

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.svenskayrkan.se
Church World Service	CWS	USA	SSA	www.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.wccco.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
Emmanuel 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

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.gbgn-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 Agréées 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.ortz
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.faihtweb.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	

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See Castle 2007 and Olivier et al 2006 (listed in the Chapter bibliography) for further resources

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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 organizations (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 group⁵.

- 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 regimen, in which case the home-based care community workers might be trained in ART adherence.

⁵ FGD Lusaka.doc - 3:30 (179:181)

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

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 bureaux 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:		Diarrhoeal diseases	128
• poliomyelitis	679	Dysentery	23
• BCG	679	Malnutrition	37
• DTC 1st	456	Trauma	200
• DTC 2nd	579	Ocular Care	30
• DTC 3rd	589	Teeth and throat	33
• yellow fever	503	Problems at birth	16
Family Planning	75 women	Problems related to pregnancy	7
Child care patients: 0 to 11 months	186		
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 STIGMA³⁶

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)