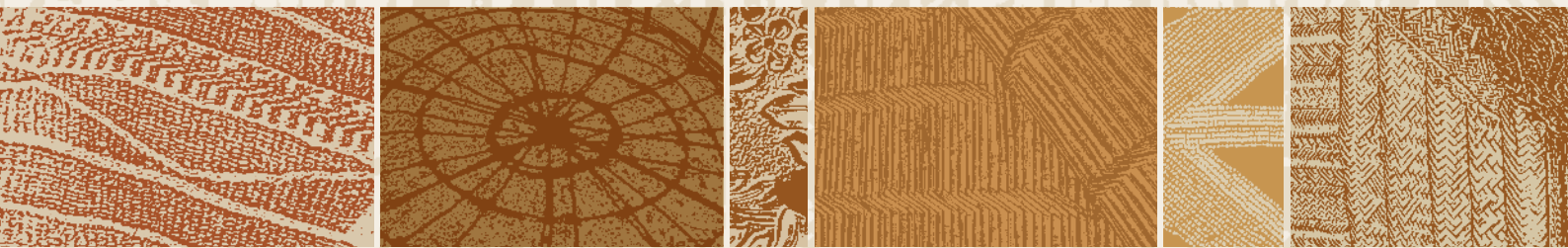


CHAPTER 8

FINDINGS AND RECOMMENDATIONS ON THE CONTRIBUTION OF RELIGIOUS ENTITIES TO HEALTH IN SUB-SAHARAN AFRICA



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In Africa, religion is integral to peoples' lives and is inherent in the minds of those involved in the health sector. Previous ARHAP work has confirmed the way in which religion and health are integrally understood. Although several studies have explored the role of faith agencies in health provision in Africa, and some refer loosely to faith based organisations providing between 30 and 70% of health services in Africa, data is patchy. While this study has not been comprehensive, it goes some way in being able to expand upon the 'patchy' data and explain how and why the scale and scope of faith based health services differ, particularly drawing on the case studies undertaken in Mali, Uganda and Zambia and the summary findings of the desk review.

The aim of the study was to explore the role of religious entities (REs) in contributing to health in SSA with a view to identifying areas for future investment. This chapter offers an overview of the importance of REs in improving health drawing on the findings of the study as well as recommendations flowing from each cluster of findings.

### 8.1 RELIGIOUS ENTITIES (REs) MAKE A SIGNIFICANT AND UNIQUE CONTRIBUTION TO HEALTH SERVICES

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

- Delivery of **facility-based health services** alongside the state health services at district and national level (Uganda, Zambia) <sup>1</sup>.
- Many faith-based hospitals are also **training centres** for the health workforce; this may still produce as much as 60% of the nursing cadres (Uganda).
- Provision at local level of **non-facility-based small-scale health related activities** including traditional medicine, home based care and HIV prevention, care and support (Zambia).
- National faith based health networks like CHAZ in Zambia and the medical bureaus in Uganda, offer **co-ordination**, fundraising, capacity development, supervision for affiliated health services and act as funding vehicles for them.
- **Advocacy** around the role of faith based facilities in health provision with government and funders (Uganda, Zambia).
- **Health promotion** and education by trusted leaders at a local level (especially Mali).

b) There is **little data** on the faith-based contribution to health, and what is available is mostly disparate and specific to a denomination and/or country. No comprehensive database of religious health facilities for SSA exists, nor of their funders and good practice exemplars; even less is known about non-facility-based services (Desk review).

c) Anecdotal evidence claims that the **religious commitment of health workers** impacts on their work ethic and quality of care (Uganda, Zambia, Mali); this has also been identified as a valuable asset for quality health care. The extent to which this ethos is related to motivation and quality of care requires further study.

**On the basis of these findings the study recommends that:**

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

- *Mapping of religious health services be undertaken to make national and local organisations aware of the assets they have and how these could be enhanced for better health outcomes. This work could draw on ARHAP's participatory mapping methodology for cross country comparability (see ARHAP-WHO 2006). This could act as launch pad for communities and countries to identify religious assets which can be mobilised for health.*
- *A database of REs providing health services at a national level should be set up for all SSA countries in order to have a comprehensive picture of the religious contribution and to make possible its closer alignment with the public health sector and its engagement by donors.*
- *The outcome of this work should be made known to national health policy-makers and planners.*

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<sup>1</sup> Where a specific finding can be linked to a case-study, the country/chapter is indicated in this manner.

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

### 8.2 FAITH-BASED HEALTH SERVICES IN SSA SHOW GREAT VARIETY IN TYPE AND EXTENT

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

**On the basis of these findings the study recommends that:**

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

- *Additional research will help develop the understanding of the variety of ways in which religious entities promote health, and particularly commonalities and patterns across different contexts in order to better identify best practices and most effective interventions.*
- *A number of proposals for further research have been highlighted in the report, especially in Chapter 4, e.g. literature in languages other than English, specific public health concerns, models for collaboration.*

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

- a) The study has highlighted the way in which REs impact on health in a range of different ways at national level where strong religious organisations are **taken seriously as partners by government** (Uganda, Zambia).
- b) The bulk of faith-based hospitals and clinics (in Uganda, Zambia) are **co-ordinated by agencies at a national level** that have a more or less formalised relationship with the ministry of health, focussed on advocacy, mobilisation of resources and ensuring co-ordinated health service delivery on the ground.
- c) The **advocacy** role of NFBHNS and their participation in policy engagements at a national level has been shown to help further the capacity of affiliated facilities (Zambia).
- d) At times clear **boundaries are placed on NFBHNS** around their involvement in what are seen as political issues; they are for example not given access to certain health information relevant to their facilities (Uganda).
- e) There is a **similarity of approach** between faith-based and public health services; they all follow the guidelines of the MoH, and are supervised by its officials (Uganda, Zambia, Mali).
- f) Faith based services complement those of the MoH and NGOs, but do have a **different ethos** resulting in valued services to marginalised groups (Uganda, Zambia, Mali).
- g) The contribution of the faith based sector to national health provision is generally acknowledged by health ministries

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in SSA, and national faith-based bodies participate in national fora such as the Zambia AIDS Council (also Uganda). Yet the **policies** in some countries are not sufficiently **enabling** for the role of REs at a national level. As one example, in Zambia the lack of consultation around the sudden removal of user fees in rural areas, left faith-based health facilities financially unprepared to implement this policy.

h) Collaboration between faith-based and public health facilities and management structures was found to be more difficult at a **district level** where there was more direct competition for limited resources such as funding and health workers (Uganda).

Hence the study recommends:

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

- *Ongoing national-level planning, policy formulation and budgeting regarding human resource issues, health service delivery and user fees, should involve NFBHNs, together with the national MoH.*
- *Financial support should be made available for parity in human resource remuneration between FBO employees and MoH employees. Special attention needs to be given to urban and rural equity.*

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

- *FBOs providing health services at district and local levels should be funded in a way that ensures that their delivery targets are seen as part of the targets of the district.*
- *Good practice examples of joint FBO and district level planning, monitoring and budgeting should be identified and documented.*
- *The study found an exemplary model of collaboration between all health providers at district level in Mukono, Uganda, but due to time constraints could not identify the factors that made this possible. Studying this model (and others in different settings) in detail could yield insights necessary for its replication in Uganda and elsewhere.*

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

- *There is a need for faith-based and MoH leadership to understand the policy-making process*
- *Joint capacity development should be undertaken at a national and district level with faith based network leaders and MoH officials; as well as separate training dealing with the specific requirements of each sector.*
- *It is important to work with and support existing health policy-making training programmes that can be further developed, piloted and adapted for use with leaders of NFBHNs and Ministries of Health.*

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

a) Originally most faith based facilities were **mission owned and funded**. Many of these facilities are now deteriorating due to a lack of funding for maintenance and modernisation (Desk review, Uganda, Zambia, Mali).

b) Across SSA health services have become the **responsibility of national governments** after independence. International agencies have provided funding for a range of national government responsibilities under severe conditions, resulting from a combination of macro-economic conditions, political decisions and global trends.

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- c) Faith based health facilities, too, in many countries are now funded to some extent by government. This ranges from being almost entirely funded out of government resources (e.g. CHAZ-affiliated facilities in Zambia) to minimal support (e.g. urban UCMB facilities in Uganda).
- d) There is **no parity in employment conditions** for health workers at faith based and state health facilities. This causes problems with recruitment and retention of staff and also potentially results in compromised quality of care (Uganda).
- e) Career expatriate **mission health workers** have become rare; few medical missionaries now serve in SSA, and most of those who do only come for short terms (Zambia).
- f) Funding is received from a **variety of funders** with differing aims and conditions. Much of this funding supports vertical programmes. Complex proposal and reporting requirements often exclude REs from accessing these funds (Uganda, Zambia).
- g) With other financial support diminishing or unreliable, some faith-based facilities rely heavily on **user fees**. This raises dilemmas around access for the poor to their services (Uganda, Zambia).

Hence the study recommends:

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

- *The emphasis should be on interventions that support strengthening of the health systems as a whole.*
- *Funders be encouraged to support integrated local health programmes.*

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

*While governments do fund NFBHNs and their affiliated facilities, the basket funding approach does not pass sufficient funding through to REs to maintain their services. Donors should consider direct funding to these bodies to enable them to maintain the services they provide.*

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

*In the case of user fees, special measures need to be put in place, given the financial impact of the removal of user fees on FBO facilities in poor communities.*

## 8.5 FAITH-BASED HEALTH SERVICES WORK UNDER SEVERE CONSTRAINTS, ESPECIALLY REGARDING THEIR WORKFORCE

- a) There was concern within government that the quality of service at faith-based facilities was compromised as they were often **severely understaffed** and that many of their staff members were under-qualified for what they did (Uganda, Zambia).
- b) Addressing the **human resource shortage** was an integral part of strengthening the health system. This included:
- ensuring that health facilities were adequately staffed
  - increasing the performance and effectiveness of health workers
  - setting up systems that ensured that volunteers were adequately compensated and provided with care
  - setting up adequate health training facilities (Zambia)

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- c) Creating a **health associate** position in which relatively well-educated school-leavers could be trained to perform some of the basic functions so that the doctors and the nurses could focus on more specialised needs (Zambia).
- d) Apart from HR needs, **funding shortages** hampered health services. Especially serious were drug shortages and the inability to provide safe and reliable transport for referrals (Uganda, Zambia).

Hence the study recommends these support strategies:

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

*In particular funding is needed for:*

- *staff costs, including benefits like housing, to help them achieve salary parity with colleagues in the public service.*
- *capacity building for existing staff, both health workers and management staff: medical specialisation; IT skills, especially HMIS and stock control; overall strategic planning, needs assessment and M & E.*

*Where possible, FBO training facilities for health workers in rural areas should be kept operating so as to encourage rural people to train as health workers and to stay on in rural areas when trained.*

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

*Where possible, FBO training facilities for health workers in rural areas should be kept operating so as to encourage rural people to train as health workers and to stay on in rural areas when trained.*

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

- a) An **extensive range** of non-facility-based health activities are provided by REs, especially in contexts where there is a high prevalence of HIV, and have emerged largely at a local level (Zambia).
- b) These initiatives **operate informally, flexibly**, and in response to available funding, so there is virtually no reliable (if any) record of who is doing what or what outcomes are achieved (Desk review, Uganda, Zambia). The rare exceptions are initiatives such as the South African Catholic Bishops Conference's extensive ART programme<sup>2</sup>, second in scale only to that of the government.
- c) Even where facility-based services are aligned with public services through NFBHNs, the district level grassroots initiatives, directly responding to the needs of vulnerable groups, are all but **invisible to public health players** and often even to the NFBHNs (Uganda, Zambia).
- d) Problems emerged when there was **inadequate collaboration** of non-facility based services, such as duplication of services; competition in obtaining funding, recruiting staff and volunteers and attracting clients; inability to access appropriate referral services (Zambia).
- e) Oftentimes, these activities are heavily reliant on **volunteers** who themselves are very poor, and often move locally from agency to agency in search of better stipends.
- f) The ready **availability of funds for HIV** services – and the huge needs in this area – are largely the *raison d'être* for the explosion in scale of these activities (Zambia).

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<sup>2</sup> The SACBC ART programme, funded by PEPFAR, operating out of car boots and community groups, is an exception to this rule. UNAIDS Best Practice 2006-2007 Choose to Care Initiative. UNAIDS.

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- g) These initiatives are often **not sustainable** due to their lack of sustainable funding and shortage of technical, financial and administrative skills. A major challenge is funding of operational costs, seldom funded by international agencies (Zambia).
- h) **Intermediary agencies** have emerged to supplement technical capacity, and provide support and training, as facilitators of small local projects; but there are far too few of these (Zambia).

Hence the study recommends a range of strategies in support of this sector:

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

*This recommendation could be facilitated by:*

- *encouraging funders to fund 'intermediary' organisations as an important requirement to support local level NGO and FBO health-promoting activities*
- *documenting the good practice of model intermediary organisations and sponsoring exchange visits to them*
- *training packages and support should be offered, so that enabling agencies can be set up widely modelled on the good practice exemplars*
- *lessons learned on the ground be harnessed for wider scale roll out through advocacy initiatives*

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

- a) Across SSA in both urban and rural contexts people commonly use **multiple healing modalities**. African traditional healing is used by the majority of health seekers, often concurrently with other possibilities for health offered by plural health systems (Uganda, Zambia, Mali).
- b) **African traditional healers** and traditional birth attendants (TBAs) are the first resort in case of ill-health for the majority of the population of SSA. They continue providing accessible health services and are increasingly open to some form of collaboration with bio-medical health providers (Uganda, Zambia, Mali).
- c) Many global, African and country health policy documents refer to the importance of traditional healing and the need to acknowledge and work with these health practitioners. Nevertheless, the case studies highlighted that seldom were traditional healers given more than **token acknowledgement** by the Ministry of Health (Zambia, Uganda) although Mali has taken more definite steps toward genuine partnering.

Hence the study recommends:

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

- *The role of traditional healers, including TBAs, needs to be actively promoted and enhanced in policy and practice - Africa-wide, and at national level, as well as at district and local levels.*
- *An active programme of engagement and training of traditional healers and health workers will need to be embarked upon.*
- *Setting up a civil society forum for health which includes REs, NGOs and traditional healers could provide a voice to lobby NEPAD, the African Union as well as individual countries in this regard.*

**8.8 WHILE THE IMPORTANT POTENTIAL OF RELIGIOUS LEADERS FOR HEALTH PROMOTION HAS BEEN CHANNELLED INTO SOME CREATIVE INITIATIVES, IT IS GENERALLY UNDERUTILISED**

- a) Religious leaders with the respect and credibility they have in communities, and drawing on the commitment for well-being shared by most religions, have the **potential** to be powerful agents in the promotion of public health agendas. As shown in the Mali case-study, inter-religious dialogue and co-ordination at national and local levels is particularly beneficial.
- b) Some religious leaders contribute to health promotion and education in a number of areas (e.g. promoting family planning and hygiene, or fighting FGM and HIV-related stigma) (Mali).
- c) The **degree to which this potential is utilised** in different countries varies widely depending on the context. In Mali the National Islamic Network for the Fight against AIDS is an example of a network that mobilises faith leaders for community health outcomes.
- d) However, the role of local religious leaders in health promotion in Mali differs by level; **national religious leaders** are more heavily involved than **local imams in rural** areas.

Hence the study recommends:

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

*Meetings should be held with the top African religious leaders of various faiths and denominations to promote awareness and action regarding their health-supporting roles and responsibilities. This could be facilitated by a number of actions, such as:*

- *Developing materials for religious leaders to encourage their active participation in health promotion*
- *Documenting best practice and utilising exchange visits*
- *Encouraging local faith leaders to be agitators for and advocates of improved basic living conditions*
- *Mobilising the agency of religious women to advance health in their communities. Women leaders should be encouraged to speak to their peers about health concerns, especially those associated with mother and child health. This needs to make use of the capacity and leadership abilities of local women, and young women in particular.*
- *Work with, expand and learn from existing programmes, for example the ‘women-to-woman’, and ‘mother-to-mother’ health promotion campaigns*

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

- *Research needs to be undertaken to identify practices advocated by faith leaders and traditional healers that are prejudicial to health and gender equity, e.g. female genital mutilation and simultaneously to identify those norms, values and beliefs internal to particular traditions that will support appropriate transformation .*
- *Social marketing campaigns need to be set in place, informed by such research, to challenge practices advocated by religious leaders that do not thwart health.*

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

- *Good practice should be documented and its development encouraged through the setting up of awards for good practice in each country.*
- *Exchange visits and roundtables of religious leaders across the SSA region should be encouraged.*

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### **8.9 REGARDING THE METHODOLOGY USED IN THE STUDY**

The use of three case studies provided the opportunity to understand in some detail the role of REs in health services, the relationships between faith groups as well as the links between faith-based health services and the ministries of health. The study also provided an understanding of the potential role of faith leaders in health promotion. While the case studies were chosen to ensure diversity in selected factors, it is not possible to draw generalisations from them e.g. for trends in other countries which are predominantly Christian, or Francophone.

The study design built on the knowledge that had emerged out of the prior work of the ARHAP mapping of local level faith based responses to HIV in Lesotho and in Zambia but did not specifically aim to be comprehensive in its overview of local level responses.

The country reports contained in Chapter 4 bring together a range of disparate data for the first time. The difficulty in accessing the data necessary for developing the country reports highlighted the lack of any comprehensive data source on faith based agencies involvement in health in SSA.

The method has highlighted key resource agencies involved in faith based health activities as well as possible data sources. However, the lack of data on who is doing what/where will continue to bedevil the needed co-ordination to ensure that REs are adequately resourced and contributing as needed on a national and district level.

Secondary data that is available is driven to a large extent by the M and E requirements of the extensive HIV funding that has been made available in the past ten years.

