligations of this organisation.

SECTION 10: AMENDMENTS TO THIS CONSTITUTION

10.1 This constitution may be amended, revised, or repealed by a vote of not less than two-thirds of the Directing Council, provided that such vote is taken at a meeting that meets the requirements of Section 6.

SECTION 11: DURATION / DISSOLUTION

11.1 The duration of the IFCHC shall be perpetual until dissolution.

11.2 The IFCHC may be dissolved by a vote of not less than three-quarters of the members of the Directing Council, unless the membership of the IFCHC is greater than the number of Directing Council members, in which case a vote of not less than three-quarters of the entire IFCHC membership will be required for dissolution.