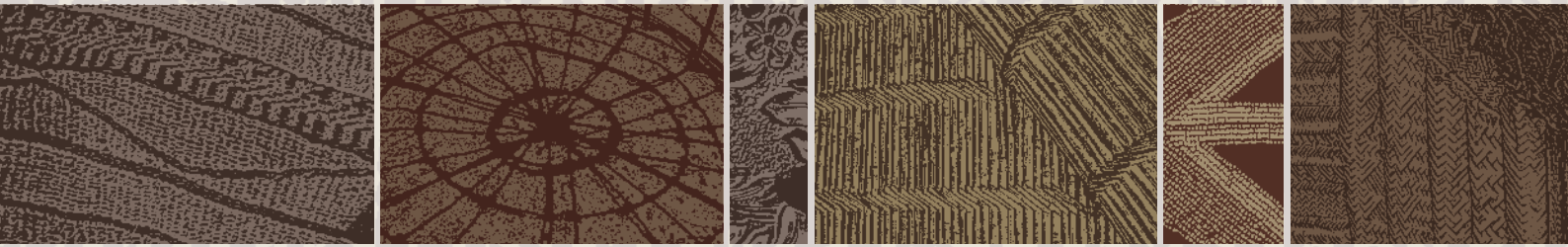


CHAPTER 5

CASE-STUDY ZAMBIA



THE CONTRIBUTION OF RELIGIOUS ENTITIES  
TO HEALTH IN SUB-SAHARAN AFRICA

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## 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.<sup>1</sup> 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<sup>2</sup> and poverty in rural areas is much more extensive than in urban areas.<sup>3</sup> The literacy rate was 68% in 2006.<sup>4</sup>

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.<sup>5</sup>

#### 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.<sup>6</sup>

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.*

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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/](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](http://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).

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Zambia has less than one third of the health workers needed to meet WHO standards.<sup>7</sup> While there are strategies in place to recruit and retain staff, staff retention remains a huge challenge, especially in rural areas.<sup>8</sup> 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.<sup>9</sup>

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.<sup>10</sup> ART was identified as another area suffering from resource shortages<sup>11</sup> but, on the other hand, vertically implemented HIV programmes<sup>12</sup> 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,<sup>13</sup> as well as inefficiencies in the historically top-heavy referral hospital sector.<sup>14</sup>

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.)<sup>15</sup> 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.<sup>16</sup>

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.<sup>17</sup> 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.

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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.

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Generally Zambia's health policy is seen to enable faith-based health services, especially because of their ability to reach remote communities,<sup>18</sup> 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."<sup>19</sup> 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.<sup>20</sup> The need for better collaboration between the Ministry of Health, REs and private for-profit health providers was raised by one informant.<sup>21</sup>

### 5.2 OVERVIEW OF RES IN ZAMBIA

#### 5.2.1 HEALTH SERVICES<sup>22</sup>

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).<sup>23</sup> 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%
RHC	Total	18	5 133	988	6 121	100%
	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;<sup>24</sup> mission hospitals do tend to have many more beds per doctor than the government-run facilities, however.<sup>25</sup> 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 KIs 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](http://ccih.org/grham/country/zambia/Tables_1.htm).

24 Blas *et al.*, 2001.

25 Blas *et al.*, 2001.

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**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.<sup>26</sup> 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.<sup>27</sup>

### 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”.<sup>28</sup>

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.<sup>29</sup> 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,<sup>30</sup> 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.<sup>31</sup>

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)*

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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).

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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.<sup>32</sup> 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.<sup>33</sup>

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.<sup>34</sup>

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."<sup>35</sup>

### 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.<sup>36</sup>

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.<sup>37</sup> 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.<sup>38</sup> 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."<sup>39</sup>

### 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.<sup>40,41</sup> Hence CHAZ was "a network of networks".

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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/](http://www.zamcart.co.zm/new_chaz/) (accessed 2007-12-04).

41 CHAZ.doc - 10:41 (85:85).

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Within CHAZ there were three main denomination-specific co-ordinating organisations,<sup>42</sup> these being necessary because of the complexity of the work and the increasing size of the sector.<sup>43</sup>

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.”<sup>44</sup> 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.<sup>45</sup> 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.*<sup>46</sup>

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).<sup>47</sup>

**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.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup> There was also a strong advocacy body – Oasis Forum – which was made up of a number of organisations, trade unions and lawyers.<sup>51</sup>

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.

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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/](http://www.zamcart.co.zm/new_chaz/) (accessed 2007-12-04).

45 [http://www.zamcart.co.zm/new\\_chaz/](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).

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## CHAPTER 5

### 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<sup>52</sup>.

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.<sup>53</sup> 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.”<sup>54</sup>

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.<sup>55</sup>

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.<sup>56</sup> FBO staff were not invited to MoH training, however, and, if they asked MoH trainers for training, the fee was quite high.<sup>57</sup>

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.*

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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).

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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.<sup>58</sup> 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.<sup>59</sup> 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.<sup>60</sup> 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?<sup>61</sup>*

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;<sup>62</sup> accessing economies of scale through sharing skills and the provision of technical assistance, including strategic planning;<sup>63</sup> providing additional funding;<sup>64</sup> 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

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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)

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### **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.<sup>65</sup> 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."<sup>66</sup> 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).<sup>67</sup> This was not a unanimous view, though; others thought that "staff at faith-based facilities have higher qualifications than elsewhere".<sup>68</sup>

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.<sup>69</sup> 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.

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<sup>65</sup> CHEP.doc - 8:25 (48:48), (CHAZ.doc - 10:33 (63:65).

<sup>66</sup> MoH-PH.doc - 1:41 (138:138)

<sup>67</sup> MoH-PH.doc - 1:25 & 26 (85:85); FGD Livingstone).

<sup>68</sup> Director of IAA.

<sup>69</sup> CHAZ.doc - 10:30 (56:56).

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A respondent mentioned greater efficiency in reporting to funders, stating that FBOs had created their own standards and maintained them.<sup>70</sup> 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”.<sup>71</sup> 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”.<sup>72</sup>

### 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”.<sup>73</sup> This gives a sense of security as they undergo their procedure, a feeling that they are experiencing this in God’s presence.<sup>74</sup>

Clients were said to express appreciation for the quality of care provided by FBOs, including the environment in which it was offered.<sup>75</sup> The same was true for care provided to them within their own homes, and the service was appreciated because it was seen as affordable.<sup>76</sup> 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.<sup>77</sup> (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.<sup>78</sup> FBOs were known to waive user fees for the poorest patients and were generally open to negotiation around this.<sup>79</sup>

## 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:

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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).

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*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.<sup>80</sup>*

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.<sup>81</sup>

*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.<sup>82</sup>*

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.<sup>83</sup>

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.<sup>84</sup>

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."<sup>85</sup>

Furthermore, FBOs were able to draw on a very strong tradition of community volunteerism. The Church was able to maximise that opportunity,<sup>86</sup> 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.<sup>87</sup> 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.<sup>88</sup> 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.<sup>89</sup> 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.<sup>90</sup> There were some critical voices, however, about expat 'experts' who came to practise on Zambians.<sup>91</sup>

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.<sup>92</sup> District officials in the public sector did not have the same access to communities and their traditional leaders, nor the credibility.<sup>93</sup> 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.<sup>94</sup> One of the advantages of funders using

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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).

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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."<sup>95</sup>

Some of the advantages of FBOs could also be disadvantages in some instances. A few specific examples mentioned were their often remote location,<sup>96</sup> challenges around procurement and licensing of drugs,<sup>97</sup> and the fact that being rooted in the community could pose a threat to confidentiality.<sup>98</sup>

A further potential weakness of FBOs was that they were not necessarily sustainable in the long-term<sup>99</sup> 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.<sup>100</sup>

### 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."<sup>101</sup>

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."<sup>102</sup>

There was an ongoing and pervasive problem of declining **external resources** for REs. Whereas in the past faith-based

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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).

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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.<sup>103</sup>

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.<sup>104</sup> 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.<sup>105</sup>*

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.<sup>106</sup> 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.<sup>107</sup> 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.”<sup>108</sup> 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

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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).

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stops, yes.”<sup>109</sup> 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.”<sup>110</sup>

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.<sup>111</sup> 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.<sup>112</sup> 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.<sup>113</sup> 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.”<sup>114</sup> 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,

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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).

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*"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."<sup>115</sup>*

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.<sup>116</sup>

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."<sup>117</sup>

### 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."<sup>118</sup>

This implied moving away from a heavy reliance on vertical programmes.<sup>119</sup> 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.<sup>120</sup>

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 through 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."<sup>121</sup>

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

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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).

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- 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.<sup>122</sup>

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.<sup>123</sup>

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.<sup>124</sup> 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”.<sup>125</sup> 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”.<sup>126</sup> 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?”<sup>127</sup>

### 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.

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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).

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## CHAPTER 5

### 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.<sup>128</sup> This could also be responsible for documenting best practice and arranging exchange visits.<sup>129</sup> At the district level there should be a body that was responsible for overall co-ordination and facilitation of activities.<sup>130</sup>

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.<sup>131</sup>

### 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.

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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).

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### 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/](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](http://www.oecd.org)

Oxfam. 2006. "Zambia uses G8 debt cancellation to make health care free for the poor". Press release. 31 March 2006.



