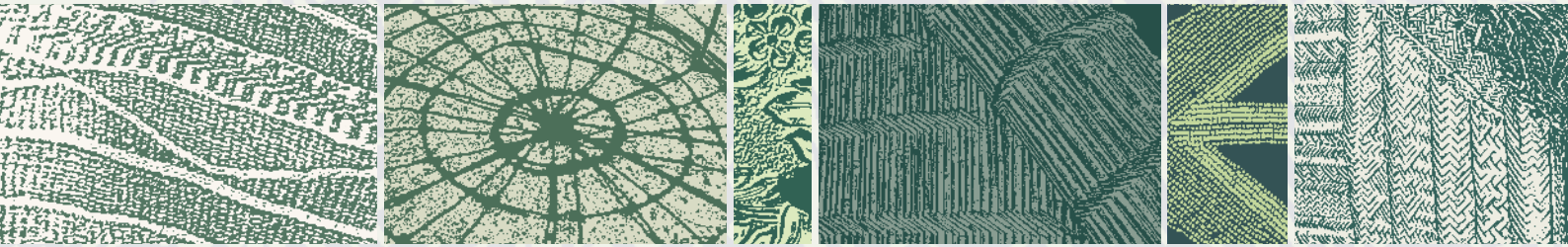


CHAPTER 7

CASE-STUDY MALI



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

CHAPTER 7

7.1 INTRODUCTION

While religion and religious entities impacted on public health in various ways in Mali, there were few religious health services per se. As a result the study approach in Mali included three local case studies which described different ways in which specific religious entities contributed to better health for the population. The chapter begins with an overview of the historical and health-and-religion context in Mali, followed by the local case-studies and a section drawing together common themes from these studies. The remainder of the chapter mirrors the structure of the other two country studies, addressing the capacity of health-supporting REs, current financial and material support for them, the ways in which they collaborate, and perceptions about them – albeit in brief, due to the paucity of faith-based health services. It concludes with sections on the constraints for REs in their endeavour to work for better health, ending with some recommendations.

7.2 OVERVIEW

7.2.1 HISTORICAL CONTEXT

Mali was a French colony until independence in 1960; thereafter it was under the rule of a dictator until 1991. Now Mali is a multi-party republic based on the French civil legal system as well as customary law. The country is divided into eight administrative regions.

As a previous French colony, at independence Mali inherited a state-controlled health service with minimal involvement by other providers such as the private sector or faith community. In contrast to Zambia and Uganda, Mali did not inherit an extensive network of mission hospitals.

7.2.2 SOCIO-DEMOGRAPHIC FEATURES

In Mali, half of the population of 12 million people were under 15 years of age.¹ Despite population growth, there was a net outflow of inhabitants due to migration by Malians to other countries. Ten percent of the population led a nomadic life, while 80% of the labour force was involved in the farming, livestock and fishing sectors.

Of those over 14 years of age, only 46% were literate; this average masked differences between men and women (54% and 40% of whom were literate, respectively).² Even these figures may be over-optimistic as Mali's most recent Demographic and Health Survey showed that over 78% of women aged 15-49 years and over 60% of men had never been to school.³

The country experienced recurring droughts and systemic famine. A critical problem was the inadequate supply of potable water. Estimates were that less than half of the population had access to sustainable improved water sources.

Given the limited natural resources and low educational levels, the country was very poor, with two thirds of the population living in poverty.⁴ Globally Mali had one of the lowest levels of human development; the UN's Human Development Indicator for 2006 showed Mali as ranking 175 out of 177 countries assessed.⁵ In addition, there was a high degree of inequality in the country, with the wealthiest 10% of the population controlling as much as 40% of the income and the poorest 10% only 1.8% of income.⁶ The poor resource base was one of the reasons that the country was heavily dependent on foreign aid. Foreign policy resulted in an IMF structural adjustment programme and the devaluation of the CFA Franc in 1994.

Mali was a predominantly Muslim country (90%), with small proportions of other faith groups (Christian and traditional or animist groups). Discrimination against woman was a major issue and female genital mutilation (FGM) was practised very widely (with over 90% of women affected).

7.2.3 BURDEN OF DISEASE

Deep poverty, inequality and low educational levels were key factors contributing to the poor health of Mali's population. Overall life expectancy at birth was 48 years. Mali had a very high risk of major infectious diseases: malaria was endemic

1 CIA 2007, estimate for 2007.

2 CIA 2007, estimate for 2003.

3 EDSM-IV 2007.

4 CIA 2007, estimate for 2001.

5 UNDP HDI 2006.

6 CIA 2007, estimate for 1994.

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and responsible for 13% of mortality and 33% of all medical consultations.⁷ However, in contrast to many sub-Saharan countries, the HIV prevalence rate for adults aged 15-49 years was low at only 1.7%.⁸

MNCR: Childhood and maternal mortality was amongst the highest in the world,⁹ with an infant mortality rate of 105.65 per 1 000 live births (2002), and maternal mortality at 577 per 100 000 live births (1996).¹⁰ According to an informant from USAID, infant mortality, however, was decreasing substantially and the rate of maternal deaths was also improving.¹¹

Save the Children identified the following health problems affecting pregnant women, and causing high maternal mortality:¹²

- anaemia, affecting about half of all women;
- malaria, a contributing factor for anaemia, was also linked to complications during pregnancy as well as miscarriage, prematurity, low birth weight;
- tetanus and lack of immunisation, which contributed to neonatal tetanus;
- sexually transmitted infections;
- high rates of FGM which could complicate labour.

An officer at the WHO-Mali identified the following structural concerns for reproductive health:

- the referral system was functional from community health centres, or CSCComs (see next section), to district facilities, but not from villages to the CSCCom;
- traditional healers were often the first point of call, and often patients with complications arrived at the CSCCom too late;
- there was no sufficient blood supply; this was the major cause of maternal death;
- low levels of uptake for family planning.

7.2.4 THE HEALTH SYSTEM

Mali's government spent just 6.6% of GDP on health care, or US \$54 per person, per year, according to the World Health Organisation.¹³ The Mali Ministry of Health was regarded as having full responsibility for the development and implementation of health policy. The health system, as is the case in much of Francophone Africa, was decentralised and the physical and financial resources needed to establish health centres were, in principle, furnished by the community (although, in practice, community resources were highly constrained).

The National Health Plan aimed to have local health services within 15km of the population. Each community health centre, known as a Centre de Santé Communautaire (CSCCom), had a staff component of three – a nurse, someone to deal with drugs and a 'midwife' who, in reality, tended to be someone with low-level training (known as a 'matron'). In addition the 'relais' acted as the liaison person between the village and the CSCCom, and was responsible for the provision of basic treatment to the population living within a 15 km radius of the facility while also being responsible for health promotion.¹⁴

The CSCComs formed the backbone of the health system providing, according to one informant, 90% of all facility-based health services.¹⁵ The CSCComs offered a basic package of health care – curative, preventive and promotive.¹⁶ Users were required to make a financial contribution for health services and had the option of contributing to a health association, which guaranteed reduced fees.

7 One World 2007.

8 UNAIDS 2007.

9 Stanton, Abderrahim and Hill 2000.

10 Save the Children 2002.

11 USAID.doc - 25:26 (37:37).

12 Save the Children 2002.

13 WHO 2007. This figure does seem exceptionally high; the figure given for 2004 by the WHO was \$16.

14 CARE.doc - 19:11 (19:19).

15 USAID.doc - 25: (21:21).

16 CARE.doc - 19:13 (22:22).

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Physical access to primary health services was, however, limited due to the vast size of the country and its very low population density: about half of the population were estimated to live more than 15km from a health facility.¹⁷ This inaccessibility had a major impact on maternal and child mortality rates. As with many aspects of governance in Mali, respondents stressed that the policy was good, but that it had not been possible to fully implement it. Nevertheless, the first 5-year Health Plan had succeed in doubling the number of CSComs, while the second plan aimed at improving the quality of the services provided now that there was considerably better coverage.¹⁸

The CSComs were managed by the community,¹⁹ through an Association for Community Health, consisting of a Board of Directors (representatives of the village, the Commune and the health staff) and a management committee. This included management of the link between the clinic and traditional healers and birth attendants. The low uptake of the CSComs was influenced, not surprisingly, by the fact that traditional healers were most often the first health provider consulted by health seekers. There was a remarkable acknowledgement of the presence and wide use of traditional healers within the MoH, with a great degree of acceptance of their value and a lack of animosity between bio-medical and traditional health providers. Traditional healers were readily available compared to the very sparsely available 'formally trained' health workers, of whom there was one per 40 000 of the population compared to one traditional healer for every 500 people.²⁰

MNCR: In order to address the very high mortality and morbidity rates amongst women and children the MoH and partner organisations had initiated a number of programmes. Free caesarean sections were available for those who had access to a medical facility. There was also free malaria treatment for children, and some medication for pregnant women.²¹

One of the biggest challenges of the health system was the lack of technical and managerial resources to build local capacity, a fact that was directly related to low school enrolment rates, especially in secondary school.²² A recent Demographic and Health Survey showed that just 3% of women and almost 8% of men had completed secondary school.²³ As a result, there were very few people available to be trained as health personnel and managers and, of those, the numbers wishing to serve in health centres in remote rural areas was even smaller.

Public health officials were involved in challenging some traditional practices. The rate of uptake for family planning was still low for cultural and religious reasons, but religious leaders had accepted birth spacing as an acceptable means of limiting family size.²⁴ Early marriage, with girls being married at 11 or 12 years, was another tradition that was being challenged by the MoH, encouraging them to delay marriage until at least 18 years.²⁵

7.2.5 THE ROLE OF RELIGIOUS ENTITIES

In Mali, there were very few FBOs providing facility-based health services, a fact confirmed by key informants. In the view of many interviewees, they were not regarded as either important, or necessary. The words of one of the respondents expressed the general sentiment:

*We need more clinics, but why faith-based ones?*²⁶

The few existing faith-based clinics were almost exclusively Christian, despite Mali being predominantly a Muslim country.²⁷ There was some debate about whether these church-owned clinics should be regarded as 'confessional' (i.e. religious) or 'private'. The office within the MoH responsible for liaison with both of these categories was unable to provide any information on the nature, scope or activities of faith-based health centres. In spite of the sparse data, it did appear that, on the whole, the clinics conformed to the requirements for CSComs (see 7.3.2 and 7.3.3 for examples).

17 One World 2007. Currently in the Mopti region, for instance, 1.8 million people live in the 80 000 square kilometres area with just 123 health centres among them (Afronews/IRIN, 2007).

18 USAID.doc - 25:25 (36:36).

19 WHO.doc - 14:10 (41:41).

20 WHO 2001.

21 National health directorate.doc - 16:3 (12:12) &16:5 (16:17).

22 Coulibaly & Hilhorst 2004, Dielman *et al.* 2006.

23 EDSM-IV 2006.

24 WHO.doc - 14:19 (67:67).

25 MoH Reprod health.doc - 15:11 (29:29).

26 Modibo Maiga, Health Policy International

27 See Section 7.8 for some explanations given for this.

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The scarcity of confessional health facilities does not, however, imply that religion and religious entities did not impact on public health in meaningful ways. Most prominent of these was the role of religious leaders in promoting health – from hand washing and hygiene to exposing HIV-related stigma or challenging FGM (see 7.4.1).

This situation in Mali appeared to be similar to that in some other countries in the region; it did however go beyond the scope of this study to determine the extent to which it is typical for Francophone and/or West African and/or Muslim countries.

7.3 LOCAL CASE STUDIES²⁸

In Mali the number of faith-based health facilities was low; hence the country study made use of local case studies of three religious agencies rather than questionnaires and focus groups (see 2.7.5). This section describes in some detail three REs typical for the religion – public health interface in Mali: a network of religious leaders responding to HIV and AIDS, and two clinics run by Muslim and Catholic groups respectively.

7.3.1 MALI LOCAL CASE-STUDY 1: THE NATIONAL ISLAMIC NETWORK FOR THE FIGHT AGAINST AIDS

7.3.1.1 THE HISTORY OF THE NETWORK

The Muslim Association for the Progress of Islam (AMUPI in French) was founded in 1980 to promote the values of Islam and provide responses to some development questions from an Islamic ethics perspective. It was, at that time, the only religious body permitted by the state and had a wide area of responsibility. AMUPI commented on issues relating to social concerns, education, trade unions and health (for example, mobilising Muslims to have their children vaccinated).

On the issue of HIV and AIDS the Association was silent – even judgemental – until 2000.²⁹ It was in this context that the National Programme for the Fight against AIDS and UNICEF engaged AMUPI in 2000 with the view to involving its members. This led to the formation of the National Committee for the Fight Against AIDS, which in 2002 became the National Islamic Network for the Fight Against AIDS (RNILS).

7.3.1.2 GOAL AND OBJECTIVES

The RNILS has made it its *mission* to fully engage in the fight against HIV and AIDS because Islam encourages people to build a healthy and strong community. The main objective of the network was to build the capacity of religious leaders in the fight against HIV and AIDS, and to co-ordinate, monitor and evaluate their interventions.

Box 7.1 The vision of RNILS

- *To work alongside the government and other actors towards a country without AIDS,*
- *To do so with compassion and support for those infected and affected by HIV,*
- *To draw on religious texts for guidance.*

The religious leaders included imams (prayer leaders and elders of major or small mosques) and ulemas (well-educated religious teachers), as well as leaders of the Islamic Women's Association.³⁰ The specific objectives were:

- co-ordination of Muslim initiatives related to the fight against HIV and AIDS
- networking at national, regional, sub-regional and international level, including with networks of other faiths
- technical and institutional capacity building, and
- fundraising, particularly in Muslim countries.³¹

7.3.1.3 MEMBERSHIP AND LEADERSHIP

Various religious associations were members of the network,³² having representation on a management committee and electing members of a Board. Three of seven Board members were currently women; a strong testimony to the commitment to gender equity in RNILS. Apart from the national office based in the capital, Bamako, the network was represented in six of the eight regions of Mali. The Network had no salaried staff and was staffed by volunteers.

²⁸ These local case studies draw mainly on interviews with key informants from the REs and documentation supplied by them. See the References (Section 7.11.2) for a list of sources. Material from other sources has been referenced.

²⁹ Protestant.doc - 21:20 (229:233).

³⁰ Policy Notes.doc - 24:5 (12:12).

³¹ RNILS: Statuts.

³² Such as AMUPI, the League of Imams and Learned People Mali, the National Union of Muslim Women Associations of Mali, the Muslim Association of Muslim Youth (AMJM), Medersas National Union in Mali and the League of Preachers of Mali.

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7.3.1.4 FUNDING

The funds for the Network came from USAID via the Health Policy Initiative, the government's National Solidarity Fund and members' contributions. While the resources of the Health Policy Initiative were used for capacity building, other funding was used to cover office expenditure. Every year, the Network developed action plans that it failed to implement, largely due to the lack of financial resources.

7.3.1.5 NETWORKING

The network was a member of the Alliance of Mali Religious Muslim and Christian Leaders against AIDS, the sub-regional Islamic Board (based in Mauritania), as well as a large network to counter AIDS in West Africa. It had close contacts with similar organisations in other African countries and many other associations had become interested in the experience of Mali and wanted to learn from the RNILS experience, which was, in the view of its President, "ahead of some countries regarding the involvement of religious leaders in the fight against AIDS."

7.3.1.6 ACTIVITIES

One of the main activities of the network was **building the capacity of religious leaders**. The Network worked towards greater involvement of religious leaders in the dissemination of prevention messages and the care of people living with HIV and orphans. The involvement of women in this struggle against AIDS was an express purpose.

In order to achieve its aims, training activities and workshops took place (see Appendix 7.1 for more detail) with the intention of encouraging those who had been trained to become multipliers in order to broaden the message:

When we train imams, these in turn must train other imams and preachers in order to disseminate information received (knowledge on HIV and AIDS, prevention of infection, treatment, stigmatisation) in the mosques during Friday prayers.

In general, there had been more training in the Kayes region and in the district of Bamako than elsewhere in the country; in 58% of the mosques in the capital there had been preaching about AIDS. In all its dealings with and pronouncements on HIV and AIDS, RNILS endeavoured to fight stigma.

Another major activity of the network was **prevention**, including the development of tools to enable the dissemination of messages:

A group of religious leaders spent seven months working out what the Qur'an says on the topic. They develop advocacy tools jointly with the religious leaders, based on the Qur'an ...³³

A range of strategies to encourage prevention had also been implemented (see Appendix 7.1 for further details).

A third major activity was the provision of care. The network's support and assistance for those infected and affected by HIV and AIDS – including people living with HIV, orphans and widows – was based on Islamic principles, which honour humanity in all its dimensions. Support of and assistance to people infected and affected by HIV and AIDS included medical, psycho-social and psycho-moral care, as well as fund-raising efforts to support care.

7.3.1.7 IMPACT

Analysis of the documents of the network and interviews with its officials showed that it had succeeded in getting Muslim leaders involved in the response to HIV and AIDS. Support from Health Policy Initiative for RNILS and similar networks had been crucial in developing the potential of religious leaders for health promotion. However, there was no real reflection on the implementation of activities. The network had been overly ambitious in trying to cover all the areas where member associations were represented, having neither a strategy nor sufficient human or financial resources to implement the action plans.

A number of suggestions had been put forward to improve and to strengthen the work and efficacy of the network, which included:

- concentrating activities where there was a need

³³ Policy Notes.doc - 24:2 & 24:3 (5:8).

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- collaboration with other non-governmental organizations, and
- targeting leaders who were not yet informed and involved in the fight against AIDS, especially in rural areas.

Reaching into rural areas, beyond the capital and other regional centres, had been a great challenge for the network.³⁴ According to its members, the network had to raise more funds for regional work, develop realistic action plans, train more leaders especially in the communes and villages, and provide detailed activity reports.

For the Network's President, the indicator of having achieved satisfactory results would be "If the young girl and the young man who must marry or that the man who must marry a second, third or fourth wife, are aware that AIDS is a reality and that they should behave so as not to contaminate others". For the activities of the network to result in behaviour change among young people and adults would take time and human, material and financial resources beyond those the network had been able to mobilise to date.

Whatever its limitations, this network appeared to be a good candidate for further development support in the form of training in areas like project management, implementation, visioning and goal setting. The network also represented the emergence of social capital in a country with an under-developed civil society.

7.3.2 MALI LOCAL CASE-STUDY 2: THE PRIVATE DISPENSARY OF FALADIÉ

7.3.2.1 THE CONTEXT AND HISTORY OF THE CLINIC IN FALADIÉ

The Catholic Church had providing health care to poor rural and urban communities for many years, even in Mali where the provision of health services was generally regarded as the responsibility of the state. The Catholic Diocese of Bamako financed five health centres, one of which was in the rural village of Faladié. Islam, Christianity and animism were the religions practised in the village, with an unusually high proportion of Christians resulting from the presence of a Catholic Mission for more than eighty years.

Box 7.2 Three phases of the Faladié clinic

1929 – 1960: French priests run the clinic

1960-2004: after Mali's independence six Belgian nuns take over

2004 -: three Malian nuns work with a local team

The village of Faladié was the central village of 18 making up the N'Tjiba Commune with a population of almost 20 000 inhabitants. According to Commune authorities, 85% of inhabitants were poor. Crop production only covered their needs for half of the year, making it difficult to pay for health care or school fees. The population was beset by health problems common to poor communities in low-income countries (see Appendix 7.2 for more details on the context).

According to an old informant from the village, the development of the centre went through three stages, characterised as follows:

1929 – 1960: During the first phase *French priests* were responsible for the mission as well as for the health centre. They started an elementary school for the children of Faladié and the surrounding villages in 1929, offering primary health care to students who were sick. By 1935, this primary health care unit had developed into a clinic for the whole community, regardless of religious affiliation. Care and medicines were given free of charge. *"It was the golden age; free medicines were effective; Fathers encouraged people in the villages to come to the clinic,"* said one resident of Faladié.

1960-2004: The second period started after Mali's independence in September 1960, with the arrival of six *Belgian nuns* who took over responsibility for the clinic. In this period the health centre was enlarged to accommodate the growing need, and outreach visits to villages were conducted. The sisters trained local villagers as matrons and caregiver-aides and spiritual advisors.

³⁴ Journalist.doc - 23:14 (42:42).

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Fee payments were introduced for consultations. According to one of the former physician-managers of the clinic they started selling 'consultation tickets' at 200FCFA (about half a US dollar) in 2002/3 after discussion with the Commune leaders. Through their personal relationships in Europe, Catholic priests and nuns were able to source specialised medicines for the pharmacy. This period was recalled with nostalgia by some of the people encountered:

The Belgian sisters were specialists in health; the laboratory was operational; the diagnosis they posed after examining the patients was accurate and patients accepted the treatment given. Effective products were given to pregnant women and malnourished children.

2004 -: Reaching old age, the sisters all returned to Belgium in 2004; they were replaced by three *Malian Catholic nuns*, one mid-wife and two nurses, who worked with a doctor and local matrons and caregiver-aides. The informants claimed that the current staff were less skilled than the Belgian sisters. In this period support from Europe decreased and user fees were increased. This income was supplemented by the sale of essential drugs, some of which were donated to the clinic.

7.3.2.2 INFRASTRUCTURE AND EQUIPMENT LEVELS

The health centre of Faladié was fairly large, was electrified and had a number of drinking water sources. The infrastructure was in good condition and well maintained. For the referral of patients there were two ambulances, one of which belonged to the health centre and the other to the village. In case of breakdown, patient transportation was provided by a vehicle belonging to the nuns.³⁵ The level of equipment of the centre was satisfactory for the primary care services it provided, but it was difficult to maintain an adequate stock of essential drugs and vaccines. Communication with the outside world was minimal because the village had no telephone connection. (More detail on the infrastructure is provided in Appendix 7.5).

7.3.2.3 STAFF

The 18 health workers included 1 doctor, 1 midwife, 2 nurses, 10 matrons, and 4 caregiver-aides, together with some support staff; a bigger team that was the norm at CSComs (see 7.2.4). There were trained traditional birth attendants linked to the centre, which sometimes received interns from local health training schools as well as students from France. This number of staff was deemed insufficient by one staff member who said, "There is too much work for each agent because the attendance rate at the centre is high". The staff members were often overwhelmed; that is why nuns did not provide home visits and spiritual counselling.

Box 7.3 The reality of referrals

There was a referral system in place for women with complicated deliveries, although it took over two hours to reach referral facilities. The health centre or commune provided the ambulance but the patients had to bear the high cost of the referral, at 25 000 FCFA (approximately US\$ 56 – covering the wage of the driver, fuel costs and the depreciation of the vehicle), paid before transportation as a rule.

7.3.2.4 SERVICES PROVIDED

The clinic provided a range of primary care services (see Appendix 7.3). The nutritional status of children who came to the centre was improving thanks to health promotion sessions conducted by the sisters. The laboratory that had long supported the health centre ceased functioning in 2004 due to a lack of qualified staff.

The attendance rate at the centre was high and increasing, according to health personnel. Community members, however, claimed that utilisation at Faladié was decreasing because of the declining quality of care, the costs of seeking care (including the high costs of consultations, the cost of getting to the facility from distant homes and the indirect cost of hospitalisation, as a relative needed to stay with a patient and provide care and meals), and the fact that two CSComs had recently been established in the Commune.

There was no religious taboo in evidence relating to the services provided by the clinic. Family planning, which had long been controversial in the Catholic Church, was provided, although the utilisation rate remained low. Women had

³⁵ At the time of our visit to Faladié both ambulances were in a state of disrepair.

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access to the contraceptive pill at their request; conversely, male informants reported that the centre did not provide condoms.

7.3.2.5 MANAGEMENT AND FINANCE

Staff expressed concern that the centre faced a lack of financial resources, hence, the shortage of staff, delays in the renewal of essential medicine stocks, and the closure of the laboratory. It was not possible to provide details on the budget because the Catholic health centre did not establish an annual budget. "This point is a weakness we are trying to solve," said the former manager of the centre.

The financial and material resources were provided by a number of sources, although it was not possible to quantify these in financial terms. Thus, the Catholic Church met the salaries of the three nuns and the doctor; revenue was raised through consultation fees and the sale of medicines (meeting the general expenses and wages of the salaried staff); the Government of Mali provided vaccines and refrigerators; some friends and facilities in Europe provided funds, laboratory equipment and training of doctors; and other funds were provided by donors like the Ambassador of the Malta Order.

Since independence, the government had recognized the Faladié health centre as a public utility infrastructure within a Commune with inadequate health care. Government support was part of the health policy of the country, which sought to provide a contribution to all structures capable of working at the community level using health staff and equipment to perform efficient work. Beyond material support, the public hospital at Kati provided supervision. Students from nursing and medical schools were sent to Faladié health centre for practical training. Data from the centre were taken into account by the Health Information System of the Ministry of Health through quarterly reports produced by the staff.

7.3.2.6 RELATIONSHIP WITH THE COMMUNITY

The community of Faladié had always perceived the health centre as a private church-owned structure that provided care to those who requested it. Their gratitude for the centre was expressed in statements like this:

Our parents were treated here; we were born in the Sisters' maternity ward; so were our children. Without this centre, we would be like the localities that have no health centre: we would have to travel kilometres for health services or be content with only traditional medicines.

The presence of the health centre was why the construction of a CCom was not seen as a priority when funding had been made available five years ago; instead, a school was built.³⁶

Owned by the Catholic Church, the Faladié health centre operated without the involvement of members of the community, unlike public CComs, which were managed by local communities (see 7.2.4). The one area where there was joint management was the use of two ambulances for transporting patients to referral facilities. Further, traditional birth attendants were trained and re-trained at the centre and made available to villagers.

Generally, however, the community felt excluded from the management of the centre; decisions were made by the priests and nuns who had not established any co-operation mechanism with the village leaders. Consultation fees increased on the decision of the clinic staff, and the villagers were not consulted but merely informed. Similarly, after a census, the church identified 30 poor people in the municipality who would be exempt from fees; again the community was not consulted.

This distance from the community may undermine the sustainability of the health centre. Already the frustration among community leaders at their exclusion from decision-making processes regarding the centre had given rise to the desire to build a community health centre in the village. As a result of such resistance to any local control, the Commune was starting preparations for its own health centre.

³⁶ Until then the Catholic school was the only school in the village. There was a sense that people needed to have a choice about where to send their children – a similar process to that now developing regarding the desire to build a CCom in Faladié.

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7.3.2.7 IMPACT

The positive perceptions of the Catholic health centre were reflected in the high utilisation rate and the fact that some patients travelled from far to attend the centre in Faladié. Unanimously, the people consulted for the study appreciated the presence of the centre and recognised that it rendered a valuable service to the villages in the commune.

The reasons given for using the Catholic health centre included:

- the quality of care offered, including at the referral hospital
- the low cost of specialised drugs
- the way the nuns welcomed patients
- the attention given to mothers and their newborn babies
- the cooking demonstrations for malnourished children, and
- the presence of an ambulance in the village.

The most controversial aspect of the health centre at Faladié, and most other Catholic health centres, was the exclusion of the community from management: "it is only the Catholics who 'make their own rules'".³⁷ By way of comparison, it was interesting to note the management model used by the Protestant health centres where community involvement was included. One informant said that many of the Protestant health centres had in essence become CSComs, albeit with church support.³⁸

There is evidence to suggest that Catholic structures were aware that this model might no longer be appropriate. The co-ordinator of the five Catholic health centres was working on a new management system for the health centres, aimed at providing and securing sufficient financial resources, and ensuring community representation in their management committees.

7.3.3 MALI LOCAL CASE-STUDY 3: THE MIPROMA CLINIC OF THE MALIAN ASSOCIATION OF YOUNG MUSLIMS

7.3.3.1 THE MALIAN ASSOCIATION OF YOUNG MUSLIMS

The Malian Association of Young Muslims, AMJM, was established in April 1991 following the advent of democracy in Mali. Its purpose was to contribute to the socio-cultural and economic development of Mali, and to bring together the youth, both girls and boys, to educate them according to Islamic ethics, and to encourage their participation in activities useful to the country in areas such as education or health. Initially the activities of the association were focused in Bamako before extending to the interior of the country.

AMJM was a member of other Muslim organizations and networks. These included: the National Islamic Network for the Fight against AIDS (RNILS), the High Islamic Council, and the National Council of Youth. It maintained good relationships with the League of Imams and Erudite of Mali, the Muslim Association for the Unity and Progress of Islam, and the National Union of Muslim Women Associations of Mali. Health had been an area of concern for AMJM from its inception, largely as a result of the difficulties faced by poor people, among them the need to travel long distances to Commune health centres and the high cost of consultation fees and medication (see Box 7.4 for health activities).

Box 7.4 Health activities offered by AMJM

- *Health consultations for Moslems in mosques, often along with donations of medicines.*
- *Free medical caravans in poor districts, with members providing free consultations and medication, donated drugs, and sensitising regarding health issues.*
- *Islamic material for sensitisation about family planning, education, environmental protection, and training in the use of this material.*
- *Advocating spirituality in health, through discussions and regular sermons.*
- *Sports activities used as opportunities for raising HIV and AIDS awareness.*

37 USAID.doc - 25:15 (22:22).

38 Protestant.doc - 21:5 (83:83) & 21:9 (91:91).

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7.3.3.2 HISTORY AND CONTEXT OF THE MIPROMA MUSLIM CLINIC

To deepen their involvement in health, the members of AMJM established a health centre, given the status of health mutuality,³⁹ called *Mutuelle Inter Professionnelle du Mali (MIPROMA)* in 1994. It was located in the District of Bamako in an area with a population of almost 95 000. The goal of the centre is to “provide curative care to patients, to facilitate treatment for patients through a chain of solidarity.” It was run just like the public CSComs, in close relationship with the MoH. Should this trial facility prove successful, the AMJM wanted to open more clinics in other areas.

7.3.3.3 INFRASTRUCTURE AND EQUIPMENT LEVELS

The MIPROMA centre occupied a double-storey, rented building which included consultation rooms, a small number of beds for hospitalisation, a pharmaceutical depot where patients could buy essential drugs, a small maternity facility and a laboratory. The building was well-maintained, was electrified and had drinking water, and the yard had benches and toilets for patients and people accompanying them. There was also a stove for the incineration of medical waste.

The clinic had sufficient equipment for consultations and gynaecological, dental and eye care, with scales and tables for consultation and delivery on hand. A refrigerator was used for storing vaccines. The health workers believed that the level of equipment at the centre was satisfactory and in good condition.

7.3.3.4 STAFF

The clinic had a total staff complement of 11, including 1 doctor, 2 nurses, 1 midwife, 1 obstetric nurse, 1 pharmaceutical depot manager, 2 matrons, 1 laboratory technician, 1 messenger and 1 security guard.

The doctor, the midwife and the obstetric nurse were paid by the government; the wages of the other eight employees were paid from user fees raised by the clinic. In addition to paid employees, health workers who were members of the association provided free services at the clinic. To take advantage of its position opposite a bustling market, five female grocery vendors were chosen to support the health centre as volunteers, as a way of encouraging women to attend the centre for pre- and post-natal consultations and child care.

7.3.3.5 SERVICES PROVIDED

The clinic provided a range of primary care services, including antenatal and postnatal consultation, deliveries, vaccination, and the sale of essential drugs. Utilisation of family planning services had more than doubled between 2005 and 2006. On certain days the clinic offered free medical consultation to old people. When appropriate, it referred patients to higher-level government facilities.

Health promotion activities included sensitisation of clients and locals about the consequences of female circumcision, HIV and AIDS, the benefits of attending the health centre, and reproductive health, including family planning. They promoted blood donation to blood banks and supported the public Sanitation Days.

7.3.3.6 MANAGEMENT AND FINANCE

The financial and other resources of the centre came from a variety of sources: the AMJM’s own capital; a start-up loan of 12 million FCFA (US \$27 000); a state grant of FCFA 800 000 (US \$1 800) a month to pay for 3 health workers; the provision of immunisation equipment and vaccines for children by the MoH; sponsored health services (for example, Almoutada Islamic wanted to pay for the provision of free consultations by the clinic), and donations in cash and kind. In 2006, MIPROMA received financial support from the Foundation for Children, Almoutada and a Turkish NGO. In addition, donations were received from Wawi and Almoutada in the form of millet, rice, sugar, clothes and oxen, which were distributed to the poor in various districts.

For members of the Mutual Benefit Association the clinic charged the same user fee as other community health centres in Mali, namely 300 FCFA (less than US \$1), while the fee was 600 FCFA (US \$1.40) for non-members.

The centre’s annual budget was 45 million FCFA (US \$100 000). In the first quarter of 2007 its income from fees amounted to US \$ 13 000 while expenditure was US \$12 000, leaving a small surplus.

³⁹ A mutuality is a non-profit insurer, owned and administered by the members and funded by their contributions, to provide benefits in case of sickness, maternity, etc.

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There were two levels of management within the clinic, namely a committee composed of the members of the AMJM, and the clinic staff members who managed the centre. The management committee of the Mutuality included members of the AMJM and representatives of the members.

The clinic submitted quarterly activity reports to the National Directorate of Health, and the data were reflected in the health information system of the MoH.

7.3.3.7 RELATIONSHIP WITH THE COMMUNITY

The clinic was open to all persons who needed health care, regardless of religion and ethnic group. People who attended the clinic came from the local and neighbouring Communes. Members of the Mutuality came from several Communes of the District of Bamako.

It seemed that although the community was excluded from direct management of the clinic, this had not frustrated the relationship with the community. Possibly the Mutuality offered the community some sense of participation.

7.3.3.8 IMPACT

While the AMJM viewed the clinic as similar to a CSCom, the patients regarded it as a sacred place, which was clearly an important matter to them. Patients said that health workers received them with more respect than community health centres did,⁴⁰ and they appreciated the fact that they might choose to be seen by either a male or female health worker. The market volunteers reported that the clients they referred to the clinic were “comfortable with the staff; medicines are within their budget.”⁴¹

The AMJM was initially criticised for its involvement in the fight against HIV and AIDS. Now, however, all Muslim associations were working on the issue. There were other difficulties, however: services at the clinic were limited; there was a shortage of staff, given the influx of patients experienced by the centre; there was a lack of suitable wards for hospitalising patients for more than a few hours; and there was a lack of beds in the maternity recovery rooms.

For the sustainability of the centre, AMJM proposed the construction of its own building to house the centre; ensuring ongoing state support in terms of personnel, finance and drugs; capacity-building for the centre staff in HIV and AIDS awareness and treatment; extension of the experiment to other Communes in Bamako and beyond; and emphasis on awareness about HIV and AIDS, malaria, family planning and female circumcision.

7.3.4 KEY THEMES EMERGING FROM THE THREE LOCAL CASE-STUDIES

It is clear from these three local case studies that religious entities had found ways to make a significant contribution to health in Mali, even though their impact on health statistics and outcomes might not be huge.

Relationships were central to strengthening the capacity to provide support for health in all cases, as highlighted through the following points:

- All three entities collaborated with the MoH which had overall responsibility for the health of the population. The style in which they did this differed, resulting in different outcomes. In practice the MIPROMA clinic worked more closely with the Ministry than the one in Faladié, and was regarded as a genuine partner. This translated into additional financial and staff support from the MoH; there may however have been implications for its autonomy.
- Networking with other faith-based groups was crucial for the Network (RNILS) and MIPROMA, and they were well integrated into a collaborative web; not so for the clinic in Faladié, where there was no evidence of networking or collaboration.
- Research indicated that communities took pride in their locally managed CSComs, but this was not found to the same degree in relation to all religiously owned facilities. In fact, in the case of the Catholic facility, there was evidence of some antagonism from the community due to its exclusion from decision making concerning the clinic.
- Community relationships were also manifested differently in each of the three case studies. Where these were

⁴⁰ Interview, 23 October 2007.

⁴¹ Interview, 24 October 2007.

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neglected, for example in Faladié, this gave rise to tensions. Regarding the other two case studies, both religious entities appeared to draw their potential for impact to some degree from their connection to the communities (e.g. the use of market vendors as agents for MIPROMA, or the influence of religious leaders in RNILS).

- It was impossible to find out how many religious clinics operated in Mali; neither the responsible MoH directorate nor religious authorities could provide figures. This does not speak only to the lack of a relationship between (some) religious entities and the MoH but also the lack of relationship between religious entities themselves.

Projects **changed over time:**

- Political reality and related developments impacted on health services. This was evidenced in the clinic in Faladié, which experienced a change of ownership at independence, leading to one of its most influential phases. However, political limitations on the role of civil society curtailed the potential of religious groups in impacting on society during the dictatorship, whereas the enabling political climate in the new democracy opened the space for civil society, and the development of networks like RNILS.
- Waning financial support from Europe, with shifts in the political landscape there as well as the growing secularisation of society, changed the size and nature of the external donor base. This had left clinics like Faladié in financial difficulty and without any clear action plans for the future to address this shortfall.
- More positively, judgemental attitudes towards people infected by HIV had given way – over time and through intense sensitisation – to more caring and compassionate approaches. However, some of the statements and programmes of RNILS did betray remnants of a negative and more dogmatic approach (such as their focus on “fighting brothels” in order to limit the spread of HIV).

Financial factors were an important determining factor in health care provision:

- The cost of providing health services and of developing and maintaining a network of religious leaders across a vast country was high, especially considering the Malian context of poverty. All three cases were hampered in the scope and scale of what they could do by the limited funds available.
- Even relatively low costs limited the potential impact of religious entities on health outcomes where poverty was so endemic. Potential patients stayed away from clinics due to the user fee charged, low as it was, resulting in low utilisation rates. Hospitalisation or referrals were not possible due to transport costs or the inability to provide meals. It was evident, however, that religious entities seemed to be able to overcome this constraint to some extent.
- For RNILS, financial constraints limited the extent to which national and regional plans could be implemented. This was even more so in rural areas, where the bulk of the population lived, and where the need for sensitisation was great.
- It was important to note that, to date, it was mainly the higher (that is, urban) level of religious leadership that had been impacted by the activities of RNILS in particular. Faith-based clinics, however, were also providing services for rural populations.

1.4 FAITH-BASED SUPPORT FOR PUBLIC HEALTH

7.4.1 HEALTH PROMOTION BY RELIGIOUS LEADERS

The findings of the local case studies presented above show clearly that the religious community in Mali – as elsewhere in sub-Saharan Africa – played an important role in society, and indeed with respect to health, even if this role was perceived in a way that differed markedly from that in other countries. In Mali there were almost no health services provided by religious groups – and very few people thought that religious entities should be involved in health services provision.

On the other hand, religious leaders of all disciplines and faiths had a crucial role in the dissemination of health messages to the population. Indeed, the notion of religious health services was often taken as referring to **health promotion** by religious leaders:

It is very important for confessional organisations to be involved in health issues. For example, they say about the case of family planning, when they call religious leaders, to make people understand that finally Islam, for example, is not against family planning. So for many issues if they look at the document⁴² and seek for references - they can help in the promotion

⁴² Referring to the Qur'an, the sacred scripture is Islam.

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of health.⁴³

Box 7.5 Religious leaders mobilise for health

An MOH official reported that in the Mopti region the population refused tetanus shots, saying that they sterilised women. He did a lot of radio broadcasts explaining to people why they were doing it. But the community never listened to him.

And finally he went to see the leaders at the mosque; it is these leaders who made people accept the tetanus shots.

MoH 1.doc - 16:14 (38:38).

Religious leaders were called on by a wide spectrum of groups to be active in health promotion at different levels, the RNILS case-study (see above) being but one example. Numerous examples of this were mentioned during key informant interviews, as presented in Appendix 7.4. As a rule, religious leaders were trusted by their followers and the messages they promoted were likely to be accepted in good faith, helping to mobilise the community (see Box 7.5).

It emerged from this study that suitable champions, i.e. strong, charismatic leaders, needed to be selected to promote specific health issues, especially those that were potentially controversial like HIV or female genital mutilation.⁴⁴ When suitable leaders had been identified they needed to be informed and trained.⁴⁵ Such persons needed to be committed to the cause, and once convinced, they became influential champions of public health issues, such as encouraging the population to take up birth spacing as a means of family planning. In various areas leaders had even been transformed from merely acting as conduits for messages to becoming contributors of their own ideas.⁴⁶ However, even the impact of such leaders might be curtailed by an environment not open to change.⁴⁷ As a rule, women were best addressed by leaders of the Islamic Women's Association.

In many cases in Mali, convincing religious leaders had involved a lengthy process of engagement where groups had been confronted with a topic and then worked through their sacred scriptures in order to identify responses that were both helpful to the health cause and in agreement with the theology:

... they did a research on the Bible and the Qur'an to pull a message [about AIDS] which combats stigma and discrimination. They have parts of the Bible and the Qur'an saying that you shouldn't do that, you shouldn't do that.⁴⁸

Material compiled through such a process was then tested in a large group of religious leaders to ensure it was in line with the Qur'an, or the Bible in the case of Christian leaders.⁴⁹ Once the basic tenet had been accepted, specific messages were prepared and distributed to mosques and churches, where they were shared with those who attended Friday prayers or Sunday services.⁵⁰ The media was also used to broadcast messages. While urban audiences were addressed via television, in rural communes, where the majority of the population lived, radio was the main mode of communication.⁵¹ This whole process was based in the concept of Shura or consultation in Islam. One informant mentioned how useful an event in 2005, called the "Caravan of Religious Leaders against AIDS", had been, because it brought together religious leaders from different faiths, people living with the disease and journalists in mobilisation of the community (see Appendix 7.4 for more detail).

The effectiveness of this method of health promotion was difficult to assess. It could be claimed that a significant percentage of religious leaders, in urban areas at least, had been sensitised and trained. This involved mainly leaders at national level, as the rollout to rural regions remained a major challenge. It was, of course, in the rural areas that the need was greatest, and the task more difficult as many rural imams were barely literate, although they had learned to recite

43 MoH Reprod health.doc - 15:25 (62:63).

44 Policy Notes.doc - 24:6 (14:14).

45 Journalist.doc - 23:4 (17:17).

46 USAID.doc - 25:9 (15:16)

47 Journalist.doc - 23:8 (26:26) & 23:9 (28:30)

48 Protestant.doc - 21:30 (318:318).

49 Policy Notes.doc - 24: (8:8).

50 PSI.doc - 22:15 (116:117).

51 PSI.doc - 22:16 (118:119).

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the Qur'an.⁵²

It must also be noted that using religious leaders for health promotion had not been equally effective for all issues. The impact of this approach on vaccination had perhaps been the greatest,⁵³ whereas success with female genital mutilation had been the most limited, as many religious leaders held a conviction that this centuries-old tradition was a practice required by the Qur'an, conflating Islam and tradition.⁵⁴ Even exposure to Muslim leaders in other countries, who were opposed to the practice, had not really had much impact.

7.4.2 TRADITIONAL HEALERS AND TRADITIONAL BIRTH ATTENDANTS

It was generally acknowledged that health-seeking behaviour in contemporary Mali almost always started with a visit to traditional health providers, as it had for past millennia, and that they still played a central role in providing the bulk of health services to the population.⁵⁵ The majority of deliveries in Mali occurred at home assisted by a birth attendant.

Traditional practitioners were more accessible to the population, in terms of their culture, location and numbers, and were usually more affordable. They offered treatment for a wide range of ailments. The TH and traditional birth attendants (TBA) were recognised as an integral part of the health system⁵⁶ and there was no secrecy about the extent of their influence, as is the case in many other parts of Africa.

This was due, at least to some degree, to the policy the government had adopted regarding traditional practitioners and their role in the health system. A Department of Traditional Medicine as well as the National Research Institute of Medicine and Traditional Medicine had been in place since 1973, with the mandate to demonstrate the value of traditional healing through scientific means. In 1980, the Minister of Health appointed a Scientific and Technical Committee to support this research.⁵⁷ As a result of the work of these institutions, seven improved traditional medicines were now on the national list of essential drugs in Mali, and 60% of new drugs that came onto the market between 1980 and 2000 were based on natural materials.⁵⁸ Further enabling policies were adopted in Mali:

- in 1994 a decree was passed that regulated private consultation clinics for traditional medicine as well as the production and sale of medicines, and
- in 1995 decrees were passed regulating the issuing of "a certificate of notoriety and morality" to traditional healers and the selling of herbal medicines.⁵⁹

While traditional healers had their own associations separate from the CSComs to promote their products and services, traditional birth attendants worked quite directly with the CSCom staff.⁶⁰ In most communes there was a committee that co-ordinated the activities of traditional practitioners with the health centre.⁶¹ The traditional practitioners, being trusted in the community, had an important role in mobilising communities around health issues alongside the religious leaders (for instance, by raising awareness about HIV or referring patients for medical care).⁶² Training of traditional healers and birth attendants by biomedical practitioners, often mediated through the CSComs, enabled them to recognise when patients needed to be referred for treatment.⁶³ This open approach resulted in a positive relationship between traditional and public health providers.

7.4.3 ROLE OF RELIGION IN HEALTH

Both Islam and Christianity in Mali were concerned with improving people's well-being, including their health (see Box 7.6).

52 USAID.doc - 25:24 (35:35).

53 Journalist.doc - 23:18 (50:50).

54 Journalist.doc - 23: (51:51).

55 TH.doc - 17:2 (33:33), PSI.doc - 22:24 (129:129) and others. WHO 2001 puts the figure of people using TH at 75% of the population.

56 MoH Reprod health.doc - 15:32 (78:78).

57 WHO 2001.

58 Sociolingomali 2007.

59 WHO 2001.

60 MoH Reprod health.doc - 15:30 (73:73); there are currently 32 associations of TH in Mali (WHO 2001).

61 TH.doc - 17:12 (73:73).

62 USAID.doc - 25:22 (31:31).

63 CARE.doc - 19:20 (46:46) & 19:21 (50:50).

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Box 7.6 A religious imperative to heal

To help is also a religious act. What is important is the human being; helping human beings (Islamic Relief.doc - 20:26 (406:410)).

Man is not only a spirit, it is also the body. You can't take care of only the spirit without the body. That is one of the reasons why the Protestant church tries to promote health (Protestant.doc - 21:15 (149:149)).

This concern was expressed in different ways in the two traditions. In the Christian context it often led to the provision of health services (see following section), whereas in the Islamic tradition the emphasis was on solidarity and social support, expressed for instance in the practice of Zakat (giving of resources to the poor). Another factor was the widespread use of Islamic medicines or cures by the majority of the population of Mali. The holy men or Qur'anic scholars (known as marabouts) might offer treatment for physical complaints through 'nassi', the ink washed off the wooden tablets that Qur'anic scholars used to write down verses of the Qur'an, either to be drunk or used to wash oneself.⁶⁴ Treatment could also take the form of 'gris-gris' (amulets containing words from the Qur'an).⁶⁵ Other Islamic Sufi treatments were used to heal physical and mental illness and to restore well-being.

It was undeniable, though, that some religious customs and traditions worked against health. For example, men did not willingly show that they made use of family planning services⁶⁶ and there was a strong patriarchal tradition where, for instance, it was men who decided whether a woman would deliver her baby at the CSCoM or be assisted at home by a TBA. A particular reading of religion does support this unhealthy skewing of gender relations and disempowerment of women, even where the precepts of the religion stress equality.

Poor literacy and education levels were also factors contributing to Mali's poor health outcomes, which could be traced back, in part to the reticence of Islamic leaders towards formal (western) schooling.⁶⁷ While Islamic precepts make education obligatory for both women and men, this was a form of resisting colonial influence. There was also the problematic issue of 'garibou', involving groups of children who were sent to learn the Qur'an with 'marabouts' (Qur'anic scholars). The children sometimes ended up in poor health and with psycho-social problems as a result of being abused by the marabout for whose family they had to work, and were often sent to beg for food.⁶⁸ Those who tried to escape frequently ended up as street children in cities or were trafficked into agricultural labour, often across national boundaries.⁶⁹

Another harmful practice that was often understood to be prescribed by Islam was female genital mutilation,⁷⁰ which was very common in Mali: according to the last census, 91% of women between 15 and 49 years had been circumcised. There was an ongoing discussion about this phenomenon: was it culture, was it tradition, or was it indeed religion that kept a practice like this in place? Attempts to involve religious leaders in challenging this practice against the demands and teachings in the Qur'an had not been very successful to date, as indicated above. This does raise the question of what vested political and economic interests are involved in maintaining a practice that is clearly out of step with the Qur'an.

7.4.4 CAPACITY OF FBOS TO PROVIDE DIRECT HEALTH SERVICES

As already stated, there were very few religious health facilities in Mali: a handful of clinics were run by the Catholic Church or the Protestant Health Association, and there was one Muslim health centre, regarded as an exception and considered by a representative of the MoH as 'private' rather than 'confessional' like the Catholic facilities. An Iranian-funded clinic was mentioned,⁷¹ but it was not clear whether this had any faith base.

Despite the paucity of facilities, there was appreciation that these facilities made an impact in the areas where they functioned (with particular reference to the Faladié and MIPROMA clinics), and that they were, at times, the only available health providers in rural locations.⁷² Their contribution to coverage of the population regarding health services, and

64 Handloff 1982.

65 Amiga et al 1992.

66 MoH Reprod health.doc - 15:6 (20:20).

67 Castle 1992, Diallo 2001.

68 Douville 2003.

69 Castle & Diarra 2003.

70 Shaaban & Harbison 2005.

71 PSI.doc - 22:20 (123:123).

72 TH.doc - 17:7 (53:53).

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improving access was acknowledged,⁷³ and they were also seen to help to improve national health indicators through their involvement in campaigns of the MoH.⁷⁴

Generally services provided at the religious facilities and staffing conditions were similar to those on offer at a CScCom.⁷⁵ Specific services provided by faith-based groups mentioned by key informants included: dispensaries, maternity facilities, vehicles for referrals, qualified nurses, preventive services like immunisation and behaviour change communication, promotion of nutrition, hygiene, and even family planning.⁷⁶ More ad hoc efforts focussed on specific health issues (such as a campaign using volunteer specialists to offer eye surgery and eye care).⁷⁷

7.5 FBO COLLABORATION

The range of networks of religious leaders involved in different health issues in Mali included both Muslim and inter-faith groups, each focusing on different health issues. The networks worked closely with each other and were also called on to support government initiatives (see the case-study in 7.3.1).

There were also representatives of a number of international faith-based networks working within Mali. Norwegian Church Aid, for example, did not offer direct health services, but supported interventions towards better governance and education (particularly for girls), providing food security, and countering gender-based violence and HIV and AIDS.⁷⁸ Besides large scale emergency food relief programmes, Islamic Relief supported child sponsorships in Mali for about 1,500 orphans and provided health care to them and their families at a clinic dedicated to this cause.⁷⁹ World Vision, a US-based Christian agency, offered sponsorship for poor children and supported local agencies working to improve health, education, clean water, food, and income generation activities.⁸⁰

There was no evidence of collaboration between faith-based health care services, which may be largely because of their geographic isolation, but also reflects the reality that there are no formal partnerships between Churches and ecumenical institutions.⁸¹ Since there were not many religious health services, there were hardly any coordinating networks to support them. The Protestant Health Association and the Catholic health desk respectively coordinated the activities of their health centres, and representatives of both also belonged to the network of religious leaders. The multiple partners who collaborated with these networks, both secular NGOs and public agencies, were discussed above (See Sect 7.3.1).

There were a number of ways, however, in which faith-based health services collaborated with the MOH (see Box 7.7).

The MOH had a special directorate for confessional and private health services, but the relevant official was unable to provide any data relating to confessional facilities, citing their failure to submit data to the health management information system and lack of capacity to follow up. It was unclear whether this situation reflected the low level of importance attached to this category of health services by the Ministry, or whether it was a result of significant under-capacity.

Collaboration with traditional healers and traditional birth attendants also occurred at various levels, as was discussed in 7.4.2 above. In addition it could be pointed out that these providers received training from the MOH and were a vital link in mobilising communities for utilisation of CScComs.⁸² Concerning collaboration of faith-based groups with traditional healers, it was pointed out that some Catholics had a good relationship with traditional healers; the same did not seem to apply to Muslim or Protestant entities.⁸³ In the case of Catholics this went beyond the interest of individual in collaboration, since the Vatican had adopted a position paper on the need for such collaboration.⁸⁴

7.6 SOURCES OF FINANCIAL AND MATERIAL SUPPORT

73 World Vision.doc - 18:11 (42:42).

74 National health directorate.doc - 16:10 (28:29).

75 CARE.doc - 19:35 (75:76)

76 World Vision.doc - 18:4 & 5 (16:17) & 18:10 (39:39), Protestant.doc - 21:24 (286:286); see also local case studies above

77 Islamic Relief.doc - 20:7 (188:188)

78 Norwegian Church Aid 2007

79 IR doc - 20:28 (158:158)

80 World Vision 2007

81 WCC 2001.

82 WHO.doc - 14:27 (98:98), USAID.doc - 25:22 (31:31)

83 TH.doc - 17:14 (75:77)

84 Vatican 1993

Box 7.7 Collaboration between REs and the MoH

- *Government provided vaccines and equipment for services rendered in accordance with MoH guidelines (National health directorate.doc - 16:19 (45:45))*
- *in the case of the MIPROMA clinic, the state supported some staff salaries (it is not clear whether this is a unique situation or if other facilities had similar agreements)*
- *confessional clinics were supervised by the public health centres and reported to them (MoH Reprod health.doc - 15:21 (47:47))*
- *patients were referred to higher level public facilities,*
- *staff benefitted from in-service training provided by the MoOH (MoH Reprod health.doc - 15:24 (57:57)).*

USAID was the only funder supporting the engagement of religious leaders for health promotion.⁸⁵ It did so through the Health Policy Initiative, which provided training on health issues, supported capacity-building and acted as a small grant-maker to the religious networks.⁸⁶ The only other income was from membership fees.

The confessional clinics did receive some financial support for staff salaries and drugs from the European mother church bodies, but this was decreasing.⁸⁷ As the religious staff members were now predominantly local, the connections to European mother bodies were less direct. There was also some support from the MoH for vaccination material and equipment, which was also available to private-for-profit facilities. Otherwise, the clinics relied on the user fees they charged and the sale of drugs, some of which were donated (see case studies above).

In the case of traditional healers, many felt neglected by the state. They claimed that they provided 80 percent of health services, yet did not receive any funding in support of this contribution.⁸⁸ While other informants confirmed that 80 percent or more of the population turned to healers as a first resort, it has to be pointed out that this does not necessarily translate into 80 percent of services. Nevertheless, traditional practitioners undoubtedly provide a substantial portion of health care and their claim to some subsidy in recognition of this is understandable.

7.7 STAKEHOLDER PERCEPTIONS OF FAITH-BASED HEALTH SUPPORT

There was unquestionably, widespread support for the role of religious leaders in health promotion, as shown above. This support became more complex in cases where health policy was not easy for religious leaders to accommodate within their religious convictions, as in the case of female genital mutilation and contraception.

Interestingly, although the faith-based health sector was very small compared to the public and even the private sectors,⁸⁹ there were quite definite perceptions about the distinction between their services and those at the CSComs, with the former regarded as providing better quality care (see Appendix 7.5 for detail).⁹⁰ Although there was no perceived need for specifically faith-based health services, where they did exist, the faith and conviction of staff working there - who were seen to be 'working for God' - was viewed positively, resulting in what was experienced as a better attitude towards, and care for, patients.⁹¹

7.8 FACTORS LIMITING THE INVOLVEMENT OF RELIGIOUS ENTITIES IN PUBLIC HEALTH IN MALI

An important challenge posed to this study was finding an explanation for the virtual absence of religious health services in Mali, compared to the other two case-study countries, namely Zambia and Uganda. The broad political and historic dimensions that underscore this scope of work have been discussed above (see 3.6).

Key informants provided some additional insight into the unique situation in Mali, as follows:

85 Journalist.doc - 23:15 (44:44).

86 Policy Notes.doc - 24:10 (18:18).

87 CARE.doc - 19:36 (76:76).

88 TH.doc - 17:17 (91:91). The same complaint was raised in Zambia.

89 CARE.doc - 19:33 (72:72).

90 World Vision.doc - 18:7 (28:28), TH.doc - 17:6 (51:51), National health directorate.doc - 15:27 (66:66), CARE.doc - 19:39 (80:80), Protestant.doc - 21:26 (294:294) & 21:28 (298:298).

91 CARE.doc - 19:38 (80:80) & 19:40 (80:80).

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1. First, the perception was common in the country that, while there was a dire need for additional health centres, this did not imply that religious groups should provide health services. It was understood that religious leaders could play a role in supporting the management of local CSComs, or helping to improve existing CSComs, but this was in contrast to actually starting and establishing confessional health centres.⁹² One source felt that there might be room for more faith-based involvement (for example, in building more infrastructure). "But it should be done in accordance with the health policy in Mali. They should not come in the same area, for example, where there is CSCom".⁹³
2. A second reason was the political context. The Christian clinics had been set up under colonial rule and hence with support from the colonial power. Following that era Mali was ruled by a dictator who allowed only one Muslim organisation, a structure with old men in positions of authority, where nothing ever changed. Only after 1991 could other associations come into being and challenge the status quo. Some of these, like the AMJM, had young well-educated members who were open to new ideas and engaged in rethinking the meaning of Islam. In this new context, setting up a clinic began to seem possible and desirable (see MIPROMA case-study above).
3. It was also put forward that, while Mali's population was predominantly Muslim, it was not a country under Islamic law, a condition that would have favoured more active religious involvement in all spheres of society.⁹⁴
4. Finally, a lack of resources – and access to external resources – were seen as factors making it almost impossible for local religious groups to set up expensive to run health services.⁹⁵

This range of suggested reasons drawn from participating informants highlighted the difficulty in pinpointing a single cause for the very different religion-health dynamic in Mali, as compared to Zambia and Uganda. A complex mix of historic, socio-economic and religious factors was at play, and continues to impact the present situation. As these factors change – and the AIDS pandemic is but one such force for change – new religious responses to the health challenges in Mali will emerge.

There are a number of other constraints that hamper FBO involvement, some of which have already been touched upon in the local case-studies. These include the following:

- the donor base for building the capacity of religious leaders was very small, which hampered the degree to which networks of religious leaders were able to extend their training and sensitisation concerning health issues; it also resulted in the discontinuation of some services previously provided by confessional services;
- there was a shortage of human resources (including managerial skills) in the country as a whole – and a reliance on volunteers – which made it difficult for networks to realise their ambitious plans, especially at regional level;
- given the geographical conditions of the country, it was hard to reach the high percentage of the population living in sparsely settled rural areas;
- low levels of education and literacy among the imams, especially in rural areas, hampered drawing them into health promotion programmes;
- there was unwillingness in some confessional services to share power with local communities, which might curtail their influence and give reason for rival CSComs to be set up in close vicinity;
- Christian clinics had not been able or willing to negotiate agreements with the MoH that would ensure them greater support (for example, through funding for staff salaries).

7.9 KEY AREAS FOR POTENTIAL INVESTMENT

7.9.1 THE HEALTH SYSTEM

Mali's health system is in need of support. National health plans that have been developed require funding support in order to make implementation possible. Decentralisation is well on its way, but the majority of villages are still without access to a public health facility. Hence, all agree that many more CSComs are needed.

There are huge needs around services to curb the high maternal and child mortality rates. A further need is for

92 National health directorate.doc - 16:17 (42:42) MoH HR.doc - 15:26 (65:66), CARE.doc - 19:46 (90:90).

93 CARE.doc - 19:45 (90:90).

94 WHO.doc - 14:8 (37:37) & Islamic Relief.doc - 20:17 (307:309).

95 PSI.doc - 22:23 (127:127); Islamic Relief.doc - 20:24 (374:374).

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reproductive health services that are acceptable to men and to the youth.⁹⁶

7.9.2 HUMAN RESOURCES

In Mali, as much as in the other case-study countries, the needs around human resources for health are great and need to be addressed. In particular, qualified personnel are needed for rural areas; this will require some incentives to recruit and retain them.⁹⁷ Potentially this is one area where, even in Mali, religious facilities and staff motivated by their faith could make a significant contribution.

7.9.3 INFRASTRUCTURE

The need to link the different levels of the health system, e.g. to enable patient referral from remote facilities to higher care, is dependent on reliable transport, and ambulances are needed to support this function.⁹⁸ Providing vehicles should be linked to maintenance support as, in many instances, these vehicles are out of operation as a result of minor technical faults. Training mechanics to keep vehicles in working order is important.

7.9.4 SPECIFIC INTERVENTIONS

Several specific interventions requiring funding support were mentioned in this study. First, the much-valued health promotion work by religious leaders was not sufficiently supported as a means of improving health outcomes in Mali.⁹⁹ In the light of this:

- the associations of religious leaders need to be supported more widely; some funding ought to be earmarked for capacity building, to impart skills on management of funds and other resources as well as on planning of activities.¹⁰⁰ Without this type of support the impact of this potentially powerful means of health promotion may simply remain a Bamako-based project, without benefiting other regions. In particular, funding is needed for the rural chapters, to make possible the extension of the positive results achieved in the cities to these populations.¹⁰¹ It is likely that this will require innovative ways of engagement and extension, especially given the typically low educational levels of rural imams, and
- support should also extend to the younger, well-educated groups, as in the AMJM, who have the potential to make a valuable contribution.¹⁰²

Other suggestions included the following:¹⁰³

- cultivating traditional herbs and processing them for treatment
- training of both traditional healers and western health workers to understand each other's approaches and to learn a common language, and
- linking traditional health providers to the CSCoM network.

7.9.5 CHANNELING OF FUNDING

Since the MoH was regarded as the main player responsible for the health of Mali's population, it was not surprising that several informants believed that all funding should be channelled to the Ministry and be distributed from there to other players, including confessional ones.¹⁰⁴ However, the office of the MoH responsible for confessional health facilities was not well-organised and had very little contact with the religious health centres.

Clearly, in a context where such a small percentage of health services is religiously based, it is not feasible or likely that these groups would be major recipients of funding, even when it is evident that they do valuable work in support of improved public health outcomes and are in need of financial support to maintain their services.¹⁰⁵

96 MoH Reprod health.doc - 15:3 (13:13).

97 WHO.doc - 14:26 (94:95).

98 CARE.doc - 19:54 (105:105).

99 USAID.doc - 25:4 (8:8).

100 Journalist.doc - 23:17 (46:48).

101 Protestant.doc - 21:36 (400:400).

102 MoH Reprod health.doc - 15:37 (91:92).

103 TH.doc - 17:19 (96:99) & 17:20 (101:101).

104 MoH Reprod health.doc - 15:34 (84:84).

105 CARE.doc - 19:56 (109:109).

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Another approach to providing this support, however, is the concept of direct funding support to the community level centres – whether confessional or not – the outcome of which will be that, as long as the communities receive the benefit of the funding, improvements will be made.¹⁰⁶

7.10 CHAPTER CONCLUSIONS AND RECOMMENDATIONS

1. The emphasis in the religion-public health interface in Mali is different from that in many other countries in sub-Saharan Africa. The role of religious leaders in health promotion is highlighted, while health service provision has a low profile. This study has explored this difference and the political and religious factors underlying it (see also Chapter 3). Further study is required to fully understand the role of religion in this context and how both potential roles for religious entities in health promotion and health provision can be nurtured and complement each other.
2. The health promotion role of religious leaders is valuable and should be supported financially.
3. Regarding the provision of health services, it is clear from the local case studies that there is a potential role in this area for religious entities, although it is unlikely that this will take the same form as in Uganda or Zambia. In Mali it will be more helpful to develop ways for religious entities to become part of the community support for CSComs, in close collaboration with the Communes, the Ministry of Health, traditional healers and religious collaborating structures. Implementation of this recommendation will require exploration of suitable forms of collaboration, involvement of local leadership with religious facilities and religious leaders with CSComs, as well as support for structures in which models can be explored and debated.
4. Given the poor health context, it is worth asking whether faith-based groups should be encouraged to expand their involvement in health service provision. Even with the low level of religious health service provision, there is acknowledgement of the good quality of care they provide. There might be ways of tapping into this ethos, to the benefit of the population.
5. It is potentially an added value that religiously motivated staff members are more willing to work in hard-to-reach areas. This potential could be made accessible to the wider community through religious facilities, or through religiously based training of health workers. Alternatively, it might be an issue adopted by the networks of religious leaders to encourage their followers to consider taking up positions in hard-to-reach areas.
6. In Mali, a combination of health-seeking strategies is common among the population. In their search for health, people turn to traditional healers and supernatural cures and prayer, as well as bio-medical interventions. Any interventions into health systems have to keep in mind that there are numerous systems operating alongside one another, influencing one another and at times curtailing one another. It may be crucial to understand this 'mixture' better before attempting to intervene with solutions directed at only one of the systems.
7. The role of African traditional healers in Mali was not studied extensively for this report. The findings do however indicate intriguing aspects about their role in society, i.e. the positive relationship with public health authorities and some formal religious groups. In any attempt for closer collaboration between African traditional and bio-medical health providers a willingness to learn from TH approaches will be crucial. A closer study of this sector in Mali, the way it operates, the degree to which they function as religious entities, the factors making possible positive relationships, could provide helpful indicators for replicating this elsewhere.
8. Given the existence of trusted and locally available traditional healers who are already working with the CSComs, it is suggested that special initiatives are developed to improve their skills so that they become more au fait and skilled in making referrals to CSComs. In addition, the traditional birth attendants constitute another locally based resource, and they are in need of training. This recommendation is important as a strategy to help address the very high maternal and infant mortality rate.
9. Traditional practitioners undoubtedly play a major role in health as first-line providers of choice and their claim to

106 National health directorate.doc - 16:20 (48:48)

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some public subsidy in recognition of this role is understandable. The study recommends that this be looked into in Mali.

10. There is an important role for women and, in particular, grand-mothers in providing advice on treatment of ill babies. As a result, it is suggested that women's groups associated with mosques be trained so as to provide sound advice to young mothers and families.
11. It is remarkable that, in Mali, as elsewhere across the globe, it was the AIDS pandemic that gave rise to collaboration across divisions. The World Council of Churches, for instance, mentions the lack of partnership structures between churches,¹⁰⁷ yet Catholic and Protestant leaders have joined Muslim colleagues in the inter-faith network against AIDS. Against the general lack of collaborative fora for religious groups, the level of inclusivity and collaboration achieved in the networks is all the more remarkable. This fact is further support for the recommendation that the networks deserve to be better resourced.
12. Despite numerous attempts to obtain information from various institutions, both public health and religious, it was not possible to determine the scale of Christian health services nor to ascertain whether their location is mainly urban or rural. While this is a limitation of the study, it is also indicative of a lack of communication, and seemingly a failure of the partners (that is, the MoH and Christian health co-ordinators) to take collaboration seriously. The study recommends that this matter receive attention by both parties; the benefits of a more open and mutually supportive approach as taken by the MIPROMA clinic are too evident to be ignored.
13. There is a need to challenge unhealthy beliefs, which are often perceived to be associated with religion, even if incorrectly so. One example of this is female genital mutilation; here the role of religious leaders could be particularly crucial in challenging this tradition that many understand as a religious imperative. Some success has been achieved with destigmatising people affected by HIV and AIDS, and even family planning by birth spacing has become acceptable. In the case of female genital mutilation it has been much more difficult to get religious leaders involved and to use them to impact on the practice. Ways to develop suitable means of addressing this issue need further study.
14. The approach in Mali is to have decentralised, primary care as a focal point for the health system. Two elements here in particular require funding: the further development of CSComs for communities that are still un-serviced; and strengthening the work of the relais as a means to take primary services into the communities outside a 5km radius of the CSCom. The latter service is not sustainable without support, as this is not a service that can depend on payment by users.

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7.11.2 SOURCES FOR MALI LOCAL CASE STUDIES

A. The National Islamic Network for the Fight Against AIDS

Persons interviewed

El Hadj Sidi Konaké
El Hadj Mamadou Traoré
Mafounè Soucko
El Hadj Wahid

Documents consulted

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RNILS: Plan d'action 2005
RNILS: Plan d'action 2006
RNILS: Politique du RNILS en matière de lutte contre le VIH/SIDA



B. Faladié health centre

Persons interviewed in the N'Tjiba Commune

Kassim Soumaoro, 2nd Deputy Mayor
Mamadou Bah, 3rd Deputy
Naba Seydou Traoré, Communal Councillor
Soumaïla Traoré, Accountant
Dosséké Traoré, Village Councillor
Karim Traoré, Village Councillor
Manè Traoré, Village Elder
Sr Odile Tounkara, Pharmacy Manager

Documents consulted

World Vision Mali: Diagnostic Study of the N'Tjiba Commune; January-February 2007
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C. MIPROMA clinic

Persons interviewed

Lassine Camara, General Treasurer
Fousséini Doumbia, Member
El Hadj Mamadou Traoré, Member
Dr Hamadoun Sangho, Advisory Committee Member
Mohamadou Lamine Djiguiné, Secretary to sports
Abdoulaye Ballo, Section VI, Member
Dr Brainina Coulibaly, Doctor of the Centre
Abdoulaye Sangho, MIPROMA Centre
Mayan Traoré, Vegetable vendor at the market
Minata Doumbia, Rice vendor
Kassim Diallo, Patient

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AMJM : Memorandum of Association and Rules of Procedures
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