

## 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 Lutte 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

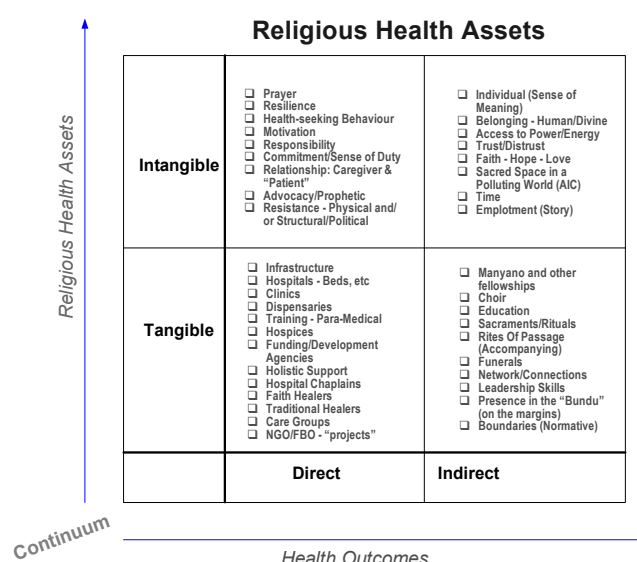
**Pro-poor health care:** Systems of health care in which the poor capture a larger share of public health care spending than the rich. (Mackintosh 2007)

**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.<sup>1</sup>



**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.

<sup>1</sup> Cochrane, J.R. 2006. "Understanding religious health assets for public health systems." DIFAM Consultation on Religion and Health. Tübingen, Germany.

QUESTIONNAIRE<sup>2</sup>

## 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/yyyy)
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 - -
--------------	-------------



<sup>2</sup> 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 detail				
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 <b>user fees</b> ?			
2. What is your policy regarding <b>user fees</b> ?			
<b>3. Source of funding (name)</b>	<b>International source?</b>	<b>Amount of funding &amp; currency</b>	<b>Project or area of activity that it covered</b>
<i>Example: Royal Netherlands Embassy</i>	<i>Yes</i>	<i>US\$ 45,000</i>	<i>Food parcels for vulnerable children in 5 districts</i>
4. If you <b>receive other forms of support</b> (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.			
<b>Source of support</b>	<b>International source?</b>	<b>Approximate value &amp; currency</b>	<b>Nature of support</b>
<i>Example: Ministry of Health</i>	<i>No</i>	<i>US\$ 45,000</i>	<i>ARVs for 150 patients</i>
5. Other comments:			

## QUESTIONNAIRE

## 3. QUESTIONS ABOUT EXTERNAL FUNDING

1. What limitations or constraints do you experience around external funding? (Tick all that apply)	Fundors 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

<p>1. List three most important FBOs you collaborate with.</p> <p>Why? Please explain why you consider them important.</p>	List 3 most important FBOs		Why? Because they .....		
	1.				
	2.				
	3.				
<p>2. List three most important faith based networks for you?</p> <p>Why? Please explain, (e.g. training, funding, service provision, referrals to the state)</p>	List 3 networks		Explain		
	1.				
	2.				
	3.				
<p>3. List three other important partners for you who are not faith based?</p> <p>Why? Please explain the nature of the partnership (e.g. training, funding, service provision, referrals to the state)</p>	List		Explain		
	1.				
	2.				
	3.				
<p>4. Is there something that could be achieved by greater collaboration?</p>	Yes		No		
<p>a. If Yes, what could be achieved and why has this not happened?</p>					
<p>5. What barriers are there to better collaboration with other FBOs?</p> <p>Please explain, e.g. funding/ religious values/ competition for clients.</p>					
<p>6. How would you rate your links with government?</p>	Excellent	Very Good	Good	Not good	Poor
<p>7. Describe your relationship with government, e.g co-referrals, staff support.</p>					
<p>8. Would better collaboration between FBOs and the public health system improve health services?</p> <p>Why? Please explain.</p>	Yes		No		
	Why?				
<p>9. What barriers are there to better collaboration with Government? e.g. funding/ religious values</p>					

## 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 <sup>3</sup>

**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.**

---

<sup>3</sup> 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
<b>Zambia</b>		
Dr Godfrey <b>Biemba</b>	Ministry of Health	Assistant Director Public Health & Research;
Abraham <b>Chikasa</b>	Christian Council of Zambia	Head of Programmes
Dr B <b>Chirwa</b>	National AIDS Council	Director general
Mr Mufalo <b>Ilitongo</b>	Catholic Diocese of Ndola	Co-ordinator: Healing & Health
Christopher Chabu <b>Kangale</b>	International HIV/AIDS <i>Alliance</i>	Programme Director
Dr Simon <b>Mphuka</b>	Churches Health Association of	Executive director
Bish Paul E <b>Musuku</b>	Evangelical Fellowship of Zambia	Director
Chikalamba <b>Muzyamba</b>	World Vision	District co-ordinator, Kitwe
Alick <b>Nyirenda</b>	Copperbelt Health Education Project	Exec Director
Dr Caroline <b>Phiri Chibawe</b>	Ministry of Health, Southern Province	Provincial Director
Lameck <b>Simwanza</b>	Women for Change	Staff member
Sydney M <b>Sipia</b>	Network of Zambian People Living	Member of Executive Committee,
Dr Rodwell <b>Vongo</b>	THPAZ	President
<b>Uganda</b>		
Dr Juliet <b>Bataringaya</b>	WHO	National professional officer, Health System
John Kikanu <b>Byarugaba</b>	Inter-religious Council of <i>Uganda</i>	HIV/AIDS Programme coordinator
Marc <b>Denys</b> and others	Public private partnership for health	Belgian Embassy, Members of PPPH donor
Dr Daniele <b>Giusti</b>	Uganda Catholic Medical <i>Bureau</i>	Executive Secretary
Dr Henry <b>Katamba</b>	Uganda Protestant Medical Bureau	Executive Secretary
Musanje <b>Kikulwe</b>	Mukono district health office	Secretary for health
Dr Ahmed <b>Kiswezi</b>	Uganda Muslim Medical <i>Bureau</i>	Executive Secretary
Dr Peter <b>Lochoro</b>	CUAMM	
Dr Jackson Abusu <b>Ojera</b>	UNICEF - Gulu zonal office	Health officer
Dr Paul <b>Onek</b>	Gulu district health office	District health officer
Dr Francis <b>Runumi</b>	Ministry of Health	Commissioner Health Services in charge of
Dr <b>Tumushabe</b>	Mukono district health office	District health officer

## LISTS OF KIIS AND FGD PARTICIPANTS

Mali		
Dr Dabo <b>Garan</b>	Islamic Relief	Medical doctor, responsible for health
Dr Binta <b>Keita</b> Diagne	MOH	Divisional head, Reproductive Health
Dr Nouhoum <b>Koïta</b>	CARE International au Mali	Child survival centre – Director, works with the MOH in support of CSComs
Prof M. <b>Koumare</b>	Traditional Healers' Network	Director general of Somepharko SA
Modibo <b>Maiga</b>	Health Policy Initiative	Director - Mali & region
Issaka <b>Sangare</b>	Sectoral AIDS Committee; Journalists for health	Communication desk for AIDS Committee; Coordinator Journalists for Health
Dr Lamine Cisse <b>Sarr</b>	WHO	Country director
Christine <b>Sow</b>	USAID - Mali	Health Team Leader
Past Daniel <b>Tangara</b>	Protestant health association of Mali	Connected to PHAM, involved in HIV work in the church
Namori <b>Traore</b>	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 <b>Banda</b>	Livingstone Moslem Society
	Past <b>Banda</b>	Calvary Chapel Church
	Sr Isabela/ Estella M <b>Bupe</b>	Linda Cath Church/Youth Alive
	Sr Mary <b>Courtney</b>	St Francis Home Based Care
	Mr <b>Kabwe</b>	Calvary Church OVC centre
	Rev Lane C <b>Kaluba</b>	UCZ Coillard Memorial
	Fr Jackson <b>Katete</b>	Livingstone Anglican Children's Project
	Rev Smart <b>Kobola</b>	Dambwa Assemblies PAOG
	Rev W <b>Mbulwe</b>	Abundant Life Church
	Mr Timothy <b>Miyoba</b>	ZINGO South
	Past Emeloah <b>Phiri</b>	Faith & Grace (Outreach Ministries)
	Past Buster <b>Tembo</b>	New Life Church for all Nations
	Mr K <b>Zyambo</b>	Mwenda Clinic
Zambia - Lusaka		
	Weston <b>Chewe</b>	Campus Crusade
	Anita Dick <b>Dumba</b>	Mother of Mercy Hospice
	Dr John <b>Hanoka</b>	Chreso Ministries
	Paul <b>Macek</b>	Catholic Relief Services
	Edward <b>Martin</b>	Adventist Health International Zambia
	Derrick <b>Mweemba</b>	Zambia Episcopal Conference
	Crispin <b>Sanjase</b>	New Apostolic Church
	Hope <b>Siwale</b>	Evangelical Fellowship of Zambia

## LISTS OF KIIS AND FGD PARTICIPANTS

**Zambia - Ndola**

Kabwe C <b>Chikolwa</b>	UCZ - Clinical Pastoral Care Centre
Mr Mufalo <b>Ilitongo</b>	Catholic Diocese of Ndola
Emilio <b>Kunda</b>	Twafane Christian Community Care
Rosemary M <b>Makarani</b>	Integrated AIDS Programme (Cath Diocese)
Ebston <b>Mambwe</b>	Bwafwano Women's group
Matilda <b>Mtonga</b> (FGD)	Cicetekelo Hospice
Muzyamba <b>Pimm</b>	<b>Copperbelt Health Education Project CHEP</b>
<b>Agnes Zalila</b>	<b>World Vision</b>
<b>Newton Zulu</b>	<b>Bridge International</b>

**Uganda – Kampala 1: lower level health centres**

Regina <b>Bakiite</b>	
Kyohainwe Sylvia <b>Bohibwa</b>	
Peter <b>Byansi</b>	Kamwokya Christian Caring Community
Gordon <b>Kitaka</b>	
Dr Hafsa <b>Lukwata</b>	Uganda Women Muslim Tabliq Association
Nabuufu <b>Rehema</b>	
Zaituma <b>Ziraba</b>	

**Uganda – Kampala 2: hospitals**

Dr G W <b>Bukenya</b>	Mengo hosp
Dr Joseph <b>Bukenya</b>	Rubaga Hosp
Dr Kaliisa <b>Cassim</b>	Old Kampala Hosp
Dr A <b>Kakeeto</b>	Saichi Abubakou Islamic hosp
Dr Namaganda <b>Kituuka</b>	St Raphael-St Francis Hosp
Dr Sinan <b>Mbulambago</b>	Kibuli Muslim Hosp
Dr Charles <b>Mugume</b>	St Stephens

**Uganda - Gulu**

Sr Emilly <b>Acircan</b>	St Mauritz H/C II
Millie <b>Among</b>	St. Mary's Hospital Lacor
Abdul R. <b>Kilama</b>	Acholi Religious Leaders Peace Initiative
Dr Martin <b>Ogwang</b>	St Mary's Hospital Lacor
Christopher <b>Okello</b>	Diocese of Northern Uganda, Gulu
George Mark <b>Oroma</b>	St Joseph's Minakulu HCII

**Uganda - Mukono**

Denis <b>Bakorueza</b>	Lugazi DHO
Namagala <b>Betty</b>	Kyetume CBHC Programme
Peter <b>Bukenya</b>	Office of DHO
Dr Kizito <b>Drake</b>	Mukono Health centre II
Sr Ambrose <b>Kibuuli</b>	Nkokonjero hospital
Rev Enos Kagodo <b>Kitto</b>	Mukono Diocese
John M <b>Kiyimba</b>	Kyetume CBHC Programme
Sr Mary Rose <b>Nahufima</b>	Ttakajjunge Health centre
Charle <b>Nkusi</b>	St Francis Naggarama Hospital
Sr Mary <b>Steven</b>	St Francis Nyenga

## APPENDICES

**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

	<b>French</b>	<b>British</b>	<b>Belgian</b>	<b>German</b>
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.	<b>Belgium:</b> <u>paternalistic colonialism</u> - direct control of the mother country; no democratic institutions. Day-to-day operations were carried out by the <u>governor general</u> . The colony was divided into 15 administrative districts. The colonial budget was voted annually by the Belgian Parliament.	<b>Germany:</b> 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	<u>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.</u>	<u>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).</u>	<b>Belgian Congo Free State and Belgian Congo (formerly Zaire, now Democratic Republic of Congo).</b>	<b>Germany:</b> <u>German Kamerun (now Cameroon), German East Africa (now Burundi, Rwanda and Tanzania) German South-West Africa (now Namibia), German Togoland.</u>
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.	

