


Contact Information
African Religious Health Assets Programme (ARHAP)
Dept. of Religious Studies
University of Cape Town
Private Bag
Rondebosch 7701
South Africa
Email: arhap@gmail.com
Phone: +27 - 21 650 3457/8
www.arhap.uct.ac.za

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The contribution of religious entities to health in sub-Saharan Africa.
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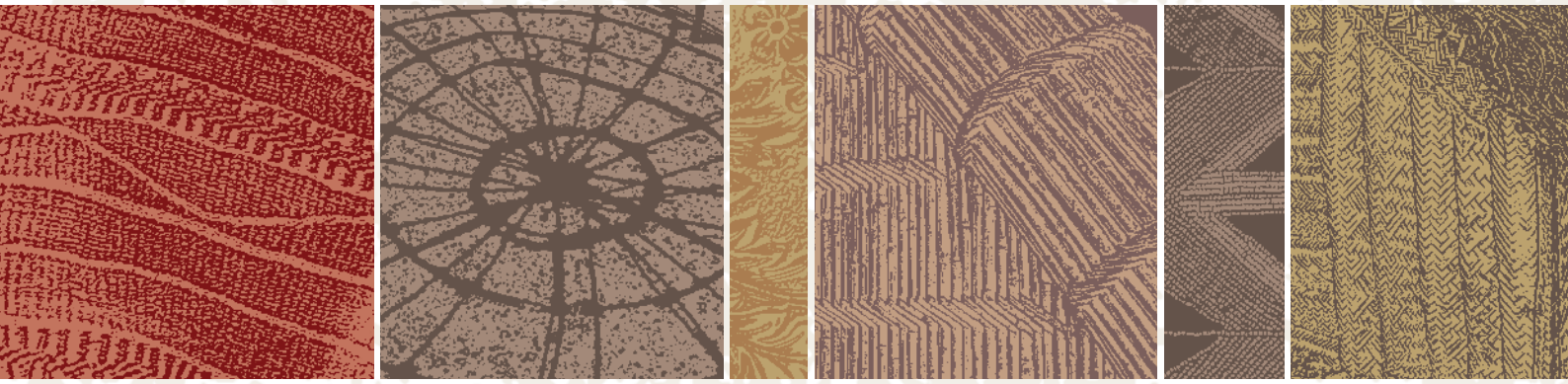
THE CONTRIBUTION OF RELIGIOUS ENTITIES TO HEALTH IN SUB-SAHARAN AFRICA

MAY 2008

AN ARHAP REPORT



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African Religious Health Assets Programme

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Barbara Schmid, Elizabeth Thomas, Jill Olivier, James Cochrane

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EXECUTIVE SUMMARY

We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. We are reliable. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away.[1]

1. BACKGROUND

While most partners in providing health care in sub-Saharan Africa agree that religious entities play an important role in providing health services, there is little comprehensive data about the scope and scale of their contribution, beyond data held by particular religious entities about their own health related work. In addition not much is known, beyond claims and often repeated statements, about the ways in which such health care is different from services provided in the public health system.

2. AIMS AND OBJECTIVES

The overall purpose of this study was to provide a description of the contribution of faith based organisations (FBOs), institutions, and networks to the health of vulnerable populations in resource-poor areas of sub-Saharan Africa (SSA); and to identify key areas for investment that would accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries.

There were two main parts to the objectives:

1) To give an overview for SSA of the coverage, role, and core health related activities of religious entities, including major networks, vis a vis public and other private sector health services delivery, and their relationship to government and to each other.
2) To give more detailed information for three country case studies in Mali, Uganda and Zambia:
    a) describing the capacity of faith based organisations to deliver health services and impact on health behaviour; the financial and/or material support they receive and how they are perceived by stakeholders;
    b) characterizing key faith based networks and describing how they work;
    c) describing how faith based organisations collaborate with each other and with governments.

From these were to be drawn recommendations about key areas for potential investment that would improve population health outcomes.

3. RESEARCH OVERVIEW

The research was conducted under the auspices of the African Religious Health Assets Programme (ARHAP), a research networks focussed on gaining a better understanding of the contribution of religious health assets to public health in Africa. The team of ARHAP researchers, from the University of Cape Town and the Medical Research Council was supported by an international, inter-disciplinary and multi-religious advisory group as well as in-country researchers.

The overview of SSA involved collection and desk review of existing databases and secondary literature. This resulted in a descriptive summary of cross cutting issues and country data summarised for 10 countries.

For the three Country case studies 4 methods were used in combination:

- 10 Key Informant Interviews per country with representatives of the public health sector, some religious leaders, academics and practitioners.
- 3 or 4 focus group discussions of ten people each per country, with representatives of identified faith based health services
- Questionnaires were distributed to the same faith based organisations, about 25 per country
- In Mali focus group discussions and Questionnaires could not be used as there are very few religious health services. In stead three in depth local case studies were conducted.

1 Canon Gideon Byamugisha on the contribution faith based organisations can make in responding to HIV and AIDS in: WHO, "Faith-based groups: Vital partners in the battle against AIDS". The "3 x 5" Target Newsletter, July/August 2004. P3. http://www.who.int/3by5/mediacentre/en/3by5newsletter_0204.pdf

4. CONTEXT

Africa has 10% of the world's population, 25% of the global disease burden and is home to nearly a third of all people living with HIV and AIDS; a number of countries in Southern Africa have HIV prevalence rates above 20%. We also find here the highest disease burden of malaria and TB with high levels of infant and child mortality, child stunting, and very poor maternal and reproductive health outcomes.

Poverty is one of the major determinants of poor health on the continent. Health systems are overstretched and buckling in working against this huge burden of disease while also responding to structural challenges. Health systems are under-resourced – mostly well below the recommended 15% of GDP - and often having to depend to a large extent on unreliable funding sources; or funds that are designated for vertical programmes rather than primary health care. The human resource crisis is severe as health workers leave their home countries and the continent in search of better salaries and working conditions elsewhere. In all of these factors the situation in rural areas is even more desperate than in the cities.

It is in this context that religious entities run vast networks of health facilities and health supporting activities. Many of them have been there for decades; and many others have sprung up in recent years, often in response to the HIV and AIDS pandemic.

5. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

In Africa, religion is integral to peoples' lives and religious entities are deeply involved in the health sector. This study undertook to expand upon the 'patchy' data about this religious involvement, drawing on the case studies undertaken in Mali, Uganda and Zambia and the findings of the desk review.

FINDING 1: RELIGIOUS ENTITIES (RES) MAKE A SIGNIFICANT AND UNIQUE CONTRIBUTION TO HEALTH SERVICES

a) REs can be described as performing these main health related functions in SSA:

- Delivery of **facility-based health services** alongside the state health services at district and national level (Uganda, Zambia)[2].
- Many faith-based hospitals are also **training centres** for the health workforce; this may still produce as much as 60% of the nursing cadres (Uganda).
- Provision at local level of **non-facility-based small-scale health related activities** including traditional medicine, home based care and HIV prevention, care and support (Zambia).
- National faith based health networks like CHAZ in Zambia and the medical bureaus in Uganda, offer **co-ordination**, fundraising, capacity development, supervision for affiliated health services and act as funding vehicles for them.
- **Advocacy** around the role of faith based facilities in health provision with government and funders (Uganda, Zambia).
- **Health promotion** and education by trusted leaders at a local level (especially Mali).

"If you think that this is a precious asset for the country, that you want to maintain, not only do you have to support it – but support it in a way that is conducive for the institution."
(UCMB, Uganda)

b) There is **little data** on the faith-based contribution to health and to date no comprehensive database of religious health facilities for SSA exists, nor of their funders and good practice exemplars; even less is known about non-facility-based services (Desk review).

"To help is also a religious act. What is important is the human being; helping human beings."
(FBO doctor, Mali)

c) Anecdotal evidence claims that the religious commitment of health workers impacts on their work ethic and quality of care (Uganda, Zambia, Mali); this has also been identified as a valuable asset for quality health care.

2 Where a specific finding can be linked to a case-study, the country/chapter is indicated in this manner.

On the basis of these findings the study recommends that

I) Mapping of religious entities contributing to health is important for optimal alignment in resource constrained settings and should be undertaken more widely leading to the establishment of a comprehensive database.

II) Further study be undertaken to verify claims about 'better' quality of care provided by faith-based health services and any potential lessons this might have for strengthening public health services in resource poor settings.

FINDING 2: FAITH-BASED HEALTH SERVICES IN SSA SHOW GREAT VARIETY IN TYPE AND EXTENT

a) The **scale and range of activities vary** from country to country as well as within countries; it is not possible to speak about REs contribution to health in sub-Saharan Africa in generalising terms (Desk review).
b) There is a very wide inter-country variation in role of REs in health, depending on the **history** of colonialism, the shifting policy environment over time and different cultural and religious influences.
c) The case-study findings show that **the contribution of REs in terms of health facilities** at country level varies from 2% in Mali to about 30% in both Uganda and Zambia with an even higher percentage in rural areas through rural hospitals and health facilities.

"We need more clinics, but why faith-based ones?"
(Health Policy Initiative, Mali)

On the basis of these findings the study recommends that

III) Further research is needed to extend the insights from this study, i.e. to identify patterns and commonalities in REs working in different contexts, to fill in gaps apparent in the desk review

FINDING 3: NATIONAL FAITH BASED HEALTH NETWORKS (NFBHNS) PLAY A CRUCIAL ROLE IN ENABLING FACILITY-BASED SERVICES, YET THEIR RIGHTFUL PLACE WITHIN NATIONAL HEALTH SYSTEMS IS NOT ALWAYS ACKNOWLEDGED.

a) The study has highlighted the way in which REs impact on health in a range of different ways at national level where strong religious organisations are **taken seriously as partners by government** (Uganda, Zambia).
b) The bulk of faith-based hospitals and clinics (in Uganda, Zambia) are **co-ordinated by agencies at a national level** with a formalised relationship with the ministry of health.
c) The advocacy role of NFBHNs and their participation in policy engagements has been shown to help further the capacity of affiliated facilities (Zambia).
d) At times clear **boundaries are placed on NFBHNs** around their involvement in what are seen as political issues; e.g. limiting their access to health information relevant to their facilities (Uganda)
e) There is a **similarity of approach** between faith-based and public health services; they all follow the guidelines of the MoH, and are supervised by its officials (Uganda, Zambia, Mali).
f) Faith based services complement those of the MoH and NGOs, but do have a different ethos resulting in valued services to marginalised groups (Uganda, Zambia, Mali).
g) The contribution of the faith based sector to national health provision is generally acknowledged by health ministries in SSA (Zambia, Uganda). Yet the **policies** in some countries are not sufficiently **enabling** for the role of REs at a national level.
h) Collaboration between faith based and public health facilities and management structures was found to be more difficult at a **district level** where there was more direct competition for limited resources such as funding and health workers (Uganda).

"FBOs are not given the space to debate things and to participate .... So they are sort of relegated to ... mopping the floor."
"We're a sort of a lesser among equals."
(NGO and MoH respondents, Zambia)

Hence the study recommends:

IV) The faith-based health sector should be involved in planning and health policy issues at a national level, where appropriate, to ensure policy is enabling for REs.

V) FBOs should be seen as part of the MoH's activities at a district level.

VI) Capacity for policy making in the health sector (e.g. understanding the policy-making process at national / district level) should be developed among faith-based and MoH leadership to facilitate joint involvement in developing enabling policy.

FINDING 4: THERE HAVE BEEN SIGNIFICANT SHIFTS IN OWNERSHIP/FUNDING/RESPONSIBILITY REGARDING FAITH-BASED HEALTH FACILITIES OVER RECENT YEARS FROM THE HISTORIC MISSION MODEL TO LOCAL AND AGENCY FUNDING, LEAVING HUGE DISCREPANCIES.

a) Originally most faith based facilities were **mission owned and funded**. Many of these facilities are now deteriorating (Desk review, Uganda, Zambia, Mali).

b) Across SSA health services have become the **responsibility of national governments** after independence who are supported by international agencies.

"For faith-based organisations, they have 32% of the required number of staff, so they are 70% short almost. I mean, you can't provide quality services like that ... Government has 50%."
(MoH spokesperson, Zambia)

c) Faith based health facilities, too, in many countries are now funded to varying extent by government.

d) But there is **no parity in employment conditions** for health workers at faith based and state health facilities. This causes problems with recruitment and retention of staff and also potentially results in compromised quality of care (Uganda).

e) Career expatriate **mission health workers** have become rare; few medical missionaries now serve in SSA (Zambia).

"All that you have to do is spend it, spend it, spend it... in Africa, it doesn't work like that. Africa time is using the sun."
(Focus group, Zambia)

f) Funding is received from a **variety of funders** with differing aims and conditions. Much of this funding supports vertical programmes. Complex proposal and reporting requirements often exclude REs from accessing these funds (Uganda, Zambia).

g) Faith-based facilities rely heavily on **user fees**. This raises dilemmas around access for the poor to their services (Uganda, Zambia).

Hence the study recommends

VII) Funders should commit to working closely with national ministries of health (MoHs) in strengthening national health systems.

VIII) NFBHNs and their crucial contribution are to be acknowledged and receive direct funding support.

IX) Policy and consultation should ensure that there is parity in access of the community to health services, whether provided by MoH or REs.

FINDING 5: FAITH-BASED HEALTH SERVICES WORK UNDER SEVERE CONSTRAINTS, ESPECIALLY REGARDING THEIR WORKFORCE

a) The quality of service at faith-based facilities was compromised as they were often **severely understaffed** and many health workers were under-qualified (Uganda, Zambia).

b) Addressing the **human resource shortage** was an integral part of strengthening the health system.

c) Creating a **health associate** position should be considered for relatively well-educated school-leavers to be trained to perform some of the basic functions (Zambia).

d) **Funding shortages** hampered health services, resulting in drug shortages and the inability to provide safe and reliable transport for referrals (Uganda, Zambia).

"You may have everything on the ground: supplies, drugs, everything. But if the human resources for health are not paid much attention to, we are not likely to go very far. It's the human resources that turn the other resources into useful means."
(NGO doctor, Uganda)

Hence the study recommends these support strategies

X) Staff costs, both for salaries and ongoing training, which are often particularly excluded from donor packages, should be considered as crucial for REs.

XI) Special consideration needs to be given at national level to how FBO facilities and training institutions can be mobilised to help address the HR problems in the health system

FINDING 6: REs PROVIDE A WIDE RANGE OF NON-FACILITY-BASED SERVICES IN RESPONSE TO IMMEDIATE LOCAL NEEDS, PLAYING A VERY IMPORTANT ROLE UNDER SERIOUS CONSTRAINTS

a) An **extensive range** of non-facility-based health activities are provided by REs at local level, directly responding to the needs of vulnerable groups (Zambia).
b) These initiatives operate **informally, flexibly**, and in response to available funding, so there is virtually no reliable record of what is done and achieved (Desk review, Uganda, Zambia).
c) The district level grassroots initiatives are all but **invisible to public health players** and often even to the NFBHNs (Uganda, Zambia).
d) Problems emerged when there was **inadequate collaboration** of non-facility based services, such as duplication of services; competition in obtaining funding, recruiting staff and volunteers and attracting clients; inability to access appropriate referral services (Zambia).
e) Oftentimes, these activities are heavily reliant on **volunteers** who themselves are very poor, and often move locally from agency to agency in search of better stipends.
f) The ready **availability of funds for HIV** services – and the huge needs in this area – are largely the raison d'être for the explosion in scale of these activities (Zambia).
g) These initiatives are often **not sustainable** due to their lack of sustainable funding and shortage of technical, financial and administrative skills. A major challenge is funding of operational costs, seldom funded by international agencies (Zambia).
h) **Intermediary agencies** have emerged to supplement technical capacity, and provide support and training to small local projects; but there are far too few of these (Zambia).

> *"Everybody wants to be able to count Lucy, everybody wants to be able to count Suzie. So you get this kind of numbers game competition that's happening. And with that comes competition for personnel."*
> *(Focus group, Zambia)*[7]

Hence the study recommends the following in support of this sector

XII)Agencies should be set up at regional level to provide technical and administrative support to local non-facility-based FBO initiatives thereby sustaining and scaling up valuable work done at this level.

FINDING 7: MIXING OF MULTIPLE HEALING MODALITIES (AFRICAN TRADITIONAL, BIO-MEDICAL, FAITH HEALING, ALTERNATIVE THERAPIES) IS A COMMON REALITY ACROSS SSA WITH MOSTLY VERY LITTLE MUTUAL ACKNOWLEDGEMENT AND COLLABORATION.

a) Across SSA African traditional healing is used by the majority of health seekers, often concurrently with other possibilities for health offered by **plural health systems** (Uganda, Zambia, Mali).
b) **African traditional healers** and traditional birth attendants (TBAs) continue providing accessible health services and are increasingly open to some form of collaboration with bio-medical health providers (Uganda, Zambia, Mali).
c) Many policy documents refer to the importance of traditional healing and the need for collaboration. Nevertheless, traditional healers were rarely given more than **token acknowledgement** by the Ministry of Health (Zambia, Uganda) although Mali has taken more definite steps toward genuine partnering.

Hence the study recommends

XIII) A policy process should be developed to integrate traditional healers into the health system.

FINDING 8: WHILE THE IMPORTANT POTENTIAL OF RELIGIOUS LEADERS FOR HEALTH PROMOTION HAS BEEN CHANNELLED INTO SOME CREATIVE INITIATIVES, IT IS GENERALLY UNDERUTILISED.

"We are not restricted in how far we can go in helping people, because we don't need the pound, we don't need the dollar, we don't need the euro to import these drugs." (Traditional healer in Zambia)[7].

a) Religious leaders have the **potential** to be powerful agents in the promotion of public health agendas. As shown in the Mali case-study, inter-religious dialogue and co-ordination at national and local levels is particularly beneficial.
b) Some religious leaders contribute to health promotion and education in a number of areas (e.g. promoting family planning or fighting FGM) (Mali).
c) The **degree to which this potential is utilised** in different countries varies widely depending on the context.
d) The role of local religious leaders in health promotion differs by level; with **national religious leaders** more heavily involved than **rural imams** (Mali).

Hence the study recommends

XIV) Religious leaders at all levels should be encouraged and trained to be actively involved in culturally appropriate health-promoting activities.

XV) Research is needed to develop ways to challenge religious leaders to advocate against traditional/religious practices prejudicial to health.

XVI) Inter-religious dialogue on health issues needs to be encouraged to strengthen faith-based efforts of different actors and align them with each other.

6. REPORT STRUCTURE

This report presents the data and findings from the study in eight chapters:

- Chapter 1 outlines the purpose of the study and its objectives;
- Chapter 2 describes the methodology followed and introduces key terms used in the report regarding faith based health organisations' involvement in health;
- Chapter 3 reviews health systems in SSA and the role of religious entities in them, drawing attention to the role of colonial histories and current international developments;
- Chapter 4 provides the results of the desk review for SSA, including ten country sheets as cameos of the complex ways in which religious entities (REs) contribute to public health in this region;
- Chapter 5 presents the Zambia case-study, with an overview of the country, description of faith based health services and health supporting/promoting activities, networking and collaboration, the constraints they face and recommendations for funding and action;
- Chapter 6, the Uganda case-study follows the same structure;
- Chapter 7 presents the Mali case-study with an emphasis on 3 local FBOs providing health services or offering health promotion;
- Chapter 8 summarises the findings of the study and its general recommendations for sustaining and enhancing the role of REs in health in SSA.

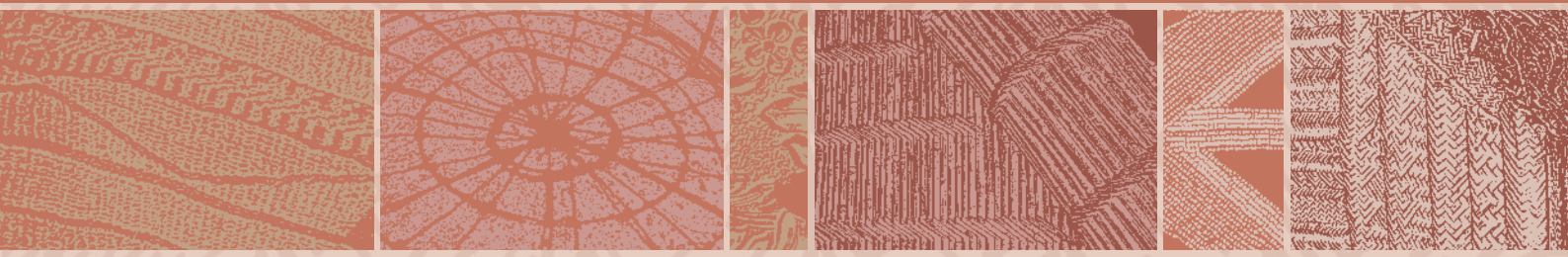
"Religious leaders play a vital role in Malian community. There are thousands and thousands of followers who listen to them, who follow them."
(NGO respondent, Mali)

The full report and country data sheets are available on the ARHAP website: www.arhap.uct.ac.za

Report reference: Schmid B, Thomas E, Olivier J and Cochrane JR. 2008. The contribution of religious entities to health in sub-Saharan Africa. Study commissioned by B & M Gates Foundation. Unpublished report. ARHAP

CHAPTER I

INTRODUCTION AND AIMS OF THE STUDY



CHAPTER 1

1.1 OVERVIEW

This chapter sketches how the study came about, and then describes the purpose of the study, and the objectives it was designed to achieve. The objectives were developed in collaboration between the Bill and Melinda Gates Foundation and the African Religious Health Assets Programme (ARHAP) research team.

1.2 HOW THE STUDY CAME ABOUT

In April 2007 the Bill and Melinda Gates Foundation approached ARHAP with a proposed scope of work for a landscaping study of the contributions of faith-based groups to public health in sub-Saharan Africa (SSA). A contract was awarded in June for the study to be conducted from July 2007 to September 2008.

1.3 PURPOSE OF THE ANALYSIS

The analysis aimed:

- to provide a description of the contribution of faith based organisations (FBOs), institutions and networks to the health of vulnerable populations in resource-poor areas of SSA, and
- to identify key areas for investment that would accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries.

1.4 OBJECTIVES OF THE ANALYSIS AND SCOPE OF WORK

There were two main components to the objectives:

1) Provide an overview of sub-Saharan Africa

a) Based on available secondary data, to summarise the relative population and geographic coverage, role, and core health and social activities (scope, scale, length of time in place) of FBOs and key networks vis á vis public-sector and other private-sector essential health services delivery in SSA. While core health and social activities might be wide ranging, the review considered both community based activities (e.g. household visits, community health workers and behaviour change communications) and facility based activities (primary, secondary and tertiary services). The review also considered aspects of maternal, newborn, child and reproductive health (MNCR) as far as was possible[1]

b) Describe the structure, key organisational and cultural characteristics of any large religious health networks and how they related officially to governments and to each other.

The focus in a) and b) was on collecting information from existing databases in countries such as, Kenya, Malawi, the Democratic Republic of Congo (DRC) and others in SSA where such work had been done over the previous ten years, keeping in mind that such databases were frequently less developed than expected, were often difficult to obtain, and varied widely in terms of format, depth and approach. The collected data was summarised. While the summary would not necessarily be representative of the whole of SSA, it would give an indication of the range of conditions that were found in countries with differing faith traditions and health systems.

1

Types of activity/service areas to consider for MNCR	
Maternal health	Antenatal care (e.g. visits, TT, syphilis screening/treatment, IPT-p, birth preparedness planning, iron folate) Home and facility delivery / intrapartum care (e.g. skilled attendants, clean delivery practices, prevention of PPH (misoprostol), EmOC – including complications referral, transport, complications management such as c-section, blood transfusions, etc.)
Newborn health	Home care (e.g. clean delivery practices, exclusive breast feeding, thermal control, hygiene, special care of low birth weight / preterm infants) Management of asphyxia, sepsis, referral and treatment of complications / illness
Child health	Immunisation, IMCI, prevention and treatment of malaria (ITNs, drug therapy) prevention and treatment of diarrhoea, case management of pneumonia, vitamin A, adequate nutrition, water, sanitation and hygiene
Reproductive health	Family planning (contraceptives), PAC, prevention and treatment of STIs, attention to adolescents

2) Conduct three country case-studies

Three countries were chosen for more in-depth case-study work: Mali, Uganda and Zambia. These were representative of a range of factors: different religious mixes, different regions of the continent, different health systems and different socio-economic status. In addition, as access to stakeholders was crucial to data collection, countries were chosen where ARHAP had existing relationships that would facilitate such access.

Case-studies were conducted in Mali, Uganda and Zambia which included (a) and (b) above, as well as choosing a sample of the most active FBOs and primary religious health networks in order to:

(c) For FBOs
   i) Describe the capacity of FBOs to deliver essential services at all levels (community, primary, secondary and tertiary health care) and identify activities intended to effect changes in health behaviour. Essential services included, but were not limited to, maternal, newborn, child and reproductive health services as noted above. 'Levels of services' included consideration of community workers and volunteers, as well as facility based staff.
   ii) Describe the combination of financial and/or material support FBOs received from donors, governments and churches. As far as possible this should consider critical inputs relevant to the maternal, newborn, child and reproductive heal services noted above.
   iii) Describe how FBOs were perceived by stakeholders, including communities and beneficiaries, by public-sector counterparts, and by influential decision-makers. Perception of opportunities, gaps in their services and their relative advantage as health providers were to be included.

(d) Characterise key FBO networks and describe how they worked, who belonged to them, what services or supports were provided, and what benefits were gained.

(e) Describe how FBOs collaborated with other FBOs and with governments and other private-sector providers to ensure access to essential services and resources, as well as the potential for collaboration.

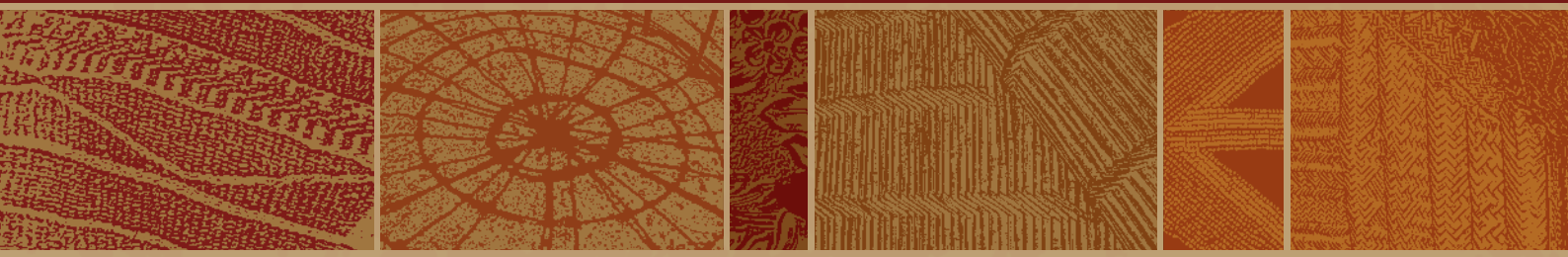
3) Identify key areas for potential investment that would catalyse addressing gaps, constraints or barriers to increased effectiveness in improving population health outcomes.

1.5 REFERENCE

ARHAP. 2006. Appreciating assets: The contribution of religion to universal access in Africa. Cape Town: Report for the World Health Organisation, African Religious Health Assets Programme.

CHAPTER 2

METHODOLOGY



CHAPTER 2

2.1 OVERVIEW

This chapter starts with a sketch of the approach used for the study, and is followed by definitions of important terms and a brief discussion of the way they are used in the study. It provides details of the researchers involved in the study and the study design they followed. The rest of the chapter outlines the methodology used in the two main parts of the study – the desk review and the collection of primary data – and in the processing of data. The chapter ends by highlighting some limitations of the study.

2.2 APPROACH

Given the lack of comprehensive data on the role of FBOs in health service provision in SSA, the aim of the study was to draw together material that had already been documented, as well as to undertake three country case-studies in order to provide a level of depth of understanding of the role and capacity of FBOs in health service provision. The use of three case-studies was not assumed to reflect the situation in SSA as a whole, but rather to identify the range of issues and variation across the continent. The case-studies were selected by the research team in conjunction with the funder to incorporate one of the key known elements, that of religious affiliation. While Mali was known to be a predominantly Muslim country, and Zambia predominantly Christian, Uganda included substantial numbers of followers of both of these major faith groups. All three to varying degrees also had elements of African indigenous religious traditions present.

2.3 DEFINITIONS AND TERMINOLOGY

For the purposes of the study, the commonly used term FBO was found to be too imprecise to describe the multiple types of religious groups contributing to public health. The report draws in this regard on terminology developed by the African Religious Health Assets Programme (ARHAP).[1]

- A **health system** includes all actors, institutions and resources that undertake health actions, where a health action is defined as one where the primary intent is to improve health. Although the defining goal of a health system is to improve population health, other intrinsic goals are: to be responsive to the population it serves, determined by the way in which people are treated and the environment in which they are treated, and to ensure that the financial burden of paying for health is fairly distributed across households (WHO, in HSP 2007).
  - **Religion** is defined as the wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organisations that range from fluid to codified, popular to formal, centralised to decentralised, and communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and a wide variety of other identifiable but smaller religious formations (ARHAP-WHO 2006).
- A **religious health asset (RHA)** is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of an RHA captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used then they remain at rest, but they are always available for use through some agentive act. The term is used broadly to encompass any religion or faith (ARHAP-WHO 2006).
- The term **religious entity (RE)** seeks to capture the broad range of tangible RHAs, incorporating religious facilities, organisations and practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more formalised religious entities such as faith based organisations, as well as those less institutionalised entities such as individual traditional healers (ARHAP-WHO 2006).
- A **faith based organisation (FBO)** is a religious entity that has a structured nature as well as religious support. It includes organisations and loose initiatives tied to religious groups (such as mission hospitals or faith-based care groups), as well as community networks (ARHAP-WHO 2006).
- **African traditional healer (TH)** denotes a complex typology and is constituted differently across Africa. For the purposes of this report, three types of indigenous health providers, or traditional healers, are indicated. They are constituted by (i) diviners, (ii) herbalists and (iii) traditional birth attendants (TBAs). Diviners practise on the basis of engagement with ancestral and spirit forces. Some herbalists distinguish themselves as working solely with herbal remedies. TBAs are community-based pregnancy and childbirth care providers, but often provide health advice, education and care beyond the field of maternity (ARHAP-WHO 2006).

1 ARHAP is a network of scholars and practitioners working towards a better understanding of the contribution of religion and religious health assets to public health. See www.arhap.uct.ac.za for information on this network and Chapter 3, Section 3.4 for a discussion of central concepts and frameworks.

A few more issues on the usage of terminology are important to clarify:

- In this study the term RE will be used as the overarching term for all faith-based health activities and co-ordinating groups. FBOs will be used only in the more narrow sense as distinct from other types of REs like faith-based networks (FBNs), national faith-based health networks (NFBHNs), congregations and denominational structures. Chapter 4 reflects the literature and hence uses FBO more commonly.
- Language about REs differs between the countries covered by this study. In Uganda ***private-not-for-profit*** (PNFP) is the term commonly used, while in Mali people refer to confessional health services.
- Health services provided by REs may be further distinguished as either facility-based (e.g. a clinic), non-facility-based (e.g. support groups, home-based care, health education projects taking place in communities and homes) or African traditional healing. These are often complemented by congregation-based initiatives and activities supporting or promoting health.2
- The work of traditional healers in Africa – adapted and defined by their culture, beliefs and environment – and their self-understanding is closely linked to religious meanings. Indeed, it is difficult in that framework to think of religion and health as separate entities.3 It is for this reason that the study includes TH throughout in its consideration of the impact and contribution of religion to public health. In some instances 'traditional' may be used in a pejorative way. This report uses the term to refer to the specific African traditions, fully acknowledging that other traditions exist elsewhere and also shape health practices and meanings given to ill-health.
- In Chapters 3 the terminology is developed further (see Sections 3.5).
- A more complete glossary of terms can be found in Appendix 2.1.

2.4 RESEARCH TEAM

2.4.1 CORE RESEARCH TEAM

The study, undertaken under the auspices of ARHAP, was led by co-principal investigators Barbara Schmid (UCT) and Liz Thomas (Medical Research Council / Centre for Health Policy in the School of Public Health, University of the Witwatersrand). The third member of the team was Jill Olivier (UCT), who undertook the desk review and overview of resources for health and religion in SSA. Additional support came from Jim Cochrane (UCT) in the study design and analysis of data. Together the team included expertise in public health, religious studies, and an understanding of the interface of faith and health. All of the team members had undertaken research together before as part of ARHAP.

Further contributions came from Phoebe Gribble (tool development, piloting), Nika Rafaely (country background data collection), Sarah Castle (French literature review), April Butchard (data entry) and Thomas Alberts (preliminary analysis).

2.4.2 COUNTRY RESEARCH TEAMS

Local researchers in Uganda, Mali and Zambia were contracted to undertake specific tasks. These tasks included:

- setting up and recruiting participants in consultation with the PIs for participation in interviews / focus groups
- distributing questionnaires and setting up actual interviews and focus groups
- helping to conduct the actual field work with co-PIs, and in the case of Mali, to do some of this independently, and
- providing additional information about the country contexts, as well as commenting on the draft country chapters.

2 The objectives for the study refer to facility-based and community-based services. The report will refer throughout to the somewhat more complex typology outlined here.

3 See Chapter 3, Section 3.4.2 for a discussion of the concept 'healthworld'; also Germond & Molapo 2006, Germond and Cochrane n.d.

The field workers were:

- Zambia: Sinatra Matimelo (Overall), Michael Bwembya (Livingstone), Roy Hamalyang'ombe (Lusaka) and Mary Mwiche (Ndola/Kitwe),
- Uganda: Peter Lochoro, and
- Mali: Aisse Diarra.

2.4.3 ADVISORY GROUP

An advisory group was appointed, bringing together expertise on Muslim and Christian health services in Africa, public health and health systems, as well as an expert for each region (West, East and Southern Africa).

The group included:

- Lucy Gilson, Deputy-director of the Centre for Health Policy, in the School of Public Health, University of the Witwatersrand
- Deborah McFarland, Professor in the Department of Global Health, Rollins School of Public Health, Emory University
- Mohammed Seedat, Professor in the College of Human Sciences at the University of South Africa
- Frank Dimmock, health consultant in Africa to the Presbyterian Church (USA) and to church health associations across East and Southern Africa
- Sam O. Orach, Assistant Executive Secretary, Uganda Catholic Medical Bureau
- Sue Parry, Ecumenical HIV/AIDS Initiative in Africa (EHAIA) Regional Coordinator for Southern Africa, and
- Modibo Maiga, Director of the Health Policy Initiative in Bamako, Mali.

The advice of this group was sought at three specific points of the study: during the study design stage, after the completion of data collection, and for review of the draft report. They were, however, also used individually as resource people regarding a range of issues during the course of the study. They helped specifically to:

- develop the study design and tools in a way appropriate to the scope of work and the regions
- obtain access databases in the regions, i.e. in case-study countries and beyond
- help in the interpretation of the data from the regions and countries, including the country case-study results
- comment on preliminary findings and various drafts of the report.

2.5 STUDY DESIGN

The study was designed to respond to the objectives defined by the funder. The approach to the desk review and use of tools was driven by the objectives shown in Table 2.1 below.

Table 2.1 Design of the analytical approach based on objectives

Objective	Aspects to include in data collection	Methodology
1) Overview of SSA		
a) Summarise data on health FBOs and key networks	▪ Relative population and geographic coverage ▪ Role ▪ Core health and social activities (scope, scale and length) ▪ Comparison with public / private sector ▪ Community based activities ▪ Facility based activities ▪ Indicators for MNCR services	Desk review of secondary data: ▪ Collect existing databases, including scan of French and Arabic literature ▪ Narrow down countries ▪ Special attention focused on case-study countries ▪ Summarise and compile data
b) Describe large religious health networks	▪ Structure, key organisational / cultural characteristics ▪ Official relationship to government ▪ Relationship with each other ▪ Their mission in health services	Desk review of secondary data: ▪ collect existing databases ▪ summarise and compile data ▪ list key contacts

Objective	Aspects to include in data collection	Methodology
2) Mali, Uganda and Zambia country case-studies		
Include a) and b)	▪ Health systems ▪ Health statistics – national / district ▪ Socio-political overview ▪ Religious background ▪ Role of REs in health – history and current	▪ Collect literature – include grey material only in hard copy ▪ Key points to look for: MNCR, health system, role of REs
c) For FBOs: i) Describe the capacity of FBOs to deliver essential services	▪ All levels (community, primary, secondary, tertiary health care) ▪ Activities aimed at health behaviour ▪ Community workers and volunteers, as well as facility-based staff ▪ Maternal, newborn, child and reproductive health services ▪ Other services, e.g. mental health ▪ Impact and performance of intermediaries, durability, and characteristics relating to the faith-based nature	▪ Questionnaires to key FBOs – for data; questionnaire based on standard public health indicators ▪ Key informant interviews (KIIs) ▪ Existing literature ▪ Focus groups (FGs) ▪ Mali: local case-studies
ii) Financial and / or material support for FBOs	▪ Combination of financial and / or material support ▪ Staffing support ▪ From donors, own governments, churches ▪ Critical inputs for MNCR (e.g. vaccines, vertical disease program drugs (ACTs, TB drugs)	▪ Questionnaire ▪ Documentation from FBOs, e.g. annual reports ▪ KIIs – Ministry of Health
iii) Describe how FBOs are perceived by stakeholders	▪ Stakeholders: communities, beneficiaries, public-sector counterparts, influential decision makers, donors and other resource partners ▪ History, reputation and misperceptions ▪ Trust and history of engagement ▪ Perception of opportunities, gaps in their services, and their relative advantages as health providers	▪ Focus groups ▪ Key informant interviews ▪ Questionnaires (open- ended questions) ▪ Existing literature
d) Characterise key FBO networks	▪ Their mandates and where they draw these from ▪ Mission statements, goals, objectives ▪ How they work ▪ Who belongs ▪ What services or supports are provided ▪ What benefits are gained	▪ FBOs' documentation / websites ▪ Questionnaires ▪ Focus groups ▪ Key informant interviews ▪ Existing literature ▪ Mali: local case-studies
e) Describe how FBOs collaborate	▪ With other FBOs and with governments and other private-sector providers ▪ For purpose of access to essential services and resources	▪ Questionnaires ▪ Focus groups ▪ Key informant interviews ▪ Existing literature
3) Identify key areas for potential investment	▪ Focus on potential to catalyse addressing gaps, constraints or barriers to increased effectiveness in improving population health outcomes ▪ Scope and scale	▪ Key informant interviews ▪ Focus groups

2.6 METHOD: OVERVIEW OF RELIGIOUS ENTITIES AND HEALTH IN SUB-SAHARAN AFRICA

The basic method for generating an overview was a desk review of existing data. The limits set for this desk review were: English and French literature and materials produced in the last 10 years, focussed on SSA. It was not possible to review Arabic literature due to time and resource constraints. A ten-year period was chosen to ensure data was up to date, and that the period was convenient and manageable. However, if considered central to this research, older materials were occasionally included.[4]

A wide variety of materials were gathered using different methods:

a) Searching of academic databases, and review of academic literature

- An electronic database search for current literature was conducted, e.g. the ARHAP literature database and electronic platforms such as EBSCO, Medline and Biblioline.
- The following search terms were used in combination: religion, faith, faith-based, faith-based organisations (e.g. religious subsets such as Islam or Christianity), non-governmental organisations, health, public health, health care, health service, maternal health, pharmaceuticals, sexual health, disease (HIV, ART, AIDS, malaria, polio, etc.), hospital, voluntary owned hospitals, mission hospitals, mission history, mission medicine, medical mission.
- Types of data collected included peer-reviewed journals and publications by established authors in the various fields), research databases and reports based on extensive studies.

b) Gathering and review of web-based information (grey literature)

- Basic internet searches used the same search terms as above, including snowball searching of prominent faith-based networks and organisations (including data from previous ARHAP research).
- Types of data collected included research papers, studies and reports, organisational self-description of work (e.g. annual reports, reviews and evaluations of projects and descriptions of areas of work).

c) Gathering and review of databases and information directly from FBOs

- Over 350 faith-based organisations were investigated, and any relevant data was collected from their websites where available. 156 organisations were then emailed directly (and repeatedly) to request databases, literature and further connections to other organisations; 28 of them responded with relevant information.
- This data collection and communication was tracked in a spreadsheet (see Appendix 4.1).
- Types of data collected included organisational databases (typically an excel spreadsheet of organisational members of a network), and self-description.

d) French literature review

- A literature review was commissioned to cover the French literature and West African data in particular.
- This involved the use of Google scholar utilising the following terms: in English: religion, health, Islam, Catholic, Protestant, colonialisation; and in French: ***sante, religion, confessionelle, services sanitaires, prevention, Islam, Catholique, Protestant, garibous, gnawa, ndepp, mutilations genitales, marabouts, decentralisation, colonisation.*** A report was submitted and has been integrated into the discussion in Chapter 4.

In all cases, materials were individually assessed in terms of relevance, interest, the scarcity of other documentation of its type, and quality (author, publication, etc).

2.7 METHOD: PRIMARY DATA COLLECTION

2.7.1 CHOICE OF CASE-STUDY COUNTRIES AND STUDY SITES

Three countries were selected for in-depth case-studies: Zambia, Uganda and Mali. In the choice a number of aspects were considered:

- diversity in terms of geographic regions, including one country each from Southern, West and East Africa
- diversity in terms of dominant religious groups, with Zambia predominantly – and officially – Christian, Uganda also strongly Christian but with a significant Muslim population, and Mali almost exclusively Muslim. African traditional religion is practised in all three countries but its influence on public health is regarded differently in each country
- some diversity regarding development and health indicators (see Table 2.2 below), and
- ease of access to data and co-researchers.

4 In 2006 ARHAP completed an extensive literature review of the intersection between religion and public health, specifically focusing on HIV and AIDS in SSA. Much of the data that was excluded here can be found in that review.

Table 2.2 Indicators for case-study countries

Indicator	Mali	Uganda	Zambia
Region	West Africa	East Africa	Southern Africa
Population (millions)	11.4	28.8	11.7
Muslim	90%	16%	1%
Christian (Catholic / Protestant)	1%	66% (33%/33%)	75% (30% / 45%)
Indigenous beliefs	9%	18%	15-24%
Life expectancy at birth (years)	48.6	50.1	37.4
Infant deaths per 1 000 live births	109	70	100
HIV prevalence, adults 15-49 years	1.7	6.7	17.1
Human poverty index (rank)	101	66	90
Human development index	174	144	166

In each country study sites were chosen representing different contexts for FBO health services. In Zambia the following three sites were identified, all of which had been sites of a previous ARHAP study:

- Lusaka (the capital), where most major FBOs are represented and the bulk of key informants are located
- Livingstone, a smaller town in the rural hinterland, with specific health challenges resulting from its situation on the major transport route and its being a tourist centre, and
- Kitwe/Ndola, an industrial region, with its deteriorating economy and health since the decline of the copper mines, which is also a case illustrating the detrimental impact of (global) political and economic developments on local health conditions.

In Uganda the capital (Kampala) was chosen as site where most KIIs would be located. Gulu in the north represented an area emerging from a 20-year conflict, a context all too common in Africa. Mukono is a small town 20 kilometres from Kampala with a more rural population and model collaboration between all health providers.

In Mali the capital Bamako was the study site, with one local case-study conducted in Faladié, a village 80 kilometres to the north.

2.7.2 TOOLS DEVELOPMENT FOR THE THREE COUNTRY STUDIES

A set of common tools were developed for use in the three country studies to enable cross-country comparisons to be drawn in the final report. Appropriate tools were developed for the objectives. These consisted of a key informant interview schedule, focus group discussion guide, questionnaires and an outline for in-depth local case-studies. An overview of each follows.

Key informant interviews (KIIs) were designed for two distinct target groups: first, national and district key role players in health services provision, and second, faith leaders. The KIIs were used to establish the views of these stakeholders of key health issues, their views of the contribution of faith-based health services, and opportunities for investment for the expansion of REs' health service provision.

Focus group discussions (FGDs) were held with representatives of FBOs and FBNs providing health services. They were selected in consultation with local researchers and advisors to reflect the key players in this field, and also in Zambia and Uganda to include both services located in the capital city and in more peripheral locations.

These agencies/ networks were also requested to complete questionnaires which probed the scope, nature and scale of the health services they provided. Themes covered in the questionnaires included the capacity to deliver specific health services; financial and other support received; collaboration and networking within the faith-based sector, with public health services and links to intermediaries; and stakeholder perceptions of the services provided.

Local case-studies would collect data by interviews of stakeholders and review of documents on the same topics as the KIIs.

In all of these special attention was paid to data on MNCR services: at facility level these were seldom available.

Copies of each of these instruments are attached as Appendices 2.2 – 2.4 respectively, with the Information sheet / consent form as Appendix 2.5

2.7.3 PILOTING

The draft questionnaire was piloted at eight facilities in Cape Town. Respondents were asked to comment on the questionnaire as well as to complete it. In spite of intense follow-up only five questionnaires were returned. Evidently it was a difficult questionnaire for self-administration, but this aspect could not be changed due to time and budget implications. Other adjustments were made to the content and structure of questions on the basis of the feedback received.

2.7.4 ETHICS

Once the tools had been developed, an ethics application was submitted to the Ethics Committee of the University of Cape Town's Faculty of Humanities. Unconditional approval was given for the study. A further process of ethics approval was followed in each of the case-study countries and the necessary approvals and permissions were obtained.

2.7.5 FIELD WORK

Intensive field work took place over a period of two months. This was managed directly by Barbara Schmid, who was responsible for all the KIIs and FGDs. Two visits were planned to each of the case-study countries. A first short exploratory visit took place for the purposes of:

- joint planning with the local principal investigator / field workers / local advisor
- developing a list of potential key FBOs and key informants (KIs) for the study and finalising study sites
- conducting first exploratory interviews, and
- initiating ethics clearance procedures.

After the first visit field workers finalised the list of respondents, set up FGDs and KIIs and distributed questionnaires to the identified FBOs. During a second visit of the PI the bulk of the actual field work was conducted jointly with local researchers. For this 10 days were allocated per country.

Zambia: In Zambia only one visit was conducted, as we could build on teams and connections from previous ARHAP work. The bulk of KIIs and one FGD took place in Lusaka. Here the focus was on representatives of the main national FBOs providing health services, and KIs from government institutions (MoH, National AIDS Council) and national offices of religious health services. In both Livingstone and Kitwe/Ndola two more KIIs were conducted, as well as one FGD in each site. Most questionnaires and FGD participants came from church-based health programmes representing a range of scales and health supporting functions; a minority were connected to actual health facilities. A total of 27 questionnaires were collected and 12 KIIs conducted.

Uganda: Most of the fieldwork happened in Kampala: 8 KIIs were from a range of public and religious bodies and two FGDs, one each with representatives of hospitals, and of lower health units and programmes. Further sites were Gulu, where 3 KIIs and a FGD were conducted, and the fieldwork was concluded with a day trip to Mukono, where two KIIs and a FGD were conducted. In Uganda most questionnaires and FGD participants represented health facilities and a small minority of non-facility-based and congregational health initiatives. A total of 21 questionnaires were collected and 12 KIIs conducted.

Mali: The study procedure was adapted after an exploratory visit of both PIs to Bamako. In Mali there are very few faith-based health services; the emphasis is on the health promotion role of religious leaders. Hence questionnaires and FGDs were replaced with three local case-studies: two church-run health centres and a network of religious leaders against AIDS. The PI visited all three sites with the local researcher who collected additional data and wrote up the cases. KIIs

were conducted with various stakeholders in Bamako only. Ms Diarra also acted as interpreter during the interviews, since almost all fieldwork was conducted in French. A total of 11 KIIs were conducted.

See Appendix 2.6 for lists of all KIIs and FGD participants.

2.8 DATA PROCESSING

For questionnaires the data were entered into Excel and processed in SPSS.

KIIs and FGD were recorded and then transcribed. The material from Mali was then checked by a translator to make sure that no information had been lost or misrepresented in the direct translation while interviewing. All transcripts were analysed using ATLAS Ti.

References to the qualitative material are given in the ATLAS Ti format for interviews. For example, UMMB.doc - 21:24 (73:75), refers to an interview ***UMMB***.doc gives the name of the document (the organisation represented by the interviewee or FGD location); 21 the document number; and 24 the code number, with the coded text start and end line (73:75) in the primary document.

For the local case-studies the field researcher compiled collected data into a provisional report.

2.9 DATA ANALYSIS

The understanding of the case-study country contexts and issues was informed by the PIs, who had also visited each of the case-study countries whilst undertaking the field work. The primary data collected for each of the case-studies was synthesised using a structured approach guided by the objectives of the study. In addition, additional themes emerged from the key informant interviews and the focus group material using ATLAS Ti coding as described above. Secondary data was used to provide the background and context to each of the country case-studies.

2.10 LIMITATIONS

The study is primarily limited by its design requiring an overview of faith and health in SSA. This implies a very wide scope in geographic extent, context and way of impacting on public health. The time allocated for design and set up, field work, analysis and synthesis (seven months) determined the extent to which the overall situation could be addressed.

Other limitations were:

- The selection of three case-studies provided a very valuable comparison between three very different contexts. However, these can in no way be seen to reflect the variation in the sub-continent as a whole.
- The researchers were explicit at all times regarding the funder of the study. The extent to which the responses were affected by the fact that the study was being undertaken for a US funder cannot be ascertained.
- The questionnaires were administered in both Zambia and Uganda to FBOs offering health services. The organisations selected differed between the two contexts. In Uganda, these were primarily health facilities, e.g. hospitals, whereas in Zambia they tended to be mostly non-facility-based programmes, e.g. HBC. This unintended difference in respondents arose from the choice of country co-researchers and the networks each was connected to, and does not reflect distinguishing features between the two countries. Together the two case-studies show the range of the scale and nature of FBOs providing health services, with conditions in non-facility-based REs highlighted in Zambia and facility-based ones in Uganda.
- The questionnaires were designed to enable some cross-country comparisons. The findings highlight that there is not a standard way of reporting on health data between RE actors and countries.
- During piloting it became clear that the questionnaire was difficult to self-administer. Return rates were not as high as had been hoped and responses to some sections were incomplete.
- The limitations for the overview of SSA are included within the review (see 4.2).

2.11 REFERENCES

ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa.* Report for the World Health Organization, Cape Town: (ARHAP) African Religious Health Assets Programme. (referenced as ARHAP-WHO 2006)

Foster G. 2003. *Study of the response by faith-based organizations to orphans and vulnerable children: Preliminary summary report.* (WCRP) World Conference of Religions for Peace and (UNICEF) United Nations Children Fund

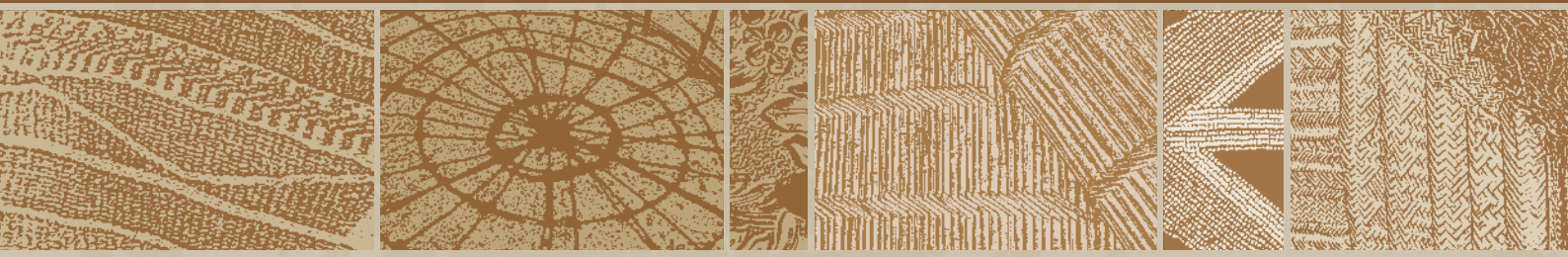
Germond P and Molapo S. 2006. "In search of bophelo in a time of AIDS: Seeking a coherence of economies of health and economies of salvation." Journal of Theology for Southern Africa **126**. pp 27-47.

Germond P and Cochrane JR. n.d. "Healthworlds: Conceptualizing the Human and Society in the Nexus of Religion and Health". Unpublished paper.

Health Systems Performance (HSP). 2007. http://www.who.int/health-systems-performance/about.htm (accessed 21.01.2008)

CHAPTER 3

CONTEXTUAL UNDERSTANDING OF THE HISTORY OF HEALTH SYSTEMS IN AFRICA AND THE ROLE OF RELIGIOUS ENTITIES



CONTEXTUAL UNDERSTANDING

3.1 INTRODUCTION

In order to appreciate the role of REs in health in SSA and to identify potential areas for investment so as to contribute to addressing health problems in SSA, the study begins with an overview of the SSA context, providing a perspective of the broad health, religious and developmental context with an historical lens. Chapter 4 explores in greater detail the secondary data available on FBOs and FBNs operating in SSA. This overview is provided for SSA as a whole, as well as for a number of individual countries and faith-based networks. In addition, Chapter 4 identifies cross-cutting themes which emerge from the literature. The case-study countries are presented in Chapters 5, 6 and 7, which provide details that draw on qualitative and quantitative research. For each country study (Zambia, Uganda and Mali) the existing contributions of REs to health are located in the light of the existing burden of disease and current health systems. Each country study concludes with recommended investments based on the existing challenges faced by REs as well as opportunities for REs to contribute to health. The final chapters provide a summary of the findings and a range of recommendations drawn from the preceding chapters.

Given that many readers will be unfamiliar with the detailed health issues and policy context facing SSA, this chapter provides the reader with:

- key indicators of the current health status of people living in SSA ;
- the importance of religious beliefs for health in sub-Saharan Africa
- an introduction to the complex understanding of health in Africa and thinking tools that have been developed to explore the role of religious health assets in health
- a new typology of FBOs that disaggregates the variety of activities found
- an overview of the historical development of health services in Africa and the emerging role of faith agencies in health services and health-related activities, and
- an outline of the current policies and frameworks to address SSAs' health challenges.

3.2 KEY HEALTH CONCERNS AND CHALLENGES IN SUB-SAHARAN AFRICA

The faith-based sector contributes to health in Africa in a number of ways. Understanding the contribution of REs to health needs to be located in a thorough understanding of the health system and other contextual factors. This is especially pertinent in considering possible interventions.

A backdrop to considering health concerns in Africa must be an understanding of the global context. Africa has 10% of the world's population, 25% of the global disease burden, 60% of all people living with HIV and AIDS, and the highest disease burden of malaria and TB. Africa, however, only has a 1% share of world wealth, less than 1% of world health spending, less than 10% of health research funding and contains less than 2% of the global health workforce.[5]

Addressing root causes of poor health and poverty are priorities. There is a vicious circle of poverty driving poor health and poor health, also resulting in poverty. The WHO's Commission on Macroeconomics and Health has shown that 'substantially improved health outcomes are a prerequisite for developing countries to break out of the cycle of poverty'[6] and that the poor are disproportionately affected by preventable diseases and bear the brunt of the financial burden of illness[7]. The African Union, in reviewing the status of African countries in achieving the MGDs, made it clear that the millennium development goals are a challenge that remain largely out of reach.[8] While AIDS, TB and malaria are the greatest challenges, the New Partnership for Africa's Development (NEPAD) is quick to highlight the 'severe burden' of other communicable diseases such as pneumonia, diarrhoea and measles in children, as well as diseases such as schistosomiasis and trypanosomiasis.[9]

A quick review of some of the major health problems in SSA follows.

3.2.1 HIV AND AIDS AND TB

In 2005 there were just under 25 million people in SSA living with HIV or AIDS. Some 75% of all women and 90% of

5 Equinet, 2007.
6 Commission on Macro Economics and Health 2001.
7 African Union 2008.
8 African Union 2008.
9 NEPAD. 2005.

children in the world living with HIV were in SSA.[10] Data shows that there are wide variations in infection between countries (with several in southern and eastern Africa having a prevalence rate in adults of more than 10%), within countries and even within urban areas. There are high levels of TB co-infection and worryingly, increasing numbers of people with multi-drug resistant TB infections. Poverty and high levels of inequality are known to create a very high risk environment for increasing numbers of HIV infection, which in turn results in lower levels of resistance to TB and malaria.

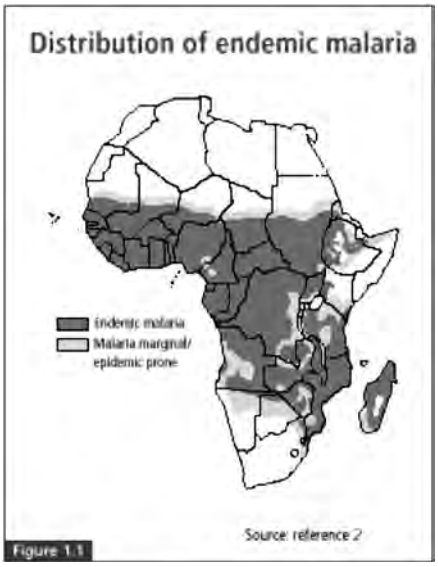


Figure 3.1 Endemic malaria

3.2.2 MALARIA

Malaria cases in Africa account for 90% of malaria cases in the world.[11] The Roll Back Malaria initiative (2003) reported that:

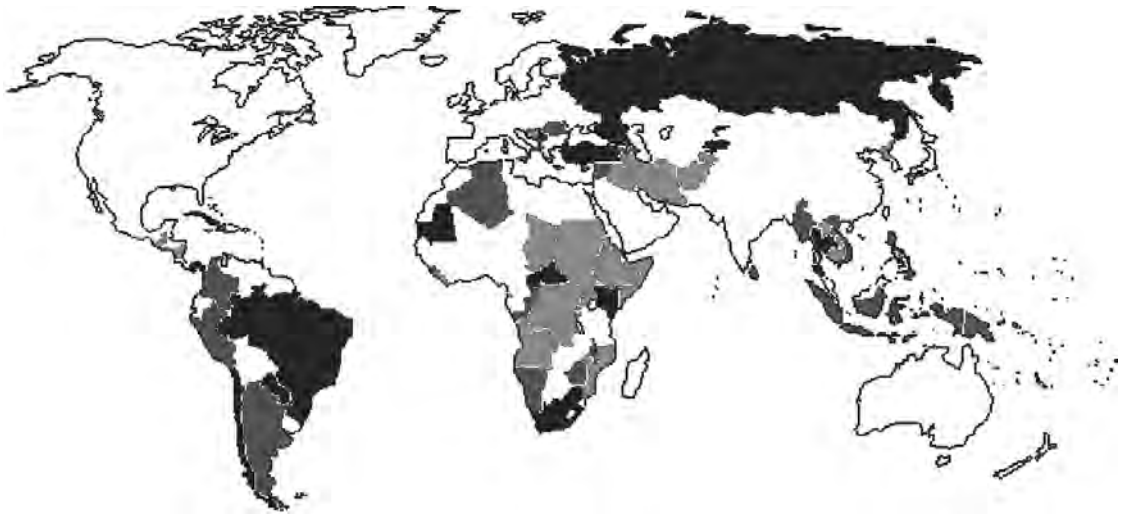
- in malaria-endemic countries in Africa, 25% to 40% of all outpatient clinic visits and up to 50% of all hospital admissions are for malaria;
- poor people are at increased risk both of becoming infected with malaria and of dying of the disease;
- malaria causes at least 20% of all deaths in children in Africa under 5 years of age;12

Although global malaria control targets have been set within the framework of the MDGs, few African countries are expected to meet these targets. Substantial support will be needed for the 80% at risk of malaria to have access to prevention and control measures in terms of the goal agreed to at the 2006 Abuja Summit.[13]

3.2.3 POOR ACCESS TO HEALTH SERVICES AND HEALTH CARE FINANCING

Access to health services in SSA currently varies between and within countries. Estimates suggest that overall across the continent, just over half the population (53%) has access to health services.[14] Subsequent chapters of this study, provide an overview of the role of the faith based sector, as an important contributor to health services in some countries, and especially in rural areas. In addition to the need for physical health facilities, the AU notes in its MDG assessment that 'although cost-effective medicines and technologies exist to prevent, control and treat these diseases, many people in

Figure 3.2 Countries involved in conflict[15]



10 USAID. 2006.
11 WHO. 1996.
12 Roll Back Malaria. 2003.
13 African Union 2008.
14 NEPAD 2006.
15 Sourced from Dr S Parry, EHAIA, 2007

the region lack access to these products'.[16] Despite the increasing burden of disease due to HIV and AIDS, budgets for health services have remained static or declined in real terms,[17] even with increasing contributions from agencies such as the Global Fund. Per capita expenditure on health is estimated by the AU to be well below $10 compared to the $34 recommended by the Commission on Macroeconomics and Health.[18] This will be dealt with in more detail below (see 3.7.6).

3.2.4 HEALTH SERVICES IN A CONTEXT OF CONFLICT

Many African countries have been or remain in states of unrest. Globally, the majority of countries in states of conflict are highlighted in Figure 3.2. Not only does conflict undermine economies, but it also impacts directly on communities and health services. Some of the direct health impacts include disease spread and death, violence (both physical and sexual), refugees and internal displacement requiring the provision of emergency health services, often in the context of the collapse of social and physical infrastructure, and high HIV prevalence in military personnel.

3.2.5 COMPETING PRIORITIES

Despite the urgency of addressing some of the major diseases, disease or target group programmes are criticised as they do not address population health needs holistically. Vertical programmes can result in the loss of opportunities to deliver more comprehensive care to isolated communities, a lack of co-ordination can lead to duplication, poaching of staff and unsustainable short-term programmes.[19] In addition to the need for health to be underpinned by broad socio-economic and development programmes, there is a widely acknowledged need for health systems strengthening, through targeted interventions. A shift in language (and policy) to "diagonal programmes" indicates donor agencies' growing awareness of the need to address both specific disease and health system needs.[20]

3.2.6 THE ROLE OF PRIVATE AND PUBLIC AGENCIES

In the view of the WHO, private providers play an important role in health care provision as a result of the gaps in state health service provision. There is a lack of regulation of this sector. The definition of public and private providers is seen to be increasingly blurred '…as medical goods and services flow between public, commercial, philanthropic traditional and informal providers'.[21]

3.2.7 TRADITIONAL MEDICINE

Traditional medicine is used by an estimated 80% of the population and yet the majority of countries have failed to acknowledge this or to put in place policies, legal frameworks and codes of conduct for traditional health practioners or stewardship of traditional medicines.[22] This results in a lack of co-ordination and very little consideration of role of traditional health services.

3.2.8 PROBLEMS WITH HEALTH SERVICES

Given the high disease burden outlined above, not surprisingly a review of health services in 18 African countries undertaken in 2005 highlighted problems which respondents experienced. Just over half of the respondents (51%) reported having a problem with health services. These problems ranged from long waiting times (nearly three quarters of respondents), shortage of medicine (66%), absence of doctors (54%), fees too high (52%), as well as other quality of care issues such as lack of respect (53%), dirty facilities (35%) and demand for bribes (26%).[23] The study found that problems with health services were greater in rural areas, including longer waiting times and a lack of medicines.

In a context of deep poverty and inequity, high burden of disease and low levels of development, SSA is facing many structural problems. These problems are a major contributor to the poor health of those living in SSA, and will feature in the desk review and each of the country case-studies of this report (see Sections 4.8, 5.1, 6.1 and 7.1). Having provided a short overview of current health challenges in SSA, the chapter now discusses the importance of religion and health for people in SSA.

16 African Union 2008.
17 NEPAD 2006.
18 African Health Ministers, Botswana, October 2005
19 WHO. 2006.
20 See for instance Ooms et al 2008.
21 WHO. 2006.
22 WHO. 2006.
23 Bratton. 2007.

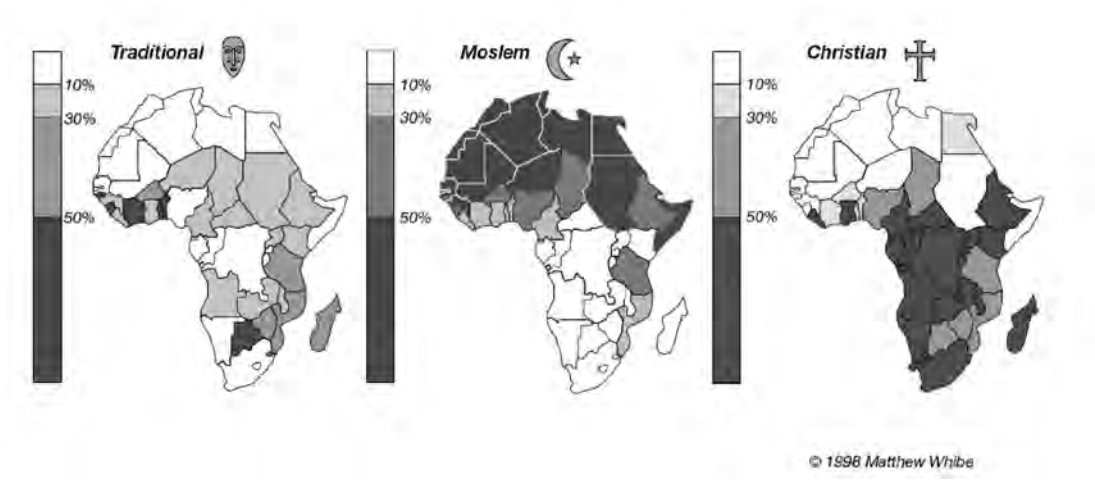
3.3 THE IMPORTANCE OF RELIGIOUS BELIEFS FOR HEALTH IN SUB-SAHARAN AFRICA

Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives[24].

3.3.1 OVERVIEW OF DOMINANT BELIEF SYSTEMS

The dominant religious beliefs in SSA are Christianity, Islam and African traditional religions. While at a country and community level there is often a complex mix of religious beliefs, adherence to Islam is concentrated in North and West Africa, while Christianity is more common in Africa south of the Equator. There is also a widespread belief in African traditional religions.

Figure 3.3 Major religions in Africa[25]



Given this complex pattern of religious beliefs, it is necessary to understand that each has different views about the meaning of health and different ways of supporting well-being This is especially important to ensure that health services and promotion initiatives are appropriate. It is beyond the scope of this chapter to explore these in detail, but the following section gives brief indicators of the issues.

Islam considers personal health to be one of the greatest blessings to have been given to human beings by God. Indeed, it is considered the greatest blessing after faith itself. This requires that people should express gratitude to God for their health and that their health should be properly cared for.[26] Health is not only recognised as an individual asset but there is also an Islamic imperative to be concerned about the community.

In addition, there is a strong recognition in the Quran of the importance of basic developmental services such as water, sanitation and education as prerequisites for the health not only of the individual, but also of the community.
Despite these very clear religious imperatives that can be mobilised for health, it has been noted that disease prevention has most often used a 'one-size-fits-all' approach with little recognition of factors such as context, religion or culture. Omar notes that health promoters would be better equipped to tailor their interventions according to the perspective of the Islamic community intended and so ensure better chances of success.[27]

Christianity also has a religious imperative requiring recognition of the sanctity of the body,[28] although the differences in Greek and Roman thought still impact on the modern day interpretation of the relative importance and value of body and spirit. Its formative language is permeated with words that refer to healing, as in the Latin salus (heal), from which

24 De Gruchy2006.
25 Parry 2005.
26 **Haytham Al Khayat 1997**.
27 Maulana 2002.
28 The body as the temple of the Holy Spirit, Bible.

the term salvation derives, and as reflected best in the German forms of heil (heal), heilig (holy) and Heilsgeschichte (salvation history), for example.

There is a strong Christian injunction to 'be of service' to others, especially those in need. This has been the basis of mission hospitals, educational programmes and church schools, over the centuries in cross-cultural mission and service programmes. Many have suggested that health workers, whatever their religious beliefs and irrespective of whether they work in the faith-based or in the public health sector, are motivated by a sense of 'vocation' and that they may well be a driving force in impacting on the quality of care.

African traditional religions are widely adhered to across SSA and are strongly informed by various indigenous systems of healing, which continue to develop over time. Generally, they tend to have a holistic view of illness, which is often seen as misfortune that can have its roots in a multitude of physical, spiritual and social wrongdoings and needs to be addressed in a holistic way.

3.3.2 TYPES OF HEALING IN AFRICA

For the purposes of this study, it is necessary to define some common 'types' of healing found in Africa which may be used individually, concurrently[29] or consecutively.

African traditional healing addresses the physical, spiritual and psychological body. A range of specialists including medicine doctors, royalty, herbalists, rainmakers, priests, birth attendants can be involved. In contrast to a western individualistic approach, the family is often seen as responsible for the overall health of family members, and also for the health of the community whose condition is both affected by and mirrored in the health of individuals. Ancestors are often understood to be part of this community. Members consult elders in the family and community when there is illness.

Spiritual healing is often characteristic of many African Independent Churches, especially those known in southern Africa as 'Zionist', but also newer forms of local Pentecostal churches. There are no formal apprenticeships, group or individual; emphasis is given to the individual's relationship to God.

Islamic healing is an ancient form of healing, incorporated Galen's 2nd Century CE understanding of the body. Mohammed's prophetic understanding of health was included into legal and medical texts early on. Islamic medicine flourished in North Africa, including Timbuktu. There were two trends in early Islamic healing: these are scientific and the prophetic traditions. The scientific tradition of Islamic medicine, very prominent before the 10th century, has been in decline since 1100 CE. In contrast, the Islamic prophetic tradition, based on healing by prayer, is commonly practised. Efforts are being made to link this approach with modern biomedicine.

Among these various religiously inspired forms of healing there is also **Western biomedicine** which originated in part from early Islamic centres of study, and biomedical science then developed further in Europe. Discoveries were brought after 1500 with traders and missionaries to Africa. This approach is rooted in the biological sciences, seeking well-defined causes and based on germ theory. Western biomedicine was expanded in Africa initially in response to the health care needs of colonial missionaries and administrators. In time, mission health services became a key form of outreach, especially in rural areas. While the biomedical approach is often of value, the costs of delivering these curative health services are prohibitive. Further, the biomedical understanding of health is seen as very limited and narrow.

3.4 OVERVIEW OF AN AFRICAN INTEGRATED UNDERSTANDING OF FAITH AND HEALTH

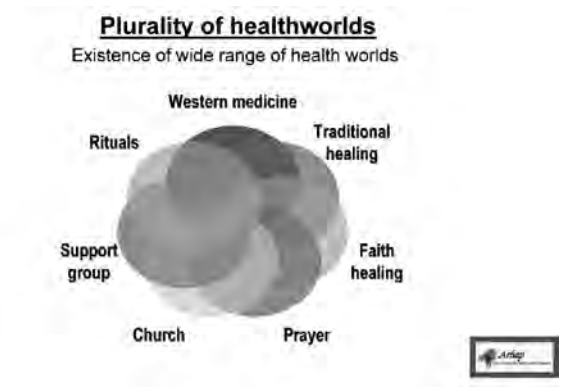
3.4.1 TOWARDS AN UNDERSTANDING OF HEALTH AND RELIGION IN AFRICA

Those involved in health research have for too long tried to avoid facing, addressing or responding to the way that Africans understand health. In particular, health and religion are understood as being inseparable, both conceptually and linguistically, if one takes religion to refer to pragmatic interpretations and reinterpretations of myth, symbol and ritual in relation to body, mind and society. In Africa traditional healing, spiritual healing and biomedical methods are used in complex ways and seldom alone. Often indigenous traditional healers are the first and most important actors in addressing ill health.

29 Thomas *et al*. 2006.

ARHAP describes this complex reality through the notion of plural healthworlds.[30] Healthworlds refers to people's conceptions of health as framed by the background store of inherited or socialised knowledge that defines their being in the world, further detailed in the glossary (see diagram below). Addressing this complexity appropriately has been difficult for health policy makers located in the biomedical paradigm. Despite the limited acknowledgement of multiple concurrent health-seeking practices (whether in relation to reproductive health or to AIDS treatment), research highlights the common use of multiple treatment modalities. Although the WHO refers to 'health' as more than the absence of disease, it has steered away from any reference to religion or faith in its health documents.

Figure 3.4 The plurality of healthworlds in Africa[31]



The understanding of the concurrent or consecutive use of a number of healing modalities as people negotiate the plural healthworlds that confront them has been very helpful in a number of studies undertaken under the auspices of ARHAP.[32] Further, this understanding is necessary in the light of the findings of this study which highlight the way in which mixing of healing modalities is the norm in Africa.[33]

3.4.2 UNDERSTANDING OF RELIGIOUS HEALTH ASSETS - ARHAP'S THEORY MATRIX

It is important to understand the potential roles that REs can play in improving health outcomes in mothers and children especially. An approach to understanding the potential 'added value' of REs to health forms part of the ARHAP theory matrix, which shows how both tangible and intangible elements make up the complex of RHAs.[34] The concept of religious 'assets' for health is important as it opens up a new way of considering the widely distributed social networks, infrastructure, belief and behaviour patterns as assets that can be mobilised for health gains.[35] The benefit of using the religious health asset matrix draws attention to factors which impact on health outcomes that are not so easily identified or measured. The matrix goes beyond the easily identifiable tangible assets, e.g. buildings and equipment, to include what have been described as 'intangible' health determinants. These include aspects of health behaviour modification programmes and the beliefs, values and commitment of health workers.

The focus on intangible assets makes possible an assessment of the contribution of FBOs not merely as alternative health service providers. Faith-based facilities may operate within a paradigm or approach that offers 'respectful treatment', which was found to be a central demand of primary care users in South Africa.[36] "Respectful treatment' was understood by Gilson et al. in terms of "positive attitudes / behaviours, thoroughness and technical competence, as well as …fair treatment".'[37] These are aspects that are included in the ARHAP matrix as some of the 'intangible' health determinants.

The mapping of religious health assets (RHAs) has been shown to be a valuable process. Developed by an ARHAP team for the WHO study in Zambia and Lesotho,[38] it provided an important pointer for using the assets language and approach

30 ARHAP-WHO 2006, Germond and Molapo 2006, Germond and Cochrane n.d.
31 Gemond, n.d.
32 ARHAP WHO 2006, Gwele M. 2005, Thomas *et al.* 2006.
33 Thomas *et al.* 2006
34 ARHAP www.uct.ac.za/arhap, Cochrane 2006.
35 De Gruchy 2003.
36 Gilson et al. 2005.
37 Gilson *et al.* 2005.
38 ARHAP-WHO 2006.

to help make religious tangible and intangible assets more accessible and conscious in the minds of stakeholders. This was seen as a way to mobilise these assets for improved health at a community and broader level.[39]
Having considered ways in which the role of religious health assets can be made more visible and tapped for better health outcomes, it is now necessary to consider how this way of thinking can be aligned and capitalised on as far as the health sector is concerned.

3.4.3 GOING BEYOND THE TRADITIONAL UNDERSTANDING OF COMPONENTS OF THE HEALTH SECTOR

Traditionally the health sector has considered the role of certain key functions in the delivery of health services. The WHO's health system performance framework offers a useful model for considering this.[40]

This framework shows the basic functions that health systems have to perform. Although all health systems are different, dependent on their context, there are a range of generic functions they perform. These key functions are that of stewardship, creating resources, service delivery and financing (see Figure 3.5).

Figure 3.5 Functions and goals in WHO's health system performance framework[41]

Considering the key functions of the health system described above, it is important to consider in what ways the faith-based sector is able to add value or contribute to the health system's goals (see Table 3.1).

While the provision of facility based health services is very important in some countries in Africa, complementing the struggling national health system, this report goes beyond the traditional description of the health sector and policy directives in Africa drawing on the ARHAP 'health assets' approach to identify the potential 'added value' from REs' involvement in health. This draws on the understanding that religious health assets include both tangible and intangible (or less tangible) health assets and that when mobilised, these benefits can be used for improved health outcomes. The study will begin to explore various factors, including:

1. the role of personal values on institutional policies and on health outcomes at various scales, e.g. advocacy for the marginalised, one-on-one spiritual support (see Box 3.1)
2. the trust that communities have in religious leaders
3. the 'special added value' of health services provided by FBOs, e.g. where those on antiretroviral treatment (ART) provided by an FBO recognised an 'added value' in the love and church blessing with which the treatment was given (see Box 3.1)
4. the ability of faith leaders to tap into the commitment of their religious communities and to mobilise volunteers for a range of grassroots health-related needs

39 See ARHAP reports on www.arhap.uct.ac.za
40 See WHO-Euro 2007.
41 http://www.euro.who.int/healthsystems/20070323_1

5. the positive and negative impacts of religious traditions on health, such as 'inclusivity' or the way in which FBOs imposed 'restrictive norms' on clients, and
6. the consideration of what potential roles faith-based agencies can play in impacting on health outcomes in SSA.

Table 3.1 Towards understanding the added value of REs to health systems

Health system functions as defined by the WHO	Contribution of faith based sector	Added value that is less tangible or health promoting
Stewardship Stewardship is the careful and responsible management of something entrusted to one's care. It involves influencing policies and actions in all sectors that may affect the health of the population. This implies the ability to formulate strategic policy direction, to ensure good regulation and the tools for implementing it as well as accountability and transparency.	Advocacy for equity in access to health services Advocacy for health policies that support the needs of vulnerable groups Promotion of fair remuneration for health workers Maintaining a good database of facilities, skills, etc.	Promoting respectful dialogue between faith based and public health officials Accountability of health-sector workers Meeting basic needs that are health determinants, e.g. access to basic services, nutrition
Creating resources People in the right place, well trained and with the right skill mix; facilities and equipment that are well located, accredited and with necessary investments in physical infrastructure; and products that are safe, accessible and appropriately used.	Provision of training of health workers Motivating to maintain facilities that meet the needs of hard-to-reach or remote communities Access to additional resources from non-traditional health sector donors Expat health workers	Training of religious leaders for health promotion Encouragement by external funders as well as personal support of local leaders/ staff and caregivers
Service delivery Achieving maximum coverage of population especially the poor and socially vulnerable Understanding the public-private mix, Quality, safety, and responsiveness of services; Proper management Service delivery infrastructure and IT Protect individuals from communicable and chronic non-communicable diseases Promote healthy lifestyles	Provision of facility-based health services, especially in remote areas Participating in MoH planning at national and district level Faith leaders to promote health, Health workers to see themselves as 'God's hands', thus contributing to high quality of care	Respectful treatment: respect for the way in which beliefs impact on health-seeking behaviour Harnessing the religious values of health workers to promote quality of health care Health worker motivation Provide a continuum of care for sick and dying: HBC, hospices, facilities for the abused, OVCs,
Financing Revenue collection, pooling of funds, purchasing of services, policy on rationing entitlement to benefits.	Inherited resources and the continued support of traditional donors such as international religious aid agencies Personal connections between projects and faith communities in the north	Religious values that contribute to donations Religious values that result in commitment to fee reduction

Box 3.1 highlights intangible factors that can be harnessed for better health outcomes. Some are specifically religious (such as prayer and spiritual support) and others are related to values and beliefs that can be harnessed for health-promoting action. The better understanding of these factors could be helpful in mobilising behaviours that are health promoting as an asset for health.

Box 3.1 The added value of religion

To give an example of the added value of FBOs working in health service provision, we draw on an ARHAP case study of Masangane, a FBO in South Africa providing ART. The recipients were asked about the added value of receiving ART from an FBO, rather than a state ART provider. Their responses indicated a range of factors seldom considered in the health sector as outcomes, yet seen by the clients as adding value to the health service they received. A number of the ways in which clients assessed the value added by the services being provided by a FBO are summarised here.

Masangane stakeholders' identification of the 'added value' due to health services being provided by a FBO, listed from more to less tangible factors:

- ***Motivated, committed volunteers*** *"We have people so willing to assist, just volunteering."*
- ***Access to communities and to potential clients*** *"You are doing community mobilisation through churches."*
- ***Credibility*** *"So when it is church related they support and accept it because the church preaches truth and honesty."*
- ***Using familiar rituals to enhance adherence*** *"You read, pray and drink your pills."*
- ***Reach out – like Jesus – to the marginalised*** *".... some people do really care not only about themselves that they must go to heaven, but they also worry about other people that they must stay healthy."*
- ***Spiritual support*** *"You do not impose religion on a person, but if a person needs spiritual support it is there."*
- ***Inclusivity*** *"Poor and rich, the church welcomes everybody."*
- ***Imposing norms on clients*** *"You know when treatment is funded by the church you get these rules and regulations, this is how you should behave."*

The quotes identify a number of beliefs of the Masangane clients that seemed to impact on the way in which they valued the ART they received.

Source: Thomas et al. 2006.

Gilson et al's work on values impacting on the performance of the health system identifies that '…values in use, conceived of broadly as the combination of personal, organisational and societal values … shape the actions of individuals working in organisations, and … influence … organisational functioning'. [42] Their study concluded that '…the literature reviewed clearly suggests that values and culture do matter to organisations. Social and personal values can shape organisational functioning or lead organisations to be in tension with their broader environment.' [43]. Further empirical work is suggested that works towards '…the clarification of the types of outcomes sought by organisations, as well as consideration of the dimensions of culture that might lead to such outcomes'[44]. Acknowledging that this is a complex terrain, Gilson et al highlight the importance of understanding the complexity of values and culture in being proactive to make health system more equitable. Further research work exploring the role of the culture of facility based FBOs and networks and the impact of the values of health workers on health outcomes and performance of facilities, could be a very valuable exploration of the added value of intangible religious health assets, especially the stewardship and health service functions of the health system, as presented in Table 3.1 above. In turn, this better understanding could lead to interventions designed to shift organisational culture in health facilities.

42 Gilson and Erasmus 2005.
43 Gilson and Erasmus 2005.
44 Gilson and Erasmus 2005.

The focus of this study is on REs and their role and capacity in health. Drawing largely from insights gained from data collection for this study, a tentative typology of FBOs has been developed to help in the identification of their scope, scale and the nature of health-related activities.

3.5 TOWARDS A TYPOLOGY OF FBOS INVOLVED IN HEALTH IN AFRICA

The term FBO has been used to describe the range of activities of agencies operating under the faith-based umbrella. In undertaking the research for this and other related studies it has become clear that it is necessary to develop a more concise typology that would contribute to a better understanding of the role and contribution of religious entities to health. The ARHAP WHO report (2006) provided a detailed multi-level categorisation, differentiating between the type of RE (congregation, clinic, support group), its primary activity, its geographic reach (local up to international) and the time it has been active.[45]

Drawing on that categorisation this study adopted a typology specific to the health-related activities of FBOs that is based on the scale, nature and scope of health-related activities provided under the umbrella of FBOs. The suggested broad areas are:

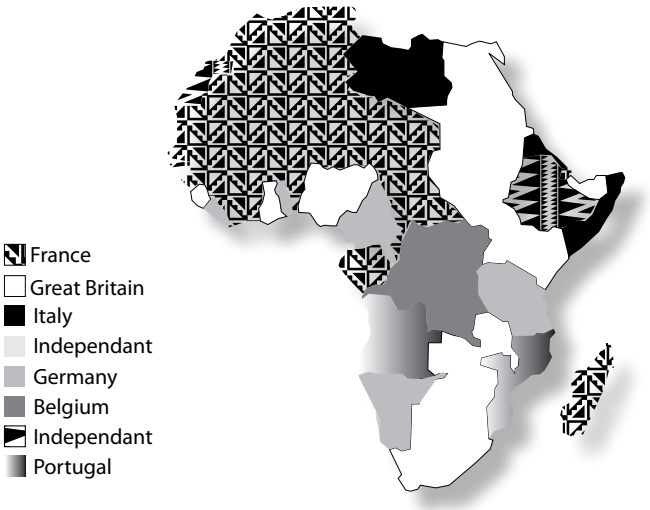
- **Types of health provider**: facility-based or non-facility-based
- **Scale of operation**: international, national, regional, district or local
- **Types of services provided**: ranging from those typically understood as being within the health sector, to a broader range of health-related activities including health promotion, and addressing wider health determinants such as poverty, debt relief, improved access to water, sanitation and housing.
- **Relationship to government**: in some cases FBOs are providing facility-based health services for government, as an agency or in parallel to government.

This categorisation will be referred to throughout the report to describe the activities of health-related FBOs in more detail.

3.6 AN OVERVIEW OF THE HISTORY OF HEALTH SERVICES IN AFRICA AND THE ROLE OF RELIGIOUS ENTITIES

It is important to consider the impact of colonial history on the development of current African country health services. The colonists had differing policies with respect to administration of the colonies, social services, attitude towards missionaries, attitude to the availability of raw materials, and the extent to which they were prepared to invest in Africa. Furthermore, these policies were not static but changed over time in response to home country policies as well as the increasing demand by African leaders for political power during the 20th century. By 1913 (see Figure 3.6) almost all of Africa was colonised; the continent had become a patchwork of European colonies.

Figure 3.6 Colonial powers in Africa circa 1913[46]



45 ARHAP-WHO 2006.
46 Scramble for Africa 2007

The European colonists' approach to the administration of their colonies was informed by their own home governance style. Furthermore, their commitment to the provision of social services in the colonies was determined by the extent of their local administration structures. The health services provided by the colonial governments since the early 20th century were focused on meeting the needs of the relatively small number of European employees of the colonial state who lived primarily in urban centres.[47] Along with the colonisation of Africa came the promotion of Christianity. Missionaries setting up mission stations also provided health and educational facilities directed at the needs of the indigenous populations. While their activities may have been well-meaning, it is undeniable that they followed closely in the footsteps of colonial powers, and were often associated with imposed problematic policies.

France, providing highly centralised control of its nine African colonies through Dakar, used local African leaders to implement their policies. As a result there was a small contingent of colonial French staff and little need to provide health and other services. In contrast, Britain implemented a decentralised system of governance in the African colonies and had a more extensive British workforce in the colonial service, for whom they provided health and other services. In Congo Belgium is reported to have provided extensive health services with doctors in every village. German colonial administrators relied heavily on native chiefs to keep order and collect taxes and implemented excellent education services. The approaches and policies of the various colonial powers are summarised in Appendix 3.1.

Health services in Europe also underwent major shifts after World War I as socialised health care became the norm, implemented by national government rather than local government. This pattern was followed in the colonies as ministries of health were set up nationally to be responsible for health service provision. As African countries fought for independence, they were left with the legacy of their colonial administrations. This included centrally funded health systems, operating out of new national capitals with little local accountability.

In time, funding from colonial powers in Europe was replaced by United Nations (UN) agencies and more recently, by other donors. In addition to the funding provided to national MoHs for facility-based health services, international funders also provided resources to congregation-based health initiatives as an attempt to prevent and address the impacts of HIV and AIDS.

Since the radical reforms suggested in the Alma Ata Declaration in 1978, the international approach of health policy has shifted to emphasise decentralisation, local participation, intersectoral action for health, primary health care and the need to reach marginalised groups.

Given the shifts in international approaches to improving health, it is necessary now to understand how these policy approaches are being translated into an African context and the concerns and challenges in SSA.

3.7 CURRENT CHALLENGES TO HEALTH SYSTEMS IN AFRICA

This chapter concludes with an overview of existing SSA policy and health-sector frameworks, as it is within these policies and frameworks that the recommendations of the study will be implemented. The focus here is on NEPAD, which developed the health strategy for the AU in its advisory capacity. The strategy is not representative for Africa as a whole, nor for SSA, but offers a useful framework in which to position the study. Both the desk review (Chap 4) and the country case-studies (Chap 5-7) discuss implications of the issues raised here for their specific contexts.

3.7.1 NEPAD'S HEALTH STRATEGY

NEPAD's health policy is based on the premise of the Rio Declaration that inter alia human beings are at the centre of concerns for sustainable key components of the NEPAD strategy, including asserting the need for intersectoral action and an integrated approach based on the 'health for all' policy, an understanding that disease-focussed programmes alone are not sufficient, a recognition of the need to address the underlying determinants of health crucial for sustainable human health and development, recognition of effective health systems and community involvement as being essential to success, and the need for countries to commit investment in people's health in their budgets.

47 Fetter 1993.

3.7.2 **FBOs** as partners in health

NEPAD acknowledges the important role of **NGO**s, development agencies and **FBO**s in achieving results and mobilising community agency in addressing health concerns. NEPAD notes that there are massive gaps to be filled and that there is a need for new sustainable indigenous organisations and government capacity to foster and enhance the potential role of agencies outside of government.[48] The NEPAD programme aims to achieve massive scaling up of community involvement in a range of health issues, focussing initially on the major cause of disease burden.[49]

3.7.3 RESOURCES FOR HEALTH

There are three sources of funding for health. An increasing proportion of country resources are being allocated to health (as per the Abuja Declaration), there is an increased allocation of debt cancellation funding to health, and there is increased support from development partners. Key to effective support is the need for untied aid, aid effectiveness and monitoring, and peer review mechanisms for accountability.[50] Investments in health should also be used to promote equity. Those who disproportionately have the highest burden of disease are those who are the poorest and most vulnerable, as well as those affected by disasters and the impact of war.

3.7.4 TARGETED STRATEGIES FAIL TO MEET GOALS

The response to reduce the burden of disease has been strengthened by funding from agencies such as UNAIDS, the Global Fund for AIDS, TB and Malaria, the Bill and Melinda Gates Foundation, UNAIDS programmes, Stop TB and IMCI. A range of targeted programmes (such as Making Pregnancy Safer) have been put in place to achieve the Millennium Development Goal goals, but the scale of response is often insufficient to make the goals achievable.[51]

3.7.5 NEED FOR COUNTRY-SPECIFIC SECTOR-WIDE HEALTH POLICIES

Given the range of challenges facing countries as well as the history of existing health systems, there is **no one-size-fits-all** plan that can be used to 'solve' countries' health problems. NEPAD notes that "the relative strengths of each stakeholder (at a country level) should be taken advantage of in order to maximise the additive contributions of all organisations".[52] Although some countries are reported to have recently reviewed their health policies with a focus on strengthening health care services, much work still needs to be done to develop national health policy, a step towards adopting sector-wide approaches (SWAp).[53]

3.7.6 HEALTH FINANCING: POLICY AND COMMITMENTS

Given the struggling economies of many countries in SSA and the almost overwhelming demand for resources to meet basic needs, accessing finance for health is a major problem. The Commission for Macroeconomics and Health estimated that US$34 per person per year was required to provide an essential package of health interventions to reach NEPAD and MDG targets. The aim is for African countries to work towards committing 15% of GDP to health expenditure. WHO estimated that 35 out of 46 member states were spending less than this on health.[54] In 2003, African countries spent on average 5% of gross domestic product (GDP) on health, half of which was expenditure by government and the other half expenditure by the private sector (to a large extent made up of contributions from households (four fifths), NGOs, insurance, etc).[55]

The donor contribution to country health budgets varied from less than 1% in Algeria to 75% in Rwanda.[56] Although there have been calls for donor co-ordination to be improved (for example, by the UK's Commission for Africa), donors tend to focus on specific disease outcomes, provide short-term funding and undermine country co-ordination efforts. Donors contribute to health in other ways such as by supporting intersectoral collaboration (which can be used to promote health though the provision of improved water and sanitation) as well as through enhancing food security, education, and political and economic development.

48 NEPAD 2005.
49 NEPAD 2005.
50 NEPAD 2005.
51 NEPAD – *Making Pregnancy Safer.*
52 NEPAD 2005.
53 WHO 2006.
54 WHO. 2006.
55 WHO. 2006.
56 WHO. 2006.For a detailed discussion of the resource constraints for African health systems and possible solutions see Flessa, 2002.

Another source of income to cover health sector costs is user fees. User fees implemented as part of structural adjustment programmes have been found to often prejudice the poorest. Nevertheless, the WHO reports that in many countries, user fees have been retained "by charging a minimal symbolic fee to ensure that services are appreciated and not used unnecessarily"[57]. Some facility-based health services provided by REs do rely on user fees as a way of generating an income.

3.7.7 BIG NEED TO STRENGTHEN HEALTH SYSTEMS

NEPAD identifies a range of health system factors that undermine the effectiveness of interventions.[58] These include the marginalisation of traditional healers and the lack of mobilisation of the capacity of the private sector and NGO / community sector. In identifying the goal and objectives for the NEPAD Africa Health Strategy (2006) considerable focus is given to the issue of strengthening health systems.[59]

The WHO Africa report identifies several key elements needed for a health system to function normally. These include adequate human resources and infrastructure, reliable evidence on public health needs and financing systems. WHO suggests that governments and all partners need to work deliberately to reinforce and build health systems, providing an enabling environment, and working closely and collaboratively with partners such as the private sector and civil society.[60] This is a significant mechanism to achieve equitable health care as envisaged in the 1978 Alma Alta Health for All Declaration. The WHO sees health systems as having an enormous and untapped potential to contribute to economic and social development. While strengthening of health systems has been identified as a key strategy necessary to support improvement in health in SSA, of concern to NEPAD is the fact that many initiatives have failed to do so.[61] Of particular concern are cases where donors have initiated programmes and then withdrawn money. Country resources have sometimes been diverted to maintain commitments to donor programmes, with the result that other elements of the health system are undermined.[62]

Strengthening health systems remains a constant theme in the health policy and research literature.[63] It is widely acknowledged that health systems' performance makes a profound difference to the quality and length of the life of the millions of people they serve.

3.7.8 TENSION BETWEEN STRENGTHENING OF HEALTH SYSTEMS FOR BIO-MEDICAL HEALTH AND TRADITIONAL HEALING

In the past, national health systems have focussed on delivery of bio-medical services, and given tacit acknowledgement at best of other health systems.64 There is a need to seek new ways for bio-medical and traditional health services to coexist in a context where users are well aware of the complexity in decision making as well as the fact that faith based providers 'offer health care with a human touch'.

In summary, Africa is home to a rapidly growing population, just over half of which (53%) has adequate access to health services. Within the context of deep poverty and inequity, health outcomes are poor. Policy guidelines have been put in place to address the most urgent health concerns. Many of these relate to the need for health system strengthening. It is within this context that the role of REs in health service provision and health promotion needs to be understood.

3.8 REFERENCES

African Religious Health Assets Programme. 2006. "Appreciating Assets: The Contribution of religion to Universal Access in Africa", Report for the WHO, Cape Town: ARHAP. (referenced as ARHAP-WHO 2006)

African Union, 2008. Health MDGs linked to the AU Commemoration of the ALMA ATA Declaration, Special Session of the AU Conference of Ministers of Health, Geneva Switzerland. 17 May 2008

57 WHO 2006.
58 NEPAD 2005.
59 NEPAD. 2005.
60 WHO 2006.
61 NEPAD 2005.
62 NEPAD 2005
63 WHO. 2000.
64 E.g. NEPAD 2006, WHO 2006.

African Health Ministers, Botswana, October 2005.

Bratton M. 2007, "Are You Being Served? Popular Satisfaction with Health and Education Services in Africa." Afrobarometer, **65**. Cape Town: IDASA.

Cochrane JR. 2006. Religion, Public Health and a Church for the 21st Century. International Review of Mission, 95 (376-377): 59-72.

Commission on Macro Economics and Health. 2001. *Macro Economics and health: Investing in Health for Macro Economic Development.* Report of the Commission on Macro Economics and Health, WHO.

De Gruchy, S. 2003. "Of agency, assets and appreciation: Theological themes for social development." Journal of Theology for Southern Africa 117:20-39.

De Gruchy, S. 2006, "Like Housework in the Economy, the Hidden Ubiquity of Religion in African Well-Being", Presentation (Atlanta: Religion and Health Connection, Rollins School of Public Health, Emory University, February 21, 2006).

Equinet. 2007. *Reclaiming resources for health; a regional analysis of equity in health in East and Southern Africa.* Johannesburg: Jacana.

Fetter B. 1993. *The health transition and colonial British Africa in International Population Conference,* Montreal 1993, 24 August - 1st September. Volume 1, [compiled by] International Union for the Scientific Study of Population [IUSSP]. Liege, Belgium, IUSSP. pp 429-39.

Flessa S. 2002. "Gesundheitsreformen in Entwicklungsländern: eine kritische Analyse aus Sicht der kirchlichen Entwicklungshilfe" [Health Reform in Developing Countries: a Critical Analysis from the Perspective of Church Developement Aid]. Frankfurt: Lembeck.

Germond P and Molapo S. 2006. „In search of bophelo in a time of AIDS: Seeking a co-herence of economies of health and economies of salvation." Journal of Theology for Southern Africa 126. pp 27-47.

Germond P and Cochrane JR. n.d. "Healthworlds: Conceptualizing the Human and Society in the Nexus of Religion and Health". Unpublished paper.

Gilson L, Palmer N and Schneider H. 2005. "Trust and Health worker performance: exploring a conceptual framework using south African evidence," Social Science and Medicine. 61 pp 1428.

Gilson L and Erasmus E. 2005. Values in Use and Organisational Culture: Exploring the relevance to Health Systems Development, A paper commissioned by the Millennium Project Task Force on Child Health and Maternal Health. (Unpublished).

Gwele M. 2005. Medical pluralism in Khayamandi, Stellenbosch. MSocSci: University of Cape Town.

Haytham Al Khayat, M 1997 The Right Path to Health: Health Education through Religion- Health An Islamic Perspective, World Health Organization, Regional Office for the Eastern Mediterranean, Alexandria, Egypt

Maulana AO. 2002. "Health promotion: an Islamic perspective", Power point presentation from www.pen.edu

NEPAD. 2005. The Health Strategy, NEPAD, Midrand, South Africa. http://www.nepad.org/2005/files/documents/129.pdf

Ooms G, Van Damme W, Baker B K, Zeitz P and Schrecker T. 2008. "The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?" *Globalization and Health* 2008, 4:6.

Parry S. 2003. *Responses of the faith-based organisations to HIV/AIDS in sub-Saharan Africa.* Harare and Geneva, (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa.

Rio Declaration. 1992. *Rio Declaration on Environment and Development.* The United Nations Conference on Environment and Development, Rio.de Janeiro.

Roll Back Malaria initiative. 2003. *Africa Malaria* Report, 2003. Geneva: WHO and UNICEF.

Scramble for Africa. 2007. http://en.wikipedia.org/wiki/Scramble_for_Africa#Belgium

Thomas L, Schmid B, Gwele M, Ngubo R and Cochrane JR. 2006. "Let us embrace": The role and significance of an integrated faith-based initiative for HIV and AIDS. Cape Town: ARHAP.

USAID. 2006. *Report on the Global epidemic*, May 2006. data.unaids.org/pub/GlobalReport/2006/2006GlobalReport_FullPresentation_en.ppt

World Health Organisation (WHO). 1996. *The World Health Report 1996: Fighting disease fostering development.* Geneva: World Health Organisation.

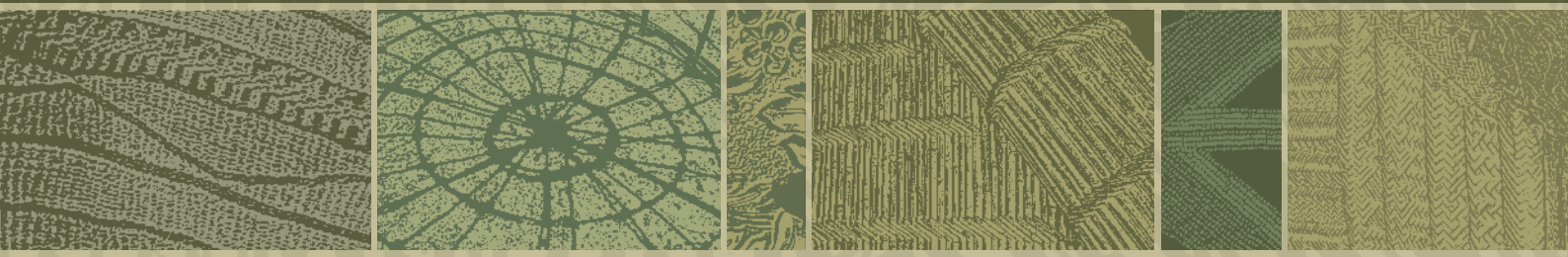
World Health Organisation (WHO). 2000. The World Health Report 2000. *Health Systems: Improving performance*. Geneva: World Health Organisation.

World Health Organisation (WHO). 2006. *The Health of the People: The African Regional Health Report,* 2006. Geneva: World Health Organisation. http://www.afro.who.int/regionaldirector/african_regional_health_report2006.pdf

WHO-Euro. 2007. http://www.euro.who.int/healthsystems/20070323_1

CHAPTER 4

OVERVIEW OF SUB-SAHARAN AFRICA: DESK REVIEW



CHAPTER 4

4.1 INTRODUCTION

This desk review seeks to locate and draw on existing databases and literature to:

- summarise the relative population and geographic coverage, role, and core health and social activities of faith based organisations (FBOs) and key networks vis á vis public-sector and other private-sector essential health service delivery in SSA, and
- describe the structure, key organisational and cultural characteristics of large religious health networks and how they officially relate to government and to each other.

Given the huge variation of faith-based activities and characteristics, it needs to be noted at the start that this summary is not intended to be representative of the whole of SSA, but rather to provide some indication of the range of conditions that are found in countries with differing faith traditions and health systems. It has to be noted that this review does not draw on insights from the case-studies reported in the following chapters, which do fill some of the gaps in the existing literature that are mentioned here.

Chapter 4 therefore begins with a discussion of the limitations of this desk review, as well as findings relating to the state of the literature that were discovered through the review process. Limitations and recommendations for future research provide the backdrop for the more detailed review that follows. The discussion then moves to the role of religious entities (REs) in national health systems (in the SSA context), followed by profiles of ten SSA countries and of a few FBOs to provide illustrations of the variation in the faith-health landscape in different areas. Finally, this chapter will highlight key strengths of religious involvement in health, followed by some challenges and limitations they face, and then some of the key concerns on the topic of collaboration and networking. In this way, a wide variety of literature and data will be drawn together to provide a context for the more detailed country studies that follow from Chapter 5.

4.2 LIMITATIONS AND FINDINGS FROM THE RESEARCH PROCESS[1]

The following concerns regarding this review are acknowledged:

- *Difficulty of tracking data:* Tracking information in the SSA context is difficult for a variety of reasons – in many cases research and reports are not available in electronic formats, are not housed in any central repositories, or are not where they are supposed to be stored. Furthermore, many FBOs in SSA do not keep detailed records of their work, and frequently motivate this saying that they are "too busy saving lives to keep records".

- ***The inappropriateness of generalisations:*** Much of the literature reviewed here speaks of the enormous diversity in terms of social, economic, cultural and religious profiles. However, the same literature often attempts to describe the African situation generally.[2] Throughout the review process it became clear that making summary statements or generalisations about the religious-health landscape was not usually meaningful. Therefore, the following section reports more common observations and presents a few country and FBO profiles which seek to display some of the complexities and varieties of the SSA context. *A recommendation emerging from the review process is that great care should be taken when applying or interpreting generalisations about the religious-health context, which may not accurately reflect many situations in SSA.*

- ***Not all FBOs and FBNs (faith-based networks) are represented in this study:*** Given the scope of this desk review, it was not possible to describe the work of all the thousands of FBOs working valiantly in health, often without any recognition. A great deal more data was collected than the study was able to present in this report, and it is acknowledged that there are exemplary organisations, programmes and interventions for which data is available, but which could not be included. Tables in the country-profile sections list some of the organisations present in these countries (from the secondary literature). This review must be seen as a profiling exercise, attempting to display the broad variety and activities of FBOs in SSA, rather than a comprehensive detailed survey. *It is hoped that these country and organisational profiles spark discussion and dialogue – and it is recommended that this profiling work continues, so that anyone with an interest in the religious-health sector in Africa could have access to current information for each country.*

1 See Chapter 2 for the methodology of this desk review.

2 See Olivier *et al.* 2006.

- ***Exclusion of types of entities:*** Recent ARHAP research for the WHO in 2006 acknowledged the importance of partner entities which are not necessarily faith-based, but which are essential to the work of REs. FBOs work in close partnership with (and are often dependent on) such entities, yet they have not been included in this review. The same applies to organisations which have some religious character but which do not explicitly call themselves faith-based, or which had faith-based origins but currently identify with other nomenclature (e.g. NGO, CBO, relief agency). In this review, each organisation mentioned below was only included if it defined itself as faith-based. Many organisations that are less explicit about their faith-based status were deliberately excluded to make space for the 'consciously' religious-health landscape.[3] *Clarification of nomenclature is needed across the range of entities with a religious character or practice, and further landscaping is needed on the roles and relationships of these religious entities in the larger spectrum.*

- ***Over-emphasis on large organisations with internet presence:*** The overview approach in this review has resulted in easier access to details about larger organisations with a strong internet presence, and those with email connections. Previous research has shown that there are many more FBOs working 'under the radar' – those working at a grassroots level, or outside formal denominational structures, who do not have the incentive or capacity for extensive documentation or information sharing. *A more extensive desk review and primary data collection or 'mapping' is recommended to overcome a research bias towards large FBOs with more readily available documentation.*

- ***Over-emphasis on CHAs in networking sections:*** Similarly, there is substantially more information available for the Christian health associations (CHAs) than the national faith-based health networks (NFBHNs) of other faiths (see Table 4.3 below). This has resulted in a possibly unbalanced presentation of the work of the CHAs, particularly in Muslim countries, in comparison with other networks. More extensive research is needed for faith-based organisations not incorporated under the Christian health association umbrella, and the networks that such organisations might belong to.

- ***Responses from FBOs limited to research time-frame:*** While over 150 FBOs were contacted by email, the information is also skewed towards those which were able to respond, and those that did so timeously. Several organisations indicated a desire to be included in this research, but were unable to provide information in the time provided.

- ***Some relevant information emerged after the research window:*** During the research process it became apparent that there has been a surge of interest in 'mapping' the activities of FBOs involved in health (and in particular in HIV and AIDS) during the period 2006/2007. Several relevant studies and reports are in process, and should emerge later in 2008 (See Appendix 4.3). *This argues for a process of long-term and sustained landscaping of the religious-health situation in Africa and elsewhere.*

- ***Difficulties in database comparison:*** Due to the disparity in the type of information found in organisational and research databases, comparison of data was done through qualitative methods, rather than quantitative compilation of data. This severely limits the ability to speak to the 'percentage' of FBOs working in health (see section 4.3 below). Not only do these statistics vary from source to source, but it is also difficult to determine what measurement criteria statements are based upon, e.g. statements interchangeably define FBOs as a percentage of 'health provision', 'health infrastructure', 'health work', 'institutional health care', 'health systems', 'the national health system (NHS)' or 'health care'. *A recommendation here would be for a clear set of indicators and measures to be clarified and put in place to begin to assess the faith-based communities' presence in the national health system(s).*

- ***Over-emphasis on English:*** Despite drawing on a commissioned sub-study of the French literature, this review reflects an international bias towards English literature and materials, and therefore on REs in English-medium countries. This bias would have such results as limiting the local information on activities in lusophone countries (such as Mozambique and Angola), where there is an acknowledged faith-based presence. The lack of Arabic would mean less information on Muslim activities in general, and the focus on English may skew the focus away from faith-based activities in the northern sections of West and Central Africa. *Further research is needed in other languages, including Arabic and Portuguese.*

3 For example, the Aga Khan hospital network was removed from this report since it does not specifically express itself to be faith-based.

- ***Organisation of information relative to research question:*** The bulk of materials found addressed the religious response to the HIV and AIDS epidemic, and it is therefore likely that despite efforts to the contrary, the religious response to HIV and AIDS has been over-emphasised in the country and organisational profiles below. This could be a result of HIV and AIDS being a more recent and highly resourced epidemic, resulting in more accessible documentation – and making it more difficult to find and collect data on other health areas. In addition, there is a significant amount of information (and work) in the area of 'development' which has health concerns and some cross-over (e.g. income generation, emergency relief, education and training). By necessity, judgements were made as to the relevance of such information at each stage of research. More intensive data collection techniques than desk review are needed to understand the comparative involvement of FBOs in diseases other than HIV and AIDS. It is unclear whether such responses are simply not happening to the same scale as responses to HIV and AIDS, or whether other issues are simply wrapped up in the 'holistic' package of faith-based care and grossly underreported.

- ***Missing or inconclusive information:*** Some of the research questions in the scope of work were simply not possible to answer in the face of secondary information 'voids'. MNCR is one area in which a focus was sought, but not generally found (see discussion below). The absence of comparative data on outcomes achieved by FBOs (with indicators such as immunization rates by diagnosis, or quality indicators) meant that this critical area is largely missing from this review. It is critical that such, "outcomes" focused research be expanded where it is available, and introduced were it is not.[4] In addition, in compiling the country profiles the researcher was frequently faced with several conflicting statistics for the same issue. All attempts were made to use the most trusted and up-to-date information – and all such statements have been rigorously referenced so that these issues can be adjusted if necessary. However, it is recommended that these country and organisational profiles be made publicly available so that they can be scrutinised and corrected by those in the know.

- ***The hidden religious-health sector:*** It is valuable to differentiate between the FBOs providing facility-based health services, most often co-ordinated/networked at a national level, and the extensive operation of small community-based FBO health activities. It has been shown in several studies that facility-based health providing FBOs are over-represented in comparison with the more amorphous and difficult-to-classify non-facility-based religious entities. That is, there is substantially more information on the more formalised FBOs working in health care, than on the more spontaneous and community-based health efforts of the various religious traditions (e.g. community support groups or traditional healing practices). This overwhelming emphasis of the literature towards faith-based health infrastructure (e.g. hospitals and clinics) is reflected in the country profiles below – despite knowledge to the contrary that other smaller and non-formal religious health entities play a critical role in the religious-health landscape. In addition, although we are certain that REs from a range of religious traditions have been working in health before that time, in the sections on the history of religion and health in the country profiles, the profiles generally start with the arrival of missionary organisations in the late 1800s.[5] This starting point reflects the available data and not the belief that religious involvement in health began at the time of colonisation and missionary movement into Africa. It would be valuable for further research to engage with the historical involvement of REs in health, but to do this from a broad view that is inclusive of indigenous religions and 'non-mainstream' religious groups.

4 See EPN 2007 for an example of such work being done on essential drug supply, see below.

5 The sections below on the "history of faith and health" are also constrained by this review being mainly limited to literature of the last 10 years. For example, there are several valuable missionary histories written in the 1980s, which are not included here, but could be valuable to further expansion of this research. See Gelfand 1988, Good 1991.

4.3 FAITH-BASED ORGANISATIONS AND HEALTH SYSTEMS

This chapter now moves to considering the role and position of FBOs in national health systems (in the SSA context) as far as is possible, given the constraints mentioned above.

4.3.1 FBOS AND FBNS ARE WIDELY PRESENT IN SSA, AND HAVE BEEN FOR A LONG TIME

It is generally accepted that religious entities have long engaged in health-related activities such as providing educational interventions and caring for individuals affected by disease. As described in Chapter 3, in many countries in Africa there is a long history of colonial mission health services. Such REs have been in the forefront or have been alone in the struggles to ameliorate suffering and provide support, and have often been doing so with little attention or documentation from public health authorities.[6] Many studies agree that FBOs are one of the critical 'missing pieces' of the puzzle that is African health systems.[7] However, it is interesting that these studies generally seem to be addressing more widely recognised facility-based religious entities (such as congregational health-activities or mission hospitals), rather than the grey area including community care groups, and traditional or charismatic healers.[8] Nevertheless, it would not be an exaggeration to say that in SSA, FBOs are present and important, at a national and local level, and are sometimes the only functioning health service available in rural locations or areas of political crisis, or post-conflict.[9]

4.3.2 FBOS AND FBNS ARE PRESENT DIFFERENTLY IN DIFFERENT PARTS OF SSA

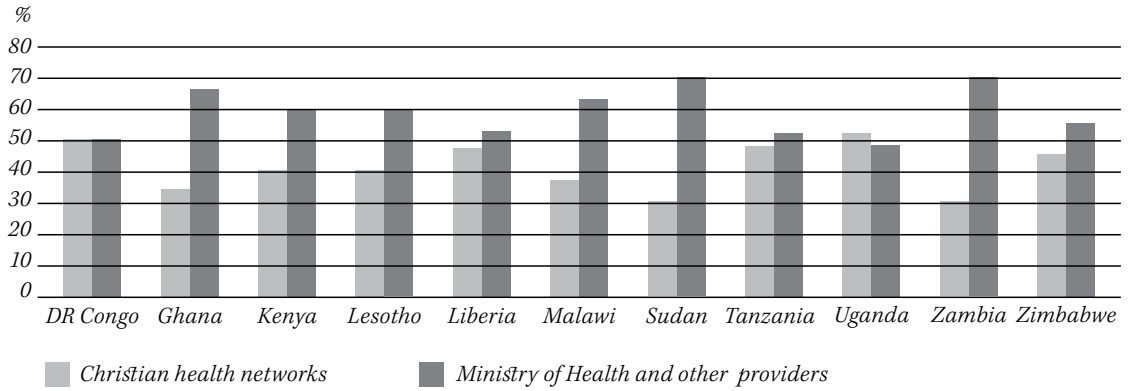
As would be expected, FBOs are differently dispersed across the regions of SSA. For example, in some West African countries such as Mali, FBOs are relatively few, and it appears that in these West African francophone areas, Islam does not tend to manifest in a direct intervention in formal health services, although this is not to say it is not involved in a holistic promotion of health,[10] (see Sections 3.3 and 7.4). In comparison, countries in Southern Africa such as Zambia are inundated with a complex range of FBOs, from facility-based health providers to organisations and activities emerging from congregational activities.[11] As mentioned above, this variety means that generalisations about 'FBOs in Africa' misrepresent the national and regional variations found on the ground.

4.3.3 RELIGIOUS ENTITIES PROVIDE 25-70% OF HEALTH PROVISION IN SSA[12]

There are a handful of studies that seek to assess the presence of FBOs within the context of their broader national health systems. The generalised estimate commonly given is that 25-70% of health services infrastructure supporting formal health services is owned (or health services are provided) by REs in Africa.[13] A 1998 study by the Institute for Development Training says "in Africa religious bodies operated approximately 40% of health resources [and] this was before the major devastation of HIV and AIDS decimated many of the governmental systems beginning in the late 1990s."[14] The full scope of the religious health 'sector' is unknown, and what information there is, remains disparate and often conflicting.[15] It is likely that even this broad estimate does not properly cover the variations – for example, it seems likely that in some Francophone Muslim countries the religious contribution to health provision is less than 25%, and in others in Southern and Central Africa it is possibly greater than 70%. One of the reasons for the wide-ranging and conflicting statistics is the absence of the use of common indicators. Some studies refer to hospital-based services, others to primary health care and yet others to the role of communities in health-supporting functions. *There is an urgent need for a new way of describing the health activities of FBOs. This system must be in line with standard health systems typologies and will allow a more systematic understanding of the role and contribution of FBOs to health at a country and regional level. It is hoped that through this overview and the three case studies of Zambia, Uganda and Mali, this study will make a contribution towards this need.*

6 See ARHAP 2006, Olivier *et al.* 2006.
7 See ARHAP 2006, Olivier *et al.* 2006.
8 See ARHAP 2006.
9 See Olivier *et al.* 2006.
10 Renders 2002. See Castle 2007.
11 ARHAP 2006.
12 See Asante 1998, Baer 2007, Benn 2003, DFID 2006, IDT 1998, Nussbaum (ed) 2005, PACANet 2002, Robinson & White 1998,
13 This figure is an amalgamation of the ranges presented in various literature. See Asante 1998, Baer 2001, Baer 2007, Baird 1999, Benn 2003, Dimmock 2006, Green *et al*. 2002, IDT 1998, Robinson & White1998.
14 IDT 1998.
15 Olivier *et al*. 2006.

Figure 4.1 Contributions of Christian health care networks Source USAID 2007



4.3.4 AN INCOMPLETE PICTURE OF RELIGIOUS RESOURCES

While visible structures such as hospitals and clinics can be counted, the multitude of smaller faith-based programmes and initiatives are rarely visible, especially to decision-makers at a national or international level.[16] ARHAP mapping undertaken in Lesotho and Zambia in 2006 revealed that while the larger, facility-based entities such as hospitals are (sometimes) visible on public health maps, the mass of smaller non-facility based programmes and initiatives are rarely visible to public health systems.[17] According to Baird, "no one has a remotely complete picture even of this resource, to say nothing of the broader range of health promoting religious assets."[18] Even the national religious co-ordinating bodies are often oblivious of their own congregations' initiatives at a local level.[19] For example, some congregations provide home-based care and support services as part of their basic day-to-day efforts, often offering regular emotional, spiritual and practical support. These efforts are frequently not recognised or incorporated into the assessments of health systems or national health efforts.[20] In addition, little is known of the comparative differences of ownership and action by religious denomination or affiliation. For example, Benn notes that "it is estimated that the Roman Catholic Church alone provides 25% of all HIV and AIDS care, including home based care and support of orphans,"[21] and CAFOD says that "around 40% of HIV and AIDS initiatives across Africa are supported by the Catholic Church."[22] However, there is little secondary data available to balance these statements against the actions of other religious groups. *Further research is needed in all these areas to begin to understand the impact of FBOs in health systems.*

4.3.5 FBOS CAN BE FLUID IN NATURE

ARHAP research in Lesotho and Zambia (2006) found that FBOs can be fluid in nature, quickly adapting to the needs and opportunities around them.[23] There is further evidence of this characteristic of FBOs, for example, Parry notes, "FBOs, throughout the region, have responded by expanding their focus from their original long-term goal of HIV and AIDS programmes into short-term responses meeting the immediate crisis of food security."[24] It is not clear at this time whether the flexibility of these FBOs is a strength or a weakness – whether they are consciously reacting to unmet needs in the community, or spontaneously being pushed and pulled by external factors such as availability of funding. It is also unclear if this is something particular to FBOs or general to civil society organisations – although some literature hints that the former could be true.[25] Benn says "many excellent community based initiatives have been started by committed Christians who are trying to serve their communities. In the future, it will be important that churches identify, recognise and support these initiatives. This might demand a high degree of flexibility and willingness to accept innovation."[26] Others note that religious-health responses often emerge well in advance of any systematic effort from outside to organise, train or resource them – that "responses of congregations to HIV/AIDS are spontaneous and holistic, with resources available,

16 ARHAP 2006.
17 ARHAP 2006.
18 Baird 1999. See Hackney 2000.
19 Liebowitz 2002.
20 ARHAP 2006, Church of England 2004, Olivier *et al.* 2006.
21 Benn 2003.
22 CAFOD 2006.
23 ARHAP 2006.
24 Parry 2002.
25 See ARHAP 2006, Olivier *et al.* 2006.
26 Benn 2001.

even before they look for external sources of help"[27] – or that many REs have implemented prevention of mother-to-child transmission programmes (PMTCT) before governments have moved beyond pilot projects.[28] *The diversity and fluidity of REs makes it particularly important that longitudinal research is done on such religious entities, so that understanding can be gained of their changes over time. Policy-makers should also heed such important differences among these institutions when devising ways to harness this potential.*[29]

4.3.6 TRADITIONAL HEALTH, HEALERS AND RELIGION ARE INADEQUATELY UNDERSTOOD

Africa is a complex environment in which to conduct research, as religious life in sub-Saharan African is characterised by a mix of indigenous and externally sourced religious worldviews,[30] interacting in multicultural contexts. Various studies have looked at the involvement of traditional healers in biomedical health programmes or systems. [31,32] Traditional health 'systems' exist in their own right, often carrying more authority with the individuals who utilise them than the biomedical system does for 'Western' health-seekers. In SSA this often results in a pluralistic mix of health-seeking strategies.[33] ARHAP's 2006 review of literature showed an increasing recognition of the role of indigenous traditional health systems, and that further attempts are being made to pull traditional practitioners into the national health systems – for example, in South Africa with new traditional health policies and regulation of traditional healers,[34] as well as acknowledgement by the WHO and the African Union in various policy documents.[35] As described in Chapter 3, this high-level policy acknowledgement is seldom translated into facility level acceptance of the importance of traditional healers in the view of health seekers. Traditional health practitioners continue to provide their services – built on a tradition where healing and well-being is not separate from religion – to vast sections of the African population alongside, and increasingly in collaboration with, western health institutions and Christian congregations. Traditional healers are also increasingly forming associative bodies (such as THPAZ in Zambia, see Chapter 5), which provide greater opportunities for advocacy and collaboration. However, the ARHAP research in Lesotho and Zambia did suggest that although traditional health practitioners were acknowledged, in practice there was little collaboration between them and other religious leaders or FBOs.[36] There is therefore a need for further investigation of this area – particularly about the collaboration, or lack thereof, between traditional health practitioners, indigenous religions, other religious entities and the biomedical health sector.

Having provided an overview of the presence of FBOs in African health systems, this chapter will now provide a few key profiles of countries, FBOs and FBNs to work towards a more specific understanding of the religious-health landscape.

4.4 PROFILING THE RELIGIOUS-HEALTH LANDSCAPE OF TEN SSA COUNTRIES

The following ten country profiles are intended to provide a range of brief depictions of the religious-health landscape. These countries were chosen for their range across a geographic area, as well as factors such as the availability of secondary data. It is intended that these profiles act as 'working documents' to provide a snapshot of these countries, but more essentially to encourage engagement and dialogue. Because of the lack of high-quality research in this area, grey literature was frequently utilised to fill in the gaps. *The advisory committee for this landscaping project suggested that these profiles could be a valuable resource for a range of interested parties, and it is therefore recommended that this becomes the start of a larger landscaping project.* Having presented some country-level profiles, this chapter will then move to look more closely at the profiles and characteristics of some FBOs working in SSA.

The countries profiled here are:

- ***West Africa:*** Mali, Ghana, Nigeria, Senegal
- ***Central Africa:*** the Democratic Republic of the Congo
- ***Southern Africa:*** Lesotho, Zambia, Malawi.
- ***East Africa:*** Kenya, Uganda

27 Zingo 2002.
28 Parry 2002.
29 Agadjanian 2005.
30 See Cochrane in Olivier *et al*. 2006.
31 ARHAP 2006, Olivier et al. 2006. See Abdool Karim et al. 1994, Chipfakacha 1997, Wreford 2005.
32 ARHAP 2006.
33 See Olivier *et al*. 2006 for a more extensive review of this topic.
34 See Abdool Karim *et al*. 1994; Richter 2003.
35 NEPAD 2003, WHO 2006.
36 ARHAP 2006.

WEST AFRICA - MALI

WHO MORTALITY SUMMARY [8]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	6.7	6.8	13.5
Life expectancy (years)	2004	44	47	46
Under-5 mortality (per 1000 live births)	2004	230	208	219
Adult mortality (per 1000)	2004	490	414	
Maternal mortality (per 100000 live births)	2000		1200	

OTHER HEALTH INFORMATION [8]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	1.9
Total expenditure on health as % of GDP	2003	4.8
Per capita expenditure on health at ave exchange rate $US	2003	16

TOP TEN CAUSES OF DEATH ALL AGES - MALI 2002 [8]	DEATHS (000)	YEARS LIFE LOST %
All causes	242	100
Lower respiratory infections	38	18
Diarrhoeal diseases	22	11
Malaria	22	11
Perinatal conditions	18	9
HIV/AIDS	12	4
Tuberculosis	9	3
Protein-energy malnutrition	8	3
Cerebrovascular disease	5	1
Ischaemic heart disease	5	1
Road traffic accidents	4	2

COUNTRY INFORMATION[6, 7]

Geography: In the heart of West Africa, Mali covers an area of 1,240,000km^2, and shares its borders with 7 countries.
Capital: Bamako

Language: French (official), Bambara 80%, numerous African languages.

Politics: A French colony under various forms of French rule, gained independence in 1960, and was under the rule of a dictator until 1991. Currently a multi-party republic based on French civil lay system as well as customary law.

Administration: 8 administrative districts outside Bamako the capital.

Urban Rural Split: 75% of this population live in rural areas

RELIGION IN MALI [5]

Predominantly Muslim (90%) with small proportions of other faith groups. Christians of all denominations account for less than 5%. The country is a secular State.

EXAMPLES OF FBOS WORKING IN MALI

National Faith-based Health Networks: The Protestant Health Association of Mali (APSM). The Interfaith Network of Religious Leaders. . .

International FBOs: Caritas, The Mission Alliance, SECAMA, Islamic Relief, World Vision, Norwegian Church Aid, MAP. . .

National FBOs: The Muslim Association for the Progress of Islam (AMUPI), Groupings of Protestant and Evangelical Churches of Mali (AGEMPEM), Enda Third World Mali, SDA Bamako, Union of Muslim Women Associations of Mali, Alliance Mission Stiftung Agape. . .

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

On independence Mali inherited a state-controlled national health service with minimal involvement by other providers such as the private sector or faith community.[See 3, 7] There is only a small tradition of Christian health service providers, nor does Islam tend to intervene directly in health.[3] "In the Sahel (regions), where most people are Muslim, Islamic primary care or hospital services do not really exist (and) Islam does not tend towards associative forms in Mali."3 Very little is known about the few facility-based health providing FBOs that exist, although those that do exist tend to be from Christian backgrounds.[3] It is said that: the Association of Evangelical and Protestant Groupings of Mali coordinates *"some health facilities belonging to a number of members."*[6]; that there are *"a few"* clinics run by the Catholic Church – "22 centres were going to be involved in an AIDS program"[6] Furthermore, in all regions of Mali, there are traditional religions which persist or syncretically adapt to mainstream faiths such as Christianity or Islam. Traditional healers and health systems therefore are part of the Malian health system, as plural health-seeking behaviour shows, e.g. mothers in Mali's Dogon country will seek out traditional amulets from Islamic teachers; give their babies a traditional enema every day to prevent illness; and simultaneously use ante-natal and immunisation services if there is a health clinic nearby.[2] There is also a widespread use of Islamic medicines or cures by the majority of the population of Mali. [3]

2. HISTORY OF FAITH AND HEALTH

Mali was a French colony under various forms of rule, gained independence in 1960, and was a dictatorship until 1991. There are several historical reasons for the lack of health-providing FBOs in Mali**:**

- In Mali (and Sahelian Africa generally), the French administrative rule was challenged and Christian missionaries never gained a strong foothold as they did in the Anglophone countries, mainly because of a strong Islamic presence. There is therefore not a strong tradition of Christian health providers.[3]
- Islam does not tend to intervene directly in health, taking a holistic perspective of the connection between religion and health, not tending toward associative forms but rather involving individuals in daily networks of prayer and study.[3]
- Until 1991, the Malian dictatorship did not encourage the development of civil society organisations – allowing only one Muslim organisation. Only after 1991 did other associations come about. [3]
- Because of low resources, local communities are currently not commonly in a position to provide for health service delivery. [3]

Nevertheless, religious leaders have played a central role in the Malian religious-health landscape, both positive (e.g. communicating health messages [3, 6],) and negative (e.g. discrimination of woman or FGM 3). Extremely low education levels in Mali have also been ascribed to conflicting Islamic educational practices and beliefs.[3] The Islamic practice of Zakat, giving resources to the poor, is a strong practice in Mali, but little is known how this directly relates to the health of communities, individuals or FBOs in Mali. [3]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. AGEMPEM: PROTESTANT AND EVANGELICAL CHURCHES OF MALI

History: The Groupings of Protestant and Evangelical Churches of Mali (AGEMPEM) brings together 30 members including 8 national churches, 14 foreign missions (African and Western) and 8 associate members, with each member maintaining its own autonomy. [6]

WEST AFRICA - MALI

Membership: The biggest churches of the association are: The Christian Evangelical Church in Mali, established mainly in the East of the country, The Evangelical Protestant Church in Mali, ❒ The Protestant Church of the Kayes region, The Federation of Baptist Churches, ❒ The Evangelical Lutheran Churches, ❒ The Assemblies of the Church of God, ❒ The Grouping of Southern Baptist Churches, ❒ The Union of Evangelical Churches in Mali. [6]

Facilities: AGEMPEM holds as an associate member the APSM (see below), which brings member's health activities and facilities together. It also established an NGO to promote social development. [6]

Activities: AGEMPEM functions with three departments, namely: evangelisation, youth and women. In the area of HIV and AIDS, AGEMPEM works through APSM, and otherwise plays an observer's role by participating in the information and reflection sessions organised by the governmental structures and others. The association thus took part in 1993 in a reflection forum which brought together religious personalities, doctors and other stakeholders of civil society with the objective of collating the reactions of the various parties involved in addressing the HIV/AIDS problem. AGEMPEM is a member of the national NGO network. [6]

e.g. APSM: THE PROTESTANT HEALTH ASSOCIATION OF MALI [6]

History: An associate member of the AGEMPEM, the APSM (Association of Evangelical and Protestant Groupings of Mali, *Association Protestante de la Santé au Mali)* was established in 1992 by the Health Personnel of the Protestant Churches and Missions in Mali. [6]

Activities: APSM's objectives are to encourage its members to provide quality health care to the Malian population, and facilitate the coordination of the medical activities of the churches and missions. The APSM designs, amongst others, literacy and health education programmes for women and children. In the area of HIV and AIDS, APSM undertakes prevention exercises, and has produced information and awareness-raising documents in Bambara, the most widely-spoken national language. APSM is currently planning to design a specific programme on HIV and AIDS which could affect all the strata of the country's population. [6]

4. COLLABORATION AND PARTNERSHIP ON HEALTH

Collaboration with government: There appears to be little collaboration between the few FBOs in Mali and the government, although some meetings do seem to take place on topics such as HIV and AIDS. [3,6]

Collaboration with civil society: FBOs do appear to collaborate with other secular NGOs – e.g. AGEMPEM is a member of the national NGO network.

Interfaith collaboration appears to be rather tenuous: A 2001 study by the WCC noted that "however deplorable this may appear, the Churches and ecumenical institutions do not yet have formal partnership relations among themselves… the Muslims claim they are in favour of collaboration with the other religions (in order to halt the spread of HIV and AIDS). The Christian organisations are also said to be prepared, but nobody is taking the initiative…Our study in Mali made it possible for us to realise that the different religious and ecumenical institutions foster within their own system partnership relations or work in networks…" [6]

Local-international collaboration: Local FBOs have some collaboration and partnerships in place with international and regional FBOs: e.g. "the Catholic Church forms part of a regional network which deals with health problems." [5] Mali is heavily dependent on donor aid. Some large international FBOs have become heavily involved, e.g. MAP has provided major funding since 2005 towards HIV/AIDS.[3] Norwegian Church Aid and World Vision are also present.

5. KEY RESOURCES

1. Afronews/IRIN. 2007. Mali finds no good way to boost health services. [online]. [Accessed 09/11/2007]. <http://www.afrol.com/articles/25054>
2. Castle S. 1992. *Intra-household variation in child care and illness management in rural Mali.* Doctoral thesis. Centre for Population Studies, London School of Hygiene and Tropical Medicine.
3. Castle S. 2007. ***The contribution of faith-based organisations: networks and traditions to health in Africa: a literature review.*** Bamako, Mali: ARHAP FBO-landscaping for the Bill and Melinda Gates Foundation.
4. Castle S and Diarra A. 2003. ***The international migration of young Malians: tradition, necessity or rite of passage?*** Bamako, Mali: Report to Save the Children USA.
5. CIA. 2007. [online]. *CIA – the 2008 world factbook.* [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
6. Josephine SK, Agapit AY and Tatagan-Agbi K. 2001. *Churches and the HIV/AIDS pandemic: analysis of the situation in ten West African countries.* Geneva: (WCC) World Council of Churches, World Alliance of YMCAs.
7. One World. 2007. [online] One World Mali country guide. [Accessed 24/11/2007]. <http://uk.oneworld.net/guides/mali/development>
8. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

WEST AFRICA - GHANA

WHO MORTALITY SUMMARY [15]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	11.2	10.9	22.1
Life expectancy (years)	2004	56	58	57
Under-5 mortality (per 1000 live births)	2004	113	111	112
Adult mortality (per 1000)	2004	349	319	
Maternal mortality (per 100000 live births)	2000		540	

OTHER HEALTH INFORMATION [15]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	3.1
Total expenditure on health as % of GDP	2003	4.5
Per capita expenditure on health at ave exchange rate $US	2003	16

TOP TEN CAUSES OF DEATH ALL AGES - GHANA 2002 [15]	DEATHS (000)	YEARS LIFE LOST %
All causes	207	100
HIV/AIDS	30	17
Malaria	23	16
Lower respiratory infections	16	10
Perinatal conditions	16	12
Cerebrovascular disease	11	2
Ischaemic heart disease	10	2
Diarrhoeal diseases	9	6
Tuberculosis	8	4
Road traffic accidents	5	3
Chronic obstructive pulmonary disease	3	1

COUNTRY INFORMATION[4]

Geography: With a total area of 238,540 km^2 Ghana is bounded by the Ivory Coast, Burkina-Faso, Togo and the Atlantic Ocean.

Capital: Accra

Language: English (official), five major local languages and around 70 other languages and dialects. Around 70 ethnic groups including: Akan (44%), Moshi-Dagomba (16%), Ewe (13%), Gurma (3%), Yoruba (1%).

Politics: Formed from the merger of the British colony of the Gold Coast and the Togoland trust territory, Ghana in 1957 became the first sub-Saharan country in colonial Africa to gain its independence. A long series of coups resulted in the suspension of Ghana's third constitution in 1981 and a ban on political parties. A new constitution, restoring multiparty politics, was approved in 1992. Lt. Jerry Rawlings, head of state since 1981, won presidential elections in 1992 and 1996, but was constitutionally prevented from running for a third term in 2000. John Kufuor succeeded him in a free and fair election.4

Administration: 10 regions; Ashanti, Brong-Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, Western

RELIGION IN GHANA[4]

Christian:68.8% (Pentecostal/Charismatic:24.1%, Protestant:18.6%, Catholic:15.1%, other:11%), Muslim:15.9%, traditional:8.5%, other:0.7%, none:6.1%

EXAMPLES OF FBOS WORKING IN GHANA

National Faith-based Health Networks: Christian Health Association of Ghana (CHAG)…

International FBOs: Adventist Development and Relief Agency (ADRA), Muslim Relief Association, Salvation Army, YMCA, World Vision, Caritas, Christian AID…

National FBOs: Christian Council of Ghana, Ahmadiyya Muslim Mission, National Catholic Secretariat , Presbyterian Church of Ghana, Catholic Drug Centre…

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

Table 1 Faith-based health care in Ghana, by faith

Faith	Percentage of health care in Ghana
Catholic	27%
Other Christian churches	11%
Muslim	1-2%

Source: EPN 2007

Well endowed with natural resources, Ghana has roughly twice the per capita output of the poorest countries in West Africa,[4] but like many SSA countries, Ghana has an inadequate infrastructure and is challenged by a variety of health challenges such as HIV/AIDS and malaria. While less has been written of traditional and non-facility based health efforts, secondary literature states that *faith-based organisations and networks currently provide 34-40% of health services in Ghana.* [7,10,13]

The Christian Health Association of Ghana (CHAG) is second only to the government as the single largest provider of health care in Ghana, catering for 35-40% of the national population.[3] In a recent study of the church health services in Ghana by EPN in 2005, it was found that the overall trend for church health services in Ghana appears to be one of improvement. Good results were seen in the areas of: government support of the church health services, integration between the government and church health services, good community involvement, a functioning drug supply system, relatively high numbers (compared with other African countries) of pharmacists, pharmaceutical technicians, and pharmaceutical assistants per hospital. However, of concern was the problem of healthcare provision in the North of the country (an area generally understood to face bigger problems in health and health services). [7]

2. HISTORY OF FAITH AND HEALTH

Facility-based FBO provision of health began with the movement of missionaries into Ghana in the early 1900s. Some examples of mission hospitals established in the colonial era are the Agogo Presbyterian Hospital built in 1931 and the Breman Asikuma Catholic Hospital (now Our Lady of Grace Hospital) built in 1943. The real expansion of mission hospitals and clinics occurred after independence of Ghana in 1957 along with the public health sector when, for example, CHAG grew from 25 health institutions in 1967 to 152 institutions in 2005. These facility-based FBOs are predominantly in the rural areas of Ghana, and are aimed at the marginalized and poor. "A few are in big towns now but were built there when the towns were small and rural. A few can now also be seen in the slumps (sic) of some of the cities. These are targeted at serving the health needs of the poor and vulnerable populations that have been created by urbanisation." [3] Religious entities have also been heavily involved in the Ghanaian education sector, with various Christian denominations influencing the education system and most of them holding formal schools. After independence, *one of the Government's priorities was to establish free primary education. However, this did not eliminate the schools run by the various religious institutions. At the same time, other religious groups, including Muslim sects, started to expand their educational network.*[14]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAG: CHRISTIAN HEALTH ASSOCIATIONOF GHANA

History: CHAG is an umbrella organization that coordinates the activities of the Christian Health Institutions and Christian Churches' Health programmes in Ghana. CHAG was founded in 1967 as Voluntary Professional Association with the assistance of the World Council of Churches, the Catholic Bishops Conference and the Christian Council of Zambia. It is a body through which all or most of the Christian Church related health facilities/

programmes liaise with the Ministry of Health to ensure proper collaboration and complementation of the government efforts at providing for the health needs of Ghanaians.[3]

Membership: CHAG is open to any Christian church-related medical institution in Ghana, which is recognized as such by the Ministry of Health. *Founding members:* Ghana Catholic Bishops Conference, Christian Council of Ghana, Ghana Pentecostal Council. *Institutional members:* the hospitals and clinics, which belong to the founding members and share in the responsibilities and benefits of CHAG. *Associate members:* other Church-related institutions which share in the aims and objectives of the association and share only some limited benefits and responsibilities.

Facilities: 152 institutions: 56 hospitals, 83 primary health care bodies and 8 health worker training centres in the - most belonging to the Catholic church (78), followed by the Presbyterians (21), and then the SDAs (10).[3. see 6,7,11 (some conflicting figures)]

Facilities are based mainly in rural parts of Ghana; and the hospitals and clinics have an aggregated total of about 6500 beds with an average of 60 beds per hospital.[3]

Activities: Main activities: policy analysis, advocacy & lobbying, capacity building of members, networking & public relations (or public image building), translating government policies in operational terms for members to implement. CHAG institutions provide a whole range of curative, preventive, promotive and rehabilitative services. Many of the mission hospitals in the rural areas providing primary level curative services also provide one or two specialized services such as eye care or specialist gynaecological surgery for which clients would otherwise have had to travel long distances to bigger centres. Some of these hospitals have been designated centres of good practices by government and are sites for training health professionals. The primary health care services include immunization, family planning, maternal and child health services and health education, adolescent reproductive health services.[3]

4. COLLABORATION AND PARTNERSHIP

Ghana appears to represent strong integration and collaboration between government and facility-based FBO health services.[7] There are efforts in place, e.g. through the 5-year Programme of Work (2002-2006) to promote collaboration and partnership between the public and private health care providers. [5] The "steady, but slow" progress of the Ghanaian public-private-partnership, which has had to work through issues such as competition and mutual lack of trust, has been presented as an exemplar for other African countries to learn from.[5]

CHAG and the Ministry of Health signed an MoU in 2003, and has further developed Administrative Instructions for its implementation. These Instructions are based on the understanding that there is a "need to improve collaboration between CHAG and the MoH with a view to attaining the collective tenets or principles enshrined in the MoU between CHAG and MoH. . .To avoid duplication and promote efficiency and effectiveness in service delivery among GHS and CHAG institutions, MoH shall promote regular dialogue, joint planning in building of facilities and delivery of services as well as monitoring and evaluation of activities of all service providers."[9]

The constitution of Ghana provides for freedom of religion, and the government makes an effort to promote interfaith understanding. At official functions, there is generally a multi-denominational invocation led by religious leaders from various faiths.See 5 However, less is known about the practice of interfaith and multi-sectoral collaboration in Ghana, e.g. on specific issues such as HIV/AIDS, or partnership between mainstream religions, traditional leaders/healers and health practitioners.

5. KEY RESOURCES

1. Anane M. 1999. The soul is willing: Religion, men and HIV/AIDS in Ghana. *In: M Foreman, (ed). AIDS and men: Taking risks or taking responsibility?* London: Panos, Zed Books, pp,79-94.
2. CHAG. 2007. [online]. CHAG website. [Accessed 10/09/2007]. <www.chagghana.org>
3. CHAG. 2006. *Annual report: June 2005 - May 2006.* [online]. CHAG website. [Accessed 10/09/2007]. <www.chagghana.org>
4. CIA. 2007. [online]. *CIA – the 2008 world factbook.* [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
5. HERA. 2005. *Public private partnership for equitable provision of quality health services, technical review 2005*. Belgium: (HERA) Health Research for Action for the Ministry of Health, Government of Tanzania.
6. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
7. EPN. 2005a. [online]. Ghana baseline survey. [Accessed 03/01/2008] <http://www.epnetwork.org/en/access/research/ghana>
8. Ghana Health Services. 2005. *The health sector in Ghana: facts and figures 2005.* Accra, Ghana: Ghana Health Services. [Accessed 20/10/2007]. <http://www.ghanahealthservice.org/includes/upload/publications/FACTS%20AND%20FIGURES%202005.pdf>
9. Government of Ghana. 2003. *Memorandum of Understanding between the Christian Health Assocaition of Ghana and the Ministry of Health.* Republic of Ghana.
10. Green A, Shaw J, Dimmock F and Conn C. 2002. A shared mission? Changing relationships between government and church health services in Africa. *International Journal of Health Planning and Management.* **17,** pp.333-353.
11. IDT. 1998. *Religious health networks survey report*. Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.
12. Josephine SK, Agapit AY and Tatagan-Agbi K. 2001. *Churches and the HIV/AIDS pandemic: analysis of the situation in ten West African countries.* Geneva: (WCC) World Council of Churches, World Alliance of YMCAs.
13. Robinson M and White G. 1998. The role of civic organisations in the provision of social services: towards synergy. *In:* G Mwabu, C Ugaz and G White (eds), *New patterns of social provision in low income countries.* Oxford: Oxford University Press and UNI.WIDER.
14. UNFPA. 2004. *Culture matters: working with communities and faith-based organisations: case studies from country programmes.* New York: United Nations Population Fund.
15. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

WEST AFRICA - NIGERIA

WHO MORTALITY SUMMARY [10]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	66.6	65.0	131.5
Life expectancy (years)	2004	45	46	46
Under-5 mortality (per 1000 live births)	2004	198	195	197
Adult mortality (per 1000)	2004	513	478	
Maternal mortality (per 100000 live births)	2000		800	

OTHER HEALTH INFORMATION [10]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	5.4
Total expenditure on health as % of GDP	2003	5.0
Per capita expenditure on health at ave exchange rate $US	2003	22

TOP TEN CAUSES OF DEATH ALL AGES - NIGERIA 2002	DEATHS (000)	YEARS LIFE LOST %
All causes	198	100
HIV/AIDS	311	15
Lower respiratory infections	219	13
Malaria	218	14
Diarrhoeal diseases	134	8
Measles	110	7
Perinatal conditions	89	6
Tuberculosis	75	3
Cerebrovascular disease	69	1
Ischaemic heart disease	64	1
Whooping cough	41	3

COUNTRY INFORMATION [5, 8, 10]

Geography: Nigeria, the giant of Africa is bounded by Benin, Niger, Cameroon, Chad and by the Atlantic Ocean. Its area is 923,770 km^2.

Capital: Abuja

Language: English (official), Hausa, Yoruba, Igbo (Ibo), Fulani. Africa's most populous country, Nigeria is composed of more than 250 ethnic groups.

Politics: British influence and control grew through the 19th century. A series of constitutions after World War II granted Nigeria greater autonomy, and independence came in 1960. Following nearly 16 years of military rule, a new constitution was adopted in 1999, and a peaceful transition to civilian government was completed. The government faces the daunting task of reforming a petroleum-based economy, whose revenues have been squandered through corruption and mismanagement, and institutionalizing democracy. In addition, the defusing longstanding ethnic and religious tensions are a priority if Nigeria is to build a sound foundation for economic growth and political stability. Although the April 2003 elections were marred by some irregularities, Nigeria is currently experiencing its longest period of civilian rule since independence. General elections in April 2007 were considered significantly flawed by Nigerian and international observers but they marked the first civilian-to-civilian transfer of power in the country's history. President Umaru Musa YAR'ADUA took office on 29 May 2007.10

Administration: 36 states and 1 territory

RELIGION IN NIGERIA [10]

Muslim 50%, Christian 40%, indigenous beliefs 10%

EXAMPLES OF FBOS WORKING IN NIGERIA

National Faith-based Health Networks: Christian Health Association of Nigeria (CHAN)…

International FBOs: Salvation Army, YMCA, Caritas, CAFOD, Christian AID, Church Mission Society…

National FBOs: Federation of Muslim Women Association, CEDPA, Christian Council of Nigeria, Christian Association of Nigeria, ECWA AIDS Ministry, PRESBY-AIDS, SDA hospital, Our Lady of Apostles Hospital, Gospel Health and Development Services (GHaDS), Christian Central Pharmacy Limited…

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

As in other SSA countries, Nigeria has a weak national health system which is challenged by diseases such as HIV/AIDS and issues of workforce and financing. The Nigerian public health system is overwhelmed by the basic health needs of the population and coverage is limited in rural areas where 66% of poor people live. As much as 15% of Nigerian children fail to survive to their fifth birthday, as a result of diseases such as malaria, and of which malnutrition contributes to 52% of deaths of children under five.[2] Secondary literature states that *faith-based organisations and networks currently provide around 40% of the health services in Nigeria.* This range is depicted by the following statements:

→ "The mission sector has played an important role within Nigeria delivering up to 40% of health services with a special emphasis on the needs of the rural poor."[3]

→ "The members of the Christian Health Association of Nigeria (CHAN), which represents the vast majority of religious health providers, provides 40% of all healthcare services in the country." [2]

There is a serious gap of knowledge on the involvement in health of the traditional-religious and Islamic communities in Nigeria. Logic says that the Muslim majority must have a strong impact here, but more is known about the Christian facility-based FBO efforts through such organisations as CHAN (see below). Future country profiles such as this would benefit from further research in this area in order to properly depict the Nigerian religious-health landscape.

2. HISTORY OF FAITH AND HEALTH

Like its SSA counterparts, Nigeria experienced a growth of missionary-instigated facility-based FBOs from the early 1900s. Examples of early mission hospitals, situated in predominantly Muslim states in Nigeria, are the ECWA Clinic (Tsanyawa, Kano), the Anglican Rural Health Project (Sokoto), and the ECWA eye hospital (Kano).[2] Today, the Government of Nigeria is embarking on Health Sector Reform and the Federal Ministry of Health is committed to Public-Private Sector partnership as part of its reform Agenda for health sector. [2] As other countries in SSA, these changes represent a changing environment for faith-based organisations.

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAN: CHRISTIAN HEALTH ASSOCIATION OF NIGERIA

History: CHAN was established in 1973 by: The Catholics Bishops Conference of Nigeria (CBCN); The Christian Council of Nigeria (CCN); and The Northern Christian Advisory Council of Nigeria (NCMAC) to facilitate cooperation between Member Institutes (MIs) and to help build capacities in order to better serve the Health needs of Nigerian population.3 "Reaching the Unreached" has been the motto of the Christian Health Association of Nigeria since its creation…CHAN strives to deliver healthcare to the furthest and most remote parts of Nigeria (where most member facilities are positioned), reaching out to those who would otherwise not benefit from health care facilities.1, 2, 7 In doing so, CHAN's members continue the legacy of the early missionaries, "catering for the poor and underprivileged who lack access to healthcare by virtue of their economic status, the remoteness of the locations in which they live or because they have been ostracised as a result of their illness. Mission hospitals place no restrictions or limitations on the clients who can access their services and strive to care for both Christians and non-Christians alike."[2]

Membership: ~400 registered Member Institutions (MIS) in all parts of Nigeria[2] operated by 15 denominations.[3]

Facilities: ~4,000 outreach health facilities. [2]

Activities: Primary Health Care Services (PHCS): activities include training of village health workers and traditional birth attendants, nutrition, immunization, maternal and child health care, growth monitoring, water and sanitation, management training for various health workers of different levels, HIV/AIDS and STD control and AIDS care activities, holistic health care activities and programme

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development, a resource centre with a bookstore. [2] As an umbrella network, CHAN works to coordinate and assists the health services of its members.

Projects:

- → CHAN Drugs Supply Services (CHANPHARM): is responsible for essential drugs importation, production and supply to member *institutions. CHANPHARM pioneer the use of Essential Drugs list and Drug Revolving fund in the country.*
- → EED: Health Advocacy Project [12] Nigerian States
- → THE GLOBAL FUND - NIGERIA: tuberculosis program
- → CHRISTIAN AID : HIV advocacy project in Gombe & Kogi States
- → GHAIN/FHI NIGERIA: ART/PMTCT Projects - 6 Member Institutions (MIs)
- → ACTION AID/CISNHA : HIV/AIDS Budget tracks project [2]

Challenges: A CHAN delegation highlighted the following concerns to the Nigerian Health Minister: the need for more assistance/collaboration in the face of fresh challenges such as dwindling resources due to donor fatigue and lack of government support and patronage of CHAN programmes, inaccessibility to resources channelled through government such as HIV/AIDS resources comprising of anti-retroviral drugs, HIV/AIDS kits and capacity development, lack of government salary support of mission staff (as is done in Ghana and Kenya). [3]

4. COLLABORATION AND NETWORKING ON HEALTH

As mentioned above, there appear to be some challenges to better collaboration between government and FBO facility-based health services. However, CHAN represents an extensive FBO system, and is in a strong position to play an advocacy role, e.g. in 2006 Nigerian Health Minister Prof. Lambo stated that "(the government needs) CHAN more than you need me to solve the chaotic situation in the Nigerian Health system."[3] It would appear that CHAN also plays a broader advocacy and collaborative role "as the largest, oldest health NGO, CHAN is regarded as the voice of Non-Government Organisation (NGOs) in Nigeria, and acts as a meeting point on health matters for Christian denominations." [2]

However, little has been recorded about the practice of multi-sectoral or interfaith collaboration beyond the CHAN network. For example, a 2001 WCC study of the faith response to HIV/AIDS in the country found little evidence of working collaborative networks in place, apart from the Christian councils. This study also noted that the apparent solidarity of churches in these networks must be understood in the particular context of Nigeria where there are periodic clashes between the Churches and Muslims. "It should also be emphasised that traditional Church officials have ruled out the possibility of collaboration with the sects (sic) which are currently proliferating in Nigeria."[8] There is much still to be researched about the specific dynamics of interfaith and ecumenical collaboration in Nigeria.

5. KEY RESOURCES

1. Baird TL. 1999. Christian hospitals in Nigeria provide post abortion care and STD management. *CCIH Forum (March),* Christian Connections for International Health.
2. CHAN. 2007. Christian Health Association of Nigeria website. [online]. [Accessed 01/08/2007]. <http://channigeria.org/articles/htfd.html>
3. CHAN. 2006. CHAN National Advocacy Committee delegation to Minister of Health Prof Lambo. [online]. [Accessed 10/09/2007]. <http://channigeria.org/articles/htfd.html>
4. Church of Nigeria. 2004. *National HIV/AIDS 4 year strategic plan 2004-2008.* Church of Nigeria, Anglican Communion.
5. CIA. 2007. [online]. *CIA – the 2008 world factbook.* [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
6. DFID. 2006. *Promoting women's rights through sharia in Northern Nigeria.* Zaria, Nigeria: (DFID) Department for International Development, and Centre for Islamic Legal Studies, Ahmadu Bello University.
7. Hackney TS. 2000. *The invisible giant: The Christian health system.* MPH degree. Atlanta, GA: Emory University.
8. Josephine SK, Agapit AY and Tatagan-Agbi K. 2001. *Churches and the HIV/AIDS pandemic: analysis of the situation in ten West African countries.* Geneva: (WCC) World Council of Churches, World Alliance of YMCAs.
9. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
10. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

WEST AFRICA - SENEGAL

WHO MORTALITY SUMMARY [13]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	5.7	5.9	11.7
Life expectancy (years)	2004	54	57	55
Under-5 mortality (per 1000 live births)	2004	141	132	137
Adult mortality (per 1000)	2004	358	288	
Maternal mortality (per 100000 live births)	2000		690	

OTHER HEALTH INFORMATION [13]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	0.8
Total expenditure on health as % of GDP	2003	5.1
Per capita expenditure on health at ave exchange rate $US	2003	29

TOP TEN CAUSES OF DEATH ALL AGES - SENEGAL 2002 1[3]	DEATHS (000)	YEARS LIFE LOST %
All causes	102	100
Lower respiratory infections	16	20
Malaria	13	16
Perinatal conditions	8	11
Diarrhoeal diseases	7	9
Tuberculosis	4	4
Cerebrovascular disease	4	2
Ischaemic heart disease	3	1
HIV/AIDS	3	3
Road traffic accidents	3	3
Whooping cough	1	2

COUNTRY INFORMATION [3, 6]

Geography: Located at the extreme end of the West African continent, covering 196,720 km^2 and sharing borders with Mauritania, Guinea, Guinea Bissau, Mali and the Atlantic Ocean.

Capital: Dakar, which was the capital of French West Africa.

Language: French (official), Wolof, Pulaar, Jola, Mandinka.

Politics: The French colonies of Senegal and the French Sudan were merged in 1959 and granted their independence as the Mali Federation in 1960. The union broke up after only a few months. Senegal was ruled by the Socialist Party for 40 years until current President Abdoulaye Wade was elected in 2000. Senegal joined with The Gambia to form the nominal confederation of Senegambia in 1982, but the envisaged integration of the two countries was never carried out, and the union was dissolved in 1989. The most significant threat within Senegal since the 1980s has been led by the Movement of Democratic Forces in the Casamance (MFDC). Although a peace agreement was signed in December 2004, internal rifts continue to keep the peace process deadlocked. Nevertheless, Senegal remains one of the most stable democracies in Africa.

Administration: 10 administrative districts

Urban Rural Split: Roughly 40% of the population live in urban centres.

RELIGION IN SENEGAL [6]

Constitutionally, Senegal is a secular state. Muslims are in the majority (80%), Christians (10%: of which the Catholics ~5% and Protestants ~2%).

EXAMPLES OF FBOS WORKING IN SENEGAL

National Faith-based Health Networks: Eglise Protestant du Senegal – Commission Medicale, The Association of Catholic Health Posts. . .

International FBOs: YMCA, YWCA, Islam and Population Network, Federation of Islamic Medical Associations. . .

National FBOs: SIDA-Service, JAMRA, APES - Association Protestante d'Entraide du Sénégal (Protestant Mutual Assistance Association in Senegal), Protestant AIDS Co-ordination Committee (PACC), Anis, Tostin, The Alliance of Religious Officials and Medical Experts in Response to the AIDS Epidemic, National Association of Imams and Ulemas. . .

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

The involvement of religious entities in health is distinctly different in Francophone Muslim-majority countries such as Senegal than in Christian-majority states in central and southern Africa. In Senegal, where most people are Muslim, Islamic primary care or hospital services rarely exist. There are however, some facility-based health providing FBOs linked to the Christian denominations – even though they are in a minority. There is little data on these, but we know, for example:

→ "Before the founding of SIDA-Service (in 1991), the Association of Catholic Health Posts was already collaborating with the Ministry of Health in controlling diseases, including sexually transmitted infections (STIs), through its 72 health facilities across Senegal. These health posts are believed to provide 40% of all medical consultations in the country."[11]

However, apart from a few exemplars (see below), little has been recorded of the level of involvement of Islamic FBOs in health. "Approximately 900 Islamic associations are registered with the Ministry of Interior, and numerous others are not registered. These religious associations account for 3.5 million adherents, and represent 45% of the Senegalese population. They are involved in diverse social activities affecting every aspect of people's lives. Christian communities—both Catholic and Protestant—comprise 4.9% of the population. They operate through well-structured institutions, such as schools, health facilities and youth movements, which allow leaders to reach all strata of Senegalese society. In general, religion plays a strong role in the culture and beliefs of the Senegalese people." [11] Although we do not know the specific level of impact on health of these non-facility based activities of FBOs, it has been noted that the Muslim community is very active and contributes in more than one respect towards the struggle against AIDS (see below). [6]

2. HISTORY OF FAITH AND HEALTH

In Francophone Africa colonial rule was centralised from France and civil administration was carried out by French expatriate civil servants, teachers, doctors etc. In Senegal, the French administrative rule was often challenged, e.g. by Cheick Amadou Bamba and other Islamic leaders. Christianity never developed and Christian missionaries never established health and educational services in the Sahel regions to the same extent as in the centre of the continent and in the Anglophone countries.[9]

Senegal and the HIV/AIDS epidemic: "Without any exaggeration, one can say that Senegal is far ahead of its neighbours of the sub-region in the struggle against AIDS." [6] Senegal's apparent success in maintaining relatively low levels of HIV and AIDS has been explained as being the result of a number of factors, including the involvement of religious leaders from early in the epidemic.[8, see 4,12] Early meetings and partnership with FBOs led to Senegal hosting the First International Colloquium on AIDS and Religion held in Dakar in late 1997. It was attended by some 250 people from 33 countries, including Muslim, Christian and Buddhist religious leaders and the ministers of health of 5 African countries.[4,12] Although religious leaders were condemned in the first stages of the epidemic for increasing stigma and discrimination, this perspective seemed to change quickly.[4]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. JAMRA

History: Founded in 1982, Jamra is a conservative Islamic NGO devoted to combating social ills, such as illicit drugs and sex work. Due to the links between this mission and HIV transmission, Jamra became involved in prevention efforts soon after the appearance of the first-known cases of AIDS in Senegal. As early as 1987, Jamra's leaders contacted the government to express their organization's interest in contributing to the national response to AIDS and to request training in the scientific aspects of the disease. However, Jamra developed its own approach by elaborating messages based on the beliefs

WEST AFRICA - SENEGAL

and convictions of its members. In 1989 Jamra and the government signed a formal agreement that provided a basis for sensitization sessions targeting Imams, Khalifs and traditional leaders. This partnership laid the groundwork for effective involvement of religious leaders in HIV and AIDS-prevention efforts in Senegal. [11]

Activities: Using outreach contacts Jamra introduced HIV and AIDS issues to religious communities. This was accomplished through organized field trips across the 10 regions of Senegal. Jamra succeeded in involving known personalities and leaders of all the five different sects (Tarikha) within the Islamic community. Adapting pedagogy by linking the Koran and scientific facts in order to establish a sensitization process, Jamra drew on messages from the Koran and Hadiths (rules dictated by the Prophet) to mobilize the Muslim community on questions that touch on Islam. [11]

e.g. SIDA-SERVICE ("AIDS-SERVICE")

History: In 1991 the Association of Catholic Health Posts of Senegal and the private Catholic schools unit of the Catholic church created SIDA-Service in response to the urgent need to inform its youth about the gravity of HIV and AIDS.11 SIDA-Service is the spearhead of the Catholic Church in the fight against HIV and AIDS, focussing mainly on prevention by targeting the youth from academic circles and women. In 1995, SIDA-Service also embarked on support and training. In 1996, it organised the first national seminar on "AIDS and religion" which brought together all the bishops of Senegal. [6]

Membership: priests, nuns, doctors, teachers, health personnel and youth.[11]

Facilities: A new "Health Promotion Centre" (HPC), used for prevention, treatment and care, and the first of its kind in Senegal or the sub-region. Psycho-social, medical and spiritual aspects are all dealt with.[5, See 11]

Activities: Members of SIDA-Service met with the bishops of each of the six Catholic dioceses, resulting in the bringing together of all the bishops. This approach progressively reached other Catholic structures such as schools, health posts, youth and women's groups, developmental initiatives, the clergy and training schools. In order to ensure total participation by the entire Christian community, SIDA-Service followed the same approach with the Protestant community despite the serious differences that exist between the two churches.[11] AIDS-Service is also active in Gambia.

4. COLLABORATION AND PARTNERSHIP ON HEALTH

While Senegal might not have the same level of technical or financial collaboration between the government and religious facility-based health providers as in some other SSA countries, there appears to be strong multi-sectoral partnership and collaboration – especially in the context of the HIV and AIDS epidemic. See 6 Reports of this collaboration show links between different Islamic networks, between Islamic and Christian leaders and FBOs, and between these groups and the secular government. "Senegal also distinguishes itself from other countries of the sub-region by the constructive progress achieved in the Islamo-Christian dialogue. The alliance of religious figures and medical experts, in response to AIDS in Senegal, is one of the precious fruits of this dialogue."[6] Another example of this is the, Alliance of Religious Officials and Medical Experts in Response to the AIDS Epidemic,[6] created in 1999. The components of this Alliance are Jamra, the National Association of Imams and Ulemas in Senegal and the Catholic Church. Unfortunately, the Protestants and evangelicals do not form part of it. FBOs such as Jamra and SIDA-Service, also form part of other networks in Senegal which bring NGOs working in health and development together. There are limited operational networks among the Christian congregations,[6] but extensive and numerous networks among the Islamic entities, such as the National Association of Imams and Ulemas which is involved in broadcasting Islamic principles regarding women's issues, population and health (e.g. HIV/AIDS). It has structures throughout the country.[6, 11]

5. KEY RESOURCES

1. Bitran R. 1995. Efficiency and quality in the public and private sectors in Senegal. Health Policy and Planning. 10 (3), pp.271-283.
2. Castle S. 2007. The contribution of faith-based organisations: networks and traditions to health in Africa: a literature review. Bamako, Mali: ARHAP FBO-landscaping for the Bill and Melinda Gates Foundation.
3. CIA. 2007. [online]. CIA – the 2008 world factbook. [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
4. Green A, Shaw J, Dimmock F and Conn C. 2002. A shared mission? Changing relationships between government and church health services in Africa. International Journal of Health Planning and Management. 17, pp.333-353.
5. IMAU. 2001. Proceedings: Islamic Associations fighting against AIDS. The 1st International Muslim Leaders Consultation On HIV/AIDS, 1–4 November 2001, Kampala, Uganda. Islamic Medical Association of Uganda.
6. Josephine SK, Agapit AY and Tatagan-Agbi K. 2001. Churches and the HIV/AIDS pandemic: analysis of the situation in ten West African countries. Geneva: (WCC) World Council of Churches, World Alliance of YMCAs.
7. Lagarde E, Enel C, Seck K, Gueye-Ndiaye A, Piau J, Pison G, Delaunay V, Ndoye I and Mboup S. 2000. Religion and protective behaviours towards AIDS in rural Senegal. AIDS. 14(13), pp.2027-2033.
8. Lom MM. 2001. Senegal's recipe for success. Africa Recovery. 15(1-2), pp.24.
9. Manji F and O'Coill C. 2002. The missionary position: NGOs and development in Africa. International Affairs. 78(3), pp.567–583.
10. Olivier J, Cochrane JR and Schmid B. 2006. ARHAP literature review: Working in a bounded field of unknowing. Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
11. Onyango P (unknown). Working with religious leaders to prevent the spread of HIV/AIDS in Senegal. (FHI) Case Study Eleven Aidscap/Senegal, AIDS Control and Prevention (Aidscap) Project, Family Health International, Dakar, Senegal.
12. Tiendrebeogo G and Buykx M. 2004. Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa. Amsterdam, Netherlands: (KIT) Koninklijk Instituut voor de Tropen.
13. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

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CENTRAL AFRICA - DEMOCRATIC REPUBLIC OF CONGO

WHO MORTALITY SUMMARY [19]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	28.5	29.0	57.5
Life expectancy (years)	2004	42	47	44
Under-5 mortality (per 1000 live births)	2004	217	192	205
Adult mortality (per 1000)	2004	576	446	
Maternal mortality (per 100000 live births)	2000		990	

OTHER HEALTH INFORMATION [19]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	4.2
Total expenditure on health as % of GDP	2003	4.0
Per capita expenditure on health at ave exchange rate $US	2003	4

TOP TEN CAUSES OF DEATH ALL AGES - DRC 2002 [19]	DEATHS (000)	YEARS LIFE LOST %
All causes	978	100
Diarrhoeal diseases	112	13
HIV/AIDS	111	11
Lower respiratory infections	108	13
Malaria	97	12
War	44	4
Perinatal conditions	39	5
Measles	37	5
Tuberculosis	33	3
Cerebrovascular disease	26	1
Ischaemic heart disease	24	1

COUNTRY INFORMATION [10, 16, 19]

Geography: DRC is located in Central Africa, bounded to the West by the Republic of Congo and Gabon, to the North by Central African Republic and Sudan, to the East by Uganda, Rwanda and Burundi, to the South by Angola, Zambia and Tanzania. DRC is geographically vast with a total area of 2,345,000 km^2 but sparsely populated.

Capital: Kinshasa

Language: French (official), Lingala (lingua franca trade language), Kingwana (dialect of Kiswahili or Swahili), Kikongo, Tshiluba.

Politics: Because of the civil war prevailing in the country since 1998, almost 1/3 of the country is under rebel occupation.

Administration: DRC is divided into 11 administrative provinces.

Urban Rural Split: 10 million of the population are living in Kinshasa the capital city, while 60% in rural areas.

RELIGION IN DRC

Roman Catholic 50%, Protestant 20%, Kimbanguist 10%, Muslim 10%, other (includes syncretic sects and indigenous beliefs) 10%[10]

EXAMPLES OF FBOS WORKING IN DRC

National Faith-based Health Networks: ECC-BDOM (see below)…
International FBOs: CAFOD, CARITAS, Christian AID, IMA, MAP, Salvation Army (Service Medical), United Methodist Committee on Relief, WCC, ACT, Church Mission Society, Tearfund…

National FBOs: Kimbanguist Medical Department, National Council of Faithbased Alliance…

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

The DRC (formerly Zaire) national health system is currently based on 515 Decentralized Health Zones. *Secondary literature states that faith-based organisations and networks currently provide between 50%-70% of health services in the DRC.* This range is depicted by the following statements:

- → "FBO networks in DRC currently not only provide 50% of health services, but also co-manage around 40% of Congo's 515 health zones."[6]
- → "…of the 515 health zones, 65 are currently co-managed by the ECC." [6,12,16]
- → "…70% of health services are delivered by churches and church related institutions with meaningful results."[13]
- → "50% of hospitals in the DRC are owned and managed by local churches."[5]
- → "In the DRC virtually the whole health care infrastructure is currently provided by faith organisations as the government health system has practically collapsed. It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home based care and support of orphans."[11]

2. HISTORY OF FAITH AND HEALTH

In the DRC, the history of medical mission and health professionals working with FBOs goes back more than a hundred years: Protestant medical mission beginning in 1882 and the Catholic mission in 1889 – including the creation of hospitals and health services. Protestant missionaries led the way in establishing the first hospitals in Congo. While we know less about the other religious group's efforts in health, a significant event was when, in an effort improve the coordination of services, 40 protestant missionary societies from 12 different countries created the Protestant Council of the Congo in 1928, and later the Protestant Church of Congo came into existence in 1971 and created the *Direction des Oeuvres Médicales* (DOM) to coordinate the health work of its members and to liaise with the government.[11] This is significant, since in 1999 the Ministry of Health turned over responsibility for health care in 60 zones to a coalition of mostly faith-based non-governmental health.[1,5] In the face of political and economic crisis and instability, FBOs have continued to play a long-term and obvious role in healthcare at a national level – and the DRC demonstrates a unique situation of public-private partnerships in health. The large Christian majority in the country means that most of the FBOs are from a Christian background, with Protestant and Catholic efforts being fore-grounded in the literature. International FBOs have also played a critical role, often providing assistance during times of conflict and to remote locations even after other organisations have pulled out. More research is needed on faith-based efforts in health at a local and community level.[See 11,16,17]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. ECC-DOM (EGLISE DU CHRIST AU CONGO - DIRECTION DES OEUVRES MÉDICALES)

History: The Protestant Church of Zaire (currently known as ECC – *Eglise du Christ au Congo)* came into existence in 1971 with around 60 member communities. At the same time, a medical office, the *Direction des Oeuvres Médicales* (DOM) was created to coordinate the health work of the ECC members and to serve as the liaison with the Ministry of Health. In 1999, in a major move, the DRC Ministry of Health formally turned over responsibility for health care in 60 zones (of a total of 306) with a population of 12,000,000 to a coalition of mostly faith-based non-governmental health organisations - with ECC-DOM as implementing partner. ECC currently co-manages 65 of the 515 health zones in the DRC. [1,5,11,16,17]

Membership: The ECC network of 64 member communities, includes denominations of: Anglican, Presbyterian, Evangelical, Baptist, Pentecostal, Methodist and Mennonite. According to the 1998 census, ECC has approximately a membership or 'footprint' of 19 million people. Organisational materials state that traditionally, its activities have often been community-based and have sought to target the people at a grassroots level, "including the vulnerable and the un-reached irrespective of gender."[11, see 16]

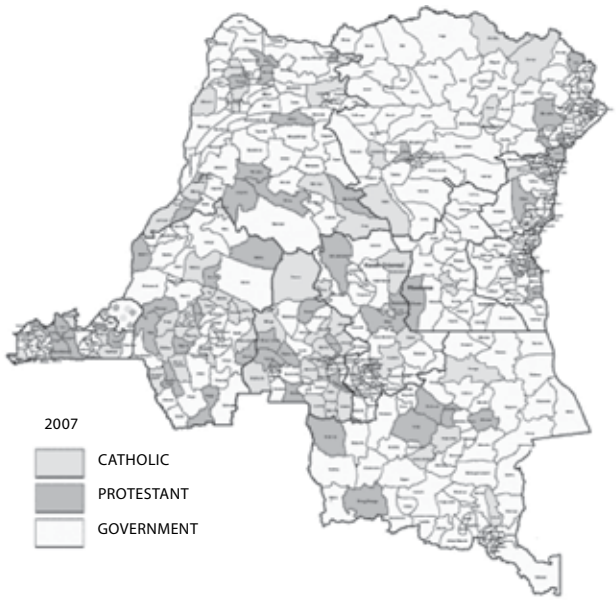
Facilities: ECC-DOM manages approximately 50 hospitals and several hundred dispensaries.[6]

Activities: Through its member communities, ECC-DOM provides community-base health care, hospital and dispensary-based care. Through its management of the SANRU health development project, ECC-DOM can be said to be involved in shaping the health delivery system of the DRC. ECC also plays an important collaborative and networking role, uniting most protestant congregations and health efforts, and playing a central role in ecumenical collaboration.

CENTRAL AFRICA - DEMOCRATIC REPUBLIC OF CONGO

Project Examples: See 6,11,14,16,17

- → (since1980) *The Basic Rural Health Project* (later known as SANRU *Projet Santé Rurale*): involved the creation of health zones around Protestant, Catholic, governmental, and other NGO-managed hospitals in partnership with USAID.
- → (since 1984) *SEQ CHAPTER project:* for the physical rehabilitation of health centers, working in collaboration with the Jewish NGO SE CHAPTER Organisation for Rehabilitation by Training and USAID.
- → (since ~2001) PMURR: World Bank funded assistance to 18 additional health zones.
- → (since 2001) *SANRU III* project: USAID and IMA funded to assist sixty health zones. ECC-DOM's current management of the SANRU III project is providing assistance to rebuilding and strengthening primary health care services in 65 health zones co-managed by Protestant and Catholic Faith-Based Organisations, providing primary health care for approximately 10 million people.[11,13,17] SANRU III also involves ECC-DOM working closely with other faith networks (Catholic, Kimbanguist), secular organisations and government health authorities. [16]



4. COLLABORATION AND PARTNERSHIP ON HEALTH

Literature suggests that a strong partnership exists in the DRC between the government, FBOs, secular NGOs and donors - built around the provision of care through the SANRU project. Some of the collaborating partners are: ECC-DOM, Service Medical of the Salvation Army, Kimbanguist Medical Department, and the Catholic church.[16] The fragile and sometimes volatile political situation in the DRC has created an unusual, and by all appearances, effective collaborative partnership in a time of crisis. This "public-private" partnership and collaboration began early - for example with a national conference being set up in 1975, co-sponsored by the medical offices of ECC and the Catholic Church with the MOH, establishing a national consensus for the concepts of "decentralized health zones" and "primary health care. [11]

Collaboration around the issue of HIV/AIDS: appears to be in effect, with the National Council of Interfaith-based Alliance (comprising 8 religious leaders) as one structure for HIV/AIDS-related discussion and lobbying. This council is set up to integrate the religious and government responses to HIV/AIDS. [16]

5. KEY RESOURCES

1. Ausherman-IDT. 1998. *Religious health networks survey report.* Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.
2. Baer F. 1992. SANRU: Lessons Learned (1981-1991), a report prepared for USAID.
3. Baer F. 1994. Health systems strengthening in West and Central Africa. Baertracks, August 1994
4. Baer F. 1994. Working with NGOs to develop integrated health systems. Presentation made at the World Bank, 1994.
5. Baer F. 2001. IMA signs $25 Million Contract for SANRU III. *Forum,* (CCIH) Christian Connections in International Health.
6. Baer FC. 2007. [online]. FBO health networks and renewing primary health care. [Accessed 03/03/2008]. <http://renewingphc.org/fbos/FBOs_and_renewing_PHC.htm>
7. Baer F and Kintaudi L. 2005. The DR Congo experience in health system development and management. *CCIH Conference, 2005.* Christian Connections for International Health.
8. Benn C. 2003. Why religious health assets matter. *ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003,* (ARHAP) African Religious Health Assets Programme.
9. CAFOD. 2007. [online]. CAFOD website. [Accessed 30/11/2007]. <http://www.cafod.org.uk>
10. CIA. 2007. [online]. CIA – the 2008 world factbook. [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
11. CCIH. 2007. [online]. GRHAM Mapping of ECC. [Accessed 01/08/2007]. <http://ccih.org/grham/>
12. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
13. ECC. 2007. Eglise du Christ au Congo website. [online]. [Accessed 03/08/2007]. <http://ecc.faithweb.com/>
14. EHAIA. 2006. [online]. WCC mapping of SSA. [Accessed 20/08/2007]. <http://www.wcc-coe.org/wcc/what/mission/ehaia-html>
15. Kintaudi L, Derstine P and Baer F. 2004. Faith-based co-management of health zones and umbrella projects in DR Congo. APHA presentation, *(APHA) American Public Health Association Meeting, 2004.*
16. Lusey-Gekawaku H. 2003. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in five countries of central Africa.* Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa
17. SANRU. 2007. [online] SANRU website. [Accessed 27/10/2007]. <http://sanru.org/about_sanru.htm>
18. Sanvee J, Akolatste Y, Tatagan A. 2001. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in 10 West and Central African Countries.* Geneva: (WCC) World Council of Churches Publications.
19. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

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SOUTHERN AFRICA - LESOTHO

WHO MORTALITY SUMMARY[12]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	0.8	1.0	1.8
Life expectancy (years)	2004	39	44	41
Under-5 mortality (per 1000 live births)	2004	87	76	82
Adult mortality (per 1000)	2004	845	728	
Maternal mortality (per 100000 live births)	2000		550	

OTHER HEALTH INFORMATION[12]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	28.9
Total expenditure on health as % of GDP	2003	5.2
Per capita expenditure on health at ave exchange rate $US	2003	31

TOP TEN CAUSES OF DEATH, ALL AGES - LESOTHO 2002 [12]	DEATHS (000)	YEARS LIFE LOST %
All causes	46	100
HIV/AIDS	29	66
Lower respiratory infections	1	4
Diarrhoeal diseases	1	5
Cerebrovascular disease	1	1
Ischaemic heart disease	1	1
Perinatal conditions	1	4
Tuberculosis	0	2
Measles	0	3
Chronic obstructive pulmonary disease	0	0
Road traffic accidents	0	1

COUNTRY INFORMATION [1]

Geography: Lesotho is a small land-locked country entirely surrounded by South Africa. It is a small mountainous country of 30,355 km^2

Capital: Maseru

Language: Lesotho is one of the few countries in Africa with one dominant indigenous language (Sesotho) and one dominant culture (Basotho)

Politics: The Kingdom of Lesotho gained its independence from Britain in 1966, with Moshoeshoe II as King, and Chief Leabua Jonathan of the Basotho National Party as Prime Minister. The next decades were characterised by both political and economic instability. The victory of the Lesotho Congress of Democrats in the 1998 elections precipitated riots and military intervention by the South African Development Community. Since that time, there has been general political stability in the country, with the LCD winning the parliamentary elections in 2002, although the opposition parties did boycott the first local elections since independence in 2005.

Administration: 18 health service areas

RELIGION IN LESOTHO [1]

Christian 91% (Catholic-38%, Evangelical-23%, Anglican-5%, Other-25%); Traditional Sesotho religio-cultural forms 8%; Baha'I 0.89%; Hindu 0.06%; Islam 0.05%. These statistics do not represent the continued vitality of Traditional Sesotho religio-cultural forms in Lesotho.

EXAMPLES OF FBOS WORKING IN LESOTHO

National Faith-based Health Networks: Christian Health Association of Lesotho (CHAL)…

International FBOs: DANCHURCHAID, Catholic Relief Services, WCC, Norwegian Church Aid, Caritas, Christian Aid, World Vision…

National FBOs: Scripture Union, Thaba Bosiu Centre (Lesotho Evangelical Church)…

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

Lesotho has a fragile health situation, and has been particularly hard hit by the HIV and AIDS epidemic which has escalated to become one of the world's most severe. There are a wide variety of FBOs working on health in Lesotho, ranging from health providers (such as the members of the Christian Health Association of Lesotho, CHAL) to the recognised but not well understood role of traditional healers, to the contributions made by the variety of religious communities and entities across Lesotho.1 e.g. It has been found that local networks of community support groups (CSGs) are hugely significant in Lesotho, particularly in communities where access to healthcare services and facilities is beyond the reach of ordinary Basotho. "Self-initiated, deeply religious, though not formally linked to any religious structure, they are identified as an important health provider in these communities.congregational support groups."[1] There has been a noticeable proliferation of religious entities involved in promoting health and wellbeing since 2000. Many of these new religious entities are directly responding to HIV/AIDS, and are "altering the nature of the religious contribution to health in Lesotho."[1] *Secondary literature states that faith-based organisations and networks currently provide between 40-50% of health services in Lesotho.*

This range is depicted by the following statements:

- "CHAL provides ~40% of the health care to the country."[4,9]
- "50% of health services provided by the government and 50% by religious institutions."[7]

2. HISTORY OF FAITH AND HEALTH

Two religious traditions dominate the religious topography of Lesotho: the historical religio-cultural formations of the Basotho and the Christian traditions of the west. The arrival of the Paris Evangelical Missionaries in 1833, followed by the Roman Catholic Church in 1863 and the Anglican Church in 1876 (all of whom who immediately established mission hospitals and clinics), began an enduring and shifting process of interaction between these two religious traditions. Another important feature of the religious scene in Lesotho is the historical relationship of the two major denominations in Lesotho, the Roman Catholic Church (RCC) and the Lesotho Evangelical Church (LEC) – both aligned with opposing political parties, and thereby linking the politico-religious landscape. These party-political dynamics have long been recognised as impacting on the articulation of ecumenical relations in the country.[1]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAL: THE CHRISTIAN HEALTH ASSOCIATION OF LESOTHO

History: In the 1960s, physicians from various mission hospitals began meeting to discuss common problems, and in the 1970s the Christian Council of Lesotho and Oxfam advocated a more formal organization. The Minister of Health also urged a more formal association in 1973, and in 1974 CHAL was founded as a voluntary association of Christian churches providing not-for-profit health care services to the Basotho, particularly in hard to reach places around the country. [3,7,8,9]

Membership: The Anglican Church of Lesotho, Assemblies of God Church, Bible Covenant Church, Lesotho Evangelical Church, Roman Catholic Church, Seventh Day Adventist Church of Southern Africa.

Facilities: 72 health centres and 8 hospitals, each serving a large geographical area, mainly in the rural areas. This amounts to ~40% of the NHS.[4,9]

Activities: CHAL assumes primary operational responsibility for public health and health services in 8 of 18 health service areas. CHAL's service programme comprises of three components: capacity building, primary health care and medical services, infrastructure improvement.

Projects: CHAL has several projects running, including: HIV/AIDS prevention and control programme, primary health care programme (MCH/FP, nutrition, environmental health), the Constituency Development Plan of Action for Child Survival and Protection, Lesotho Rural Health Development project, and the rural clinic improvement/maintenance program.[9]

Collaboration: CHAL presently enjoys the support of the following

SOUTHERN AFRICA - LESOTHO

partners and donors: the Government of Lesotho, Irish Aid, SolidarMed, Medecins sans Frontiere (MSF), World Food Programme (WFP), UNICEF, and Global Fund. See 3,7,8,9 Like other such associations in SSA, CHAL has recently faced both workforce- and financial crises, with dwindling grants from external sources. In 2003 the Supplementary Emergency Funding Facility (SEFF), was put in place as a response to this financial crisis facing most CHAL facilities. The objective of SEFF was to provide temporary financial support to CHAL facilities so that the quality of services to be provided could be improved to the minimum acceptable level. The amount of SEFF received by each facility is calculated at 20% of the overall operating costs, including salaries. In 2004/05 total amount to CHAL was M37. 5 million, which is approximately 14% of the total recurrent budget of the Ministry.9 The SEFF arrangement was replaced by a new MoU between the government and CHAL in February 2007. Individual Letters of Intent are being developed and signed at district level between government and CHAL providers. An accreditation process is also underway to grade facilities on qualitative criteria. There is a transition taking place in Lesotho from Health Service Areas to Districts as the health catchment areas. "While this transition is in accord with decentralization plans of government…it will potentially jeopardize the decentralization and supervision of health services and negatively impact the level of collaboration between CHAL and the government providers at local level." [13]

4. COLLABORATION AND PARTNERSHIP ON HEALTH

As mentioned above, the party-political dynamics intertwined with religious identity have long been recognised as impacting on the articulation of ecumenical relations in the country.1 In the ARHAP study for the WHO, researchers found that in Lesotho, FBOs operate within a network of relationships with other local and translocal entities, with some FBOs functioning as key hubs. However, other than the CHAL-MoH link, FBOs were not found to be integrated with public health facilities. However, the local FBOs that were integrated into collaborative networks that included a number of important entities not "indigenous" to the area, were able to draw on a wide network of local, national and international relationships, e.g. World Vision Lesotho was found to be an important actor, as were FBOs affiliated to international denominational structures such as RCC or SDA. 1 It was also found that Muslims and the Traditional Healers Associations were not extensively connected to many church organisations – and participants from Christian FBOs were keen to work with Muslims, but showed less enthusiasm to collaborate with Traditional Healers. There was some evidence that a "competitive nature" of some Christian FBOs also contributed to the lack of collaboration.[1]

> Cooperation amongst REs is expected to be higher in rural areas where churches are compelled to accept traditional values…the finding highlights the unevenness of these networks with some entities being established as clear "hubs" while others function on the periphery existing as isolated organisations, entities and initiatives. There is clearly a lot of work that needs to be done if collaboration is to take place amongst (religious entities) and between these entities and public healthcare professional, services and facilities.[1]

The collaboration between CHAL and the MoH appears to be strong – with CHAL being one of the few organisations that links government efforts with religious community.[1] However, this is also a shifting relationship. The previous health service area arrangement meant that the hospital in charge of that area was also responsible for supervising all health centers in that area - regardless of whether it is a CHAL or government facility, creating an interesting collaborative situation.[9] Transitions towards "catchment areas" and new policies such as the standardisation of user fees in 2008 (across all government and CHAL facilities) are creating a new collaborative environment in Lesotho.[13]

5. KEY RESOURCES

1. ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa.* Cape Town: Report for the World Health Organisation, African Religious Health Assets Programme.
2. Barton T, Thamae S and Ntoanyane M. 1997. *AIDS in Lesotho: A community-based response: A summary evaluation of the CHAL-DCA AIDS Project.* Maseru, Lesotho: Christian Health Association of Lesotho and DanChurchAid.
3. CHAL. 2006. CHAL Pamphlet. CHAL, Maseru: Christian Health Association of Lesotho.
4. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
5. Global Ministries. 2007. [online] Global Ministries website. [Accessed 24/10/2007]. <http://www.globalministries.org/africa/Projects/afr-les5.htm>
6. Government of Lesotho. 2002. *Service agreement between the Government of Lesotho and the Christian Health Association of Lesotho.* Maseru, Lesotho: Government of Lesotho.
7. Green A, Shaw J, Dimmock F and Conn C. 2002. A shared mission? Changing relationships between government and church health services in Africa. *International Journal of Health Planning and Management.* **17,** pp.333-353.
8. IDT. 1998. *Religious health networks survey report.* Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.
9. MOH-Lesotho. 2007. [online]. Christian Health Association of Lesotho, Ministry of Health, Government of Lesotho website. [Accessed 24/10/2007]. <http://www.health.gov.ls/partners/partners_service.php>
10. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP bibliography: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
11. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
12. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.
13. Dimmock F. 2008. Personal correspondence. Advisory group. ARHAP-Gates FBO-Landscaping project.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

SOUTHERN AFRICA - ZAMBIA

WHO MORTALITY SUMMARY[22]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	5.8	5.8	11.7
Life expectancy (years)	2004	40	40	40
Under-5 mortality (per 1000 live births)	2004	190	173	182
Adult mortality (per 1000)	2004	683	656	
Maternal mortality (per 100000 live births)	2000		750	

OTHER HEALTH INFORMATION 22	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	16.5
Total expenditure on health as % of GDP	2003	5.4
Per capita expenditure on health at ave exchange rate $US	2003	21

TOP TEN CAUSES OF DEATH ALL AGES - ZAMBIA 2002 22	DEATHS (000)	YEARS LIFE LOST %
All causes	224	100
HIV/AIDS	96	42
Lower respiratory infections	26	13
Malaria	19	10
Diarrhoeal diseases	15	8
Perinatal conditions	7	5
Tuberculosis	7	3
Cerebrovascular disease	4	1
Ischaemic heart disease	4	1
Measles	2	2
Road traffic accidents	1	1

COUNTRY INFORMATION1, [19,16]

Geography: Located in Southern Africa, Zambia is a landlocked country with an area of 752,612km2, surrounded by Angola, Botswana, DRC, Malawi, Mozambique, Tanzania, Namibia, and Zimbabwe.

Capital: Lusaka

Language: English (official). There are over 80 languages spoken, 5 officially used in education and administration: Bemba, Lozi, Nyanja, Tonga and Tumbuka.

Politics: Zambia gained its independence from Britain in 1964. Following the introduction of multiparty democracy in 1991, the MMD came to power and has remained there since. Zambia underwent major economic changes due to the Structural Adjustment Program implemented in the 1990s which had an impact upon the public provision of health, education and community services. Privatization also saw major changes to the mining industry which has historically been the economic backbone of Zambia. Political instability among its neighbors, Angola, Namibia, Zimbabwe, DRC, and Mozambique has had a strongly negative impact upon the economy.

Administration: Zambia is divided into 9 administrative districts

RELIGION IN ZAMBIA[1]

Zambia is a predominantly religious nation, officially declared a Christian nation in 1991. 85% Christian; 5% Muslim; 5% other faiths, including Hinduism and the Baha'i Faith; 5% atheist. Among the Christians, there are: Catholics(32%), Mainline Protestants(~27%), Evangelical Protestants(12.5%), and Charismatic Pentecostals(~20.2%). Pentecostal Charismatics are clearly the fastest growing religious body in Zambia. African Traditional Religions are not dominant in the public eye, but are evident as a minority tradition in many communities. Islam is growing in Zambia, and is strong in the eastern province.

EXAMPLES OF FBOS WORKING IN ZAMBIA

National Faith-based Health Networks: Christian Health Association of Zambia (CHAZ), Zambian Inter-Faith Networking Group ZINGO, Traditional Health Practitioners Association of Zambia (THPAZ). . .

International FBOs: CAFOD, Caritas, Care, Catholic Relief Services, Christian AID, LWF, Interchurch Medical Assistance (IMA), Salvation Army, World Vision International, YWCA. . .

National FBOs: Zambia Christian Refugee Service, Cheshire Home, St Francis Care. . .

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

Zambia is characterised by a significant presence of FBOs active in health, from facility-based health providers to non-facility based community activities. ARHAP research in Zambia in 2006 found a significant portion of these organizations were working in the health sector "under the radar" with little recognition or acknowledgement.[1] *Secondary literature states that faith-based organisations and networks currently represent between 30-50% of health provision in Zambia.* This range is depicted by the following statements:

- → "The Christian Health Association of Zambia operates 30% of all health services."[16, 17]
- → "Mission hospitals provide slightly over 50% of formal health care in rural areas and about 30% of total health care at national level."[15]
- → "Religious organizations provide up to 40% of health provision in Zambia."[21]
- → "In Zambia, 53% of hospitals are owned by religious groups."[3, see 9]
- → "Up to 50% of healthcare provision in Zambia is through church-owned hospitals."[18]

2. THE HISTORY OF FAITH AND HEALTH

While less has been written on the history of traditional African religions' involvement in health, Zambia does have a rich mission history, with the Christian faith being introduced by foreign missionary groups in the 1890s and immediately setting up health outposts and hospitals. Many Zambian FBOs have been profiled in secondary literature, e.g. Mazala notes that "Catholic and Salvation

Summary of Health Institutions by Type, Size and Ownership

The following tables (except Table 1.1a) come directly from *"Health Institutions in Zambia. A Listing of Health Facilities According to Levels and Location for 2002"* by the Central Board of Health.

Table 1.1a: Summary of Health Institutions by Type , Size and Ownership

System Level	Partner	Nbre	Beds	Cots	Total	%
1st Level Hospitals	Government	30	2383	344	2727	36%
	Mission	28	2755	515	3271	43%
	Private	12	1323	491	1814	24%
	Total	70	6461	1151	7612	100%
2nd Level Hospitals	Government	12	3334	741	4075	67%
	Mission	5	1780	163	1753	29%
	Private	1	209	84	293	5%
	Total	18	5133	988	6121	100%
RHC	Government	980	8467	568	9035	82%
	Mission	60	1696	141	1836	17%
	Private	24	90	1	100	1%
	Total	1072	10258	714	10972	100%
UHC	Government	177	1300	250	1550	89%
	Mission	0	0	0	0	0%
	Private	62	138	61	199	11%
	Total	218	1438	311	1752	100%

Source: CCIH 2007

Army HBC programs are among the most long standing and effective in Africa".[15] It is also significant that Zambia has an extremely high level of religiosity and religious community involvement.[12] It has been noted that until the 1960's most health care was provided by various Christian denominations in Zambia.[15]

The general health status of Zambia's population has worsened over the past decade, with infant and maternal mortality one of the highest in Africa. In 1992, the Zambian Government began taking a new decentralized approach to health services, which marked a radical departure from past approaches, often centralized and non-consultative. Despite the MOH's accomplishments, much remains to be done before all Zambians have access to quality

SOUTHERN AFRICA - ZAMBIA

health care.[1] Like other countries in SSA, Zambia has been hard hit by epidemic diseases such as HIV/AIDS and workforce crises in the health sector. When Chiluba and the MMD came to power, Zambia was declared to be a Christian nation, and this was followed by the establishment of a religious desk in state house and government funding of religious groups. "by the mid 1990s in Zambia, (i) poverty and unemployment were on the increase due to the Structural Adjustment Program and privatization, (ii) the public health sector was struggling for the same reasons; and (iii) there was a rise in the public profile of Evangelical and Pentecostal Christianity."1 This situation (the emerging health and humanitarian crisis, the availability of financial grants to FBOs, and the emergence of public structures such as the District AIDS Task Forces which drew on the clergy as an important leadership constituency) helps to explain a dramatic proliferation of religious entities and initiatives in Zambia in the past decade, in particular since 2005, many of whom are involved in promoting health and wellbeing in a variety of ways. This is altering the nature of the religious contribution to health in Zambia.[See 1,4]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAZ: THE CHRISTIAN HEALTH ASSOCIATION OF ZAMBIA

History: CHAZ was formed in 1970 (then as CMAZ: The Churches Medical Association of Zambia) through the merging of the Medical Committee of the Christian Council of Zambia and the health department of the Zambia Episcopal Conference, following a recommendation by the World Council of Churches. CHAZ represents the interests of church administered health institutions in Zambia.[6]

Membership: CHAZ is the national network of mission hospitals and health centres operated by 16 churches, and also includes non-institutional members. [2,16,17]

Facilities: 92 health facilities including 31 hospitals and 58 rural health centres,16 based in all regions of the country, providing 30% of all health care and 50% of rural health care.6

Activities: CHAZ provides member churches with representation and advocacy, administrative and logistical support, technical support, and resource mobilization assistance.6 The MOH, through CBOH contracts with CHAZ for provision of health services and it pays the salaries of CHAZ employees.16 Church Hospitals given 75% operating budget, decentralised to District Health Boards.2 An MOU was signed between CHAZ and the Zambian government in 1996.

4. COLLABORATION AND PARTNERSHIP ON HEALTH

Because of Zambia's status as a Christian nation, and the prominence of religious groups and leaders in a wide variety of government working groups and positions, it appears that Zambia has a strong collaborative framework in which FBOs are able to function. Research found a great deal of integration between FBOs and public health facilities. There is also integration as a result of many religious leaders also working in state entities – that is, there appear to be many individuals who "wear many different hats". This, in turn, builds institutional networks.[1] The HIV/AIDS epidemic has also resulted in increased multi-sectoral collaboration between FBOs and secular organisations.[1] Leaders of Christian FBOs are particularly engaged in networks, both religious (e.g. the Expanded Church Response Taskforce and ZINGO) and public (e.g. the District AIDS Task Force). Networks include a number of important entities that are not "indigenous" to the area, and which suggest that FBOs in a local context draw strength from a wide network of local, national and international relationships. This includes "mother bodies" of the churches CCZ and EFZ, as well as health and development agencies. Christian FBOs are integrated into these networks much more than FBOs of other faiths, and non-Christian religious groupings seemed isolated at times, despite these other groups also working in health. 1 It has been noted that most of the parent network organisations are situated in Lusaka.[24]

5. KEY RESOURCES

1. ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa.* Cape Town: Report for the World Health Organisation, African Religious Health Assets Programme.
2. Baer FC. 2007. [online]. FBO health networks and renewing primary health care. [Accessed 03/03/2008]. <http://renewingphc.org/fbos/FBOs_and_renewing_PHC.htm>
3. Baird TL. 1999. Christian hospitals in Nigeria provide post abortion care and STD management. *CCIH Forum (March),* Christian Connections for International Health.
4. CADRE. 2007. OSISA study report. Personal correspondence with Karen Birdsell, 15/11/2007.
5. CHAZ. 2006. Christian Health Association of Zambia website. [online]. [Accessed 20/03/2006]. <www.chaz.org.zm>
6. CCIH. 2007. [online]. GRHAM Mapping of ECC. [Accessed 01/08/2007]. <http://ccih.org/grham/>
7. Central Statistics. 2003. Zambia Demographic and Health Survey (ZDHS) 2001-2002. Calverton Maryland USA: Central Statistical O.ce, Central Board of Health, and ORC Macro.
8. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
9. Hackney TS. 2000. *The invisible giant: The Christian health system.* MPH degree. Atlanta, GA: Emory University.
10. Government of Zambia. 2004. *Revised MOU between the Christian Health Association of Zambia and the Government of Zambia – revised 2004.* Lusaka, Zambia: Republic of Zambia.
11. Lucas S. 2004. Community, care, change, and hope: Local responses to HIV in Zambia. Synergy project: *A lessons learned case study.* (SSS) Social and Scientific Systems.
12. Asunka J, Gyimah-Boadi E and Mattes R. 2008. *Religion and democratic development in Africa.* Forthcoming.
13. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP bibliography: Working in a bounded field of unknowing.* Cape Town, South Africa: African Religious Health Assets Programme, University of Cape Town.
14. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
15. Mazala EM. 2003. *Situational analysis of the church response to HIV/AIDS in Zambia.* Lusaka: Expanded Church Response Trust (ECR) and Pan African Christian Aids Network (PACANET).
16. MOH-Zambia. 1998. *Zambia national health accounts 1995-1998.* Lusaka: Ministry Of Health / Central Board of Health. Government of Lesotho.
17. MOH-Zambia. 2002. *Zambia national health accounts 1995-1998.* Lusaka: Ministry Of Health / Central Board of Health. Government of Lesotho.
18. Nussbaum S (ed). 2005. *The contribution of Christian congregations to the battle with HIV and AIDS at the community level.* Oxford, Global Mapping International for Oxford Centre for Mission Studies.
19. Parry S. 2002. *Responses of the churches to HIV/AIDS: three Southern African Countries.* Harare and Geneva: (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office.
20. RCZ. 2007. *Directory of congregations and institutions.* Lusaka, Zambia: Reformed Church in Zambia.
21. Robinson M and White G. 1998. The role of civic organisations in the provision of social services: towards synergy. In: G Mwabu, C Ugaz and G White (eds), *New patterns of social provision in low income countries.* Oxford: Oxford University Press and UNI.WIDER.
22. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.
23. Zambezi RN. 2005. *Church-based interventions for HIV/AIDS prevention in Ndola, Zambia.* MPH. Department of Global Health Rollins School of Public Health, University of Exeter, Emory University.
24. ZINGO. 2002. Faith-based organisations (FBO) responses to *HIV/AIDS in Livingstone, Lusaka and Kitwe – Zambia. Strategic visioning for a Zambia free of HIV/AIDS.* Lusaka: Zambia Interfaith Networking Group on HIV/AIDS and the National AIDS Council of Zambia.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

SOUTHERN AFRICA - MALAWI

WHO MORTALITY SUMMARY[11]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	6.4	6.5	12.9
Life expectancy (years)	2004	41	41	41
Under-5 mortality (per 1000 live births)	2004	179	172	175
Adult mortality (per 1000)	2004	663	638	
Maternal mortality (per 100000 live births)	2000		1800	

OTHER HEALTH INFORMATION[11]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	14.2
Total expenditure on health as % of GDP	2003	9.3
Per capita expenditure on health at ave exchange rate $US	2003	13

TOP TEN CAUSES OF DEATH ALL AGES - MALAWI 2002[11]	DEATHS (000)	YEARS LIFE LOST %
All causes	252	100
HIV/AIDS	86	35
Lower respiratory infections	29	13
Malaria	20	10
Diarrhoeal diseases	19	9
Perinatal conditions	8	4
Cerebrovascular disease	7	1
Ischaemic heart disease	6	1
Tuberculosis	6	2
Road traffic accidents	3	1
Protein-energy malnutrition	2	1

COUNTRY INFORMATION[12]

Geography: Located in Southern Africa, landlocked Malawi shares borders with Mozambique, Tanzania and Zambia, is 118,480km2 in total.

Capital: Lilongwe

Language: Chichewa 57.2% (official), Chinyanja 12.8%, Chiyao 10.1%, Chitumbuka 9.5%, Chisena 2.7%, Chilomwe 2.4%, Chitonga 1.7%, other 3.6%.

Politics: Established in 1891, the British protectorate of Nyasaland became the independent nation of Malawi in 1964. After three decades of one-party rule the country held multiparty elections in 1994, under a provisional constitution which came into full effect the following year. President Mutharika, elected in May 2004, struggled to assert his authority against his predecessor, culminating in Mutharika starting his own party, the Democratic Progressive Party (DPP), and has continued with a halting anti-corruption campaign against abuses carried out under the previous regime. Increasing corruption, population growth, increasing pressure on agricultural lands, and the spread of HIV/AIDS pose major problems for the country.

Administration: 27 administrative districts. These districts all have traditional authorities, or former chieftains, who serve as the local government throughout the country.10

Urban Rural Split: The economy is predominately agricultural, with about 85% of the population living in rural areas.

RELIGION IN MALAWI

~80% Christian; 13% Muslim; 5% traditional African religions; and 2 % Hindu or other faiths. 10 Major Christian denominations are Catholics(25%), Protestants(20%), and AICs(17%); groups like Evangelicals and Pentecostals are rapidly growing in Malawi, particularly in urban areas, and together account for about 32% of the country's Christians. Muslims comprise the majority in the South and Protestants dominant in the North.[8]

EXAMPLES OF FBOS WORKING IN MALAWI

National Faith-based Health Networks: Christian Health Association of Malawi (CHAM)…

International FBOs: Emmanuel Healthcare, Presbytarian Church USA, Word Alive Ministries, World Relief, Church of Central Africa Presbytarian, Adventist Development and Relief Agency, Catholic Development Commission…

National FBOs: Muslim Association of Malawi, Assemblies of GOD AIDS Response Programme…

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

TABLE 3.1 DISTRIBUTION OF HEALTH FACILITIES IN MALAWI, BY OWNERSHIP, 1998

	MOHP	Local Govt	Other Govt	CHAM	Firms	Private*	Total
Central hospitals	3	0	0	0	0	0	3
District hospitals	22	0	0	0**	0	0	22
Hospitals	1	0	0	22**	7	3	33
Mental hospitals	1	0	0	0	0	0	1
Rural Hospital	18	0	0	16	0	0	34
Urban Health Centers	8	0	0	0	0	0	8
Health Centers	193	11	33	55	36	10	371
Maternity Units	0	12		4	0	11	27
Dispensaries	45	3	5	13	83	76	225
Closed	2	0		0	0	0	2
Total	291	26	40	146	126	100	729
Percentage share (%)	39.9	3.6	5.5	20.0	17.3	13.7	100

* There are of course exceptions to NGO direct provision such as Banja La Mtsogolo.

Source: Government of Malawi 2001

Malawi ranks among the world's least developed countries. It shares many of the same challenges as its neighboring states do - including a weakened health system and a variety of public health and development challenges, ranging from a rampant HIV/AIDS epidemic, to the technical problems of medical workforce crisis. The extremely high maternal mortality ratio in Malawi can be seen as evidence of the lack of trained midwives and access to care in Malawi.[13] Health service providers in Malawi can also be separated into the traditional and modern sectors, with a large number of people using the two systems simultaneously or consecutively. "There are two main categories of *traditional health providers:* traditional healers dealing with diseases/spirits, and traditional birth attendants (TBAs). TBAs have more established links with the modern health sector, having been trained to support primary health care since 1992."[2] Within the modern health sector, there are three main health service providers namely; the public sector, non-profit private sector and the private-for-profit sector.

The Ministry of Health and Population (MOHP) is the largest provider of public health services.[2] The non-profit private sector comprises the mission sector grouped mainly under the Christian Health Association of Malawi (CHAM).[2] *Secondary literature states that faith-based organisations and networks currently provide between 35-40% of health services in Lesotho.*[4,9,10]

→ As can be seen in the table insert, the MOHP has the largest number of facilities (39.9% of the total health facilities), followed by CHAM (20%).[2] Two specialist hospitals have been added to the CHAM membership since this table was produced: St John of God Mental Hospital and Cure Children's Orthopedic Hospital.[13]

2. HISTORY OF FAITH AND HEALTH

The arrival of Arab merchants and the British in Malawi brought with them Islam and Christianity respectively. Missionary David Livingstone is one of the fathers of Christianity in Malawi. The early Christian missionaries not only spread their religion but also provided social services such as schools and hospitals. Christian churches grew quickly and, in some cases, were looked upon as vehicles for modernization. "To this day, religion in Malawi, especially Christianity, has a strong service and development dimension. Christian churches and organisations in Malawi boast over 159 health facilities, 200 schools, numerous successful businesses, farms, recreational facilities and a myriad of churches. The clergy are respected and highly *esteemed members of society." [10] Churches in Malawi play a vocal role in matters ranging from politics and policy to health and development. "Collectively, they have an infrastructure that is even more vast than that of the government, covering every district, town and village in the country, and functioning as a source of education, health, agricultural and financial information and service delivery." [10]*

SOUTHERN AFRICA - MALAWI

The HIV/AIDS epidemic has also spurred on religious involvement in health. FBOs have been involved in the epidemic since its early stages, with religious leaders taking a vocal position (although not unmarred by controversy and failures in understanding the complicated nature of the epidemic, fuelling stigma and discrimination). However, as the 2004 UNFPA report notes, "Faith-based organisations have come a long way since 1985 in helping to care for the spiritual, material and physical needs of those affected by HIV/AIDS. Moreover, this support is growing. In the last five years alone, at least 40 religious institutions have begun responding to the HIV/AIDS epidemic on a national and local level. The potential to expand this support through carefully formed partnerships is enormous."10 It is, however, interesting to note that the UNFPA report continues to recognize that despite having a vast coverage, and immense *potential,* the majority of FBOs are concentrated in the South and Central regions – making HIV/AIDS-related efforts in the northern part of the country scarce. Moreover, the work of religious organisations is concentrated in urban centers, in part because funds for HIV/AIDS projects are more readily available there. [10]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAM: THE CHRISTIAN HEALTH ASSOCIATION OF MALAWI

History: CHAM was established in 1966 under the name "Private Hospitals Association of Malawi" following a meeting of the World Council of Churches and church leaders in Malawi. In 1991 the Association changed its name to "Christian Health Association of Malawi" to reflect its Christian identity and its focus on broader health ministry as opposed to the previous name with reference to the terms "Private Hospital".[6]

Membership: Membership consist of 18 different churches and church organisations, i.e. ecumenical and interdenominational churches that operate health facilities, and CHAM includes both Catholic and Protestant hospitals. There are also 12 associate members.

Facilities: 28 hospitals and 125 health centres, making up ~ 37% of the NHS.[1] (these figures are disputed)

Activities: the improvement and expansion of health facilities, facilitation of interdenominational cooperation, collaboration with government and other organisations, the development and coordination of training programmes including nursing schools, the provision and coordination of support services.[1, 2]

Challenges: lack of medical supplies and hospital beds, shortage of trained personnel and volunteer counsellors, increased exposure of medical personnel to HIV infection, limited human resources and long-term funding. [10]

4. COLLABORATION AND PARTNERSHIPS ON HEALTH

There are some indications that collaboration between FBOs (such as CHAM) and the Malawian government is not as strong as it is in some neighboring countries such as Zambia. There is, however, an MOU between the government of the republic of Malawi and CHAM, revised in 2002. This MOU is structured on the understanding that it is the Malawian Government's primary responsibility "to provide health services to the nation and CHAM's role is to complement Government efforts in line with Government policy."[3] Towards this end, the government undertakes to provide financial assistance to CHAM units. Nevertheless, a 2004 UNFPA study notes that (in the context of HIV/AIDS), "most faith-based organisations and religious institutions involved in HIV/AIDS prevention and care feel that they have been marginalized to a large extent by the government and NGOs…(hindering) the formation of long-term partnerships. The result is that many faith-based organisations have carried out their work without due attention and recognition."[10] This has resulted in an interesting situation in Malawi where FBOs are *mainly* working in partnership with other FBOs. As the UNFPA study notes, "this has limited the funding that is available to them and kept their efforts out of international view. Some religious institutions have been able to tap funding from sister organisations abroad, usually within the same denomination. Those without international connections have been forced to raise funds from the meagre resources available within Malawi."[10] Therefore, not only does multisectoral health-related activities appear restrained, but there are also limited relations between FBOs and the traditional health sector, e.g. in 2004, only one FBO was noted as having activities which involved and targeted cultural leaders and traditional healers.[10]

5. KEY RESOURCES

1. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005*. (CCIH) Christian Connections for International Health Conference.
2. Government of Malawi. 2001. *National Health Accounts (NHA): A broader perspective of the Malawian health sector, 1998/9 financial year.* Lilongwe, Malawi: Ministry of Health and Population, Republic of Malawi.
3. Government of Malawi. 2002. *Memorandum of Understanding between the Christian Health Association of Malawi and the Government of Malawi, 09 Dec 2002.* Llilongwe: Government of Malawi.
4. Green A, Shaw J, Dimmock F and Conn C. 2002. A shared mission? Changing relationships between government and church health services in Africa. *International Journal of Health Planning and Management.* **17,** pp.333-353.
5. Malawi Report. 2001. Towards Government-religious organisations collaboration in HIV/AIDS prevention and care. *In: S Parry. Responses of the faith-based organisations to HIV/AIDS in sub-Saharan Africa.* 2003. Harare and Geneva: WCC and EHAIA.
6. IDT. 1998. *Religious health networks survey report.* Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.
7. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town
8. Trinitapoli J and Regnerus R. 2005. Religious responses to AIDS in sub-Saharan Africa: An examination of religious congregations in rural Malawi. *American Sociological Association Annual Meeting, Philadelphia, PA.*
9. UNFPA. 2007. *Malawi: mobilizing traditional and religious leaders in the fight against HIV/AIDS.* Lessons from the Field: United Nations Population Fund. [Accessed 11/14/2007]. <www.unfpa.org/culture/case_studies/malawi_study.htm>
10. UNFPA. 2004. *Culture matters: working with communities and faith-based organisations: case studies from country programmes.* New York: United Nations Population Fund.
11. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organisation, Regional Office for Africa.
12. CIA. 2007. [online]. *CIA – the 2008 world factbook.* [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
13. Dimmock F. 2008. Personal correspondence. Advisory group. ARHAP-Gates FBO-Landscaping project.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

EAST AFRICA – KENYA

WHO MORTALITY SUMMARY[21]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	17.2	17.1	34.3
Life expectancy (years)	2004	51	50	51
Under-5 mortality (per 1000 live births)	2004	129	110	120
Adult mortality (per 1000)	2004	477	502	
Maternal mortality (per 100000 live births)	2000		1000	

OTHER HEALTH INFORMATION[21]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	6.7
Total expenditure on health as % of GDP	2003	4.3
Per capita expenditure on health at ave exchange rate $US	2003	20

TOP TEN CAUSES OF DEATH ALL AGES - KENYA 2002 [21]	DEATHS (000)	YEARS LIFE LOST %
All causes	376	100
HIV/AIDS	144	40
Lower respiratory infections	37	11
Diarrhoeal diseases	24	8
Tuberculosis	19	5
Malaria	18	6
Cerebrovascular disease	14	1
Ischaemic heart disease	13	1
Perinatal conditions	13	5
Road traffic accidents	7	2
Chronic obstructive pulmonary disease	6	1

COUNTRY INFORMATION[7, 15]

Geography: Eastern Africa, bordering the Indian Ocean, between Somalia and Tanzania, 582,650 km2

Capital: Nairobi

Language: English (official), Kiswahili (official), numerous indigenous languages - Kenya's social diversity is reflected in various ethnic groups. They are divided on a linguistic basis into Bantu, Nilotic and Cushitic groups.
Politics: Kenya has been politically stable since independence in 1963. After nearly 30 years of single party rule, the country introduced multi-party democracy in 1991. An election-related conflict situation developed in 2008.

Administration: 7 provinces and 1 area.

Urban Rural Split: 80% of the country's population lives in remote rural areas.10

EXAMPLES OF FBOS WORKING IN KENYA

National Faith-based Health Networks: Christian Health Association of Kenya, Kenya Episcopal Conference. . .

International FBOs: Catholic Medical Mission Board, Catholic Relief Services, Ecumenical Pharmaceutical Network, German Institute for Medical Mission, Inter-Church Organisation for Development, IMA World Health, MAP, Mildmay, Medicus Mundi, Salvation Army, Scripture Union, Tearfund, World Council of Churches, World Vision, YWCA, All Africa Conference of Churches. . .

National FBOs: Centre for Urban Mission, Faraja Trust, Inter-Diocesan Christian Community Services, Mission for Essential Drugs and Supply, Fellowship of Christian Unions, Children of God Relief Institute
Sustainable Healthcare Foundation. . .

RELIGION IN KENYA[7]

Protestant 45%, Roman Catholic 33%, Muslim 10%, indigenous beliefs 10%, other 2%. A majority of Kenyans are Christian, but estimates for the percentage of the population that adheres to Islam or indigenous beliefs vary widely.

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

Like other SSA countries, Kenya has a fragile health system. A stated aim of Kenya's health care policy is to provide cost-shared health services and to locate a health facility within 10 kilometres of each citizen. WCC research notes that the increase in the number of health facilities and hospital beds has more than kept pace with the growth in population. However, many rural families continue to have limited access to health care due to the inability to pay user charges, the lack of transport and lack of drugs and other essential supplies to local health centres.[15] Although less is known about community-based projects run by FBOs, especially congregational activities, the facility-based health-providing FBOs have a strong and organised presence in the Kenyan health sector. *Secondary literature states that faith-based organisations and networks currently provide more than 40% of health services in Kenya.* This is depicted by the following statements:

→ "The present Minister of Health, Hon. Mrs. Charity Ngilu, recently recognized the work of FBOs and singled out the Catholic Church as contributing up to 40% of the national struggle against HIV/AIDS."[3]

→ In Kenya there are 974 faith-based facilities, 964 belonging to KEC and CHAK together - providing 40% of national health services.[18] (see adjacent table) "KEC and CHAK together have an allocation volume of 10 million - of whom about 1.5 million are inpatients and about 700,000 actual admissions per year."[14]

Capacity and distribution of faith based health facilities

	Large hospital (Secondary referral)	Medium hospital (Primary referral)	Health Centre	Dispensary	Programs (CBHC)	Total
KEC	10	35	92	282	46	465
CHAK	7	19	47	317	52	442
Others			4	23	40	67
Total	17	54	143	622	138	974

Source: Mwenda 2007

2. THE HISTORY OF FAITH AND HEALTH

Less is known about the historical involvement of non-mainline religions in health, e.g. the role of traditional religions and healers, other minority religions, as well as the more recent growth of charismatic FBOs. The mainline religions have historically set up health centres and hospitals as missionaries arrived in Kenya. e.g. Catholic health care in Kenya has a long history, dating back to pre-independent Kenya in the early 1900s and continuing to present day. These FBOs have traditionally provided to communities in remote areas where other health providing agencies do not have infrastructure.[7] There is also records of Islamic hospitals and health centers being established during the colonial period, e.g. the Aga Khan Hospital in Nairobi was opened in 1958.[1] More recently, as in other fragile African health systems, FBOs working in health have come under increasing strain. An area of particular concern has been the issue of workforce, with thousands of health professionals leaving the country. Another area of crisis for FBOs arose in the 1990s, when "much of the support FBOs (in Kenya) were getting from the big congregations, churches and donors, as well as the assistance received from the government from as far back as the fifties and sixties, came to an end."[14] FBOs have also become involved in responses to epidemics such as HIV and AIDS, e.g. the Presbyterian Church of East Africa has had HIV/AIDS prevention, care and support programmes in the country since the late 1980s.See [15]

EAST AFRICA – KENYA

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. CHAK – THE CHRISTIAN HEALTH ASSOCIATION OF KENYA

History: CHAK was established in 1930 and is an umbrella organisation of health facilities or programs owned by Christian denominations or missionary groups who are providing health services in Kenya. It is estimated that CHAK members provide 20-40% of the Kenyan national health service.[4,5,6,10]

Membership: CHAK members are affiliated to 33 Protestant church denominations. [4, 5,6]

Facilities: CHAK has 455 registered members, including 25 hospitals, 48 health centres, 324 dispensaries, 10 nursing training colleges and 58 church health programs.4, 7 Most are in rural areas where 80% of the country's population lives.[7,20]

Activities: CHAK's core functions on behalf of its members are advocacy & representation, capacity building, health care technical services, technical support, networking, communication and HIV/AIDS programs.4,7 CHAK member facilities provide a wide range of preventive, rehabilitative and curative health services.[4]

e.g. KENYA EPISCOPAL CONFERENCE (KEC) - CATHOLIC HEALTH COMMISSION (CHC)

History: Catholic health care provision in Kenya dates back to pre-independent Kenya in the early 1900s. Catholic health care facilities provide health care to communities in "remote places (with no) health providing infrastructure."7 CHC provides oversight and coordination of Catholic health facilities, "the members" being the facilities themselves.

Facilities: 430 units including: 45 hospitals, 92 health centers, 282 dispensaries and 46 community based programmes.

Activities: CHC provides oversight, advocacy, lobbying and representation capacity building, networking, and management to its members. CHC membe facilities provide a holistic and wide range of preventive, rehabilitative an curative health services and programs.[21]

4. COLLABORATION AND PARTNERSHIP ON HEALTH

Although there have been disputes in the past, there appears to be developin collaborative structures and channels between CHAK, KEC and the Kenya government, and several working groups, such as the *Technical Working Grou Ministry of Health-Faith Based Health Services (MOH-FBHS-TWG).* During a recen HR crisis when nurses from the FBOs were being recruited into the governmen health facilities, swift advocacy on the part of CHAK and KEC appeared t generate dialogue and have working results.[3,4] There is strong collaboratio between the mainline Christian health providers, e.g. CHAK and KEC jointly ow the MEDS project, which provides essential drugs and medical supplies, as we as training of church and other not-for-profit health facilities in the managemen and appropriate use of drugs. "MEDS' current clientele of more than 1,50 health facilities in Kenya and other countries (Sudan, DRC, Ethiopia, Somali and Tanzania) include church facilities, other FBOs, NGOs, relief agencies, donor funded public health-care projects, community-based health-care initiatives, an a number of government facilities."[3] This provides some indication of the leve of cross-over and collaboration that exists in Kenya. There is also inter-religious and religious-secular collaboration in Kenya, often built around the HIV and AID epidemic – e.g. seen in the *Kenya Inter Religious AIDS Consortium* (KIRAC).[15] CHA was recently appointed to host the first secretariat for African Countries CHA a platform intended to support and coordinate networking, communicatio sharing of information, experiences and planning for the African CHAs.[4]

5. KEY RESOURCES

1. AKDS. 2007. [online]. AKDS website. [Accessed 03/08/2007]. <http:www.akds.org/>
2. CCIH. 2007b. [online]. GRHAM Mapping of ECC. [Accessed 01/08/2007]. <http://ccih.org/grham/>
3. CHAK. 2007. [online]. Christian Health Association of Kenya website. [Accessed 01/08/2007]. <http;//www.chak.or.ke>
4. CHAK. 2006. Annual Report 2006. Christian Health Association of Kenya. [online]. [Accessed 01/08/2007]. <http;//www.chak.or.ke>
5. CHAK. 2005. Christian Health Association of Kenya. Brochure. Nairobi: Christian Health Association of Kenya. [online]. [Accessed 01/08/2007]. <http;//www.chak.or.ke>
6. CHAK. 2007. *A situational analysis study of the faith based health services vis-à-vis the government health services.* Report to the MOH-FBHS Technical Working Group. Christian Health Association of Kenya and German Technical Cooperation.
7. CIA. 2007. [online]. *CIA – the 2008 world factbook.* [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
8. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
9. EPN. 2007. [online]. Ecumenical Pharmaceutical Network website. [Accessed 20/08/2007]. <http://www.epnetwork.org>
10. IDT. 1998. *Religious health networks survey report.* Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.
11. IHP. 2003. Role and involvement of faith-based organisations in HIV/AIDS pandemic: brief summary: Inventory of the Catholic Church's response to HIV/AIDS in Kenya. (ICASA) *International Conference in HIV/AIDS and STDs in Africa.* Kenya, (IHP) Emory Interfaith Health Program
12. Kenya Catholic Secretariat. 2003. *Inventory of the Catholic Church's response to HIV/AIDS in Kenya.* Nairobi, Kenya: Kenya Episcopal Conference.
13. Makau N, Niemeyer LL and Okello N. 1996. *The response of Kenya churches to the AIDS epidemic and their perceived barriers to behaviour change.* Nairobi, Kenya: MAP International.
14. Mandi F. 2006. Planning, developing and supporting the faith-based health workforce. *African Christian Health Associations' Human Resources for Health Mini-Forum.* Nairobi, Kenya: The Capacity Project and Medicus Mundi International.
15. Molonzya M. 2003. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in six countries of Eastern Africa.* Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa.
16. Musau, Stephen *et al.* 1999. *Health financing in mission hospitals - Cost study for East Africa.* Nairobi, Kenya: Management Sciences for Health /USAID Kenya.
17. Musau, Stephen et al. 1998. *Cost analysis for PCEA Chogoria Hospital - Case study.* Nairobi, Kenya: Management Sciences for Health, USAID Kenya.
18. Mwenda S. 2007. HR crisis in Kenya, the dilemma of FBOs. *Church Health Association Conference, Dar es Salaam/Bagamoyo Tanzania.* Christian Social Services Commission.
19. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
20. Webster L. 2005. *From policies to people: an analysis of the mechanisms in place to resource community responses to HIV and AIDS in Kenya.* Tearfund HIV/AIDS Briefing Paper 6. Teddington, UK: Tearfund.
21. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this count – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

EAST AFRICA - UGANDA

WHO MORTALITY SUMMARY [28]	YEAR	MALES	FEMALES	BOTH SEXES
Population (millions)	2005	14.4	14.4	28.8
Life expectancy (years)	2004	48	51	49
Under-5 mortality (per 1000 live births)	2004	144	132	138
Adult mortality (per 1000)	2004	525	446	
Maternal mortality (per 100000 live births)	2000		880	

OTHER HEALTH INFORMATION [28]	YEAR	%
HIV prevalence among adults (15 - 49) Both sexes	2003	4.1
Total expenditure on health as % of GDP	2003	7.3
Per capita expenditure on health at ave exchange rate $US	2003	18

TOP TEN CAUSES OF DEATH ALL AGES - UGANDA 2002 [28]	DEATHS (000)	YEARS LIFE LOST %
All causes	380	100
HIV/AIDS	94	24
Malaria	41	13
Lower respiratory infections	39	13
Diarrhoeal diseases	30	9
Perinatal conditions	16	5
Tuberculosis	**15**	**3**
Cerebrovascular disease	11	1
Ischaemic heart disease	10	1
Measles	7	3
Tetanus	7	3

COUNTRY INFORMATION[11]

Geography: Uganda is located in East Africa bordered by Kenya, Tanzania, Burundi, DRC, Rwanda and Sudan. Uganda's total area is 236,040 km^2.
Capital: Kampala

Language: English (official). 2 major linguistic groups: Bantu and Nilotic.

Politics: Following the fall of the military regimes in 1986, a series of political and economic reforms have been implemented. However, military opposition has persisted in some areas, denying these areas on-going national development initiatives and increased risk of disease infection.

Administration: 56 administrative districts.

Urban Rural Split: Uganda has a predominantly rural population.

RELIGION IN UGANDA[11, 24]

There are conflicting stats for religion in Uganda. Generally, Uganda is a highly religious, but officially secular state. Predominantly 66% Christian (33% Catholic & 33% Protestant), 16% Muslim, and indigenous beliefs 18%.

EXAMPLES OF FBOS WORKING IN UGANDA

National Faith-based Health Networks: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB), represent the majority of the facility-based FBO PNFP organizations in Uganda[1]. . .

International FBOs: Church Missionary Society, Africa Inland Church, Bible Churchman's Missionary Society, Young Women's Christian Association of Uganda. . .

National FBOs: Joint Medical Store, Church Human Services AIDS Program, Youth Alive Uganda, Scripture Union of Uganda, IRCU, Islamic Medical Association of Uganda, THETHA. . .

1. FAITH-BASED ORGANISATIONS AND NETWORKS IN NATIONAL HEALTH SYSTEM(S)

Uganda currently has one of the poorest health infrastructures in SSA. It has a high prevalence of illness and the associated temporary or permanent disability. Access to quality health care is limited, and geographical access is limited to 47% of the population.[11] Although Uganda's economy has enjoyed a high economic growth rate, but despite various health sector reforms, Uganda's health system has been described as being chronically under funded.[10] As with other countries in SSA, workforce problems continue to be a major challenge with staff shortages and the problem of mal-distribution of staff. *Secondary literature states that faith-based organisations and networks currently provide between 20-60% of health services in Uganda.* This range is depicted by the following statements:

- "Hospitals run by (FBOs) have long provided over 50% of beds and 60% of hospital services in Uganda." [3]
- "Currently, facility-based PNFPs are for the largest majority belonging to religious denominations and are coordinated by three (faith-based) Medical Bureaus. The three networks own 44 (42.3%) of the 104 hospitals, 558 (22%) of the 2,536 lower level health facilities and 19 (70.7%) of the 27 nursing and midwifery training schools in Uganda.[3]
- "…autonomous dioceses and parishes own 70% of all private not-for-profit health facilities, which total 450 lower-level units and 42 hospitals….The rest are owned by NGOs (16%), some of which are also religious, community-based organizations (6%), and by district councils, mosques, and individuals (8%). [15]
- These faith-based facilities are most often found in remote rural settings.[3,22]

Traditional medicine is reported to be extensively used (90%) for day to day health care needs by the rural Uganda population,10 and both the national health system and the private sector are considered to be inclusive of traditional practitioners. See 4, [22] Uganda's relative success with the HIV and AIDS epidemic has frequently been accrued (at least in part) to the engagement of religious groups and leaders – e.g. playing a key role in delivering information, providing services and changing behaviour,[8,11,14] FBOs were involved in the national effort from early in the epidemic: "in 1987, the major religious organisations in Uganda got involved in AIDS prevention with funding from the WHO…channelled through the Ministry of Health. By 1992, USAID had also decided to allocate funds to these FBOs."[20]

2. HISTORY OF FAITH AND HEALTH

1890s-1962: Uganda was settled by protestant and catholic missionaries around 1890, the first religious not-for-profit health unit established by missionaries in 1897, and hospital and health centers established throughout the country thereafter.[17] "At their departure, missionaries handed over the management to the local (congregations)," and as new parishes were established, they routinely set up their own social services, particularly health services.[15] In many cases parishioners contributed to

> Everybody knows that church and faith based health units exist and operate, that they are a sizeable component of the system and that they aim at delivering health care out of a concern of equity and social justice. Quite often these units are known for being quite resilient and efficient. They have in fact been able to weather out difficult periods of the history of the country without ever failing to provide their service to the people. Unfortunately, because they charge people for a proportion of the cost of the service they provide, they are equated to the private and business oriented sector, hence they are thought to be "well off". This is a seriously wrong conception that needs to be corrected. The careful reader of these notes will certainly not fail to identify the signs of an ongoing and rapid worsening new crisis that can be averted only if major and bold policy decisions are taken and enacted.[22]

the investment cost of these facilities, sometimes aided by donations from the respective medial bureau or outside sources.[15] In this period, the colonial Government recognized the social role exercised by this sector, and provided public subsidies. At that time the first umbrella organisations (bureaus) were established: UPMB in 1955 and UCMB in 1956.

1962-1971: Formalised as a British protectorate in 1894, Uganda gained independence in 1962. The new Ministry of Health inherited several hospital facilities, some run by mission agencies. In this period, Uganda was reported as having the best health care system in the sub-region.[4, see 15] Health care was provided free of charge, and access to care was relatively good. Steady improvements were experienced in most health indicators.

1970s-1980s: As a result of the political and military turmoil of the 1970s and 1980s, the government de facto retreated from funding and providing public services. The health care burden was taken up by private for-profit sector and religious providers. The latter were able to mobilize external resources to sustain activities during the turbulent times.[17] In fact, they even found resources to develop considering "the majority of dispensaries owned by religious providers were built between 1960 and 1990." [15] Despite these efforts, health indicators fell dramatically.[10,15] Uganda's workforce problems intensified, with highly qualified staff fleeing the political situation.[27]

1980s-1990s: Peace was restored in the late-1980s and in the subsequent economic recovery, the government implemented a program of infrastructure rehabilitation in the health sector. This coincided with political, administrative, and financial decentralization, which led to limited recurrent funding for health facilities.[15] "National government's investment in health was very limited and ad hoc investment was made in hospital facilities.[4] In the absence of a national health plan, "multiple donors set up vertical health programmes and UNICEF became known as the 'alternative' Ministry of Health".[4]

1990s-current: Around 2000 there was a shift towards PHC backed by a reallocation of resources to this level of care; and accompanied by a significant increase of resources to the sector overall, facilitated by the Sector Wide Approach. However, around 2005, the budgetary allocations that had thereto progressively grown started stagnating and, later, decreasing. At the same time government started investing more and more in its own employees. "This decision has inflicted a severe blow to the FBOs that are part of the PNFP and has triggered the appearance of downward trends that resemble…the deep crisis registered in the early 90s."[22]

3. PROFILING KEY FAITH-BASED ORGANISATIONS AND NETWORKS

e.g. UPMB: UGANDA PROTESTANT MEDICAL BUREAU

History: UPMB is an umbrella organization of Protestant churches and church-related organizations involved in health care in Uganda. UPBM came into existence in 1957 to provide co-ordination and collaboration between medical care institutions affiliated to the Protestant churches in Uganda and the Ministry of Health. It then became the official channel for disbursing government grants-in-aid to the hospitals, evolving into a national umbrella organisation.[1,26]

Facilities: 15 Hospitals,26 and 115 HCs,4 representing ~20% of the NHS.[4]

Activities: UPMB performs the following roles on behalf of member churches: capacity building and support supervision, participation in policy formulation, advocacy, networking and resource mobilization. [26]

Collaboration: Church Missionary Society (CMS), Rwanda Mission, SDA-USA, African In-land Mission (AIM), Bible Churchman's Missionary Society, The Netherland Churches. UPMB also works closely with sister organizations UCMB and UMMB to present a common voice to stakeholders and partners in support of the work of Church and Muslim based Private not for profit health (PNFP) facilities. At the national level, UPMB is currently represented on all working groups of the Ministry of Health. These include: the Health Policy Advisory Committee, the Sector Working Group, the Joint Review Mission, the Public-Private Partnership Working Group and the Human Resource Development Working Group. [1,26]

e.g. UCMB: UGANDA CATHOLIC MEDICAL BUREAU

History: UCMB was established in 1956 with the main purpose of overseeing the procurement of medical drugs and equipment and distributing aid provided by the colonial government to the voluntary health sector. With the establishment of the Uganda Episcopal Conference, UCMB became the technical arm of the Conference's Health Commission.[1]

Facilities: 27 hospitals, 232 health centers and 11 health training schools. ~30% of UCMB's operating costs are supported by the government.[1]

Activities: "The UCMB invested in human resource management, financial management, health management information systems, assistance to dioceses to compile strategic plans, and last but not least in quality improvement by adopting a gradually more sophisticated accreditation system called "faithful to the mission". The strengthened capacity pays off in an improved performance at unit level (in terms of utilisation, cost, quality of care) and a better negotiation position with the MoH at central and local level."[1]

e.g. UMMB: UGANDA MUSLIM MEDICAL BUREAU

History: UMMB is the most recent of the 3 bureaus, founded in 1998 in Uganda. It is the technical arm of the health services component of the Uganda Muslim Supreme Council. The membership of the Bureau consists of Muslim founded, non-profit institutions and organizations involved in health care.[1]

Facilities: 5 hospitals, 65 health centers and 45 sub health centers.[1]

Activities: UMMB plays a coordination, advisory, advocacy, training and supervisory role to the management of Muslim health facilities and initiatives. [1]

4. COLLABORATION AND PARTNERSHIP ON HEALTH

Uganda epitomises a close collaboration between FBOs (of various faiths), as well as between FBOs and government.[1] As can be seen above, FBOs are involved in a variety of government programs and working groups. This is not to say that there are not matters of concern on the table, such as the role of the FBOs within the public-private partnership. However, it does appear that by uniting around strong umbrella bodies (UPMB, UCMB, UMMB), the FBOs are able to play an advocacy role. The bureaus appear to work closely together.[22] The *Joint Medical Store* is an example of collaboration as a joint venture between UCMB and UPMB established in 1979.[6] Various congregations also belong to regional and international networks, for example the Anglican Church of Uganda belongs to a continental network, the *Pan African Christian AIDS Network*.[11] HIV and AIDS-related networks appear to play an important role in building collaboration, e.g. a WCC study found that the *Inter Religious Council of Uganda* plays a key role.

5. KEY RESOURCES

1. CCIH. 2007b. [online]. GRHAM Mapping of ECC. [Accessed 01/08/2007]. <http://ccih.org/grham/>
2. CIA. 2007. [online]. CIA – the 2008 world factbook. [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>
3. HERA. 2005. *Public private partnership for equitable provision of quality health services, technical review 2005.* Belgium: (HERA) Health Research for Action for the Ministry of Health, Government of Tanzania.
4. Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005.* (CCIH) Christian Connections for International Health Conference.
5. IMAU. 1998. *AIDS education through Imams: A spiritually motivated community effort in Uganda.* Geneva: (UNAIDS) Joint United Nations Programme on HIV/AIDS and (IMAU) Islamic Medical Association of Uganda.
6. JMS. 2007. [online]. Joint Medical Store website. [Accessed 24/11/2007]. <http://www.jms.co.ug/>
7. Kagimu M. 2003. Faith-based community mobilisation and education for antiretroviral therapy in Uganda. *Sexual Health Exchange.* **3**, pp.1-3.
8. Liebowitz J. 2002. *The impact of faith-based organisations on HIV/AIDS prevention and mitigation in Africa.* KwaZulu Natal: (HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal.
9. Liebowitz J. 2003. *Faith-based organisations and HIV/AIDS in Uganda and KwaZulu-Natal.* KwaZulu Natal: (HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal.
10. Lochoro P. 2008. *Uganda and its health system, Uganda summary and literature review.* ARHAP FBO Landscaping Project for the Bill and Melinda Gates Foundation.
11. Molonzya M. 2003**.** *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in six countries of Eastern Africa.* Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa.
12. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP bibliography: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
13. Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
14. Otolok-Tanga E, Atuyambe L, Murphy C, Ringheim KE, Woldehanna S. 2007. Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: a case study of Uganda. *African Health Sciences* **7**(1).
15. Reinikka R and Svensson J. 2003. *Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda.* Washington, DC: World Bank.
16. Republic of Uganda. 2000. *National health accounts for Uganda: tracking expenditure in the health sector – both public and private FY 1997/98.* Kampala, Uganda: Ministry of Health Economic Policy Research Centre.
17. Republic of Uganda. 2001a. *Facility-based private not-for-profit health providers: A quantitative survey.* Kampala: Ministry of Health in collaboration with Uganda Catholic, Muslim, and Protestant Medical Bureaux, National Health Consumers Organisation and Tropical Business Research.
18. Republic of Uganda. 2001b. *Policy for partnership with facility-based private not-for-profit health providers.* Kampala: Ministry of Health, Republic of Uganda
19. Republic of Uganda, MOH. 2007. [online]. Ministry of Health website. [Accessed 27/06/2005]. <http://www.health.go.ug/profile.htm>
20. Tiendrebeogo G and Buykx M. 2004. *Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa.* Amsterdam, Netherlands: (KIT) Koninklijk Instituut voor de Tropen.
21. UCMB. 2007. [online]. Ugandan Catholic Medical Bureau website. [Accessed 09/11/2007]. <http://www.ucmb.co.ug/>
22. UCMB-UPMB-UMMB. 2007. Facts and figures of the PNFPs: knowing and understanding the facility-based PNFP health subsector in Uganda. Kampala, Uganda: Ugandan Catholic Medical Bureau, Ugandan Protestant Medical Bureau, Ugandan Muslim Medical Bureau.
23. UNAIDS. 1998a. A measure of success in Uganda. *UNAIDS case study.* Geneva: (UNAIDS) Joint United Nations Programme on HIV/AIDS.
24. UNAIDS. 1998b Islamic Medical Association of Uganda: UNIAIDS Best Practice Collection. [Accessed 24/11/2007]. <http://www.unaids.org/publications/documents/sectors/religion/imamscse.pdf>
25. UNFPA. 2004. *Culture matters: working with communities and faith-based organisations: case studies from country programmes.* New York: United Nations Population Fund.
26. UPMB. 2007. [online]. Uganda Protestant Medical Bureau. [Accessed 02/11/2007]. <http://www.upmb.co.ug/>
27. WHO Afro. 2004. *Migration of health professionals in six countries: a synthesis report.* Brazaville: (WHO) World Health Organization, Regional Office for Africa.
28. WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.
29. Whyte MA. 1996. Talking about AIDS: the biography of a local AIDS program within the church of Uganda. ***In***: Il Schenker, G Sabar-Friedman and F Sy (eds). *AIDS education: Interventions in multicultural societies.* New York: Plenum Press, pp.221-238.

This profile page is a working document that seeks to summarize current available information about the faith-health sector in this country – with an inadvertent focus on facility-based religious entities, for which there is more readily available data.

4.5 PROFILING FAITH-BASED ORGANISATIONS AND NETWORKS

The following section presents profiles of a few of the FBOs and FBNs operating in SSA, demonstrating the variety of organisations at work in SSA,.

Any attempt to disaggregate religious entities and develop a suitable nomenclature makes it clear that religious entities in SSA are not easily pigeon-holed. The first problem is the great variety of religious entities working in health. The second concern is that frequently, the 'faith' element is submerged into other data. For example, in Uganda health providing FBOs are regarded as part of the private-not-for-profit (PNFP) sector,.[37,38] This makes it difficult to disagreggate the 'faith-based' out of the national data, or to provide longitudinal observations of the baith-based sector over time. Furthermore, positioning an organisation as 'faith-based' through secondary literature alone can be hazardous. For example, Kilembe Mines Hospital in Tanzania is owned by a parastatal body but is managed by the Catholic Diocese of Kasese.[39] FBOs are by nature complex and varied, and any classification will inevitably allocate FBOs to categories that don't quite fit. For that reason, we will consider the profiles of some FBOs in the most general of terms: national/local FBOs, international FBOs and FBNs (faith-based networks). Further organizational profiles are also available within the country profiles above.

4.5.1 LOCAL / NATIONAL FAITH-BASED ORGANISATIONS

Local/National FBOs: FBOs working at a national or local level.

Box 4.1 Types of REs working in health at a national level in SSA:

Mission hospitals, voluntary owned agencies or voluntary hospitals, ecumenical organisations / bodies / networks, Christian Councils running health programmes, pharmaceutical organisations owned by FBOs, community-based FBOs running everything from HIV and AIDS HBC to OVC care, FBOs organising traditional birth attendants, denominational bodies co-ordinating health work nationally, churches, congregations, congregational networks, congregations running health projects, community support groups, inter-religious networks, women's groups running health programmes, youth groups running HIV and AIDS prevention programmes, home-based care units, other specific health programmes, community groups, Christian health networks, Christian health associations, Islamic health networks, faith based organisations, national faith based health networks, religious health networks, religious co-ordinating bodies, relief agencies, traditional healers' networks, international religious bodies ...

In the 2006 research in Lesotho and Zambia by ARHAP, it was found that the variety of ways that religious entities got involved in HIV and AIDS at a national and local level was astounding. They include examples from well-established 'mission' hospitals and clinics to HBC and OVC programmes, local Islamic groups providing financial support to wings of government hospitals, and Christian groups transporting patients to hospital on bicycles.[40] There still is no means to satisfactorily group or classify the huge range of religious entities involved in health in SSA. This is certainly an area of research requiring attention, as well as consultation with stakeholders.

Three FBOs working at a national level were chosen from the collected resources with the intention of broadening understanding of the range of FBOs working in SSA; they are profiled below.

EECMY-DASSC (*Ethiopia*)

Ethiopian Evangelical Church Mekane Yesus - Development and Social Services Commission [41]

Background: Ethiopian Evangelical Church Mekane Yesus (EECMY) holds 20 church units or synods in Ethiopia. Its background in health intervention goes back to the intervention of the American Presbyterian Mission in social service activities in the early 1950s.

37 Reinikka & Svensson 2003. See UCMB-UPMB-UMMB 2007.

38 The converse of this is the more recent trend for PEPFAR reporting and related studies to disaggregate 'FBO' from 'NGO', see Oomman *et al.* 2007.

39 UCMB-UPMB-UMMB 2007.

40 ARHAP 2006.

41 Unless stated otherwise, this section is based on EECMY programme documentation: see EECMY 2007, ECCMY 1999, EECMY-DASSC 2007.

Facilities: EECMY's Development and Social Services Commission (DASSC) operates 52 health institutions located in various regions of Ethiopia, including 2 medium general hospitals, 48 health stations and 2 health posts. These facilities render preventive and curative health care and health promotion.

Projects in SSA: Some social welfare projects being run are: micro-project for community self-help, gender and development, water development, micro-hydro power programme, community based child development, Addis Ababa community based rehabilitation of disabilities, food security, natural resources and environmental protection, Armachiho food security project, Filtu water and sanitation project, emergency relief and rehabilitation programme, cross-border ethnic conflict victims rehabilitation, Gambella, Borena Drought Relief Project, Dehan Sekotta Drought Mitigation Project, Child and Youth Care Programme (CYCP), Education Programme, Compassion-assisted child support programme, information, PR, Advocacy for Peace, Justice and Human Rights

- Projects specific to health are: HIV and AIDS prevention and control, health programme, nutrition and hygiene programme (NHP), e.g. HIV and AIDS programmes, including educational materials, youth groups (e.g. "Virgin Club"); or community based reproductive health family planning and polio eradication initiative projects.

ZINGO (Zambia)

Zambia Interfaith Networking Group on HIV/AIDS [42]

Background: ZINGO was formed in 1997 to assist religious communities to become more involved in HIV and AIDS prevention and impact mitigation. ZINGO consists of umbrella organisations: Council of Christian Churches in Zambia (CCZ); Evangelical Fellowship of Zambia (EFZ); Zambia Episcopal Conference (ZEC); Independent Churches of Zambia (ICOZ); Islamic Society of Zambia; Bahai and Hindu communities. ZINGO provides a unified platform where REs can discuss issues related to the challenges brought about by HIV and AIDS and subsequently initiate, strengthen and expand upon existing HIV and AIDS prevention and care programmes. Believing that "a lack of coordination and collaboration with other FBOs has often resulted in a lot of gaps and duplication of efforts not to mention inefficient usage of resources," ZINGO aims at "coordinating their different activities in order to have a complementary approach."[43]

- *Organisational objectives:* To facilitate dialogue and interaction among members of faith-based communities in order to strengthen their response to HIV and AIDS in Zambia; to represent the unified interests of religious umbrella bodies in policy debate on HIV and AIDS interventions inclusive of prevention, care and support and impact mitigation; to co-ordinate FBO activities that are directed to HIV and AIDS; and to set up a data base at the secretariat on HIV- and AIDS-related information.
- *Key thematic areas:* prevention of new infections through behaviour change communication, impact mitigation (care of orphans and vulnerable children, and PLWHA), focus on youth, gender and sexuality issues, reduction of stigma associated with HIV and AIDS.

Activities: "The organisation has been helpful in providing the voice of faith-based organisations on HIV/AIDS-related issues. In the early days, it focused its work on sensitising the churches/religious organisations to recognise that they should be involved and think of other churches and religious groups at the community level they could work with in HIV/AIDS prevention and care."[44] ZINGO has been involved in the development of inter-religious HIV and AIDS training manuals, facilitated communication and networking, youth sexuality training, open fora (e.g. parent-child dialogue), encouragement of social marketing of condoms, tracking of joint efforts against HIV and AIDS, development of a resource centre, technical support, information, and assistance to members, strengthening relations with NGOs, working with the National AIDS Council.

Collaboration: As a networking organisation, ZINGO has foregrounded collaboration and partnership, and appears to have successfully brought a variety of faith groups together in the context of HIV and AIDS. "It was agreed from the very onset that doctrinal and philosophical differences should be put aside so that members could be able to work together. The members acknowledged that at the community/congregation level where HIV and AIDS manifested itself, people had partners outside their own religion or church, they interacted with people not based on religion but other types of affiliation, therefore rather than have one church or religious group run an HIV and AIDS programme and send out

42 Unless stated otherwise, this section is based on ZINGO programme documentation: see Ayami 2004, CCIH 2007a, ZINGO 2002.
43 ZINGO 2002.
44 CCIH 2007a.

messages that might be in conflict with the other religious groups, it was important to work together and have common messages where there was agreement."[45]

TSA *(Malawi)*

The Salvation Army – Malawi Command [46]

Background: The Salvation Army in Malawi started its mission work in 1955 and officially registered in 1967. In the 1990's The Salvation Army Malawi joined the TSA international commitment of reaching out the community needs in its 'advancement of Christian religion, education, relief of poverty beneficial to society or the community of mankind as a whole'. "This is seen as a mission of God's Love in a practical way".

Activities: In Malawi, the involvement of TSA in health does not seem to revolve around facility-based health services as they do in other SSA countries. Here involvement appears to focus on health and development projects, including: water and sanitation; food security; women empowerment, adult literacy and income generating activities (IGA) and micro-credit scheme, goat / livestock; flood and drought relief emergency programmes, child and human anti-trafficking, HIV and AIDS prevention, care and support, health and nutrition, OVC care and psychosocial support, etc. Their HIV and AIDS programme includes over 50 development staff, more than 60 officers (clergy) and more than 500 community volunteers, and numbers 5000 direct programme beneficiaries.

Collaboration: TSA Malawi has collaborative connections within its own denominational network, as well as with local and international churches, charitable organisations and government institutions. For example, in relation to HIV and AIDS in Malawi, TSA collaborates with a variety of bodies such as: the Evangelism Association of Malawi, the Malawi Council of Churches, Malawi National Aids Support Organisation, Malawi National AIDS Commission, Malawi Interfaith Association, Malawi AIDS Counseling and Resource Organisation, churches and FBOs, CBOs, other interfaith and church bodies like the Christian Health Association of Malawi…"and many other NGO's, church organisations and Institutions related to church/ Faith based and Charity Development".

4.5.2 INTERNATIONAL FAITH BASED ORGANISATIONS

Large international faith-based groups, which might have local country offices, and might also function as a 'network' rather than an organisation.

Many of the international FBOs working in SSA are playing critical roles in both supporting FBOs on the ground, and in running critical programmes and interventions themselves. *The intention of presenting two international FBOs is to illustrate the range of religious entities working in SSA.* Please see a listing of international FBOs in Appendix 4.1.

EPN

Ecumenical Pharmaceutical Network [47]

Location: Head offices in Kenya (Nairobi). EPN's SSA members are based in: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe. However, several members work outside their own countries.

Background: Established in 1981, EPN was formerly known as the Pharmaceutical Programme of the World Council of Churches / Community Initiatives and Social Services, which evolved out of the Council's Christian Medical Commission. It later evolved into an independent network with a secretariat based in Africa, and an international NGO in Kenya. "EPN is an independent, apolitical non-profit Christian organisation that works in a context of increasing poverty and need for health services."[48] It is a worldwide network (with members in 31 countries) that supports church-related health services in addressing pharmaceutical-related needs. The purpose of the network is to increase capacity of church-related health services to provide equitable, effective and efficient pharmaceutical services. Its mission is "to facilitate development of

45 CCIH 2007a.

46 Unless stated otherwise, this section is based on TSA programme documentation: see McInnes 1997, TSA 2007.

47 Unless stated otherwise, this section is based on EPN programme documentation: see EPN 2007a, EPN 2007b, EPN 2007c, EPN 2005a, EPN 2005b, EPN 2004, Mwiindi 2007, WHO and EPN 2006.

48 EPN 2005a.

compassionate, just and sustainable quality pharmaceutical care in and through the church health care system."[49] The network's intermediate beneficiaries are its members – church-related health services and their representatives. "We believe our Network is both a means of achieving impact and an end in itself. In view of our goal, EPN believes that the benefits of the network can be seen through members having a stronger voice that is more successful in creating policy and practice change at all levels; having a better knowledge of issues and opportunities, resulting in improved decision making; and harnessing their joint power and synergy in order to carry out programmes in identified areas."[50]

Membership: There are currently 108 members from 31 countries around the world.

Activities: Programme areas: 1) development of an active network with increased impact, 2) maximising access to essential medicines for church health services, 3) increasing the capacity of church leaders and church-related health services to respond to the challenge of HIV and AIDS treatment, 4) training of pharmaceutical assistance not recognised in most countries. EPN's primary methods are: research, advocacy, information sharing, and capacity building, implemented through country focal points, country strategies, and a central support team.[51]

Projects in SSA: EPN runs several different projects, including research, e.g:

- *Increasing Access to ARVs/ART in Africa Project:* The apparent inability of the churches, both as community leaders through their priests, pastors, and congregations and as managers and owners of church health services, to take their full part in the response to ART is hindering the positive impacts of these new treatments. The purpose of this project is to increase the capacity of church leaders and church health services to deal with HIV and AIDS treatment and related organisational management.
- In 2003 EPN collaborated with the WHO in a "descriptive, comparative multi-country study on the work of 16 EPN member faith-based drug supply organisations (DSOs) and their contribution to medicines supply in 11 SSA countries."[52]

Collaboration: Due to EPN's deliberate structure and workings as a "network" it appears to have strong collaborative partnerships in place, especially with the NFBHNs (see below). Further collaboration with other health-related organisations also exists, e.g. the WHO, HAI Africa, International Dispensary Association, Management Sciences for Health, International Network on Rational Use of Drugs, and Mèdecins Sans Frontières.

Table 4.1 Population served by drug supply organisations Source: EPN 2006

Table 7b: Proportion of the population served by 15 DSOs in 10 countries				
Countries	DSO	Population (HDR 04) (Millions)	% of population served according to DSOs	Population served per DSO (Millions)
Cameroon	CAP/EPC			
Cameroon	CBC			
Cameroon	EEC	Total 15.7	Total 30%	Total 4.7
Cameroon	OCASC			
Cameroon	OSEELC			
Cameroon	PCC			
D.R.Congo	ECC/DOM	51.2	60%	30.7
Ghana	CDC	20.5	40%	8.2
Kenya	MEDS	31.5	40%	12.6
Malawi	Cham	11.9	37%	4.4
Nigeria	CHANpharm	120.9	25%	30.2
Rwanda	BUFMAR	8.3	40%	3.3
South Africa**	AMFA	–	–	–
Tanzania	CSSC	36.3	40%	14.5
Uganda	JMS	2.5	40%	10
Zambia	CHAZ	10.7	33%	3.5
	Total	284,4	43%	112.1

49 Mwiindi 2007.
50 Mwiindi 2007.
51 EPN 2005a.
52 See WHO & EPN 2006.

IR

Islamic Relief Worldwide [53]

Location: Head office in Birmingham, UK. SSA projects in Ethiopia, Chad, Kenya, Malawi, Mali, Mauritius, Niger, South Africa and Sudan.

Background: Islamic Relief Worldwide is an international relief and development charity founded in the UK in 1984, with branches in 35 countries. "Regardless of race, religion or gender, (Islamic Relief works) in four main sectors: emergency relief, development, orphans, and poverty alleviation endowments (Waqf)."[54]

Activities: Main areas: responding to emergencies; caring for orphans and children in need; supporting education, providing access to health and water, promoting sustainable livelihoods, campaigning and advocacy on humanitarian issues. IR's work in health and nutrition includes:

- *Mother and child health care programmes*, e.g. training of traditional birth attendants, mother and child health centres
- Construction and rehabilitation of medical clinics, e.g. new 'Centre of Hope' in Mali's capital city Bamako which provides medical and nutritional care, and psychological support for orphans and their mothers
- Distribution of medical equipment and ambulances to hospitals, e.g. malaria-related equipment to hospitals in Sudan
- Farming programmes to improve agriculture and food security
- School food for malnourished children
- Immunisation and health check-ups
- Physical and psychological care for victims of war
- Raising health and dietary awareness in poor communities, e.g. HIV and AIDS awareness programmes (and provision of medical care) in South Africa; malaria campaigns in Sudan, community-owned radio station in Mali, which includes health awareness such as cholera campaigns.

Table 4.2 Islamic Relief

Sector	Amount
Emergency and rrelief	28,090
Integrated community development	22,764
Orphan welfare	4,414
Quebani meat gifts	3,516
Income generation	2,969
Healthcare and nutrition	2,556
Education and training	2,029
Ramadan food gifts	1,817
Other*	727
Water and sanitation	715
Total	**70,487**

Source: IR 2005 – Amounts in 1 000 GBP

Projects in SSA:

Ethiopia: (since 2000), emergency relief and long-term development projects, mostly focused in the Somali region, working with local communities to improve access to education, healthcare, water and sanitation.

Kenya: (since 1993), began emergency relief for people affected by the food crisis in 2006. Projects included water-tanks to rural areas and supplementary feeding. Post-emergency phase, IR's current focus is on the vulnerable: children under 5, pregnant women and nursing mothers. IR is working in partnership with the European Commission for Humanitarian Aid on a water, nutrition and sanitation programme for 2007. In 2007 IR launched an appeal for 27 000 mosquito nets to protect women and children from Rift valley fever.

Malawi: Emergency food aid and long-term projects.

Mali: (since 1997), helping people affected by civil war in the northern regions. Today, IR's work in Mali is focused on long-term development, including projects covering water and sanitation, education, community-based development and child-friendly villages. IRW also runs the orphans sponsorship programme in Mali, which includes food and clothes distribution, as well as monthly sponsorship.

Niger: (since 2005), began with an emergency programme to address the food and nutritional crisis, now programmes cover health, nutrition, water and sanitation. Health and nutrition interventions include therapeutic feeding centres in 4

53 Unless stated otherwise, this section is based on Islamic Relief programme documentation: see Islamic Relief 2007a, Islamic Relief 2007b, Islamic Relief 2007c, Islamic Relief 2007d, Islamic Relief 2005.

54 Islamic Relief 2007b.

district hospitals for severely malnourished children with medical complications. There are also 35 community integrated health centres with supplementary feeding centres to provide rehabilitation for moderately malnourished children. IR provides free access to health care for malnourished children, their mothers, and pregnant and nursing women. Water and sanitation activities include drilling or digging of wells, installation of hand pumps, construction of public latrines and raising community awareness to prevent mass outbreaks of disease.

Somalia: (since 1996), working in the sectors of water and sanitation, health, education and capacity building. Emergency programmes have also included emergency food and helping displaced people.

South Africa: (since 2003), orphan sponsorship and seasonal Ramadhan and Qurbani programmes.

Sudan: (since 1984) emergency relief, expanded to post-war recovery, integrated rehabilitation and community development, including maternal and child health care facilities and support.

Chad: (since 2007), connected to emergency relief in Darfur, providing support to displaced people including emergency relief (shelter, income generation, orphan support).

Collaboration: IR claims increased co-ordination with international NGOs that "share a similar vision", and has "strong working relationships with numerous organisations, based on sincerity, trust and positive results."[55]

4.5.3 NATIONAL FAITH-BASED HEALTH NETWORKS

National faith-based health networks (NFBHNs): Country-level providers of health services, or networks of health service providers (e.g. Christian Health Associations).[56]

> *FBO health networks are a special type of FBO association, usually at the national level, that is organisationally committed to the co-ordination of health and healing through the network of its members. That network, sometimes tightly and often loosely structured, usually includes facility-based, congregational-based and community-based health services. FBOs health networks, and individuals working through them, have played an important role in the development of the concepts of primary health care. Today in sub-Saharan Africa, national FBO health networks often provide 25-50% of health services.*[57]

Apart from a few outliers such as UMMB (see table below), most of the NFBHNs are Christian health associations (CHAs). In addition, in this desk review it was found that there is a great deal more secondary literature emerging (in English and French) from the Christian health associations than from the Islamic organisations. We therefore know more about the CHAs, as is evident in the country and organisational profiling in this chapter. CHAs are national or regional networks of church health facilities and programmes which have come together to create a stronger voice in advocacy and facilitate technical support, networking, communication and capacity building. There is a variety of CHAs in Africa with membership drawn from the Catholic Church, several Protestant churches or a combination of both. CHAs in Africa are at different levels of organisational development and partnership engagement with African governments, but are often facing some of the same challenges. The core functions of CHAs are: to support health services provided by their members through their activities in advocacy, technical assistance and training, capacity building / institutional strengthening, resource mobilisation / administration, research, monitoring and evaluation, joint procurement and equipment maintenance, communication, and health information.[58]

Although the CHAs and their members face various critical challenges such as financing and workforce concerns (see country profiles above), it would appear that these associations are exemplars of the positive impact of collaboration, networking and resource sharing. Indeed, it would seem that in countries that do have such national faith-based health networks, there is stronger collaboration between FBOs, as well as between FBOs and secular groups – in particular a stronger advocacy role with government. The NFBHN appears to be a valuable type of FBO that draws together different faith-health activities, and provides support in a variety of ways, from technical to emotional. These FBOs also appear to have a higher level of technical capacity than the majority of community-based FBOs (most likely as a result of their mainly facility-based members being immersed in the biomedical health-service sector).[59] Research to substantiate or refute these impressions gained from the review would be useful. Some positive developments include the establishment of new CHAs (such as CHAs in Sudan, established in 2007), as well as the drive to coordinate the work of the CHAs through the establishment of the new African Christian Health Association platform (based in Kenya from 2007).

55 Islamic Relief 2007a.
56 USAID 2007b.
57 Baer 2007.
58 See CHAK 2006, CSSC 2007a, Dimmock 2007, Dimmock 2006.
59 See challenges below.

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The following pages provide a listing of the NFBHNs identified in the secondary literature. This includes a few organisations that are not clearly of NFBHN nature (e.g the South African organisations), but have been identified as such in the documentation of the Christian Health Associations.[60]

Table 4.3 National Faith-based Health Networks in SSA [61]

		Organisation	*% of NHS*	*Organisational description*
CENTRAL AFRICA	**Central African Republic**	**ASSOMESCA:** Oeuvres Médicales des Eglises pour la Santé en CentrAfrique		Established in 1989 with 16 member groups, 8 Protestant and 8 Catholic. Association of Protestant and Catholic medical work in CAR. Participating members include Lutherans, the national work associated with Baptist Mid-Mission, Grace Bethren, Catholic, Swiss Pentecostal, Apostolic, Swedish Baptist and a few independent groups. ASSOMESCA operates a drug distribution agenst system in CAR, with customers (church member groups) in CAR, DRC and Congo. (Kawasaki 2001.)
	Rwanda	**BUFMAR:** Bureau des Formations Médicales Agréees de Rwanda [The Office of Church-affiliated Health Facilities in Rwanda]		Established in 1975, BUFMAR is an umbrella organisation that represents both the Catholic and Protestant churches and their health facilities and programmes throughout Rwanda. It is comprised of 24 Christian churches and services with 120 health facilities. Church-affiliated health facilities represent 45% of hospitals and 35% of primary level care facilities (health centres, dispensaries, health posts).
	Democratic Republic of the Congo	**ECC-DOM:** Eglise du Christ au Congo - Direction des Oeuvres Médicales	*~40%*	Established in 1971, created to co-ordinate the health work of the ECC members and to serve as liaison with the Ministry of Health. In 1999, became a major partner in health care in the DRC, currently co-managing 65 of the 515 health zones in the DRC. It has 64 members, 50 hospitals and several hundred dispensaries. (See country profile above.)
EAST AFRICA	**South Sudan**	**CEAS:** Church Ecumenical Action in Sudan	*~50%*	Established in 2005, CEAS is an ecumenical organisation that has 4 general hospitals, 30 specialist hospitals and 5 training schools, mostly managed by FBOs.
	Sudan	**CHAS:** Christian Health Association of Sudan	~35%	Established in 2005. Currently building network and projects.
	Kenya	**KEC:** Kenya Episcopal Conference, Catholic Health Commission (CHC)	~20%	Catholic health care provision in Kenya dates back to the early 1900s. The Catholic Health Commission provides oversight and co-ordination of Catholic health facilities: 430 health units: 45 hospitals, 92 health centres, 282 dispensaries and 46 community-based programmes. CHC provides oversight, advocacy, lobbying and representation, capacity building, networking, and management to its members. CHC member facilities provide a holistic and wide range of preventive, rehabilitative and curative health services and programmes.
	Kenya	**CHAK:** Christian Health Association of Kenya	*~20%*	Established in 1930, is an umbrella organisation of over 296 member health units consisting of 24 hospitals, 43 health centres and 298 dispensaries, and 51 church health programmes owned by Christian denominations or missionary groups providing health services in various parts of Kenya.
	Tanzania	**CSSC:** Christian Social Services Commission	*~40 %*	Established in 1992, made up of the Tanzania Episcopal Conference and the Christian Council of Tanzania. The Commission has two executive organs, the Christian Medical Board of Tanzania (CMBT) and the Christian Education Board of Tanzania (CEBT) for health and education respectively. CSSC coordinates 87 church-owned hospitals, 82 health centres and 613 registered dispensaries. (CSSC 2007a & 2007b.)
	Uganda	**UCMB:** Uganda Catholic Medical Bureau	*~32%*	Established in 1956, co-ordination of health units is organised on the intermediate (diocesan) level and at the national level by the Health Commission of the Episcopal Conference and its technical arm, the UCMB. Involves 27 hospitals, 232 health centres, 11 health training schools.
	Uganda	**UPMB:** Uganda Protestant Medical Bureau	*~20%*	Established in 1957, as an umbrella organisation of Protestant churches and church-related organisations involved in health care in Uganda. 17 hospitals, 115 health centres.
	Uganda	**UMMB:** Uganda Muslim Medical Bureau		Established in 1998, as the technical arm of the health services component of the Uganda Muslim Supreme Council. UMMB plays a co-ordination, advisory, advocacy, training and supervisory role to the management of Muslim health facilities and initiatives. The membership of the Bureau consists of Muslim-founded, non-profit institutions and organisations involved in health care. UMMB co-ordinates all member units and is the main link between member units and the GOU. UMMB's health facilities comprise 5 hospitals, 65 health centres and 45 sub-health centres.
	Ethiopia	**CRDA:** Christian Relief and Development Association		Established in 1973, umbrella organisation of 212 NGOs and FBOs. Established as a relief co-ordinating agency by 13 religion based and secular humanitarian organisations. Today it focuses on development, capacity building, advocacy and networking.

60 CSSC 2007b.

61 Unless stated otherwise, this table is based on the following sources: Baer 2007, CCIH 2007b, CHAK 2006, CSSC 2007, Dimmock 2006, Dimmock 2007, Green et al. 2002. These 'percentage of national health system' statements are taken from the secondary literature, and are frequently rough estimates requiring further investigation.

		Organisation	% of NHS	Organisational description
SOUTHERN AFRICA	**Angola**	**CICA:** Angolan Council of Christian Churches Christian Medical Commission		*Established in 1977, CICA is an ecumenical institution. Today it has 20 members. CICA provides guidance and technical assistance in community assistance and development, literacy, vocational training, community health (including HIV and AIDS), development of youth, ecumenical co-operation, and peace education and reconciliation.*
	Botswana	**AMMB:** Association of Medical Missions for Botswana		*Initially the association began as part of the Botswana Christian Council's work but eventually developed into a fully-fledged association. It was registered in 1973.*
	Lesotho	**CHAL:** Christian Health Association of Lesotho	*~40%*	*Founded in 1974, CHAL is an umbrella organisation of Christian health organisations, including 8 hospitals and 75 health centres.*
	Malawi	**CHAM:** Christian Health Association of Malawi	*~37 %*	*Founded in 1966, members are ecumenical and interdenominational churches that operate health facilities. 30 hospitals and 125 health centres.*
	Namibia	**CNN:** Council of Churches in Namibia		*Formed in 1978, CNN is an ecumenical body that is focused on religious, education and social concerns. (CNN 2007.)*
	South Africa	**SACBC:** South African Catholic Bishops Conferen		*Catholic Bishops conference of Botswana, South Africa and Swaziland – also coordinates several large-scale health and social programs, coordinating facilities and programmes run by members, for example through its AIDS Desk, or the associate body CATHCA (Catholic Health Care Association), which currently holds 177 hospitals, clinics and health programmes. (See SACBC 2007)*
	South Africa	**SACC:** South African Council of Churches		*Council of churches in South Africa that co-ordinates several ecumenical projects related to health. It has 27 member churches, also including independent and charismatic churches.(See Parry 2005.)*
	Swaziland	**CHAS:** Christian Health Association of Swaziland		*Established in 1995, with 7 mainline churches, 3 hospitals and 27 clinics (as at 1989). (IDT 1998.)*
	Zambia	**CHAZ:** Churches Health Association of Zambia	*~30 %*	*Founded in 1970, 30 hospitals and more than 60 health centres, about 30% of NHS, professional staff paid by GRZ, MoU signed in 1996, church hospitals given 75% operating budget, decentralised to district health boards, CHAZ now includes non-institutional members. Mapping of facilities in process (05/05)*
	Zimbabwe	**ZACH:** Zimbabwe Association of Church Related Hospitals	*~45 %*	*Founded in 1974, 79 hospitals and 46 HCs. (There are grossly conflicting stats available for ZACH. These are from Green et al. 2002.*
WEST AFRICA	**Cameroon**	**FEMEC-CAM:** Federation of Protestant Churches and Missions in Cameroon		*Established in 1968. A federation of 11 protestant churches and missions in Cameroon.*
	Ghana	**CHAG:** Christian Health Association of Ghana	*~34%*	*Founded in 1967, is an umbrella network to 152 institutions: 56 hospitals, 83 primary health care bodies and 8 health manpower-training centres in the country.(See Ghana country profile above.)*
	Liberia	**CHAL:** Christian Health Association of Liberia	*~47%*	*Founded in 1975, is an ecumenical umbrella body of Liberian churches involved in the health sector. 5 hospitals, 67 health centres. CHAL intervenes in several fields, namely: drug supply, PHC, capacity building, water and health, family education and HIV and AIDS control.*
	Nigeria	**CHAN:** Christian Health Association of Nigeria	*~20 %*	*Established in 1973, about 400 registered member institutions in all parts of Nigeria operated by 15 denominations. Members hold about 4 000 outreach health facilities.(See Nigeria country profile above.)*
	Senegal	**EPSCM-SEN:** Eglise Protestant du Senegal Commission Medicale		*Protestant umbrella group in Senegal.*
	Sierra Leone	**CHASL:** Christian Health Association of Sierra Leone	*~30 %*	*Established in 1975, members are heads of churches and health institutions. Facilities include hospitals and health centres.*
	Togo	**APROMESTO:** L'Association Protestant des Oeuvres Medico-sociales du Togo (The Protestant Association Medico-Social Works of Togo)		*Established in 1994, bringing together 7 churches of the Christian Council of Togo, aimed at co-ordinating the action of the health centres and hospitals belonging to these churches, sensitising the faithful in the struggle against AIDS, train the nursing personnel and resolving the health problem through concerted actions. Generally, APROMESTO encourages the team of health facilities to establish a psychosocial care unit and draw up AIDS projects in order to address the epidemic more effectively.*

4.6 AREAS OF FBO INVOLVEMENT IN HEALTH

This chapter will now focus on some of the key areas of involvement of faith-based organisations that are highlighted by the secondary literature.

4.6.1 HIV AND AIDS WORK A PRIMARY FOCUS

FBO health networks and community-based and congregational-based health programmes provide a wide spectrum of clinical and outreach services.[62]

There is a heavy skewing of the literature over the last ten years towards documentation of the religious response to HIV and AIDS. This makes it appear to the reader that the primary focus of the faith-based health work is on HIV and AIDS. However, this would be inaccurate, as there are few studies that look at denominational health responses in their entirety, measuring activities on HIV and AIDS against that.[62] The boom in reporting is logically a response to the demands of, and interest in the epidemic – and as a result the reporting on the daily health work of FBOs is less prominent. The ARHAP literature review (2006) noted the following generalisations in relation to FBOs responses to HIV and AIDS in SSA, some of these reflecting the non-specific HIV and AIDS themes mentioned above: [63]

- Religious responses are more prevalent than is currently recognised, and are making a difference in the communities in which they are based.
- Religious responses range across the continuum of prevention, care and support, treatment and rights, and are often 'holistic' in nature, focusing on the emotional and spiritual aspects of care as well as the physical.
- There is also general acknowledgement that religious responses do not always fit into the norm or schema of health responses, often employing a variety of strategies at the same time.
- There is, however, still a startling lack of information on religious organisations' activities in the HIV and AIDS sector, particularly in relation to small-scale or community initiatives which remain undocumented.
- Much remains to be understood about the nature, scale and scope of these contributions and the way in which they supplement and interface with more centralised responses to the HIV and AIDS crisis.[64]
- There appears to be a crucial lack of alignment between health systems (and resources) and religious communities.[65]
- Orphans and vulnerable children are a primary focus of FBOs in the HIV and AIDS arena, and they are well suited to this work and a viable option for further support.[66]
- FBOs are also particularly focused on care, often at a home-based or community level.
- In some cases an element of 'special care' has been attributed to religious interventions.[67]
- Religious responses to HIV and AIDS can include factors that contribute to stigma and discrimination, as well as those which mitigate against them.[68]
- Similarly, literature on religious responses to HIV and AIDS is mainly focused on issues of sexuality, where religion is seen both as a tool for prevention or behaviour change, and as a cause of risky behaviour.[69]
- Finally, it is recognised that in an African setting, there is a complex blending of multiple religious and cultural practices which needs to be acknowledged, particularly in relation to sexual practices,[70] and in relation to beliefs and behaviours linked to traditional religions and practices.[71]

62 See Appendix 4.3 regarding studies emerging in 2008.
63 Olivier *et al*. 2006. See ARHAP 2006.
64 See Birdsall 2005.
65 See DIFAEM 2005, Josephine *et al*. 2001, Taylor 2005b.
66 See Foster 2003, Young 2005.
67 See Reinikka & Svensson 2003, Thomas *et al.* 2006.
68 See Parker & Birdsall 2005.
69 See Agadjanian 2005, Garner 2000, Green 2006, Lagarde et al. 2000, Takyi 2003.
70 See Baylies & Bujra 2000, Gausset 2001, Kapungwe 2003, Malungo 2001, Yamba 1997.
71 See Chipfakacha 1997, King 2000.

4.6.2 HOSPITALS AND CLINICS

Facility-based FBOs such as hospitals or clinics provide a full range of health services. This desk review has already alluded to these services in several places. The section on NFBHNs (above, table 4.3) and the country profiles (above, section 4.4) show some of the 'numbers' involved – of FBOs running and managing hundreds of hospitals and clinics – all involved in primary and secondary health care. Much of this care is in the area of MNCR, although the full range of PHC is provided at these facilities. *It would be useful to further research and amalgamate current available data on faith-based medical care in these SSA countries to better understand its level and character in comparison to that of government facilities.*[72]

4.6.3 FBOS INVOLVED IN A VARIETY OF HEALTH CONCERNS

Birdsall, reviewing FBOs activities South Africa in 2005, notes that the AIDS-related work of FBOs is often embedded within broader service portfolios, making it difficult to disentangle purely 'AIDS-related services' from the total range of services provided.[73] This is one indication of the difficulty in making generalisable statements about the religious-health situation, especially when the recent literature is so heavily skewed towards one epidemicThere are health programmes (sometimes linked to health care facilities) which address a range of public health concerns, but there is a dearth of literature on these responses. The literature does mention specific health responses such as tuberculosis[74], tobacco control[75], malaria[76], polio[77], sexual violence[78] and MNCR (described below). *Further research is needed to understand the involvement of FBOs at different levels in health issues other than HIV and AIDS. It is unclear whether such responses are simply not happening to the same scale as responses to HIV and AIDS, or whether other issues are simply wrapped up in the 'holistic' package of faith-based care and grossly underreported.*

Box 4.2 Faith-based MNCR

FBOs play a crucial role in increasing access to maternal and newborn health services throughout the household-to-hospital continuum of care...It is estimated that (worldwide) 90% of these FBO facility and community-based programmes offer MNH services. Chand & Patterson 2007.

4.6.4 MATERNAL, NEWBORN, CHILD AND REPRODUCTIVE HEALTH (MNCR)

Several studies mention that FBOs play a crucial role in increasing access to maternal and newborn health services. This is primarily through the RE health care facilities, but there are also community based programmes (either connected or working alone), which work in support of women and children, such as congregations' promotion of women's health through women's groups.[79] As with the care of orphans and vulnerable children, this appears to be an area of care for which FBOs are well-suited and (theologically) comfortable. Again, there are few studies focused specifically on the coverage and extent of FBOs in MNCR,. However, of particular importance is the new study by USAID entitled *Faithbased models for improving maternal and newborn health.*[80] This study states that "FBOs play a crucial role in increasing access to maternal and newborn health services throughout the household-to-hospital continuum of care…It is estimated that (worldwide) 90% of these FBO facility and community-based programmes offer MNH services."[81]

There is a substantial amount of literature on the involvement of FBOs in reproductive health and family planning through religious leaders and organisations. The HIV and AIDS epidemic has shifted much of the focus to issues of sexuality and behaviour change.[82] Several reports have suggested that FBOs in Uganda, Senegal and (to a lesser extent) Malawi may have been partially (yet significantly) responsible for positive behaviour change in those countries by promoting AIDS prevention through a variety of methods, ranging from the relatively passive (e.g. inviting or allowing AIDS educators to address congregations) to the more active (e.g. using the prestige and moral authority of the religion to advocate behaviour such as fidelity or abstinence).[83] The responses of FBOs to sexuality are often informed by their

72 More research is emerging in this area – see for example CHAK 2007a
73 Birdsall 2005.
74 Colvin *et al*. 2003, Wilkinson *et al*. 1999.
75 Jabbour & Houad 2004.
76 Mhango 2001.
77 UNICEF 2004b.
78 Erasmus & Mans 2005.
79 See Chand & Patterson 2007, Olivier *et al*. 2006.
80 Chand & Patterson 2007.
81 Chand & Patterson 2007.
82 See Olivier *et al*.
83 See Green 2003, Liebowitz 2002, Chand & Patterson 2007.

faith, denominational or congregational attitudes to abortion, condom usage and female genital mutilation[84]. This also has implications for the provision of health services and accessing targeted funding.

4.6.5 PHARMACEUTICALS AND DRUG SUPPLY

A growing area of interest is the way in which FBOs relate to medical systems, for example, drug supply systems. More FBOs are involved in the area of pharmaceuticals and drug supply than would be expected, yet there is still a lack of information in this area. [85] Some examples of this involvement are:

- *The Ecumenical Pharmaceutical Network* (EPN – see detail above 4.5.2) works with church health institutions and organisations and leads the campaign for essential medicine access.[86] In a study they completed in collaboration with the WHO, EPN indicates that "the population served by 15 faith-based drug distribution organisations in 10 sub-Saharan countries [served] from 25-60% of those in need."[87]
- Kenya: *Mission for Essential Drugs and Supply* (MEDS) – jointly owned by CHAK and KEC.
- Uganda: *Joint Medical Store* (JMS) – a joint venture of UCMB and UPMB.[88]
- In Kivu, in DRC, the international Catholic aid group Caritas has recently sponsored a pharmaceutical production laboratory that will be under the auspices of the local church diocese, thus making cheaper generic pharmaceuticals available to the community.[89]
- ASSOMESCA operates a drug distribution agent system in the Central African Republic, with customers (church member groups) in CAR, DRC and Congo.[90]

In the Islamic context of Sahel and Francophone West Africa, there is little modern pharmaceutical provision by Islamic groups. However, the use of traditional and Islamic medicines or cures is widespread in these areas, often in combination with modern pharmaceutical products gained elsewhere.[91] This is an interesting area of reflection, as even in areas of SSA where FBOs are providing pharmaceuticals, it is common practice that 'traditional' remedies are often simultaneously in use. It has also been indicated that health-seeking behaviour is influenced by religious tradition.[92] *Again, this shows the problematic of speaking of religion and FBOs as a single entity, and the need for further investigation into the way traditional health practices and faith healing interface with bio-medical care.*

4.6.6 EDUCATION AND OTHER DEVELOPMENTAL ISSUES RELATING TO HEALTH

Finally, there is an ill-defined area between the FBOs involved in health, and those involved in development.[93] Obviously this also relates to the definition of health (narrowly or broadly) as a range of concerns such as education, water and sanitation, are regarded as relevant to public health.

The World Bank President, James Wolfensohn, noted in 2002 that "half the work in education and health in sub-Saharan Africa is done by the church".[94] It is worth noting here briefly that the involvement of FBOs in education is another resource for health, given the widely acknowledged impact that improving the health of mothers has on child health outcomes.[95] "Faith groups have historically played an essential role in providing services and relief to poor people. They often run the only schools and health clinics in rural communities in sub-Saharan Africa. They have been estimated to provide 50% of health and education services."[96] As described for the provision of health services by REs in this study, the provision of education services by REs is also poorly documented, and likely under-reported. *The potential for promoting health through education and educational facilities is understood. However, beyond anecdotal evidence,[97] not enough is known about the positive and negative98 health effects of religious involvement in education on a broad scale.*

84 Masterson & Swanson 2000, Sahl et al. 2004, Tostan 2007.
85 See Kawasaki 2001, Logez & Everard 2004, Vogel & Stephens 1989.
86 EPN 2007c.
87 See CHAK 2007.
88 See JMS 2007.
89 Moriza 2005.
90 Kawasaki 2001.
91 See Castle 2007.
92 ARHAP 2006
93 ARHAP 2006.
94 Wolfensohn, in Kitchen 2002.
95 See Olivier *et al*. 2006.
96 Taylor 2006.
97 See Castel 2007, Olivier *et al.* 2006.
98 For example, it has been suggested that in Mali, conflicting religious schooling is responsible for Mali's poor education levels. See Castle 2007

Regarding the wider development terrain, most of the large international faith-based development agencies run focussed health programmes (specifically HIV and AIDS programmes). Other community-based development programmes are focused on issues such as education and training, conflict resolution, water and sanitation, income generation or emergency relief (such as food parcels), or support for OVC. There is no clear boundary between health activities and development activities that contributes to health. This is an area of concern as emerging mapping or landscaping studies, generally classify entities by their primary activity (e.g. development / relief / health).[99] This frequently underplays the involvement of many FBOs, as well as the development-focused activities that obviously have a critical impact on health. The religious-health landscape in SSA is just as much an issue of development as one of health care, and it would benefit the research and work in this area to develop an encompassing way of viewing this landscape.

4.7 STRENGTHS OF FBO INVOLVEMENT IN HEALTH

A large number of studies note that there are distinctive characteristics of FBOs that make them viable partners for funding in Africa.[100] Often the reasons for this are linked to the strengths of REs discussed below, noting that they are clearly not generalisable to all FBOs or regions:

4.7.1 REACH AND ACCESS[101]

FBOs have unique reach (specifically congregations of any faith); the widest network coverage in the continent; are found in all communities; are found in inaccessible and rural areas; and have access to communities (including dedicated volunteers, networks or educated leadership). In Uganda PNFPs were found to be more likely to provide pro-poor services and services with a public good element, and charge lower prices for services than for-profit facilities;[102] The fact that REs have coverage and location in predominantly rural areas in SSA is reiterated in the literature as possibly one of the most critical issues, making them good partners for collaboration in health.

Box 4.3 Quotes on strengths of REs

Health services are often concentrated in urban areas while rural areas, where most of the population lives, are underserved. Mission hospitals and health care centres are frequently the only such services to be found in these areas. Parry 2003.

Everybody knows that church and faith based health units...are a sizeable component of the system and that they aim at delivering health care out of a concern of equity and social justice. Quite often these units are known for being quite resilient and efficient. UCMB-UPMB-UMMB 2007.

PEPFAR...sees FBOs as possessing particular ability to influence the behaviour and attitudes of their community members by building on relationships of trust and respect. Birdsall & Kelly 2007

Working with church networks and physical and organisational structures contributes to the rapid spread of the programme at minimum cost and, most importantly, to the ownership of the programme by the diocese. UNFPA 2004.

There is a widespread prevailing belief that CBOs and FBOs are an underutilised resource for expanding the reach of services to the poorest of the poor and 'spending money where it most helps.' Birdsall & Kelly 2007.

4.7.2 AVAILABILITY AND ACCESSIBILITY[103]

FBOs play an integral part of life and society in most parts of Africa; they have the largest constituency of people (in terms of potential to change behaviour); they hold credibility with their communities; they have an understanding of, and acceptance within, communities, often because of a longstanding presence; they have great potential to change behaviour[104]; religious leaders are in key positions to influence critical choices around sexual practice; and they are among the first responders to community needs.

and the Uganda country profile above.

99 See ARHAP 2006 for discussion on this, and attempts to ameliorate this.

100 See for example DFID's position in Taylor 2007, PEPFAR in Birdsall & Kelly 2007, World Bank 2004.

101 See DIFAEM 2005, Olivier et al. 2006, Parry 2003, Taylor 2005, Taylor 2006.

102 Reinikka & Svensson 2003.

103 See DIFAEM 2005, Olivier *et al*. 2006, Parry 2003, Taylor 2006, Taylor 2005.

104 A controversial point in public health circles, see below regarding the challenges of working with FBOs.

4.7.3 NETWORKS[105]

FBOs have a well-developed networks extending from the international to grassroots communities. This enables them to mobilise large numbers of volunteers and gives them the potential to scale up national responses through denominational networks that link to community groups and congregations. "FBOs operate in parallel to governments, providing virtually all the same major services as government at primary and secondary care level but filling in the gaps where government fails to provide."[106] They are rooted in local structures; and they represent an already established independent civil society network.

4.7.4 MOTIVATION AND SUSTAINABILITY[107]

The faith-based motivation means that workers (both paid and volunteers) persevere despite few resources and difficult circumstances;[108] religious motivation urging compassion for those less fortunate contribute to care and support;[109] and FBOs are seen to be reliable and trustworthy.

The list of statements made about FBOs (see Box 4.3) reflects an underlying posivitism towards working with FBOs in health. This emerges from individual studies, as well as from large international secular organisations.[110] Of course, these stated strengths are balanced by the knowledge that REs have not always responded helpfully to health concerns, and in fact have sometimes been more harmful. We will consider some of these issues in the next section which looks at challenges facing FBOs as well as those who want to work with FBOs.

4.8 CHALLENGES AND LIMITATIONS

4.8.1 WORKFORCE IN CRISIS

Another critical area of challenge requiring intervention is that of workforce or human resources. As mentioned above, the health sector in Africa is severely weakened in responding to health needs by the challenges of: health service provision, quality of care, exodus of highly qualified and experienced health professionals, low morale among medical doctors and nurses, and low payment of health professional salaries and wages.[111] Many FBO staff members are working in desperate conditions, sometimes threatened by the environment in which they work (e.g. the effects of HIV and AIDS or the political environment).[112] FBOs are faced with a constant outflow of medical, academic and religious professionals, but are particularly challenged by the exodus of health workers (as a result of death, or to other sectors, public health facilities or to other countries).[113] Some points for consideration regarding the FBO workforce crisis are:

- Although the literature does claim that FBOs have some inherent faith aspect that increases the dedication of FBO staff, there is no knowledge as to what role this factor plays in relation to the HR crisis.[114]

Box 4.4 Crisis for church hospitals

Many [church-related hospitals] are facing an acute crisis...they are confronted with increasing competition from private and government institutions, difficult health care reforms, challenges of epidemiological transition and new emerging diseases like HIV and AIDS and unreliable or sometimes unco-operative governments.

They are confronted with the challenge to combine holistic services and increasing poverty with the requirements of scientific medicine that is becoming more and more sophisticated and expensive.

In summary they are facing the difficult dilemma to be faithful to their Christian vocation to serve the poor according to their need and at the same time to find sustainable solutions for the organisation and financing of effective quality services. Benn 2002

105 See DIFAEM 2005, Olivier *et al*. 2006, Parry 2003, Taylor 2005, Taylor 2006.
106 Parry 2003.
107 See DIFAEM 2005, Olivier *et al*. 2006, Parry 2003, Taylor 2005, Taylor 2006.
108 Reinikka & Svensson 2003 – this is the most understudied points of the above list and is in critical need of further research.
109 UNFPA 2005.
110 See Birdsall & Kelly 2007, Taylor 2005b, Taylor 2007, UNFPA 2005.
111 See Mandi 2006, CSSC 2007, WHO 2006.
112 Parry 2002.
113 See WHO Afro 2004.
114 See above, Reinikka & Svensson 2003.

- 'Overseas' missionaries have declined significantly in number, and there has been a shift from long-term postings to short-term assignments. "'Career missionaries' are nearly extinct".[115] CHAs note that medical missionaries created a strong north-south partnership in human resources: they bring in specialised skills and resources at no cost to the hospitals since they are supported by partners from abroad, they are dedicated to their assignment and are most often stable. They provide some budgetary relief for hospitals.[116]
- In CHAK's annual report of 2006 they note a crisis situation where hundreds of nurses were recruited from the FBOs by the government, a situation requiring emergency advocacy and intervention.[117]
- CHAs (or NFBHNs) play pivotal roles in managing and supporting the health-care workforce. "Among the most challenging issues such organisations face is human resources for health. At stake is the survival of many mission hospitals and services to populations commonly underserved by other providers. These challenges demand new and creative approaches by CHA networks and their members."[118]
- For example, CHAK and KEC note that the most serious challenges they are facing include: remuneration that is competitive in the labour market, motivation of the workers, development through further training, HR management and management transition, challenges of governance and church politics when dealing with HR, HR instability due to high turnover, proliferation of both international and local NGOs creating greener pastures, taking away the most experienced workers into project management, improved terms of service in the government, demands in society from health professionals.[119]
- CHAs are reported to be meeting together to work on these challenges, and have formed the African Christian Health Associations' Technical Working Group on Human Resources for Health which intends to help CHAs plan, develop, and support their human resources for health (HRH).[120]

This crisis of workforce not only affects the facility-based health providing FBOs, but also the smaller organisations offering care. *It is an area of critical challenge requiring advocacy from religious leaders, innovative ideas from policy-makers and effective collaborative efforts and structures (both between different religions, and between FBOs, secular organisations and governments).*

4.8.2 LACK OF CAPACITY AND DOCUMENTATION

A critical area of challenge for FBOs is a general lack of documentation, including communication, information systems, monitoring and evaluation, programme reporting, programme documentation, basic project descriptions, histories and the underlying skills that enable this type of activity. This is a challenge not only for the more formalised health-providing organisations, but also for community based efforts. Again, this is an area where generalisation across *all* FBOs in SSA is self-defeating. There are of course some exemplar FBOs at both national and community levels that are very competent in this matter, e.g. nationally, UCMB's HMIS system was considered to be superior and was subsequently adopted by the Ugandan MoH,[121] or at a community level the St Francis Homecare FBO in Livingstone, Zambia was identified as an local exemplar by colleagues.[122] Nevertheless, despite these exemplars, the secondary literature repeatedly points to this as an area of challenge for FBOs - generally. Reasons given for this weakness include:[123]

Box 4.5 Too little documentation on REs

Even though FBOs have been providing health care for over a century, little has been written about them. FBOs should become proactive in writing, publishing and sharing, through various channels, their knowledge, successes and challenges. Chand & Patterson 2007.

If we are serious about collaborative partnerships, then here is an area for technical assistance Parry 2002.

Community based organisations are weak at evaluation, but FBOs within this category are even worse. Birdsall & Kelly 2005

115 Dimmock 2008.
116 CSSC 2007a.
117 CHAK 2006.
118 Mandi 2006.
119 Mandi 2006.
120 Mandi 2006. See Shwerzel 2007, CSSC 2007a.
121 Dimmock 2008.
122 ARHAP 2006.
123 See Birdsall & Kelly 2005, Chand & Patterson 2007, Lusey-Gekawaku 2003, Munene 2003, Parry 2002, Taylor 2005b & 2006, Woldehanna et al. 2005.

- FBOs perceive themselves to be implementers: they are the 'doers' with an attitude of 'getting on with the work' – that is, they are 'too busy saving lives' in critical conditions to spend time on documentation.
- FBO efforts have grown spontaneously and organically from community needs, and either do not have formal NGO status, or have grown into organisations without the information planning.
- The documentation that is happening is often vertical reporting to donors that does not get used in other ways within the programme.
- FBOs lack knowledge of specific donor requirements, and the capacity to handle a variety of such requirements from multiple donors (for example, project proposals, monitoring, evaluation and reports).
- Those working in FBOs, which are often based on a large volunteer base, do not have the technical skills required to meet the documentation requirements of overseeing agencies or funders.

It is impossible to judge the long-term effects of this area of weakness. It may appear at first that this is mainly a concern for those doing research on the religious-health landscape, and indeed, as several of the above recommendations have shown, there is a critical shortfall in knowledge about the activities of FBOs in SSA. However, this is not merely a matter of research for research's sake, but rather a question of what impact this has on decision-makers and on the FBOs themselves. Regarding the decision-makers: as mentioned above, the way that the faith-based sector has been working 'under the radar' of the public health system has resulted both in service gaps and overlapping services, and ultimately the wasting of desperately needed resources.[124] Being 'invisible' must be, in part, a result of those policy-makers and decision-makers not knowing what the religious communities are doing. Furthermore, studies of the SSA faith sector by potential funders have consistently pointed to the lack of documentation as one in need of sustained capacity building.[125] Therefore, this weakness of FBOs may be having a profound impact on what funders, policy-makers and decision-makers generally understand about the religious-health landscape, for example, on who is drawn into partnership or whose models of best practice are encouraged. It may also be having negative effects on organisational capacity and sustainability from the FBOs' perspective, where important knowledge is not being shared and potential gains are being lost. *Therefore, a recommendation that emerges from the secondary literature is that many smaller FBOs would benefit from support through technical assistance or 'incubation' of their organisational capacity in the area of documentation and technical skills.*

However, a caveat to this must be recognition that some FBOs and their activities may not be suited to this kind of support. In fact, it is possible that over-emphasis of this with certain FBOs could damage the spontaneous response to needs,[126] by forcing a specific model on grassroots 'homegrown' responses. In Zambia it was found that some FBOs were instinctively knowledgeable about tapping into funding resources, e.g. through directed HIV and AIDS activities, while others were completely cut off and running health programmes with no outside assistance due in part to a lack of knowledge and technical skills.[127] The argument here is not that all FBOs should immediately join a standardised M&E process suited to any NGO. In fact, as Taylor points out, "many of the distinctive contributions of the church are intangibles, such as dignity for the dying or prayers with the sick, and so are difficult to monitor or evaluate."[128] If a range of FBOs are operating in intangible spheres, then standard documentation processes would not recognize this – resulting in both a lack of outside recognition, and missing the opportunity for organizations to develop their internal capacity through M&E or documentation processes. What this does suggest is that there is a need for a closer investigation into the relation between FBOs, their faith-based organisational culture, their technical capacity and their funding situation and organisational development.

Box 4.6: Public or private?

It is important to note in this respect that FBO-managed health facilities are more public than private sector. The medical work of FBOs health networks has for many years been considered part of the "private sector". This has encouraged an atmosphere of competition, rather than collaboration, with the public sector. In fact, the not-for-profit philosophy of most FBOs and NGOs links them much more to the public sector. And not just for the provision of health services, but also for the management of the support system. Baer 1994.

124 See ARHAP 2006, Olivier *et al*. 2006.
125 See Chand & Patterson 2007, Taylor 2006.
126 See above, also Olivier *et al*. 2006.
127 ARHAP 2006.
128 Taylor 2006.

4.8.3 FINANCING

Another area of critical concern is the financing of FBOs.

Faith vocation versus sustainable financing

One theme that emerges repeatedly from the secondary literature is the dilemma health-providing FBOs find themselves in when their 'mission' to serve the poor and marginalised comes into direct conflict with financial survival. It has been noted that FBOs mainly base their work on an altruistic perspective, e.g. in Uganda it has been found that they "are more likely to provide pro-poor services and services with a public good element; and charge lower prices for services than for-profit facilities, although they provide a similar (observable) quality of care."[129] However, serving the poor must be financed, and in countries with a very low per-capita income it is extremely difficult to maintain high quality hospital services that are accessible and affordable for the poor. Benn concludes that faith-based hospitals are coming under increasing strain, and "under the best of circumstances, the government will have to increase its contribution, the hospitals have to maximise their potential for managerial capacity and efficiency and the international partners have to maintain and reassess their support not only for capital investments but also for recurrent costs."[130]

This is a critical time in the history of some of these facility-based health providing FBOs – as they are being pushed to weigh their organisational culture and reason for being, against the realities of financial support and survival. *It is not clear whether this challenge has been felt by other non-facility based community FBOs,. This is perhaps also an area of challenge to the greater ecumenical community – as an issue in which they can become engaged in dialogue and advocacy – as it is a challenge that cuts to the heart of the religious-health landscape, arguing that if FBOs do have the unique strengths listed above, a 'value added', then now is the time to consider just what that value added is 'worth' and therefore, in what ways it is to be supported.*

Further financial challenges

There is not adequate information on the financing of FBOs, especially over time. Anecdotally, FBOs are often reluctant to disclose financial records and transactions to scrutiny (for a variety of reasons), making financial assessment of the religious-health landscape difficult.[131] Financial information that is available indicates the wide variety of sources that FBOs are tapping into in SSA – such as government funds, external church donations, external development agency funds, local donations, other local organisations, mother bodies or faith networks, zakat, donors (particularly HIV and AIDS related funds such as the Global Fund and PEPFAR), and individual donors.

There is not the space here to list all the complex issues surrounding the financing of FBOs, or to make structured financial recommendations. We therefore present a few of the primary concerns raised in the literature:[132]

- Funding is an issue that is only rarely addressed in the literature published on religious organisations, and yet is an issue at the core of the religion-health interface. For example, global funding initiatives are increasingly seeing religious organisations as desirable channels of funding,[133] assuming that the capacity is there to absorb health funding at these levels, and that it would be spent wisely and efficiently. REs, in turn, consistently report a lack of funding as the reason for their lack of increased capacity. Yet there is alarmingly little (public) literature on the financial situation of religious organisations.[134]
- There are conflicting reports as to what degree REs are able to access funding (again, this conflict can in part be explained by the huge variation of entities customarily incorporated under the term 'faith based organisation'). However, in general, it would appear that some REs receive funds from a variety of public and private sources (national and international), but not enough is known about the scale of funding or about the processes of accessing these funds. "Nevertheless, anecdotal evidence suggests that many REs are created, run (and sustained) despite a financial shortfall – because of religious commitments. Current evidence for this is minimal, but it is worth investigating."[135]
- Parry has also noted that there is grossly inequitable resource allocation, and that while REs are encouraged, and expected, to expand their services to meet the growing needs (e.g. of a multi-dimensional HIV and AIDS crisis),

129 Reinikka & Svensson 2003.
130 Benn 2002.
131 ARHAP 2006, see also preliminary workshop reports from that study.
132 See CSSC 2007a, Mandi 2006.
133 See 4.7 above, Birdsall & Kelly 2007, Taylor 2007, World Bank 2004.
134 Olivier *et al*. 2006. See Birdsell & Kelly 2007, Taylor 2005a, 2005b & 2006, Tearfund 2006, Munene 2003.
135 Olivier *et al*. 2006.

donors seldom provide core funding. "REs are finding it increasingly difficult to run these expanded programmes looking only to their traditional sources of funds. Many do not receive external support, having to raise their own support locally in resource-constrained settings. Yet they are providing parallel services to government and more."[136]

- FBOs are not tapping into all available funding sources: "FBOs are providing a huge share of the services…Yet despite substantial efforts and good will by all, churches and other faith-based organisations have not yet been consistently successful in accessing resources for their response to HIV and AIDS from international funding agencies."[137] For example, Munene notes that "79% of churches and Christian NGOs responding to HIV and AIDS in Namibia said they receive no outside funding."[138]
- Donor funding: all donor funding has a limited period, and binding conditions can be problematic. Donor support (mainly through projects) can be highly unpredictable, volatile and unsustainable.[139] There is concern over the growing dependence of FBOs on, not-always-reliable foreign assistance.[140]
- Untracked funding: there are funds being channelled directly from international sources (such as US congregations) to FBOs working on the ground without being tracked. In addition, it should be noted that Islam has a strong tradition of solidarity and social support. This is symbolised in the practice of Zakat which is universal in the Islamic world and has been seen by some as an alternative to international aid. Zakat is a Pillar of Islam which requires the giving of resources (money, food, material objects) to the poor. These are direct payments from Islamic communities, for example, to poor families who may receive payments for medicines or food. In Chipata, Zambia, it was found that while the Muslim community did not have many associations or health-facilities in place, they were financing a wing of the local government hospital as part of their social responsibility.[141] However these types of direct (smaller) payments are rarely recognised.[142]
- Vertical financing is reported as a concern as vertical programmes can disregard integration and institutional HR concerns and also fail to support national health system priorities. "What figures do not say is that the source of donor income, contrary to the traditional donors of the sub-sector that had always been present but in very limited proportions, is now represented by disease oriented financing (Global Fund, PEPFAR). This financing approach is extremely specific, targets a narrow scope of inputs, is unpredictable, short term and almost invariably excludes system cost like human resources."[143]

This is another area requiring further investigation, and perhaps research at the organisational case study level, as well as the national and macro levels.

4.8.4 CRISIS RESPONSE

There are of course more general challenges which most FBOs face, the first of which is that the African health systems in which they work are "weak and dysfunctional…[and the] key elements required for health systems to function properly are: adequate numbers of skilled health workers, basic infrastructure and equipment; essential medicines and supplies; and health financing systems. It is also important to establish effective health information systems….Most countries in the African region have carried out health sector reforms to improve their health service delivery. Despite these efforts, health systems in many countries of the African region are weak and not fully functional."[144] In addition, SSA health care systems are coming under increasing pressure from HIV and AIDS in particular, and a wider complex of health crises in general.[145]

There is evidence that, like the health systems, religious entities are also struggling under increasingly trying circumstances, as many have to work under the constant strain of having to do more with less. As Parry notes in her study of HIV and AIDS responses in SSA, "Rural mission hospitals record an increasing burden as patients are discharged from urban health facilities to return to their homes in rural areas. All these services, already inadequate before the onset of HIV, are

136 Olivier *et al*. 2006, see Parry 2002.
137 DIFAEM 2005.
138 Munene 2003.
139 UCMB-UPMB-UMMB 2007.
140 Dimmock 2008.
141 ARHAP 2006.
142 Boudahrain 1984, Converset & Binois 2006.
143 UCMB-UPMB-UMMB 2007.
144 WHO 2006.
145 See Bateman 2003, Benatar 2004.

overburdened with the increased patient load and opportunistic infections, especially TB, and the staff are over-worked. With few increases in resources, these same health facilities are having to expand their services to encompass home based care, counseling, testing, prevention of mother-to-child transmission and all the additional documentation that accompanies these activities. Morale is low and there is high mortality within this sector as well."[146] It should therefore not be forgotten that all FBOs in SSA work in this context of increasingly strained resources – not only the facility-based health providing FBOs, but also the community-based initiatives. Again, not enough is known about the longitudinal effects of these crises on the activities of FBOs. *However, expectations for the involvement of FBOs in health should be tempered by an understanding of the crisis contexts in which they work and the increasing burden that they carry.*

Furthermore, FBOs in SSA are frequently working in conflict situations which have a heavy impact on health delivery, infrastructure and outreach.[147] FBO personnel work in the face of personal risk, and outreach (such as mobile services, vaccination programmes, antenatal care and preventative services) is made difficult.[148] This is also true for some rural areas with no conflict, for example, the CHAs noted that an additional concern in the workforce crisis is women not wanting to work in rural areas because of personal safety concerns.[149] Historically, health services and personnel have been directly targeted as a deliberate strategy as part of the conflict process.[150] A further related challenge is the demand being placed on REs in SSA, responding to the health, social and spiritual needs of refugee and displaced population groups. These might be in conflict or post-conflict situations or as a result of natural events. [151] This is an area where further research would be valuable, especially as it is not only the large international FBOs which are responding to this crisis, but also local congregations.[152]

4.8.5 UNHELPFUL RELIGIOUS ATTITUDES

While this is not a focus of this landscaping, it is necessary to point out that several studies have focused on the negative impact of religion – and by association FBOs – on health. Generally however, over the last five years, this theme has mainly appeared as a qualification to balance studies on the 'positive' impact of FBOs in SSA. It has been well documented that "religion is a powerful cultural force, with both a positive and negative impact on programming."[153] For example, areas of negative impact are issues of sexuality, practices such as FGM; where condom use is prohibited; discouraging education of adolescents on reproductive health; limitation of open discussion on sexuality, gender relations, and intergenerational relations; increasing stigmatisation of people living with HIV and AIDS; and an increased sense of fatalism.[154] It is impossible to generalise about such an impact from FBOs in SSA. In the face of sometimes conflicting religious and health 'directives', some REs openly struggle, engaging in theological debates and advocating for change,[155] while others work around the conflict so as to be able to 'get the work done', despite sometimes conflicting theological directives.[156] Different religious groups have differing positions on contentious health practices, with their theological background influencing their practice.[157] An example is the Catholic Church in Africa, which has simultaneously come under fire from health practitioners for its stance against condoms, and at the same time been lauded as one of the largest health and education providers in Africa due to its theological understanding of care.[158] Religious attitudes emerge in the health sector in a variety of ways, and there is a substantial and growing literature on this topic.

4.9 COLLABORATION AND NETWORKING

Having looked at some of the challenges facing FBOs in SSA, the final section of this desk review briefly considers themes of collaboration and networking found in the secondary literature.

4.9.1 DIALECTIC: ECUMENICAL CO-OPERATION AND EXCLUSION

Ecumenical collaboration has varied widely by place and over time. It can be said in the same breath that FBOs have a

146 Parry 2002.
147 See Chapter 3.
148 Parry 2008, see Lusey-Gekawaku 2003.
149 Mandi 2006.
150 See Parry 2008.
151 Dimmock 2008.
152 See ARHAP 2006, Olivier *et al.* 2006.
153 UNFPA 2005.
154 See Liebowitz 2002, Shaaban & Harbison 2005, Tiendrebeogo & Buykx 2004, UNFPA 2005.
155 See Olivier *et al.* 2006 – outpouring of theological engagement with HIV and AIDS.
156 See Olivier *et al.* 2006, Farrell 2004.
157 See Olivier *et al.* 2006.
158 See above and Olivier *et al.* 2006.

strong historical tradition of ecumenical co-operation (e.g. between Protestant and Catholic health facilities), and that collaboration between religious groups historically has been marred by suspicion and disassociation (e.g. between Christian and Islamic groups, or between 'mainline' churches and the charismatic movements).[159]

4.9.2 NATIONAL FAITH-BASED HEALTH NETWORKS

Umbrella networks such as the CHAs profiled above clearly play a critical role in the development and maintenance of collaborative frameworks. There is a lack of such networks between churches in places such as Rwanda, Togo or Mali, where WCC researchers found that "with the exception of the national or foreign medical missions who are making regular attempts to collaborate, there are scarcely any collaborative relations among the Churches in the form of an operational network. We can [however] see the timid beginnings of such initiatives."[160] NFBHNs forge collaboration between their own members, between their members and the government, between other NFBHNs (in their own countries and beyond), as well as the broader spectrum of secular and non-profit actors. *Research is needed on these networks and what lessons they have learned through practice – and the current study is hoping to make a contribution to this.*

4.9.3 ASSOCIATIONAL INFRASTRUCTURE AT NATIONAL AND LOCAL LEVELS

Liebowitz argues that within most of the FBOs involved in his study in South African and Uganda, "a strong associational infrastructure (exists) at the national and local levels."[161] The Catholic Church is an obvious example, with links between denominational bodies, episcopal councils, international agencies (such as Caritas, CAFOD or Catholic relief) and local structures. Liebowitz gives the example of the Anglican Church of Uganda, which forms an associational infrastructure that includes the Mothers' Union, Fathers' Union, youth groups and other church-related associations, and argues that this provides an advantage to organisations within this umbrella, particularly in rural areas where religious groups are often based.[162] It would seem that such collaboration provides support and access to broader networks and resources for local organisations, while the national level structures gain (further) access to local communities. *However, not enough is known about the spread or consistency of such "intra-religious" collaborative networks, nor about the comparative skills of different co-ordinating bodies.*

4.9.4 DENOMINATIONAL BODIES AND INTERNATIONAL FBOS AS SUB-REGIONAL NETWORKS

Denominational bodies as well as international FBOs frequently work as 'networks', as well as running programmes themselves. For example, the Lutheran World Federation provides both support and a collaborative structure for its members, who are mainly Lutheran religious entities. The Catholic Church appears to be particularly effective in working as a sub-regional network, and facilitating collaboration between its various bodies and organisations. [163]

4.9.5 MULTISECTORAL COLLABORATION

The literature suggests that there has recently been an increase in collaboration between FBOs and secular groups (NGOs, technical groups, government), particularly as a result of the push towards multisectoral HIV and AIDS action.[164] For example, in Kenya: "the Kenya AIDS NGOs Consortium (KANCO), the Kenya Inter Religious AIDS Consortium (KIRAC), the Christian Health Association of Kenya (CHAK) and the Ecumenical Pharmaceutical Network are the avenues for networking for churches and ecumenical organisations and other secular organisations engaged in the fight against HIV/AIDS."[165] It is likely that such collaboration around HIV and AIDS has led to further networking and partnership in other health-related areas. A recent study of 114 FBOs in six Southern African countries identified that 85% of them were a member of an association or co-ordinating body (see Table 4.4).[166]

159 See country profiles above.
160 Josephine *et al*. 2001.
161 Liebowitz 2002.
162 Liebowitz 2002.
163 See Appendix 4.3 – research on the Anglican network in SSA should emerge later in 2008, see Olivier et al. 2006.
164 See ARHAP 2006.
165 Molonzya 2003.
166 Birdsell & Kelly 2007.

Table 4.4 FBOs belonging to an HIV and AIDS association Source: CADRE 2006

Question 4.6: Proportion of responding FBO's (n=144) that is part of an HIV AIDS association or coordinating body		
	Member of an HIV AIDS association or coordinating body	
	n	%
Lesotho (n=24)	19	79.2%
Malawi (n=22)	21	95.5%
Mozambique (n=22)	21	95.5%
Namibia (n=35)	33	94.3%
Swaziland (n=26)	24	92.3%
Zambia(n=15)	14	92.3%
Overall(n=144)	127	88.2%

However, there appears to be a different level of collaboration between formal FBOs (those of the NGO variety) and those of the 'congregational' type. "Many church leaders have failed to engage with secular organisations because they consider their differing values as a threat to the church. They may also have little experience in dealing with the sophisticated bureaucracies of international development agencies, which work within short-term, fixed project cycles, while the church feels unappreciated for its long-term commitment. Secular organisations may in turn doubt the effectiveness of the church, and be uncomfortable about the spiritual emphasis. This lack of trust and understanding can have serious implications in terms of co-ordination and planning around national and local strategies for responses to AIDS."[167] This is just one explanation, but it begins to unpack some of the difficulties some FBOs may have in collaborating with secular groups. Nevertheless, in the ARHAP research in Zambia, the majority of the FBOs working in health had met previously on local 'task forces' and 'working groups' – even though a minority (mainly the Traditional Healers Association and Islamic leaders) were not involved in these multi-sectoral collaborative structures.[168]

4.9.6 LIMITED COLLABORATION OF FBOS WITH NATIONAL HEALTH SYSTEMS

As mentioned above, FBOs in SSA countries frequently own a large portion of the health infrastructure and make a wide-ranging contribution to health provision. However, some studies talk of the 'hidden giant' that is the religious sector, or of faith-based organisations being 'unaligned' with public health systems and sectors.[169] In 1998, Asante noted that there has been only limited integration of REs into national health systems and large development programmes.[170] This appears to still be the case in some countries, where a lack of collaboration between FBOs and governments or government health ministries remains.[171] In other countries, significant progress has been made in developing collaboration relationships – most notably those countries with effective NFBHNs. For example, there are a few countries in which government service agreements have been established with NFBHNs, for example:

- memorandum of understanding (MOU) between CHAM and the Government of Malawi, 2002
- memorandum of understanding between CHAZ and the Government of Zambia, revised 2004
- memorandum of understanding between CHAG and MoH of Ghana, 2003, and
- service agreement between the Government of Lesotho and CHAL, 2002.

The tracking of such MOUs, and other such service agreements which support collaborative partnerships – and discovering how this translates into action - is beyond the aegis of this desk review, but remains an important area for further enquiry.

Reporting on a CHA meeting, Mandi lays out the main challenges of collaboration between FBOs (in this case CHAs) and government as being: lack of co-ordination among FBOs when lobbying since they usually approach governments independently and not as a united front; FBOs do not have adequate lobbying or negotiating powers; there is a lack of trust between governments and FBOs; FBOs fear that if they partner with governments, they will be absorbed and lose their identities; governments view FBOs as direct competitors rather than partners.[172] Mandi does note that, in some contexts, the government has a department in the Ministry of Health for liaison with FBOs, e.g. in Uganda, Zambia and Mali.

167 Taylor 2006.
168 ARHAP 2006.
169 See Olivier *et al.* 2006.
170 Asante 1998.
171 See country profiles above.
172 Mandi 2006.

4.9.7 DIALECTIC REGARDING ADVOCACY ROLE IN HEALTH

The secondary literature on the religious-health landscape of SSA simultaneously speaks of FBOs' (and religious leaders') prominent role as health advocates in the public arena "frequently taking centre stage and utilising public media channels to project their messages";[173] and the conflicting understanding that advocacy and lobbying is one of the areas of great weakness, where FBOs and religious leaders have the 'untapped' *potential* to play a greater public role.[174] It is possible that religious leaders of different traditions have different attitudes towards advocacy and involvement in public life. There is therefore a range of engagement in advocacy, with religious leaders utilising a variety of advocacy tools and methods. The level of involvement seems to depend on what topic is being addressed (e.g. polio eradication, malaria control and HIV prevention have had strong profiles) and from what religious tradition (e.g. in South Africa the Anglican Church have a strong tradition of a vocal leadership on a range of social topics).[175] *Further investigation is necessary to better understand the effects of such varied advocacy efforts on specific health issues and how such advocacy could be strengthened.*

This section on collaboration and partnership only touches on some of the many ways FBOs collaborate with each other, with other secular organisations and with the government. These networks of relationships are possibly one of the reasons FBOs have managed to sustain their work in times of crisis. The UNFPA recommends that "collaboration, dialogue and partnership should be on an ongoing basis, rather than for a single programme or event. Mature relationships and partnerships would then mature, and create possibilities for other joint activities".[176] This recommendation continues to be apt in the context of collaboration in the religious-health landscape, of which unfortunately little has been formally recorded. Furthermore, *the continuum between communication, coordination, cooperation, collaboration and partnership, requires further research, as there are many examples of effective collaboration and partnership which can be learned from across SSA*.[177]

4.10 SUMMARY AND RECOMMENDATIONS

This chapter sought to provide an overview of the religious-health landscape of SSA. Two overarching themes were that there is a lack of systematic evidence in many key areas, and that generalisation across the vast and varied SSA region should be treated with caution as it tends to obscure understanding of the faith-based sector. With such a better understanding – of the role, characteristics and achievements of the faith-based sector – further engagement would be possible, to improve health and well-being. Nevertheless, it would not be too strong a statement to say that the secondary literature depicts a situation in which facility-based and non-facility-based FBOs are working actively, and being challenged in resource-poor contexts. These FBOs frequently claim a preference for working with the rural, poor and marginalised, and generally have backed up that claim with long-term action and presence. It is a great pity that more is not known about these FBOs, their survival strategies, their resilience and intention to make a difference. Not only for purposes of policy or planning, but because something might be there to be learned of an integral intention to care and to act in response to need - in adverse circumstances – which could be translated to the broader aim of making health services work for those who need them most.

In line with the objective of this study, to understand the role of FBOs in SSA to guide future investments and to enhance their role in health, this chapter has reviewed existing databases and literature. The chapter has highlighted these issues:

- There is a need for research to understand and document the role played by FBOS across different scales and countries. The ten country profiles have gone some way towards bringing a range of faith and health data together.
- A standardised nomenclature is required to help with cross-country comparisons and consideration of the overall role of FBOs in health in SSA.
- Challenges facing FBOs in health activities have been highlighted. These include HR, funding, liaison with government and technical capacity.
- A range of actions have been identified that could be used to build the capacity and response of non- facility-based FBOs.

173 See Olivier *et al.* 2006.
174 See ARHAP 2006, Birdsell & Kelly 2007, Josephine *et al.* 2001, Lusey-Gekawaku 2003, Taylor 2006
175 See ARHAP 2006, Olivier *et al*. 2006.
176 UNFPA 2004.
177 Dimmock 2008.

- Specific research is needed to be able to better understand the capacity and constraints of certain sectors of the faith sector in health activities.
- A number of recommendations have been made with the view to understanding, sustaining and enhancing the role of FBOs in health in SSA. These follow.

4.10.1 RECOMMENDATIONS

Research recommendations

- Great care should be taken when applying or interpreting generalisations about the religious-health context, which may not accurately reflect many situations in SSA.
- The advisory committee for this landscaping project suggested that these profiles could be a valuable resource for a range of interested parties, and it is therefore recommended that this becomes the start of a larger landscaping project.
- The FBO and related nomenclature needs development through a collaborative process. Indicators and measures should also be developed to better 'normalise' assessments of the faith-based communities' presence in the national health system(s).
- A more extensive desk review and primary data collection or 'mapping' is needed to overcome a research bias towards large FBOs with more readily available documentation.
- Further research is required in languages other than English.

Areas for further research

- Religious responses to other public health concerns, beyond HIV and AIDS.
- To balance the literature so that a broad view of the religious-health landscape may be understood, inclusive of indigenous religions and 'non-mainstream' religious groups.
- There is a need for further investigation about collaboration, or lack thereof, between traditional health practitioners, indigenous religions, other religious entities and the biomedical health sector.
- Research is needed on the comparative activities or presence of different religious groups in SSA in health.
- The diversity and fluidity (and responsiveness) of REs makes longitudinal research on religious entities important. Policy-makers should heed such important differences among REs while devising ways to harness this potential.
- More intensive data collection techniques than desk review are needed to understand the comparative involvement of FBOs at different levels in diseases other than HIV and AIDS. It is unclear whether such responses are simply not happening to the same scale as responses to HIV and AIDS, or whether other issues are simply wrapped up in the 'holistic' package of faith-based care and grossly underreported.
- The potential for promoting health through education and educational facilities is understood. However, beyond anecdotal evidence, not enough is known about the positive and negative health effects of religious involvement in education on a broad scale.
- There is a need for a closer investigation into the relation between FBOs, their faith-based organisational culture, their technical capacity and their funding situation and organisational development.
- The different collaborative networks that FBOs take part in require closer investigation.
- The continuum between communication, coordination, cooperation, collaboration and partnership, requires further research, as there are many examples of effective collaboration and partnership which can be learned from across SSA.
- Government-FBO service agreements and their translation into action need further investigation since they encompass many of the issues challenging FBOs.
- It would be useful to further research and amalgamate current available data on faith-based medical care in these SSA countries to better understand its level and character in comparison to that of government facilities.
- Further investigation is necessary to better understand the effects of such varied advocacy efforts on specific health issues and how such advocacy could be strengthened.

Recommendations for FBO engagement

- A recommendation that emerges from the secondary literature is that many smaller FBOs would benefit from support through technical assistance or 'incubation' of their organisational capacity in the area of documentation and technical skills.
- The workforce crisis is an area of critical challenge requiring advocacy from religious leaders, innovative ideas from policy-makers and effective collaborative efforts and structures (both between different religions, and between FBOs, secular organisations and governments).
- This is a critical time in the history of some of these facility-based health providing FBOs – as they are being pushed to weigh their organisational culture and reason for being, against the realities of financial support and survival. This is perhaps an area of challenge to the greater ecumenical community – as an issue in which they can become engaged in dialogue and advocacy – as it is a challenge that cuts to the heart of the religious-health landscape, arguing that if FBOs do have unique strengths, or an 'added value', then now is the time to consider just what that added value is worth.

4.11 REFERENCES

Abdool Karim SS, Ziqubu-Page TT, Arendse R. 1994. Bridging the gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa. Supplement, *South African Medical Journal.* **84**, pp.1-16.

Afronews/IRIN. 2007. Mali finds no good way to boost health services. [online]. [Accessed 09/11/2007]. <http://www.afrol.com/articles/25054>

Agadjanian V. 2005. Gender, religious involvement, and HIV/AIDS prevention in Mozambique. *Social Science and Medicine.* **61**(7), pp.1529-1539.

Aga Khan Foundation. 1998. *Sharing responsibilities for better health: the role of NGOs in health sector reform in East Africa.*September 9-11. Aga Khan Foundation.

AKDS. 2007a. [online]. AKDS website. [Accessed 03/08/2007]. <http://www.akdn.org/>

AKDS. 2007b. [online]. AKDS hospitals website. [Accessed 03/08/2007]. <http://www.agakhanhospitals.org/nairobi/about.asp>

Anane M. 1999. The soul is willing: Religion, men and HIV/AIDS in Ghana. In: M Foreman, (ed). *AIDS and men: Taking risks or taking responsibility?* London: Panos, Zed Books, pp,79-94.

ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa.* Cape Town: Report for the World Health Organisation, African Religious Health Assets Programme.

Asante RKO. 1998. *Sustainability of church hospitals in developing countries: a search for criteria for success.* Geneva: (WCC) World Council of Churches.

Asunka J, Gyimah-Boadi E and Mattes R. 2008. *Religion and democratic development in Africa.* Forthcoming.

Ayami JY. 2004. The role of interfaith collaboration in the elimination of stigma in Zambia. *Sexual Health Exchange* 1(2004), pp.14-15.

Baer FC. 2007. [online]. FBO health networks and renewing primary health care. [Accessed 03/03/2008]. <http://renewingphc.org/fbos/FBOs_and_renewing_PHC.htm>

Baer F. 2001. IMA signs $25 Million Contract for SANRU III. *Forum*, (CCIH) Christian Connections in International Health.

Baer F. 1994. Health systems strengthening in West and Central Africa. Baertracks, August 1994

Baer F. 1994. Working with NGOs to develop integrated health systems. Presentation made at the World Bank, 1994.

Baer F. 1992. SANRU: Lessons Learned (1981-1991), a report prepared for USAID.

Baer F and Kintaudi L. 2005. The DR Congo experience in health system development and management. *CCIH Conference*, 2005. Christian Connections for International Health.

Baird TL. 1999. Christian hospitals in Nigeria provide post abortion care and STD management. *CCIH Forum (March),* Christian Connections for International Health.

Barton T, Thamae S and Ntoanyane M. 1997. AIDS in Lesotho: *A community-based response: A summary evaluation of the CHAL-DCA AIDS Project.* Maseru, Lesotho: Christian Health Association of Lesotho and DanChurchAid.

Bateman C. 2003. Health care workers cracking under HIV/AIDS workload. *South African Medical Journal.* **93,** pp.734-736.

Baylies C and Bujra J. 2000. AIDS, *sexuality and gender in Africa: collective strategies and struggles in Tanzania and Zambia.* London and New York: Routledge.

Benatar SR. 2004. Health care reform and the crisis of HIV and AIDS in South Africa. *The New England Journal of Medicine.* **351**(1), pp.81-93.

Benn C. 2003. Why religious health assets matter. *ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003,* (ARHAP) African Religious Health Assets Programme.

Benn C. 2002. The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic. *Journal of Theology for Southern Africa.* **113**(July), pp.3-18.

Benn C. 2001. Concepts for church related health care in the 21st century. In: Neglected dimensions in health and healing: Concepts and explorations in an ecumenical perspective, Tübingen, *(DIFAEM) German Institute for Medical Mission Study Document.* **3**, pp.59-73.

Birdsall K. 2005. *Faith-based responses to HIV/AIDS in South Africa: an analysis of the activities of faith-based organisations (FBOs) in the national HIV/AIDS database.* Johannesburg, South Africa: (CADRE) Centre for AIDS Development, Research and Evaluation.

Birdsall K and Kelly K. 2007. *Pioneers, partners, providers: the dynamics of civil society and AIDS funding in Southern Africa.* Johannesburg, South Africa: (CADRE) Centre for AIDS Development, Research and Evaluation and the Open Society Initiative for Southern Africa.

Birdsall K and Kelly K. 2005. Community responses to HIV/AIDS in South Africa: Findings from a multi-country survey Johannesburg, South Africa: (CADRE) Centre for AIDS Development, Research and Evaluation.

Bitran R. 1995. Efficiency and quality in the public and private sectors in Senegal. *Health Policy and Planning.* **10** (3), pp.271-283.

Boudahrain A. 1984. Pour un système islamique de protection sociale par la Zakât in XVI Congrès de l'Institut International de Droit d'Expression Française (I.D.E.F.) Rabat, 20-27 novembre 1983: Religion, Philosophie et Droit. *Revue Juridique et Politique, Indépendance et Cooperation.* **38**(2), pp.298-314.

CADRE. 2007. OSISA study report. Personal correspondence with Karen Birdsell, 15/11/2007.

CAFOD. 2007. [online]. CAFOD website. [Accessed 30/11/2007]. <http://www.cafod.org.uk>

CAFOD. 2006. *Review of the year 2005-2006.* London, UK: (CAFOD) Catholic Agency for Overseas Development.

Castle S. 2007. *The contribution of faith-based organisations: networks and traditions to health in Africa: a literature review.* Bamako, Mali: ARHAP FBO-landscaping for the Bill and Melinda Gates Foundation.

Castle S. 1992. *Intra-household variation in child care and illness management in rural Mali.* Doctoral thesis. Centre for Population Studies, London School of Hygiene and Tropical Medicine.

Castle S and Diarra A. 2003. *The international migration of young Malians: tradition, necessity or rite of passage?* Bamako, Mali: Report to Save the Children USA.

CCIH. 2007a. [online] CCIH website. [Accessed 01/10/2007]. <http://ccih.org>

CCIH. 2007b. [online]. GRHAM Mapping of ECC. [Accessed 01/08/2007]. <http://ccih.org/grham/>

Central Statistics. 2003. Zambia Demographic and Health Survey (ZDHS) 2001-2002. Calverton Maryland USA: Central Statistical O.ce, Central Board of Health, and ORC Macro.

CHAG. 2007. [online]. CHAG website. [Accessed 10/09/2007]. <www.chagghana.org>

CHAG. 2006. Annual report: June 2005 - May 2006. [online]. CHAG website. [Accessed 10/09/2007]. <www.chagghana.org>

CHAK. 2007a. A situational analysis study of the faith based health services vis-à-vis the government health services. Report to the MOH-FBHS Technical Working Group. Christian Health Association of Kenya and German Technical Cooperation.

CHAK. 2007b. [online]. Christian Health Association of Kenya website. [Accessed 01/08/2007]. <http;//www.chak.or.ke>

CHAK. 2006. Annual Report 2006. Christian Health Association of Kenya. [online]. [Accessed 01/08/2007]. <http;//www.chak.or.ke>

CHAK. 2005. Christian Health Association of Kenya. Brochure. Nairobi: Christian Health Association of Kenya. [online]. [Accessed 01/08/2007]. <http;//www.chak.or.ke>

CHAL. 2006. CHAL *Pamphlet.* CHAL, Maseru: Christian Health Association of Lesotho.

CHAN. 2007. Christian Health Association of Nigeria website. [online]. [Accessed 01/08/2007]. <http://channigeria.org/articles/htfd.html>

CHAN. 2006. CHAN National Advocacy Committee delegation to Minister of Health Prof Lambo. [online]. [Accessed 10/09/2007]. <http://channigeria.org/articles/htfd.html>

Chand S and Patterson J. 2007. *Faithbased models for improving maternal and newborn health*. Baltimore, USA: USAID-ACCESS.

CHAZ. 2006. Christian Health Association of Zambia website. [online]. [Accessed 20/03/2006]. <www.chaz.org.zm>

Chipfakacha VG. 1997. STD/HIV/AIDS knowledge, beliefs and practices of traditional healers in Botswana. AIDS Care. 9(4), pp.417 – 425.

Church of England. 2004. *Telling the story: being positive about HIV/AIDS*. London, UK: Mission and Public Affairs Council, Church of England.

Church of Nigeria. 2004. *National HIV/AIDS 4 year strategic plan 2004-2008*. Church of Nigeria, Anglican Communion.

CIA. 2007. [online]. *CIA – the 2008 world factbook*. [Accessed 03/01/2008]. <https://www.cia.gov/library/publications/the-world-factbook/index.html>

CNN. 2007. [online]. Council of Churches of Namibia website. [Accessed 03/01/2008]. <http://www.thenamibiandream.info/Information/CouncilofChurchesinNamibia/tabid/80/Default.aspx>

Colvin M, Gumede L, Grimwade K, Maher D and Wilkinson D. 2003. Contribution of traditional healers to a rural tuberculosis control programme in Hlabisa, South Africa. *International Journal of Tuberculosis Lung Disease*. **7**(9), pp.86-91.

Converset E and Binois JM. 2006. *La zakat au Soudan; une alterantive islamique à l'aide humanitaire internationale?* Concept paper. Institu universitaire d'études du développement. Geneva: IUED.

CSSC. 2007a. Christian Health Associations at crossroad toward achieving health millenium development goals. *Christian Health Association's Conference, 16-18 January 2007, Dar es Salaam*. Tanzania: (CSSC) Christian Social Services Commission, pp.1-28.

CSSC. 2007b. *Christian Health Association's Conference planning document*. Tanzania: (CSSC) Christian Social Services Commission.

DIFAEM. 2005. *Global assessment of faith-based organizations' access to resources for HIV and AIDS response*. Tubingen, Germany: (DIFAEM) German Institute for Medical Mission.

DFID. 2006. *Promoting women's rights through sharia in Northern Nigeria*. Zaria, Nigeria: (DFID) Department for International Development, and Centre for Islamic Legal Studies, Ahmadu Bello University.

Dimmock F. 2008. Personal correspondence. Advisory group. ARHAP-Gates FBO-Landscaping project. Cape Town, South Africa.

Dimmock F. 2007. Faithbased health networks in Africa. Partnerships for Health and Wholeness, May 2007, Bagamoyo. (CCIH) Christian Connections for International Health Conference.

Dimmock F. 2005. Christian health associations in Africa. Presentation. *CCIH Annual Conference, May 2005*. (CCIH) Christian Connections for International Health Conference.

ECC. 2007. Eglise du Christ au Congo website. [online]. [Accessed 03/08/2007]. <http://ecc.faithweb.com/>

EECMY. 2007. Ethiopian Evangelical Church Mekane Yesus website. [online]. [Accessed 03/08/2007]. <http://www.eecmy.org>

EECMY. 1999. *HIV/AIDS/STD Prevention and Control Programme Strategic Plans (2000-2004)*. Addis Ababa, Ethiopia, Ethiopian Evangelical Church Mekane Yesus.

EECMY-DASSC. 2007. *Half year report 2007*. Addis Abbiba: Ethiopian Evangelical Church Mekane Yesus.

EHAIA. 2006. [online]. WCC mapping of SSA. [Accessed 20/08/2007]. <http://www.wcc-coe.org/wcc/what/mission/ehaia-html>

EPN. 2007a. *Annual report 2006*. Nairobi, Kenya: Ecumenical Pharmaceutical Network.

EPN. 2007b. [online]. Maximising access to essential medicines for church health services and their clients. [Accessed 20/08/2007]. <http://www.epnetwork.org/en/access>

EPN. 2007c. [online]. Ecumenical Pharmaceutical Network website. [Accessed 20/08/2007]. <http://www.epnetwork.org>

EPN. 2005a. [online]. Ghana baseline survey. [Accessed 03/01/2008] <http://www.epnetwork.org/en/access/research/ghana>

EPN. 2005b. *Organisational strategy 2004–2007: strengthening the network and intensifying its impact*. Nairobi, Kenya: Ecumenical Pharmaceutical Network.

EPN. 2004. [online]. Multi-country study for faith-based drug supply organisations (DSOs). [Accessec 24/10/2007/]. <http://www.epnetwork.org/en/taxonomy/term/54>

Erasmus JC and Mans G. 2005. Churches as service providers for victims of sexual violence and crime: A case study from the Paarl community. *Acta Criminologica,* **18**(1), pp.140-163.

Farrell M. 2004. Condoning or condemning the condom: Lessons learned from Uganda. *Sexual Health Exchange* 1(2004), pp.7-8

Flessa S. 1998. The costs of hospital services: A case study of evangelical Lutheran church hospitals in Tanzania. *Health Policy and Planning,* **13**(4), pp.397-407.

Foster G. 2003. *Study of the response by faith-based organisations to orphans and vulnerable children: Preliminary summary report*. New York: (WCRP) World Conference of Religions for Peace and (UNICEF) United Nations Children Fund.

Garner RC. 2000. Safe sects? Dynamic religion and AIDS in South Africa. *Journal of Modern African Studies*. **38**(1), pp.41-69.

Gausset Q. 2001. AIDS and cultural practices in Africa: The case of the Tonga (Zambia). *Social Science and Medicine.* **52**: 81.

Gelfand M. 1988. *Godley medicine in Zimbabwe.* Zimbabwe, Harare: Mambo Press.

Ghana Health Services. 2005. *The health sector in Ghana: facts and figures 2005.* Accra, Ghana: Ghana Health Services. [Accessed 20/10/2007]. <http://www.ghanahealthservice.org/includes/upload/publications/FACTS%20AND%20FIGURES%202005.pdf>

Global Ministries. 2007. [online] Global Ministries website. [Accessed 24/10/2007]. <http://www.globalministries.org/africa/Projects/afr-les5.htm>

Good CM. 1991. Pioneer medical missions in colonial Africa. *Social Science and Medicine.* **32**(1), pp.1-10.

Government of Ghana. 2003. *Memorandum of Understanding between the Christian Health Assocaition of Ghana and the Ministry of Health.* Republic of Ghana.

Government of Lesotho. 2002. *Service agreement between the Government of Lesotho and the Christian Health Association of Lesotho.* Maseru, Lesotho: Government of Lesotho.

Government of Malawi. 2002. *Memorandum of Understanding between the Christian Health Association of Malawi and the Government of Malawi,* 09 Dec 2002. Llilongwe: Government of Malawi.

Government of Malawi. 2001. *National Health Accounts (NHA)*: A broader perspective of the *Malawian health sector, 1998/9 financial year.* Lilongwe, Malawi: Ministry of Health and Population, Republic of Malawi.

Government of Zambia. 2004. *Revised memorandum of understanding between the Christian Health Association of Zambia and the Government of Zambia – revised 2004.* Lusaka, Zambia: Republic of Zambia.

Green EC. 2003. *Faith-based organisations: contributions to HIV prevention.* Washington DC: (USAID) US Agency for International Development and the Synergy Project, TvT Associates, Harvard Center for Population and Development Studies.

Green EC. 2003. The impact of religious health organisations in promoting HIV/AIDS prevention. *In: EC Green (ed), The AIDS crisis in developing countries.* Westport, CT: Praeger Publishers.

Green A, Shaw J, Dimmock F and Conn C. 2002. A shared mission? Changing relationships between government and church health services in Africa. *International Journal of Health Planning and Management.* **17**, pp.333-353.

Hackney TS. 2000. The invisible giant: The Christian health system. MPH degree. Atlanta, GA: Emory University.

HERA. 2005. *Public private partnership for equitable provision of quality health services, technical review 2005.* Belgium: (HERA) Health Research for Action for the Ministry of Health, Government of Tanzania.

IDT. 1998. *Religious health networks survey report.* Los Altos, CA: (IDT) The Institute for Development Training for the David and Lucille Packard Foundation.

IHP. 2003. Role and involvement of faith-based organisations in HIV/AIDS pandemic: brief summary: Inventory of the Catholic Church's response to HIV/AIDS in Kenya. (ICASA) *International Conference in HIV/AIDS and STDs in Africa. Kenya*, (IHP) Emory Interfaith Health Programme

IMAU. 2001. Proceedings: Islamic Associations fighting against AIDS. *The 1st International Muslim Leaders Consultation On HIV/AIDS, 1–4 November 2001, Kampala, Uganda.* Islamic Medical Association of Uganda.

IMAU. 1998. *AIDS education through Imams: A spiritually motivated community effort in Uganda.* Geneva: (UNAIDS) Joint United Nations Programme on HIV/AIDS and (IMAU) Islamic Medical Association of Uganda.

Islamic Relief. 2007a. [online] Islamic Relief worldwide, website. [Accessed 03/01/2008]. <http://www.islamic-relief.com>

Islamic Relief. 2007b. [online] Islamic Relief South Africa. [Accessed 03/01/2008]. <http://www.islamic-relief.co.za>.

Islamic Relief. 2007c. Darfur and Chad, scarred by conflict. *Partnership.* **32**(Autumn), pp.1-21.

Islamic Relief. 2007d. *Strategy 2007-2009, working for change.* Birmingham, UK: Islamic Relief Worldwide.

Islamic Relief. 2005. *Annual report 2005*. Birmingham, UK: Islamic Relief Worldwide.

Jabbour S and Houad FM. 2004. *Religion-based tobacco control interventions: how should WHO proceed?* Bulletin of the WHO. Geneva, Switzerland: (WHO) World Health Organisation.

JMS. 2007. [online]. Joint Medical Store website. [Accessed 24/11/2007]. <http://www.jms.co.ug/>

Josephine SK, Agapit AY and Tatagan-Agbi K. 2001. *Churches and the HIV/AIDS pandemic: analysis of the situation in ten West African countries.* Geneva: (WCC) World Council of Churches, World Alliance of YMCAs.

Kagimu M. 2003. Faith-based community mobilisation and education for antiretroviral therapy in Uganda. Sexual Health Exchange. 3, pp.1-3.

Kapungwe A. 2003. Traditional cultural practices of imparting sex education and the fight against HIV/AIDS: The case of initiation ceremonies for girls in Zambia. *African Sociological Review.* **7**(1), pp.35-52.

Kawasaki E. 2001. *The drug supply system of missionary organisations in developing countries: evaluation and analysis of the efficiency and capacity of systems.* Department of International Health, Boston University School of Public Health.

Kenya Catholic Secretariat. 2003. *Inventory of the Catholic Church's response to HIV/AIDS in Kenya.* Nairobi, Kenya: Kenya Episcopal Conference.

King, R. 2000. *Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: a literature review.* Geneva: Joint United Nations Programme on HIV/AIDS.

Kintaudi L, Derstine P and Baer F. 2004. Faith-based co-management of health zones and umbrella projects in DR Congo. APHA presentation, *(APHA) American Public Health Association Meeting, 2004.*

Kitchen M. 2002. World must coordinate efforts, end waste, says Wolfensohn. UN Wire, 24/10/2002.

Lagarde E, Enel C, Seck K, Gueye-Ndiaye A, Piau J, Pison G, Delaunay V, Ndoye I and Mboup S. 2000. Religion and protective behaviours towards AIDS in rural Senegal. *AIDS.* **14**(13), pp.2027-2033.

Liebowitz J. 2003. *Faith-based organisations and HIV/AIDS in Uganda and KwaZulu-Natal.* KwaZulu Natal: (HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal.

Liebowitz J. 2002. *The impact of faith-based organisations on HIV/AIDS prevention and mitigation in Africa*. KwaZulu Natal: (HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal.

Lochoro P. 2008. *Uganda and its health system, Uganda summary and literature review.* ARHAP FBO Landscaping Project for the Bill and Melinda Gates Foundation.

Logez S and Everard M. 2004. Multi-country study on drug supply and distribution activities of faith-based supply organisations in sub-Saharan African countries, 2003. EPN/WHO Feedback meeting: *Promoting use of effective medicines supply strategies in Africa. Nairobi, Kenya.*

Lom MM. 2001. Senegal's recipe for success. *Africa Recovery.* 15(1-2), pp.24.

Lucas S. 2004. Community, care, change, and hope: Local responses to HIV in Zambia. Synergy project: *A lessons learned case study.* (SSS) Social and Scientific Systems.

Lusey-Gekawaku H. 2003. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in five countries of central Africa.* Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa

Makau N, Niemeyer LL and Okello N. 1996. *The response of Kenya churches to the AIDS epidemic and their perceived barriers to behaviour change.* Nairobi, Kenya: MAP International.

Malawi Report. 2001. Towards government-religious organisations collaboration in HIV/AIDS prevention and care. In: S Parry. *Responses of the faith-based organisations to HIV/AIDS in sub-Saharan Africa.* 2003. Harare and Geneva: WCC and EHAIA.

Malungo JRS. 2001. Sexual cleansing (kusalazya) and levirate marriage (kunjilila mung'anda) in the era of AIDS: Changes in perceptions and practices in Zambia. *Social Science and Medicine.* **53**, pp.371-382.

Mandi F. 2006. Planning, developing and supporting the faith-based health workforce. *African Christian Health Associations' Human Resources for Health Mini-Forum.* Nairobi, Kenya: The Capacity Project and Medicus Mundi International.

Manji F and O'Coill C. 2002. The missionary position: NGOs and development in Africa. *International Affairs.* **78**(3), pp.567–583.

Masterson JM and Swanson JH. 2000. *Female genital cutting: Breaking the silence, enabling change.* Washington: (ICRW) International Center for Research on Women.

Mazala EM. 2003. *Situational analysis of the church response to HIV/AIDS in Zambia.* Lusaka: Expanded Church Response Trust (ECR) and Pan African Christian Aids Network (PACANET).

McInnes, B. 1997. *Flag across the Zambezi (History 1922-1997).* Zambia: The Salvation Army Zambia.

Mhango L. 2001. *Highlights of Presbyterian Church (USA) bednet programme.* Mzuzu, Malawi: Presbyterian Church (USA).

Molonzya M. 2003. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in six countries of Eastern Africa.* Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa.

MOH-Lesotho. 2007. [online]. Christian Health Association of Lesotho, Ministry of Health, Government of Lesotho website. [Accessed 24/10/2007]. <http://www.health.gov.ls/partners/partners_service.php>

MOH-Zambia. 2002. *Zambia national health accounts 1995-1998.* Lusaka: Ministry Of Health / Central Board of Health. Government of Lesotho.

MOH-Zambia. 1998. *Zambia national health accounts 1995-1998.* Lusaka: Ministry Of Health / Central Board of Health. Government of Lesotho.

Miatudila M, Kidinda-Shandungo J, and Baer F. 2006. SANRU III Final Evaluation. Kinshasa, DRC: Interchurch Medical Assistance (I.M.A.)

Miroza J. 2005. Le Nord-Kivu enrichi d'un laboratoire pharmaceutique. [online]. [Accessed 09/11/2007]. <http://www.santetropicale.com/actualites/0505/0505_15.htm>

Mugambi JNK. 2000. *African heritage and contemporary Christianity.* Nairobi, Kenya: Longhorn Publishers.

Munene JAW. 2003. *A situational analysis of the church's responses to HIV/AIDS.* (PACANet) Christian HIV/AIDS Country Coordinating Mechanisms in Zambia, Swaziland, Uganda and Namibia.

Musau, Stephen et al. 1999. *Health financing in mission hospitals - Cost study for East Africa.* Nairobi, Kenya: Management Sciences for Health /USAID Kenya.

Musau, Stephen et al. 1998. *Cost analysis for PCEA Chogoria Hospital - Case study.* Nairobi, Kenya: Management Sciences for Health, USAID Kenya.

Mwenda S. 2007. HR crisis in Kenya, the dilema of FBOs. *Church Health Association Conference, Dar es Salaam/Bagamoyo Tanzania.* Christian Social Services Commission.

Mwiindi J. 2007. EPN, a tool for CHAs. *Church Health Association Conference, Dar es Salaam/Bagamoyo Tanzania.* Christian Social Services Commission.

NEPAD. 2003. The New Partnership For Africa's Development, Health Strategy. [online]. [Accessed 03/01/2008]. <http://www.afro.who.int/dsd/nepad_health_strategy.pdf>

Nussbaum S (ed). 2005. *The contribution of Christian congregations to the battle with HIV and AIDS at the community level.* Oxford, Global Mapping International for Oxford Centre for Mission Studies.

Olivier J, Cochrane JR and Schmid B. 2006. ARHAP *bibliography: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.

Olivier J, Cochrane JR and Schmid B. 2006. ARHAP *literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.

One World. 2007. [online] One World Mali country guide. [Accessed 24/11/2007]. <http://uk.oneworld.net/guides/mali/development>

Onyango P (unknown). *Working with religious leaders to prevent the spread of HIV/AIDS in Senegal.* (FHI) Case Study Eleven Aidscap/Senegal, AIDS Control and Prevention (Aidscap) Project, Family Health International, Dakar, Senegal.

Oomman N, Bernstein M, Rosenzweig S. 2007. *Following the funding for HIV/AIDS: a comparative analysis of the funding practices of PEPFAR, the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia.* HIV/AIDS Monitor and Center for Global Development.

Otolok-Tanga E, Atuyambe L, Murphy C, Ringheim KE, Woldehanna S. 2007. Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: a case study of Uganda. African Health Sciences **7**(1).

PACANet. 2002. Keeping the promise? African churches speak! PACANet response to the UN General Assembly Special Session on HIV/AIDS Review of the 2001 Declaration of Commitments.

Parker W and Birdsall K. 2005. HIV/AIDS, stigma and faith-based organisations: a review. Johannesburg: (CADRE) Centre for AIDS Development, Research and Evaluation and DFID Futures Group MSP.

Parry S. 2008. Personal correspondence. Advisory Committee. ARHAP-Gates Foundation FBO Landscaping Project. Cape Town, South Africa.

Parry S. 2005. *Responses of the churches to HIV and AIDS in South Africa.* Geneva: (WCC) World Council of Churches.

Parry S. 2003. Responses of the faith-based organisations to *HIV/AIDS in sub-Saharan Africa.* Harare and Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa.

Parry S. 2002. *Responses of the churches to HIV/AIDS: three Southern African Countries.* Harare and Geneva: (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office.

PEPFAR. 2005. *The president's emergency plan for AIDS relief: community and faith-based organisations.* Washington, USA: (PEPFAR) The President's Emergency Plan for AIDS Relief.

RCZ. 2007. *Directory of congregations and institutions.* Lusaka, Zambia: Reformed Church in Zambia.

Reinikka R and Svensson J. 2003. *Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda.* Washington, DC: World Bank.

Renders M. 2002. An ambiguous adventure: Muslim organisations and the discourse of 'development' in Senegal. *Journal of Religion in Africa.* **32**(1), pp.61-82.

Republic of Uganda, MOH. 2007. [online]. Ministry of Health website. [Accessed 27/06/2005]. <http://www.health.go.ug/profile.htm>

Republic of Uganda. 2001a. *Facility-based private not-for-profit health providers: A quantitative survey.* Kampala: Ministry of Health in collaboration with Uganda Catholic, Muslim, and Protestant Medical Bureaux, National Health Consumers Organisation and Tropical Business Research.

Republic of Uganda. 2001b. *Policy for partnership with facility-based private not-for-profit health providers.* Kampala: Ministry of Health, Republic of Uganda.

Republic of Uganda. 2000. *National health accounts for Uganda: tracking expenditure in the health sector – both public and private FY 1997/98.* Kampala, Uganda: Ministry of Health Economic Policy Research Centre.

Richter M. 2003. *Traditional medicines and traditional healers in South Africa.* Cape Town, South Africa: (TAC) Treatment Action Campaign and Aids Law project.

Robinson M and White G. 1998. The role of civic organisations in the provision of social services: towards synergy. In: G Mwabu, C Ugaz and G White (eds), *New patterns of social provision in low income countries.* Oxford: Oxford University Press and UNI.WIDER.

SACBC. 2007. [online]. South African Catholic Bishops Conference website. [Accessed 21/09/2007]. <http://sacbc.org.za/>

SACBC. 2003. *South African Catholic Bishops Conference statements on HIV/AIDS 2002-2003.* Pretoria, South Africa: (SACBC) South African Catholic Bishops Conference.

Sahl IMG, Elkarib AAK and Mohamed EMI. 2004. Towards a new 'silif': Breaking the silence on FGM among the Beja pastoralists of eastern Sudan. *Development Practice Series 1*, Nairobi and London, (ACORD) Agency for Co-operation and Research in Development.

SANRU. 2007. [online] SANRU website. [Accessed 27/10/2007]. <http://sanru.org/about_sanru.htm>

Sanvee J, Akolatste Y, Tatagan A. 2001. *The churches confronted with the problem of HIV/AIDS: Analysis of the situation in 10 West and Central African Countries.* Geneva: (WCC) World Council of Churches Publications.

Schwerzel P. 2007. *Development of a framework for the development of a benefit and motivation package for rural health workers in voluntary agencies (VA) owned hospitals: based on findings in the Lake Zone.* HRH Global Resource Center; (IMA) Interchurch Medical Assistance.

Shaaban L and Harbison S. 2005. Reaching the tipping point against female genital mutilation. The Lancet. **366**, pp.347-349.

Takyi BK. 2003. Religion and women's health in Ghana: Insights into HIV/AIDS preventive and protective behaviour. *Social Science and Medicine.* **56**, pp.1221-1234.

Taylor N. 2007. *DFID, faith and AIDS: A review for the update of taking action.* London: UK Consortium on AIDS and International Development.

Tearfund. 2006. *Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa.* Teddington, UK: Tearfund

Taylor N. 2006. *Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa.* HIV/AIDS Briefing Paper 7. Teddington, UK: Tearfund.

Taylor N. 2005a. *Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS*. HIV/AIDS Briefing Paper 4. Teddington, UK: Tearfund.

Taylor N. 2005b. *The warriors and the faithful: The World Bank MAP and local faith-based initiatives in the fight against HIV and AIDS*. HIV/AIDS Briefing Paper 5. Teddington, UK: Tearfund.

Thomas L, Schmid B, Gwele M, Ngubo R and Cochrane JR. 2006. *Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS*. Cape Town: (ARHAP) African Religious Health Assets Programme.

Tiendrebeogo G. 2003. *External review of the church response to AIDS in the Eastern province in Cameroon*. The Hague, Netherlands: Report to CORDAID.

Tiendrebeogo G and Buykx M. 2004. *Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa*. Amsterdam, Netherlands: (KIT) Koninklijk Instituut voor de Tropen.

Tiendrebeogo G, Buykx M and Beelen N. 2004. Faith-based responses and opportunities for a multisectoral approach. *Sexual Health Exchange*. **1**, pp.1-3.

Tostan. 2007. [online] TOSTAN website. [Accessed 09/11/2007]. <http://www.tostan.org/>

Trinitapoli J and Regnerus R. 2005. Religious responses to AIDS in sub-Saharan Africa: An examination of religious congregations in rural Malawi. *American Sociological Association Annual Meeting,* Philadelphia, PA.

TSA. 2007. [online]. The Salvation Army International website. [Accessed 09/11/2007]. <http://www.salvationarmy.org>

UCMB. 2007. [online]. Ugandan Catholic Medical Bureau website. [Accessed 09/11/2007]. <http://www.ucmb.co.ug/>

UCMB-UPMB-UMMB. 2007. Facts and figures of the PNFPs: knowing and understanding the facility-based PNFP health subsector in Uganda. Kampala, Uganda: Ugandan Catholic Medical Bureau, Ugandan Protestant Medical Bureau, Ugandan Muslim Medical Bureau.

USAID. 2007. *Working with faith-based organisations to strengthen human resources for health*. The Capacity Project. [Accessed 27/11/2007]. <www.capacityproject.org>

USAID. 2004. *USAID's work with faith and community-based organisations*. (USAID) United States Agency for International Development. [Accessed 10/12/2004]. <http://www.usaid.gov/our_work/global_health/aids?TechAreas/community/fbocbofactsheet.html>

UNAIDS. 1998a. A measure of success in Uganda. UNAIDS case study. Geneva: (UNAIDS) Joint United Nations Programme on HIV/AIDS.

UNAIDS. 1998b Islamic Medical Association of Uganda: UNIAIDS Best Practice Collection. [Accessed 24/11/2007]. <http://www.unaids.org/publications/documents/sectors/religion/imamscse.pdf>

UNFPA. 2007. *Malawi: mobilizing traditional and religious leaders in the fight against HIV/AIDS*. Lessons from the Field: United Nations Population Fund. [Accessed 11/14/2007]. <www.unfpa.org/culture/case_studies/malawi_study.htm>

UNFPA. 2005. *Culture in the context of UNFPA programmeming: ICDP+10 survey results on culture and religion*. New York: United Nations Population Fund.

UNFPA. 2004. *Culture matters: working with communities and faith-based organisations: case studies from country programmes*. New York: United Nations Population Fund.

UNICEF. 2004a. Sharing common goals: faith-based organisations and children. (UNICEF) United Nations Children's Fund. [Accessed 25/05/2004]. < http://www.unicef.org/media_4537.html>

UNICEF. 2004b. Building trust in immunization: partnering with religious leaders and groups. (UNICEF) United Nations Children's Fund. [Accessed 27/10/2007]. <http://www.comminit.com/redirect.cgi?r=http://www.unicef.org/publications/building_trust_immunization.pdf>

UNICEF. 2005. Christian polio eradication partnership in Angola. (UNICEF) United Nations Children's Fund. [Accessed 27/10/2007]. <http://www.comminit.com/en/node/127825>

UPMB. 2007. [online]. Uganda Protestant Medical Bureau. [Accessed 02/11/2007]. <http://www.upmb.co.ug/>

Vogel RJ and Stephens B. 1989. Availability of pharmaceuticals in sub-Saharan Africa: Role of the public, private and church mission sectors. Social Science and Medicine. 29(4), pp.479-486.

Ward N, Kader R and Dankyau M. 2004. The role of faith-based organisations in Africa. Sexual Health Exchange 1(2004), pp.4-5.

Webster L. 2005. *From policies to people: an analysis of the mechanisms in place to resource community responses to HIV and AIDS in Kenya*. Tearfund HIV/AIDS Briefing Paper 6. Teddington, UK: Tearfund.

WHO. 2006. *Africa Regional Health Report 2006.* Geneva: (WHO) World Health Organization.

WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

WHO Afro. 2004. *Migration of health professionals in six countries: a synthesis report.* Brazaville: (WHO) World Health Organization, Regional Office for Africa.

WHO-EPN. 2006. *Multi-country study of medicine supply and distribution activities of faith-based organisations in sub-Saharan African countries.* Geneva, Switzerland: (WHO) World Health Organization and (EPN) Ecumenical Pharmaceutical Network.

Whyte MA. 1996. Talking about AIDS: the biography of a local AIDS program within the church of Uganda. In: Il Schenker, G Sabar-Friedman and F Sy (eds). AIDS education: *Interventions in multicultural societies.* New York: Plenum Press, pp.221-238.

Wilkinson D, Gcabashe L, Lurie M. 1999. Traditional healers as tuberculosis treatment supervisors: Precedent and potential. *International Journal of Tuberculour Lung Disease.* **3**, pp.838-842.

Woldehanna S, Ringheim K, Murphy C, Keikelame MJ, Gibson J, Odyniec G, Clerisme C, Uttekar BP, Nyamongo IK, Savosnick P, Im-Em W, Tanga EO, Atuyambe L and Perry T. 2005. Faith in action: *Examining the role of faith-based organisations in addressing HIV/AIDS. A multi country key informant survey.* Washington, DC: (GHC) Global Health Council.

World Bank. 2004. Concept note. *HIV/ AIDS Workshop for Faith-based Organisations and National AIDS Councils Accra, Ghana, January 2004.* Washington, DC: World Bank.

Wreford J. 2005. *'We can help!' - A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa.* Working paper. Cape Town: (CSSR) Centre for Social Science Research, University of Cape Town.

Yamba CB. 1997. Cosmologies in turmoil: Witchfinding and AIDS in Chiawa, Zambia. *Africa.* **67**(2), pp.200-223.

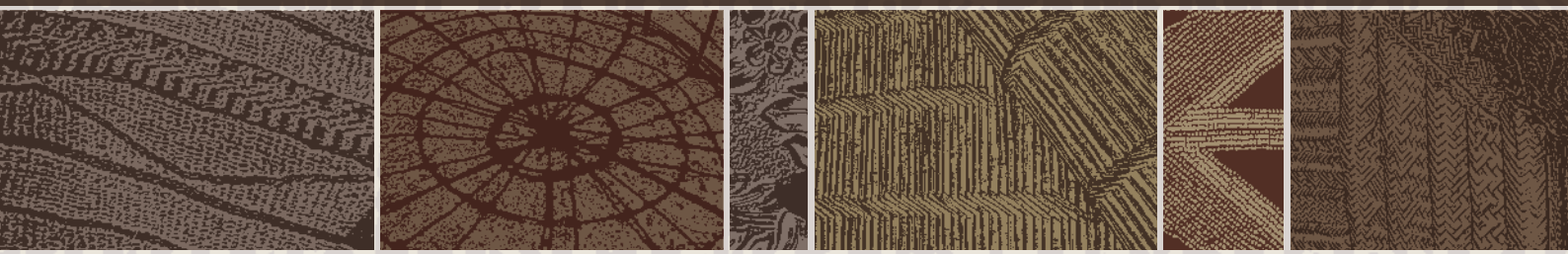
Young H. 2005. *More than words? Action for orphans and vulnerable children in Africa: Monitoring progress towards the UN declaration of commitment on HIV/AIDS.* Milton Keynes, UK: World Vision.

Zambezi RN. 2005. *Church-based interventions for HIV/AIDS prevention in Ndola, Zambia.* MPH. Department of Global Health Rollins School of Public Health, University of Exeter, Emory University.

ZINGO. 2002. *Faith-based organisations (FBO) responses to HIV/AIDS in Livingstone, Lusaka and Kitwe – Zambia. Strategic visioning for a Zambia free of HIV/AIDS.* Lusaka, Zambia: (ZINGO) Zambia Interfaith Networking Group on HIV/AIDS and (NAC) the National AIDS Council of Zambia.

CHAPTER 5

CASE-STUDY ZAMBIA



CHAPTER 5

5.1 OVERVIEW

5.1.1 HISTORICAL CONTEXT

During the colonial period, a number of mission hospitals were established primarily in the rural areas of Zambia. During the first post-independence regime, which started in 1961, the government began to propagate the ideology of socialism. Church-owned facilities such as medical institutions and schools were taken over by the government. In 1991, when the second regime came into power, it was decided to return these institutions to the churches concerned.[1] However, times had changed and, when the churches 'took back' health facilities, they did so with depleted resources and for nostalgic rather than for pragmatic reasons, according to one respondent. In the meantime, Zambia had also been through a period of structural adjustment which had had a major impact on the economy, health and welfare of the population.

5.1.2 SOCIO-DEMOGRAPHIC FEATURES

Zambia has a population of 12 million, two thirds of whom live on less than a dollar a day. Eighty-five percent of the population works in the agricultural sector[2] and poverty in rural areas is much more extensive than in urban areas.[3] The literacy rate was 68% in 2006.[4]

The economy has been through positive times over the past few years and public-sector reforms in the mid-2000s have led to growing investor and donor confidence. However, Zambia remains dependent on foreign aid for about a third of its budget. New aid strategies are planned which will ensure investment is focussed on a few selected sectors, including education and health, with health expenditure planned to increase. With respect to the health sector, the UK's Department for International Development (DFID) is now responsible for co-ordinating the 15 or more international donors involved under the new Zambia Joint Assistance strategy.[5]

5.1.3 BURDEN OF DISEASE

The burden of disease includes the major diseases associated with poverty (see Appendix 5.1 for more detail). Zambia has some of the poorest health outcomes in sub-Saharan Africa for mothers and children. Life expectancy at birth dropped from around 40 to just under 38 years between 1997 and 2004. In this period, 28% of under fives were recorded as underweight. The infant, child and maternal mortality rates in 2004 were amongst the highest in Southern and East Africa. These data highlight an area which is certainly not receiving enough attention and resources, especially at the primary care level, as confirmed by key informants.[6]

The HIV and AIDS pandemics have exacerbated the health problems of the population. About one million Zambians are HIV infected and it is estimated that a fifth of those infected require anti-retroviral treatment (ART). OECD reports that the lack of specialised staff is the main obstacle to the further provision of ART. As a result of the high HIV prevalence in the country, estimates are that there are already about 1.2 million orphans.

5.1.4 THE HEALTH SYSTEM

Public-sector reforms adopted in 1993 included decentralisation as a key component. This strategy is still to be adequately implemented and the 2006 Decentralisation Implementation Plan remains a largely unfunded policy. Local authorities are very constrained in providing health and other services due to the lack of resources available to them. This has made the environment difficult for actors involved in the health sector. One informant described the health-care system

> *…as heavily burdened. Attempts to reform the health services are hampered by resource constraints: lack of staff and frequent strikes as a result of poor salaries, and limited equipment.*

1 Benn H. 2007. UK Hansard Zambia: Health Services 14 Jun 2007: Column 1251W. London: UK Government.
CHAZ. 2007. http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04)
Equinet. 2007. Reclaiming resources for health; a regional analysis of equity in health in East and Southern Africa. Johannesburg: Jacana.
Masiye F. 2007. Investigating health system performance: An application of data envelopment analysis to Zambian Hospitals. BMC Health Services Research 2007.
OECD. 2007. Zambia Country study, African Economic Outlook, Paris: OECD. www.oecd.org
Oxfam. 2006. "Zambia uses G8 debt cancellation to make health care free for the poor". Press release. 31 March 2006.
AIDS Alliance.doc - 6:13 (18:18).
2 Zambia profile 2007.
3 World Bank, quoted in OECD 2007.
4 OECD 2006.
5 Benn 2007
6 MoH-PH.doc - 1:61 (208:208); AIDS Alliance.doc - 6:26 (34:34).

Zambia has less than one third of the health workers needed to meet WHO standards.[7] While there are strategies in place to recruit and retain staff, staff retention remains a huge challenge, especially in rural areas.[8] One strategy to cope with this is the use of volunteers: of the 32 agencies responding to the questionnaire, all but two used volunteers. Very few of the agencies provided any monetary remuneration to these volunteers but volunteers tend to receive food parcels and a contribution to transport costs (with occasional other benefits such as training, clothes and shoes). The numbers of people reached by volunteers working for the agencies were extensive, with several agencies serving over 3 000 people a month while some were responsible for up to 50 000 clients receiving home-based care monthly. [9]

The severe shortfall in health workers impacts on health outcomes, especially for women and children. For example, less than half (43.4%) of births were attended by a skilled birth attendant. One respondent stated that maternal mortality rates are rising.[10] ART was identified as another area suffering from resource shortages[11] but, on the other hand, vertically implemented HIV programmes[12] were also identified as a factor contributing to resource shortages in other areas of the health system.

Box 5.1 Scandalous MNCR effort

"[If] you look at how much resources go into reproductive health, it's just a scandal. In my opinion, it's a scandal."

CHAZ.doc - 10:7 (31:32).

Shortfalls in infrastructure were also identified,[13] as well as inefficiencies in the historically top-heavy referral hospital sector.[14]

With respect to financing, there have been several changes with respect to user fees. User fees were introduced under IMF and World Bank pressure in the early 1990s, resulting in rural households being most disadvantaged in their access to health care. User fees were then abolished for rural communities in 2006, improving access for the rural poor in 54 of the 72 health districts. (However, user fees still apply in urban contexts although it is likely that the user fee policy will be set aside in the low income peri-urban areas.)[15] The demand for rural health services is said to have increased by a third and concerns have been raised about the impact of this on the quality of care, given drug shortages and the fact that staff are overworked. Access to ART was made free in 2005.

5.1.5 THE ROLE OF RELIGIOUS ENTITIES (RES)

The private for-profit sector appears to be playing an increasingly important role, given problems in the public sector. As one informant stated, the "mushrooming of private clinics" is seen as an "… indicator that this is a failure in our public health system everywhere". Indeed, a hierarchy of services appears to be forming: the private for-profit sector serves those who can afford to pay and is located mainly in urban areas; public facilities serve those less able to afford fees and who have access to these facilities; and faith-based facilities serve especially the rural poor who, because of their remote locale, do not have alternative options. Traditional healers are used widely across different income groups, but especially by the poor.[16]

Half of the facility-based health services in rural areas are provided by faith based organisations, with these organisations amounting nationally to 30% of facility-based health services.[17] More recently, local faith communities have responded to the rapidly expanding needs of vulnerable groups as a result of HIV and AIDS. These non-facility-based FBOs are more difficult to quantify but are very important. Overall, FBOs face similar constraints, in terms of funding and staffing, to public services.

7 Reflects 2004 data from Equinet 2007 p146.
8 FGD Lusaka and MoH-PH.doc.
9 Questionnaire data.
10 MoH-PH.doc - 1:65 (212:212).
11 Nat AIDS Council.doc - 3:20 (103:107).
12 See Chap 3.2.5 about trends toward 'diagonal support'
13 MoH-PH.doc - 1:68 (216:216).
14 Masiye 2007
15 Oxfam, 2006.
16 TH Alliance.doc - 11:51 (113:113).
17 See the discussion around the problem of interpreting such figures in Chapter 4, Sec 4.3.3.

Generally Zambia's health policy is seen to enable faith-based health services, especially because of their ability to reach remote communities,[18] and the majority of health workers working in these facilities are government employees. However, there are government policies and approaches that have some negative impacts on the ability of faith-based services to provide affordable services (see Appendix 5.2).

REs comply with government health policy guidelines, address the same priorities and fit within the same framework but still, according to one respondent, "'there are significant differences."[19] In the view of some informants, faith-based agencies are recognised as settling into the breach where government services fail to meet the needs of communities. The difference in roles and responsibilities between government and REs was described as 'causing confusion'. There are some complaints (by REs) that they are not seen as an equal partner by government, even though they are involved – through the Churches Health Association of Zambia (CHAZ, see 5.2.4 below) – in many fora where policy is developed.[20] The need for better collaboration between the Ministry of Health, REs and private for-profit health providers was raised by one informant.[21]

5.2 OVERVIEW OF RES IN ZAMBIA

5.2.1 HEALTH SERVICES[22]

With respect to **facility-based health services**, mission hospitals provide 40% and 28% of first-level and second-level hospital beds respectively (see Table 5.1).[23] FBOs play only a small role in rural primary health care centres and no role in urban health centres, thus reflecting the fact that most facilities were set up during colonial times and before the Alma Ata declaration.

(**Mission** category includes FBOs; **RHC** = Rural health centres)

Table 5.1 Summary of Zambian health institutions

System level	Partner	No.	Beds	Cots	Total	Percentage
1st level hospitals	Government	30	2 383	344	2 727	36%
	Mission	28	2 755	316	3 071	40%
	Private	12	1 323	491	1 814	24%
	Total	70	6 461	1 151	7 612	100%
2nd level hospitals	Government	12	3 334	741	4 075	67%
	Mission	5	1 590	163	1 753	28%
	Private	1	209	84	293	5%
	Total	18	5 133	988	6 121	100%
RHC	Government	980	8 467	569	9 036	82%
	Mission	68	1 695	141	1 836	17%
	Private	24	96	4	100	1%
	Total	1 072	10 258	714	10	972

Government employs most of the human resources deployed in these facilities, which is a drain on government resources;[24] mission hospitals do tend to have many more beds per doctor than the government-run facilities, however.[25] Basic salaries were reported to not be enough to retain staff. Funds are needed to improve the remuneration package and the environment for health workers. Access to drugs, equipment and other basic requirements were identified as being very important for improved care and to reduce the frustration level of the staff.

18 FGD Lusaka.doc - 3:9 (72:72).
19 MoH-PH.doc - 1:3 (23:23).
20 CHAZ.doc - 10:49 (103:104).
21 MoH-PH.doc - 1:77 (241:241).
22 The data for this and the following sections is based on KIIs with representatives from the Ministry of Health (MoH), Director General of National AIDS Council (NAC), Programme Director, International AIDS Alliance (IAA), Executive Director of Churches Health Association of Zambia (CHAZ), Executive Director, Copperbelt Health Education Programme (CHEP), President of the Traditional Health Practitioners Association of Zambia (THPAZ) and FGDs with representatives from health FBOs in Livingstone, Lusaka, and Ndola/Kitwe.
23 Global religious Health assets mapping, http://ccih.org/grham/country/zambia/Tables_1.htm.
24 Blas *et al.*, 2001.
25 Blas *et al.*, 2001.

Non-facility-based religious health initiatives are rich and diverse, mushrooming relatively recently (mainly during the mid to late 1990s) in response to local needs. It was on these initiatives – rather than the mission hospitals – that the Zambia case study focused with respect to questionnaires and focus group discussions. The 30 FBOs that completed the questionnaire described themselves as not-for-profit and motivated by their beliefs.[26] Over half of them described themselves as community-based primary health service providers, but seldom only as such. Most commonly they provided a range of allied services, including health education, support groups, development interventions as well as other services. With respect to health services, provision was primarily HIV related (including support to orphans and vulnerable children (OVCs), home-based care (HBC) services, hospice and ART). Far less common was the provision of more general facility-based services such as prevention of mother to child transmission (PMTCT), primary health care, malaria and medical rehabilitation. (This is also a sampling bias of the data described in Chapter 2.) Preventive health did not feature much as an activity of religious groups; this is potentially an important role (see Chapter 7.4.1) and should be made part of clergy training.[27]

Box 5.2: Religious constraints

The Ministry of Health also highlighted that post-abortion services and condom distribution to unmarried youth were examples of services not provided by faith-based facilities'. This was in no way regarded as problematic by any of the respondents, including the government key informants and the focus groups.

Certain activities were not being provided by FBOs due to their religious convictions, as acknowledged explicitly by half of the agencies. In almost all cases, these agencies responded that "Yes - condom distribution is against church policy".[28]

The majority of agencies engaged in a complex variety of behaviour-change activities. These included peer education; drama; "abstain, be faithful or condomise" (ABC) messages; debates; community open air discussions and meetings; preaching of the gospel and gospel values. Most targeted youth, young mothers, HIV-positive persons, rural people and OVCs. Included were disabled people, prison populations, refugees and migrants.[29] These non-facility-based agencies were clearly largely serving broad-based basic grassroots needs when compared to the activities of the facility-based health services described above.

With respect to advocacy, the focus groups and key informant participants reported that 'While local clergy do not generally play a role in advocacy for health, and churches generally are thought to not be vocal enough, bigger religious structures certainly do'. The strong public voice of the Catholic Church was highlighted,[30] as well as the joint role of the Episcopal Conference, the Evangelical Association and the Christian Council within the Oasis Forum (see the description of networks below) in calling government to re-think its policies.[31]

With respect to traditional healers, their holistic approach to healing is one highly valued by community members.

Box 5.3: Advantages of traditional healing

We have abundant natural resources in terms of medicinal plants which work. So we are not inhibited, we are not restricted in how far we can go in helping people, because we don't need the pound, we don't need the dollar, we don't need the euro to import these drugs.

It's another advantage that you live within the community. We will treat people and make them pay in cash or in kind, or instalments, [it] is a very big advantage.

We take the extra time to listen to the background history of the patient, the historical background, we don't just deal with a physical body. We deal with the spiritual, the whole family is involved. It's not just one patient, but the family is involved, the family, the history of the family.

Source: Vongo.doc - 11:30-34 (76:81)

26 Data drawn from the questionnaires undertaken for this study. The scale of operation of the 30 agencies varied considerably. While only one reported providing in-patient care to less than 50 patients per month, three were actively engaged in outpatient outreach and care to over 14 000 clients each. This included ART as well as other allied services such as VCT directly or through multiple community based activities. While few provided dispensary services, one –the Catholic Diocese of Ndola – as an umbrella body for health service providers, reached 64 000 people with dispensary services monthly.

27 Director of International AIDS Alliance.

28 Questionnaire data.

29 Questionnaire data.

30 CHEP.doc - 8:20 (36:37).

31 AIDS Alliance.doc - 6:60 (77:77).

While government is working towards collaboration and integration of these services, clear Zambian policies have not yet been defined about how traditional healers fit into the health system and healers receive no government funding.[32] As a first step to facilitate co-ordination, government has encouraged the traditional healers to form an association, known as the Traditional Health Practitioners Association of Zambia (THPAZ); see Sect 5.2.4 below).

5.2.2 HEALTH FACILITIES

FBOs included in the questionnaire reported having from one or two to over 20 facilities, depending on the agency. The number of beds per facility ranged from none to over 300. This was a function of the type of services provided. While the majority of facilities were owned by the agency reporting, some were owned by the community. Occasionally the facilities were shared with other agencies.[33]

Almost all facilities were made out of brick, although some were prefabricated and others were even more informal structures. Regarding infrastructure, electricity was most often reported as being 'always' available, although sometimes it was never available at more peripherally located sites. Most sites always had access to telephones; however, the reliability of the service was not always assured. Two thirds of the sites had reliable email access. Transport or ambulance services were not available in about a third of the sites. Access to water was reported most commonly as being generally reliable; however, water from certain sources, such as boreholes and communal taps, was only sometimes available.[34]

The quality of facilities in the old mission hospitals was referred to as being poor with problems, for example, regarding laboratory and theatre facilities: "If there are [these facilities], then it's completely run down or maybe they will show you a room and this used to be a theatre, you know, it's just not there."[35]

5.2.3 GEOGRAPHIC DISTRIBUTION

There was an even distribution of sites sampled in urban, peri-urban and rural contexts. A few agencies (such as the Salvation Army) had facilities in a range of contexts. Catchment populations seemed to be predominantly from local areas, although people from locations further afield would also be served.[36]

Focus groups indicated that FBOs tended to be the only facilities available in rural or hard-to-reach areas, while MoH health facilities tended to be in the more densely populated areas, in major towns and along major railway lines.[37] Even faith-based facilities that were based in towns had a history of providing outreach services in far-off areas, although they were no longer able to fund these as regularly. As a result, some patients had to walk for nine hours to reach the nearest clinic.[38] In addition, most rural facilities were completely unable to provide the emergency services required. They tended only to provide limited care to these populations – "maybe that they're just providing, you know, really first aid service, basically just dealing with the malaria and of course, maybe maternity wings for all mothers." [39]

5.2.4 FAITH-BASED HEALTH NETWORKS

There were a number of faith-based networks (FBNs) operating in Zambia. These provided overall co-ordination, networking for members, access to funding and other resources, and a way in which small organisations and individual health service providers (such as traditional healers) could interface with policy makers and donors at a national level.

CHAZ (the Churches Health Association of Zambia), which is described in Chapter 4, Section 4.4, was the key Christian network for facility-based services. It was created in 1970 as an umbrella organisation to represent work done by church-administered (or mission) health institutions in Zambia. There were 129 health institutions and community-based church organisations affiliated to CHAZ, representing 16 different churches and church organisations, and covering 32 hospitals, 60 health centres and clinics, as well as 33 community-based organisations.[40],[41] Hence CHAZ was "a network of networks".

32 MoH-PH.doc - 1:5 (27:27), TH Alliance.doc - 11:22 (55:55).
33 Questionnaire data.
34 Questionnaire data.
35 Christian Council.doc.
36 Questionnaire data.
37 FGD Lusaka.doc - 3:14 (84:84).
38 FGD Livingstone.doc - 1:21 (124:124).
39 CCZ.doc
40 http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04).
41 CHAZ.doc - 10:41 (85:85).

Within CHAZ there were three main denomination-specific co-ordinating organisations,[42] these being necessary because of the complexity of the work and the increasing size of the sector.[43]

The stated mission of CHAZ was to be "committed to providing technical, administrative and logistical services for affiliate members to serve communities with holistic quality health services that reflect Christian values, so that people live healthy and productive lives."[44] The organisation had a good working relationship with government and participated actively in the dialogue on health care reform. At national level its main function was representing the interest of member institutions to the government through the Ministry of Health. This included negotiating support from government through grants, secondment of personnel, drug supplies and rations for patients. CHAZ was represented on various national policy and implementation committees such as the National AIDS Council, the Central Board of Health, the General Nursing Council, the Medical Council of Zambia and the Pharmacy and Poisons Board.[45] Participation in CHAZ also offered members a range of benefits relating to the sharing of skills and resources (see Appendix 5.3).

CHAZ appeared to function as an exemplary network. As one informant put it:

> *CHAZ is a very good example of the best practice. I mean, you know, the ability to bring in all faiths and all mission hospitals under one umbrella organisation is really impressive even of itself. And the amount of co-ordination they are able to achieve and with that, the amount of voice and influence, they have in government circles, is equally impressive, I think.46*

Another network was the Zambia Interfaith Networking Group on HIV/AIDS, ZINGO, which is also described in Chapter 4 (see Sect 4.5.1). It encompassed both Christian and non-Christian communities and operated in parallel to ZNAN, the Zambia National AIDS Network (ZNAN and the Expanded Church Response are specifically HIV networks with the latter specifically for Christian communities).[47]

THPAZ defined itself as an NGO (not a FBO) yet it is included here as it was a network of traditional healers, for whom faith was part and parcel of their work. Leadership of THPAZ was provided by a democratically elected structure falling under the auspices of the Electoral Commission of Zambia.[48] THPAZ functioned as a link between government and traditional healers and was active in participating on bodies like the National AIDS Council and the country coordinating mechanism (CCM) for the Global Fund; lobbying government for appropriate legislation and policy regarding traditional medicine; developing an ethical code of practice for THs (although it had no power to enforce this code); and the sensitisation and training of the network's 40 000 members. There were no stipulated guidelines that defined criteria for inclusion, exclusion, disciplinary action, etc.

There were a number of other networks. These included the Zambian National AIDS Network (ZNAN) which was a network of almost all AIDS service organisations in the country.[49] It was the recipient of basket funding, redistributing resources to agencies such as THPAZ. In addition to the umbrella body, there were a range of other networks and co-ordinating bodies such as local co-ordinating bodies like the Livingstone Home-based care Association and, within the tradition of another faith, the Islamic Health Association. [50] There was also a strong advocacy body – Oasis Forum – which was made up of a number of organisations, trade unions and lawyers.[51].

The FBNs described above varied considerably in size, ranging from THPAZ with its 40,000 members to the much smaller Islamic Health Association. They provided opportunities for bridging between health networks as well as links to government and donors. Some provided members with a range of benefits (such as capacity development and other support) while also representing the interests of the group as a whole. There was very strong affirmation by the respondents regarding the importance of the facilitating networks.

42 There is the Episcopal Conference, for the Catholic programmes, including Catholic Relief Services, the Caritas movement, Jesuits Refugee programmes. Then the Evangelical Association of Zambia co-ordinates all evangelical health programmes, and the Christian Council which co-ordinates various mainline Protestant movements. (AIDS Alliance.doc - 6:48 (62:63)).
43 FGD Ndola 2.doc - 5:20 (55:60).
44 http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04).
45 http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04), AIDS Alliance.doc - 6:50 (63:63), MoH-PH.doc - 1:4 (23:27).
46 FGD Lusaka.doc - 3:32 (205:205).
47 MoH-PH.doc - 1:47 (162:162).
48 TH Alliance.doc - 11:41 (15:16)).
49 MoH-PH.doc - 1:46 (154:154).
50 AIDS Alliance.doc - 6:47 (62:62).
51 CHEP.doc - 8:29 (37:37).

5.3 COLLABORATION OF RELIGIOUS ENTITIES

5.3.1 COLLABORATION WITH GOVERNMENT

In the provision of **facility-based health services**, formal memoranda of understanding and agreements were often in place. There was complexity in the arrangements around funding, the range of activities REs undertook and donor requirements.

At a **national level,** there was a memorandum of understanding between the Minister of Health and CHAZ; this acted as the overall framework that governed the relationship. Facility-based FBOs participated through CHAZ in the sector advisory group and in various other committees (for example, the National AIDS Council and CCM of the Global Fund) as well as in health-related statutory bodies and overall planning and budgetary processes.

At a **regional level**, there were regional Consultative Meetings that took place between the REs and government health providers. These were organised by CHAZ as a way of ensuring that there was full collaboration and inclusion of church health services in the overall health service and that resources that flowed down to the districts did accrue to the church health services[52].

At the **district level** CHAZ had no structures; however its affiliated institutions participated in the district planning process and reported to the District Health Office; they were also part of the district health management team.[53] It is likely that, at this level, both the facility-based FBOs as well as the non-facility-based FBOs needed to be in a close collaborative relationship with district health government structures.

Overall, the MoH could be described as providing an enabling environment and setting a policy framework, although one respondent felt that with respect to FBOs the partnership was not equal and the FBOs were "relegated to a … kind of, mopping the floor."[54]

With respect to the relationship between **non-facility-based entities** and government, there were some co-ordination mechanisms but the focus groups in Lusaka and Ndola were not convinced that local level co-ordination really happened.[55]

Apart from the above-mentioned areas of collaboration there were others that occurred between government and FBOs, both facility-based and non-facility-based. Reference has already been made to many health workers in the religious sector being on the government payroll, although the lack of parity between workers at faith-based and government facilities was raised as a problem. Government also enabled FBOs to access drugs and other resources (such as HIV testing kits). 'Split responsibilities' were also found: for example, REs sometimes took on the 'softer aspects' of getting people onto treatment, such as preparing patients for treatment and providing home-based care, relief food and malaria bed-nets.[56] FBO staff were not invited to MoH training, however, and, if they asked MoH trainers for training, the fee was quite high.[57]

A good relationship had developed between **traditional healers** and government. A number of comments from traditional healer informants referred to the importance of the traditional healing system and the formal health system operating synergistically, although it is not known to what extent this view was widely held in the MoH or by facility-based health providers. There were those who raised a concern that there was an emerging trend in 'charismatic healing' and traditional healers who claimed to heal HIV and AIDS. The very presence of THPAZ and its increasing visibility in the newspapers was reported as a new phenomenon which was questioned by some. As one person from the Christian sector put it:

> *… for me, I think, maybe for us as a church, it's more an indication of an absence of quality care or an absence of equality and the health system in the country.*

52 MoH-PH.doc - 1:54 (176:176).
53 MoH-PH.doc - 1:52 (170:170)).
54 AIDS Alliance.doc - 6:66 (85:85).
55 FGD Lusaka.doc - 3:97 (226:226), FGD Ndola 1.doc - 4:22 (142:147).
56 FGD Livingstone.doc - 1:88 (389:389) & 1:91 (393:393) & 1:81 (378:378), FGD Lusaka.doc - 3:79 (471:473).
57 FGD Livingstone.doc - 1:18 (113:113).

The ambivalence of health practitioners of the biomedical tradition and religious leaders towards traditional healers was understandable yet raised the question of the role of traditional healers in health.

5.3.2 COLLABORATION BETWEEN REs

Respondents pointed to three rationales for collaboration between REs (referring mainly to non- facility-based services), including requirements by donors, requirements by government and spontaneous institution-level collaboration arising from shared needs (see Appendix 5.4). Most Zambian agencies responding to the questionnaire were affiliated to an umbrella agency although some of these were international agencies (such as the Salvation Army). A few were not affiliated.[58] Various respondents highlighted a number of problems which emerged when there was inadequate collaboration, referring mainly to non-facility based services. These included: duplication of services and competition in obtaining funding, recruiting staff (including volunteers) and attracting clients; isolation from the rest of the health system; inability to access appropriate referral services; and the wastage of resources through, for example, the need to constantly re-train staff, given staff mobility.[59] These forthright examples highlighted the importance, especially at the local level, of RE collaboration and the need for donors to be aware and sensitive to how their approaches could undermine the capacity and good work of the non-facility-based FBOs.

Box 5.4 Competition between FBOs

"Everybody wants to be able to count Lucy, everybody wants to be able to count Suzie. So you get this kind of numbers game competition that's happening. And with that comes competition for personnel." (Focus group Zambia)

5.3.3 ROLE OF INTERMEDIARIES IN FACILITATING THE ACTIVITIES OF NON-FACILITY BASED FBOs

The question arose as to what extent 'intermediary organisations' could play a role in addressing some of the constraints faced by FBOs and supporting them in accessing funding and managing resources more efficiently. Few such organisations existed in the FBO/CBO sector in Zambia, where the emphasis was more on implementation. CHAZ did have this function but, given its huge network supporting facility-based health services, it was unable to address the scale of needs. In addition, the South African AIDS Trust provided funding and technical support.[60] There was also the Copperbelt Health Education Programme: although it only operated in the Copperbelt, there was extensive knowledge of its role in facilitating and supporting FBO and NGO activities. Representatives of non-facility-based FBOs who participated in the focus groups in Ndola and Livingstone specifically identified the need for the services that this intermediary was currently meeting.

Respondents agreed that there was a need for more intermediaries:

> *So I think in Zambia, we still have a challenge of, actually, the organisation that will provide the technical support to the emerging groups. Because there are so many CBOs, you know, every day people are starting up organisations, every day, but who nurtures them?*[61]

A number of needs were mentioned that could be addressed in this way. These included input into the policy of members; co-ordination of all health care services provided by REs;[62] accessing economies of scale through sharing skills and the provision of technical assistance, including strategic planning;[63] providing additional funding;[64] providing administrative support regarding work permits, clearance of goods and procurement; providing institutional support for infrastructure and human resources; and supporting the development of a health programme and pharmaceutical programme (see also Appendix 5.5) .

5.4 STAKEHOLDER PERCEPTIONS OF FBOS

5.4.1 GOVERNMENT PERCEPTION OF FBOS

Government perceptions of FBOs had changed over the years. They were previously seen as working in isolation and

58 Questionnaire data.
59 FGD Ndola 1.doc - 4:20 (130:130), FGD Lusaka.doc - 3:101 (234:234) & 3:98 (230:230), FGD Livingstone.doc - 1:79 (374:374).
60 FGD Ndola 2.doc - 5:38 (41:41).
61 FGD Ndola 2.doc - 5:14 (41:41).
62 AIDS Alliance.doc - 6:14 (19:19)
63 FGD Lusaka.doc - 3:94 (153:153)
64 CHAZ.doc - 10:3 (18:18)

Box 5.5: Appreciation of faith values

A senior Ministry of Health official said, "I think for faith-based organisations, for church health institutions, the provision of health service is not just a matter of duty. It's a matter of a calling and a vocation, so that when a worker discharges their duties, it's not because, it's not from 8 o'clock to 17:00 hours; it's as long as is necessary to provide the service. That's not the attitude for everyone".

Source: MoH-PH.doc - 1:31 (102:102)

providing services in order to win adherents to the faith.[65] As one senior Department of Health official explained, this was no longer so: "Both government and international health agencies have a greater appreciation for the value of FBOs and their contribution to health."[66] Religious affiliation was generally not a criterion in FBOs, either for who could use services or for who was employed.

Government is appreciative of the values that FBOs harness in support of health care. An MoH official, based in the south of the country, identified and valued the similarity in approach between FBOs and government health services, as the FBO facilities had the same integrated approach to health as the ministry of health. This was contrasted with other agencies that focussed on vertical programmes like fighting malaria, not considering health needs in their entirety.

Notwithstanding the positive view of FBOs by government, there were also tensions due to competition for funding. The MoH expressed concern regarding the unlevelled playing fields, insofar as MoH hospitals were not able to access donations in the way that FBO health facilities were perceived to be able to access additional staff and necessary resources from their traditional support base overseas. There was also a view that FBO staff were better off and that the health facilities were better provided for through donations and support from the international faith community. It was not necessarily true that these perceptions were founded in reality.

There was concern within government that the quality of service at FBOs was compromised as they were severely understaffed and that many of their staff members were under-qualified for what they did (for example, the practice of using "classified daily employees", general workers who dressed wounds, gave injections and drugs, and even worked in the laboratory in order to take some of the workload off professional staff).[67] This was not a unanimous view, though; others thought that "staff at faith-based facilities have higher qualifications than elsewhere".[68]

An MoH doctor raised the concern that there had been complaints about the way in which faith-based facilities were headed by someone appointed on the basis of denominational membership. Hence a minister, rather than a health worker, could hold a position that required technical medical knowledge.[69] This resulted in friction between management and the medical staff, who were not appointed by – or necessarily members of – the RE owning the facility.

Another concern was that, while FBO facilities might often provide a spread and quality of service that was comparable to, or better than public facilities, it was reported that "sometimes mission hospitals let drugs expire and this reflects badly on the Ministry of Health."

Nevertheless, mission hospitals were seen as attracting people of calibre and commitment, who without the faith commitment would not make the sacrifice to live in a rural context.

5.4.2 PERCEPTION OF FBOs BY OTHER AGENCIES

World Vision had a very positive view of the role of FBOs providing health services. One of the differences identified between government and FBO health facilities was the quality of care and especially the trust in individual health workers that patients had developed, as well as the long-standing name of a facility as being a place of good care over the years.

65 CHEP.doc - 8:25 (48:48), (CHAZ.doc - 10:33 (63:65).
66 MoH-PH.doc - 1:41 (138:138)
67 MoH-PH.doc - 1:25 & 26 (85:85); FGD Livingstone).
68 Director of IAA.
69 CHAZ.doc - 10:30 (56:56).

A respondent mentioned greater efficiency in reporting to funders, stating that FBOs had created their own standards and maintained them.[70] This was in contradiction of the widely held perception that FBOs were weak in this area. Coming from an NGO offering technical support to FBOs, it must, however, carry some weight, and the statement was supported by a comment from a MoH official that "They have more resources to draw on, from historical funders, and are hence better equipped, in terms of diagnostic facilities and in terms of drug supply. But they are also better managed and generally are able to provide more services".[71] CHAZ was also highlighted as an agency with exemplary reporting and oversight of all the FBO health facility activities in the country.

The services provided by FBOs were largely positively perceived by a representative of the National AIDS Council to be "… providing quality health services and that perception has remained".[72]

5.4.3 CLIENTS' PERCEPTIONS OF FBOS

Comments in this section were not sourced from actual health seekers using faith-based facilities, as the study was not designed to provide this sort of information. Rather, this section reflects comments made by key informants and focus group participants.

Box 5.6: Better quality of care from REs?

There was a perception that they would get treated fairly, that they would not necessarily have to wait in unduly long lines, that there would not be undue bureaucracy and that user fees were much more negotiable than they would be in the public sector. This was because there was a commitment to serve the poor and the suffering, and a sense of vocation; in public facilities there was a sense that it was "just people's job".

Source: FGD Lusaka.doc - 3:5 (61:61).

The general perception in the focus groups was that often people preferred to go to religious facilities. Zambia is a predominantly Christian country. The focus group participants said that "…many people have a need for prayer, spiritual care to be part of the treatment they receive; coming to a mission hospital, that will be provided".[73] This gives a sense of security as they undergo their procedure, a feeling that they are experiencing this in God's presence.[74]

Clients were said to express appreciation for the quality of care provided by FBOs, including the environment in which it was offered.[75] The same was true for care provided to them within their own homes, and the service was appreciated because it was seen as affordable.[76] In addition, it was more likely that clients would be given medicine when attending a mission clinic or hospital, whereas in a government hospital they would be given a prescription and have to buy the drugs.[77] (See also Box 5.6)

Clients generally had an expectation that the church should provide free services and not charge user fees, and that they ought to receive free drugs rather than be given prescriptions.[78] FBOs were known to waive user fees for the poorest patients and were generally open to negotiation around this.[79]

5.5 STRENGTHS AND WEAKNESSES OF FBOS

In FGDs in Lusaka and Livingstone the perception was voiced that the service at Mission Hospitals was better than that at public facilities, because it was shaped by the values that the faith-based organisations had:

70 CHEP.
71 MoH-PH.doc - 1:33 (102:102).
72 National AIDS Council.doc - 3:8 (51:51).
73 AIDS Alliance.doc - 6:31 (41:41).
74 FGD Lusaka.doc - 3:1 (40:44).
75 FGD Lusaka.
76 FGD Ndola.
77 FGD Livingstone.
78 FGD Ndola 1.doc - 4:1 (31:31).
79 FGD Lusaka.doc - 3:5 (61:61).

The people who work there, are driven more by faith, because they know that it's a service which was started off by Jesus himself and that whenever they are serving man, they are seeing the face of God in that man. So that makes a difference in the quality of service that they are providing to these people.80

Some of the values upheld by FBOs were the sanctity of life; an all-embracing love for humanity; an anthropology viewing every human being as an image of God that entitled him/her to the highest quality of care; and willingness to spend more time with the patients.[81]

FBOs are appreciated very well, because of the holistic approach they give to this thing. They provide spiritual care and meet the material needs of the sick.82

The holistic care extended beyond medical services, which were complemented by integrated development work. So malaria prevention, for example, might require mobilising a community to drain stagnant water areas.[83]

The attitude of staff at these facilities towards work and towards the patients was characterised by commitment, showing a human face, and having the motivation to help others. As a result they were perceived to be more resilient, they worked longer hours and complained less. On the other hand, this did have incentives attached: individuals gained respect, for example as 'those who don't go on strike' when other health workers went on strike.[84]

Regarding training of health workers, it was reported that most of the "… training institutions are in faith-based health institutions, that's where they produce most of these quality staff. So that's a very, very big positive to the health provisioning in general in the entire country, but I think still the numbers are not adequate."[85]

Furthermore, FBOs were able to draw on a very strong tradition of community volunteerism. The Church was able to maximise that opportunity,[86] partly due to the attitudes already mentioned and partly because it provided better support for carers than the MoH did. This included resources that supported the volunteers in their work (raincoats, shoes, bicycles, lunch allowances), but more importantly the creation of a common identity through forums that inspired and motivated them.[87] Unfortunately, though, it was common for volunteers to move from one organisation to another, trying to get the best kind of deal. This resulted in a volunteer base in communities that was constantly in flux.[88] Little was known about the core values of volunteers and the extent to which their involvement in health was based on a values and religious commitment rather than on financial need.

FBOs also had access to human resources in the global market through their links to mother organisations overseas.[89] FBOs were able to draw health staff from abroad, including volunteers, but no longer to the same extent as it had been possible in the past.[90] There were some critical voices, however, about expat 'experts' who came to practise on Zambians.[91]

Another advantage of FBOs was that they were "almost everywhere". This made them convenient partners, including for government structures who appreciated drawing on structures that were already in place and well accepted by the communities.[92] District officials in the public sector did not have the same access to communities and their traditional leaders, nor the credibility.[93] By way of contrast, the Church was well placed to spread public health prevention messages, it could mobilise people, and it had multiple means for passing on information.[94] One of the advantages of funders using

80 FGD Lusaka.doc - 3:85 (68:68).
81 FGD Livingstone; FGD Lusaka.
82 FGD Ndola 1.doc - 4:2 (34:34).
83 FGD Lusaka.doc - 3:92 (118:118).
84 CHEP.doc - 8:21 (40:41).
85 World Vision.doc.
86 FGD Lusaka.doc - 3:19 (106:106).
87 CHEP.doc - 8:35 (66:66).
88 FGD Lusaka.doc - 3:99 (230:230).
89 FGD Lusaka.doc - 3:17 (100:100).
90 CHAZ.doc - 10:54 (110:116).
91 Focus Group and a MoH official.
92 FGD Ndola 1.doc - 4:14 (68:68).
93 FGD Lusaka.doc - 3:15 (88:88).
94 FGD Lusaka.doc - 3:23 (116:116).

FBOs was that they could be a conduit of resources and opportunities to grassroots communities and they had a religious imperative to see the resources as God's rather than as their own.

A further result of the community presence and volunteer base of FBOs was the ability to "take the health care system right into the household, where people get supported at household level to prevent disease, as well as to treat disease in that environment." In contrast, '… where government tried to replicate this system in their "community health care worker model" 'it had not had the same impact.[95]

Some of the advantages of FBOs could also be disadvantages in some instances. A few specific examples mentioned were their often remote location,[96] challenges around procurement and licensing of drugs,[97] and the fact that being rooted in the community could pose a threat to confidentiality.[98]

A further potential weakness of FBOs was that they were not necessarily sustainable in the long-term[99] and therefore could not be relied on completely to continue providing their services into the long term, especially given increasing difficulties in attracting and retaining staff.

In addition, some faith groups had taken a faith line on health that discouraged believers from using any drugs and relying on God's healing alone. This had had very negative implications. There was, therefore, a need for careful consideration of the fact that not all FBO activities were value-free or in the best interests of the sick. Nonetheless, many REs had changed their attitudes, for example, towards condoms.[100]

5.6 CONSTRAINTS

5.6.1 CONSTRAINTS AROUND FUNDING

With respect to **government funding**, REs providing health services were seen as part of the national health care system and were therefore funded, especially where there was no other hospital serving a community. Although this was the stated policy, one focus group member asked: "Is the level of support of faith-based institutions comparable to those of the public institutions? I would answer, 'no'. In other words, we're a sort of a lesser among equals." [101]

FBOs providing health services were able to access drugs (such as TB drugs and vaccinations) directly from government through a centralised drug supply system but certain inputs, such as fuel for ambulances, were not covered by government grants.

Although not well-quantified, it has been estimated that around 90% of the human resources in faith-based facilities were government employees. This raised the question of the degree to which FBOs were really autonomous and what, in fact, made them 'faith-based'?.

Box 5.7: Whose responsibility is it?

Services provided by REs and NGOs "are supposed to be provided by the government, but the government is failing, that's why the church is coming in to fill in the gaps.... The government is supposed to have incentives, a deliberate policy so that they create incentives for FBOs that are assisting the communities."

Source: FGD Livingstone.doc-1:52 (272:282).

Unfortunately the government was not involved in funding non-facility-based services of REs. If it were to be involved, said one respondent, it would "be much better because FBOs are actually, you know, closer to the people."[102]

There was an ongoing and pervasive problem of declining **external resources** for REs. Whereas in the past faith-based

95 AIDS Alliance.doc - 6:36 (49:49) & 6:37 (51:51).
96 MoH-PH.doc - 1:37 (114:114).
97 AIDS Alliance.doc, IAA.
98 FGD Ndola 1.doc - 4:4 (35:35) & 4:36 (46:46).
99 EFZ.doc
100 CHAZ.doc - 10:15 (42:42).
101 FGD Lusaka.doc - 3:86 (80:80).
102 FGD Livingstone.doc - 1:50 (270:270).

hospitals were supported by international partners, they were now expected to be more self-reliant and this was very difficult in a context of a very poor national congregational base. There were, however, some international funding agencies that worked together with a number of African countries in the provision of health services through FBOs. These were referred to as the "FORCISA Nordic countries," a Fellowship of Council of Churches in Southern Africa and the Nordic countries, focussed on collaboration on HIV issues.

Existing networks, congregational links and past missionaries were identified as being drawn on to help tap into possible resources for mission hospitals, noting that the bridges between the local church and overseas churches no longer operated so well. Occasionally a Bishop was able, on overseas trips, to access some once-off funding.

Networks such as CHAZ relied on a variety of external funding sources which are detailed in Appendix 5.6.

Non-facility-based FBOs described the great problems they experienced in raising funds from donors. These obstacles included: the lack of co-ordination of fund-raising between these types of FBOs; the short funding cycles; the increasing complexity of the application process; donors' proposal expectations; rapid application turnaround times; and the investment needed in preparing proposals.[103]

In addition, donors' shifts in policy meant that they were increasingly seeking to fund at a regional level rather than at the level of individual institutions (and similarly beginning to favour funding government rather than small FBOs, including participation in basket funding). FBOs described the difficulty of having to liaise with others in order to access funding via agencies such as the Global Fund. This highlighted the need for intermediary agencies that could help facilitate local, small FBOs and NGOs to access funding.

The nature of the activities that donors were prepared to fund had also become more restrictive: as an informant noted, funders say, "I can only fund the problem in this line. Other than this, I can't, I can't help". So helping the community has become very difficult.[104] There was a feeling that donors were target-driven (with targets being based on numbers rather than qualitative aspects), and therefore they were not interested in how the benefit from the funding could be maximised but rather whether or not the targets had been reached. The Lusaka focus group described that:

> *The donors will tell you they want certain numbers, okay, but you are able to do so much more than what they require. So there was a point in time when we were told that we had to stop enrolling patients on treatment, because we had reached the numbers within three months and then they needed those numbers, you know, over a period of time.*[105]

Another concern raised was the expectation by donors that the FBOs would be able to cover their administrative costs (such as administrative personnel, rental and electricity bills), banking and other basic organisational requirements. This was not the case. The fact that FBOs did not have the resources to fund their basic operating costs impacted on their efficiency as organisations.[106] This further supported the idea of the need for intermediary agencies such as the Copperbelt Health Education Programme to be set up so as to provide administrative support to small FBOs.

A lack of flexibility on behalf of the donors with respect to time-frames was also raised as a major concern. This related to the problem of needing to spend funds allocated within donor-defined time-frames rather than in terms of what might be appropriate for the project.[107] As one informant said, "All that you have to do is spend it, spend it, spend it… in Africa, it doesn't work like that. Africa time is using the sun."[108]. While donor funding should be enabling and encourage the appropriate responses, there was a great degree of frustration expressed by REs regarding the unhelpful ways in which funding was given.

Concern was also raised about the impact of short-term funding on the capacity of REs and the sustainability of their services. In Lusaka the focus group said, "we implement a programme and when it's about to mature,… the funding

103 FGD Livingstone.doc - 1:44 (238:238) & 1:45 (244:244).
104 FGD Livingstone.doc - 1:54 (292:292).
105 FGD Lusaka.doc - 3:47 (291:291).
106 FGD Ndola 2.doc - 5:30 (92:92); FGD Livingstone.doc - 1:101 (455:455).
107 FGD Livingstone.doc - 1:104 (495:495).
108 FGD Livingstone.doc - 1:105 (497:497).

stops, yes."[109] Funding was also erratic or very short-term; this could be a result of the lack of stability in the exchange rate, as well as in the procedures of the US government: "We've had three of them in the last four years where there's a stalemate on the approval of the [US] budget, which means that all programmes go to minimal burn level and those minimal burn levels can have huge detrimental impacts on health outcomes". Of particular concern was that "…the local organisations do not have the buffer funding that is able to carry them through cycles of no funding, or delayed donor funding."[110]

Because of the problem of funding instability, and the unhealthy dependency on donors which threatened the autonomy of REs, there was a comment that there was a need for income generation to sustain projects and institutions. On a smaller scale income generation activities for volunteers were essential to help provide for their needs.

5.6.2 A SHORTAGE OF HUMAN RESOURCES

Staff shortages, especially those with appropriate skills and qualifications, were the biggest constraint on realising the potential of faith-based health services. The problem was greatest in rural areas.[111] FBOs providing health services reported that staff turnover varied in Zambia, with some facilities reporting low turnover while others, particularly in rural areas, reported high turnover of highly trained staff, especially those with clinical skills and specialist administrative skills such as monitoring and evaluation, and project management.[112] Some of those leaving included volunteers and home-based carers. The flying doctor service that had provided medical care at remote hospitals was no longer operative for financial reasons

The attractive positions and better conditions provided by donors such as PEPFAR were cited as one of the reasons for loss of staff, as well as the general brain drain to greener pastures overseas. About two thirds of respondents felt that the challenges faced regarding human resources were similar for the public and faith-based sectors, but at least one respondent mentioned the better working conditions at REs, including more concern for the personal well-being of staff and better equipment and supplies of drugs.[113] Others mentioned, however, that government posts meant a regular salary and extra benefits that were not available to FBO staff, and noted that the vacancy rate in REs was higher than in the public sector "For faith-based organisations, they have 32% of the required number of staff, 32%, so they are 70% short almost. I mean, you can't provide quality services like that … Government has 50%. Yes, overall, that's the overall picture".[114] These contrasting views seemed to differ by location as well as by FBO facility provider.

The loss of staff impacted on performance and quality of care. It led to FBOs not being able to meet targets and having to recruit part-time replacements. Doctors at times had to do nurses' jobs, and staff were overloaded and stressed.

Box 5.8: Desperate staff shortages

We went to this one mission station and there's one nurse. She is providing service for a catchment area of about 12 000 people. And she was saying that a doctor comes in maybe once in three months, so she's like literally 24 hours at the clinic. If there is an emergency, she goes home and changes, maybe to refresh and then comes back to the clinic. That's the kind of challenge we are talking about.

Source: Christian Council.doc.

In conclusion, Zambia's rural population is heavily dependent on faith-based health facilities. Problems of declining infrastructure, poor accessibility, limited funding and the declining resource base of long-term expatriate mission health workers, as well as a lack of parity in benefit packages, undermined the capacity of these institutions and put their future ability to provide health services at risk.

5.6.3 THE SINGLE-DISEASE FOCUS

In response to the question about the focus of future donor funding, the focus groups and others raised concerns about the single disease focus of programmes. One person said,

109 FGD Lusaka.doc - 3:38 (245:249).
110 FGD Lusaka.doc - 3:49 (295:295).
111 CHAZ.doc - 10:6 (24:25).
112 MoH-PH.doc - 1:18 (35:35) & CHAZ.doc - 10:6 (24:25).
113 KII Catholic Health Services.
114 MoH-PH.doc - 1:74 (224:229).

"I think if I were given an opportunity to make recommendations to any number of donors, it would be to focus more increasingly on the integration of multiple priority diseases, as opposed to just a single programme. Because I think what happens when you do that is, depending on the resources given to that single programme, all efforts sort of shift behind a single disease at the expense of something else. A good example in Zambia is the investments going to HIV/ AIDS."[115]

HIV and AIDS programmes received more resources and were seen as having a higher profile. As a result volunteers competed to work in certain HIV projects and other important health-related activities – especially with respect to maternal and child health – were disbanded.[116]

Given the context of deep poverty, there was clear motivation in the focus groups for the need for programmes to be multi-sectoral, "rather than carrying out one intervention. That way I think it will help change the lives, I think, especially in the rural communities … rather than us looking at issues of HIV and AIDS, but we also look at issues of empowerment, yes. Yes, poverty reduction."[117]

5.7 KEY AREAS FOR POTENTIAL INVESTMENT

5.7.1 STRENGTHENING PRIMARY HEALTH CARE

A key faith leader identified prevention and primary health care as the priority health concern requiring funding. Pointing out that the hospitals dealt with the results of a lack of primary health care, prevention of disease was 'the' priority for funding. Primary health care needed to be supported by health systems strengthening: "for a long time we have been crying about health systems strengthening. I think it's an area where a lot of investment is needed. HR, human resource, administrative skills, transport and all these big, big areas, you know".[118]

This implied moving away from a heavy reliance on vertical programmes.[119] An official from the MoH suggested, in the context of government priorities, that government funding for programmes could be made available as long as these were aligned with the MoH priorities. Given the support already available for ART, she proposed that the funders should concentrate on child and maternal health, reproductive health, diarrhoeal diseases and malaria. Her overall concern was the need to look at health as a whole rather than concentrating on single issues and programmes.[120]

However, the additional services that the largely non-facility based agencies specified as being needed were largely HIV-related. These included more VCT, ART, PMTCT services and CD4 testing, as well as dealing with the consequences of the epidemic though OVC care and welfare projects. Specific mention was made of the need for outreach of health services to rural areas. One respondent reminded that "AIDS impacts negatively and it actually reverses gains that are achieved, so a focus on AIDS would then help to deal with the other problems".[121]

In addition to the support of directly health-related activities, there was a ready acknowledgement amongst respondents of the underlying causes of poor health and the importance of broader developmental programmes. These included:

- food security with its multiple facets, including drought-resistant crops, small-scale agriculture and access to basic water supplies
- integrated developmental approaches to rural development that were sustainable
- special OVC programmes on an ongoing basis, including funding for education support, and
- community participation initiatives, which were also raised as ways in which in the past communities had been mobilised for health through joint projects such as building staff houses.

5.7.2 ADDRESSING HUMAN RESOURCE AND OTHER RESOURCE SHORTAGES

Addressing the human resource shortage was an integral part of strengthening the health system. This included:

- ensuring that health facilities were adequately staffed
- increasing the performance and effectiveness of health workers

115 FGD Lusaka.doc - 3:40 (264:264).
116 FGD Lusaka.doc - 3:102 (264:264).
117 FGD Lusaka.doc - 3:62 (356:364).
118 CHAZ.doc - 10:59 (126:126).
119 KII MoH Southern Province.
120 KII MoH Southern Province.
121 Nat AIDS Council.doc - 3:19 (99:99).

- setting up systems that ensured that volunteers were adequately compensated and provided with care (that is, care for the carers)
- setting up adequate health training facilities (with consideration to be given to the proposed Catholic university), and
- creating a health associate position in which relatively well-educated school-leavers could be trained to do some of the basic functions so that the doctors and the nurses could focus on more specialised needs.[122]

An official from the MoH suggested, in the context of government priorities, that government funding should be directed to the existing severe human resource problems in faith-based facilities, as well as providing incentives to retain staff.[123]

In addition to the importance of skilled technical staff, a range of specific needs were identified to support these primary-level services, including drugs, transport, equipment, training and inputs such as seeds, hoes and shovels for development projects.[124] One group identified the need for a chapel for the provision of holistic healing, as their chapel was presently being used for VCT.

Indeed, it was felt that the national health plan should consider the infrastructural needs of all health facilities, including mission hospitals. Support also needed to be given to rural clinics. The provision of health facilities alone was not enough. Houses for rural doctors, accessible roads, and sustainable provision for transport for sick people and volunteers were also needed.

5.7.3 BUILDING THE CAPACITY OF RES

In addition to the ideas outlined for capacity development within the health system, the respondents were very keen to make suggestions regarding the need for those involved in RE management to be given the opportunity to address skills shortages. These included management, monitoring and evaluation functions, funding proposal writing.

Another area of skills development required was public health and advocacy skills. This would involve building "churches' capacity to influence pro-poor policies and that they can be able to mobilise masses".[125] Put in another way, there was a need "to invest in educating pastors, priests and people who have influence on people of faith to start looking at issues of policy, to start looking at issues of preventive medicine, so that the Church becomes an environment to support spiritual teaching, as well social movement to bring about better health".[126] This point linked to another comment about expanding capacity development into broader health-promoting activities: "What if we begin to educate not only just for HIV, but what if we begin to do capacity building for areas that target poverty reduction?"[127]

5.7.4 IMPROVING THE WAY DONOR FUNDS ARE ALLOCATED

The focus groups and key informants provided rich material regarding specific actions donors could take to improve population health outcomes. Focus group participants voiced frustration regarding the pre-occupation with vertical programmes, pre-determined aims of donors, their insensitivity to local needs and conditions, and the multiple agencies involved in funding specific HIV-related programmes. They proposed that funding approaches should be reconceptualised so that funding could meet long-term, sustainable health and development outcomes. The principles on which this approach should be based would include:

- the determination of priorities at a local level (which would, amongst other things, necessitate consultation by donors with local stakeholders)
- integrated poverty-reduction and health-promoting strategies developed at a district level (including, for example, food parcels, food gardens and other nutrition programmes)
- co-ordination of funding from donors and government at a district level
- consideration of the long-term capacity development needs of community- and faith-based institutions, and
- provision of reliable funding to support the administrative costs incurred by CBOs and FBOs.

122 FGD Lusaka.doc - 3:69 (383:384).
123 MoH South Prov.doc.
124 FGD Livingstone.doc - 1:95 (425:425) & 1:94 (423:423).
125 AIDS Alliance.doc - 6:69 (93:93).
126 AIDS Alliance.doc - 6:63 (80:80).
127 FGD Lusaka.doc - 3:67 (378:378).

5.7.5 IMPROVING COLLABORATIVE STRUCTURES

It was proposed that a network of all REs should be set up to ensure that there was adequate co-ordination and networking.[128] This could also be responsible for documenting best practice and arranging exchange visits.[129] At the district level there should be a body that was responsible for overall co-ordination and facilitation of activities.[130]

A suggestion was also made that a 'healers' council' should be set up for liaison with traditional healers under an Act of Parliament that would ensure that this would be a viable and functional organisation with statutory budgetary allocations. Further research was also needed to advance the use of traditional medicines.[131]

5.8 CHAPTER RECOMMENDATIONS

In Zambia, REs played a major role in the provision of health services through health facilities, providing 30% of all facility-based health services in the country and 50% of those in rural areas. In addition, local non-facility-based FBOs were widespread and responded proactively to a range of health and welfare needs. Both types of service provided a complementary and very important health resource for the population. Recommendations are provided separately for each sub-sector below.

5.8.1 FACILITY-BASED HEALTH SERVICES

Given that REs providing hospital services were a major player in rural facility-based health services and that these services and facilities were under financial and human resource pressure, it is recommended that:

- **planning** be undertaken between CHAZ and MoH to identify the resources needed to maintain and enhance the quality of care provided by these facilities;
- special consideration needs to be given at national level to how faith-based facilities and training institutions can be mobilised to help address the **HR problems in the health system**;
- where possible, faith-based **training** facilities for health workers in rural areas should be kept operating so as to encourage rural people to train as health workers and to stay on in rural areas when trained;
- **policy**: care should be taken that there is parity in access of the community to health services, whether provided by MoH or REs. In the case of user fees, special measures need to be put in place, given the financial impact of the removal of user fees on faith-based facilities;.
- **funding** should include consideration of salaries, benefits, accommodation, infrastructure, equipment and drugs; and
- **co-ordination**: every effort should be taken to make sure that the faith-based health services are integrated into the planning, financing, and monitoring and evaluation of districts, rather than seen as 'separate' or competing health services.

5.8.2 NON-FACILITY-BASED HEALTH SERVICES

- There is a need for agencies that can support FBOs operating at a grassroots level. The work of the Copperbelt Health Education Programme should be evaluated and documented with a view to setting up a series of district-based parallel support agencies.
- Funding of REs needs to consider the role and sustainability of organisational capacity.
- Funding should be made available in a way that is locally responsive and appropriate. Funders should be aware that their 'pre-determined' themes and targets could be completely inappropriate for local contexts.
- Donors need to work together at a district level.
- Funding mechanisms need to be simplified to help ensure limited capacity and resources are not wasted in putting proposals together.
- Income generation projects are needed for volunteers.
- The mechanism developed to enable the MoH to liaise with traditional healers should be developed further.

128 FGD Ndola 2.doc - 5:42 (54:54).
129 FGD Ndola 2.doc - 5:28-29 (90:90).
130 FGD Ndola 2.doc - 5:21 (61:61).
131 TH Alliance.doc - 11:50 (110:110).

5.9 REFERENCES

Benn H. 2007. *UK Hansard Zambia: Health Services 14 Jun 2007: Column 1251W.* London: UK Government.

CHAZ. 2007. http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04)

Equinet. 2007. Reclaiming resources for health; a regional analysis of equity in health in East and Southern Africa. Johannesburg: Jacana.

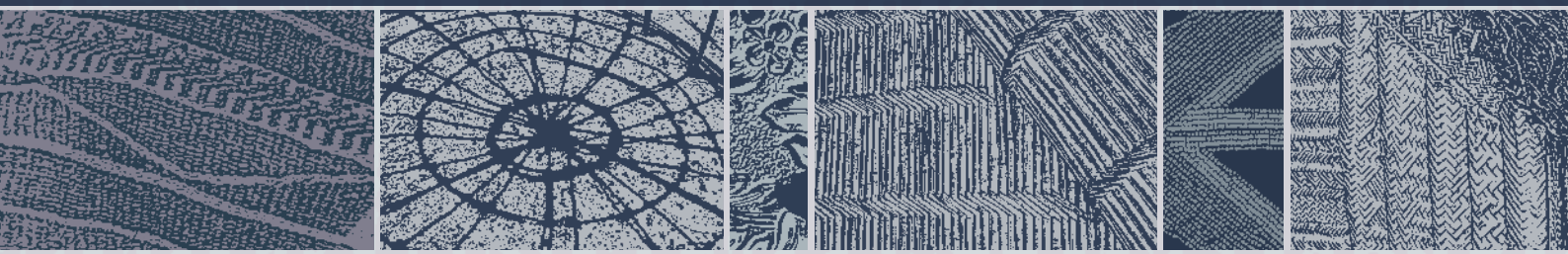
Masiye F. 2007. I*nvestigating health system performance: An application of data envelopment analysis to Zambian Hospitals*. BMC Health Services Research 2007.

OECD. 2007. *Zambia Country study, African Economic Outlook,* Paris: OECD. www.oecd.org

Oxfam. 2006. "Zambia uses G8 debt cancellation to make health care free for the poor". Press release. 31 March 2006.

CHAPTER 6

CASE-STUDY UGANDA



CHAPTER 6

6.1 INTRODUCTION

This chapter begins with an overview of the health system in Uganda and the forces that have shaped it, indicating the role of the faith-based sector in this context. It describes the contribution religious groups make to public health, provides an indication of the capacity of health-supporting REs, their sources of financial and material support, collaboration and networking in the sector and with other actors, and outlines some common perceptions of the sector by various stakeholders. It concludes with sections on the constraints for REs in their endeavour to work for better health, considerations on how they can be supported in this endeavour, and makes some recommendations.

6.2 OVERVIEW

6.2.1 HISTORICAL CONTEXT

Protestant and Catholic missionaries settled in Uganda in around 1890. The country remained under British control until it gained independence in 1962. The new Ministry of Health inherited several hospital facilities, some run by mission agencies. In the period from independence to 1971, Uganda was reported as having the best health care system in the sub-region.[1]

In the 1970s, divisions in the country led to ongoing strife. During this period of turmoil, there was little investment in health care and facilities became run-down. Other than faith-based organisations, many health-providing NGOs ceased to operate. Several key informants in this study confirmed the importance of mission hospitals in the early colonial period and during times of turmoil in later years.

A new phase began with the coming to power of the National Resistance Movement led by President Museveni in 1986,[2] when considerable investment was focussed on political and economic preconditions for growth. During this period, the national government's investment in health was very limited, with some ad-hoc investment made in hospital facilities.[3] In the late 1980s and early 1990s, in the absence of a national health plan, multiple donors set up vertical health programmes[4] and UNICEF became known as the 'alternative' Ministry of Health.[5]

6.2.2 SOCIO-DEMOGRAPHIC FEATURES

In 2007, Uganda's population stood at almost 31 million people, over half of whom were under 15 years of age.[6] Figures from the mid-2000s indicated that only two thirds of those over 15 years of age were literate.[7] Eighty-five percent of the population were Christian (half of which were Catholic and half Protestant, of which Anglicans were the largest group) and 12% were Muslim.[8]

Despite the considerable international aid focused on economic performance after the war, Uganda remained one of the world's poorest countries: it is ranked 145 of 177 in terms of the Human Development Index of 2006.[9] The proportion of the population in poverty fell from 56% in 1992 to 34% in 2000, in part due to economic growth of 6% per annum in the period 1990-2006.[10] However, there was a parallel increase in income inequalities during this period,[11] with Gini Coefficients shifting from 0.35 to 0.45 in the period from 1992-2003.[12] The high proportion of the population still in poverty could be attributed to the slow pace of rural development and poverty reduction, in a context where the majority of the population was rural and agriculture contributed about a third of the GDP. Other contributing factors included high rates of HIV and AIDS, slow private-sector development, ongoing political instability in the north, heavy reliance on international aid and weak institutional and human capacity.

1 Enable 2006.
2 World Bank 2005.
3 Enable 2006.
4 See Chap 3.2.5 about the trend toward 'diagonal support'.
5 Enable 2006.
6 Mayanja 2005.
7 Kintu *et al.* 2005.
8 US State Department 2007.
9 World Bank 2005.
10 World Bank 2005.
11 World Bank 2005.
12 Ugandan Ministry of Finance, 2004 in Okuonzi 2004.

6.2.3 BURDEN OF DISEASE

The key health problems in the country were HIV and AIDS, malaria, TB and a number of other typical infectious diseases.[13] These were compounded by high rates of malnutrition.[14] Furthermore, inferior maternal and perinatal conditions added considerably to the workload of health centres; their inability to respond adequately resulted in an unacceptably high maternal mortality rate in Uganda.[15]

6.2.4 THE HEALTH SYSTEM

Health Sector reform was introduced in Uganda in 1994, based on principles laid out by the World Bank. Reform was a precondition for countries to be able to access external aid. Many held the view that these reforms not only failed to improve health services but were also instrumental in undermining the health system.[16]

The decentralisation strategy of this period has been interpreted by some as an excuse for central government to abdicate its responsibility in health service provision. Further, although considerable financial resources were made available by international donors to support this strategy, this often did not result in the anticipated improvements, as the donors and the MoH earmarked the funds for specific uses.[17]

In line with the underlying principles of the reform, user fees were introduced in the early 1990s (again as a condition of receipt of a World Bank loan)[18]. However, user fees only managed to offset 5% of costs and did not lead to improvements in health services or health outcomes, as many people were deterred from using the health system. This, together with political factors, led to the decision to end user fees at public health facilities in 2001.

Around the same time, a Health Sector Plan and National Minimum Health Package were adopted to ensure allocation of funds to priority health problems on an equitable basis.[19] Over 50% of Uganda's health funding remained sourced from international aid in 2004[20] and a health sector-wide approach (SWAp) was adopted "to improve health status and services through a coordination of resources". A national social health insurance scheme was to commence in January 2009.

Nonetheless, Uganda's health system remained chronically under-funded, with only US $5 per capita being spent by the government in 2006, with an additional US $3 being received from the donor community. This was considerably lower than the US $34 per capita suggested by the Commission for Macroeconomics and Health. Only a third of the budget went to primary facilities, while over half was invested in secondary and tertiary facilities.[21]

In 2007, a number of shortfalls in the health system in Uganda were highlighted in a report by the Auditor General, which noted that "hospitals and other frontline health centres were … systematically failing to provide adequate services to patients".[22] Often equipment was poorly maintained, there were insufficient staff and drugs (especially in rural areas) and there was evidence of some corruption.

6.2.5 THE ROLE OF RELIGIOUS HEALTH SERVICES

In Uganda the private sector was understood to include traditional healers, non-governmental organisations (NGOs) (including FBOs) and private health care providers. The term 'private-not-for-profit' (PNFP) was used for organisations guided by the concern for welfare of the population rather than profit. The majority of such organisations were founded by religious bodies, to the extent that the term, loosely applied, was almost synonymous with the Ugandan religious health sector, although it strictly included secular groups that provided a minority of PNFP services. Henceforth this chapter refers to the religious sector as PNFPs, as is common in the country.

13 WHO 2007.
14 PL.doc - 17:3 (9:9).
15 PL.doc - 17:40 (72:72). In 2000 the maternal mortality rate was 880 per 100000 live births (WHO Afro 2006).
16 Okuonzi BMJ 2004.
17 Okuonzi 2004.
18 Okuonzi 2004.
19 Mayanja R. 2005.
20 Okuonzi 2004.
21 Enable 2006.
22 plusnews 2007.

PFNPs were seen as especially important given their responsibility for around one third[23] of service provision (17% of all out-patient consultations, 35% of all deliveries and 29% of all DPT3 immunisation doses, according to a 2007 report).[24] The Health Sector Strategic Plan identified the importance of strengthening partnerships with the private sector, given its extensive role. Indeed, the reforms of the early 1990s had already identified the private sector and NGOs as key providers of health and social services. The National Health Plan did not distinguish between public facilities and PNFPs and its guidelines applied to both.[25] Traditional healers (TH) also played an important role in providing primary health services to about 60% of the population.[26]

6.3 CAPACITY OF PNFPS IN UGANDA TO PROVIDE HEALTH SERVICES

6.3.1 HEALTH SERVICES

Most agencies surveyed by this study, with respect to facility-based services, as well as the focus groups, reported that they provided hospital or general health services. Of the 18 agencies interviewed, six were Muslim, seven Catholic and the balance from Protestant churches. All of them were affiliated to one of the three faith-based medical bureaus (see 6.3.2).[27]

The health services provided by the agencies were predominantly community-based, primary and secondary health services, although three included tertiary hospitals. Many of the agencies reported serving large numbers of outpatients monthly (that is, over 10 000 outpatients, with some having as many as 17 000 outpatients), although some were much smaller in scale, serving 60 outpatients a month. Over two thirds offered dispensary services and these provided for a range of between 100 and 20 000 patients per month. While a few of the facilities provided inpatient care to fewer than 100 patients a month, several were much larger in scale, with between 500 and 3 000 patients on a monthly basis.[28]

Key informants also commented on the wide range of curative, preventive and promotive services provided by PNFP facilities.[29] These included "everything that it takes to be a private hospital", in addition to training institutions and outreach services.[30] Clearly then, PNFPs provided an impressive range of health services that were similar to and sometimes went beyond those of the MoH.

Box 6.1 Does "working for God" matter?

An independent survey found that PNFPs in Uganda provided similar services to those of the public sector in terms of inpatient care, laboratory services and immunisation, but were more likely than their public counterparts to provide outreach, health education, antenatal care and training of nurses and community health workers – services with a strong public good component.

(Reinikka & Svensson 2003.)

MNCR: Many of the surveyed agencies reported that they specifically targeted women, children under 5 years, as well as youth living in rural areas. Two specifically mentioned services for pregnant women.[31] Maternal health was a serious concern for health providers in Uganda; accordingly a number of PNFP facilities had reduced user fees that applied to this group to make their services more accessible.

When asked what additional services they would like to provide in future, agencies identified the following:

- higher level specialist services
- diagnostic equipment (such as scans, ultra-sound)
- better laboratories
- cancer treatment, and ear, nose, throat, dental and eye care
- improved services to rural areas (especially with respect to ambulance services and deliveries), and
- more antiretroviral treatment (ART) and prevention of mother-to-child transmission (PMTCT).[32]

23 MoH.doc - 19:2 (16:16).
24 UCMB 2007.
25 UNICEF.doc- 15:10 (22:22)
26 ROU 2006.
27 Questionnaire data.
28 Questionnaire data.
29 WHO.doc – 14:6 (57:57)
30 UMMB.doc - 21:24 (73:73).
31 Questionnaire data.
32 Questionnaire data.

Managers of health facilities were aware of the challenges around scaling up ART, especially at a time where the sustainability of services was already in question. However, they found it difficult to resist the public pressure to enrol more people on ART, and were attracted by the prospect of an additional allowance for managers of such services made available by funding agencies.[33]

A number of existing resources were identified as providing a platform on which to expand services, including the skill and commitment of staff and the considerable infrastructure in the form of existing buildings. The key limiting factor was funding, for equipment (including maintenance), remodelled and new buildings, and the training of new personnel and supervision.[34]

Regarding **non-facility-based health services**, PNFPs provided a range of services in support of the work they did through their health facilities. These health-supporting initiatives added another dimension to the holistic package of services to improve community well-being. Accessing data on these services was difficult, however, as they often lacked co-ordinating structures and proper governance systems. Many of these services were run by groups not affiliated to any of the bureaus, although some were co-ordinated by central bodies, for example the Uganda Protestant Medical Bureau (see later) or the HIV/AIDS Focal Point at the Catholic Secretariat. According to an official of the Focal Point, Catholic groups were quite individualistic in their approach, offering small scale interventions directed at HIV awareness.[35] This is a common situation across Africa (see Chapter 4, e.g. Sec 4.8.2). As a result, this study did not manage to obtain much information on the scale of these services.

Approximately half of the agencies assessed in the study were involved in home-based care services that varied considerably in scale (ranging from 20 to more than 7 000 patients on their books).[36] In the case of the Gulu region, it was reported that faith-based programmes offered a range of services, with VCT a common focus in rural areas; others provided adherence and other support to people on ART.[37] According to a 2001 survey in Uganda, 16% of agencies providing HIV-related and AIDS-related services were faith-based, with an emphasis on prevention, mitigation and capacity-building, and were described as having a "special edge on providing psychosocial support to people living with HIV and AIDS (PLWAs), the orphans, and the widows".[38] These were largely grassroots groups that were fairly evenly distributed throughout the country, including its more remote areas where not many other services existed.

A total of 145 000 **traditional healers** (TH) were reportedly providing health services in Uganda, compared to 90 000 workers in the bio-medical sectors.[39] They were respected in their communities as indigenous resource persons with the potential to influence behaviour, but also as providers of health services that were "potentially effective and affordable alternatives" for treatment.[40]

Traditional medicine was reported to be used extensively for day-to-day health care needs by the rural Ugandan population.[41] In addition, traditional birth attendants were trained by the MoH and worked in collaboration with local facilities, referring patients where this was required.[42]

Traditional and modern health practitioners together against AIDS and other diseases (THETA) was started in 1990 with the purpose of involving THs in the response to AIDS.[43] The association worked with traditional healers in HIV and AIDS education, counselling and improved patient care and had developed a curriculum for training THs in basic clinical diagnosis for AIDS. To date their programmes have impacted on more than 1 000 healers, of which 400 have undergone extensive 18-month training and 300 have been certified. It was estimated that as many as one million persons have benefited from their services.[44]

33 Personal communication, Dr S Orach, UCMB.
34 Questionnaire data.
35 UCMB 2003.
36 Questionnaire data.
37 FGD Gulu.doc - 7:49 (129:129) & 7:50 (131:131).
38 AMREF-Uganda, 2001.
39 Dr Runumi in the MoH gave these figures. According to."Human resource for health" in AHSPR 2006/7 the combined health workforce in public and PNFP facilities was only 36,100.
40 AIDSUganda 2007.
41 Kamatenesi-Mugisha *et al* 2006.
42 DHO Gulu.doc – 16:4 (16:16)
43 THETA 2007.
44 AIDSUganda 2007.

However, official recognition and more widespread collaboration with THs by public providers was still lacking. While the government acknowledged that "integration of traditional and complementary medicine … has the potential to augment, strengthen and promote better health care for all",[45] no policy framework had been adopted to enable such integration,[46] nor had issues like safety, efficacy or quality of treatment been addressed, or resources put aside to enable implementation. A draft policy on traditional and complementary medicine, intended as part of a comprehensive Public Private Partnership for Health (PPPH) policy, was yet to pass through the Ministry of Health to Cabinet and Parliament for approval.[47] On the other hand, no fully representative association of THs existed with whom government could negotiate the policy.[48]

6.3.2 FAITH-BASED HEALTH NETWORKS

There were three medical bureaus in Uganda, namely (in order of seniority, regarding both duration and size): the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau and the Uganda Muslim Medical Bureau. As the newest of the three bureaus, the Uganda Muslim Medical Bureau was still in a phase of expanding its reach, while the older bureaus with their extensive services had taken the strategic decision to restrict physical expansion in favour of sustainability and quality during the current financially difficult period.[49]

The bureaus' primary mandate was to support and oversee health services within their separate denominations. The bureaus also worked closely together on most matters, especially regarding the relationship with government. One informant characterised their activities as follows:

> *The bulk of PNFP services is faith-based …. and the bulk of these is represented by the three medical bureaux. Whatever agenda we have followed, we haven't taken it forward as religious, but as non-profit health sector. PNFPs are implementers. And the bureaus represent them at the national level, in front of the donors and they are a kind of broker and catalyst of agents of change for the network.50*

More detail on the wide range of functions of medical bureaus and some of their formalised joint structures were mentioned (see also Uganda country profile in Chapter 4) :

- General facilitation of health units;
- technical support on management of human resources, finances, the information system and governance through workshops;
- advocacy to strengthen the position of PNFPs and inform government and other role players of their specific situation and needs; develop the relationship with government; resource mobilisation from central government;[51]
- fund raising and distribution of funds received;[52]
- mediation between donors and health units, e.g. drug donations;
- UPMB and UMMB jointly manage a small sub grant programme promoting PMTCT.[53]
- UCMB has done extensive analysis on costing of services:

  > *And the completeness of the minimum care package. Because everybody speaks of the minimum care package and nobody knows whether the units deliver it or not and to which extent. But we know. And we can monitor whether the extent to which the package is delivered increases or shrinks over time.54*

- UCMB has been instrumental in the modification of the health management information system for generation, analysis, and dissemination of information; this system is now adopted by the Ministry of Health. "It was commissioned

45 ROU 2006.
46 The National Health Policy of 2000 recognised the important role that TH could play in health care delivery. A policy draft regulating the interaction was prepared in September 2006 and was pending approval. See ROU 2006.
47 Personal communication, Dr. S. Orach, UCMB.
48 ROU 2006.
49 Personal communication, Dr S. Orach, UCMB.
50 UCMB.doc- 18:2 (9:9) &18:15 (31:32)
51 Mukono DHO 1.doc - 23:41 (68:68)
52 UMMB.doc - 21:2 (12:12)
53 UMMB.doc - 21:53 (163:163)
54 UCMB.doc - 18:33 (57:57)

by us as an attempt of going towards a workload related staffing norm, rather than a bureaucratically established staffing norm. "[55]

- responding to new challenges: UPMB has developed programmes in its training schools to develop staff capacity in counselling to respond to increasing chronic illnesses;[56]
- UMMB Mediates between its health units to ensure that equipment is shared, and staff rotated in order to build capacity and improve discipline;[57]
- UPMB helps its health facilities to link to projects and programmes, specifically around HIV/AIDS and malaria, such as building capacity and management of ART;[58]
- international networking , e.g. with Christian health associations in Kenya and Tanzania around best practices;[59]

There is an informal relationship between the three bureaus, which has however resulted in some formalised structures. Joint activities include:

- the Joint Medical Stores; started in 1979; a legal entity with its own structures of governance, serving both PNFP units and those of governments and the private sector sourcing and distributing quality drugs and medical equipment;[60]
- the bureaus worked towards forming a cartel of PNFP health training institutions; this did not come about formally, but they collaborate loosely on running their training schools;[61]

The Uganda Catholic Medical Bureau owns the biggest proportion of facilities, and UPMB has 258 health facilities distributed across the country; with the 'junior partner', UMMB, running 5 hospitals, as well as 6 health centre III's. and 62 health centre II's. In the latter case the number of facilities has increased by 30-40% in the last 5 years.[62]

The **Inter-Religious Council of Uganda** was another network which brought together five different religious denominations in Uganda to address issues of common interest.[63] Among these issues was an AIDS programme with a focus on implementation through existing facilities and religious programmes at grassroots level, including the scaling up of ART provision at rural facilities. While the religious leaders of the groups involved had established this body, it had no effective system of governance.[64] More details on the functions of the Council are included in Appendix 6.1 (A), while Appendix 6.1 (B) lists the range of other networks which made a faith-based contribution to health in Uganda, either nationally or regionally: the impact of these networks is varied.

6.3.3 HEALTH FACILITIES

Overall, PNFPs provided 44 hospitals out of the total 104 hospitals in Uganda (that is, 42%), and 558 of the 2 536 lower level health units (that is, 22%).[65] PNFP facilities make up a varying fraction of the total number of facilities in different areas of the country and in different levels of facilities. Table 6.1 provides information on districts covered by the study.[66]

These data illustrate the considerable scale of PNFP health facilities in Uganda as well as their emphasis on hospitals, rather than primary care. This imbalance reflects the historical evolution of PNFP facilities, most of which were built before the Primary Health Care movement. The district health officer (DHO) in Gulu took a critical view of this condition:

> *PNFPs have stagnated. … The PNFP services are now dwindling, their impact is less. They could do more. Lacor [the main UCMB hospital in Gulu] has continued growing, may have over-grown. It should have gone out with its services. The need is for expanding health centres in other areas.*[67]

55 UCMB.doc - 18:34 (59:59)
56 UPMB.doc - 20:37 (85:85)
57 FGD Kampala 2.doc 10:1 (129:129)
58 UPMB.doc - 20:45 (110:112)
59 UPMB.doc - 20:46 (112:112)
60 UCMB.doc - 18:12 (25:27)
61 UCMB.doc - 18:14 (27:27)
62 UPMB.doc - 20:28 (71:71), UMMB.doc - 21:1 (6:10) & 21:29 (79:79)
63 IRCU.doc - 26:1 (5:5)
64 UCMB.doc- 18:6 (17:18)
65 UCMB 2007
66 Data for the 3 districts from MoH Clinical Services (quoting health facility inventory 2004), *Uganda Districts*, 2005, Other than for hospitals the source distinguishes between government and private facilities; the bulk of private are religious, but not all. No MoH hospital figures for Kampala were given.
67 Gulu DHO.doc - 16:17 (50:51).

Table 6.1 Private and public health facilities in selected Uganda districts

	Kampala		Mukono		Gulu	
	MoH	PNFP	MoH	PNFP	MoH	PNFP
Hospitals	(1 tertiary)	7, incl 3 tertiary	1	3	2	1
Beds	2 800	1 100	100	350	350	460
	MoH	Private	MoH	Private	MoH	Private
HC IV	3	1	4	0	3	0
HC III	11 + 1 clinic	8	20	2 + 83 clinics	13	3 + 25 clinics
Dispensary	30	16 + 230 clinics	9	12	26	2

Note: HC I = Health Centre 1: village health team with no facility
HC II = Health Centre II: outpatient department only
HC III = Health Centre III: outpatient department + ward, focus on maternal and child health;
HC IV = outpatient ward, theatre, laboratory + maternity – can handle complications.

While it would be desirable for future planning to shift the focus to providing more primary care, with the current financial constraints that seems unlikely, as this is the least sustainable level of care, both in terms of raising income through user fees and attracting staff.

Agencies assessed in the study varied greatly in the scale of their operations, some providing a single facility, while others operated more than ten (Church of Uganda) or even more than twenty (Catholic Medical Bureau). The scale of the facilities themselves also varied, ranging from 9 000 beds in the biggest agency to only a few in the smallest. Several agencies had more than 300 beds per facility. While the majority of facilities were owned by the agencies themselves, some were owned by the community, and occasionally the facilities were shared with other agencies.[68]

Where it was possible to obtain data, facilities were constructed of brick. Electricity was most often reported to be 'sometimes available'; although in a few cases it was 'never available'. Access to water was most commonly described as being generally reliable; however, sources such as boreholes and communal taps were less so. About two thirds of facilities reported always having access to telephones, with the balance having either no access or intermittent access. Half of the sites had reliable e-mail access. In a quarter of the sites, ambulance or transport services were not available.[69] Regarding infrastructure at PNFP facilities, experiences ranged from being able to maintain government standards to lacking the basics (water and electricity, modern equipment, ambulances).[70] These responses were reflective of the varying conditions that existed on the ground, in particular between rural and urban facilities, but also between those of the well-established Catholic and Protestant bureaus and those belonging to the newer Muslim network, which was still getting off the ground and having to do so in difficult conditions.

Despite the problems faced by the PNFP facilities surveyed, they tended to be well resourced compared to the general conditions in the country. It must be emphasised, however, that the sample surveyed was mostly urban, where conditions were generally better, whereas the bulk of the PNFP facilities were located in rural regions. Nonetheless, key informants acknowledged that some of the PNFP facilities were model health providers. The Uganda Catholic Medical Bureau-affiliated Lacor hospital in Gulu, for instance, compared favourably with the regional referral facility in terms of equipment and staffing, and had a reputation that attracted patients from even beyond the borders.[71]

6.3.4 GEOGRAPHIC DISTRIBUTION

Agencies in the survey provided services in urban and rural areas, although peri-urban areas were a dominant group served by these agencies. In terms of the breakdown of locations from which clients were drawn, all agencies identified a primary location, while also noting that clients came from other locations too. Even where facilities were located in rural areas, these facilities were also patronised by those living in urban and peri-urban locations. The same applied to

68 Questionnaire data.
69 Questionnaire data.
70 UPMB.doc - 20:30 (73:73), UMMB.doc - 21:14 (44:44) & 21:15 (46:46).
71 UNICEF.doc - 15:4 (12:12).

facilities in urban areas, with a significant proportion of clients coming from rural areas.[72] The implications with regard to time and transportation costs incurred by clients need to be explored further. It is likely that this pattern was a result of the shortage of facilities close to home, although the preference for faith-based services could also be a factor.

As indicated above, this survey was not conducted on a representative sample but had an urban bias. The consensus from PNFP representatives in most focus groups and other key informants (including the WHO representative) was that the bulk of PNFP facilities were rural, especially those with lower level units, while the major hospitals were located in the bigger centres. It must also be noted that in many cases hospitals were originally built in rural areas, but had over time attracted developments like a school or trading centres around them, so that their locations are no longer 'deep rural'.[73] The conscious focus for PNFPs, however, had been to serve those most in need – the poor and difficult-to-reach populations – in accordance with their mission; as a result a high proportion of rural facilities were run by PNFPs.[74]

Box 6.2 Providing health services amid conflict

Gulu in the North of Uganda is only just emerging from 20 years of civil war. Over 90% of the population in the area were displaced with 1,5 million persons living in camps.

Some implications for health services:

- *high morbidity due to communicable diseases and psycho-social conditions in IDP camps*
- *complicated burn cases*
- *2 000 to 10 000 IDPs seeking safety from attacks crowding into hospital premises every night*
- *difficulties for IDPs returning to areas devastated by the war; and for the MoH trying to reach them with health services*
- *the added stresses on health staff and accordingly greater difficulties in retaining them*
- *competing for staff with 250 NGOs working in the area, many of them war-related*

Sources: Gulu FGD, KII in Gulu, St Mary's 2005/06

There were of course regional differences. In Kampala, for instance, there were a number of private for profit facilities, and even some of the PNFP facilities had high cost wards. In Mukono, the PNFP facilities are "equitably distributed throughout the districts. They are rural. They handle the poor".[75] Key informants from Gulu district health office (DHO), however, commented that church facilities were mainly either in big urban centres or semi-urban centres, and not enough was done for the more remote areas, especially those to which internally displaced persons were currently returning (see Box 6.2). The sentiment was that PNFPs should focus on areas where there were no government facilities.[76] It was not made clear, however, why that should be the responsibility of the PNFPs. Under current circumstances, it was understandable that they were not able to take this on, notwithstanding their commitment to serve the disadvantaged, as they barely had the resources to maintain existing facilities.

6.3.5 TRAINING SCHOOLS

The aspect of the health system in which the PNFP contribution was proportionally most significant was the training of health workers. Twenty of the 27 nursing and midwifery training schools in Uganda (that is, 71%) belonged to this sector, accounting for 60% of nurses and midwives in the country.[77] They provided excellent training, as acknowledged by the Director for planning in the MoH:

> *A nurse trained under the PNFPs performs much better than a nurse trained through the Ministry of Education. The quality is much better for PNFPs.*[78]

Further, the only training for health managers available in Uganda was offered by two Christian institutions.[79]

PNFPs also placed a premium on offering career development opportunities to staff in their facilities and aimed to provide decentralised training facilities so that staff could train in the area from which they came. Both these strategies helped to

72 Questionnaire data.
73 Mukono DHO 1.doc - 23:20 (31:31).
74 UPMB.doc - 20:4 (11:11).
75 Mukono DHO 1.doc - 23:42 (74:74).
76 UNICEF.doc - 15:10 (22:22); Gulu DHO.doc - 16:14 (40:40).
77 UCMB 2007.
78 MoH.doc - 19:18 (45:45).
79 UCMB.doc- 18:53 (60:60).

retain staff.[80] The three bureaus had put in place scholarship programmes for all staff categories, with a focus on nurses, and had developed training programmes that equipped them for the conditions they experienced and for new needs in the health sector.[81] One example was the growing need for counselling of patients with chronic illnesses. Sadly this strategy of developing a multi-skilled, competent work force did not always succeed as a means of retaining staff:

> *However, you find that those health workers who joined our network become competent. If you look at a health worker who has joined government, and one who has joined our network, over five years the one who has joined our network will be skilled, multi-skilled. We will have built their capacity – and those are the ones we are losing, because they become marketable … [it] has made us vulnerable to the people who want skilled labour.*[82]

The training of high-quality health workers was a critical contribution of PNFPs to the Ugandan health system, yet one that seemed to get little support from the state. Instead the government poached the staff trained in PNFP training schools – a further frustrating element in the relationship between PNFPs and the MoH, especially since there is no shortage of medically trained people in the country. A member of the PPPH group claimed: "And you can find in Kampala, taxi drivers with a medical degree. You can find them here, no problem".[83] These could be recruited directly from training schools, rather than from the PNFP facilities.

6.3.6 HEALTH-SUPPORTING AND PROMOTING ACTIVITIES

Besides their involvement in direct health services, whether facility-based or not, religious entities often offered services and activities that were supportive of public health, such as welfare and development services. This applied to about half of the agencies surveyed by this study. They provided very tangible services to orphans and vulnerable children (OVC), economic empowerment and poverty alleviation in addition to food parcels, and care for refugees. Additionally, they provided psychosocial support, spiritual guidance and pastoral care for the sick. Some agencies undertook monitoring and evaluation and advocacy work, and some provided information regarding skills development or leadership. Most agencies described work related to achieving behaviour change (with respect to risky behaviour and in relation to sex education), generally targeting youth but also mothers, and sometimes including health messages on topics like immunisation. The proportion of time committed to health versus non-health activities varied widely, presumably in accordance with the goals of the agency, although availability of funding could not be discounted as a contributing factor.[84]

Further examples were given by agencies of providing seeds and implements to achieve food security, general counselling services, spiritual guidance and sensitisation about diseases such as Ebola or HIV.[85] A study of faith-based OVC programmes in Uganda reported a range of services provided, ranging in scale from congregation level projects offering material and psycho-social support to up to 50 OVC, to NGOs with an average of 1 000 OVC in their care. The less formal initiatives were usually reactive rather than pro-active, acting as seasonal 'shock absorbers'.[86]

Their community base offered opportunities for PNFPs to work in ways and in areas that were not available to state entities. Primary among these was the potential for health promotion in communities. A number of key informants confirmed the role religious leaders played in health promotion, for instance by supporting within their networks messages on vaccination or promoting antenatal care and prevention of HIV.[87] Those religious leaders who had received training regarding the content of health promotion were effective at transmitting the messages, due to the respect with which they were regarded in communities. In addition they were regarded as more suited for some aspects of HIV-related services, like family support, psycho-social care, and palliative care because "a religious leader does it better than a medical worker. Because he uses the spiritual part of appealing to talk to these people".[88]

Compared to the prominence that this role for religious leaders had in Mali (see Chapter 7), it was surprising that not more was made of it in Uganda, with its much-documented campaigns against HIV. One reason for this may be that

80 PL.doc - 17:30 (60:60).
81 UPMB.doc - 20:36 (85:85).
82 UPMB.doc - 20:36 (85:85).
83 PPPH.doc - 22:20 (43:43).
84 Questionnaire data.
85 FGD Gulu.doc - 7:51(132:133) & 7:15 (53:53).
86 Muhangi 2003.
87 WHO.doc - 14:12 (106:106), IRCU.doc - 26:16 (92:92) & 26:17 (92:92).
88 Mukono DHO 1.doc - 23:30 (45:45) & 23:29 (45:45).

religious leaders do this work as part of their routine rather than as part of projects, so that the work is not accompanied by the distribution of commodities, nor publicised on radios and through posters. Religious leaders were consequently 'invisible' and their impact was easily attributed to more visible players.

In summary it can be stated that the capacity of religious entities in Uganda to deliver health services and promote health and well-being, though hampered by resource constraints, was nevertheless strong. This sector was an asset to the country and the health system and deserved to be strengthened.

6.4 PNFP COLLABORATION

6.4.1 COLLABORATION WITH GOVERNMENT

PNFPs were appreciative of the recognition they received from government in various forms. For example, PNFP representatives participated in the National Health Assembly, the Joint Review missions with donors and government, and the health policy advisory committee.[89] In addition, a central organ for collaboration with government was PPPH, formed in 2003,[90] with a PPPH Working Group for the Health Policy Advisory Committee including representatives of the donor community, MoH, PNFP, private-for-profit and traditional and complementary medicine as members. A draft policy had been developed, stipulating a partnership between PNFPs and government, rather than competition, which also spelled out how resources, especially financial resources, were to be allocated. Unfortunately the policy had not been fully implemented and recommended posts for district focal persons for PNFP collaboration had largely not been filled.[91] This delay was due, among other factors, to a change of leadership in the Ministry, along with a change of attitude towards PNFPs, and misguided attempts to include providers of natural and herbal therapies in the same policy.[92]

For the national government, collaboration was not only about increasing efficiency but also about acknowledging that part of the responsibility for the health of Ugandans was borne by private providers.[93] Government had a lot to gain from this partnership and was clear on what it expected in return for its subsidy: a reduction of user fees at PNFP facilities, which in turn would improve coverage.

Initially there was mutual suspicion between the partners, with PNFPs fearing that they might lose their autonomy and government uneasy about supporting something without being fully in control of it.[94] Some of these doubts and frustrations lingered on. For the PNFPs, these centred on several issues:

- a sense of not being taken seriously as partners, expressed by one informant as follows: "they like our data, but we are not a planning priority at district level, notification comes late"[95]; and by another: "We are remembered last ... They are putting us at the bottom always. It is not proper"[96]
- poor communication from the MoH (for example, around changes to the ART regimen,[97] and
- failure to implement decisions that were made in the course of negotiation.[98]

In addition, the issues raised by the MoH for discussion tended not to be about the main concern for PNFPs, namely, human resources. Instead, they focused on logistical or technical problems like reforming the accounting or health information system, or how to increase the vaccination coverage, issues on which PNFPs might not feel they had a particular contribution to make.[99]

The only current concern raised by representatives of the MoH was about some facilities being given PNFP status, and hence benefiting from the budget allocation, where the criteria for admission seemed doubtful.[100] Yet, on the whole there was a positive sense about the collaboration, as expressed by a member of the PPPH: "The main thing, individuals have problems, but the PNFP sector never made opposition against anything of the government rules and regulations

89 UPMB.doc - 20:26 (66:66).
90 MoH.doc - 19:8 (32:33).
91 FGD Mukono.doc - 8:84 (230:230), UPMB.doc - 20:20 (49:49).
92 UPMB.doc - 20:25 (62:62), PPPH.doc - 22:39 (71:71).
93 MoH.doc - 19:1 (14:14).
94 MoH.doc - 19:8 (32:33), 19:10 (35:36) & 19:11 (37:37).
95 FGD FGD Kampala 1.doc - 9:5 (101:101).
96 UMMB.doc - 21:63 (203:203).
97 FGD – Kampala 1.doc.
98 WHO.doc - 14 (122:126); UPMB.doc - 20:24 (56:56).
99 UCMB.doc- 18:27 (51:51).
100 Mukono DHO 1.doc - 23:53 (88:88) & 23:54 (96:97).

and policies."[101]

Despite strong commitment to collaboration within the MoH, it proved difficult to implement at district levels:[102] "Because the districts had the autonomy to choose who and to what extent they collaborate with, this policy of collaborating with faith-based organisations did not move that fast". [103] There is reluctance to fully collaborate with PNFPs, partly because of competition for staff and other resources:

> *When we talk with the local authorities there, it seems they consider the PNFP like a sort of competitor for the health resources. So integration at a local level is more difficult than at a national level. Because there, it is touching the budget.*[104]

Yet it was at district level where the real nitty-gritty of collaboration needed to happen. The district level was where funds were shared with PNFP facilities and staff members were recruited. It was where the challenge was for the bureaus to create the linkage that would make a difference to their facilities.[105] There were, however, examples of good practice in certain districts, including some functioning collaboration structures. In Wakiso district the chair of the PNFP collaboration was accessible and an open relationship existed.[106] The situation in Mukono seemed exemplary and is described in some detail in Box 6.3. Appendix 6.2 provides more detail of other examples of functional collaboration, including structures, systems and practical achievements. This shows that, despite the problems at district level, functional partnerships did exist, especially around crises and when there were special needs.

6.4.2 COLLABORATION BETWEEN PNFPS

Box 6.3 Example of good collaboration practice: The district of Mukono

*In this district 20 km outside Kampala, all those working for health seem to follow the philosophy "**not to make them enemies but to make them friends so that we work together**"*

1. Collaboration between government and PNFPs

In the district health team, PNFP representatives meet regularly with members of the District Health Office and they are fully involved – and heard – in planning processes. There is open communication and joint decision taking on issues like determining user fees.

It is one of the few districts where a PNFP focal person has been appointed to direct and follow up on PNFP-related issues. The district health office is fully behind its PNFP contingent, supporting their health units by seconding staff and encouraging them to network among themselves.

The role of religious leaders for health promotion is certainly valued here, respecting that, once they have been given information on health matters, religious leaders need to find their own ways to respond. So the district health office makes available a meeting place for them to deliberate. On Catholics and condoms the District Health Officer said: "What is important is understanding their belief and their values and then you go with them."

2. Collaboration between PNFPs

There was an active private not-for-profit coordination committee with the District Health Officer as an ex-officio member. Members conducted quarterly meetings and seminars and arranged exchange visits between PNFP units. They used these opportunities to learn from each other, sharing skills on reporting, budgeting, strategic planning and health management information systems. The coordinator of the committee acted as liaison person with the District Health Office.

3. Collaboration of PNFPs with traditional birth attendants

Here too the approach is to find the best possible way of working together. Nurses and midwives are encouraged to supervise and train traditional birth attendants, particularly in modern, safe means of delivering and help them to recognise danger signs during pregnancy in order to refer patients to health centres.

Sources: Mukono FGD, Interviews with officers of the District Health Office

101 PPPH.doc - 22:26 (47:47).
102 WHO.doc - 14:14 (122:122).
103 PL.doc - 17:9 (22:22).
104 PPPH.doc - 22:10 (25:25).
105 UPMB.doc - 20:34 (82:83) & 20:47 (114:114).
106 FGD Kampala 1.doc.

Big international NGOs like World Vision tended to collaborate amongst each other rather than working with small indigenous FBOs. However, some did use local FBOs for implementation of activities such as counselling and testing, helping to equip them for these functions through workshops.[107]

Among facilities affiliated to each of the three bureaus, however, there was a high degree of collaboration. This was also in evidence between the bureaus and other PNFP networks. (see Section 6.3.2).

Focus groups were asked to comment on the need for intermediary organisations to improve collaboration, also as a way of overcoming the resource constraints discussed elsewhere in this report. Responses indicated that the medical bureaus were seen as serving this purpose, and highlighted some concerns that other intermediaries might simply serve their own interests. There were also perceptions that at times services were outsourced to overcome weaknesses.[108] It did seem that, for the higher-level facilities, the bureaus were able to perform an intermediary role, offering co-ordination and supervision, capacity building, and a common voice in communication with government. The fact that so little was known about the non-facility-based activities of religious entities did, however, indicate that there was a need for intermediary organisations working at this level, supporting this more loosely structured and more vulnerable dimension of the health-supporting functions of religious groups. Support was particularly required on reporting, fund-raising, management and governance

6.4.3 COLLABORATION WITH TRADITIONAL HEALERS

Informants hardly commented on the reality or value of traditional healers and traditional birth attendants, except in the model collaboration district of Mukono (see Box 6.3). Here traditional healers were organised and had an office in the district health complex. An AIDS educator specifically targeted traditional healers in the district. Traditional birth attendants were also trained and engaged, receiving kits for safer delivery; in return they referred mothers with their children to health centres for immunisations. [109] More examples of collaboration occurred, e.g.

- dialogue around ante-natal care, hygiene and malaria;
- sensitisation so THs and TBAs refer patients to health centres if needed;
- there are instances where traditional birth attendants do their round in the wards after the official round; generally, however, they operate more in secret;
- THs plant their medical herbs in the hospital grounds.

The only area where collaboration was difficult was in urging traditional healers to refer patients to health centres as 'they know that they are going to lose their market." [110]

Several PNFP representatives expressed negative sentiments about the potential of collaboration with traditional healers, tending towards caricature, while others accepted the reality that patients visit healers and and even expressed that ""We can learn from them, too." In this positive vein, the Catholic health network in Mukono had developed a number of community resource persons, including traditional healers, to strengthen their community involvement.[111]

6.5 SOURCES OF FINANCIAL AND MATERIAL SUPPORT

6.5.1 GOVERNMENT FUNDING

Historically, missionary hospitals were funded by the European and North American hospitals that founded them. These original donors had been easy to approach, only requiring an official "to write one sentence to say we want money to put up a house for nurses, and the money would come".[112] Support from this source had decreased significantly.[113] The current trend was a shift towards the sector-wide approach with most funds going into government's central 'basket'.[114] This change had made PNFPs turn to government for financial support.

107 PL.doc - 17:25 (50:50), FGD Gulu.doc - 7:54 (139:139)
108 FGD Kampala – 1.doc.
109 FGD Mukono.doc - 8:47 (130:130)
110 Mukono DHO 2.doc - 24:16 (74:76), 24:17 (78:78) & 24:19 (96:98)
111 FGD Mukono.doc - 8:52 (138:138).
112 FGD Mukono.doc - 8:67 (186:186).
113 PL.doc - 17:32 (62:62).
114 UPMB.doc - 20:31 (73:73).

In Uganda, government support for PNFPs started in 1998/99. The subsidy increased rapidly from 4.4 billion shillings[115] (US$2.6m), to 17.74 billion shillings (US$10m) by 2002/03 where it has remained ever since, despite the increasing costs of providing health care.[116] The government subsidy was used for procuring drugs and other supplies and to pay some staff allowances. Higher-level facilities like hospitals might get funding directly from the Ministry of Finance while lower level health facilities received primary health care funding through the district, together with certain supplies.[117] This funding covered maintenance of the units, drugs, and staff allowances, as well as outreach services.[118] Reporting was required along specified budget items.[119]

Box 6.4 Undertaking number One

At the end of the joint review of the health sector the different stakeholders agreed on this limited number of undertakings for the next 12 months. But now for 3 years consecutively the undertaking number one said that the health sector budget should cater for funds to close the remuneration gap between PNFP and public health workers, in order to stop the drainage of human resources from the PNFP to government health centres. And that government health centres recruit really new people that came on the job market, because a lot of nurses and doctors and all the health staff are trained and are coming on the job market.

To date this undertaking has not been implemented.

Source: PPPH.doc - 22:20 (43:43).

Apart from the fact that the funding was clearly insufficient ("chicken feed, truly speaking, if you compare it to the work", as one respondent noted[120]), it was unpredictable both in terms of timing and amount, as in times of crisis government cut back its allocations to PNFPs. Delivery of essential drugs could also be delayed.[121] As a result facilities were substantially under-resourced, with the Uganda Muslim Medical Bureau estimating that it only had about 35% or 40% of the funds it required for operation of its facilities.[122]

Government did face a dilemma regarding its support of private facilities, even though they were not-for-profit, in that the public sector was itself experiencing acute shortages and had the added pressure of providing free services for the benefit of patients. This challenge accounted for the fact that none of the additional 32 billion or 30 billion shillings (US$19m) that was available for the health sector in the 2007/8 fiscal year was put towards an increased subsidy to the PNFPs.[123]

Nonetheless, PNFPs expected that their contribution of more than 30% to health provision in Uganda should be funded at a level that acknowledged the extent of their contribution, especially as these services came 'cheap' to government, given PNFPs own contributions.[124] After all, if the PNFPs had not existed, the government would have had to provide almost double their current workload – and they would be "'messing up".[125] Some MoH actors admitted that what they granted was not commensurate with the service burden faced by PNFPs.[126]

6.5.2 SECONDMENT OF GOVERNMENT STAFF

Another form of government support was the secondment of MoH staff to PNFP facilities and the paying of their salaries by government. These staff members had originally all been doctors, but recently nurses had also been seconded to lower level units.[127] These doctors and nurses made up approximately 4% of the PNFP workforce.[128]

Seconded staff members were paid at public service rates, which tend to be higher. This salary discrepancy within a single unit often caused tensions between equally qualified staff, although it seemed that PNFP staff members appreciated the lightening of their workloads and the opportunity to take leave that this allowed.

115 Uganda Shilling (USH or UGX) 1700 USh = 1 US$ (Jan 2008)..
116 PPPH.doc - 22:19 (42:42).
117 UNICEF.doc - 15:7 (16:16).
118 FGD Gulu.doc - 7:22 (69:69), FGD Gulu.doc - 7:24 (73:73).
119 UMMB.doc - 21:71 (234:234) & 21:67 (222:223).
120 FGD Mukono.doc - 8:64 (180:180).
121 FGD Kampala 2.doc - .10:3 (193:193)
122 UMMB.doc - 21:64 (207:207).
123 PPPH.doc - 22:22 (44:44)
124 UMMB.doc - 21:54 (169:169)
125 (PPPH.doc - 22:29 (51:51)
126 MoH.doc - 19:33 (83:83)
127 FGD Mukono.doc - 8:79 (213:213); Mukono DHO 2.doc - 24:6 (22:22).
128 UCMB 2007.

Clearly government recognised the value of the PNFP sector and was aware of its responsibility to provide support in the current human resource crisis. Yet this aspect of the relationship between government and PNFPs was the most fraught, with high levels of frustration on the side of the PNFPs, which considered the government partly responsible for the crisis. First, recent developments in human resource policy (such as salary top-ups) had created better working conditions for health staff in public facilities, which PNFP facilities were not able to mimic. [129] As a result, many former PFNP staff members had been recruited to public facilities, leaving an even greater gap behind. Second, the decentralisation policy had placed responsibility for health services at the district level. This too had encouraged the flow of staff from PNFP to public facilities. While the MoH at national level was eager to support PNFP facilities, this did not necessarily happen at district level, where decisions about actual collaboration and staff secondments were taken.[130]

PNFPs were frustrated that the government had not implemented its undertakings (see Box 6.4). While PNFPs only required about 8,5 billion shilling (US$ 5m), which was half of the current annual subsidy,[131] to achieve parity of salaries at current salary levels, public salaries were due to increase again soon, skewing the disparity even further.

6.5.3 USER FEES

User fees were a large funding source for most PNFPs. In urban facilities that served populations capable of paying for services, fees can make up over 90% of total funds.[132] Further away from towns, there was greater reliance on government and donor funding.[133] In 2006, the typical breakdown of funds in Uganda Catholic Medical Bureau facilities was 22% from government, 38% from user fees and 40% from donors (the latter having increased from 22% in the previous eight years).[134]

The need to charge user fees had always been problematic, as they acted as a barrier to access (often with catastrophic consequences),[135] but PNFPs had not been able to afford to abolish fees, along with the public sector, because of financial pressures. Once government started subsidising PNFPs, this additional income was used to lower fees "transforming these subsidies into access for the poor".[136] Thus, from 1997/98 to 2005/06, access to a 65% sample of PNFP hospitals increased by 66% in terms of standard units of output (although there was a slight decrease in the 2005/06 figures compared to the previous year, following the stagnation of the subsidy).[137] Primary targets for user fee reductions tended to be children under 5 years and pregnant women, in accordance with the commitment of PNFPs to reach the vulnerable and under-privileged. In some cases – as in Lacor, Gulu – donor support had made it possible to completely abolish fees for these patient groups.[138]

6.5.4 DIRECT DONOR FUNDING

The main source of funding for health in Uganda was from global initiatives and multi-lateral organisations like the European Union.[139] The bulk of this funding went to government but some funders – particularly the US government – dealt directly with faith-based organisations.[140] Accessing these funds could be difficult, however, given competition between many organisations.[141] More details on specific funding partners appear in Appendix 6.3.

6.6 STAKEHOLDER PERCEPTIONS OF PNFP SERVICES

In 2003 a World Bank report based on a quantitative survey[142] compared government, private for-profit, and private not-for-profit (religious) providers of primary health care in Uganda. The study found that religious not-for-profit facilities were

129 PPPH.doc - 22:18 (41:41).
130 PL.doc -17:9 (22:22)
131 PPH.doc - 22:30 (54:54) & 22:29 (51:51).
132 Some examples of user fees as percentage of budget for PNFP facilities in Kampala were given; (The figures are percentages of running costs; they do not cover capital development):
- St Stephen: 20% of budget.; 15% came from government; balance from donors.
- Kibuli Muslim Hospital: user fees made up 70%, government subsidy about 8%. High cost wards subsidised the lower cost ones.
- Rubaga Hospital, St Raphael and Mengo: they made up 94-96% of running cost.

133 PL.doc - 17:31 (62:62).
134 UCMB.doc- 18:45 (83:83).
135 PPPH.doc - 22:14 (35:35).
136 UCMB.doc- 18:36 (67:67).
137 UCMB 2007. SUOs reflect the following data: IP, OPD attendance, ANC, Immunisation and deliveries.
138 PL.doc - 17:20 (41:41) & 17:21 (42:42).
139 PL.doc - 17:34 (62:62) &17:36 (64:64).
140 PL.doc - 17:35 (64:64).
141 UMMB.doc - 21:6 (20:20).
142 Reinikka & Svensson 2003.

more likely to: provide pro-poor services and services with a public good element; charge lower prices for services than for-profit units; and provide better quality care than their government counterparts,[143] although government facilities had better equipment.

This study supports these findings. There was a general sense, from the full range of stakeholders including government officials, that PNFP facilities were able to do more with the same resources compared to public facilities.[144] PNFPs were perceived as accessible, achieving good utilisation rates for poor communities.[145] In some cases they offered more services than government facilities (such as circumcision offered by Muslim clinics, home visits, and counselling by trained counsellors).

In addition, they were seen to have better infrastructure, be better staffed and have more reliable support services, especially drug supplies. This contributed to the widely held perception of *better quality* services. In Gulu a FGD member reported that a survey among clients showed a high satisfaction rate.[146] Mengo hospital, a PNFP facility in Kampala, conducted a survey in 2002 on the perceptions of nursing care at the facility. The results showed that staff members were more available there than at public facilities nearby, and hence patients were confident that they would be attended to.[147] This was despite the ongoing difficulty of attracting and retaining skilled staff.[148]

Finally, PNFP services appeared to be more efficient.[149] As an official from the MoH stated:

> *The unit costs for health services in the PNFPs are much lower than from government. So we know a shilling invested in through the PNFPs has higher rate of return than one in the government.* [150]

A WHO informant confirmed this, claiming that in many cases clients expressed their 'vote' for PNFP services by making use of them despite their cost[151] and even when there was a public facility "less than 100m away".[152]

The positive performance of PNFP services received acknowledgement from the MoH through the secondment of MoH staff to PNFP facilities, the provision of grants for immunisation and school health programmes on behalf of the government, and support for the PPPH.[153]

Reasons advanced for the accessibility, efficiency and quality advantages of PNFP-provided services include:

1) The values base that guides service provision

The faith base of the PNFPs was regarded as a distinguishing characteristic (in contrast to the technical content of their service which was defined by government guidelines in the same way as those of any other facility). These values translated, firstly, into explicit commitments to serve low-income communities.[154] Thus, some of the agencies assessed by the study included special mention of meeting the needs of the most vulnerable in their mandates. Terminology relating to promoting life, quality services, sustainability and cost-effective service provision was also evident.

Second, the fact that PNFPs felt accountability to 'the people of God'[155] led to improved monitoring and feedback. For example, the UCMB expected all its health units and levels of co-ordination to monitor their output in terms of indicators for access, quality, efficiency, staff productivity and equity.[156] The Bureau gave feedback to the hospitals and dioceses under the same framework and was even influencing the MoH to use this concept for its national assessment.

143 The quality measure is based on observed treatment practice, observed supply (that is, availability of health infrastructure), prescription practices, and exit poll data.
144 WHO.doc - 14:3 (40:40), UNICEF.doc - 15:14 (27:27), MoH.doc - 19:9 (34:34), Gulu DHO.doc - 16:16 (46:47), Mukono DHO 2.doc - 24:8 (35:35).
145 UPMB.doc - 20:11 (28:28).
146 FGD Gulu.doc - 7:39 (101:101).
147 We tried to obtain a copy of this study, but have not succeeded.
148 Mukono DHO 1.doc - 23:4 (11:11).
149 IRCU.doc - 26:42 (194:196).
150 MoH.doc - 19:17 (44:44).
151 WHO.doc - 14:8 (84:84).
152 FGD Mukono.doc - 8:6 (51:51).
153 FGD Kampala 2.doc - 10:4 (71:71).
154 FGD Mukono.doc - 8:24 (72:72), PPPH.doc - 22:2 (21:21).
155 UCMB.doc- 18:20 (37:37).
156 Dr S. Orach of the UCMB.

Third, health workers were motivated to treat patients with dignity and respect.[157] As one informant put it, "There is a strong motivation. We can always make appeal to something that others find difficult to appeal to."[158] Thus, FGD members in Kampala referred to the "special touch" among staff members, who had time and understanding for patients.[159] Staff were also resourceful in bringing their services to their clients: "People will put a vaccine carrier on their bicycle or even walk with it on foot, sit under a tree, give services".[160]

Fourth, PNFPs' faith base might also account for institutions taking decisions that were risky (such as lowering user fees despite financial difficulties), trusting that this measure would enable them to fulfil their commission to the poor and yet not work to their detriment.[161] At the same time this very motivation might act to the disadvantage of PNFPs as it prevented the medical bureaus from taking the one action that might get their plea to government heard:

> *The temptation would be, when you have exhausted all the channels of communication, when all the evidence that you proposed doesn't work. When reason doesn't work, you only have threats. That we cannot use … Ethically, it is a road that is closed to us. And therefore we are weak.*[162]

2) PNFPs are grounded in communities

Religious groups were 'grounded' in all communities, their presence easing access for services.[163] PNFPs were often located 'deep in the villages' where there were no other health services.[164] They were also useful channels to mobilise communities.[165] Traditional healers, in particular, gave culturally sensitive service, and showed flexibility regarding payment.[166]

3) The provision of spiritual and follow-up support

The fact that spiritual care was offered alongside physical care was regarded as helpful for the clients, especially at the end of life.[167] In addition, the connection between the facility and a religious congregation offered the possibility of follow-up care and, in general, holistic care that went beyond medical needs.

4) Strong structures and systems of governance "We are setting the standards."[168]

This was another feature of PNFPs. Working conditions were indeed quite different in the PNFP sector than it was in government facilities, as shown by the comment of an influential decision maker in an international NGO supporting the health system in Uganda:

> *The management there is quite good, disciplining the staff there and looking at how they really do their work, and a little bit of motivation.*[169]

Specifically the PPPH group mentioned that in PNFP hospitals the director was often trained in both medicine and management. The fact that the authority was close at hand at PNFPs accounted for better discipline, better supervision and stricter financial management.[170] The availability of essential drugs and diagnostic equipment – which was often not the case at public facilities – was another factor motivating staff to remain at these facilities despite lower pay.[171] As quoted in the World Bank study, "Thus, working for God appears to matter!"[172]

5) Weaknesses

There were, however, some weaknesses inherent in the PNFP sector. One was their raising of user fees. It was acknowledged that clients had a perception that services should be free – in keeping with the missionary spirit of old

157 PPPH.doc - 22:46 (94:94).
158 UCMB.doc- 18:35 (66:66).
159 Kampala 1.doc - 9:7 (20:20), FGD Mukono.doc - 8:2 (48:48).
160 UMMB.doc - 21:34 (95:95).
161 UCMB.doc- 18:37 (68:68).
162 UCMB.doc- 18:38 (70:70).
163 IRCU.doc - 26:35 (168:170).
164 FGD Mukono.doc - 8:18 (62:62).
165 FGD Mukono.doc - 8:48 (131:131).
166 FGD Kampala 1.doc - 9:2 (192:192).
167 FGD Gulu.doc - 7:13 (51:51).
168 FGD Kampala 1.doc - 9:3 (111:111).
169 UNICEF.doc - 15:17 (29:29).
170 PPPH.doc - 22:43 (86:86) & 22:44 (87:87), Mukono DHO 2.doc - 24:9 (37:37).
171 FGD Mukono.doc - 8:3 (49:49), FGD Gulu.doc - 7:68 (176:176).
172 Reinikka & Svensson, 2003.

Box 6.5 Levelling user fees: "You have to sell a chicken …"

When you come to out-patients, you are sick. What the patient knows is that "I have a fever and I am unwell" and he cannot guess whether this disease will require ten thousand shillings or thirty-thousand shillings. … Of-course, the facility will be making a lot of losses on some patients and we will also be getting marginal profits on some others. But in the end it is more predictable if people know, you have to sell a chicken and you will get the care you need at the hospital.

Source: PL.doc - 17:16 (31:31).

(and with conditions at public facilities). Yet even then the user fee was still lower, in effect, than what was paid at public facilities, where patients might be expected to 'pay under the table' to 'facilitate the nurse' before getting any service, as officials of the MoH and PPPH members admitted.[173] In addition, drugs would be available and included in the fee; at public facilities patients would get a prescription and have to buy medicines.[174]

Despite these realities, the fact remained that the user fees, low as they were, did deter some patients from using the facilities.[175]

There was no uniform policy regarding clients who arrived at facilities and were unable to pay; in some cases they would be treated anyway;[176] in others they might receive some first aid and be advised to go to a public health centre.[177]

6) Religious motivations

A concern was raised that faith-based services might be sectarian or used as a channel to win adherents, although the informant did acknowledge that this was no longer so.[178] PNFPs confirmed that indeed their facilities were open to all in as much as health cut across religion, even though clients might have a preference to attend facilities of their own denomination.[179] A shift in perception about PNFPs had come about, according to a District Health Officer, since:

- the PNFPs were drawn into the system through the subsidy
- community leaders had become involved in budgeting for these facilities, hence regarding them as 'their facility'
- PNFP facilities had been able to participate in government programmes as a result of the subsidy, and
- PNFP facilities were in some cases placed in charge of the health sub-districts.[180]

Nonetheless, members of the focus group did recognise that religious language was potentially exclusive and 'unhealthy' (for example, the refusal to promote condoms, the denial of post-abortion care, and the theology of some churches that stated "you are saved and need no medicine").[181]

When asked if their religious beliefs impacted on the services they provided, about half of the agencies explained that their religious convictions limited their health messages in some way.

For example, Catholic and Islamic organisations did not promote abortions or "artificial methods of contraception", including condoms, due to their religious convictions (although there might be counselling around family planning).[182] None of the key informants from the MoH or agencies like WHO who commented on this regarded the issue as problematic since these services could be accessed elsewhere.[183] Both DHO officers in Mukono stressed that religious convictions about such matters had to be respected, and that there were open lines of communication around this issue between their office and 'the bishops'.[184]

This fitted well with the stance Uganda developed in its HIV prevention campaigns, allowing different actors to make their specific contribution according to their values and capabilities rather than expecting all to have the same role. The only critical comment was heard in one focus group (Kampala lower units), on the failure to make condoms available

173 Mukono DHO 2.doc - 24:10 (41:44); PPPH.doc - 22:33 (59:59).
174 FGD Kampala 2.doc - 10:5 (41:41).
175 FGD Kampala 1.doc.
176 FGD Mukono.doc - 8:26 (73:73).
177 UMMB.doc - 21:46 (133:133).
178 MoH.doc (21:22).
179 FGD Kampala1.doc.
180 Mukono DHO 1.doc - 23:32 (53:53) & 23:33 (54:55).
181 FGD Kampala 1.doc - 9:8 (138:142).
182 Questionnaire data.
183 WHO.doc - 14:6 (57:57); UNICEF.doc - 15:8 (18:18).
184 Mukono DHO 2.doc - 24:11 (48:48).

even to discordant couples; and on the lack of services targeting youth on issues such as abortion, unwanted pregnancy and early marriage.

6.7 CONSTRAINTS

6.7.1 A SHORTAGE OF HUMAN RESOURCES: "AN EXODUS OF HEALTH WORKERS"

When asked what restrained the capacity of PNFP health services, respondents most commonly referred to the crisis in human resources: "an exodus, not a shift of health workers".[185] A recent census assessed the human resource gap in the health sector and found that the gap in the PNFP facilities represented 54% of the overall gap (that is, a shortage of 1 974 medical/clinical staff and 657 others).[186] Considering that PNFPs provided about 30% of health services, it was clear that they were under more severe strain than other players.

Apart from the general shortage of funding, one of the causes of this problem was the increased salary packages negotiated by the government with the World Bank; once recruitment began it was PNFP staff who responded, attracted not only by higher salary packages (PNFPs paid 65% to 85% of public salaries), but also by more reliable pension schemes and shorter working hours.[187]

In short, a lighter workload, the possibility to press for higher salaries, the ability to work privately during official working hours to top up one's income - all of these factors added to the attraction. Indeed, two thirds of the respondents to the survey thought that the conditions experienced by staff working in FBO facilities were different to those in the public health system. [188]

Staff turnover in surveyed agencies was generally reported as high, although it was low in some facilities. The main groups leaving were nurses and midwives although other groups included medical officers as well as laboratory technicians. The impact of the high turnover was that junior staff members were often appointed in the place of the departing experienced staff, resulting in patient disappointment, loss of trust as well as heavy workloads for remaining staff until such time as vacated posts could be filled.[189]

As a result PNFP facilities were not staffed according to government specifications.[190] They lost staff to bigger hospitals, public and private for-profit facilities, NGOs or specially funded programmes for vertical interventions within public or private facilities, all of which were able to offer better remuneration packages. However, the biggest drain on staff was the public sector. During 2005/6, PNFPs lost 16% of their staff component; attrition among the specific cadres of enrolled nurses and midwives, the cadres that provided the bulk of care to patients, was 46% in the same year. At least 40% of these, but possibly almost twice that number, joined government.[191] This situation seems all the more frustrating, considering that often the departing staff members were trained in PNFP training schools.

One approach used by PNFPs to compensate was the use of volunteers. Of the 16 organisations responding in the questionnaire, only two did not use volunteers. In addition to a contribution to transport costs, volunteers almost always were reported to receive a stipend. This varied considerably from 10 000 to 200 000 U shillings a month.[192] Volunteers were sourced from the global denominational networks, including medical staff;[193] but the numbers were decreasing, and at times they were only willing to come for very short-term placements.[194]

6.7.2 CONSTRAINTS AROUND FUNDING

An important factor limiting the capacity of PNFPs to provide health services was their **lack of funding**, as discussed earlier. The major implication of the lack of funding was the impact this had on the ability to hire and retain staff.

Another funding-related problem was **funding restrictions and exclusions.** PNFP representatives expressed a number

185 UPMB.doc - 20:21 (50:50).
186 UCMB 2007, MoH 2003.
187 UPMB.doc - 20:22 (52:52), UMMB.doc - 21:19 (57:57); FGD Mukono.doc - 8:82 (222:222).
188 Questionnaire data.
189 Questionnaire data.
190 Gulu DHO.doc - 16:9 (33:33).
191 UCMB 2007.
192 Questionnaire data.
193 MoH.doc - 19 :35(25 :25)
194 Mukono DHO 2.doc - 24:14 (58:60).

of concerns about current funding trends, the rigidity of funders regarding what their funds could be used for, and how they had to be accounted for, all factors that restrict PNFPs' capacity to act. Examples of these constraints included:

- Some donors overlook PNFPs.[195]
- Government prioritises primary health care at the expense of curative services. "Cancer is completely left and the government takes it very clearly that they asked the private sector to help. But, I mean, poor people also get cancer. The rich can always afford."[196]
- Funders prefer programmes that allow them to 'harvest outputs';[197] and tend to fund these outputs, but not the system that produces them.
- Recurrent costs for items like remuneration, salaries, running of water, electricity, fuel are excluded by many funders[198].
- It is difficult to find funders willing to support PNFPs HR costs to enable them to retain staff, and train more staff.
- Bigger facilities or more space is needed, e.g. for new ART programmes; crowding increases TB risk.[199] Yet infrastructure development and consumables are not funded.[200]
- Funding for admin costs needs to be more balanced; the 7% ceiling most funders impose is not sufficient.[201]
- MDGs cannot be achieved if vaccines are not available, nor fridges to store them.[202]
- Transport is a major problem in rural areas; both affordable ambulance services for patients but also transport for staff to supervise facilities.[203] In the context of overwhelming poverty, as in Gulu where 65% of the population live on less than one dollar a day, people cannot pay for transport to come to the health centre.[204] In Mukono where a substantial part of the population lives on islands, the transport issue becomes even more vexing.
- No operational research is funded, nor conducted into the causes of the problems in the health service.[205]

6.7.3 THE SINGLE DISEASE FOCUS: AREAS OF PRIVILEGE IN A DESPERATE CONTEXT

Key informants highlighted several problems that resulted from funding designated for specific single disease responses, such as the Global Fund (see Box 6.6). For example, having funds so tightly specified made it impossible to make those funds available for disasters like the recent flooding in Uganda.[206] In addition, having generously funded programmes within a system, even within one facility, resulted in situations where patients with the same complaint might receive a very different quality of treatment, because for one the complaint was AIDS-related, and for the other it was not.[207] Further, on the system level the favoured status of AIDS programmes and their staff above the general health system that supported these programmes led to eventual collapse of both when the structures that made programmes function could no longer continue operating as resources got drawn away.[208] Lastly, people with HIV or AIDS found support in many quarters; as these were not co-ordinated they often collected benefits from multiple services.[209]

Box 6.6 Impact of vertical programmes

For the IRCU, their bread and butter is the success of the project. If they fail to make the target, the project goes. For us (UCMB) that's not the end of it. I mean for us it's the sustainability of the health unit that provides AIDS services along with all the other services. And we can't skew to transform a general hospital into an AIDS specialised hospital, because those guys dealing with AIDS patients get double the salary of the others because there, there is money and for the others there is no money.

So you have an area of privilege created inside institutions, that is the AIDS area, while the majority of the work of the institution is general care.

Source: UCMB.doc - 18:7 (19:21)

195 FGD Kampala 1.doc.
196 FGD Gulu.doc - 7:69 (179:180)
197 FGD Mukono.doc - 8:68 (188:188)
198 FGD Gulu.doc - 7:73 (188:188)
199 FGD Kampala 1.doc.
200 UNICEF.doc - 15:22 (36:36)
201 FGD Kampala 1.doc.
202 FGD Kampala 1.doc.
203 FGD Gulu.doc - 7:59 (152:153)
204 FGD Gulu.doc - 7:70 (180:180)
205 FGD Kampala 1.doc.
206 WHO.doc - 14:17 (134:138).
207 FGD Gulu.doc - 7:87 (217:217).
208 FGD Mukono.doc - 8:78 (209:209).
209 FGD Gulu.doc - 7:88 (217:217).

6.7.4 SUSTAINABILITY AND CONTINUITY

The primary requirement for sustainability of health services was a stable source of resources. In the case of Uganda's PNFPs this was not a given, considering that its government was unable to commit itself, being itself dependent for 50% of its budget on donors whose policies back home could change.[210] Linked to this condition, informants mentioned two other requirements for sustainability:

- funding for development and expansion of infrastructure;[211] and
- a reliable source of drugs.[212]

An intriguing suggestion came from one respondent who pleaded for managers with the "capacity to negotiate with those who have the money to finance the health services"[213] and reinforce the fact that there were two partners in decisions around funding priorities, not one donor and one recipient. This echoed the strong plea we heard in Zambia for a consultative process around decision making for funding of health services.

6.7.5 WORKING IN CONTEXTS OF EXTREME POVERTY

A number of difficulties arise when providing health services in contexts of extreme poverty, unfortunately a common condition for PNFP facilities in Uganda. The problem was evident when patients came to a PNFP facility after having tried basic drugs elsewhere that had failed. They then needed a higher level of treatment, which was more expensive – and often unaffordable for both patient and facility.[214] Referrals were complicated by the lack of affordable transport, but even more so by the inability of people to provide meals for hospitalised relatives, especially when this involved travel as well.[215]

The matron at Lacor hospital in Gulu told about a small dip in the number of outpatients when schools opened, as people who had already spent money to send children to school had nothing left for health expenses.[216] She was also concerned about patients who "run away from hospital", where they received free treatment, but needed to provide their own meals. Often their relatives were unable to provide them with regular meals or could not afford transport fees to bring the food, and so they abandoned their treatment and went home. In some cases, as in Lacor, the facility did provide food for malnourished patients and had a supply of food supplements or a dry ration for the most needy patients; but some who were in need of this did not feel free to discuss their need with staff and preferred to 'abscond'.[217] A similar problem occurred with patients who were on ART and needed support to be able to buy nutritious food in order to be able to take the drugs.[218]

One way of responding to this problem was to create some sort of 'Samaritan Fund' to cater for such desperately poor clients, either to support them with nutrition or to make it possible to waive the user fees for them. It was then also necessary to have some criteria for awarding this support. [219] Additional subsidies or funding for staff salaries of PNFP units would free up their resources for lowering user fees and thus becoming more accessible to the most needy patients.[220]

6.8 KEY AREAS FOR POTENTIAL INVESTMENT

Key informants and other respondents involved in the study expressed strong support and made numerous pleas around funding, pointing out that what most needed to be funded was not a particular aspect of health care or vertical intervention, but *the health system* as such. The primary area of concern for most participants was the human resource needs.

210 MoH.doc - 19:29 (76:76)).
211 Mukono DHO 1.doc - 23:44 (75:75).
212 FGD Gulu.doc - 7:60 (154:154).
213 UCMB.doc- 18:43 (80:80).
214 FGD Mukono.doc - 8:73 (204:204).
215 Mukono DHO 1.doc - 23:7 (14:14) & 23:8 (14:14).
216 FGD Gulu.doc - 7:83 (205:205).
217 FGD Gulu.doc - 7:92 (243:244) & 7:93 (249:249).
218 FGD Mukono.doc - 8:66 (184:184).
219 FGD Gulu.doc - 7:84 (206:207).
220 Mukono DHO 1.doc - 23:45 (76:76).

6.8.1 HUMAN RESOURCE: "THE RESOURCE THAT TURNS OTHER RESOURCES INTO USEFUL MEANS"

> *If I were to advocate for funding for the PNFPs, I would look critically at the areas of staffing, and if there is a way that these donors can support staffing. Because what I see as very critical is that you may have everything on the ground: supplies, drugs, everything. But if the human resources for health are not paid much attention to, we are not likely to go very far. In other words it's the human resources that turn the other resources into useful means.*[221]

This was the area prominently highlighted by KIs and FGDs alike as the one crucial aspect of the health system that most needed funding, but which, ironically, seemed most definitely excluded by many potential donors and development partners. To attract and retain staff required funding for the following:

- salaries for qualified staff, commensurate to market rates
- benefits to include medical insurance, transport, secure retirement benefits
- care for carers for overworked, burnt-out staff
- incentives to attract professional staff to hard to reach areas, and
- provision of personal development opportunities for staff, e.g. sponsorship opportunities for further studies.

Many facilities were under-staffed and the staff members that were there were of lower cadres.[222] Capacity building was needed – and needed to be funded – in order to retain current staff and attract others. Specific funding requirements for training and capacity building included:

- support of health training schools, especially in remote areas
- training of specialists
- strengthening of management in the medical bureaus' networks
- IT skills for staff, especially staff in HMIS and stock control, and
- overall strategic planning, needs assessment and M & E.

6.8.2 INFRASTRUCTURE AND OPERATIONAL COSTS

Various areas of concern were noted that required support for the functionality of the health system as a whole:

- a reliable drug supply
- funds to replace outdated equipment
- reliable transport
- concerning the actual structures housing health facilities funding was required for own buildings, and additional space in lower-level facilities
- own laboratories and theatres, and
- staff quarters.

A further cluster of requirements concerned institutional support, i.e. funds for operational costs and to support networking structures.

6.8.4 SPECIFIC INTERVENTIONS

In addition to funding for those aspects of the health system as a whole, as mentioned above, funding was also needed for some specific needs. No specific vertical interventions were mentioned as requiring funding, although there were facilities that indicated that they would provide or scale up certain treatments if funding was available (See Section 6.3.1). Where specific needs were raised they concerned the impact of poverty as discussed above (See sect 6.7.5).

6.8.5 WHERE FUNDING SHOULD GO

It was clear that both government health services and those provided by religious entities were in need of additional funding to address the concerns raised here – and the growing needs of a growing population. [223]

Some respondents favoured the basket funding approach, where funds – even if intended to support PNFPs – would be channelled through the MoH and reach PNFPs through direct subsidies or via the districts. Such funding would encounter the difficulties sketched above (see Section 6.5.1). Not surprisingly, then, a majority of respondents considered

221 UNICEF.doc - 15:18 (32:32).
222 FGD Gulu.doc - 7:62 (158:160).
223 MoH.doc - 19:21 (52:52).

direct funding through the Medical Bureaus as more efficient and reliable.[224] At least one MoH official agreed that PNFP partners needed donor support and that this was best done directly.[225] The only concern raised about direct funding was that the balance between funding big urban facilities and rural lower level units should be in favour of the latter.[226] It was suggested that decisions about how to allocate funds should not be dictated to PNFPs,[227] but should be negotiated in a genuine partnership.

6.9 RECOMMENDATIONS

If you think that this is a precious asset for the country, that you want to maintain, not only you have to support it - but support it in a way that is conducive for the institution. Because you are not dealing with programmes. You are dealing with institutions.[228]

1) It is recommended that government provide more certainty to the subsidy for the PNFP sector. Subsidies that had been received from government had been translated into lower user fees and hence better utilisation. But unless the subsidies were reliable, it was not possible for PNFPs to continue reducing their fees, as they had to consider the possibility of lower subsidies in the following round.

2) Parity in salaries between PNFP and public sector staff was needed if the PNFPs were to survive. Donors funding the state should use their power to ensure that their money was not used to harm a social sector that was so important for the country, by going into unilateral salary increases for MoH employees.

3) MNCR conditions were a great concern but improving services was expensive, as it required such a comprehensive infrastructure. The way in which PNFP facilities had used the little leeway they had with limited financial resources to make services more accessible for pregnancy-related needs, was much appreciated. Funding that would allow all facilities to provide these services free of charge would make a big difference to utilisation rates. Also, ensuring safe and reliable transport would make referrals for delivery complications to higher care units possible.

4) The 'invisibility' of congregation-based health initiatives did lead to their contribution being undervalued, also by potential funders. It was recommended that intermediaries be set up to co-ordinate these REs and strengthen their technical capacity, addressing local contexts and needs.

5) PNFP health training schools were an important contribution to the national health system, with 60% of nurses trained at RE facilities. This was an opportunity for imparting the ethos and values inherent in religious traditions to health care staff beyond the faith-based facilities. It did require at the very least an investment from the public institutions that would benefit by employing trainees (and by extension western governments that recruited health workers from Africa).

6) The study found an exemplary model of collaboration between all health providers at district level in Mukono, but could not identify the factors that made this possible. Studying this model (and others in different settings) in detail could yield insights necessary for its replication in Uganda and elsewhere.

7) It is important that the areas and extent of collaboration with TH be expanded and deepened. This applied to the state as much as to the PNFP sector. This would require representative association(s) of traditional healers in order to negotiate on behalf of the whole sector.

224 FGD Mukono.doc - 8:98 (291:291).
225 Mukono DHO 1.doc - 23:48 (81:81) & 23:51 (85:85).
226 Gulu DHO.doc - 16:21 (56:58).
227 WHO.doc - 14:17 (134:138).
228 UCMB.doc- 18:47 (87:88).

4.6 REFERENCES

AIDSUganda 2007. http://www.aidsuganda.org/response/govt_sectors/cso_programs/theta.htm (accessed 2007-12-20)

AMREF-Uganda. 2001. *Inventory of agencies with HIV/AIDS activities and HIV/AIDS interventions in Uganda.* African Medical and Research Foundation (AMREF-Uganda), the Uganda AIDS Commission Secretariat.

Kamatenesi-Mugisha M and Orem-Origa H. 2007. "Medicinal Plants used to induce childbirth in western Uganda". *Journal of Ethonopharmacology.* **109**(3) pp 1-9.

Kintu P, Nanyunja M, Nzabanita A, Magoola R. 2005. "Development of HMIS in poor countries: Uganda as a case study". *Health Policy and Development Journal.* **3** (1) pp 46-53.

Mayanja R. 2005. Decentralised health care services delivery in selected districts in Uganda, M Ed Thesis, University of the Western Cape, Cape. (Unpublished thesis)

Muhangi D. 2003. *Documentation study of the reposnes of religious organisations to orphans and vulnerable children.* Uganda country study report. Kampala: UNICEF.

Ministry of Health (MoH). 2003; Human Resource Inventory 2003, in Health Sector Strategic Plan II 2005/06 – 2009/10 Vol I. Kampala: Mo.H.

Okuonzi, Sam Agatre 2004. Dying for Economic Growth? Evidence of a Flawed Economic Policy in Uganda. *The Lancet.* **364** pp 1632-37.

plusnews. 2007. "Uganda: government audit exposes ailing health system". Kampala, 7 June 2007, UN Office for the co-ordination of Humanitarian Affairs. www.plusnews.org

Republic of Uganda (ROU). 2006. *Traditional and complementary medicine: National policy and implementation guidelines for traditional and complementary medicine practitioners.* Policy Draft. Kampala: Republic of Uganda.

Reinikka R. and Svensson J. 2003. Working for God? Evaluating Service Delivery of Religious Not-for-Profit Health Care Providers in Uganda. World Bank.

THETA. 2007. http://www.thetaug.org/history.html (accessed 2007-12-20)

UCMB 2003. *Consultation Conference Report: Consensus for the Operational Plan 2004-2006.* Kampala: UCMB.

UCMB, UPMB & UMMB, 2007. *Facts and figures of the PNFPs. Knowing and understanding the facility-based PNFP health sub-sector in Uganda.* Kampala: UCMB.

Uganda Districts Information Handbook, Expanded Edition 2005-2006. Kampala: Fountain Publishers. 2005.

Ugandan Ministry of Health. 2000. *Uganda Health Sector Strategic Plan (2000/2001 – 2004/05)*, Kampala: Government of Uganda.

Ugandan Ministry of Health. 2007. *Annual Health Sector Performance Report*. Kampala: Government of Uganda. www.health.go.ug/docs/AHSPR06.pdf

Ugandan Ministry of Finance. 2004. *The Poverty Eradication Action Plan 2004/05-2007/08.* Kampala: Ministry of Finance Planning and Economic Development.

US Department of State. 2007. *Fact Sheet on Uganda*, USA.

World Bank. 2005. *Uganda Poverty Assessment Report* World Bank. African Region.

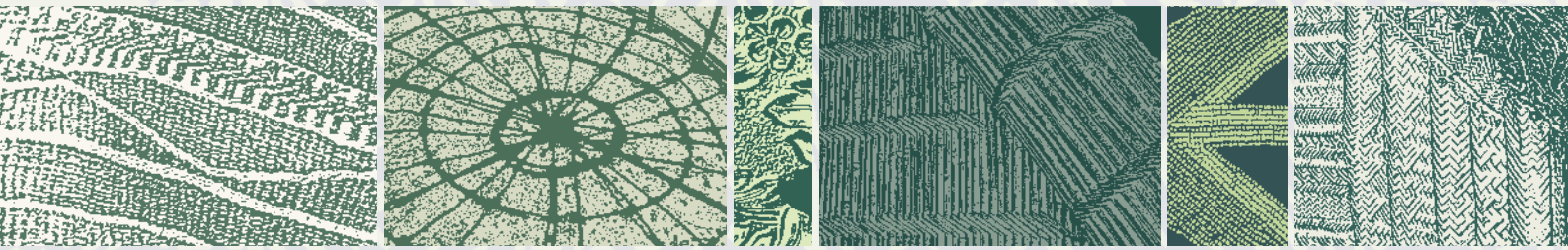
World Bank. 2003. World Development Report of 2003, *Sustainable Development in a Dynamic World,* Washington: World Bank.

WHO Afro. 2006. Country health system fact sheets 2006. Brazzaville: (WHO) World Health Organization, Regional Office for Africa.

World Health Organization (WHO). 2007. *Malaria Country Profile.* WHO,.www.afro.int/malaria/cpountry-profile/uganda.pdf, (accessed 12 December 2007).

CHAPTER 7

CASE-STUDY MALI



CHAPTER 7

7.1 INTRODUCTION

While religion and religious entities impacted on public health in various ways in Mali, there were few religious health services per se. As a result the study approach in Mali included three local case studies which described different ways in which specific religious entities contributed to better health for the population. The chapter begins with an overview of the historical and health-and-religion context in Mali, followed by the local case-studies and a section drawing together common themes from these studies. The remainder of the chapter mirrors the structure of the other two country studies, addressing the capacity of health-supporting REs, current financial and material support for them, the ways in which they collaborate, and perceptions about them – albeit in brief, due to the paucity of faith-based health services. It concludes with sections on the constraints for REs in their endeavour to work for better health, ending with some recommendations.

7.2 OVERVIEW

7.2.1 HISTORICAL CONTEXT

Mali was a French colony until independence in 1960; thereafter it was under the rule of a dictator until 1991. Now Mali is a multi-party republic based on the French civil legal system as well as customary law. The country is divided into eight administrative regions.

As a previous French colony, at independence Mali inherited a state-controlled health service with minimal involvement by other providers such as the private sector or faith community. In contrast to Zambia and Uganda, Mali did not inherit an extensive network of mission hospitals.

7.2.2 SOCIO-DEMOGRAPHIC FEATURES

In Mali, half of the population of 12 million people were under 15 years of age.[1] Despite population growth, there was a net outflow of inhabitants due to migration by Malians to other countries. Ten percent of the population led a nomadic life, while 80% of the labour force was involved in the farming, livestock and fishing sectors.

Of those over 14 years of age, only 46% were literate; this average masked differences between men and women (54% and 40% of whom were literate, respectively).[2] Even these figures may be over-optimistic as Mali's most recent Demographic and Health Survey showed that over 78% of women aged 15-49 years and over 60% of men had never been to school.[3]

The country experienced recurring droughts and systemic famine. A critical problem was the inadequate supply of potable water. Estimates were that less than half of the population had access to sustainable improved water sources.

Given the limited natural resources and low educational levels, the country was very poor, with two thirds of the population living in poverty.[4] Globally Mali had one of the lowest levels of human development; the UN's Human Development Indicator for 2006 showed Mali as ranking 175 out of 177 countries assessed.[5] In addition, there was a high degree of inequality in the country, with the wealthiest 10% of the population controlling as much as 40% of the income and the poorest 10% only 1.8% of income.[6] The poor resource base was one of the reasons that the country was heavily dependent on foreign aid. Foreign policy resulted in an IMF structural adjustment programme and the devaluation of the CFA Franc in 1994.

Mali was a predominantly Muslim country (90%), with small proportions of other faith groups (Christian and traditional or animist groups). Discrimination against woman was a major issue and female genital mutilation (FGM) was practised very widely (with over 90% of women affected).

7.2.3 BURDEN OF DISEASE

Deep poverty, inequality and low educational levels were key factors contributing to the poor health of Mali's population. Overall life expectancy at birth was 48 years. Mali had a very high risk of major infectious diseases: malaria was endemic

1 CIA 2007 , estimate for 2007.
2 CIA 2007, estimate for 2003.
3 EDSM-IV 2007.
4 CIA 2007, estimate for 2001.
5 UNDP HDI 2006.
6 CIA 2007, estimate for 1994.

and responsible for 13% of mortality and 33% of all medical consultations.[7] However, in contrast to many sub-Saharan countries, the HIV prevalence rate for adults aged 15-49 years was low at only 1.7%.[8]

MNCR: Childhood and maternal mortality was amongst the highest in the world,[9] with an infant mortality rate of 105.65 per 1 000 live births (2002), and maternal mortality at 577 per 100 000 live births (1996).[10] According to an informant from USAID, infant mortality, however, was decreasing substantially and the rate of maternal deaths was also improving.[11]

Save the Children identified the following health problems affecting pregnant women, and causing high maternal mortality:[12]

- anaemia, affecting about half of all women;
- malaria, a contributing factor for anaemia, was also linked to complications during pregnancy as well as miscarriage, prematurity, low birth weight;
- tetanus and lack of immunisation, which contributed to neonatal tetanus;
- sexually transmitted infections;
- high rates of FGM which could complicate labour.

An officer at the WHO-Mali identified the following structural concerns for reproductive health:

- the referral system was functional from community health centres, or CSComs (see next section), to district facilities, but not from villages to the CSCom;.
- traditional healers were often the first point of call, and often patients with complications arrived at the CSCom too late;
- there was no sufficient blood supply; this was the major cause of maternal death;
- low levels of uptake for family planning.

7.2.4 THE HEALTH SYSTEM

Mali's government spent just 6.6% of GDP on health care, or US $54 per person, per year, according to the World Health Organisation.[13] The Mali Ministry of Health was regarded as having full responsibility for the development and implementation of health policy. The health system, as is the case in much of Francophone Africa, was decentralised and the physical and financial resources needed to establish health centres were, in principle, furnished by the community (although, in practice, community resources were highly constrained).

The National Health Plan aimed to have local health services within 15km of the population. Each community health centre, known as a Centre de Santé Communautaire (CSCom), had a staff component of three – a nurse, someone to deal with drugs and a 'midwife' who, in reality, tended to be someone with low-level training (known as a 'matron'). In addition the 'relais' acted as the liaison person between the village and the CSCom, and was responsible for the provision of basic treatment to the population living within a 15 km radius of the facility while also being responsible for health promotion.[14]

The CSComs formed the backbone of the health system providing, according to one informant, 90% of all facility-based health services.[15] The CSComs offered a basic package of health care – curative, preventive and promotive.[16] Users were required to make a financial contribution for health services and had the option of contributing to a health association, which guaranteed reduced fees.

7 One World 2007.
8 UNAIDS 2007.
9 Stanton, Abderrahim and Hill 2000.
10 Save the Children 2002.
11 USAID.doc - 25:26 (37:37).
12 Save the Children 2002.
13 WHO 2007. This figure does seem exceptionally high; the figure given for 2004 by the WHO was $16.
14 CARE.doc - 19:11 (19:19).
15 USAID.doc - 25: (21:21).
16 CARE.doc - 19:13 (22:22).

Physical access to primary health services was, however, limited due to the vast size of the country and its very low population density: about half of the population were estimated to live more than 15km from a health facility.[17] This inaccessibility had a major impact on maternal and child mortality rates. As with many aspects of governance in Mali, respondents stressed that the policy was good, but that it had not been possible to fully implement it. Nevertheless, the first 5-year Health Plan had succeed in doubling the number of CSComs, while the second plan aimed at improving the quality of the services provided now that there was considerably better coverage.[18]

The CSComs were managed by the community,[19] through an Association for Community Health, consisting of a Board of Directors (representatives of the village, the Commune and the health staff) and a management committee. This included management of the link between the clinic and traditional healers and birth attendants. The low uptake of the CSComs was influenced, not surprisingly, by the fact that traditional healers were most often the first health provider consulted by health seekers. There was a remarkable acknowledgement of the presence and wide use of traditional healers within the MoH, with a great degree of acceptance of their value and a lack of animosity between bio-medical and traditional health providers. Traditional healers were readily available compared to the very sparsely available 'formally trained' health workers, of whom there was one per 40 000 of the population compared to one traditional healer for every 500 people.[20]

MNCR: In order to address the very high mortality and morbidity rates amongst women and children the MoH and partner organisations had initiated a number of programmes. Free caesarean sections were available for those who had access to a medical facility. There was also free malaria treatment for children, and some medication for pregnant women.[21]

One of the biggest challenges of the health system was the lack of technical and managerial resources to build local capacity, a fact that was directly related to low school enrolment rates, especially in secondary school.[22] A recent Demographic and Health Survey showed that just 3% of women and almost 8% of men had completed secondary school.[23] As a result, there were very few people available to be trained as health personnel and managers and, of those, the numbers wishing to serve in health centres in remote rural areas was even smaller.

Public health officials were involved in challenging some traditional practices. The rate of uptake for family planning was still low for cultural and religious reasons, but religious leaders had accepted birth spacing as an acceptable means of limiting family size.[24] Early marriage, with girls being married at 11 or 12 years, was another tradition that was being challenged by the MoH, encouraging them to delay marriage until at least 18 years. [25]

7.2.5 THE ROLE OF RELIGIOUS ENTITIES

In Mali, there were very few FBOs providing facility-based health services, a fact confirmed by key informants. In the view of many interviewees, they were not regarded as either important, or necessary. The words of one of the respondents expressed the general sentiment:

> *We need more clinics, but why faith-based ones?*[26]

The few existing faith-based clinics were almost exclusively Christian, despite Mali being predominantly a Muslim country.[27] There was some debate about whether these church-owned clinics should be regarded as 'confessional' (i.e. religious) or 'private'. The office within the MoH responsible for liaison with both of these categories was unable to provide any information on the nature, scope or activities of faith-based health centres. In spite of the sparse data, it did appear that, on the whole, the clinics conformed to the requirements for CSComs (see 7.3.2 and 7.3.3 for examples).

17 One World 2007. Currently in the Mopti region, for instance, 1.8 million people live in the 80 000 square kilometres area with just 123 health centres among them (Afronews/IRIN, 2007).
18 USAID.doc - 25:25 (36:36).
19 WHO.doc - 14:10 (41:41).
20 WHO 2001.
21 National health directorate.doc - 16:3 (12:12) &16:5 (16:17).
22 Coulibaly & Hilhorst 2004, Dielman *et al.* 2006.
23 EDSM-IV 2006.
24 WHO.doc - 14:19 (67:67).
25 MoH Reprod health.doc - 15:11 (29:29).
26 Modibo Maiga, Health Policy International
27 See Section 7.8 for some explanations given for this.

The scarcity of confessional health facilities does not, however, imply that religion and religious entities did not impact on public health in meaningful ways. Most prominent of these was the role of religious leaders in promoting health – from hand washing and hygiene to exposing HIV-related stigma or challenging FGM (see 7.4.1).

This situation in Mali appeared to be similar to that in some other countries in the region; it did however go beyond the scope of this study to determine the extent to which it is typical for Francophone and/or West African and/or Muslim countries.

7.3 LOCAL CASE STUDIES[28]

In Mali the number of faith-based health facilities was low; hence the country study made use of local case studies of three religious agencies rather than questionnaires and focus groups (see 2.7.5). This section describes in some detail three REs typical for the religion – public health interface in Mali: a network of religious leaders responding to HIV and AIDS, and two clinics run by Muslim and Catholic groups respectively.

7.3.1 MALI LOCAL CASE-STUDY 1: THE NATIONAL ISLAMIC NETWORK FOR THE FIGHT AGAINST AIDS

7.3.1.1 THE HISTORY OF THE NETWORK

The Muslim Association for the Progress of Islam (AMUPI in French) was founded in 1980 to promote the values of Islam and provide responses to some development questions from an Islamic ethics perspective. It was, at that time, the only religious body permitted by the state and had a wide area of responsibility. AMUPI commented on issues relating to social concerns, education, trade unions and health (for example, mobilising Muslims to have their children vaccinated).

On the issue of HIV and AIDS the Association was silent – even judgemental – until 2000.[29] It was in this context that the National Programme for the Fight against AIDS and UNICEF engaged AMUPI in 2000 with the view to involving its members. This led to the formation of the National Committee for the Fight Against AIDS, which in 2002 became the National Islamic Network for the Fight Against AIDS (RNILS).

7.3.1.2 GOAL AND OBJECTIVES

The RNILS has made it its ***mission*** to fully engage in the fight against HIV and AIDS because Islam encourages people to build a healthy and strong community. The main objective of the network was to build the capacity of religious leaders in the fight against HIV and AIDS, and to co-ordinate, monitor and evaluate their interventions.

Box 7.1 The vision of RNILS

- *To work alongside the government and other actors towards a country without AIDS,*
- *To do so with compassion and support for those infected and affected by HIV,*
- *To draw on religious texts for guidance.*

The religious leaders included imams (prayer leaders and elders of major or small mosques) and ulemas (well-educated religious teachers), as well as leaders of the Islamic Women's Association.[30] The specific objectives were:

- co-ordination of Muslim initiatives related to the fight against HIV and AIDS
- networking at national, regional, sub-regional and international level, including with networks of other faiths
- technical and institutional capacity building, and
- fundraising, particularly in Muslim countries.[31]

7.3.1.3 MEMBERSHIP AND LEADERSHIP

Various religious associations were members of the network,[32] having representation on a management committee and electing members of a Board. Three of seven Board members were currently women; a strong testimony to the commitment to gender equity in RNILS. Apart from the national office based in the capital, Bamako, the network was represented in six of the eight regions of Mali. The Network had no salaried staff and was staffed by volunteers.

28 These local case studies draw mainly on interviews with key informants from the REs and documentation supplied by them. See the References (Section 7.11.2) for a list of sources. Material from other sources has been referenced.
29 Protestant.doc - 21:20 (229:233).
30 Policy Notes.doc - 24:5 (12:12).
31 RNILS: Statuts.
32 Such as AMUPI, the League of Imams and Learned People Mali, the National Union of Muslim Women Associations of Mali, the Muslim Association of Muslim Youth (AMJM), Medersas National Union in Mali and the League of Preachers of Mali.

7.3.1.4 FUNDING

The funds for the Network came from USAID via the Health Policy Initiative, the government's National Solidarity Fund and members' contributions. While the resources of the Health Policy Initiative were used for capacity building, other funding was used to cover office expenditure. Every year, the Network developed action plans that it failed to implement, largely due to the lack of financial resources.

7.3.1.5 NETWORKING

The network was a member of the Alliance of Mali Religious Muslim and Christian Leaders against AIDS, the sub-regional Islamic Board (based in Mauritania), as well as a large network to counter AIDS in West Africa. It had close contacts with similar organisations in other African countries and many other associations had become interested in the experience of Mali and wanted to learn from the RNILS experience, which was, in the view of its President, "ahead of some countries regarding the involvement of religious leaders in the fight against AIDS."

7.3.1.6 ACTIVITIES

One of the main activities of the network was **building the capacity of religious leaders.** The Network worked towards greater involvement of religious leaders in the dissemination of prevention messages and the care of people living with HIV and orphans. The involvement of women in this struggle against AIDS was an express purpose.

In order to achieve its aims, training activities and workshops took place (see Appendix 7.1 for more detail) with the intention of encouraging those who had been trained to become multiplicators in order to broaden the message:

> *When we train imams, these in turn must train other imams and preachers in order to disseminate information received (knowledge on HIV and AIDS, prevention of infection, treatment, stigmatisation) in the mosques during Friday prayers.*

In general, there had been more training in the Kayes region and in the district of Bamako than elsewhere in the country; in 58% of the mosques in the capital there had been preaching about AIDS. In all its dealings with and pronouncements on HIV and AIDS, RNILS endeavoured to fight stigma.

Another major activity of the network was **prevention**, including the development of tools to enable the dissemination of messages:

> *A group of religious leaders spent seven months working out what the Qur'an says on the topic. They develop advocacy tools jointly with the religious leaders, based on the Qur'an ….*[33]

A range of strategies to encourage prevention had also been implemented (see Appendix 7.1 for further details).

A third major activity was the provision of care. The network's support and assistance for those infected and affected by HIV and AIDS – including people living with HIV, orphans and widows – was based on Islamic principles, which honour humanity in all its dimensions. Support of and assistance to people infected and affected by HIV and AIDS included medical, psycho-social and psycho-moral care, as well as fund-raising efforts to support care.

7.3.1.7 IMPACT

Analysis of the documents of the network and interviews with its officials showed that it had succeeded in getting Muslim leaders involved in the response to HIV and AIDS. Support from Health Policy Initiative for RNILS and similar networks had been crucial in developing the potential of religious leaders for health promotion. However, there was no real reflection on the implementation of activities. The network had been overly ambitious in trying to cover all the areas where member associations were represented, having neither a strategy nor sufficient human or financial resources to implement the action plans.

A number of suggestions had been put forward to improve and to strengthen the work and efficacy of the network, which included:

- concentrating activities where there was a need

33 Policy Notes.doc - 24:2 & 24:3 (5:8).

- collaboration with other non-governmental organizations, and
- targeting leaders who were not yet informed and involved in the fight against AIDS, especially in rural areas.

Reaching into rural areas, beyond the capital and other regional centres, had been a great challenge for the network.[34] According to its members, the network had to raise more funds for regional work, develop realistic action plans, train more leaders especially in the communes and villages, and provide detailed activity reports.

For the Network's President, the indicator of having achieved satisfactory results would be "If the young girl and the young man who must marry or that the man who must marry a second, third or fourth wife, are aware that AIDS is a reality and that they should behave so as not to contaminate others". For the activities of the network to result in behaviour change among young people and adults would take time and human, material and financial resources beyond those the network had been able to mobilise to date.

Whatever its limitations, this network appeared to be a good candidate for further development support in the form of training in areas like project management, implementation, visioning and goal setting. The network also represented the emergence of social capital in a country with an under-developed civil society.

7.3.2 MALI LOCAL CASE-STUDY 2: THE PRIVATE DISPENSARY OF FALADIÉ

7.3.2.1 THE CONTEXT AND HISTORY OF THE CLINIC IN FALADIÉ

The Catholic Church had providing health care to poor rural and urban communities for many years, even in Mali where the provision of health services was generally regarded as the responsibility of the state. The Catholic Diocese of Bamako financed five health centres, one of which was in the rural village of Faladié. Islam, Christianity and animism were the religions practised in the village, with an unusually high proportion of Christians resulting from the presence of a Catholic Mission for more than eighty years.

Box 7.2 Three phases of the Faladié clinic
1929 – 1960: French priests run the clinic
1960-2004: after Mali's independence six Belgian nuns take over
2004 -: three Malian nuns work with a local team

The village of Faladié was the central village of 18 making up the N'Tjiba Commune with a population of almost 20 000 inhabitants. According to Commune authorities, 85% of inhabitants were poor. Crop production only covered their needs for half of the year, making it difficult to pay for health care or school fees. The population was beset by health problems common to poor communities in low-income countries (see Appendix 7.2 for more details on the context).

According to an old informant from the village, the development of the centre went through three stages, characterised as follows:

1929 – 1960: During the first phase ***French priests*** were responsible for the mission as well as for the health centre. They started an elementary school for the children of Faladié and the surrounding villages in 1929, offering primary health care to students who were sick. By 1935, this primary health care unit had developed into a clinic for the whole community, regardless of religious affiliation. Care and medicines were given free of charge. *"It was the golden age; free medicines were effective; Fathers encouraged people in the villages to come to the clinic,"* said one resident of Faladié.

1960-2004: The second period started after Mali's independence in September 1960, with the arrival of six ***Belgian nuns*** who took over responsibility for the clinic. In this period the health centre was enlarged to accommodate the growing need, and outreach visits to villages were conducted. The sisters trained local villagers as matrons and caregiver-aides and spiritual advisors.

34 Journalist.doc - 23:14 (42:42).

Fee payments were introduced for consultations. According to one of the former physician-managers of the clinic they started selling 'consultation tickets' at 200FCFA (about half a US dollar) in 2002/3 after discussion with the Commune leaders. Through their personal relationships in Europe, Catholic priests and nuns were able to source specialised medicines for the pharmacy. This period was recalled with nostalgia by some of the people encountered:

> *The Belgian sisters were specialists in health; the laboratory was operational; the diagnosis they posed after examining the patients was accurate and patients accepted the treatment given. Effective products were given to pregnant women and malnourished children.*

2004 -: Reaching old age, the sisters all returned to Belgium in 2004; they were replaced by three ***Malian Catholic nuns***, one mid-wife and two nurses, who worked with a doctor and local matrons and caregiver-aides. The informants claimed that the current staff were less skilled than the Belgian sisters. In this period support from Europe decreased and user fees were increased. This income was supplemented by the sale of essential drugs, some of which were donated to the clinic.

7.3.2.2 INFRASTRUCTURE AND EQUIPMENT LEVELS

The health centre of Faladié was fairly large, was electrified and had a number of drinking water sources. The infrastructure was in good condition and well maintained. For the referral of patients there were two ambulances, one of which belonged to the health centre and the other to the village. In case of breakdown, patient transportation was provided by a vehicle belonging to the nuns.[35] The level of equipment of the centre was satisfactory for the primary care services it provided, but it was difficult to maintain an adequate stock of essential drugs and vaccines. Communication with the outside world was minimal because the village had no telephone connection. (More detail on the infrastructure is provided in Appendix 7.5).

7.3.2.3 STAFF

The 18 health workers included 1 doctor, 1 midwife, 2 nurses, 10 matrons, and 4 caregiver-aides, together with some support staff; a bigger team that was the norm at CSComs (see 7.2.4). There were trained traditional birth attendants linked to the centre, which sometimes received interns from local health training schools as well as students from France. This number of staff was deemed insufficient by one staff member who said, "There is too much work for each agent because the attendance rate at the centre is high". The staff members were often overwhelmed; that is why nuns did not provide home visits and spiritual counselling.

Box 7.3 The reality of referrals

There was a referral system in place for women with complicated deliveries, although it took over two hours to reach referral facilities. The health centre or commune provided the ambulance but the patients had to bear the high cost of the referral, at 25 000 FCFA (approximately US$ 56 – covering the wage of the driver, fuel costs and the depreciation of the vehicle), paid before transportation as a rule.

7.3.2.4 SERVICES PROVIDED

The clinic provided a range of primary care services (see Appendix 7.3). The nutritional status of children who came to the centre was improving thanks to health promotion sessions conducted by the sisters. The laboratory that had long supported the health centre ceased functioning in 2004 due to a lack of qualified staff.

The attendance rate at the centre was high and increasing, according to health personnel. Community members, however, claimed that utilisation at Faladié was decreasing because of the declining quality of care, the costs of seeking care (including the high costs of consultations, the cost of getting to the facility from distant homes and the indirect cost of hospitalisation, as a relative needed to stay with a patient and provide care and meals), and the fact that two CSComs had recently been established in the Commune.

There was no religious taboo in evidence relating to the services provided by the clinic. Family planning, which had long been controversial in the Catholic Church, was provided, although the utilisation rate remained low. Women had

35 At the time of our visit to Faladié both ambulances were in a state of disrepair.

access to the contraceptive pill at their request; conversely, male informants reported that the centre did not provide condoms.

7.3.2.5 MANAGEMENT AND FINANCE

Staff expressed concern that the centre faced a lack of financial resources, hence, the shortage of staff, delays in the renewal of essential medicine stocks, and the closure of the laboratory. It was not possible to provide details on the budget because the Catholic health centre did not establish an annual budget. "This point is a weakness we are trying to solve," said the former manager of the centre.

The financial and material resources were provided by a number of sources, although it was not possible to quantify these in financial terms. Thus, the Catholic Church met the salaries of the three nuns and the doctor; revenue was raised through consultation fees and the sale of medicines (meeting the general expenses and wages of the salaried staff): the Government of Mali provided vaccines and refrigerators; some friends and facilities in Europe provided funds, laboratory equipment and training of doctors; and other funds were provided by donors like the Ambassador of the Malta Order.

Since independence, the government had recognized the Faladié health centre as a public utility infrastructure within a Commune with inadequate health care. Government support was part of the health policy of the country, which sought to provide a contribution to all structures capable of working at the community level using health staff and equipment to perform efficient work. Beyond material support, the public hospital at Kati provided supervision. Students from nursing and medical schools were sent to Faladié health centre for practical training. Data from the centre were taken into account by the Health Information System of the Ministry of Health through quarterly reports produced by the staff.

7.3.2.6 RELATIONSHIP WITH THE COMMUNITY

The community of Faladié had always perceived the health centre as a private church-owned structure that provided care to those who requested it. Their gratitude for the centre was expressed in statements like this:

> *Our parents were treated here; we were born in the Sisters' maternity ward; so were our children. Without this centre, we would be like the localities that have no health centre: we would have to travel kilometres for health services or be content with only traditional medicines.*

The presence of the health centre was why the construction of a CSCom was not seen as a priority when funding had been made available five years ago; instead, a school was built.[36]

Owned by the Catholic Church, the Faladié health centre operated without the involvement of members of the community, unlike public CSComs, which were managed by local communities (see 7.2.4). The one area where there was joint management was the use of two ambulances for transporting patients to referral facilities. Further, traditional birth attendants were trained and re-trained at the centre and made available to villagers.

Generally, however, the community felt excluded from the management of the centre; decisions were made by the priests and nuns who had not established any co-operation mechanism with the village leaders. Consultation fees increased on the decision of the clinic staff, and the villagers were not consulted but merely informed. Similarly, after a census, the church identified 30 poor people in the municipality who would be exempt from fees; again the community was not consulted.

This distance from the community may undermine the sustainability of the health centre. Already the frustration among community leaders at their exclusion from decision-making processes regarding the centre had given rise to the desire to build a community health centre in the village. As a result of such resistance to any local control, the Commune was starting preparations for its own health centre.

36 Until then the Catholic school was the only school in the village. There was a sense that people needed to have a choice about where to send their children – a similar process to that now developing regarding the desire to build a CSCom in Faladié.

7.3.2.7 IMPACT

The positive perceptions of the Catholic health centre were reflected in the high utilisation rate and the fact that some patients travelled from far to attend the centre in Faladié. Unanimously, the people consulted for the study appreciated the presence of the centre and recognised that it rendered a valuable service to the villages in the commune.

The reasons given for using the Catholic health centre included:

- the quality of care offered, including at the referral hospital
- the low cost of specialised drugs
- the way the nuns welcomed patients
- the attention given to mothers and their newborn babies
- the cooking demonstrations for malnourished children, and
- the presence of an ambulance in the village.

The most controversial aspect of the health centre at Faladié, and most other Catholic health centres, was the exclusion of the community from management: "it is only the Catholics who 'make their own rules".[37] By way of comparison, it was interesting to note the management model used by the Protestant health centres where community involvement was included. One informant said that many of the Protestant health centres had in essence become CSComs, albeit with church support.[38]

There is evidence to suggest that Catholic structures were aware that this model might no longer be appropriate. The co-ordinator of the five Catholic health centres was working on a new management system for the health centres, aimed at providing and securing sufficient financial resources, and ensuring community representation in their management committees.

7.3.3 MALI LOCAL CASE-STUDY 3: THE MIPROMA CLINIC OF THE MALIAN ASSOCIATION OF YOUNG MUSLIMS

7.3.3.1 THE MALIAN ASSOCIATION OF YOUNG MUSLIMS

The Malian Association of Young Muslims, AMJM, was established in April 1991 following the advent of democracy in Mali. Its purpose was to contribute to the socio-cultural and economic development of Mali, and to bring together the youth, both girls and boys, to educate them according to Islamic ethics, and to encourage their participation in activities useful to the country in areas such as education or health. Initially the activities of the association were focused in Bamako before extending to the interior of the country.

AMJM was a member of other Muslim organizations and networks. These included: the National Islamic Network for the Fight against AIDS (RNILS), the High Islamic Council, and the National Council of Youth. It maintained good relationships with the League of Imams and Erudite of Mali, the Muslim Association for the Unity and Progress of Islam, and the National Union of Muslim Women Associations of Mali. Health had been an area of concern for AMJM from its inception, largely as a result of the difficulties faced by poor people, among them the need to travel long distances to Commune health centres and the high cost of consultation fees and medication (see Box 7.4 for health activities).

Box 7.4 Health activities offered by AMJM

- *Health consultations for Moslems in mosques, often along with donations of medicines.*
- *Free medical caravans in poor districts, with members providing free consultations and medication, donated drugs, and sensitising regarding health issues.*
- *Islamic material for sensitisation about family planning, education, environmental protection, and training in the use of this material.*
- *Advocating spirituality in health, through discussions and regular sermons.*
- *Sports activities used as opportunities for raising HIV and AIDS awareness.*

37 USAID.doc - 25:15 (22:22).
38 Protestant.doc - 21:5 (83:83) & 21:9 (91:91).

7.3.3.2 HISTORY AND CONTEXT OF THE MIPROMA MUSLIM CLINIC

To deepen their involvement in health, the members of AMJM established a health centre, given the status of health mutuality,[39] called Mutuelle Inter Professionelle du Mali (MIPROMA) in 1994. It was located in the District of Bamako in an area with a population of almost 95 000. The goal of the centre is to "provide curative care to patients, to facilitate treatment for patients through a chain of solidarity." It was run just like the public CSComs, in close relationship with the MoH. Should this trial facility prove successful, the AMJM wanted to open more clinics in other areas.

7.3.3.3 INFRASTRUCTURE AND EQUIPMENT LEVELS

The MIPROMA centre occupied a double-storey, rented building which included consultation rooms, a small number of beds for hospitalisation, a pharmaceutical depot where patients could buy essential drugs, a small maternity facility and a laboratory. The building was well-maintained, was electrified and had drinking water, and the yard had benches and toilets for patients and people accompanying them. There was also a stove for the incineration of medical waste.

The clinic had sufficient equipment for consultations and gynaecological, dental and eye care, with scales and tables for consultation and delivery on hand. A refrigerator was used for storing vaccines. The health workers believed that the level of equipment at the centre was satisfactory and in good condition.

7.3.3.4 STAFF

The clinic had a total staff complement of 11, including 1 doctor, 2 nurses, 1 midwife, 1 obstetric nurse, 1 pharmaceutical depot manager, 2 matrons, 1 laboratory technician, 1 messenger and 1 security guard.

The doctor, the midwife and the obstetric nurse were paid by the government; the wages of the other eight employees were paid from user fees raised by the clinic. In addition to paid employees, health workers who were members of the association provided free services at the clinic. To take advantage of its position opposite a bustling market, five female grocery vendors were chosen to support the health centre as volunteers, as a way of encouraging women to attend the centre for pre- and post-natal consultations and child care.

7.3.3.5 SERVICES PROVIDED

The clinic provided a range of primary care services, including antenatal and postnatal consultation, deliveries, vaccination, and the sale of essential drugs. Utilisation of family planning services had more than doubled between 2005 and 2006. On certain days the clinic offered free medical consultation to old people. When appropriate, it referred patients to higher-level government facilities.

Health promotion activities included sensitisation of clients and locals about the consequences of female circumcision, HIV and AIDS, the benefits of attending the health centre, and reproductive health, including family planning. They promoted blood donation to blood banks and supported the public Sanitation Days.

7.3.3.6 MANAGEMENT AND FINANCE

The financial and other resources of the centre came from a variety of sources: the AMJM's own capital; a start-up loan of 12 million FCFA (US $27 000); a state grant of FCFA 800 000 (US $1 800) a month to pay for 3 health workers; the provision of immunisation equipment and vaccines for children by the MoH; sponsored health services (for example, Almoutada Islamic wanted to pay for the provision of free consultations by the clinic), and donations in cash and kind. In 2006, MIPROMA received financial support from the Foundation for Children, Almoutada and a Turkish NGO. In addition, donations were received from Wawi and Almoutada in the form of millet, rice, sugar, clothes and oxen, which were distributed to the poor in various districts.

For members of the Mutual Benefit Association the clinic charged the same user fee as other community health centres in Mali, namely 300 FCFA (less than US $1), while the fee was 600 FCFA (US $1.40) for non-members.

The centre's annual budget was 45 million FCFA (US $100 000). In the first quarter of 2007 its income from fees amounted to US $ 13 000 while expenditure was US $12 000, leaving a small surplus.

39 A mutuality is a non-profit insurer, owned and administered by the members and funded by their contributions, to provide benefits in case of sickness, maternity, etc.

There were two levels of management within the clinic, namely a committee composed of the members of the AMJM, and the clinic staff members who managed the centre. The management committee of the Mutuality included members of the AMJM and representatives of the members.

The clinic submitted quarterly activity reports to the National Directorate of Health, and the data were reflected in the health information system of the MoH.

7.3.3.7 RELATIONSHIP WITH THE COMMUNITY

The clinic was open to all persons who needed health care, regardless of religion and ethnic group. People who attended the clinic came from the local and neighbouring Communes. Members of the Mutuality came from several Communes of the District of Bamako.

It seemed that although the community was excluded from direct management of the clinic, this had not frustrated the relationship with the community. Possibly the Mutuality offered the community some sense of participation.

7.3.3.8 IMPACT

While the AMJM viewed the clinic as similar to a CSCom, the patients regarded it as a sacred place, which was clearly an important matter to them. Patients said that health workers received them with more respect than community health centres did,[40] and they appreciated the fact that they might choose to be seen by either a male or female health worker. The market volunteers reported that the clients they referred to the clinic were "comfortable with the staff; medicines are within their budget."[41]

The AMJM was initially criticised for its involvement in the fight against HIV and AIDS. Now, however, all Muslim associations were working on the issue. There were other difficulties, however: services at the clinic were limited; there was a shortage of staff, given the influx of patients experienced by the centre; there was a lack of suitable wards for hospitalising patients for more than a few hours; and there was a lack of beds in the maternity recovery rooms.

For the sustainability of the centre, AMJM proposed the construction of its own building to house the centre; ensuring ongoing state support in terms of personnel, finance and drugs; capacity-building for the centre staff in HIV and AIDS awareness and treatment; extension of the experiment to other Communes in Bamako and beyond; and emphasis on awareness about HIV and AIDS, malaria, family planning and female circumcision.

7.3.4 KEY THEMES EMERGING FROM THE THREE LOCAL CASE-STUDIES

It is clear from these three local case studies that religious entities had found ways to make a significant contribution to health in Mali, even though their impact on health statistics and outcomes might not be huge.

Relationships were central to strengthening the capacity to provide support for health in all cases, as highlighted through the following points:

- All three entities collaborated with the MoH which had overall responsibility for the health of the population. The style in which they did this differed, resulting in different outcomes. In practice the MIPROMA clinic worked more closely with the Ministry than the one in Faladié, and was regarded as a genuine partner. This translated into additional financial and staff support from the MoH; there may however have been implications for its autonomy.
- Networking with other faith-based groups was crucial for the Network (RNILS) and MIPROMA, and they were well integrated into a collaborative web; not so for the clinic in Faladié, where there was no evidence of networking or collaboration.
- Research indicated that communities took pride in their locally managed CSComs, but this was not found to the same degree in relation to all religiously owned facilities. In fact, in the case of the Catholic facility, there was evidence of some antagonism from the community due to its exclusion from decision making concerning the clinic.
- Community relationships were also manifested differently in each of the three case studies. Where these were

40 Interview, 23 October 2007.
41 Interview, 24 October 2007.

neglected, for example in Faladié, this gave rise to tensions. Regarding the other two case studies, both religious entities appeared to draw their potential for impact to some degree from their connection to the communities (e.g. the use of market vendors as agents for MIPROMA, or the influence of religious leaders in RNILS).

- It was impossible to find out how many religious clinics operated in Mali; neither the responsible MoH directorate nor religious authorities could provide figures. This does not speak only to the lack of a relationship between (some) religious entities and the MoH but also the lack of relationship between religious entities themselves.

Projects **changed over time**:

- Political reality and related developments impacted on health services. This was evidenced in the clinic in Faladié, which experienced a change of ownership at independence, leading to one of its most influential phases. However, political limitations on the role of civil society curtailed the potential of religious groups in impacting on society during the dictatorship, whereas the enabling political climate in the new democracy opened the space for civil society, and the development of networks like RNILS.
- Waning financial support from Europe, with shifts in the political landscape there as well as the growing secularisation of society, changed the size and nature of the external donor base. This had left clinics like Faladié in financial difficulty and without any clear action plans for the future to address this shortfall.
- More positively, judgemental attitudes towards people infected by HIV had given way – over time and through intense sensitisation – to more caring and compassionate approaches. However, some of the statements and programmes of RNILS did betray remnants of a negative and more dogmatic approach (such as their focus on "fighting brothels" in order to limit the spread of HIV).

Financial factors were an important determining factor in health care provision:

- The cost of providing health services and of developing and maintaining a network of religious leaders across a vast country was high, especially considering the Malian context of poverty. All three cases were hampered in the scope and scale of what they could do by the limited funds available.
- Even relatively low costs limited the potential impact of religious entities on health outcomes where poverty was so endemic. Potential patients stayed away from clinics due to the user fee charged, low as it was, resulting in low utilisation rates. Hospitalisation or referrals were not possible due to transport costs or the inability to provide meals. It was evident, however, that religious entities seemed to be able to overcome this constraint to some extent.
- For RNILS, financial constraints limited the extent to which national and regional plans could be implemented. This was even more so in rural areas, where the bulk of the population lived, and where the need for sensitisation was great.
- It was important to note that, to date, it was mainly the higher (that is, urban) level of religious leadership that had been impacted by the activities of RNILS in particular. Faith-based clinics, however, were also providing services for rural populations.

1.4 FAITH-BASED SUPPORT FOR PUBLIC HEALTH

7.4.1 HEALTH PROMOTION BY RELIGIOUS LEADERS

The findings of the local case studies presented above show clearly that the religious community in Mali – as elsewhere in sub-Saharan Africa – played an important role in society, and indeed with respect to health, even if this role was perceived in a way that differed markedly from that in other countries. In Mali there were almost no health services provided by religious groups – and very few people thought that religious entities should be involved in health services provision.

On the other hand, religious leaders of all disciplines and faiths had a crucial role in the dissemination of health messages to the population. Indeed, the notion of religious health services was often taken as referring to ***health promotion*** by religious leaders:

> *It is very important for confessional organisations to be involved in health issues. For example, they say about the case of family planning, when they call religious leaders, to make people understand that finally Islam, for example, is not against family planning. So for many issues if they look at the document*[42] *and seek for references - they can help in the promotion*

42 Referring to the Qur'an, the sacred scripture is Islam.

of health.[43]

Box 7.5 Religious leaders mobilise for health

An MOH official reported that in the Mopti region the population refused tetanus shots, saying that they sterilised women. He did a lot of radio broadcasts explaining to people why they were doing it. But the community never listened to him.

And finally he went to see the leaders at the mosque; it is these leaders who made people accept the tetanus shots.

MoH 1.doc - 16:14 (38:38).

Religious leaders were called on by a wide spectrum of groups to be active in health promotion at different levels, the RNILS case-study (see above) being but one example. Numerous examples of this were mentioned during key informant interviews, as presented in Appendix 7.4. As a rule, religious leaders were trusted by their followers and the messages they promoted were likely to be accepted in good faith, helping to mobilise the community (see Box 7.5).

It emerged from this study that suitable champions, i.e. strong, charismatic leaders, needed to be selected to promote specific health issues, especially those that were potentially controversial like HIV or female genital mutilation.[44] When suitable leaders had been identified they needed to be informed and trained.[45] Such persons needed to be committed to the cause, and once convinced, they became influential champions of public health issues, such as encouraging the population to take up birth spacing as a means of family planning. In various areas leaders had even been transformed from merely acting as conduits for messages to becoming contributors of their own ideas.[46] However, even the impact of such leaders might be curtailed by an environment not open to change.[47] As a rule, women were best addressed by leaders of the Islamic Women's Association.

In many cases in Mali, convincing religious leaders had involved a lengthy process of engagement where groups had been confronted with a topic and then worked through their sacred scriptures in order to identify responses that were both helpful to the health cause and in agreement with the theology:

> *… they did a research on the Bible and the Qur'an to pull a message [about AIDS] which combats stigma and discrimination. They have parts of the Bible and the Qur'an saying that you shouldn't do that, you shouldn't do that.*[48]

Material compiled through such a process was then tested in a large group of religious leaders to ensure it was in line with the Qur'an, or the Bible in the case of Christian leaders.[49] Once the basic tenet had been accepted, specific messages were prepared and distributed to mosques and churches, where they were shared with those who attended Friday prayers or Sunday services.[50] The media was also used to broadcast messages. While urban audiences were addressed via television, in rural communes, where the majority of the population lived, radio was the main mode of communication.[51] This whole process was based in the concept of Shura or consultation in Islam. One informant mentioned how useful an event in 2005, called the "Caravan of Religious Leaders against AIDS", had been, because it brought together religious leaders from different faiths, people living with the disease and journalists in mobilisation of the community (see Appendix 7.4 for more detail).

The effectiveness of this method of health promotion was difficult to assess. It could be claimed that a significant percentage of religious leaders, in urban areas at least, had been sensitised and trained. This involved mainly leaders at national level, as the rollout to rural regions remained a major challenge. It was, of course, in the rural areas that the need was greatest, and the task more difficult as many rural imams were barely literate, although they had learned to recite

43 MoH Reprod health.doc - 15:25 (62:63).
44 Policy Notes.doc - 24:6 (14:14).
45 Journalist.doc - 23:4 (17:17).
46 USAID.doc - 25:9 (15:16)
47 Journalist.doc – 23.8 (26:26) & 23:9 (28:30)
48 Protestant.doc - 21:30 (318:318).
49 Policy Notes.doc - 24: (8:8).
50 PSI.doc - 22:15 (116:117).
51 PSI.doc - 22:16 (118:119).

the Qur'an.[52]

It must also be noted that using religious leaders for health promotion had not been equally effective for all issues. The impact of this approach on vaccination had perhaps been the greatest,[53] whereas success with female genital mutilation had been the most limited, as many religious leaders held a conviction that this centuries-old tradition was a practice required by the Qur'an, conflating Islam and tradition.[54] Even exposure to Muslim leaders in other countries, who were opposed to the practice, had not really had much impact.

7.4.2 TRADITIONAL HEALERS AND TRADITIONAL BIRTH ATTENDANTS

It was generally acknowledged that health-seeking behaviour in contemporary Mali almost always started with a visit to traditional health providers, as it had for past millennia, and that they still played a central role in providing the bulk of health services to the population.[55] The majority of deliveries in Mali occurred at home assisted by a birth attendant.

Traditional practitioners were more accessible to the population, in terms of their culture, location and numbers, and were usually more affordable. They offered treatment for a wide range of ailments. The TH and traditional birth attendants (TBA) were recognised as an integral part of the health system[56] and there was no secrecy about the extent of their influence, as is the case in many other parts of Africa.

This was due, at least to some degree, to the policy the government had adopted regarding traditional practitioners and their role in the health system. A Department of Traditional Medicine as well as the National Research Institute of Medicine and Traditional Medicine had been in place since 1973, with the mandate to demonstrate the value of traditional healing through scientific means. In 1980, the Minister of Health appointed a Scientific and Technical Committee to support this research.[57] As a result of the work of these institutions, seven improved traditional medicines were now on the national list of essential drugs in Mali, and 60% of new drugs that came onto the market between 1980 and 2000 were based on natural materials.[58] Further enabling policies were adopted in Mali:

- in 1994 a decree was passed that regulated private consultation clinics for traditional medicine as well as the production and sale of medicines, and
- in 1995 decrees were passed regulating the issuing of "a certificate of notoriety and morality" to traditional healers and the selling of herbal medicines.[59]

While traditional healers had their own associations separate from the CSComs to promote their products and services, traditional birth attendants worked quite directly with the CSCom staff.[60] In most communes there was a committee that co-ordinated the activities of traditional practitioners with the health centre.[61] The traditional practitioners, being trusted in the community, had an important role in mobilising communities around health issues alongside the religious leaders (for instance, by raising awareness about HIV or referring patients for medical care).[62] Training of traditional healers and birth attendants by biomedical practitioners, often mediated through the CSComs, enabled them to recognise when patients needed to be referred for treatment.[63] This open approach resulted in a positive relationship between traditional and public health providers.

7.4.3 ROLE OF RELIGION IN HEALTH

Both Islam and Christianity in Mali were concerned with improving people's well-being, including their health (see Box 7.6).

52 USAID.doc - 25:24 (35:35).
53 Journalist.doc - 23:18 (50:50.
54 Journalist.doc - 23: (51:51).
55 TH.doc - 17:2 (33:33), PSI.doc - 22:24 (129:129) and others. WHO 2001 puts the figure of people using TH at 75% of the population.
56 MoH Reprod health.doc - 15:32 (78:78).
57 WHO 2001.
58 Sociolingomali 2007.
59 WHO 2001.
60 MoH Reprod health.doc - 15:30 (73:73); there are currently 32 associations of TH in Mali (WHO 2001).
61 TH.doc - 17:12 (73:73).
62 USAID.doc - 25:22 (31:31).
63 CARE.doc - 19:20 (46:46) & 19:21 (50:50).

Box 7.6 A religious imperative to heal

To help is also a religious act. What is important is the human being; helping human beings (Islamic Relief.doc - 20:26 (406:410)).

Man is not only a spirit, it is also the body. You can't take care of only the spirit without the body. That is one of the reasons why the Protestant church tries to promote health (Protestant.doc - 21:15 (149:149)).

This concern was expressed in different ways in the two traditions. In the Christian context it often led to the provision of health services (see following section), whereas in the Islamic tradition the emphasis was on solidarity and social support, expressed for instance in the practice of Zakat (giving of resources to the poor). Another factor was the widespread use of Islamic medicines or cures by the majority of the population of Mali. The holy men or Qur'anic scholars (known as marabouts) might offer treatment for physical complaints through 'nassi', the ink washed off the wooden tablets that Qur'anic scholars used to write down verses of the Qur'an, either to be drunk or used to wash oneself.[64] Treatment could also take the form of 'gris-gris' (amulets containing words from the Qur'an).[65] Other Islamic Sufi treatments were used to heal physical and mental illness and to restore well-being.

It was undeniable, though, that some religious customs and traditions worked against health. For example, men did not willingly show that they made use of family planning services[66] and there was a strong patriarchal tradition where, for instance, it was men who decided whether a woman would deliver her baby at the CSCom or be assisted at home by a TBA. A particular reading of religion does support this unhealthy skewing of gender relations and disempowerment of women, even where the precepts of the religion stress equality.

Poor literacy and education levels were also factors contributing to Mali's poor health outcomes, which could be traced back, in part to the reticence of Islamic leaders towards formal (western) schooling.[67] While Islamic precepts make education obligatory for both women and men, this was a form of resisting colonial influence. There was also the problematic issue of 'garibou', involving groups of children who were sent to learn the Qur'an with 'marabouts' (Qur'anic scholars). The children sometimes ended up in poor health and with psycho-social problems as a result of being abused by the marabout for whose family they had to work, and were often sent to beg for food.[68] Those who tried to escape frequently ended up as street children in cities or were trafficked into agricultural labour, often across national boundaries.[69]

Another harmful practice that was often understood to be prescribed by Islam was female genital mutilation,[70] which was very common in Mali: according to the last census, 91% of women between 15 and 49 years had been circumcised. There was an ongoing discussion about this phenomenon: was it culture, was it tradition, or was it indeed religion that kept a practice like this in place? Attempts to involve religious leaders in challenging this practice against the demands and teachings in the Qur'an had not been very successful to date, as indicated above. This does raise the question of what vested political and economic interests are involved in maintaining a practice that is clearly out of step with the Qur'an.

7.4.4 CAPACITY OF FBOS TO PROVIDE DIRECT HEALTH SERVICES

As already stated, there were very few religious health facilities in Mali: a handful of clinics were run by the Catholic Church or the Protestant Health Association, and there was one Muslim health centre, regarded as an exception and considered by a representative of the MoH as 'private' rather than 'confessional' like the Catholic facilities. An Iranian-funded clinic was mentioned,[71] but it was not clear whether this had any faith base.

Despite the paucity of facilities, there was appreciation that these facilities made an impact in the areas where they functioned (with particular reference to the Faladié and MIPROMA clinics), and that they were, at times, the only available health providers in rural locations.[72] Their contribution to coverage of the population regarding health services, and

64 Handloff 1982.
65 Amiga et al 1992.
66 MoH Reprod health.doc - 15:6 (20:20).
67 Castle 1992, Diallo 2001.
68 Douville 2003.
69 Castle & Diarra 2003.
70 Shaaban & Harbison 2005.
71 PSI.doc - 22:20 (123:123).
72 TH.doc - 17:7 (53:53).

improving access was acknowledged,[73] and they were also seen to help to improve national health indicators through their involvement in campaigns of the MoH.[74]

Generally services provided at the religious facilities and staffing conditions were similar to those on offer at a CSCom.[75] Specific services provided by faith-based groups mentioned by key informants included: dispensaries, maternity facilities, vehicles for referrals, qualified nurses, preventive services like immunisation and behaviour change communication, promotion of nutrition, hygiene, and even family planning.[76] More ad hoc efforts focussed on specific health issues (such as a campaign using volunteer specialists to offer eye surgery and eye care).[77]

7.5 FBO COLLABORATION

The range of networks of religious leaders involved in different health issues in Mali included both Muslim and inter-faith groups, each focusing on different health issues. The networks worked closely with each other and were also called on to support government initiatives (see the case-study in 7.3.1).

There were also representatives of a number of international faith-based networks working within Mali. Norwegian Church Aid, for example, did not offer direct health services, but supported interventions towards better governance and education (particularly for girls), providing food security, and countering gender-based violence and HIV and AIDS.[78] Besides large scale emergency food relief programmes, Islamic Relief supported child sponsorships in Mali for about 1,500 orphans and provided health care to them and their families at a clinic dedicated to this cause.[79] World Vision, a US-based Christian agency, offered sponsorship for poor children and supported local agencies working to improve health, education, clean water, food, and income generation activities.[80]

There was no evidence of collaboration between faith-based health care services, which may be largely because of their geographic isolation, but also reflects the reality that there are no formal partnerships between Churches and ecumenical institutions.[81] Since there were not many religious health services, there were hardly any coordinating networks to support them. The Protestant Health Association and the Catholic health desk respectively coordinated the activities of their health centres, and representatives of both also belonged to the network of religious leaders. The multiple partners who collaborated with these networks, both secular NGOs and public agencies, were discussed above (See Sect 7.3.1).

There were a number of ways, however, in which faith-based health services collaborated with the MOH (see Box 7.7).

The MOH had a special directorate for confessional and private health services, but the relevant official was unable to provide any data relating to confessional facilities, citing their failure to submit data to the health management information system and lack of capacity to follow up. It was unclear whether this situation reflected the low level of importance attached to this category of health services by the Ministry, or whether it was a result of significant under-capacity.

Collaboration with traditional healers and traditional birth attendants also occurred at various levels, as was discussed in 7.4.2 above. In addition it could be pointed out that these providers received training from the MOH and were a vital link in mobilising communities for utilisation of CSComs.[82] Concerning collaboration of faith-based groups with traditional healers, it was pointed out that some Catholics had a good relationship with traditional healers; the same did not seem to apply to Muslim or Protestant entities.[83] In the case of Catholics this went beyond the interest of individual in collaboration, since the Vatican had adopted a position paper on the need for such collaboration.[84]

7.6 SOURCES OF FINANCIAL AND MATERIAL SUPPORT

73 World Vision.doc - 18:11 (42:42).
74 National health directorate.doc - 16:10 (28:29).
75 CARE.doc - 19:35 (75:76)
76 World Vision.doc - 18:4 & 5 (16:17) & 18:10 (39:39), Protestant.doc - 21:24 (286:286); see also local case studies above
77 Islamic Relief.doc - 20:7 (188:188)
78 Norwegian Church Aid 2007
79 IR doc - 20:28 (158:158)
80 World Vision 2007
81 WCC 2001.
82 WHO.doc - 14:27 (98:98), USAID.doc - 25:22 (31:31)
83 TH.doc - 17:14 (75:77)
84 Vatican 1993

Box 7.7 Collaboration between REs and the MoH

- *Government provided vaccines and equipment for services rendered in accordance with MoH guidelines (National health directorate.doc - 16:19 (45:45))*
- *in the case of the MIPROMA clinic, the state supported some staff salaries (it is not clear whether this is a unique situation or if other facilities had similar agreements)*
- *confessional clinics were supervised by the public health centres and reported to them (MoH Reprod health.doc - 15:21 (47:47))*
- *patients were referred to higher level public facilities,*
- *staff benefitted from in-service training provided by the MoOH (MoH Reprod health.doc - 15:24 (57:57)).*

USAID was the only funder supporting the engagement of religious leaders for health promotion.[85] It did so through the Health Policy Initiative, which provided training on health issues, supported capacity-building and acted as a small grant-maker to the religious networks.[86] The only other income was from membership fees.

The confessional clinics did receive some financial support for staff salaries and drugs from the European mother church bodies, but this was decreasing.[87] As the religious staff members were now predominantly local, the connections to European mother bodies were less direct. There was also some support from the MoH for vaccination material and equipment, which was also available to private-for-profit facilities. Otherwise, the clinics relied on the user fees they charged and the sale of drugs, some of which were donated (see case studies above).

In the case of traditional healers, many felt neglected by the state. They claimed that they provided 80 percent of health services, yet did not receive any funding in support of this contribution.[88] While other informants confirmed that 80 percent or more of the population turned to healers as a first resort, it has to be pointed out that this does not necessarily translate into 80 percent of services. Nevertheless, traditional practitioners undoubtedly provide a substantial portion of health care and their claim to some subsidy in recognition of this is understandable.

7.7 STAKEHOLDER PERCEPTIONS OF FAITH-BASED HEALTH SUPPORT

There was unquestionably, widespread support for the role of religious leaders in health promotion, as shown above. This support became more complex in cases where health policy was not easy for religious leaders to accommodate within their religious convictions, as in the case of female genital mutilation and contraception.

Interestingly, although the faith-based health sector was very small compared to the public and even the private sectors,[89] there were quite definite perceptions about the distinction between their services and those at the CSComs, with the former regarded as providing better quality care (see Appendix 7.5 for detail).[90] Although there was no perceived need for specifically faith-based health services, where they did exist, the faith and conviction of staff working there - who were seen to be 'working for God' - was viewed positively, resulting in what was experienced as a better attitude towards, and care for, patients.[91]

7.8 FACTORS LIMITING THE INVOLVEMENT OF RELIGIOUS ENTITIES IN PUBLIC HEALTH IN MALI

An important challenge posed to this study was finding an explanation for the virtual absence of religious health services in Mali, compared to the other two case-study countries, namely Zambia and Uganda. The broad political and historic dimensions that underscore this scope of work have been discussed above (see 3.6).

Key informants provided some additional insight into the unique situation in Mali, as follows:

85 Journalist.doc - 23:15 (44:44).
86 Policy Notes.doc - 24:10 (18:18).
87 CARE.doc - 19:36 (76:76).
88 TH.doc - 17:17 (91:91). The same complaint was raised in Zambia.
89 CARE.doc - 19:33 (72:72).
90 World Vision.doc - 18:7 (28:28), TH.doc - 17:6 (51:51), National health directorate.doc - 15:27 (66:66), CARE.doc - 19:39 (80:80), Protestant.doc - 21:26 (294:294) & 21:28 (298:298).
91 CARE.doc - 19:38 (80:80) & 19:40 (80:80).

1. First, the perception was common in the country that, while there was a dire need for additional health centres, this did not imply that religious groups should provide health services. It was understood that religious leaders could play a role in supporting the management of local CSComs, or helping to improve existing CSComs, but this was in contrast to actually starting and establishing confessional health centres.[92] One source felt that there might be room for more faith-based involvement (for example, in building more infrastructure). "But it should be done in accordance with the health policy in Mali. They should not come in the same area, for example, where there is CSCom".[93]

2. A second reason was the political context. The Christian clinics had been set up under colonial rule and hence with support from the colonial power. Following that era Mali was ruled by a dictator who allowed only one Muslim organisation, a structure with old men in positions of authority, where nothing ever changed. Only after 1991 could other associations come into being and challenge the status quo. Some of these, like the AMJM, had young well-educated members who were open to new ideas and engaged in rethinking the meaning of Islam. In this new context, setting up a clinic began to seem possible and desirable (see MIPROMA case-study above).

3. It was also put forward that, while Mali's population was predominantly Muslim, it was not a country under Islamic law, a condition that would have favoured more active religious involvement in all spheres of society.[94]

4. Finally, a lack of resources – and access to external resources – were seen as factors making it almost impossible for local religious groups to set up expensive to run health services.[95]

This range of suggested reasons drawn from participating informants highlighted the difficulty in pinpointing a single cause for the very different religion-health dynamic in Mali, as compared to Zambia and Uganda. A complex mix of historic, socio-economic and religious factors was at play, and continues to impact the present situation. As these factors change – and the AIDS pandemic is but one such force for change – new religious responses to the health challenges in Mali will emerge.

There are a number of other constraints that hamper FBO involvement, some of which have already been touched upon in the local case-studies. These include the following:

- the donor base for building the capacity of religious leaders was very small, which hampered the degree to which networks of religious leaders were able to extend their training and sensitisation concerning health issues; it also resulted in the discontinuation of some services previously provided by confessional services;
- there was a shortage of human resources (including managerial skills) in the country as a whole – and a reliance on volunteers – which made it difficult for networks to realise their ambitious plans, especially at regional level;
- given the geographical conditions of the country, it was hard to reach the high percentage of the population living in sparsely settled rural areas;
- low levels of education and literacy among the imams, especially in rural areas, hampered drawing them into health promotion programmes;
- there was unwillingness in some confessional services to share power with local communities, which might curtail their influence and give reason for rival CSComs to be set up in close vicinity;
- Christian clinics had not been able or willing to negotiate agreements with the MoH that would ensure them greater support (for example, through funding for staff salaries).

7.9 KEY AREAS FOR POTENTIAL INVESTMENT

7.9.1 THE HEALTH SYSTEM

Mali's health system is in need of support. National health plans that have been developed require funding support in order to make implementation possible. Decentralisation is well on its way, but the majority of villages are still without access to a public health facility. Hence, all agree that many more CSComs are needed.

There are huge needs around services to curb the high maternal and child mortality rates. A further need is for

92 National health directorate.doc - 16:17 (42:42) MoH HR.doc - 15:26 (65:66), CARE.doc - 19:46 (90:90).
93 CARE.doc - 19:45 (90:90).
94 WHO.doc - 14:8 (37:37) & Islamic Relief.doc - 20:17 (307:309).
95 PSI.doc - 22:23 (127:127); Islamic Relief.doc - 20:24 (374:374).

reproductive health services that are acceptable to men and to the youth.[96]

7.9.2 HUMAN RESOURCES

In Mali, as much as in the other case-study countries, the needs around human resources for health are great and need to be addressed. In particular, qualified personnel are needed for rural areas; this will require some incentives to recruit and retain them.[97] Potentially this is one area where, even in Mali, religious facilities and staff motivated by their faith could make a significant contribution.

7.9.3 INFRASTRUCTURE

The need to link the different levels of the health system, e.g. to enable patient referral from remote facilities to higher care, is dependent on reliable transport, and ambulances are needed to support this function.[98] Providing vehicles should be linked to maintenance support as, in many instances, these vehicles are out of operation as a result of minor technical faults. Training mechanics to keep vehicles in working order is important.

7.9.4 SPECIFIC INTERVENTIONS

Several specific interventions requiring funding support were mentioned in this study. First, the much-valued health promotion work by religious leaders was not sufficiently supported as a means of improving health outcomes in Mali.[99] In the light of this:

- the associations of religious leaders need to be supported more widely; some funding ought to be earmarked f or capacity building, to impart skills on management of funds and other resources as well as on planning of activities.[100] Without this type of support the impact of this potentially powerful means of health promotion may simply remain a Bamako-based project, without benefiting other regions. In particular, funding is needed for the rural chapters, to make possible the extension of the positive results achieved in the cities to these populations.[101] It is likely that this will require innovative ways of engagement and extension, especially given the typically low educational levels of rural imams, and
- support should also extend to the younger, well-educated groups, as in the AMJM, who have the potential to make a valuable contribution.[102]

Other suggestions included the following:[103]

- cultivating traditional herbs and processing them for treatment
- training of both traditional healers and western health workers to understand each other's approaches and to learn a common language, and
- linking traditional health providers to the CSCom network.

7.9.5 CHANNELING OF FUNDING

Since the MoH was regarded as the main player responsible for the health of Mali's population, it was not surprising that several informants believed that all funding should be channelled to the Ministry and be distributed from there to other players, including confessional ones.[104] However, the office of the MoH responsible for confessional health facilities was not well-organised and had very little contact with the religious health centres.

Clearly, in a context where such a small percentage of health services is religiously based, it is not feasible or likely that these groups would be major recipients of funding, even when it is evident that they do valuable work in support of improved public health outcomes and are in need of financial support to maintain their services.[105]

96 MoH Reprod health.doc - 15:3 (13:13).
97 WHO.doc - 14:26 (94:95).
98 CARE.doc - 19:54 (105:105).
99 USAID.doc - 25:4 (8:8).
100 Journalist.doc - 23:17 (46:48).
101 Protestant.doc - 21:36 (400:400).
102 MoH Reprod health.doc - 15:37 (91:92).
103 TH.doc - 17:19 (96:99) & 17:20 (101:101).
104 MoH Reprod health.doc - 15:34 (84:84).
105 CARE.doc - 19:56 (109:109)

Another approach to providing this support, however, is the concept of direct funding support to the community level centres – whether confessional or not – the outcome of which will be that, as long as the communities receive the benefit of the funding, improvements will be made.[106]

7.10 CHAPTER CONCLUSIONS AND RECOMMENDATIONS

1. The emphasis in the religion-public health interface in Mali is different from that in many other countries in sub-Saharan Africa. The role of religious leaders in health promotion is highlighted, while health service provision has a low profile. This study has explored this difference and the political and religious factors underlying it (see also Chapter 3). Further study is required to fully understand the role of religion in this context and how both potential roles for religious entities in health promotion and health provision can be nurtured and complement each other.

2. The health promotion role of religious leaders is valuable and should be supported financially.

3. Regarding the provision of health services, it is clear from the local case studies that there is a potential role in this area for religious entities, although it is unlikely that this will take the same form as in Uganda or Zambia. In Mali it will be more helpful to develop ways for religious entities to become part of the community support for CSComs, in close collaboration with the Communes, the Ministry of Health, traditional healers and religious collaborating structures. Implementation of this recommendation will require exploration of suitable forms of collaboration, involvement of local leadership with religious facilities and religious leaders with CSComs, as well as support for structures in which models can be explored and debated.

4. Given the poor health context, it is worth asking whether faith-based groups should be encouraged to expand their involvement in health service provision. Even with the low level of religious health service provision, there is acknowledgement of the good quality of care they provide. There might be ways of tapping into this ethos, to the benefit of the population.

5. It is potentially an added value that religiously motivated staff members are more willing to work in hard-to-reach areas. This potential could be made accessible to the wider community through religious facilities, or through religiously based training of health workers. Alternatively, it might be an issue adopted by the networks of religious leaders to encourage their followers to consider taking up positions in hard-to-reach areas.

6. In Mali, a combination of health-seeking strategies is common among the population. In their search for health, people turn to traditional healers and supernatural cures and prayer, as well as bio-medical interventions. Any interventions into health systems have to keep in mind that there are numerous systems operating alongside one another, influencing one another and at times curtailing one another. It may be crucial to understand this 'mixture' better before attempting to intervene with solutions directed at only one of the systems.

7. The role of African traditional healers in Mali was not studied extensively for this report. The findings do however indicate intriguing aspects about their role in society, i.e. the positive relationship with public health authorities and some formal religious groups. In any attempt for closer collaboration between African traditional and bio-medical health providers a willingness to learn from TH approaches will be crucial. A closer study of this sector in Mali, the way it operates, the degree to which they function as religious entities, the factors making possible positive relationships, could provide helpful indicators for replicating this elsewhere.

8. Given the existence of trusted and locally available traditional healers who are already working with the CSComs, it is suggested that special initiatives are developed to improve their skills so that they become more au fait and skilled in making referrals to CSComs. In addition, the traditional birth attendants constitute another locally based resource, and they are in need of training. This recommendation is important as a strategy to help address the very high maternal and infant mortality rate.

9. Traditional practitioners undoubtedly play a major role in health as first-line providers of choice and their claim to

106 National health directorate.doc - 16:20 (48:48)

some public subsidy in recognition of this role is understandable. The study recommends that this be looked into in Mali.

10. There is an important role for women and, in particular, grand-mothers in providing advice on treatment of ill babies. As a result, it is suggested that women's groups associated with mosques be trained so as to provide sound advice to young mothers and families.

11. It is remarkable that, in Mali, as elsewhere across the globe, it was the AIDS pandemic that gave rise to collaboration across divisions. The World Council of Churches, for instance, mentions the lack of partnership structures between churches,[107] yet Catholic and Protestant leaders have joined Muslim colleagues in the inter-faith network against AIDS. Against the general lack of collaborative fora for religious groups, the level of inclusivity and collaboration achieved in the networks is all the more remarkable. This fact is further support for the recommendation that the networks deserve to be better resourced.

12. Despite numerous attempts to obtain information from various institutions, both public health and religious, it was not possible to determine the scale of Christian health services nor to ascertain whether their location is mainly urban or rural. While this is a limitation of the study, it is also indicative of a lack of communication, and seemingly a failure of the partners (that is, the MoH and Christian health co-ordinators) to take collaboration seriously. The study recommends that this matter receive attention by both parties; the benefits of a more open and mutually supportive approach as taken by the MIPROMA clinic are too evident to be ignored.

13. There is a need to challenge unhealthy beliefs, which are often perceived to be associated with religion, even if incorrectly so. One example of this is female genital mutilation; here the role of religious leaders could be particularly crucial in challenging this tradition that many understand as a religious imperative. Some success has been achieved with destigmatising people affected by HIV and AIDS, and even family planning by birth spacing has become acceptable. In the case of female genital mutilation it has been much more difficult to get religious leaders involved and to use them to impact on the practice. Ways to develop suitable means of addressing this issue need further study.

14. The approach in Mali is to have decentralised, primary care as a focal point for the health system. Two elements here in particular require funding: the further development of CSComs for communities that are still un-serviced; and strengthening the work of the relais as a means to take primary services into the communities outside a 5km radius of the CSCom. The latter service is not sustainable without support, as this is not a service that can depend on payment by users.

7.11 REFERENCES AND SOURCES

7.11.1 BIBLIOGRAPHY

Afronews/IRIN. 2007. *Mali finds no good way to boost health services*. http://www.afrol.com/articles/25054 (11th April 2007; consulted 9th November 2007)

Amiga, M, Sanogo, N. Doucoure A & N Johns (1992) La Méthode des Groupes Focalisés (Focus Groups) appliqué à l'étude des problèmes de la contraception dans les circles de Kayes, Mopt et le District de Bamako. Médecine d'Afrique Noir, Vol 39: 1-4.

Castle S (1992) *Intra-Household Variation in Child Care and Illness Management in Rural Mali*. Doctoral thesis. Centre for Population Studies, London School of Hygiene and Tropical Medicine.

Castle, S & A. Diarra (2003) *The International Migration of Young Malians: Tradition, Necessity or Rite of Passage?* Report to Save the Children USA, Bamako, Mali.

Central Intelligence Agency (CIA). 2007. The world fact book - Mali. https://www.cia.gov/library/publications/the-world-factbook/geos/ml.html

Coulibaly A and Hilhost T. 2004. La mise en place de la décentralisation au Mali: cas de deux communes rurales. Drylands Issue Paper F127. International Institute for Environment and Development. London :IIED

Dielman M, Jurrien T, Toure T and Martineau T. 2006. "The match between motivation and performance management of health

107 WCC 2001.

sector workers in Mali". *Human Resources for Health.* **4:**2 2doi:10.1186/1478-4491-4-2.

Diallo, K (2001) L'influence des facteurs familiaux, scolaires et individuels sur l'abandon scolaire des filles en milieu rural de la region de Segou, Mali. Doctoral thesis, Université de Montréal, Specialité Sciences de l'Education.

Douville, O (2003) Enfants et adolescents en danger dans la rue a Bamako; Questions cliniques et anthropologiques à partir d'une pratique. Psychopathologie africaine, 2003-2004, XXXI: 1-33.

EDSM-IV. 2006. *Enquête Démographique de la Santé du Mali* (Mali Demographic and Health Survey). Centre pour la Population et la Sante (CPS/MSSPA) Direction National de la statistique et de l'Information (DNSI). Bamako, Mali : CERPOD.

EDSM-IV. 2007. *Enquête Démographique de la Santé du Mali* (Mali Demographic and Health Survey). Centre pour la Population et la Sante (CPS/MSSPA) Direction National de la statistique et de l'Information (DNSI). Bamako, Mali : CERPOD.

Handloff, R (1982) Prayers, amulets, and charms: Health and social control. African Studies Review, Vol. 25, No. 2/3:185-194.

Norwegian Church Aid (2007, consulted 9th November 2007). http://www.eurodad.org/members/index.aspx?id=242&LangType=1036

One World UK Mali Country Guide (2007).

Save the Children (2002). State of the world's newborns: Mali. http://www.savethechildren.org/publications/technical-resources/saving-newborn-lives/country-documents/Mali-Executive-Summary-2002_English.pdf

Shaaban, L & S. Harbison (2005) Reaching the tipping point against female genital mutilation.The Lancet, 2005, n°366 :347-349.

Sociolingomali (2007). http://sociolingomali.wordpress.com/2007/05/21/traditional-medicine-in-mali/ (accessed 13.01.2008)

Stanton, S, Abderrahim, A & K Hill (2000) An assessment of DHS maternal mortality indicators. Studies in Family Planning, 31,(2): 111-123.

United Nations Development Programme (UNDP HDI). 2007. *Human Development Report 2007.* http://hdr.undp.org/en/statistics/ (consulted 9th November 2007)

UNAIDS. 2007. Country responses. Mali. http://www.unaids.org/en/CountryResponses/Countries/mali.asp (accessed 25.01.2008)

Vatican. 1993. *l'attention pastorale envers les religions traditionnelles* Lettre du Conseil Contifical pour le Cialogue Interreligieu auPrésidents des Conférences Episcopales en Asie, auAmériques et en Océanie. http://www.vatican.va/roman_curia/pontifical_councils/interelg/documents/rc_pc_interelg_doc_21111993_trad-relig_fr.html (accessed 9 November 2007).

World Vision. 2007. http://www.worldvision.org/worldvision/projects.nsf (accessed 9 November 2007).

WCC 2001. Churches and the HIV/AIDS pandemic. Analysis of the situation in 10 West/Central African countries. Geneva, World Council of Churches & World Alliance of YMCAs

World Health Organization. 2001. Legal Status of Traditional Medicine and Complementary /Alternative Medicine: A Worldwide Review. (WHO) World Health Organization. http://whqlibdoc.who.int/hq/2001/WHO_EDM_TRM_2001.2.pdf (accessed 13.01.2008)

WHO. 2007. WHO country statistics. Mali. (WHO) World Health Organization. http://www.who.int/countries/mli/en/ (accessed 25.01.2008)

7.11.2 SOURCES FOR MALI LOCAL CASE STUDIES

A. The National Islamic Network for the Fight Against AIDS

Persons interviewed

El Hadj Sidi Konaké
El Hadj Mamadou Traoré
Mafounè Soucko
El Hadj Wahid

Documents consulted

RNILS: Statuts et règlement intérieur
RNILS: Plan d'action 2005
RNILS: Plan d'action 2006
RNILS: Politique du RNILS en matière de lutte contre le VIH/SIDA

B. Faladié health centre

Persons interviewed in the N'Tjiba Commune

Kassim Soumaoro, 2nd Deputy Mayor
Mamadou Bah, 3rd Deputy
Naba Seydou Traoré, Communal Councillor
Soumaïla Traoré, Accountant
Dosséké Traoré, Village Councillor
Karim Traoré, Village Councillor
Manè Traoré, Village Elder
Sr Odile Tounkara, Pharmacy Manager

Documents consulted

World Vision Mali: Diagnostic Study of the N'Tjiba Commune; January-February 2007
N'Tjiba Commune: The Socio-Economic Development Program of the Commune; 2004

C. MIPROMA clinic

Persons interviewed

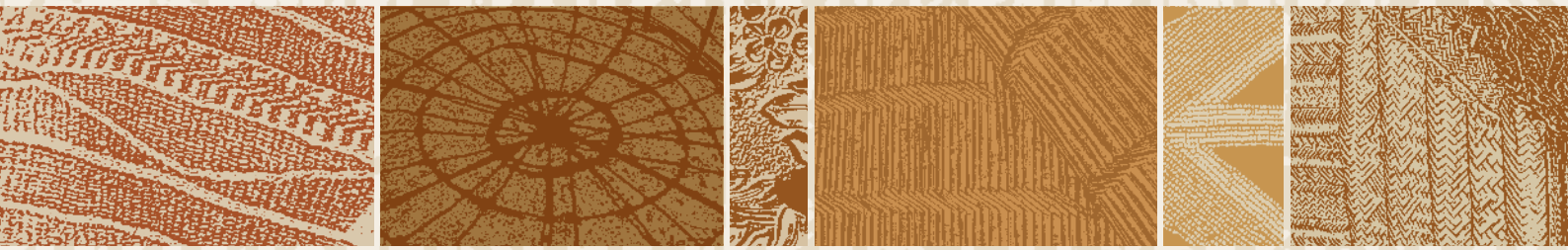
Lassine Camara, General Treasurer
Fousséini Doumbia, Member
El Hadj Mamadou Traoré, Member
Dr Hamadoun Sangho, Advisory Committee Member
Mohamadou Lamine Djiguiné, Secretary to sports
Abdoulaye Ballo, Section VI, Member
Dr Brainina Coulibaly, Doctor of the Centre
Abdoulaye Sangho, MIPROMA Centre
Mayan Traoré, Vegetable vendor at the market
Minata Doumbia, Rice vendor
Kassim Diallo, Patient

Documents consulted

AMJM : Memorandum of Association and Rules of Procedures
AMJM : Action Plan: 2006 et 2007.
MIPROMA : Quarterly Activity Report: from 0-04 to 30-07- 2007-11-11
MIPROMA : Financial Report, 2006

CHAPTER 8

FINDINGS AND RECOMMENDATIONS ON THE CONTRIBUTION OF RELIGIOUS ENTITIES TO HEALTH IN SUB-SAHARAN AFRICA



CHAPTER 8

In Africa, religion is integral to peoples' lives and is inherent in the minds of those involved in the health sector. Previous ARHAP work has confirmed the way in which religion and health are integrally understood. Although several studies have explored the role of faith agencies in health provision in Africa, and some refer loosely to faith based organisations providing between 30 and 70% of health services in Africa, data is patchy. While this study has not been comprehensive, it goes some way in being able to expand upon the 'patchy' data and explain how and why the scale and scope of faith based health services differ, particularly drawing on the case studies undertaken in Mali, Uganda and Zambia and the summary findings of the desk review.

The aim of the study was to explore the role of religious entities (REs) in contributing to health in SSA with a view to identifying areas for future investment. This chapter offers an overview of the importance of REs in improving health drawing on the findings of the study as well as recommendations flowing from each cluster of findings.

8.1 RELIGIOUS ENTITIES (REs) MAKE A SIGNIFICANT AND UNIQUE CONTRIBUTION TO HEALTH SERVICES

a) REs can be described as performing these main health related functions in SSA:
- Delivery of **facility-based health services** alongside the state health services at district and national level (Uganda, Zambia) [1].
- Many faith-based hospitals are also **training centres** for the health workforce; this may still produce as much as 60% of the nursing cadres (Uganda).
- Provision at local level of **non-facility-based small-scale health related activities** including traditional medicine, home based care and HIV prevention, care and support (Zambia).
- National faith based health networks like CHAZ in Zambia and the medical bureaus in Uganda, offer **co-ordination**, fundraising, capacity development, supervision for affiliated health services and act as funding vehicles for them.
- **Advocacy** around the role of faith based facilities in health provision with government and funders (Uganda, Zambia).
- **Health promotion** and education by trusted leaders at a local level (especially Mali).

b) There is **little data** on the faith-based contribution to health, and what is available is mostly disparate and specific to a denomination and/or country. No comprehensive database of religious health facilities for SSA exists, nor of their funders and good practice exemplars; even less is known about non-facility-based services (Desk review).

c) Anecdotal evidence claims that the **religious commitment of health workers** impacts on their work ethic and quality of care (Uganda, Zambia, Mali); this has also been identified as a valuable asset for quality health care. The extent to which this ethos is related to motivation and quality of care requires further study.

On the basis of these findings the study recommends that:

I Mapping of religious entities contributing to health is important for optimal alignment in resource constrained settings and should be undertaken more widely leading to the establishment of a comprehensive database.

- *Mapping of religious health services be undertaken to make national and local organisations aware of the assets they have and how these could be enhanced for better health outcomes. This work could draw on ARHAP's participatory mapping methodology for cross country comparability (see ARHAP-WHO 2006). This could act as launch pad for communities and countries to identify religious assets which can be mobilised for health.*
- *A database of REs providing health services at a national level should be set up for all SSA countries in order to have a comprehensive picture of the religious contribution and to make possible its closer alignment with the public health sector and its engagement by donors.*
- *The outcome of this work should be made known to national health policy-makers and planners.*

1 Where a specific finding can be linked to a case-study, the country/chapter is indicated in this manner.

II Further study be undertaken to verify claims about 'better' quality of care provided by faith-based health services and any potential lessons this might have for strengthening public health services in resource

8.2 FAITH-BASED HEALTH SERVICES IN SSA SHOW GREAT VARIETY IN TYPE AND EXTENT

a) The **scale and range of activities vary** from country to country as well as within countries; it is not possible to speak about REs contribution to health in sub-Saharan Africa in generalising terms (Desk review).

b) There is a very wide inter-country variation in role of REs in health, especially because of the **history** of colonialism and the shifting policy environment over time in terms of public private partnership approach, user fees, structural adjustment policies. The different cultural and religious influences present add a further level of complexity.

c) The case-study findings show that **the contribution of REs in terms of health facilities** at country level varies from 2% in Mali to about 30% in both Uganda and Zambia with an even higher percentage in rural areas through rural hospitals and health facilities.

On the basis of these findings the study recommends that:

III Further research is needed to extend the insights from this study, i.e. to identify patterns and commonalities in REs working in different contexts, to fill in gaps apparent in the desk review

- *Additional research will help develop the understanding of the variety of ways in which religious entities promote health, and particularly commonalities and patterns across different contexts in order to better identify best practices and most effective interventions.*
- *A number of proposals for further research have been highlighted in the report, especially in Chapter 4, e.g. literature in languages other than English, specific public health concerns, models for collaboration.*

8.3 NATIONAL FAITH BASED HEALTH NETWORKS (NFBHNS) PLAY A CRUCIAL ROLE IN ENABLING FACILITY-BASED SERVICES, YET THEIR RIGHTFUL PLACE WITHIN NATIONAL HEALTH SYSTEMS IS NOT ALWAYS ACKNOWLEDGED.

a) The study has highlighted the way in which REs impact on health in a range of different ways at national level where strong religious organisations are **taken seriously as partners by government** (Uganda, Zambia).

b) The bulk of faith-based hospitals and clinics (in Uganda, Zambia) are **co-ordinated by agencies at a national level** that have a more or less formalised relationship with the ministry of health, focussed on advocacy, mobilisation of resources and ensuring co-ordinated health service delivery on the ground.

c) The **advocacy** role of NFBHNs and their participation in policy engagements at a national level has been shown to help further the capacity of affiliated facilities (Zambia).

d) At times clear **boundaries are placed on NFBHNs** around their involvement in what are seen as political issues; they are for example not given access to certain health information relevant to their facilities (Uganda).

e) There is a **similarity of approach** between faith-based and public health services; they all follow the guidelines of the MoH, and are supervised by its officials (Uganda, Zambia, Mali).

f) Faith based services complement those of the MoH and NGOs, but do have a **different ethos** resulting in valued services to marginalised groups (Uganda, Zambia, Mali).

g) The contribution of the faith based sector to national health provision is generally acknowledged by health ministries

in SSA, and national faith-based bodies participate in national fora such as the Zambia AIDS Council (also Uganda). Yet the **policies** in some countries are not sufficiently **enabling** for the role of REs at a national level. As one example, in Zambia the lack of consultation around the sudden removal of user fees in rural areas, left faith-based health facilities financially unprepared to implement this policy.

h) Collaboration between faith-based and public health facilities and management structures was found to be more difficult at a **district level** where there was more direct competition for limited resources such as funding and health workers (Uganda).

Hence the study recommends:

IV The faith-based health sector should be involved in planning and health policy issues at a national level, where appropriate, to ensure policy is enabling for REs.

- *Ongoing national-level planning, policy formulation and budgeting regarding human resource issues, health service delivery and user fees, should involve NFBHNs, together with the national MoH.*
- *Financial support should be made available for parity in human resource remuneration between FBO employees and MoH employees. Special attention needs to be given to urban and rural equity.*

V FBOs should be seen as part of the MoH's activities at a district level.

- *FBOs providing health services at district and local levels should be funded in a way that ensures that their delivery targets are seen as part of the targets of the district.*
- *Good practice examples of joint FBO and district level planning, monitoring and budgeting should be identified and documented.*
- *The study found an exemplary model of collaboration between all health providers at district level in Mukono, Uganda, but due to time constraints could not identify the factors that made this possible. Studying this model (and others in different settings) in detail could yield insights necessary for its replication in Uganda and elsewhere.*

VI Capacity for policy making in the health sector (e.g. understanding the policy-making process at national / district level) should be developed among faith-based and MoH leadership to facilitate joint involvement in developing enabling policy.

- *There is a need for faith-based and MoH leadership to understand the policy-making process*
- *Joint capacity development should be undertaken at a national and district level with faith based network leaders and MoH officials; as well as separate training dealing with the specific requirements of each sector.*
- *It is important to work with and support existing health policy-making training programmes that can be further developed, piloted and adapted for use with leaders of NFBHNs and Ministries of Health.*

8.4 THERE HAVE BEEN SIGNIFICANT SHIFTS IN OWNERSHIP/FUNDING/RESPONSIBILITY REGARDING FAITH-BASED HEALTH FACILITIES OVER RECENT YEARS FROM THE HISTORIC MISSION MODEL TO LOCAL AND AGENCY FUNDING, LEAVING HUGE DISCREPANCIES

a) Originally most faith based facilities were **mission owned and funded**. Many of these facilities are now deteriorating due to a lack of funding for maintenance and modernisation (Desk review, Uganda, Zambia, Mali).

b) Across SSA health services have become the **responsibility of national governments** after independence. International agencies have provided funding for a range of national government responsibilities under severe conditions, resulting from a combination of macro-economic conditions, political decisions and global trends.

c) Faith based health facilities, too, in many countries are now funded to some extent by government. This ranges from being almost entirely funded out of government resources (e.g. CHAZ-affiliated facilities in Zambia) to minimal support (e.g. urban UCMB facilities in Uganda).

d) There is **no parity in employment conditions** for health workers at faith based and state health facilities. This causes problems with recruitment and retention of staff and also potentially results in compromised quality of care (Uganda).

e) Career expatriate **mission health workers** have become rare; few medical missionaries now serve in SSA, and most of those who do only come for short terms (Zambia).

f) Funding is received from a **variety of funders** with differing aims and conditions. Much of this funding supports vertical programmes. Complex proposal and reporting requirements often exclude REs from accessing these funds (Uganda, Zambia).

g) With other financial support diminishing or unreliable, some faith-based facilities rely heavily on **user fees**. This raises dilemmas around access for the poor to their services (Uganda, Zambia).

Hence the study recommends:

VII Funders should commit to working closely with national ministries of health (MoHs) in strengthening national health systems.

- *The emphasis should be on interventions that support strengthening of the health systems as a whole.*
- *Funders be encouraged to support integrated local health programmes.*

VIII NFBHNs and their crucial contribution are to be acknowledged and receive direct funding support.

While governments do fund NFBHNs and their affiliated facilities, the basket funding approach does not pass sufficient funding through to REs to maintain their services. Donors should consider direct funding to these bodies to enable them to maintain the services they provide.

IX Policy and consultation should ensure that there is parity in access of the community to health services, whether provided by MoH or REs.

In the case of user fees, special measures need to be put in place, given the financial impact of the removal of user fees on FBO facilities in poor communities.

8.5 FAITH-BASED HEALTH SERVICES WORK UNDER SEVERE CONSTRAINTS, ESPECIALLY REGARDING THEIR WORKFORCE

a) There was concern within government that the quality of service at faith-based facilities was compromised as they were often **severely understaffed** and that many of their staff members were under-qualified for what they did (Uganda, Zambia).

b) Addressing the **human resource shortage** was an integral part of strengthening the health system. This included:

- ensuring that health facilities were adequately staffed
- increasing the performance and effectiveness of health workers
- setting up systems that ensured that volunteers were adequately compensated and provided with care
- setting up adequate health training facilities (Zambia)

c) Creating a **health associate** position in which relatively well-educated school-leavers could be trained to perform some of the basic functions so that the doctors and the nurses could focus on more specialised needs (Zambia).

d) Apart from HR needs, **funding shortages** hampered health services. Especially serious were drug shortages and the inability to provide safe and reliable transport for referrals (Uganda, Zambia).

Hence the study recommends these support strategies:

X) Staff costs, both for salaries and ongoing training, which are often particularly excluded from donor packages, should be considered as crucial for REs.

In particular funding is needed for:

- *staff costs, including benefits like housing, to help them achieve salary parity with colleagues in the public service.*
- *capacity building for existing staff, both health workers and management staff: medical specialisation; IT skills, especially HMIS and stock control; overall strategic planning, needs assessment and M & E.*

  Where possible, FBO training facilities for health workers in rural areas should be kept operating so as to encourage rural people to train as health workers and to stay on in rural areas when trained.

XI Special consideration needs to be given at national level to how FBO facilities and training institutions can be mobilised to help address the HR problems in the health system

Where possible, FBO training facilities for health workers in rural areas should be kept operating so as to encourage rural people to train as health workers and to stay on in rural areas when trained.

8.6 REs PROVIDE A WIDE RANGE OF NON-FACILITY-BASED SERVICES IN RESPONSE TO IMMEDIATE LOCAL NEEDS, PLAYING A VERY IMPORTANT ROLE UNDER SERIOUS CONSTRAINTS

a) An **extensive range** of non-facility-based health activities are provided by REs, especially in contexts where there is a high prevalence of HIV, and have emerged largely at a local level (Zambia).

b) These initiatives **operate informally, flexibly**, and in response to available funding, so there is virtually no reliable (if any) record of who is doing what or what outcomes are achieved (Desk review, Uganda, Zambia). The rare exceptions are initiatives such as the South African Catholic Bishops Conference's extensive ART programme[2] , second in scale only to that of the government.

c) Even where facility-based services are aligned with public services through NFBHNs, the district level grassroots initiatives, directly responding to the needs of vulnerable groups, are all but **invisible to public health players** and often even to the NFBHNs (Uganda, Zambia).

d) Problems emerged when there was **inadequate collaboration** of non-facility based services, such as duplication of services; competition in obtaining funding, recruiting staff and volunteers and attracting clients; inability to access appropriate referral services (Zambia).

e) Oftentimes, these activities are heavily reliant on **volunteers** who themselves are very poor, and often move locally from agency to agency in search of better stipends.

f) The ready **availability of funds for HIV** services – and the huge needs in this area – are largely the raison d'être for the explosion in scale of these activities (Zambia).

2 The SACBC ART programme, funded by PEPFAR, operating out of car boots and community groups, is an exception to this rule. UNAIDS Best Practice 2006-2007 Choose to Care Initiative. UNAIDS.

g) These initiatives are often **not sustainable** due to their lack of sustainable funding and shortage of technical, financial and administrative skills. A major challenge is funding of operational costs, seldom funded by international agencies (Zambia).

h) **Intermediary agencies** have emerged to supplement technical capacity, and provide support and training, as facilitators of small local projects; but there are far too few of these (Zambia).

Hence the study recommends a range of strategies in support of this sector:

XII Agencies should be set up at regional level to provide technical and administrative support to local non-facility-based initiatives thereby sustaining and scaling up valuable work done at this level.

This recommendation could be facilitated by:

- *encouraging funders to fund 'intermediary' organisations as an important requirement to support local level NGO and FBO health-promoting activities*
- *documenting the good practice of model intermediary organisations and sponsoring exchange visits to them*
- *training packages and support should be offered, so that enabling agencies can be set up widely modelled on the good practice exemplars*
- *lessons learned on the ground be harnessed for wider scale roll out through advocacy initiatives*

8.7 MIXING OF MULTIPLE HEALING MODALITIES (AFRICAN TRADITIONAL, BIO-MEDICAL, FAITH HEALING, ALTERNATIVE THERAPIES) IS A COMMON REALITY ACROSS SSA WITH MOSTLY VERY LITTLE MUTUAL ACKNOWLEDGEMENT AND COLLABORATION

a) Across SSA in both urban and rural contexts people commonly use **multiple healing modalities**. African traditional healing is used by the majority of health seekers, often concurrently with other possibilities for health offered by plural health systems (Uganda, Zambia, Mali).

b) **African traditional healers** and traditional birth attendants (TBAs) are the first resort in case of ill-health for the majority of the population of SSA. They continue providing accessible health services and are increasingly open to some form of collaboration with bio-medical health providers (Uganda, Zambia, Mali).

c) Many global, African and country health policy documents refer to the importance of traditional healing and the need to acknowledge and work with these health practitioners. Nevertheless, the case studies highlighted that seldom were traditional healers given more than **token acknowledgement** by the Ministry of Health (Zambia, Uganda) although Mali has taken more definite steps toward genuine partnering.

Hence the study recommends:

XIII A policy process should be developed to integrate traditional healers into the health system.

- *The role of traditional healers, including TBAs, needs to be actively promoted and enhanced in policy and practice - Africa-wide, and at national level, as well as at district and local levels.*
- *An active programme of engagement and training of traditional healers and health workers will need to be embarked upon.*
- *Setting up a civil society forum for health which includes REs, NGOs and traditional healers could provide a voice to lobby NEPAD, the African Union as well as individual countries in this regard.*

8.8 WHILE THE IMPORTANT POTENTIAL OF RELIGIOUS LEADERS FOR HEALTH PROMOTION HAS BEEN CHANNELLED INTO SOME CREATIVE INITIATIVES, IT IS GENERALLY UNDERUTILISED

a) Religious leaders with the respect and credibility they have in communities, and drawing on the commitment for well-being shared by most religions, have the **potential** to be powerful agents in the promotion of public health agendas. As shown in the Mali case-study, inter-religious dialogue and co-ordination at national and local levels is particularly beneficial.

b) Some religious leaders contribute to health promotion and education in a number of areas (e.g. promoting family planning and hygiene, or fighting FGM and HIV-related stigma) (Mali).

c) The **degree to which this potential is utilised** in different countries varies widely depending on the context. In Mali the National Islamic Network for the Fight against AIDS is an example of a network that mobilises faith leaders for community health outcomes.

d) However, the role of local religious leaders in health promotion in Mali differs by level; **national religious leaders** are more heavily involved than **local imams in rural** areas.

Hence the study recommends:

XIV Religious leaders at all levels should be encouraged and trained to be actively involved in culturally appropriate health-promoting activities.

Meetings should be held with the top African religious leaders of various faiths and denominations to promote awareness and action regarding their health-supporting roles and responsibilities. This could be facilitated by a number of actions, such as:

- *Developing materials for religious leaders to encourage their active participation in health promotion*
- *Documenting best practice and utilising exchange visits*
- *Encouraging local faith leaders to be agitators for and advocates of improved basic living conditions*
- *Mobilising the agency of religious women to advance health in their communities. Women leaders should be encouraged to speak to their peers about health concerns, especially those associated with mother and child health. This needs to make use of the capacity and leadership abilities of local women, and young women in particular.*
- *Work with, expand and learn from existing programmes, for example the 'women-to-woman', and 'mother-to-mother' health promotion campaigns*

XV Research is needed to develop ways to challenge religious leaders to advocate against traditional/ religious practices prejudicial to health.

- *Research needs to be undertaken to identify practices advocated by faith leaders and traditional healers that are prejudicial to health and gender equity, e.g. female genital mutilation and simultaneously to identify those norms, values and beliefs internal to particular traditions that will support appropriate transformation .*
- *Social marketing campaigns need to be set in place, informed by such research, to challenge practices advocated by religious leaders that do not thwart health.*

XVI Inter-religious dialogue on health issues needs to be encouraged to strengthen faith-based efforts of different actors and align them with each other.

- *Good practice should be documented and its development encouraged though the setting up of awards for good practice in each country.*
- *Exchange visits and roundtables of religious leaders across the SSA region should be encouraged.*

8.9 REGARDING THE METHODOLOGY USED IN THE STUDY

The use of three case studies provided the opportunity to understand in some detail the role of REs in health services, the relationships between faith groups as well as the links between faith-based health services and the ministries of health. The study also provided an understanding of the potential role of faith leaders in health promotion. While the case studies were chosen to ensure diversity in selected factors, it is not possible to draw generalisations from them e.g. for trends in other countries which are predominantly Christian, or Francophone.

The study design built on the knowledge that had emerged out of the prior work of the ARHAP mapping of local level faith based responses to HIV in Lesotho and in Zambia but did not specifically aim to be comprehensive in its overview of local level responses.

The country reports contained in Chapter 4 bring together a range of disparate data for the first time. The difficulty in accessing the data necessary for developing the country reports highlighted the lack of any comprehensive data source on faith based agencies involvement in health in SSA.

The method has highlighted key resource agencies involved in faith based health activities as well as possible data sources. However, the lack of data on who is doing what/where will continue to bedevil the needed co-ordination to ensure that REs are adequately resourced and contributing as needed on a national and district level.

Secondary data that is available is driven to a large extent by the M and E requirements of the extensive HIV funding that has been made available in the past ten years.

ACRONYMS

ACTs	Artemisinin-based combination therapy (for malaria)
ARHAP	African Religious Health Assets Programme
ART	antiretroviral treatment
AU	African Union
BoD	burden of disease
CBOs	community based organisations
CHAs	Christian health associations
DFID	Department for International Development
DHO	District Health Office
DRC	Democratic Republic of the Congo
FBNs	faith based networks
FBOs	faith based organisations
FGDs	focus group discussions
FGM	female genital mutilation, also female circumcision or cutting
GDP	gross domestic product
HBC	home based care
HIMS	health information management system
HR	human resources
IDP	internally displaced person
IMF	International Monetary Fund
IMR	infant mortality rate
KIs	key informants
KIIs	key informant interviews
MDGs	Millennium Development Goals
MNCR	maternal, newborn, child and reproductive health
MoH	Ministry of Health
NEPAD	New Partnership for Africa's Development
NFBHNs	national faith based health networks
NGOs	non-governmental organisations
NHS	national health system
OPD	out patient department
OVCs	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PI	principal investigator
PLWHAs	people living with HIV and AIDS
PMTCT	prevention of mother-to-child transmission
PNFP	private-not-for-profit
RE	religious entity
RHA	religious health asset
RNILS	Reseau Nationale Islamique Luttre SIDA - National Islamic Network for the Fight against AIDS (in Mali)
SAPs	structural adjustment programmes
SSA	sub-Saharan Africa
STIs	sexually transmitted infections
SWAp	sector-wide approaches
TB	tuberculosis
TBAs	traditional birth attendants
THs	traditional healers
UCT	University of Cape Town
UN	United Nations
WHO	World Health Organization

GLOSSARY OF SELECTED TERMS

Access to health services: Percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour. (UNICEF)

African Religious Health Assets Programme (ARHAP): An international network of scholars and practitioners dedicated to developing a better understanding of and greater appreciation for the role of religious health assets for public health in sub-Saharan Africa.

African traditional healer (TH) denotes a complex typology and is constituted differently across Africa. This report pays attention to three types of indigenous health providers, or traditional healers: (i) Diviners practise on the basis of engagement with ancestral and spirit forces. (ii) Herbalists distinguish themselves as working solely with herbal remedies. (iii) Traditional birth attendants (TBAs) are community-based pregnancy and childbirth care providers, often providing general health advice and care. (ARHAP-WHO 2006)

Burden of disease: The total significance of disease for society beyond the immediate cost of treatment. It is measured in years of life lost to ill health as the difference between total life expectancy and disability-adjusted life expectancy. (UNESCO)

Congregational health initiative: health work linked to local congregation(s), with differing levels of formality and organisation.

District health system: This is comprised of a well-defined population, living within a clearly delineated administrative and geographical area, and including all organisations and individuals promoting health or providing health care. (WHO 1998)

Facility-based/non-facility-based: The report distinguishes between:

health services such as hospitals, clinics, surgeries, dispensaries – that are run from a facility, and usually provide formal health services;

health services such as support groups, home-based care, health education – which are taking place in communities and homes; such services are as a rule more informal and less dependant on external expertise and funding. There are exceptions, where high-tech interventions are operated from community groups.

Faith based organisation (FBO): Those religious entities that have a structured nature as well as religious support. This includes organisations and loose initiatives tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks (ARHAP WHO). The term excludes groups formed for the purpose of forming / developing / promoting a religious commitment, such as congregations or denominations.

Healthworld refers to people's conceptions of health and their health-seeking behaviour as framed by the background store of inherited or socialised knowledge that defines their being in the world. It is shaped by the health policies of governments, the variety of health practices available to them, and the interaction between health and religious practices, as well as questions of social development and environmental realities. (ARHAP)

Health workers: Individuals who are trained and employed to provide various health services.

Health system: A health system includes all actors, institutions and resources that undertake health actions, where a health action is defined as one where the primary intent is to improve health. Although the defining goal of a health system is to improve population health, other intrinsic goals are: to be responsive to the population it serves, determined by the way in which people are treated and the environment in which they are treated, and to ensure that the financial burden of paying for health is fairly distributed across households. (WHO, in HSP 2007)

Intersectoral action for health (IAH) is 'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone' (WHO 1997). This definition is interpreted to include collaborative action between different departments and bodies within government, as well as between actors within and outside government, such as civil society, including REs.

National faith-based health networks (NFBHNs): Country-level providers of health services, or networks of health service providers (e.g. Christian Health Associations) . (USAID 2007)

Policy: Broad statement of goals, objectives and means that creates the framework for activity. Often takes the form of explicit written documents, but may also be implicit or unwritten. (Buse et al. 2005)

Primary Health Care is understood as a strategy for organising health systems to promote health. It encompasses essential health care made universally available to individuals and families by a means acceptable to them and at a cost that the society can afford, as well as intersectoral action for health. It is the nucleus of a country's health system and contributes to national socio-economic development. It is founded on recognition of the need for political action to address the social determinants of health inequity, taking account of the particular configuration of power relations within any society. (PAHO 2007)

GLOSSARY OF SELECTED TERMS

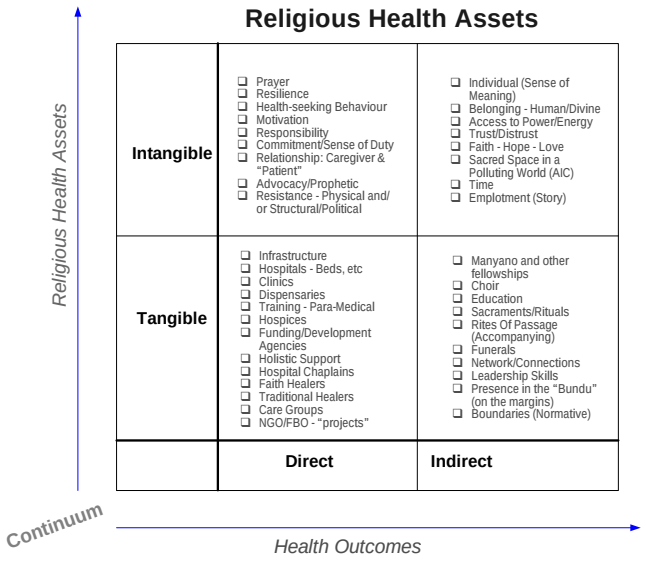
Pro-poor health care: Systems of health care in which the poor capture a larger share of public health care spending than the rich. (Mackintosh 2007)

Religion: A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations. (ARHAP WHO)

Religious coordinating body (RCB): Intermediary organisations responsible for supervising and coordinating religious activities of congregations; RCB may also supervise and support the health work of congregations. Examples: a diocese or National Evangelical Fellowship.

Religious entity (RE): This term seeks to capture the broad range of tangible RHAs, incorporating religious facilities, organisations as well as practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more traditional religious entities such as faith-based organisations, as well as those more amorphous entities such as individual traditional healers. (ARHAP WHO)

Religious health asset (RHA) is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith. (ARHAP WHO) RHAs may be tangible or intangible as illustrated in the RHA matrix below.[1]



Social determinants of health are the economic and social conditions under which people live which greatly influence collective and personal well-being. Determinants like unemployment, unsafe workplaces, urban slums, globalisation, gender and lack of access to health systems are known to be among the worst causes of poor health and inequalities between and within countries. (WHO)

Traditional healer: see African Traditional Healer

Traditional medicine: Indigenous treatment regimes which manifest themselves in three principal forms: (i) home or folk remedies, (ii) herbalist medicine, and (iii) diviner treatment regimes, or a combination of the three. (ARHAP WHO)

Vertical programmes: Targeted disease-specific programmes, e.g. ART, delivered through the health system. Such programmes can weaken the health system, are often separately funded, hence better resourced, and draw expertise and other resources away from the primary health care and essential health system functions.

1 Cochrane, J.R. 2006. "Understanding religious health assets for public health systems." DIFAM Consultationon Religion and Health. Tübingen, Germany.

QUESTIONNAIRE[2]

QUESTIONNAIRE FOR FBOS

The contribution of faith based organizations to health in sub-Saharan Africa

COVERSHEET

(To be completed by the researcher)

Study site – tick one shaded box	**Mali**	**Uganda**	**Zambia**
	Bamako	Kampala	Lusaka
		Gulu	Livingstone
			Ndola
		Name	Date- (dd/mm/yyy)
Research team member who requested the completion of the questionnaire:			
Reach team member who received the completed questionnaire:			
Checked for completeness by:			
Consent form signed:			
Copy of Annual report received:			

ARHAP Coding	GL - QF - -

2 A slightly simplified version of the questionnaire was used for faith based networks; for Uganda some terms were changed.

QUESTIONNAIRE

A. RESPONDENT AND ORGANISATION'S CONTACT DETAILS

1. Name of person completing the Questionnaire	First name(s)	Surname
2. Your position in the organisation		
3. Name of organisation		
4. Physical address of organisation:		
5. Name of District and Province		
6. Postal address (if different from Physical address)		
7. Email		
8. Telephone and fax	Tel:	Fax
9. Attach a copy of your latest annual report. Please indicate the reporting year.		Report year:

QUESTIONNAIRE

B. GENERAL INFORMATION ON YOUR ORGANISATION

1. NATURE AND HISTORY OF YOUR ORGANISATION

			Year
1. In what year did your organisation start working in this country			
2. In what year did your organisation start providing health services in this Country			
3. What type of organisation is this? (e.g. hospital (prim/sec/tertiary), clinic, HBC programme, ARV provision ….)			
4. Which category describes your organisation best? (Tick the appropriate block.)	Government/ public		Private for profit
	Private not for profit		Other (specify)
5. What is its mandate/mission statement? (Attach if available)			
6. What is the religious affiliation of the organization? (Tick appropriate block and specify denomination/group if applicable)	Christian		If Christian, specify Denomination
	Muslim		Other, specify:
7. Is your organisation affiliated to a religious umbrella organisation? (e.g. Catholic Relief Services, denominational body, Health desk of CCZ or similar)	Yes	No	If yes, name the umbrella org:
8. How would you describe the primary area of operations of your organisation? (Tick)	Urban	Peri urban	Rural
9. What percentage of the people served would be described as living in each of the following type of area? (Indicate by rough ten-percentiles, e.g. 0%, 10%, 20%, 30%, 40%, etc.)	Urban		%
	Peri urban		%
	Rural		%

2. INFRASTRUCTURE AVAILABLE AT YOUR FACILITY

Tick the blocks that describe your facility/facilities best.

1. Number of facilities/sites	Only 1	2-4	5-10	More than 10
2. Indicate the total number of beds and cots in your facilities	No of beds		No of cots	
If you have more than 1 facility/site please answer the remaining questions as they apply to the majority of these:				
3. Type of building/facility	Brick	Pre-fabricated	Shack	Other (Specify)
4. What best describes the ownership of the facility	We own it	Community owned	We rent it	We share it with others
5. Electricity	Always available	Sometimes available	Never available	
6. Clean water supply	Always available	Sometimes available	Never available	
7. Main source of water	Piped with own tap	Communal tap	Open well	Other (specify)
8. Reliable telephone (landline/cellular)	Always available	Sometimes available	Never available	
9. Reliable e-mail / internet	Always available	Sometimes available	Never available	
10. Ambulance / transport service	Always available	Sometimes available	Never available	

QUESTIONNAIRE

C. STAFF OF YOUR ORGANISATION AND HR TRENDS

1. IN THE LAST YEAR (2006/7) WHAT WERE THE NUMBER OF HEALTH CARE WORKERS IN YOUR FBO AND THEIR WORK STATUS?

Insert numbers where applicable or go to the next number if not applicable

Staff in your organisation	Total Number	Number of Positions vacant	No. who are Citizens of your country	No. who are Inter-national Staff	No. who No. who are Unpaid volunteers
1. Specialist doctors					
2. Doctor					
3. Nurse					
4. Pharmacist					
5. Trained midwife					
6. Physio-therapist					
7. Family planning worker					
8. Traditional birth attendant					
10. Social worker					
11. Home based carer					
12. Health educator					
13. Trainer					
14. Laboratory technician					
15. Nurse aide					
16. Administrative staff					
17. Cleaning staff					
18. Certified/registered HIV Counsellor					
19. General counsellor					
20. Spiritual counsellor					
21. Child care worker					
22. Other (specify)					
23. Other (specify)					

QUESTIONNAIRE

2. VACANT POSTS

This set of questions refers to losses of staff from your organisation and resulting vacant posts and skill shortages.

1. How much staff turnover do you experience?	Very high	A lot	Some	Little	Don't know
2. Explain how vacant positions impacted on the quality and scale of your service provision.					
3. List the skill area/areas where you have experienced the most staff losses over the last 5 years.					
4. What is the main reason for loss of staff from your FBO?					
5.Do you think that the problems you experience in this regard are similar to those in the public health system? (Tick one)	Similar		Different		Can't say
a. If they are different, please explain what is different.					

3. VOLUNTEER POLICY

1. Do you have volunteers working in or for your FBO? (Tick)	Yes	No	
If yes, please answer questions 2 – 3 below; If No, proceed to Sect 3.			
2. Do your volunteers receive stipends? (Tick)	Yes	No	
a. If Yes, how much do they receive per month? (state currency and amount)	Stipends range from …… to ……		
3. Do your volunteers receive other incentives? (Tick and/or specify)	Food parcels	Transport costs	Other (specify)

QUESTIONNAIRE

D. SERVICES PROVIDED

1. TYPE OF SERVICES PROVIDED AT YOUR FACILITY

Facility Type					
1. Indicate the primary identity of your FBO (Tick)	Health Provider	Development agency	Educa-tion provider	Support group	Other (specify):
2. If you provide health care indicate the level of care provided (Tick all that apply.)	Tertiary care	Secondary care	Primary care	Community based care	Other (specify):
	Out-patients / month	In-patients / month	HBC clients / month	Clients / month (non-medical)	
3. Number of people served through your medical and non– health services (Give approximate numbers)					
3. Do you provide dispensary services?	Yes	No	If yes, indicate number of patients served/ month		

2. ARE THESE HEALTH SERVICES AVAILABLE? IF YES, INDICATE THE NUMBER OF CASES SERVED / MONTH.

Please note additional questions below on non-health services (D3) as well as on Maternal, Newborn, Child and Reproductive health in Sect E.

	No	Yes	If Yes, No of cases / month
1. Mental Health service			
2. Treatment of chronic diseases			
3. Treatment of minor ailments			
4. TB treatment			
5. Malaria treatment			
6. HIV/AIDS awareness/prevention			
7. Voluntary counselling & testing (HIV)			
8. Anti-retroviral treatment			
9. X-ray facility			
10. Dispensary			
11. Nutrition support			
12. Palliative care			
13. Home based care			
14. Spiritual Counselling			
15. Training			If Yes, specify types of training provided
16. Other, specify			

QUESTIONNAIRE

3. NON-HEALTH SERVICES

1. Does your organisation conduct activities not directly related to health?	Yes	No
a. If YES: list the non-health services you provide		
b. If YES: approximately what percentage of the organisation's time was spent on health services in these years? (an estimate is good enough)	2001	%
	2006	%
	2007	%

4. TARGET GROUPS FOR SPECIAL SERVICES

1. Do any of your programmes provide specific targeted services to any of the following groups? (Tick **as many categories** as apply.)			
Migrant workers or others who partly live away from home	Long-distance transport workers (e.g. drivers)	Uniformed services	
Men who have sex with men	Women	Men	
Adolescent girls	Youths	Children under 5	
People with disabilities	Farm workers	People working in informal economy	
Commercial sex workers	Street children	Substance abusers	
Prison inmates or their families	Rural communities	Other minority groups (specify)	
2. Please list any other specific target groups not mentioned above. What specific services are targeted to these groups?			
3. Are you involved in behavioural change activities? (Tick)	Yes	No	
a. If Yes, describe the activity/activities.			
b. If yes, please describe the target group for which you provide these activities.			
4. Are there any health services that you specifically do not provide because of your faith basis?	Yes	No	Don't know
a. If Yes, list the health services and why they are not provided. explain			

QUESTIONNAIRE

5. CHANGE IN SERVICES PROVIDED

1. Are there services that you do not currently provide that you would like to provide?	Yes	No	Don't know	
b. If yes, what additional services would you like to provide?				
c. If Yes, what opportunities exist to offer these additional services? (e.g. funding, training,…)				
d. If yes, what would you need in order to be able to offer these additional services?				
Please explain				
2. Has the proportion of time spent on any of the above activities changed over the last two years?	Not at all	A little	Quite a lot	A lot
e. If Yes, What areas of health service activity are growth areas in your organisation?				
f. If Yes, What health service or activity in your organisation currently receives less attention than they did in previous years?				

QUESTIONNAIRE

E. SPECIFIC MNCR SERVICES PROVIDED

Does your organization address MNCR (maternal, newborn, child and reproductive health services) needs? If YES, complete the questions below. If not, skip to Section F on p 11.

1. MATERNAL HEALTH SERVICES

Maternal Health Indicators	The services available and accessible (Tick if Yes)
1. Antenatal care visit	
2. Management of PPH	
3. Syphilis/HIV screening and treatment	
4. Births in Health Facilities	
5. Trained Attendance at birth (including births at home)	
6. Caesarean sections	
7. Complication management of C/sections	
8. Emergency complication referrals	
9. Ambulance / Transportation to higher care	
10. Post natal care/ visits	
11. PMTCT	
12. TT	
	Number / month
13. Approximate number of clients served / month in Maternal health services	

QUESTIONNAIRE

2. NEWBORN HEALTH SERVICES

Newborn Health Indicator		Number / month
1. Number of births		
2. Number of births for whom you provide post delivery care		
	Services available and accessible	Further details
3. Post delivery care visits to facility		Indicate how many days after birth:
List services provided:		
4.Post delivery home care- e.g. clean delivery practices, exclusive breast feeding, thermal control, hygiene		Indicate how many days after birth:
List services provided:		
5.Special care low birth weight/preterm		What services are available:
1. Management of asphyxia		
2. Management of umbilical sepsis		
8.Tetanus post natal care		
9.Children under 1 year commence immunization programme		Age at 1st vaccination:
10.BCG administration		

QUESTIONNAIRE

3.CHILD HEALTH SERVICES

Child Health Indicators	Services available and accessible	Further detai			
1. Vaccination - measles		DPT1	DPT3	Quality	
2. Vaccination – other (specify)		DPT1	DPT3	Quality	
3. IMCI					
4. Treatment of diarrhea					
5. Pneumonia					
6. Other acute respiratory infections					
7. Malaria- prevention (Tick all that apply)		ITN	IRS	Intermittent preventive therapy	Other
8. Malaria- treatment					
9. AIDS		Specify services			
10. HIV follow-up on PMTC					
11.Other diseases and injuries		Specify services			
12.Pneumonia and case management of condition					
13.Malnutrition (Tick all that apply)		Identify maln.	Treat maln	Identify anemia	Treat anemia	Vit A Supp
14.Underweight children					
		Number / month			
14.Approximate number of clients served / month in Child health services					

QUESTIONNAIRE

4. REPRODUCTIVE HEALTH SERVICES

Reproductive Health Indicators	Services available and accessible
1.Do you provide the following contraceptive services?	
2. Female & male sterilization	
3. IUD	
4. Injectable	
5. Male & female condoms	
6. Diaphragm	
7. Foam/jelly	
8. Emergency contraception	
9. Do you provide the following services?	
10. Screening for cancer(Pap smears, Breast examination)	
11. STI's- prevention and treatment	
12. VCT	
13. PAC	
14. Are the RH services 'youth friendly'?	
	Number / month
15. Approximate number of clients served / month in Reproductive health services	

QUESTIONNAIRE

F. ANNUAL EXPENDITURE AND SOURCES OF FUNDING

1. EXPENDITURE

1. Please indicate your organisation's total expenditure on health services in the financial year 2006/2007. If not the last financial year, specify year……..	Amount and currency		
2. What percentage of this expenditure would you estimate was for:			
a. Maternal, Newborn, Child and Reproductive Health	%		
b. HIV services- health promotion and education, Voluntary counselling and testing (VCT) and PMTCT, awareness campaigning, provision of ART	%		
c. Other health services, specify:	%		
3. What was your organisation's annual expenditure in the following years for:	2004	2005	2006
a. Total services			
b. Health services			

2. FUNDING

If you are willing to answer questions about your funding, please provide the following information regarding your health service funding in 2006.

1. What percentage of your income is raised through **user fees**?			
2. What is your policy regarding **user fees**?			
3. Source of funding (name)	**International source?**	**Amount of funding & currency**	**Project or area of activity that it covered**
Example: Royal Netherlands Embassy	*Yes*	*US$ 45,000*	*Food parcels for vulnerable children in 5 districts*
4. If you **receive other forms of support** (for example, staffing, equipment, supplies, drugs (vaccines), vehicles, donations of food, use of facilities) from sources not listed above, please give details about what you have received and from whom.			
Source of support	**International source?**	**Approximate value & currency**	**Nature of support**
Example: Ministry of Health	*No*	*US$ 45,000*	*ARVs for 150 patients*
5. Other comments:			

QUESTIONNAIRE

3. QUESTIONS ABOUT EXTERNAL FUNDING

1. What limitations or constraints do you experience around external funding? (Tick all that apply)	Funders impose conditions	
	Not allowed certain programmes	
	No funds for essential services	
	Insufficient infra-structural support	
	Uncertainty about long term support,	
	Unhelpful competition for funds	
	Other (specify):	
2. Are there agencies that help you access funding/act as	Yes	No
a. If Yes, list the most important agencies and what kind of		
3. What are the key areas you think funders should		
4. When considering the problems in the public health system in meeting the health service needs of communities, for which services do you think additional funding could be helpful to overcome the gaps?		

QUESTIONNAIRE

G. COLLABORATION WITH FBOS AND OTHER AGENCIES

1. List three most important FBOs you collaborate with. Why? Please explain why you consider them important.	List 3 most important FBOs		Why? Because they …..		
	1.				
	2.				
	3.				
2. List three most important faith based networks for you? Why? Please explain, (e.g. training, funding, service provision, referrals to the state)	List 3 networks		Explain		
	1.				
	2.				
	3.				
3. List three other important partners for you who are not faith based? Why? Please explain the nature of the partnership (e.g. training, funding, service provision, referrals to the state)	List		Explain		
	1.				
	2.				
	3.				
4. Is there something that could be achieved by greater collaboration?	Yes		No		
a. If Yes, what could be achieved and why has this not happened?					
5. What barriers are there to better collaboration with other FBOs? Please explain, e.g. funding/ religious values/ competition for clients.					
6. How would you rate your links with government?	Excellent	Very Good	Good	Not good	Poor
7. Describe your relationship with government, e.g co-referrals, staff support.					
8. Would better collaboration between FBOs and the public health system improve health services? Why? Please explain.	Yes		No		
	Why?				
9. What barriers are there to better collaboration with Government? e.g. funding/ religious values					

QUESTIONNAIRE

H. THE FAITH-BASED NATURE OF YOUR ORGANISATION

1. How important is the faith dimension to the staff and leadership of the organisation? (Tick one)	Most important			
	Very Important			
	Some what important			
	Not important			
	Don't know			
2. In what ways would you say that your health services are 'different' due to them being delivered by a FBO?				
3. Describe the support provided by your FBO to your health care personnel?				
4. Is this support for health workers different compared to what is done in public health services? Please explain:				
5. In your opinion, do FBOs have any advantage in health care service provision over other service providers? What are these advantages?				
6. In your opinion, do FBOs have any disadvantage in health care service provision over other service providers? What are these disadvantages?				
7. How do you think FBO's are perceived by the following stakeholders (Tick one of the blocks for each stakeholder below and add an explanation in the last column):				
	Very favourable	Somewhat favourable	Somewhat unfavourable	Very unfavourable
a. Communities you serve				
b. Public sector health workers				
c. Private sector health workers				
d. Government				

KEY INFORMANT INTERVIEW SCHEDULE

ARHAP Coding	**GL - KI - -**
Date	Name:
	Org:

CONTEXT/HISTORY

The interviewer will have already established background on the Country's health system, current issues from set up visit and background reading.

1.1. What do you think are the key issues facing health services in your country/ region?
1.2. Are there new or planned policies (health, macro-economic) that will impact on PNFPs providing health services?
1.3. Some people have said 'when national health systems fail, people turn to religious entities' – how relevant do you think this is in your context? And why?

CAPACITY OF PNFPS AND THE SERVICES THEY PROVIDE

1.4. Describe how you see the capacity of PNFPs to deliver essential health services?
1.5. What health services do PNFPs provide?
1.6. Are there services they don't provide? Why not
1.7. Are PNFPs providing health services concentrated in certain spatial areas? And where? If so, why?
1.8. The funder has asked especially about a range of services for women and children (below). Do you have data on the country/ region's provision of the services below? We are also looking for the extent to which PNFPs are providing these services? Do you have this data, or do you know where can we get it?

Now: Hand them a separate sheet (see end)

PERCEPTIONS OF PNFP CONTRIBUTION TO HEALTH

1.9. How do you perceive PNFPs as health service providers?
1.10. How do you think PNFPs are perceived as health service providers by other stakeholders? Clients / MoH / Other (Private) providers
1.11. Thinking about PNFPs providing health services, how do you perceive the opportunities, gaps in their services, and their relative advantage as health providers. Disadvantages?
1.12. Has your perception of PNFPs as health service providers changed over time? If so why?
1.13. Has the perception of others, of 'PNFPs as health service providers' changed over time?

KEY NETWORKS/COLLABORATION BETWEEN PUBLIC HEALTH AND RELIGIOUS SERVICES

1.14. Please describe the key PNFP networks in your country/ region that provide health services?
1.15. We are interested in how they work; who belongs, what services or supports are provided by the networks and what benefits are gained. In addition, who leads them & how the type of leadership impacts on their success?
1.16. Please describe the relationship between different PNFP health service providers, the ways in which they collaborate (distinguish between levels – national/regional/local)
1.17. Please describe the relationship between PNFP health service providers and public health agencies in general (distinguish between levels – national/regional/local)

The potential role of PNFPs in health services

1.18. What would be needed to make PNFPs providing health services to be more effective and sustainable?
1.19. Do you see PNFPs as potentially being able to fill gaps in health service provision? How? Why?
1.20. What would be the factors limiting (constraints/ barriers) PNFPs filling these health service gaps?? What is needed for them to be able to fill some gaps?

KEY AREAS FOR INVESTMENT

1.21. Who provides the financial and/or material support for PNFPs providing health services?
1.22. Describe how you understand the extent and nature of funding of PNFPs providing health services from multiple sources such as donors, government (national), churches, membership etc?

KEY INFORMANT INTERVIEW SCHEDULE

1.23. What specific inputs are funded by government or other funding agencies eg salaries or buildings?
What critical inputs for MNCR (eg vaccines, vertical disease program drugs [ACTs, TB drugs], or ORS).
1.24. If international donors were interested in specifically funding PNFPs providing health services, would there be specific things you would suggest be funded? If so what and why?
Are there any services that PNFPs should not be funded to do? Why?

CLOSING

We have discussed a range of issues, perhaps you had additional comments/ questions? It would be good to talk about them now before closing.

Reports requested:

General health indicators:

Mortality
Hospitalisation rates
MNCR

FOCUS GROUP DISCUSSION GUIDE

The FBO representatives attending the Focus Group would already have completed the questionnaire for their organisation.

The aim of the focus group is to probe certain issues further. These issues will be guided by the country and local contexts and information gleaned from the country desktop reviews, field work set up phase as well as the Key Informant Interviews that would have preceded the focus groups.

Perceptions about FBO provided health services

- How are FBOs perceived by stakeholders (ie communities, beneficiaries, public sector counterparts, influential decision makers)?
- To what extent are FBO health services seen or experienced as 'different' because of their faith-based nature?
- How do other stakeholders (eg donors, Ministry of Health, beneficiaries) see the opportunities and/or gaps in

FBO health services?

- Do they see a relative advantage for FBOs as health providers, and if so, in what way?

FBO health services

- What do you think are the critical issues regarding the financial and/or material support for FBO health providers that impact on the scale, effectiveness and sustainability of the services provided?
- Are intermediaries important to the capacity of FBOs to deliver essential services, and if so, what do you think is their impact on the sustainability of these services?

FBO networks and collaboration

- We want to understand the role and nature of key FBO networks better. How do these networks operate? What benefits accrue to those who are actively involved? Are there groups that are excluded? Who and Why?
- How do FBOs collaborate with other FBO and with governments and other private sector providers for purpose of access to essential services and resources. How do you see the potential for further collaboration?
- Are there best practices in Africa of how access to essential health services and resources has been ensured through collaboration between FBOs and with governments? What potential exists for further collaboration (or stronger collaboration where they already exist?

Investment in FBOs as health service providers

- What is your advice re potential areas of investment?
- We have been asked to identify key areas for potential investment in health services. Help us to understand the potential of additional funding to help to address gaps, constraints, or barriers to increased effectiveness in improving population health outcomes…. as well as if additional resources are needed to help FBO health services to expand in scope and scale if appropriate.

INFORMATION SHEET: KEY INFORMANT INTERVIEW

INFORMATION SHEET AND CONSENT FORM FOR RESPONDENTS [3]

Study conducted by ARHAP

Funded by the Bill & Melinda Gates Foundation

Key informants on FBOs providing health services in Mali, Uganda and Zambia will be asked to participate in this study. This information sheet provides details about the research study, so that you are able to give your informed consent to participate in this study.

We are conducting a 3 country case study of Faith Based Organizations (FBO) and Networks providing health services. The purpose of the study is to describe the contribution of faith based organizations, institutions and networks to the health of vulnerable populations in resource-poor areas of Sub-Saharan Africa (SSA).

- **The procedures for the study?**

The study consists of two parts:

1. A self-administered Questionnaire completed by representatives of key FBOs that provide health services, followed by a Focus Group Discussion of FBO representatives.

This is complemented by the part of the study in which *your involvement* is requested, i.e.:

2. A semi-structured interview with key informants on the health service, addressing the broader health context, the faith-based contribution to health services, networking & collaboration and key areas for investment . This interview will be recorded.

- **What are the expected benefits to you or to others for participating in this research study?**

You will not be paid for your participation in the study but can be reimbursed for any expenses.

The results of this research study, commissioned by an international health funder, will be used to identify areas for investment that would accelerate, scale up and sustain access to effective health services, and/or encourage policy and resource development in African countries.

- **Your right to participate, not participate, or withdraw from this study.**
  - Your participation in this study is voluntary. Complete answers are most helpful for the research, but if you decide to participate, you may refuse to answer any question and you are free to stop at any time.
  - We expect that completing the interview will take 1 to 2 hours.
  - All information collected for the study will be kept confidential. Your responses to our questions will only be used for research purposes.
  - You have the right to ask questions at any point before or after the interview.
  - This study has been reviewed and approved by the ethical review committee of The University of Cape Town.

- **Who is carrying out this study?** Researchers from the University of Cape Town and the Medical Research Council, all of them linked to the African Religious Health Assets Program (ARHAP) in conjunction with a local team of researchers. The principal investigators are Barbara Schmid and Liz Thomas.

If you have questions about this study you can contact Barbara Schmid at +27 - 21 650 3457 or + 27 - 72 402 1495 or Barbara.schmid@uct.ac.za or the local researcher for Uganda, Dr Peter Lochoro at + 256 4126 7585.

If you agree to participate, please sign the attached consent form.

Should you not agree to participate, we thank you for letting us tell you about the research study.

3 There were slight variations in wording in the Information sheets for the FGD participants; and different contact information for the different countries.

INFORMED CONSENT FORM: KEY INFORMANT INTERVIEW

Study conducted by ARHAP
Funded by the B & M Gates Foundation

By signing below, I confirm that I have been informed about the research into Faith-based health services and that I agree (initial the appropriate blocks you agree to)

to be interviewed;	
to have the process taped;	
to have photos taken.	

If there is any part of the subject information sheet that you do not understand or you want to know more about, you should ask the researcher before signing.

SIGNATURE OF PARTICIPANT _____

PRINTED NAME _____

ORGANISATION _____

DATE _____

SIGNATURE OF RESEARCHER _____

PRINTED NAME _____

LOCATION _____

LISTS OF KIIS AND FGD PARTICIPANTS

A. KEY INFORMANTS

Name	Organisation	Position
Zambia		
Dr Godfrey **Biemba**	Ministry of Health	Assistant Director Public Health & Research;
Abraham **Chikasa**	Christian Council of Zambia	Head of Programmes
Dr B **Chirwa**	National AIDS Council	Director general
Mr Mufalo **Ilitongo**	Catholic Diocese of Ndola	Co-ordinator: Healing & Health
Christopher Chabu **Kangale**	International HIV/AIDS *Alliance*	Programme Director
Dr Simon **Mphuka**	Churches Health Association of	Executive director
Bish Paul E **Musuku**	Evangelical Fellowship of Zambia	Director
Chikalamba **Muzyamba**	World Vision	District co-ordinator, Kitwe
Alick **Nyirenda**	Copperbelt Health Education Project	Exec Director
Dr Caroline **Phiri Chibawe**	Ministry of Health, Southern Province	Provincial Director
Lameck **Simwanza**	Women for Change	Staff member
Sydney M **Sipia**	Network of Zambian People Living	Member of Executive Committee,
Dr Rodwell **Vongo**	THPAZ	President
Uganda		
Dr Juliet **Bataringaya**	WHO	National professional officer, Health System
John Kikanu **Byarugaba**	Inter-religious Council of *Uganda*	HIV/AIDS Programme coordinator
Marc **Denys** and others	Public private partnership for health	Belgian Embassy, Members of PPPH donor
Dr Daniele **Giusti**	Uganda Catholic Medical *Bureau*	Executive Secretary
Dr Henry **Katamba**	Uganda Protestant Medical Bureau	Executive Secretary
Musanje **Kikulwe**	Mukono district health office	Secretary for health
Dr Ahmed **Kiswezi**	Uganda Muslim Medical *Bureau*	Executive Secretary
Dr Peter **Lochoro**	CUAMM	
Dr Jackson Abusu **Ojera**	UNICEF - Gulu zonal office	Health officer
Dr Paul **Onek**	Gulu district health office	District health officer
Dr Francis **Runumi**	Ministry of Health	Commissioner Health Services in charge of
Dr **Tumushabe**	Mukono district health office	District health officer

LISTS OF KIIS AND FGD PARTICIPANTS

Mali		
Dr Dabo **Garan**	Islamic Relief	Medical doctor, responsible for health
Dr Binta **Keita** Diagne	MOH	Divisional head, Reproductive Health
Dr Nouhoum **Koïta**	CARE International au Mali	Child survival centre – Director, works with the MOH in support of CSComs
Prof M. **Koumare**	Traditional Healers' Network	Director general of Somepharko SA
Modibo **Maiga**	Health Policy Initiative	Director - Mali & region
Issaka **Sangare**	Sectoral AIDS Committee; Journalists for health	Communication desk for AIDS Committee; Coordinator Journalists for Health
Dr Lamine Cisse **Sarr**	WHO	Country director
Christine **Sow**	USAID - Mali	Health Team Leader
Past Daniel **Tangara**	Protestant health association *of* Mali	Connected to PHAM, involved in HIV work in the church
Namori **Traore**	MOH	Deputy director, National Directorate of Health
I. Maiga, S. Y. Sangare, M. Fofana	Population Services International	Staff team
	World Vision	Staff member

B. FOCUS GROUP DISCUSSION PARTICIPANTS

Location	Name	Organisation
Zambia - Livingstone		
	Jakub J **Banda**	Livingstone Moslem Society
	Past **Banda**	Calvary Chapel Church
	Sr Isabela/ Estella M **Bupe**	Linda Cath Church/Youth Alive
	Sr Mary **Courtney**	St Francis Home Based Care
	Mr **Kabwe**	Calvary Church OVC centre
	Rev Lane C **Kaluba**	UCZ Coillard Memorial
	Fr Jackson **Katete**	Livingstone Anglican Children's Project
	Rev Smart **Kobola**	Dambwa Assemblies PAOG
	Rev W **Mbulwe**	Abundant Life Church
	Mr Timothy **Miyoba**	ZINGO South
	Past Emeloah **Phiri**	Faith & Grace (Outreach Ministries)
	Past Buster **Tembo**	New Life Church for all Nations
	Mr K **Zyambo**	Mwenda Clinic
Zambia - Lusaka		
	Weston **Chewe**	Campus Crusade
	Anita Dick **Dumba**	Mother of Mercy Hospice
	Dr John **Hanoka**	Chreso Ministries
	Paul **Macek**	Catholic Relief Services
	Edward **Martin**	Adventist Health International Zambia
	Derrick **Mweemba**	Zambia Episcopal Conference
	Crispin **Sanjase**	New Apostolic Church
	Hope **Siwale**	Evangelical Fellowship of Zambia

LISTS OF KIIS AND FGD PARTICIPANTS

Zambia - Ndola		
	Kabwe C **Chikolwa**	UCZ - Clinical Pastoral Care Centre
	Mr Mufalo **Ilitongo**	Catholic Diocese of Ndola
	Emilio **Kunda**	Twafane Christian Community Care
	Rosemary M **Makarani**	Integrated AIDS Programme (Cath Diocese)
	Ebston **Mambwe**	Bwafwano Women's group
	Matilda **Mtonga** (FGD)	Cicetekelo Hospice
	Muzyamba **Pimm**	Copperbelt Health Education Project CHEP
	Agnes **Zalila**	World Vision
	Newton **Zulu**	Bridge International
Uganda – Kampala 1: lower level health centres		
	Regina **Bakiite**	
	Kyohainwe Sylvia **Bohibwa**	
	Peter **Byansi**	Kamwokya Christian Caring Community
	Gordon **Kitaka**	
	Dr Hafsa **Lukwata**	Uganda Women Muslim Tabliq Association
	Nabuufu **Rehema**	
	Zaituma **Ziraba**	
Uganda – Kampala 2: hospitals		
	Dr G W **Bukenya**	Mengo hosp
	Dr Joseph **Bukenya**	Rubaga Hosp
	Dr Kaliisa **Cassim**	Old Kampala Hosp
	Dr A **Kakeeto**	Saichi Abubakou Islamic hosp
	Dr Namaganda **Kituuka**	St Raphael-St Francis Hosp
	Dr Sinan **Mbulambago**	Kibuli Muslim Hosp
	Dr Charles **Mugume**	St Stephens
Uganda - Gulu		
	Sr Emilly **Acircan**	St Mauritz H/C I/
	Millie **Among**	St. Mary's Hospital Lacor
	Abdul R. **Kilama**	Acholi Religious Leaders Peace Initiative
	Dr Martin **Ogwang**	St Mary's Hospital Lacor
	Christopher **Okello**	Diocese of Northern Uganda, Gulu
	George Mark **Oroma**	St Joseph's Minakulu HCII
Uganda - Mukono		
	Denis **Bakorueza**	Lugazi DHO
	Namagala **Betty**	Kyetume CBHC Programme
	Peter **Bukenya**	Office of DHO
	Dr Kizito **Drake**	Mukono Health centre II
	Sr Ambrose **Kibuuli**	Nkokonjero hospital
	Rev Enos Kagodo **Kitto**	Mukono Diocese
	John M **Kiyimba**	Kyetume CBHC Programme
	Sr Mary Rose **Nahufima**	Ttakajjunge Health centre
	Charle **Nkusi**	St Francis Naggarama Hospital
	Sr Mary **Steven**	St Francis Nyenga

C. INFORMANTS FOR THE LOCAL CASE-STUDIES IN MALI

The National Islamic Network for the Fight Against AIDS

- El Hadj Sidi Konaké
- El Hadj Mamadou Traoré
- Mafounè Soucko
- El Hadj Wahid

Faladié health centre

- Kassim Soumaoro, 2nd Deputy Mayor
- Mamadou Bah, 3rd Deputy
- Naba Seydou Traoré, Communal Councillor
- Soumaïla Traoré, Accountant
- Dosséké Traoré, Village Councillor
- Karim Traoré, Village Councillor
- Manè Traoré, Village Elder
- Sr Odile Tounkara, Pharmacy Manager

MIPROMA clinic

- Lassine Camara, General Treasurer
- Fousséini Doumbia, Member
- El Hadj Mamadou Traoré, Member
- Dr Hamadoun Sangho, Advisory Committee Member
- Mohamadou Lamine Djiguiné, Secretary to sports
- Abdoulaye Ballo, Section VI, Member
- Dr Brainina Coulibaly, Doctor of the Centre
- Abdoulaye Sangho, MIPROMA Centre
- Mayan Traoré, Vegetable vendor at the market
- Minata Doumbia, Rice vendor
- Kassim Diallo, Patient

SELECTED COLONIAL SYSTEMS IN AFRICA AND THEIR IMPACT ON HEALTH

	French	British	Belgian	German
Type of colonial administration	Centralised, controlled from Paris with one Dakar-based administration for the 9 countries, the leader of each being in turn responsible for local districts, limited French personnel but rather assimilated some of the African leaders.	Decentralised power from Westminster with African country/ protectorate administration based on strong settler cadre of officials.	**Belgium:** paternalistic colonialism - direct control of the mother country; no democratic institutions. Day-to-day operations were carried out by the governor general. The colony was divided into 15 administrative districts. The colonial budget was voted annually by the Belgian Parliament.	**Germany:** after 1907 reforms led the colonial administration to be a model of colonial efficiency. German colonial administrators relied heavily on native chiefs to keep order and collect taxes.
Countries	Tunisia, Morocco, French West Africa, Mauritania, Senegal, Cameroon, French Sudan (now Mali), Guinea, Ivory Coast, Niger, Upper Volta (now Burkina Faso), Dahomey (now Benin), French Equatorial Africa, Gabon , Middle Congo (now the Republic of the Congo), Oubangi-Chari (now the Central African Republic), Chad, French Somaliland (now Djibouti), Madagascar, Comoros.	Egypt, Anglo-Egyptian Sudan (now Sudan), British East Africa, Kenya, Uganda, British Somaliland, Southern Rhodesia (now Zimbabwe), Northern Rhodesia (now Zambia), Bechuanaland (now Botswana), South Africa, The Gambia, Sierra Leone, Nigeria, Cameroon (western provinces), British Gold Coast (now Ghana), Nyasaland (now Malawi).	**Belgian** Congo Free State and Belgian Congo (formerly Zaire, now Democratic Republic of Congo).	**Germany**: German Kamerun (now Cameroon), German East Africa (now Burundi, Rwanda and Tanzania) German South-West Africa (now Namibia), German Togoland.
How colonial administration impacted on health	Health was not one of the primary activities arranged from France but was managed for all the colonies by one ministry in Dakar.	Mission hospitals were originally set up to service the health needs of the extensive colonial settlers.	In the Congo primary and high schools were built as well as hospitals, and many Congolese had access to them. Even the ethnic languages were taught at school, a rare occurrence in colonial education. Doctors and medics achieved great victories against malaria.	

INTERNATIONAL FAITH BASED ORGANISATIONS

Listing of some of the international FBOs investigated during the desk review process

ORGANISATION NAME	ACRONYM	LOCATION OF ORG	AREA OF AFRICA ATTENTION	WEB ADDRESS
AIDS Care Education and Training	ACET	UK	SSA, INCLUDING: DRC, Nigeria, South Africa, Uganda, Zimbabwe…	www.acet-international.org
Action by Churches Together	ACT	Switzerland	SSA, INCLUDING: DRC, Uganda, Kenya, Zambia, Malawi...	www.act-intl.org
Adventist Development and Relief Agency International	ADRA	USA	SSA	www.adra.org
African Jesuit AIDS Network	AJAN	Kenya	SSA	www.jesuitaids.net
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	ANARELA	South Africa	SSA	www.anerela.org
Aga Khan Development Foundation	AKDF	France	SSA, INCLUDING: Kenya, Uganda, Tanzania…	www.akdn.org, www.agakhanhospitals.org
All African Conference of Churches	AACC	Kenya	SSA	www.aacc-ceta.org/en/default.asp
Anglican Communion	AC	Various	SSA	www.anglicancommunion.org
Caritas International	CARITAS	Vatican	SSA, INCLUDING: Africa, DRC, Liberia, Nigeria, Mali, Kenya, Ghana, Lesotho, Malawi, Senegal, Uganda, Zambia…	www.caritas.org
Catholic Agency for Overseas Development	CAFOD	London, UK	SSA	www.cafod.org.uk
Catholic Medical Missions Board	CMMB	USA	SSA, INCLUDING: Kenya, Botswana, Nigeria, South Africa, Swaziland, Zambia, Lesotho, Namibia…	www.cmmb.org
Catholic Relief Services	CRS		SSA, INCLUDING: Kenya…	www.catholicrelief.org
Christian AID	CA	UK	SSA, INCLUDING: DRC, Ghana, Kenya, Lesotho, Malawi, Mali, Nigeria, Senegal, Tanzania, Uganda, Zambia	www.christian-aid.org.uk
Christian AIDS Bureau of Southern Africa	CABSA	South Africa	SSA	www.cabsa.co.za/newsite/index.asp
Christian HIV/AIDS Alliance	CHAA	UK	SSA	www.chaa.info
Christian Relief and Development Agency	CRDA	various	SSA	
Church Mission Society	CMS	UK (various)	SSA, INCLUDING: Burundi, Rwanda, Kenya, Uganda, Tanzania, Nigeria and DRC…	http://www.cms-uk.org
Church of Sweden AID		Sweden	SSA	www.svenskakyrkan.se
Church World Service	CWS	USA	SSA	ww.churchworldservice.org/ www.cwsea.org/
DanChurchAid		Denmark	SSA, INCLUDING: Angola, Malawi, Burundi, DRC, Ethiopia, Kenya, Sudan, Uganda, Zimbabwe, Tanzania, Zambia…	www.danchurchaid.org
Ecumenical HIV/AIDS Initiative in Africa	EHAIA	Geneva, SWZ	SSA	www.wcccoe.org/wcc/what/mission/ehaia-e.html
Ecumenical Pharmaceutical Network	EPN	Nairobi, Kenya	SSA, INCLUDING: Zambia, Uganda, Kenya, Malawi, Ghana…	www.epnetwork.org/en/access
Emmanual Healthcare	EMMS	USA	SSA, INCLUDING: Malawi…	www.emms.org/about/index.php
Federation of Islamic Medical Associations	FIMA	Islamabad	SSA, INCLUDING: Senegal, Uganda…	www.fimaweb.net/main/index.html
German Institute for Medical Mission	DIFAEM	Germany	SSA, INCLUDING: Kenya, Malawi, Ghana…	www.difaem.de
Global AIDS Interfaith Alliance	GAIA	USA	SSA	www.thegaia.org
IMA World Health	IMA	USA	SSA, INCLUDING: Kenya, DRC, Zambia…	www.interchurch.org
Inter-Church Organisation for Development	ICCO	Netherlands	SSA	www.icco.nl
International Dispensary Association	IDA	Netherlands	SSA, INCLUDING: Uganda, Zambia, Kenya…	www.idafoundation.org
Islamic Relief Worldwide	IR	Birmingham. UK	SSA, INCLUDING: Ethiopia, Kenya, Malawi, Mali, Niger, South Africa, Sudan, (Chad)	www.islamic-relief.com
Lutheran World Federation	LWF	Geneva, SWZ	SSA	www.lutheranworld.org
Medical Assistance Program, International	MAP	Nairobi, Kenya	SSA	www.map.org
Medicus Mundi International	MMI	Geneva, SWZ	SSA	www.medicusmundi.org
Mildmay International		UK	SSA, INCLUDING: Uganda, Kenya, Zimbabwe, Tanzania…	www.mildmay.org.uk

APPENDIX 4.1

INTERNATIONAL FAITH BASED ORGANISATIONS

Mothers' Union	MU	UK	SSA	www.themothersunion.org
Norwegian Church Aid	NCA	Norway	SSA, INCLUDING: Zambia, Malawi, Lesotho. . .	//english.nca.no
Pan African Christian HIV/AIDS Network	PACANet	Kampala, Uganda	SSA	www.pacanet.net
Pan African Christian Women Alliance	PACWA	Kenya	SSA, INCLUDING: Kenya. . .	
Presbyterian Church USA – International Health Ministries	PC USA - IHM	USA	SSA	www.pcusa.org/health/international/
Salvation Army: International	SA	Various	SSA, INCLUDING: DRC, Congo, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Saint Helena, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe. . .	www1.salvationarmy.org/ihq/www_sa.nsf
Samaritan's Purse	SP	USA	SSA	www.samaritanspurse.org
Secours Catholique	SC	France	SSA, INCLUDING: CAR. . .	www.secours-catholique.asso.fr/
Serving in Mission	SIM	Various	SSA	www.sim.org
Swedish Evangelical Mission	SEM	Sweden	SSA	www.efs.nu
Tearfund		UK	SSA, INCLUDING: Angola, Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania and Zambia. . .	www.tearfund.org
The Episcopal Relief and Development	ECUSA	USA	SSA, INCLUDING: Angola. . .	www.er-d.org
United Evangelical Mission	UEM	Germany	SSA	www.vemission.org
United Methodist Committee on Relief	UMCR	USA	SSA	//new.gbgm-umc.org/umcor
United Society for the Propagation of the Gospel	USPG	UK, London	SSA, INCLUDING: Ghana, Angola, Mozambique, Namibia, South Africa,	www.uspg.org.uk
World Conference of Religions for Peace	WCRP	USA, Kenya	SSA, INCLUDING: Uganda, Kenya, Malawi, Mozambique, Namibia,	www.wcrp.org
World Council of Churches	WCC	Geneva, SWZ	SSA	www.wcc-coe.org
World Faiths Development Dialogue, The	WFDD	UK	SSA	www.wfdd.org.uk
World Federation of Catholic Medical Associations	FIAMC	International	SSA	www.fiamc.org
World Hope International	WHI	Canada	SSA, INCLUDING: Liberia, Zambia, Malawi, Mozambique, South Africa. . .	www.worldhope.org/countries/zambia.htm
World Relief	WR	USA	SSA, INCLUDING: Burkina Faso, Burundi, Congo, Kenya, Malawi,	www.wr.org
World Vision	WV	USA, Geneva SWZ	SSA, INCLUDING: Zambia, Uganda, Mali. . .	www.wvi.org,
Young Men's Christian Association	YMCA	International, local	SSA	www.ymca.int
Young Women's Christian Association	YWCA	International, local	SSA	www.worldywca.org

NATIONAL FAITH BASED ORGANISATIONS

APPENDIX 4.1 continued

NATIONAL FAITH-BASED ORGANISATIONS

It is impossible to list here the hundreds of national FBOs encountered through the desk review process. (See the country profiles above for a few examples).

Some key, national, associated forms were:

- → Denominational bodies
- → Churches and congregations of any faith, running health programs
- → Catholic Doctor's Guilds
- → Catholic Health Services
- → Catholic Health Care Associations
- → Christian Councils
- → Islamic Councils
- → Islamic Medical Associations
- → Traditional Healers Associations
- → Women's Fellowships
- → Christian Medical Fellowships
- → Inter-religious Councils
- → Interfaith Fora

ORGANISATIONS WITH FBO RESEARCH

Several organisations were found to have significant information on the FBO landscape. These included:

- → International agencies: e.g. WHO, DFID, UNFPA, UNICEF, USAID, World Bank
- → ARHAP: African Religious Health Assets Programme www.arhap.uct.ac.za
- → CADRE: Centre for AIDS Development, Research and Evaluation www.cadre.org.za
- → CEDPA: Centre for Development and Population Activities www.cedpa.org
- → CCIH: Christian Connections for International Health www.ccih.org
- → CORAT: Christian Organisations Research Advisory Trust www.coratafrica.com
- → FHI: Family Health International www.fhi.org
- → HEARD: Health Economics and Research Division www.und.ac.za/und/heard
- → HERA: Health Research for Action www.herabelgium.com/en/hera/hera.php
- → HIVAN: Centre for HIV/AIDS Networking www.hivan.org.za
- → HSRC: Human Sciences Research Council South Africa www.hsrc.ac.za
- → PEPFAR: The United States President's Emergency Plan for AIDS Relief www.pepfar.gov/partners
- → The Policy Project www.policyproject.com
- → Sexual Health Exchange www.sexualhealthexchange.org
- → The CORE Initiative www.coreinitiative.org

NATIONAL FAITH BASED ORGANISATIONS

APPENDIX 4.1 continued

NATIONAL FAITH-BASED HEALTH NETWORKS

ORGANISATION NAME	ACRONYM	LOCATION OF ORG	WEB ADDRESS
Angolan Council of Christian Churches	CICA	Angola	www.cicaangola.org
L'Association Protestant des Oeuvres Medico-sociales du Togo (The Protestant Association Medico-Social Works of Togo)	APROMESTO	Togo	
Association of Medical Missions for Botswana	AMMB	Botswana	
Bureau des Formations Médicales Agréees de Rwanda [The Office of Church-affiliated Health Facilities in Rwanda]	BUFMAR	Rwanda	
Christian Health Association of Ghana	CHAG	Ghana	www.chagghana.org
Christian Health Association of Kenya	CHAK	Kenya	www.chak.or.ke
Christian Health Association of Lesotho	CHAL	Lesotho	
Christian Health Association of Liberia	CHAL	Liberia	
Christian Health Association of Malawi	CHAM	Malawi	
Christian Health Association of Nigeria	CHAN	Nigeria	//channigeria.org
Christian Health Association of Sierra Leone	CHASL	Sierra Leone	
Christian Health Association of Sudan	CHAS	Sudan	www.ccih.org/grham/country/sudan
Christian Health Association of Swaziland	CHAS	Swaziland	
Christian Health Association Platform (in Kenya)	CHA	Kenya	
Christian Relief and Development Association	CRDA	Ethiopia	www.crdaethiopia.org
Christian Social Services Commission (CHA Tanzania)	CSSC	Tanzania et al	www.cssc.or.tz
Church Ecumenical Action in Sudan	CEAS	South Sudan	
Churches Health Association of Zambia	CHAZ	Zambia	www.chaz.org.zm
Council of Churches in Namibia	CNN	Namibia	
Eglise du Christ au Congo	ECC-DRC	DRC	http://ecc.faithweb.com/
Eglise Protestant du Senegal Commission Medicale	EPSCM-SEN	Senegal	
Federation of Protestant Churches and Missions in Cameroon	FEMEC-CAM	Cameroon	www.wagne.net/femec/gb/members.htm
Kenya Episcopal Conference	KEC	Kenya	www.kec.or.ke
Oeuvres médicales des Eglises pour la Santé en CentrAfrique	ASSOMESCA	Central African Republic	
South African Catholic Bishops Conference	SACBC	South Africa	//sacbc.org.za/
South African Council of Churches	SACC	South Africa	www.sacc.org.za
Uganda Catholic Medical Bureau	UCMB	Uganda	www.ucmb.co.ug
Uganda Protestant Medical Bureau	UPMB	Uganda	www.upmb.co.ug
Uganda Muslim Medical Bureau	UMMB	Uganda	
Zimbabwe Association of Church Related Hospitals	ZACH	Zimbabwe	

ADDITIONAL BIBLIOGRAPHY

See Castle 2007 and Olivier et al 2006 (listed in the Chapter bibliography) for further resources

Abate E. 2001. Human sexuality and AIDS: An Ethiopian church perspective. *Word and World.* **21**(2), pp.152-159.

Agadjanian V. 1999. Women in Zionist churches in greater Maputo, Mozambique: healing, social networks, and survival strategies. *Annual Meeting of the African Studies Association, 11-14 November 1999, Philadelphia, PA.*

ANARELA+. 2007a. *Interfaith positive action: 2006 general report.* South Africa: (ANARELA+) African Network of Religious Leaders Living with or Personally Affected by HIV&AIDS.

ANARELA+. 2007b. [online]. ANARELA+ website. [Accessed 04/09/2007]. <www.anerela.org>

ARHAP. 2003. *Assets and agency: Papers and proceedings.* Report on ARHAP Assets and Agency Colloquium. Pietermaritzburg. South Africa: (ARHAP) African Religious Health Assets Programme.

ARHAP. 2004. ARHAP: *Tools workshop report.* Report on ARHAP: Tools Workshop Colloquium. Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme.

ARHAP. 2005. ARHAP: *Case study focus - papers and proceedings.* Report on ARHAP: International Case Study Colloquium. Johannesburg, South Africa: (ARHAP) African Religious Health Assets Programme.

Baer FC. 1998. The role of church groups in managing health districts. CCIH Forum, November 1998. (CCIH) Christian Connections in International Health.

Becker C. 2001. *Prolégomènes à une réflexion sur l'Etat colonial, le droit et la santé dans l'Ouest Africain francophone; Questionnaires à propos des pratiques et des réglementation sanitaires.* Bamako, Mali: CNRS Research paper.

Belshaw D, Calderisi R and Sugden C. 2001. Faith in development: Partnership between the World Bank and the churches of Africa. Washington, DC: World Bank and Regnum Books International.

Burket MK. 2006. *Advancing reproductive health and family planning through religious leaders and faith-based organisations.* Washington: Pathfinder International.

Bura M. 1999. *Community health funds and managed health care - a practical guide for provider-based health funds for communities in developing countries.* Arusha: (ELCT) Evangelical Lutheran Church in Tanzania.

Byamugisha G, Steinitz LY, Williams G and Zondi P. 2002. *Journeys of faith: Church-based responses to HIV and AIDS in three southern African countries.* Pietermaritzburg: Cluster Publications.

Caines K, *et al.* 2003. *Impact of public-private partnerships addressing access to pharmaceuticals in low income countries: Uganda pilot study.* [Accessed 24/08/2005]. <http://www.dfid.gov.uk/pubs/files/ipphaccesspharmaceuticalsuganda.pdf>

Calver V. 2000. *AIDS Orphans in Africa: Lessons learned and possible strategies for the local church and World Relief.* Nairobi, Kenya: World Relief, HIV/AIDS Team.

CDC. 2002. *Faith-based responses to HIV/AIDS in South Africa: Summary of findings.* (ASR) Africa Strategic Research Corporation, (CDC) Centres for Disease Control.

Chikwendu E. 2004. Faith-based organisations in anti-HIV/AIDS work among African youth and women. Dialectical Anthropology 28(3/4), pp.307-327.

Clifford P. 2003. HIV/AIDS and the Churches in Tanzania. London: UK. Christian Aid.

Cole J. 2006. Building bridges of hope: An evaluation of the Anglican Church of Southern Africa's response to the HIV and AIDS pandemic - the Isiseko Sokomoleza (Building the Foundation) Programme: 2003-2006. South Africa: Anglican Church of Southern Africa HIV & AIDS Office.

Crespo R. 2005. The future of Christian hospitals in developing countries: The call for a new paradigm of ministry. McLean, VA: (CCIH) Christian Connections for International Health.

Cucuzza L and Moch L. 2003. Faith community responses to HIV/AIDS: Integrating reproductive health and HIV/AIDS for non-governmental organisations, faith-based organisations and community-based organisations. Washington: (CEDPA) Centre for Development and Population Activities, and ENABLE Project.

Dawad S. 2005. Policy brief: Faith-based organisations and HIV/AIDS in Uganda and Kwa-Zulu Natal (South Africa). Durban, South Africa: (HEARD) Heath Economics and HIV/AIDS Research Division, University of Kwa-Zulu Natal.

DeHaven M, Hunter IB, Wilder L, Walton JW, Berry J. 2004. Health programmes in faith-based organisations: Are they effective? American Journal of Public Health. 94(6), pp.1030-1036.

Dejong J. 1991. Non-governmental organisation and health delivery in Sub-Saharan Africa. Working Paper 708. Washington DC: World Bank.

ADDITIONAL BIBLIOGRAPHY

De Waal M and Nakedi O. 2005. Turning of the tide: A qualitative study of SACBC funded antiretroviral treatment programmes. South Africa: (SACBC) South African Catholics Bishops Conference and The University of Pretoria.

DFID. 2006. Promoting women's rights through sharia in Northern Nigeria. Zaria, Nigeria: (DFID) Department for International Development, and Centre for Islamic Legal Studies, Ahmadu Bello University.

DFID. 2006. Faith in development position paper. London, UK: (DFID) Department for International Development.

DIFAEM. 2002. The future role of church related hospitals and health services in developing countries. Report about an international consultation. Tubingen: (DIFAEM) German Institute for Medical Mission.

Ditumelo. 2008. Assessing the Capacity of Faith-based Organisations for HIV Prevention in Seven Health Districts in Botswana. Forthcoming. Ditumelo, University of Botswana.

DON. 1998. STI, HIV/AIDS and adolescent sexuality: Improving teenage reproductive health. The study of adolescents' knowledge, attitudes and practices. Diocese of Namirembe Health Department, HIV/AIDS Project.

Dortzbach D. 1998. AIDS in Kenya: The Church's challenge and the lessons learned. Nairobi: MAP International.

Farrell M. 2003. Condoms and AIDS prevention: A comparison of three faith-based organisations in Uganda. *AIDS and Anthropology Bulletin.* **15**(3).

Fenton C, Baggaley R and Nyirenda A. 2003. *The churches' response to HIV and AIDS in Southern Africa: are they doing enough?* London: Christian Aid and Copperbelt Health. Education Project (CHEP).

FHI. 2000. *HIV/AIDS prevention, care and support across faith-based communities. An annotated bibliography of resources.* (FHI) Family Health International and USAID

Flessa S. 1997. *Costing of health services of the Evangelical Lutheran Church in Tanzania: Methodology and results.* Working Paper. Arusha.

Gaie J, Jensen K, Lefa M, Nkomazana F and Sebina L. 2005. *Preliminary report: faith-based HIV prevention initiatives in Botswana.* Gabarone, Botswana: Tumelo Project, Department of Theology and Religious Studies, University of Botswana.

Gennrich D and Gill A. 2004. *Churches and HIV/AIDS: Exploring how local churches are integrating HIV/AIDS in the life and ministries of the church and how those most directly affected experience these.* Pietermaritzburg, South Africa: (PACSA) Pietermaritzburg Agency for Christian Social Awareness.

Gilson L, Adusei J, Arhin DC, Hongoro C, Mujinja P, Sagoe K. (forthcoming 2008). Should African governments contract out clinical health services to church providers? *In:* Contractual Relationships between the Public and Private Sectors, pp. 276-302.

Green EC, Nantulya V, Oppong Y and Harrison T. 2003. Literature review and preliminary analysis of 'ABC' factors (abstinence, being faithful or partner reduction, condom use) in six developing countries. Cambridge MA: Harvard Center for Population and Development Studies

Gruenais ME. 1999. Does religion protect from AIDS? Congolese religious congregations face pandemic HIV infection. *Cahiers d'Etudes Africaines.* 39(2), pp.253-270.

Green EC. 2000. Calling on the religious community: Faith-based initiatives to help combat the HIV/AIDS pandemic. *Global AIDSLINK.* 58, pp.4-5.

Hafner C. 2007. *Working with faith-based organisations to strengthen human resources for health.* Capacity Project

HAI. 2000. *Inventory of HIV and AIDS programmes in Sub-Saharan Africa. Africa Now! A Leadership Summit to Define African Priorities for AIDS.* Cambridge, MA: (HAI) Harvard AIDS Institute.

Haule S and Baer F. 2007. CSSC Geographic and Human Resource Information Systems. Presentation. HRH Global Resource Center; Interchurch Medical Assistance.

HCP. 2002. *Public-private partnerships for public health.* Harvard: Harvard Center for Population and Development Studies.

Hearn J. 2002. The 'invisible' NGO: US evangelical missions in Kenya. *Journal of Religion in Africa.* **32**, pp.32-60.

Hendriks HJ, Erasmus JC and Mans GG. 2004. Congregations as providers of social service and HIV/AIDS care. *NGTT Supplement.* **45**(2), pp.380-402.

Hogerzeil HV and Lamberts PJN. 1984. Supply of essential drugs for church hospitals in Ghana. *Tropical Doctor.* **14**, pp.9-13.

Judge M and Schaay N. 2001. *Planning our response to HIV/AIDS: A step by step guide to HIV/AIDS planning for the Anglican Communion.* Washington and Cape Town: Policy Project and (CAPA) Council of Anglican Provinces of Africa.

Kagee A, Toefy Y, Simbayi L and Kalichman S. 2005. The prevalence of HIV in three predominantly Muslim residential areas in the Cape Town metropole. *South African Medical Journal.* **95**(7), pp.512-516.

ADDITIONAL BIBLIOGRAPHY

Kagimu M, Marum E and Serwadda D. 1995. Planning and evaluating strategies for AIDS health education interventions in the Muslim community in Uganda. *AIDS Education and Prevention.* **7**, pp.10-21.

Kagimu M, Marum E, Wabwire-Mangen F, Nakyanjo N, Walakira Y and Hogle J. 1998. Evaluation of the effectiveness of AIDS health education interventions in the Muslim community in Uganda. *AIDS Education and Prevention.* **10**(3), pp. 215-228.

Kealotswe ON. 2001. Healing in the African Independent Churches in the era of AIDS in Botswana: A comparative study of the concept of diagelo and the care of home-based patients in Botswana. *Missionalia.* **29**(2), pp.220-231.

Kiiti N, Ijumba P and Dortzbach D. 1995. *AIDS prevention and Kenya's church leaders: Assessment of knowledge, attitudes, and practices.* MAP International, FHI, AIDSCAP and USAID.

Krakauer M. 2004. *Churches responses' to AIDS in two communities in Kwa-Zulu Natal.* Development Studies. Oxford, UK: Oxford University. Master of Philosophy.

Lee C, Brewster-Lee D, Devine B, Bingham G. 2003. *Global fund responsiveness to faith-based organisations.* Virginia: (CCIH) Christian Connections for International Health and Ecumenical Pharmaceutical Network Report.

Marazzi M, Guidotti G, Liotta G and Palombi L. 2005. *Dream, an integrated faith-based initiative to treat HIV/AIDS in Mozambique: Case study.* Geneva, Switzerland: (WHO) World Health Organisation.

Marshall K (2001). *Development and religion: A different lens on development debates*. Peabody Journal of Education 76(3): 339-375

Marshall M and Taylor N. 2006. Tackling HIV and AIDS with faith-based communities: learning from attitudes on gender relations and sexual rights within local evangelical churches in Burkina Faso, Zimbabwe, and South Africa. *Gender and Development.* **14**(3), pp.363-374.

Martin R. 1999. The future of Christian hospitals in developing countries: The call for a new paradigm of ministry. *APHA Meeting*, (APHA) American Public Health Association.

Mash R and Kareithi R. 2005. *Youth and sexuality research: Ages 12-19 years in the Diocese of Cape Town South Africa.* Cape Town, South Africa: Fikelela AIDS Project.

McFarland DA and Cochrane JR. 2006. Aligning religious health assets to strengthen public health systems in Africa. *Ethics and Africa Conference, Conference Proceedings, May 29-31, 2006*. University of Cape Town, forthcoming

MOH-Ethiopia. 2003. NGOs Involvement in the Ethiopian health sector: facts, challenges, and suggestions for collaborative environment. John Snow, USAID, Federal Ministry of Health, Health Care Financing Secretariat.

Muhangi D. 2004. *Documentation study of the responses by religious organisations to orphans and vulnerable children: Uganda country study report.* Kampala: (UNICEF) United Nations Children's Fund, (WCRP) World Conference on Religious for Peace and Inter-Religious Council of Uganda.

Munro A. 2005. *The Catholic Church and the provision of antiretroviral treatment.* Pretoria, South Africa, (SACBC) Southern African Catholic Bishops' Conference

Munro A. 2002. *Belated, but powerful: The response of the Catholic Church to HIV/AIDS in five southern African countries.* Pretoria, South Africa: Southern African Catholic Bishops' Conference.

Munro A. 2001. *HIV/AIDS in Africa. Grace and truth, a journal of Catholic reflection.* Hilton, South Africa: St Joseph's Theological Institute.

Okaalet P. 2002. *The role of faith-based organisations in the fight against HIV and AIDS*. Nairobi: MAP International

Orubuloye IO, Caldwell JC and Caldwell P. 1993. The role of religious leaders in changing sexual behaviour in Southwest Nigeria in an era of AIDS. *Health Transition Review.* **3**, pp.93-104.

Otolok-Tanga E et al. 2007. Examining the actions of faith-based organisations and their influence on HIV/AIDS-related stigma: a case study of Uganda. African Health Sciences. 7(1).

Paterson G. 2003. Church leadership and HIV/AIDS: The new commitment. *Discussion Paper 001*. (EAA) Ecumenical Advocacy Alliance.

Paterson G. 2001. *HIV/AIDS and churches in sub-Saharan Africa.* London: Christian Aid.

Paterson G. 1996. *Love in a time of AIDS: Women, health and the challenge of HIV.* Geneva: (WCC) World Council of Churches.

Pfeiffer J. 2004. Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: A clash of AIDS prevention messages. *Medical Anthropology Quarterly.* **18**, pp.77-103.

Phiri IA, Haddad B and Masenya M (eds). 2003. *African women, HIV/AIDS and faith communities.* Pietermaritzburg: Cluster Publications.

Policy-Project. 2003. *Strengthening faith-based resources, a factsheet.* Washington, DC: Policy Project.

ADDITIONAL BIBLIOGRAPHY

Policy-Project. 2002. *Faith in action: A united response to HIV/AIDS (A report on the national indaba).* Washington and Cape Town: Policy Project and (SADOH) South African National Department of Health.

Rajput NOF. 2001. Faith communities dealing with issues of sexuality: The Islamic perspective. *12th International Conference on HIV/AIDS and STDs in Africa (ICASA). UNAIDS Round Table on Faith-base Strategies, Achievements and Challenges in their Response to the HIV/AIDS pandemic, Ouagadougou, Burkina Faso,*

Rankin S, Lindgren T, Rankin W and Ng'oma J. 2005. Donkey work: women, religion, and HIV/AIDS in Malawi. *Health Care for Women International.* **26**(1), pp.4-16.

Rankin W and Wilson C. 2000. African women with HIV, faith-based answers might ease the social problems that lead to AIDS. *British Medical Journal.* **321**, pp.1543-1544.

Rode H. 2005. Capacity building at Mulanje mission hospital. *PraxisNote* 11, Oxford, (INTRAC) the International NGO Training and Research Centre.

Salvation-Army. 1999. *Journey into hope: Report on consultation with Christian leaders, development organisations and UNAIDS on HIV/AIDS related issues.* London: Salvation Army International, Health Services.

Schmid B. 2002. *The Churches' response to the HIV/AIDS pandemic: A case study of Christian agencies in the Cape Town area.* MSocSci. Religious Studies. Cape Town: University of Cape Town.

Schneider G. 2007. *Capacity building: what does it mean? Millennium development goal 6: malaria, HIV.* HRH Global Resource Center; Interchurch Medical Assistance

Shorter A and Onyancha E. 1998. *The church and AIDS in Africa: A case study - Nairobi City.* Nairobi: Paulines Publications Africa.

Smith DJ. 2004. Youth, sin and sex in Nigeria: Christianity and HIV/AIDS-related beliefs and behaviour among rural-urban migrants. *Culture, Health and Sexuality.* **6**(5), pp.425-437.

Ssekkadde SB. 2003. HIV/AIDS and orphans in Uganda: *A church community response from the Diocese of Namirembe, Province of the Church of Uganda.* Diocese of Namirembe, Province of the Church of Uganda.

Thomas S. 2004. Building communities of character: Foreign aid policy and faith-based organisations. *SAIS Review.* **24**(2), pp.133-148.

Turshen M. 1999. *Privatizing health services in Africa.* New Brunswick: Rutgers University Press.

UNICEF. 2003. *The role of faith-based organisations in providing support to orphans and vulnerable children in Africa.* New York, NY: (UNICEF) United Nations Children's Fund and (WCRP) World Conference of Religions for Peace.

Walkup RB. 2000. *Faith in the field: Faith-based organisations in the developing world.* Virginia, (CCIH) Christian Connections for International Health.

Ward N, Kader R and Dankyau M. 2004. Bridging the gaps between religion and sexual and reproductive health and rights: The role of faith-based organisations in Africa. *Sexual Health Exchange.* **1.**

Wawer M, Serwadda D, Gray R, Sewankambo N, Li C and Kiwanuka N. 1996. Religion, behaviours, and circumcision as determinants of HIV dynamics in rural Uganda. *International Conference on AIDS.* **11**(2), pp483.

WCC. 2000. *Facing AIDS: The challenge, the churches' response.* WCC Study Document. Geneva: (WCC) World Council of Churches.

WCC. 2001. *Plan of action: The ecumenical response to HIV/AIDS in Africa.* Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa. Nairobi, Kenya: (WCC) World Council of Churches.

Weaver R. 2004. *Reaching out? Donor approaches to faith-based organisations in the response to HIV/AIDS.* HIV/AIDS Briefing Paper 1. Teddington, UK: Tearfund.

DESK REVIEW RESOURCES

Databases and Research Reports Emerging in 2008

Mapping has taken off in the religious-health sector, and several reports and studies will emerge after the end-date of this landscaping review. The following are studies that are expected in 2008:

Country	Information
SSA	Anglican SSA Study
Africa	Order of Catholic Monks and Nuns
Zambia	Japanese International Cooperation Agency: Full health facility census with GPS – ongoing
CHA	The Christian Health Association Platform (based in Kenya) will be consolidating the information for the various CHAs, starting early 2008
Tanzania	CSSC health network mapping
Kenya	Mapping of the health network of CHAK and KEC (just beginning) with an eventual collaboration with the MOH to develop an integrated database for all health facilities. Partners include CHAK,
SSudan	CHAS network
Liberia	Mapping of all health facilities including the CHALi network, and management of the transition gap
DR Congo	Mapping of 515 health zones including an identification of those that are co-managed by faith-based groups or NGOs. Situational analysis study: The first ever comprehensive analysis study
Africa	IMA World Health, CCIH and GMI have their own initiatives to research and document the work of faith-based partners and networks in a number of countries.
Malawi, DRC & Kenya	ARHAP study for Tearfund and UNAIDS on collaboration between Christian-national FBOs and HIV/AIDS policy, due for completion end 2008.

Databases held for sub-Saharan Africa

The following table depicts some of the 'databases' that were collected for the desk review.

Database	Country Focus	Data Type
ECC (Englise du Christ au Congo)	DRC	CCIH GRHAM Mapping information: ECC members: Health zone, hospital affiliation, number of beds, function, ECC community affiliation. List of 65 health zones co-managed by members: incl population served. List of ECC health facilities (80): zone, health zone, number of beds. Maps of health zones.
CHAS (Christian Health Association of Sudan)	Sudan	CCIH GRHAM Mapping Information: Members, facilities by region (46), facility type, member facilities, map of health facilities
CHAS (Christian Health Association of Sudan)	Sudan	Contact list: 92 individual members representing full range of organisations (including internationals eg Tearfund) – contact information
CHAK (Christian Health Association of Kenya)	Kenya	CCIH GRHAM Mapping Information: number of members, type and number (406) of facilities held by members, map, contact info for facilities
CSSC Database Information	Tanzania	CSSC Website Health Facility Directory: Name, owner, contact information
UCMB (Uganda Catholic Medical Bureau)	Uganda	Lower Level Basic Database: Unit (261), level, HC, beds, diocese, district, year established UCMB Hospitals: unit(30), location, diocese, beds, year established
UMMB (Uganda Muslim Medical Bureau)	Uganda	The UMMB health units: human resource:(July 2007): 62 units, type
ARHAP-WHO	Lesotho & Zambia	ARHAP-WHO Mapping Databases: Organization Identification, GPS Location, Organization Typology (including activities)

DESK REVIEW RESOURCES

CATHCA: 2007 Statistics Database	South Africa	Member Database: 177 entries: organisations in CATHCA network. Including name of organisation, location, main service provided (eg hospice, hospital, HBC), contact, staff type and number, patient number, patient information (eg curative, palliative, TB cases etc).
SACBC: 2007 Project Database	South Africa	Member Project Database: 200 entries: projects of Catholic diocese in South Africa, name of project and contact information
HIVAN: HIV911 Database	South Africa	Self-declared FBOs involved in AIDS work in South Africa: Organization (372), Overview, Nature of Organization, Age, Number of People, Email, Web, Services, FBO type
CHAZ (Churches Health Association of Zambia)	Zambia	CCIH GRHAM Mapping Information: CHAZ member hospitals (region, owner, beds, cots), health institutions (size, type, ownership, beds)
CCIH (Christian Connections for Intern Health)	Zimbabwe	Directory of Church Sponsored HIV/AIDS Programs in Zimbabwe: Organisation name, area of operation, target group, contact details
CHAG (Christian Health Association of Ghana)	Ghana	Directory of members: Institution (70), Type of Institution (mainly hospitals and clinics), Church Affiliation, District/Region
CHASL (Christian Health Assoc of Sierra Leone)	Sierra Leone	Directory of members: Institution,Type of Institution, Affiliation, District/Region
Across SSA Databases		
CADRE: Open Society Initiative for Southern Africa (OSISA) Survey	Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia	Focusing on AIDS funding trends for civil society rganizations (including FBOs). Relevant fields: Organisation details, details of service, funding source and expenditure, staff details, services provided
Afrobarometer	SSA	Large scale: mainly religious worldviews
World Values Survey	SSA	Large scale: mainly religious worldviews, FBOs as civil society
Lutheran World Federation	SSA	Members Directory: (and "HIV Mapping Database")
EPN (Ecumenical Pharmaceutical Network)	SSA	Members Directory: Faith-based Drug Supply Organizations
Caritas Members Directory	SSA	Members Directory

THE BURDEN OF DISEASE IN ZAMBIA

The burden of disease includes the major diseases associated with poverty such as malnutrition, poor child health, TB, inadequate access to basic services as well as tropical diseases (malaria), HIV and AIDS, and STIs. The ten priority areas in the Zambian Basic Health Care Package are child health and nutrition, integrated reproductive health, HIV and AIDS, TB, STIs, malaria, human resources, infrastructure and equipment, and free or cost sharing services in some areas. Key informants identified their view of the major health issues in Zambia. These were identified as AIDS, tuberculosis, malaria, nutrition, access to water and sanitation, followed by non-communicable diseases like diabetes, heart disease and cancers, for example.

MNCR: Zambia has some of the poorest health outcomes in SSA for mothers and children. Life expectancy at birth dropped from 40.1 years to 37.7 years between 1997 and 2004. In this period, 28% of under fives were recorded as underweight. In 2004 the infant, child and maternal mortality rates were amongst the highest in Southern and East Africa. The infant mortality rate was 102 per 1 000, the child mortality rate was 182 per 1 000 and the maternal mortality rates was 730 per 100 000. Nearly half (47%) of under fives were stunted and 28% were underweight (2007 OECD).

This data highlights an area which is certainly not receiving enough attention and resources, as these two quotes illustrate:

> *So like for CHAZ, it was a big challenge in terms of reproductive health, because there are not enough resources. A lot of money is going into HIV, malaria, TB, but not as much in reproductive. So I think that is a challenge that FBOs are facing (Biemba.doc - 1:61 (208:208)).*

> *I think the church could do more around issues of maternal health, child health. And they could do a lot more around under-five clinic provision, breastfeeding programs. (Kangale.doc - 6:26 (34:34)).*

The poor child and maternal health outcomes are indicators of inadequate primary health care and poverty. The removal of user fees in rural areas resulted in increased demand for health services, and hopefully contributed to improved MNCR health outcomes. Unfortunately, data is not yet available to show the implications of changes in user fees on health outcomes.

HIV and AIDS have exacerbated the health problems of the population. About one million Zambians are HIV infected and it is estimated that a fifth of those infected (200 000) require ART. OECD reports that the lack of specialised staff is the main obstacle to the further provision of ART. Treatment was provided to an estimated 90 000 Zambians in December 2006. As a result of the high HIV prevalence in the country, estimates are that there are already about 1.2 million orphans. The national HIV and AIDS response by the government is progressing under the National AIDS Council. The aim is to bring down the national HIV prevalence to below 10% in 15-49 year olds by 2010.

When probed, the key informants repeatedly identified the major causes for poor health as poverty, structural adjustment programmes implemented in Zambia, insufficient funding for health services and human resource constraints.

GOVERNMENT POLICIES IMPACTING ON FAITH BASED ORGANISATIONS

Government policies were found have to explicitly or implicitly impacted on the functioning of FBOs. A number of key informants commented on this:

- The National AIDS Council prescribed co-management of TB and HIV; this stretched health services, including faith-based rural facilities, even more.[1]
- User fees were abolished a year ago in rural areas. Although this had been done in good faith to assist the rural communities access health care better, the impact had been that demand for health services had increased, but at the same time FBO hospital income had been reduced by at least 10%. [2]
- The compensation grant, promised by government to make up for the resulting shortfall had not been implemented, and rural mission hospitals were still waiting for it.[3]
- Government, responsible for the majority of FBO facility workers' salaries, had said that it would no longer pay for cleaners and drivers, etc.
- The Witchcraft Act and other legislation dating back to the colonial era and relating to the work of traditional healers was no longer relevant and made the traditional healers' work difficult. [4]
- A proposed NGO bill, which would have limited the autonomy of all NGOs, including faith based ones, was withdrawn after protest.

1 .CHEP.doc.
2 MOH-PH.doc - 1:38 (122:122).
3 CHAZ.doc - 10:2 (14:18).
4 TH Alliance.doc.

ADVANTAGES TO MEMBERS OF BELONGING TO CHAZ

Services listed on the CHAZ website

Health Programmes

- The CHAZ AIDS Care and Prevention programme was developed in 1987 as a response to the growing problem of HIV/AIDS in the country. The programme concentrated on promoting educational activities in rural areas to achieve prevention of HIV transmission and development of home-based care. The control of sexually transmitted diseases is another important component of the AIDS programme.
- The TB programme is focused mainly on the promotion of Directly Observed Treatment Therapy (DOT) and improvement of skills of the laboratory and health facility staff to diagnose and manage TB.
- The malaria control programme ensures the promotion of Insecticide treated bed-nets focusing on pregnant women and children under five. There is also a primary eye care programme, which focuses on the primary prevention of eye diseases and management of cataracts in rural areas The primary health care (PHC) programme administered by CHAZ has aimed at providing assistance to members in implementing PHC activities. Activities that have been supported have included the training of community health workers (CHW) and traditional birth attendants (TBA), immunisation, nutrition rehabilitation, micronutrient supplementation and family planning. CHAZ provides funds and other requisites to support these activities.

Pharmaceutical Programme

The other programme undertaken by CHAZ is that of support to member institutions through provision of drugs. The drugs come to CHAZ mainly as donations from agencies overseas. CHAZ distributes these drugs to member institutions with only a minimal handling charge. The availability of donated drugs has in the past been rather irregular the most necessary items are not always available. A drug store is now in place and a drug revolving fund has been secured, which will solicit, procure, store and make available essential drugs to members and government health institutions at reasonable cost. CHAZ promotes rational drug use at member institutions and supports by training various cadres of health workers in management of pharmaceuticals.

TYPES OF COLLABORATION BETWEEN FBOS (MAINLY NON-FACILITY-BASED)

These were outlined by the Lusaka Focus group[5].

- One is a donor-mandated collaboration, where a donor may come in and say, "You must collaborate" and obviously they have the influence, because they provide the resources. That's particularly true of the PEPFAR funding, where the donor level co-ordination is quite strong and so they'll insist on home-based care programmes that are PEPFAR funded, referring to ART programmes that are that PEPFAR funded, even though they may not be the same recipient institution,
- Government-mandated collaboration is encouraged in some cases and that's particularly at the policy level where you're developing protocols, national drug policy, referral policy and systems. That is often times mandated by government and encouraged, so everybody within the district health management team, which is the structure the government set up at the local level, has to be working together to collaborate.
- There's more spontaneous institution-level collaboration in which institutions see a need and then seek out people to collaborate with. For instance, you might have a district hospital who has drugs to scale up the anti-retroviral therapy, but they are not seeing the patients coming in, so they might seek out a mobile VCT provider and the home-based care provider in the community, which may be separate institutions and try to work with them for cross-training purposes, cross-referral purposes, joint trainings in some cases in an attempt to ensure that people being tested and reached in home-based care get fed up into ART services when they need them and vice versa. So when the people are now on ART and they're back in their communities, then they need support in ensuring adequate adherence to the drug regiment, in which case the home-based care community workers might be trained in ART adherence.

5 FGD Lusaka.doc - 3:30 (179:181)

APPENDIX 5.5

NEEDS THAT COULD BE ADDRESSED BY AN INTERMEDIARY

- Proposal writing, including advice and information on specific requirements of donors, approaching donors on their behalf.[6]
- Joint approach to the State and bigger institutions.[7]
- A focal point in the district for sharing information between FBOs and CBOs, including quarterly reports on their activities and services to facilitate collaboration.[8]
- Support in financial management to improve accountability.[9]
- Sub-granting.[10]

APPENDIX 5.6

EXTERNAL FUNDING FOR FBO NETWORKS

CHAZ was reported to receive funding from the Global Fund while other agencies were also sub-recipients from this source. CHAZ had signed a grant agreement with the Global Fund to disburse US $10 million in two years to FBOs for HIV and AIDS, TB and malaria. This was a challenge and opportunity for CHAZ to contribute to scaling up of interventions in the country.

There were a range of other co-operating partners collaborating with CHAZ. These included: DanChurchAid, NORAD, Development Cooperation Ireland, CORDAID, Catholic Medical Missions Board, Canadian Public Health Association, Leprosy Mission International and the Southern African AIDS Programme (SAT).[11]

In addition to the funding from external agencies to government and CHAZ, individual denominational networks and community non-facility-based FBOs were also recipients of funding. The president of the traditional healers' association, THPAZ, spoke about sporadic funding by WHO in addition to long term support (over 15 years) from the Norwegian government.

6 FGD Livingstone
7 FGD Livingstone.
8 FGD Livingstone.
9 FGD Ndola.
10 FGD Ndola.
11 http://www.zamcart.co.zm/new_chaz/ (accessed 2007-12-04).

PNFP NETWORKS IN UGANDA

A. FUNCTIONS OF THE IRCU FOR FAITH-BASED HEALTH SERVICES

The Inter-religious Council of Uganda (IRCU) was formed by the authorities of a number of faith groups to work towards issues like peace, human rights, gender equality and HIV and AIDS. The HIV and AIDS desk performs the following services:

- it channels resources to faith based facilities and programmes offering HIV and AIDS related services;[12]
- scales up ART through helping facilities get accredited to the MoH for provision of ART, and sourcing/appointing staff for the ART component of these programmes and their monitoring and evaluation (M&E);[13]
- assists facilities with personnel; where there is personnel but not enough or suitably qualified they provide a stipend;[14]
- offers logistical support for ART adherence and other community work on care and support in rural communities;[15]
- supports resource mobilisation, capacity building and support supervision to faith based implementing partners;[16]
- provides laboratory equipment to hospitals, e.g. CD4 machines;[17]
- acts as forum to share experiences, and access funding.[18]

B. NATIONAL AND REGIONAL NETWORKS SUPPORTING FAITH BASED HEALTH SERVICES IN UGANDA

Besides the medical bureaux and the IRCU a number of other more or less formalised networks support faith-based health services. These include

- the Uganda Community Based Health Care Association, an umbrella body for secular and religious groups providing HBC;
- Uganda Christian AIDS Network is a Pentecostal network which operates independently, yet lacks a strong coordinating mechanism;
- PACANet, an international Christian AIDS network, has recently opened an office in Uganda;
- the Islamic Medical Association of Uganda, works in partnership with the UMMB; it promotes the formation of medical staff, teaching an Islamic approach towards HIV/AIDS prevention, treatment and care;[19]
- PNFP coordination committees are a means of co-ordination among faith based organisations in many districts;
- an informal forum for the three PNFP hospitals in Kampala for discussion of HR issues like salaries; it aims to prevent movement of staff between them facilities. This type of collaboration which places common interests above the specific short term interest of ones own facility is an excellent example of collaborative practice that should be widely duplicated;
- Diocesan Health Boards in Gulu, and likely elsewhere, extend the work of the medical bureaus into the districts; they facilitate meetings of Catholic facilities where common issues are raised and joint strategies developed;[20]

12 FGD Mukono.doc - 8:42 (111:111)
13 IRCU.doc - 26:24 (112:112)
14 IRCU.doc - 26:22 (104:104)
15 IRCU.doc - 26:22 (104:104)
16 IRCU.doc - 26:7 (21:21)
17 IRCU.doc - 26:22 (104:104)
18 FGD Kampala 1.doc - 9:4 (226:226)
19 UMMB.doc - 21:50 (156:156)
20 FGD Gulu.doc - 7:31 (93:93)

COLLABORATION BETWEEN GOVERNMENT AND PNFPS IN UGANDA

A. COLLABORATION STRUCTURES AT DISTRICT LEVEL

District level is where the real collaboration opportunities and challenges lie. A number of districts have achieved good collaboration between government and PNFPs. Examples are:

- Each district health office is supposed to have a focal person for PNFPs of all faith groups. Due to the delay in adopting the policy these have not been assigned yet in the majority of districts.[21]
- The district health management team meeting involves the major stake-holders; most private stake-holders don't participate but the faith based organisations do.[22] The intention is that PNFPs participate routinely in the planning and quarterly and annual review processes, discussion of district level resource mobilisation and allocation. In reality they are not always notified of meetings.
- District health officers do support supervision also of PNFP facilities.[23]
- Weekly meetings are held for representatives of all hospitals in a district which enable them to get the bigger picture of developments in the district;[24]
- All districts have a [government initiated] District AIDS Committee and all the faith based organisations and others come together under this committee to harmonise HIV and AIDS services and to try and identify gaps that may need to be filled.[25]

B. AREAS OF PRACTICAL COLLABORATION

- Duplication of facilities is avoided; there is a policy that where PNFP facilities already exist, no public facilities will be erected; instead support is channelled to the existing facility. As a result local PNFPs can reduce their fees, and become more accessible to patients who would otherwise have had to pay for transport to a public facility far away.[26]
- Similarly duplication of specialist services is avoided;[27]
- A referral system exists between facilities of different levels, irrespective of whether they are public or PNFP, but depending on where required services are available.[28]
- Some services are shared, e.g. in Gulu the teaching responsibility for the local medical school and blood transfusion services are shared by the public and PNFP hospitals;[29]
- Practical cooperation around disasters, like the Ebola epidemic during which a central communication system was in place; or mass accidents.[30]

21 Gulu DHO.doc - 16:7 (24:25), PPPH.doc - 22:11 (25:25)
22 PL.doc - 17:24 (46:46)
23 FGD Gulu.doc - 7:27 (83:83)
24 FGD Gulu.doc - 7:46 (110:110)
25 PL.doc - 17:23 (45:45)
26 PPPH.doc - 22:27 (48:48), 22:28 (48:49) & 22:32 (58:58)
27 FGD Gulu.doc - 7:35 (96:97)
28 FGD Gulu.doc - 7:38 (99:99)
29 FGD Gulu.doc - 7:38 (99:99)
30 FGD Gulu.doc - 7:44 (109:109) & 7:33 (95:95)

SPECIFIC FUNDING PARTNERS

A number of international agencies support specific aspects of the health system in Uganda or specific actors within it:

- UNICEF is particularly targeting childhood conditions and to some extent maternal health in selected districts. Although it is the biggest funder outside of government in these districts, the amounts are not sufficient to make much impact on particularly maternal and neo-natal health, an area that is in need of huge investment.[31]
- UNICEF has been channelling supplies into districts – to both public and private actors there.
- European church-groups do still support health work in Uganda. Such donations from abroad are often intended for investment processes and improvement of infra-structure.[32]
- CUAMM, an Italian agency also has maternal health as a top priority; they only support programmes in one or two regions.[33]
- The UPMB receives 50% of its operating resources from churches in Germany and also the Netherlands.[34]

31 PL.doc – 17 (73:74)
32 PPPH.doc - 22:13 (36:36) &22:15 (37:37)
33 PL.doc – 17 (76:76)
34 UPMB.doc - 20:48 (118:118)

LOCAL CASE STUDY 1: RNILS ACTIVITIES

A. BUILDING THE CAPACITY OF RELIGIOUS LEADERS TO RESPOND APPROPRIATELY TO THE HIV AND AIDS PANDEMICS

The following actions are required:

- planning and curriculum development for capacity building;
- awareness and advocacy directed at Fatwa specialists in order to find answers to the unanswered questions such as the use of condoms; and
- Training madrasa teachers during the vacations and holidays.

B. STRATEGIES TO ENCOURAGE PREVENTION OF HIV/AIDS

One of the strategies is to consider statistics showing that contamination occurs mainly through sexual relations; hence guidelines and procedures for raising awareness among men, women and youth involve the following:

- information and awareness sessions on AIDS transmission, prevention and treatment are conducted in mosques and at gatherings of the Muslim women and youth associations;
- education of children through integration of preventive information in school curricula, focusing on abstinence before marriage;
- training of village delegates in rural districts; and
- debates and question-and-answer sessions in the media, led by religious leaders and including national and local radio as well as television and newspapers.

In these interventions five themes are covered: prevention, statistics about HIV, HIV-related discrimination and stigma, vulnerability of women, and offering hope to people who are infected or affected by HIV.[35]

Specific interventions include encouraging voluntary HIV testing of couples before marriage, sensitisation activities during the HIV and AIDS struggle month (December), and stopping the proliferation of brothels and prostitution.

35 PSI.doc - 22:9 (71:71)

LOCAL CASE STUDY 2: CONTEXT OF FALADIÉ

The village of Faladié is the central one of 18 villages making up the N'Tjiba Commune. It is located 60 km from the nearest town, Kati, and 75 km from Bamako, the capital of Mali.

Official figures for 2000 give a figure of 18,850 inhabitants for the commune; while the village of Faladié's has 254 households with a population of 2,763, including 1,409 women. The major ethnic group in the village is the Bambara. Islam, Christianity and animism are the religions practiced in the village, with an unusually high proportion of Christians resulting from the presence of a Catholic Mission for more than eighty years.

According to Commune authorities, 5% of the households are rich and 85% poor. Crop production only covers their needs for half of the year because they have no farm equipment and insufficient land workers. As a result they cannot pay for health care for their members or school fees for the children.

The diseases most frequently cited by clinic personnel and the population are: malaria, diarrhoea (among children), snake and dog bites, acute respiratory infections, anaemia, malnutrition (among children and pregnant women), injuries, sexually transmitted infections, and high and low blood pressure (hypertension and hypotension). According to the Catholic nuns at the clinic, there are cases of HIV and AIDS; due to the lack of testing equipment people showing clinical signs are sent to the hospital in Kati. The health centre receives no feedback on their status.

Although Faladié has the oldest health centre in the Commune, it is now surrounded by Community health centres, commonly referred to by the French acronym CSCom, in Daban (10 km) and Kalifabougou (12 km). In the Circle of Kati, Faladié health centre refers patients to the Hospital of Kati and the Hospital of Point G in Bamako.

LOCAL CASE STUDY 2: INFRASTRUCTURE & HEALTH SERVICES AT FALADIÉ

A. INFRASTRUCTURE

The health centre has four blocks comprising:

- the clinic block, with a pharmacy, consultation and care rooms;
- a maternity block consisting of a delivery room and a 15-bed ward;
- a paediatric block for consultation and hospitalization of children; and
- the hospitalization ward with 15 beds.

In addition to these wards, there is a meeting room, a mortuary and a hangar where vaccination clinics are conducted. The centre is electrified and has drinking water sources (a solar pump and two large diameter wells). The infrastructure is in good condition and well maintained.

B. SERVICES CURRENTLY OFFERED BY HEALTH PERSONNEL AT THE CENTRE

The following types of services are offered:

- curative care for common diseases;
- preventive care including vaccinations;
- prenatal and postnatal care as well as deliveries;
- family planning (the rate of uptake is increasing);
- sale of essential and specialized drugs; and
- practical training for national and private Health School students.

The Sister managing the pharmacy gave some statistics from the quarterly report January-March 2004 (see below). This would have been the last statistical report prepared by the Belgian staff; the fact that it was this report that was presented suggests that it may be the last time an HMIS report was prepared.

Quarterly report, January-March 2004: Faladié

Treatment provided		Care provided to patients	
Prenatal Visits	847	Malaria	438
Child delivery	249	Respiratory diseases	450
Vaccinations: • poliomyelitis	679	Diarrhoeal diseases	128
• BCG	679	Dysentery	23
• DTC 1st	456	Malnutrition	37
• DTC 2nd	579	Trauma	200
• DTC 3rd	589	Ocular Care	30
• yellow fever	503	Teeth and throat	33
Family Planning	75 women	Problems at birth	16
Child care patients: 0 to 11 months	186	Problems related to pregnancy	7
VAT (pregnant women) 1st / 2nd	145 / 132		
Vitamin A (age range)	666		

INVOLVEMENT BY RELIGIOUS LEADERS IN HEALTH PROMOTION IN MALI

A. EXAMPLES

A number of respondents had made use of religious leaders for health promotion in a wide range of health issues:

- the country director of WHO involved religious leaders in workshops on malaria and HIV;
- the director of reproductive health in the MOH, and a director of the international NGO CARE, referred to the role of the leaders in family planning;
- the Deputy director, National Directorate of Health, could not get tetanus shots accepted until he had the backing of the imams;
- the Director of Health Policy Initiative told of their role in promoting immunisation and common hygiene;
- Population Services International mentioned sensitisation about the risks fasting during Ramadan may hold for diabetics, and their attempts to impact on female genital mutilation.

Various groups have structured interventions with, and through, religious leaders, e.g. Health Policy Initiative works extensively with religious leaders, USAID supports their engagement through Policy, and the National Programme against FGM and the National Programme against AIDS use them for getting their messages across to the population.

B. CARAVAN AGAINST AIDS STIGMA[36]

The caravan was organized by the West African Network of Religious Leaders Living with or Personally Affected by AIDS.

For four weeks, the Caravan made its way through several West African countries in order to sensitize the residents to the situation of those infected with HIV. They set off on November 4, 2005, from Mauritania's capital, Nouakchott. Mali, Senegal, Burkina Faso and Niger were also stations on the route of the Christian and Muslim representatives, who planned the campaign as a way of drawing attention to the plight of AIDS sufferers.

Mali's Minister of Health, Maiga Zenaib Mint Youba, commented enthusiastically as the caravan arrived in Bamako: "The composition of the caravan, with Muslims, Catholics and Protestants, with people living with the disease as well as journalists, is extremely impressive."

36 http://www.qantara.de/webcom/show_article.php/_c-478/_nr-367/i.html?PHPSESSID

PERCEPTIONS OF THE FAITH-BASED HEALTH SECTOR COMPARED TO CSCOMS

Respondents' perceptions about the distinction between confessional services and those at the CSComs, generally regarded the former as providing better quality. Specific comments included:[37]

- A representative of a faith based organisation supporting health work in Mali, stated that they achieve better utilisation rates.
- A pharmacist-cum-traditional healer found that they provided better services and a higher quality of care.
- An informant from the National Directorate of Health confirmed that "people think that the quality of care is higher in confessional centres than in public centres."[38]
- His colleague in reproductive health claimed that they had better equipment and their staff were better trained.
- An informant from the international NGO CARE thought that this might be a result of their having access to outside funding. Since, as a rule, 90% of costs and equipment for CSComs is provided by government, far exceeding any support the faith-based clinics receive from their religious base, this does not seem likely.

A pastor close to the Protestant Health Association commented that, even though the confessional clinics charged user fees, these were very low.

37 World Vision.doc - 18:7 (28:28), TH.doc - 17:6 (51:51), MoH 1.doc - 15:27 (66:66), CARE.doc - 19:39 (80:80), Prot.doc - 21:26 (294:294) & 21:28 (298:298).

38 MoH.doc - 16:15 (40:40)