

EXECUTIVE SUMMARY¹



We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. We are reliable. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away.²

1. BACKGROUND

While most partners in providing health care in sub-Saharan Africa agree that religious entities play an important role in providing health services, there is little comprehensive data about the scope and scale of their contribution, beyond data held by particular religious entities about their own health related work. In addition not much is known, beyond claims and often repeated statements, about the ways in which such health care is different from services provided in the public health system.

2. AIMS AND OBJECTIVES

The overall purpose of this study was to provide a description of the contribution of faith based organisations (FBOs), institutions, and networks to the health of vulnerable populations in resource-poor areas of sub-Saharan Africa (SSA); and to identify key areas for investment that would accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries.

There were two main parts to the objectives:

- 1) To give an *overview for SSA* of the coverage, role, and core health related activities of religious entities, including major networks, vis a vis public and other private sector health services delivery, and their relationship to government and to each other.
- 2) To give more detailed information for three country case studies in Mali, Uganda and Zambia:
 - a) describing the capacity of faith based organisations to deliver health services and impact on health behaviour; the financial and/or material support they receive and how they are perceived by stakeholders;
 - b) characterizing key faith based networks and describing how they work;
 - c) describing *how* faith based organisations collaborate with each other and with governments.

¹ Schmid B, Thomas E, Olivier J and Cochrane JR. 2008. *The contribution of religious entities to health in sub-Saharan Africa*. Study funded by Bill & Melinda Gates Foundation. Unpublished report. ARHAP.

² Canon Gideon Byamugisha on the contribution faith based organisations can make in responding to HIV and AIDS in: WHO, "Faith-based groups: Vital partners in the battle against AIDS". *The "3 x 5" Target Newsletter*, July/August 2004. P3. http://www.who.int/3by5/mediacentre/en/3by5newsletter_0204.pdf

From these were to be drawn recommendations about key areas for potential investment that would improve population health outcomes.

3. RESEARCH OVERVIEW

The research was conducted under the auspices of the African Religious Health Assets Programme (ARHAP), a research networks focussed on gaining a better understanding of the contribution of religious health assets to public health in Africa. The team of ARHAP researchers, from the University of Cape Town and the Medical Research Council was supported by an international, inter-disciplinary and multi-religious advisory group as well as in-country researchers.

The overview of SSA involved collection and desk review of existing databases and secondary literature. This resulted in a descriptive summary of cross cutting issues and country data summarised for 10 countries.

For the three Country case studies 4 methods were used in combination:

- 10 Key Informant Interviews per country with representatives of the public health sector, some religious leaders, academics and practitioners.
- 3 or 4 focus group discussions of ten people each per country, with representatives of identified faith based health services
- Questionnaires were distributed to the same faith based organisations, about 25 per country
- In Mali focus group discussions and Questionnaires could not be used as there are very few religious health services. In stead three in depth local case studies were conducted.

4. CONTEXT

Africa has 10% of the world's population, 25% of the global disease burden and is home to nearly a third of all people living with HIV and AIDS; a number of countries in Southern Africa have HIV prevalence rates above 20%. We also find here the highest disease burden of malaria and TB with high levels of infant and child mortality, child stunting, and very poor maternal and reproductive health outcomes.

Poverty is one of the major determinants of poor health on the continent. Health systems are overstretched and buckling in working against this huge burden of disease while also responding to structural challenges. Health systems are under-resourced – mostly well below the recommended 15% of GDP - and often having to depend to a large extent on unreliable funding sources; or funds that are designated for vertical programmes rather than primary health care. The human resource crisis is severe as health workers leave their home countries and the continent in search of better salaries and working conditions elsewhere. In all of these factors the situation in rural areas is even more desperate than in the cities.

It is in this context that religious entities run vast networks of health facilities and health supporting activities. Many of them have been there for decades; and many others have sprung up in recent years, often in response to the HIV and AIDS pandemic.

5. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

In Africa, religion is integral to peoples' lives and religious entities are deeply involved in the health sector. This study undertook to expand upon the 'patchy' data about this religious involvement, drawing on the case studies undertaken in Mali, Uganda and Zambia and the findings of the desk review.

Finding 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)³.
 - 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 to date 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).

"If you think that this is a precious asset for the country, that you want to maintain, not only do you have to support it - but support it in a way that is conducive for the institution."

(UCMB, Uganda)

"To help is also a religious act. What is important is the human being; helping human beings."

(FBO doctor, Mali)

- 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.

On the basis of these findings the study recommends that

- I) Mapping of religious entities contributing to health should be undertaken and a comprehensive database established.**
- 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 poor settings.**

Finding 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, depending on the **history** of colonialism, the shifting policy environment over time and different cultural and religious influences.

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

(Health Policy Initiative, Mali)

³ Where a specific finding can be linked to a case-study, the country/chapter is indicated in this manner.

- 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.**

Finding 3: National faith based health networks (NFBHNs) play a crucial role in enabling facility-based services, which yet have a contested place within national health systems.

- 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** with a formalised relationship with the ministry of health.
- c) The **advocacy** role of NFBHNs and their participation in policy engagements 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; e.g. limiting their access to 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 in SSA (Zambia, Uganda). Yet the **policies** in some countries are not sufficiently **enabling** for the role of REs at a national level.
- 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).

"FBOs are not given the space to debate things and to participate So they are sort of relegated to ... mopping the floor."
"We're a sort of a lesser among equals."
 (NGO and MoH respondents, Zambia)

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.**
- V) FBOs should be seen as part of the MoH's activities at a district level.**
- VI) Capacity for policy making in the health sector should be developed.**

Finding 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.

“For faith-based organisations, they have 32% of the required number of staff, so they are 70% short almost. I mean, you can’t provide quality services like that ... Government has 50%.”

(MoH spokesperson, Zambia)

- a) Originally most faith based facilities were **mission owned and funded**. Many of these facilities are now deteriorating (Desk review, Uganda, Zambia, Mali).
- b) Across SSA health services have become the **responsibility of national governments** after independence who are supported by international agencies.
- c) Faith based health facilities, too, in many countries are now funded to varying extent by government.
- d) But 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 (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) Faith-based facilities rely heavily on **user fees**. This raises dilemmas around access for the poor to their services (Uganda, Zambia).

“All that you have to do is spend it, spend it, spend it... in Africa, it doesn’t work like that. Africa time is using the sun.”

(Focus group, Zambia)

Hence the study recommends:

- VII) Funders should commit to working closely with national ministries of health (MoHs) in strengthening national health systems.**
- VIII) NFBHNs and their crucial contribution are to be acknowledged and receive direct funding support.**
- IX) Policy and consultation should ensure that there is parity in access of the community to health services, whether provided by MoH or REs.**

Finding 5: Faith-based health services work under severe constraints, especially regarding their workforce

- a) The quality of service at faith-based facilities was compromised as they were often **severely understaffed** and many health workers were under-qualified (Uganda, Zambia).
- b) Addressing the **human resource shortage** was an integral part of strengthening the health system.
- c) Creating a **health associate** position should be

“You may have everything on the ground: supplies, drugs, everything. But if the human resources for health are not paid much attention to, we are not likely to go very far. It’s the human resources that turn the other resources into useful means.”

(NGO doctor, Uganda)

considered for relatively well-educated school-leavers to be trained to perform some of the basic functions (Zambia).

- d) **Funding shortages** hampered health services, resulting in 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, often particularly excluded from donor packages to REs, should be considered as crucial.**
- 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.**

Finding 6: A wide range of non-facility-based services in response to immediate local needs are provided by REs, playing a very important role under serious constraints

- a) An **extensive range** of non-facility-based health activities are provided by REs at local level, directly responding to the needs of vulnerable groups (Zambia).

“Everybody wants to be able to count Lucy, everybody wants to be able to count Suzie. So you get this kind of numbers game competition that's happening. And with that comes competition for personnel.”

(Focus group, Zambia)

- b) These initiatives operate **informally, flexibly**, and in response to available funding, so there is virtually no reliable record of what is done and achieved (Desk review, Uganda, Zambia).
- c) The district level grassroots initiatives 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).
- 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 to small local projects; but there are far too few of these (Zambia).

Hence the study recommends the following 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 FBO initiatives.**

Finding 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 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) continue providing accessible health services and are increasingly open to some form of collaboration with bio-medical health providers (Uganda, Zambia, Mali).
- c) Many policy documents refer to the importance of traditional healing and the need for collaboration. Nevertheless, traditional healers were rarely given more than **token acknowledgement** by the Ministry of Health (Zambia, Uganda) although Mali has taken more definite steps toward genuine partnering.

“We are not restricted in how far we can go in helping people, because we don’t need the pound, we don’t need the dollar, we don’t need the euro to import these drugs.”

(Traditional healer in Zambia)

Hence the study recommends

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

Finding 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 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 or fighting FGM) (Mali).
- c) The **degree to which this potential is utilised** in different countries varies widely depending on the context.
- d) The role of local religious leaders in health promotion differs by level; with **national religious leaders** more heavily involved than **rural imams** (Mali).

“Religious leaders play a vital role in Malian community. There are thousands and thousands of followers who listen to them, who follow them.”

(NGO respondent, Mali)

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.

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

XVI) Inter-religious dialogue on health issues needs to be encouraged.

6. REPORT STRUCTURE

This report presents the data and findings from the study in eight chapters:

- Chapter 1 outlines the purpose of the study and its objectives;
- Chapter 2 describes the methodology followed and introduces key terms used in the report regarding faith based health organisations' involvement in health;
- Chapter 3 reviews health systems in SSA and the role of religious entities in them, drawing attention to the role of colonial histories and current international developments;
- Chapter 4 provides the results of the desk review for SSA, including ten country sheets as cameos of the complex ways in which religious entities (REs) contribute to public health in this region;
- Chapter 5 presents the Zambia case-study, with an overview of the country, description of faith based health services and health supporting/promoting activities, networking and collaboration, the constraints they face and recommendations for funding and action;
- Chapter 6, the Uganda case-study follows the same structure;
- Chapter 7 presents the Mali case-study with an emphasis on 3 local FBOs providing health services or offering health promotion;
- Chapter 8 summarises the findings of the study and its general recommendations for sustaining and enhancing the role of REs in health in SSA.

The full report and country data sheets are available on the ARHAP website: www.arhap.uct.ac.za

