When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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INTRODUCTION

Over some years now, the African Religious Health Assets Programme (ARHAP) has sought to map and assess religious entities engaged in health prevention, care, support and treatment, and it has developed tools for aligning religious and community health assets in partnership with formal health services and systems. In the process, ARHAP has provided evidence for just how widespread, and varying in range and type, religious entities engaged in health work are (ARHAP 2006; Schmid et al 2008; Haddad et al 2008).

Many of them, however, are not visible to formal public health institutions. They may be ubiquitous in many contexts, delivering large-scale services in the aggregate, but individually they are often small, flexible, frequently grassroots-based or linked, and without the organisational and material capacities to make their presence and voice more widely felt. They do not easily find a relationship to formal health institutions or systems, even as they provide for a great deal of health interventions, often in circumstances where the state or corporate agencies do not operate well, or at all. In this respect, a breakdown in public health practice and policy contributes to the failure of sustainable interventions.

I argue here, drawing on ARHAP’s experience, that one of the most critical factors in addressing this breakdown of an effective alignment of religious health assets and public health is the role of credible, or trustworthy, intermediaries. I shall explore this claim by revisiting earlier work by Thomas Carroll (1992), who analyzed thirty intermediary organisations in Latin America. I shall focus on a particular kind of intermediary, which Carroll calls a grassroots support organisation, while briefly indicating other uses of the term.

My purpose is to show why it is so important, in the context of contemporary challenges to public health (HIV in particular), to take up
or support intermediary grassroots support roles as a critical contribution to both aligning religious health assets with public health agencies and institutions, and to scaling up a sustainable response to major public health challenges in Africa. I begin by briefly describing the kind of context for which such intermediaries are so crucial.

The Context

To the southeast of Lesotho, in the South African province of the Eastern Cape, and nestling in the foothills of the majestic Drakensberg Mountains, lies the old trader town of Matatiele, earlier a place of gunrunning and cattle rustling. Its surrounding hills, washed golden brown during the crisp dry winter, turn verdant green in the summer when drenching thunderstorms fill the rivers. The lush image is superficial, and belies the poverty of the soil, often less than an inch deep. Over-grazing, in part a result of the past forced removal of people to their so-called ‘homelands’ onto land that cannot sustain them, has opened what soil there is to the ravages of water, forming deep erosion ‘dongas’ everywhere one looks.

Family kraals scattered across the hills and valleys are often inaccessible except by pickup or 4x4. Schools, short of facilities, frequently crowd eighty or more children into a classroom or, as frequently, teach them outside because no classroom is available. Poor schooling since the institution of Bantu Education by the Apartheid state some fifty or more years ago has created a multi-generational loss of skills and made many unemployable. Work is scarce, the few available jobs hard to come by, and most are not well paid. If one has money, it purchases less in such places that in urban areas. A balanced diet is close to a joke for most. Since early in the twentieth century the men of the area have wandered to the mines up north or the industries of the distant cities, on a scale that has left the traditional ties of family, community and clan wholly undone.

Those who live in the kraals spend hours every day fetching water, dealing with sanitary issues under difficult conditions, or sitting in smoky huts cooking meagre food. They spend as much time being ill, or looking after those who are ill, as on most things. This area, free of malaria but not of Kwashiorkor, has been badly struck by TB and HIV. Funerals are more common than marriages. Even though there are now three anti-retroviral treatment (ART) sites in the area, many people have difficulty getting to them, and there is inadequate support to monitor the use of the drugs or assist those who have developed AIDS. If one does make it to the hospital, one often encounters thoroughly stretched and overstressed staff that has to deal not only with the trauma but also with a health system that is also in trouble in many ways, through institutional failure, financial difficulties, workforce shortages, inadequate equipment, shortfalls in drugs and medicines, and the like.
This is the kind of environment where community-based organisations (CBOs) of necessity emerge in response to the needs. But, critically, they are frequently without the kind of extended, skilled support and accompaniment that they all too often need to transform their circumstances over time. Though circumstances vary from place to place, Matatiele’s is not some exceptional situation. Similar descriptions could be given of other areas across the country, in countries across Africa, and beyond. With contextual and historical variations on the theme, it could also serve as a description of health care and its delivery in the poorer townships on the edges of the large cities of South Africa, perhaps even of disadvantaged communities all over the globe.

The social, environmental, economic and political factors that affect health care and illness are a global challenge to the health of the public. Those responsible for public health are meanwhile well aware, despite some major victories and advances over the last hundred and fifty years, that health systems are in crisis all over the place (Garrett 2000; Hall & Taylor 2003; Hofrichter 2003; Kim, Millen, Irwin, & Gershman 2000; Sanders, Todd, & Chopra 2005; Whiteford & Manderson 2000). But wherever it might be, the situation may not be as bleak as it seems.

We know that the formal health system, in most contexts, is matched by an astonishing range of semi-formal and informal practices of care and support in local communities, far more extensive than any official accounting of health services. It is a policy mistake to look only at what happens inside the doors of the clinic or the hospital, into which people come only briefly in their journeys to find and maintain health. What happens before someone enters that door, and again after they leave, is crucial both to their health and to the ability of the formal health system to support their health—surely a minimal aim of any health system (even if it cannot be the aim of individual doctors or nurses). To meet that aim, one has to go outside the doors and into communities. But we still find that policy in most formal healthcare facilities remains systemically blind to the widespread community-based health organisations, groups and activities that surround them. The two realities are misaligned, and that misalignment has negative consequences for the sustainable enhancement of the health of populations.

THE CHALLENGE

How to tackle this misalignment? How to engage with the myriad small, local, community-based entities that engage directly in health interventions? They are, after all, often scattered, fragmentary, shifting and, because they tend to be dependent for their management on particular individuals, and for their work on volunteer caregivers, unstable. Can one stabilise them, and in the process, strengthen the public health system as a whole?
The needs of people in the kind of context I have described are known to many. All manner of attempts to do something about them can be found. Local people try to do what they can for themselves, including forming grass-roots community-based organisations (CBOs) with sometimes-astonishing capacities. Other efforts come from organisations and businesses, from government agents tasked with service delivery, from non-governmental organisations (NGOs) with particular missions or mandates of their own, from religious bodies who have a presence in the area, from donors near and far, from large and small associations in civil society that seek to network their activities at scale, and from international agencies set up to deal with the challenges of health and development.

Among the best-known kind of CBOs in the context of the HIV pandemic are the vast number of groups who try to care for orphans and vulnerable children, usually made up of local women (see Foster 2005). But in ARHAP’s research in Lesotho and Zambia, we were able to show that CBOs, including local congregationally-based groups, engage in activities as wide-ranging as HIV education, counselling, advocacy, behavioural change, support for orphaned children or widows, material support, transport to health facilities, convening activities for joint action or discussion, and accompaniment of people living with or affected by HIV and AIDS (ARHAP 2006).

Also in the mix are broader networks. Some, such as Christian Health Associations (CHA’s) or Islamic Medical Associations, seek to optimise the use and maintenance of their facilities such as hospitals, dispensaries and clinics. Others act as intermediaries between CBOs, donors and governments. Indeed, most large donors act via intermediary organisations and they rarely fund CBOs directly (see Foster 2005).

It is on the role of the intermediary that I wish to focus. What I have in mind is a particular kind of intermediary, one that has a specific focus on linking to grassroots activity. The grassroots activity I mean refers to the work of CBOs who are able to leverage religious health assets for community health. My over-riding concerns are two-fold: 1) how community-based initiatives or organisations that do a lot of the work on the ground are to be supported; 2) how the work they do is to be meaningfully, and in a trustworthy manner, aligned with formal public health services.

Interventions by others external to the context of local CBOs, including government, donors, NGOs, and corporate actors, however well meant, often inundate CBOs with human and managerial demands that are very difficult for them to handle. The complications introduced by monies provided—an avalanche in the context of HIV!—adds to the burden. The particular challenges I want to address concern: the capacity, transparency and accountability of CBOs; and the vital role of appropriate intermediaries for effective, efficient, and sustainable interventions for health. Let me then succinctly describe key aspects of these challenges to interventions in local community contexts,
commenting on what tends regularly to derail expected outcomes.

First, material resources, in general, are hard to spread evenly and appropriately. Access to and control over money in particular, ipso facto a scarce resource, regularly unleashes many tricky dynamics. Accountability for its use in accordance with the intention behind its provision is thus one critical issue, as is accountability by the provider to the community for the conditions of its provision. Trust must work in both directions.

Second, CBOs generally find themselves faced with demands to develop management skills and organisational competencies they do not have: for financial accounting, banking, the writing of proposals and production of reports, perhaps registration for non-profit status, and the like. Most of these demands come from external actors—donors, government agencies, or associational structures—who expect the CBO to match their norms, practices and procedures, which are often unfamiliar or even alien to people in CBOs.

Finally, where a variety of educational and training schemes are introduced by actors external to the community, they most often depend upon knowledge generated elsewhere, standards set by others, and pre-set expectations of change or action to match the investment. Even highly trumpeted participatory or action research-based approaches fall into these traps once their methods are instrumentalised to become techniques rather than transformative practices, as easily happens when external interests or agendas predominate.

The most critical point is simply this: Community-based organisations or groups that come into being to deal with some locally defined need, or to leverage some locally identified asset seen to be crucial in the survival and possible thriving of the community, are then faced with a situation where they are pushed to become what they are not, and to pay attention to matters which take them away from or complicate what they do best, thus undermining the very work that makes them valuable in the first place.

CBOs are frequently torn apart in the process, especially when jealousies and suspicions about monies, resources, or ties and connections—who has them, controls them, dispenses them—enter into the equation, as they regularly do (see, for comparison, de Vries 1992). Alternatively, they simply collapse under the weight of the tasks they are required to take on as they struggle to gain and maintain the skills and competencies required to leverage money, resources, and social capital.

More generally, as Foster (2005:1) notes in his report on bottlenecks in channelling resources to communities responding to orphans and vulnerable children in four countries (South Africa, Swaziland, Mozambique and Zimbabwe), ‘Neither donors, government departments, intermediary non-governmental organisations (NGOs) nor community groups could provide examples of effective mechanisms for channelling resources on a scale that meets the level of need.’ The bottlenecks that exist—because of low priority commitments to CBO activities, patterns of funding that are not designed to meet community needs, weak
monitoring, evaluation and quality control of programmes, and poor data collection for health system purposes—lead him to conclude that ‘CBOs need long term funding that is ‘drip-fed’ – continuous, small, steady amounts of resources to ensure that communities can sustain their responses …’ (Foster 2005, 1).

Looking at it from the point of view of health care, it is clear that formal health systems cannot address this kind of challenge. They are simply not set up for it, leaving aside rare, and not always successful, experiments such as the introduction of ‘barefoot doctors’ in China (Zhang & Unschuld 2008). Similarly, the grand goals of primary health care as set out in the 1978 Alma Ata Declaration, which were supposed to prioritize local community engagement, have not been met in the face of other priorities and the emasculation of the necessary policy framework by governments (see Cueto 2004; Hall & Taylor 2003).

Using ARHAP’s asset-based approach, one might be better placed were one to ask what it is that one can build on that communities already have. Translated into the context of grassroots CBOs, it means asking too, first, how one can avoid requiring CBOs to function as if they were NGOs or formal institutions, and second, what kind of structure or institution is needed to support and sustain their activity.

Thus, in what follows, I set out what I take to be the necessary parameters for the role of what I will call a ‘trustworthy intermediary.’ Adding the adjective ‘trustworthy’ already signals a normative, and not simply a descriptive analysis, of the role of intermediaries charged with acting in relation to local communities and their CBOs. This kind of intermediary has already been defined very well by Thomas Carroll in his seemingly insufficiently appreciated book on ‘intermediary NGOs’ (Carroll 1992). I shall therefore draw on and apply his analysis, adding to it some discussion of trust.

**BUILDING TRUSTWORTHY INTERMEDIARIES**

To clarify my understanding of ‘intermediary support organisations’, let me refer first to some alternative views. McQuarrie, Guthrie & Hess (2005:3), criticizing what they call a ‘common-sensical’ use of the term (that intermediaries are ‘organizations that work with organizations rather than individuals and that aren’t for-profit or state organizations’), define an intermediary, instead, as ‘an organization that endeavours to coordinate practices that are disparate enough that they can’t be effectively solved by impersonal steering media such as the market or common tacit practices and institutions’. Their definition is specifically tailored to theories in organisational sociology and economic sociology.

For my purposes, however, a common-sensical use remains valuable. It is supported by Brown and Kalegaonkar who focus on the role of support organisations in the NGO sector that ‘serve critical support functions, such as strengthening individual and organizational capacities,
mobilizing material resources, providing information and intellectual
resources, building alliances for mutual support, and building bridges
across sectoral differences’ (Brown & Kalegaonkar 2002:231). Though
I would not restrict it to the NGO sector alone, this definition is closer
to my own concerns, which are focused primarily on CBOs.

Here Caroll’s thinking is highly relevant, resting as it does on a
strong record as a development practitioner and on studies of thirty
‘best-practice’ supra-local, indigenous intermediary NGOs among the
five or six hundred that were funded by the Inter-American Foundation
(IAF). He begins with a precise and extensive survey of scholarly writings
on intermediaries, including Hirschman (1984), Korten (1980; 1987),

Carroll then distinguishes between two major kinds of intermediaries.
One is member-based, composed of affiliates who join together to
maximise their opportunities for joint action or advocacy. Classic
elements in Africa that ARHAP has come across are numerous religious
health associations, mostly linking denominational bodies responsible
for medical facilities of various kinds. Their members gain access to
medicines, equipment, and training programmes, and benefit from the
engagement in policy forums with national governments. Carroll calls
them ‘Member Support Organizations’ (MSOs), whose ‘two principal
functions are providing technical and representational services and
operating central facilities for members’ (Carroll 1992:14).

The other kind of intermediary, my central interest, takes the form of
an organisation that supports multiple grassroots organisations (which
I equate here with community-based organisations). Such a Grassroots
Support Organisations (GSO) is ‘a promotional and service organisation
whose beneficiaries are not members’ (Carroll 1992:12). It is primarily a
facilitator organization. Unlike an MSO that practices representational
advocacy on behalf of its constituent members, a GSO usually advocates
and lobbies for causes independently. Vital to what Carroll means by a
GSO is that its linking role—to government, donors, outside agencies,
and other relevant actors— is based not on control over grassroots groups,
but on support of them.

Thus a GSO’s mediating role between beneficiary CBOs and external
institutions that hold financial, economic and political resources involves
‘brokering, negotiating and risk-shouldering activities’ (Carroll 1992:26-
7). Risk-shouldering includes supporting CBO efforts to gain legitimacy,
make claims, and defend their interests, as well as forestalling or blunting
aggression or hostility directed against them. This role can be understood
via a term Carroll introduces that I would like to emphasise, the Spanish
word acompañamiento, best translated as ‘supportive partnership’ (Carroll

In my view, such supportive or ‘accompanying’ partnerships (a role
that may also be taken for a while by individuals, such as a pastor, a church
worker, an activist or a concerned citizen) are commonly to be found behind almost any durable, effective community-based organisation. But herein lies the rub. Unless grassroots support of CBOs goes beyond the brave work of committed individuals even when they work alongside many other committed but unconnected individuals, scaling up sustainable responses to health challenges such as HIV and AIDS is nigh impossible. Any hope of sufficiently and sustainably scaling up locally rooted responses to these challenges will require serious investment in intermediary GSOs.

ARHAP has come across very few GSOs who can relate to many grassroots organisations simultaneously and who can help them do their work better, while supporting aspects of that work for which CBOs are usually neither well-equipped nor suited. This may include such seemingly mundane tasks as writing funding proposals or reports, setting up accounting procedures and practices, handling logistics for visits and communications, as well as more complex tasks like wider lobbying and advocacy work, establishing and maintaining broader alliances, and creating opportunities for learning and training.

Yet precisely these forms of support are often needed. Expecting individual community-based organisations to take on many of these tasks potentially sets them up for failure. Finding, or establishing, the kind of GSO which could support grassroots organisations at this level is the critical shift essential for sustaining, scaling up and expanding the work of grassroots organisations.

One instance of an exemplary GSO is that of the Copperbelt Health Education Project (CHEP). It bears being understood far better and replicated far more widely, as a first order intervention for the future. At any one time it supports 80 or more community-based organisations—orphan care groups, treatment support groups, home-based care groups, and so on—on the Zambian Copperbelt (see http://www.chep.org.zm/; also Nyirenda 2009; Southern Africa AIDS Training Programme & the International HIV/AIDS Alliance 2004; Chipili, Mouli, and Williams 1992). CHEP accompanies these CBOs over long periods of time, carrying out virtually all the activities mentioned above, mixing periodic learning and training with ongoing support, ensuring that this support continues for as long as the CBO desires, and in some few cases, assisting a well-established and now skilled and durable CBO to become a GSO in its own right as it begins to help others in similar situations—generally something that happens only after several years of support and accompaniment.

Key to CHEP being able to play this role is the question of trust, increasingly seen as a definable and critical element of any successful, durable intervention (see Froestad 2005a; Froestad 2005b; Gilson 2003; Gilson 2005; Thiede 2005). What would count as trust in this context? Following on what ARHAP has learned from CHEP, I suggest at least six elements are needed for a GSO to establish the foundations of trust.
1. Assisting with tasks that overwhelm or exceed a CBO’s current capabilities, and doing so in an ongoing rather than sporadic manner.
2. Raising, handling and accounting for funds for the CBO in appropriate and transparent ways.
3. Making available learning and training to strengthen the work of the CBO and, critically, following this up in the field.
4. Communicating with third parties on behalf of the CBO in an open fashion, on a shared basis, and with input and critique from the CBO.
5. Ensuring that all support is experienced by the CBO as such, and not as control.
6. Accompanying the CBO over the long haul, thus making the GSO a partner upon which the CBO can rely as part of its ongoing social capital and sustainability.

This latter point has significant implications for those local and district level religious bodies who have a durable and historical presence in any particular area, for this makes them well situated to play the necessary role, especially if their own social capital includes national and international connections, as if often the case. That so few of the many religious bodies who might play this role do so is regrettable, especially if they claim to have the health of their public at heart.

**Assessing GSOs, and Beyond ....**

Grassroots Support Organisations, like NGOs in general, inevitably face questions about accountability and responsiveness to their primary constituency. Brown & Kalegaonkar (2002:234-5) identify ‘five challenges that grow out of the characteristics of the development NGO sector itself: (a) amateurism, (b) restricted focus, (c) material scarcity, (d) fragmentation, and (e) paternalism,’ with paternalism being a particularly insidious and debilitating factor in the context of marginalised communities, and thus a particular danger for GSOs. These challenges raise the question of how one is to assess the quality and work of any GSO.

Carroll, again, offers an important set of criteria, which are a combination of ‘hard’ measures and ‘soft’ criteria. ‘Hard’ criteria refer to measures of effectiveness and efficiency, usually in terms of tangible outcomes and impact. ‘Soft’ criteria refer to more intangible goals of participation, raised awareness, and enhanced self-reliance. Without attempting to replicate Carroll’s detailed discussion of these criteria, for which his work is mandatory reading, I simply note that he isolates six criteria (1992: 252-4), collected in three overarching categories, as follows:
Table 1: Categories and criteria for assessing GSO’s (Thomas Caroll)

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<th>Development Services (in our case, health promotion and provision)</th>
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<tr>
<td>Service delivery</td>
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<td>Poverty reach</td>
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<td>Participation and empowerment</td>
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<td>Responsiveness/Accountability</td>
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<td>Reinforcing base capacity</td>
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<tr>
<td>Wider impact (including solidarities, ties, networks and other connections)</td>
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<td>Innovation</td>
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<td>Policy</td>
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In appendices, Carroll provides the details on how one might apply these measures. Here I merely indicate that such tools exist, and that, adapted or supplemented, they can be used to assess GSOs, so I will not discuss them further here, for my primary concern lies elsewhere.

This has less to do with evaluating or assessing GSOs, and more with the fact that so few ‘trustworthy intermediaries’ exist in southern Africa (no doubt elsewhere too). CHEP is exemplary in its character as a GSO, but it is remarkably hard to find many similar examples, even in the context of HIV and AIDS where the challenges at base community level are so deep and CBOs, often unsupported, are so widely present.

What we do have far more frequently are MSOs, such as the various Church Health Associations in Zambia and many other countries, or HIV alliances of one kind or another. They certainly play important roles, such as advocacy to the state or coordination of training, generally speaking, but they do not, and usually cannot play the role of sustained, long-term support and accompaniment so crucial to CBOs in the field, themselves a significant element for strengthening an adequately extended and equitable health system. At the same time, ‘a grassroots link may be crucial to building local capacity, organizations that support actors beyond grassroots organizations can be central to large-scale programs or to policy influence at the national or international level’ (Brown & Kalegaonkar 2002:239). In short, GSOs need to live in relation to relevant MSOs. MSOs are fairly widespread, GSOs are not—yet they are the key to scaling up community related responses to health crises. Critical at this point in time, I argue therefore, is the need for MSOs, and healthcare systems generally, to invest far more heavily, both materially and humanly, to enable and maintain functioning GSOs at local, district or provincial level.
CONCLUSION

Carroll’s work on intermediary NGOs probes a significant number of best practices chosen from a large number of organisations across at least two levels of identification (grassroots, and membership organisations). Through it, he produces a profound categorisation of what makes for a good intermediary, and how one can tell. Strangely, despite its seminal lessons, his book rarely features in writings about intermediaries in development practice. Why this should be so is open to speculation, but it is puzzling. Carroll (1992:2-3) himself points to some possible reasons for this relative lack of interest. Arguments have been made that GSOs are: one or two steps removed from the grassroots and therefore less ‘genuine’ than CBOs themselves (an ideological objection); temporary and not enduringly rooted in communities (a pragmatic objection); not intrinsically accountable to primary grassroots groups (a practical objection); open to siphoning off money that should go to the poor (an ethical objection); and, hard to classify (an epistemological objection).

Nevertheless, the lack of investment in GSOs remains unclear, for other types of NGOs or organisations are no less susceptible to such arguments, and often more so. My own experience in the work of ARHAP (and other development activities in the past) suggests that trustworthy GSOs are a major benefit where they exist, and that investment in establishing them where they do not would make a major difference in sustaining and scaling up community-based responses to health challenges in our time. The kind of situation captured by the narrative of Matatiele with which I began highlights precisely the need for GSOs in situations where they do not exist, and support for them where they do.

There are multiple CBOs in the two health districts covered by Matatiele and Mount Fletcher doing critical work in dealing with HIV, AIDS, TB, and OVC. Very few are able to access the resources they need, or find the support they require to manage their work. Nothing and no-one is in place to play the role of the ‘drip-feed’ support organisation that Foster has identified as crucial to orphan care groups, clearly a notion applicable well beyond that particular need. There are organisations that might, if reconfigured, play such a role in the area, though they seem not to recognise either the need or the possibility. This is linked, I would say, to a lack of vision, an inclination to keep doing that with which one is familiar, to stick within established boundaries—precisely where boundary-crossing leadership is vital.

My argument is that the vital grassroots initiatives of CBOs of one kind or another represent a crucial point of leverage to alter the health of the population for the better, to expand the possibilities of achieving some greater level of comprehensive well-being than currently exists. But those possibilities cannot rest in their hands alone, and alone they cannot in the long run succeed. Equally, the formal health system cannot substitute for what they do, nor can it play the intermediary
role. Neither primary grassroots organisations nor formal health system functionaries are easily able to create the communication channels and mechanisms that would be necessary to allow them to supplement each other, strengthen each other, and hence, enhance the health status of the relevant population.

At the same time, the situation cries out for this. Given the great strain on public infrastructure and resources, scaling up a response to HIV and other major health challenges must include the determined, focused and rapid evolution of intermediary grassroots support organisations. If, for example, one were to set up a GSO to support just ten primary grassroots organisations in the greater Matatiele-Mount Fletcher area, one would be supporting sustainability for dozens of people engaged in dealing with the health of the population, and probably many hundreds that they reach. Moreover, one would be providing a framework whereby their work would be linked to the work of those responsible for the formal health system, a mutual benefit that might have incalculable long-term impact in building trustworthy relationships between those who live in an area and those who are tasked to provide services to them.

This, of course, is a thought experiment, not a reality. But that such realities are possible is clear in the work of the Copperbelt Health Education Project in Zambia. Do the costs of supporting GSOs match the benefits? That would be an ongoing question, and one that would need monitoring. Yet the example of CHEP suggests that we find in GSOs a far better cost-benefit relationship, if one wishes to stick with this criteria alone, than is the case with the formal health system on its own, with isolated and fragmented CBOs on their own, or with NGOs that are not indigenous or support-oriented (see Southern Africa AIDS Training Programme & the International HIV/AIDS Alliance, 2004). Because CBOs, at least in Africa, are so often containers of considerable and wide-ranging religious health assets, tangible and intangible, a focus on GSO intermediaries also becomes something that anyone interested in the role and contribution of religion to public health should take very seriously. This includes religious bodies who act as MSOs, as donors, or as partners in local initiatives, and NGOs and faith institutions with the health and well-being of the public as a desired goal.

I have argued that trustworthy GSO intermediaries are the critical component we need. Where they exist at all, they need to be supported. Where they do not, they need to be built. The criteria are there for doing this, the standards for establishing appropriate practice are available, the examples are there, and the nascent possibilities for achieving it lie within many existing organisations if they are helped to redefine themselves accordingly. And their promise, to me at least, seems as clear as the brightest day.
REFERENCES


Trustworthy Intermediaries: Role of Religious Agents


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