Contents

Acknowledgements xi

About the Contributors xiii

Preface: The Hope of Alignment xvi
  Introduction xvi
  From the Past to the Present xvii
  The African Religious Health Assets Programme (ARHAP) xix
  When Religion and Health Align xxiii

Section 1
Overview and State of the Field

1. The Continued Paradigm Shift in Global Health and the Role of the Faith Community 2
  Christoph Benn
  Introduction 2
  Developments in the Last Decade 3
  AIDS as a Catalyst for Equity in Global Health 5
  A Paradigm Shift In Global Health Ethics? 6
  Can the Faith and the Health Communities Find a Common Language? 9
  Conclusion 13

2. Discovering Fire: Changes in International Thinking on Health Care—The Challenge for Religion 16
  Gillian Paterson

3. ‘An FB-oh?’: Mapping the Etymology of the Religious Entity Engaged in Health 24
  Jill Olivier
  Mapping the ‘Faith-Based Organisation’ Landscape 24
Exploring the Terminological Battlefield: Why Does it Matter? 30
A Clash of Paradigms and Forms of Evidence 32
The Power in Naming 36
Conclusion: Power and Resistance 38

Steve de Gruchy, James R Cochrane, Jill Olivier, Sinatra Matimelo

An Historical Overview 44
Four Key Ideas Behind PIRHANA 45
The Theoretical Foundations of PIRHANA 47
An Overview of the PIRHANA Tool 50
Technical Research Matters 54
What Does Participatory Inquiry Achieve and What Not? 56
Conclusion 59

5. Boundary Leaders: Seeing and Leading in the Midst of the Whole 62
Mimi Kiser

Institute for Public Health and Faith Collaborations 63
Recognising the Systems Nature of Health Challenges 63
Leadership that Sees the Self in the Whole 66
Liberative Pedagogy 68
Analysis 70

6. Liquid Boundaries: Implications for Leaders
Mobilising Religious Health Assets for Transformation 75
Gary Gunderson

Section 2
HIV and AIDS

7. A Purpose-Driven Response: Building United Action against HIV & AIDS for the Church in Mozambique 86
Geoff Foster, Carina Winberg, Earnest Maswera, Cynthia Mwase-Kasanda
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>86</td>
</tr>
<tr>
<td>Background</td>
<td>87</td>
</tr>
<tr>
<td>Methodology</td>
<td>88</td>
</tr>
<tr>
<td>Results</td>
<td>89</td>
</tr>
<tr>
<td>Discussion</td>
<td>95</td>
</tr>
<tr>
<td>Conclusion</td>
<td>100</td>
</tr>
</tbody>
</table>

### 8. Challenges and Possibilities of Religious Health Assets: Charting an Islamic Response to the HIV and AIDS Pandemic

*Muhammad Khalid Sayed*

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>105</td>
</tr>
<tr>
<td>Potential Problems of an Orthodox Islamic Response to HIV and AIDS</td>
<td>107</td>
</tr>
<tr>
<td>Islamic Marriage and the Risk to Women of Contracting HIV</td>
<td>108</td>
</tr>
<tr>
<td>The ‘Islam-centred’ Response by Positive Muslims to HIV and AIDS</td>
<td>110</td>
</tr>
<tr>
<td>Islamic Jurisprudence for an Orthodox-Centred Response Effective Against HIV and AIDS</td>
<td>111</td>
</tr>
<tr>
<td>Conclusion</td>
<td>116</td>
</tr>
</tbody>
</table>

### 9. Tough Negotiations: Religion and Sex in Culture and in Human Lives

*John Blevins*

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIRASH Workshops: The Research Findings of a New Methodological Tool</td>
<td>118</td>
</tr>
<tr>
<td>Findings from the Workshops</td>
<td>119</td>
</tr>
<tr>
<td>Conclusion from the Workshops and Further Questions</td>
<td>120</td>
</tr>
<tr>
<td>Christian Theology and Sexuality</td>
<td>121</td>
</tr>
<tr>
<td>Religion, Sexuality and Identity</td>
<td>122</td>
</tr>
<tr>
<td>Critiquing Modern Power, Grounded in Social Justice</td>
<td>123</td>
</tr>
<tr>
<td>Towards Religious Communities with many Sexual Subjects</td>
<td>124</td>
</tr>
</tbody>
</table>

### 10. On the Pedagogy of HIV and AIDS: Conversations with Indigenes

*Sepetla Molapo*

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>135</td>
</tr>
<tr>
<td>On the Pedagogy of HIV and AIDS: A Brief Overview</td>
<td>136</td>
</tr>
<tr>
<td>On Definitions of HIV and AIDS: Indigenes as Adherents of the Dominant HIV and AIDS Pedagogy</td>
<td>137</td>
</tr>
</tbody>
</table>
On Defeated and Contaminated Blood: Understanding the Causes of HIV and AIDS among Indigenes 139
What about Safe Sex? Indigenes on Sex that Involves the Use of Condoms 142
Concluding Remarks 145

Section 3

Practice

11. Trustworthy Intermediaries: Role of Religious Agents on the Boundaries of Public Health 150

James R Cochrane

Introduction 150
The Context 151
The Challenge 152
Building Trustworthy Intermediaries 155
Assessing GSOs, and Beyond …. 158
Conclusion 160

12. The Relevance of Healthworlds to Health System Thinking About Access 164

Lucy Gilson

Introduction 164
Understanding Access and Addressing Access Barriers 165
Unpacking Acceptability 167
Bridging the Worlds of Patients and Providers: What Role for Trust? 170
What are the Implications of These Insights for Improving Health Care Access? 173
To conclude 176


Frank Dimmock with Tali Cassidy

Introduction 178
Method of CHAs Study 179
Historical Background of CHAs 179
Section 4
LOOKING BEYOND AND AHEAD

15. Frontiers of Public Health and Social Transformation: Faith at the Table
Katherine Marshall
Setting the Scene 212
Caveats and Definitions 214
Navigating Disconnects and Tensions around Religion and Development 215
Trends in International Development, Faith, and Health 220
Faith and Health: Moving towards More Concrete Action 224
Malaria and Faith – A Case Study 228
Ideas on Paths Forward 231

Index 235
维护和加强非洲宗教健康资产：
面临的挑战及下十年的展望

Frank Dimmock

非洲健康联络，美国联合卫理公会，马塞卢，莱索托

联合

Tali Cassidy

ARHAP, University of Cape Town

第一章

INTRODUCTION

国家卫生系统的维护是非洲大陆面临的挑战，包括全球负面趋势的增加，如食品和燃料价格的上涨，气候变化和国家预算的减少。公共卫生服务在非洲各国正日益过载、人手不足和资金不足。与此同时，为减少疾病和贫困相关的疾病而设立的宏大健康和发展目标（例如，千年发展目标）已设定，旨在减少疾病和贫困相关的疾病。现在，比以往任何时候都更加重要的是，将公共卫生政策与初级卫生保健原则和目标对齐，以促进健康、公平、接近和对所有人公平。

在这一背景下，2009年进行了一项关于基督徒健康协会（CHAs）在非洲的角色的调查，以识别在国家卫生系统中维持和加强其角色的挑战和机遇。本章将呈现这一调查的结果。首先，概述了研究方法，随后是基督健康协会的历史背景，以及其功能、职能和使命的广泛概述。

1 粗稿和数据的这一章来自Frank Dimmock，Tali Cassidy协助完成。
comparative advantage of CHAs as informed by academic sources, survey responses and years of Dimmock’s experience in the field. Threats and challenges to CHAs are then discussed. The survey results indicate the need to focus on three broad areas during the next decade, and these will be presented at the end.

**Method of CHAs Study**

In February of 2009, a questionnaire was developed and circulated among representatives attending the Fourth Biennial CHAs Assembly in Kampala, Uganda. The purpose of the questionnaire was to give the Associations the opportunity to reflect on their relationship with their governments, church proprietors, donors, and members, and on how those relationships are shaping their identity and continued existence.

The questionnaire included 14 questions probing the nature and strength of the relationship between CHAs and their respective governments and donors, their Christian mandate, their human resource and financial situations, and the value of continental networking. Responses were received from 18 networks in 16 countries of sub-Saharan Africa, including Benin, Cameroon, Central African Republic, Chad, Ghana, Kenya, Zambia, Ethiopia, Lesotho, Malawi, Sudan, Tanzania, Togo, Uganda, Zimbabwe and Liberia. They represent a significant portion of the religious health providers in Africa. Countries with CHAs not reporting include DR Congo, Nigeria, Sierra Leone and Senegal.

Besides information gathered from the questionnaire and follow-up conversations by Dimmock wherever possible, some data comes from CHA Constitutions.

**Historical Background of CHAs**

For more than a century, throughout sub-Saharan Africa, Christian health care workers have played a significant role in providing preventive and curative health services to the public. Motivated by compassion and a moral imperative, religious communities were providing holistic care before colonial or government health services were developed. Estimates of their direct contribution to national health systems vary widely due to the absence of standard indicators (Schmid et al. 2008:47). However, evidence based on currently available data regarding numbers of health facilities, type of ownership, management, and services offered suggest that in many sub-Saharan Africa countries 25-70% of health services are provided by religious entities (REs; ibid:49). Indirectly, through community and congregation-based primary health care, HIV and AIDS services and social welfare programmes, they reach even larger, mostly rural, sections of the population.

In 1958, a missionary doctor, James McGilvray, encouraged the churches in the Philippines to form a coordinating body of faith-based health work. During the 1960s, he directed the Christian Medical
Commission (CMC) of the World Council of Churches (WCC) to conduct surveys of church-related health services in several African countries together with national church bodies (CMC 1990:ii-iii). These surveys led to the formation of Christian Health Associations in Malawi, Ghana, Uganda, Zambia, Zimbabwe (then Rhodesia), Botswana, Nigeria, and Lesotho. During the 1970s, additional associations were established in Senegal, Sierra Leone, Mali, Liberia, Benin, Togo, Cameroon, Central African Republic, Democratic Republic of the Congo (DRC), Rwanda, Kenya, and Tanzania. More recently, CHAS (Sudan) was registered in 2008, and currently ecumenical health partners are meeting in Ethiopia to establish a CHA there.

Thus, now over 20 sub-Saharan African countries have coordinating bodies for Christian health work. The map shows countries with active CHAs (light grey), associations in formation (Chad and Ethiopia), limited or currently inactive CHAs (Mali, Angola and Botswana), and those represented in CHA assemblies though they do not have registered associations (Swaziland, Burkina Faso and Niger). In most countries, Catholic and Protestant churches are combined into a single association; exceptions include Kenya, Uganda, Chad and Togo. Table 1 gives an overview of the current CHAs at the time of writing.
<table>
<thead>
<tr>
<th>Country</th>
<th>Network/Association</th>
<th>Year Founded</th>
<th>Website</th>
<th>National Public Health Facilities (%)</th>
<th>No. of Hospitals</th>
<th>No. of HCs or lower units</th>
<th>No. of Training Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>CICA</td>
<td>1977</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benin</td>
<td>AMCES/Bethesda</td>
<td>2002</td>
<td><a href="http://www.amces-benin.org">www.amces-benin.org</a></td>
<td>40%</td>
<td>6</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>Botswana</td>
<td>AMMB</td>
<td>1974</td>
<td></td>
<td>18%</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Cameroon</td>
<td>CEPCA</td>
<td>1957</td>
<td></td>
<td>38%</td>
<td>46</td>
<td>389</td>
<td>5</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>ASSOMESCA</td>
<td>1989</td>
<td></td>
<td>~20%</td>
<td>2</td>
<td>62</td>
<td>19</td>
</tr>
<tr>
<td>Chad</td>
<td>AEST/UNAD-sante</td>
<td>2009</td>
<td></td>
<td>8</td>
<td>130</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DRC</td>
<td>ECC</td>
<td>1971</td>
<td><a href="http://www.sanru.org">www.sanru.org</a></td>
<td>50% +</td>
<td>89</td>
<td>600</td>
<td>20</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>CHAE</td>
<td>forming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>CHAG</td>
<td>1967</td>
<td><a href="http://www.chagghana.org">www.chagghana.org</a></td>
<td>42%</td>
<td>58</td>
<td>104</td>
<td>10</td>
</tr>
<tr>
<td>Kenya</td>
<td>CHAK</td>
<td>1940-1987</td>
<td><a href="http://www.chak.or.ke">www.chak.or.ke</a></td>
<td>21</td>
<td>415</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>KEC</td>
<td>1957</td>
<td><a href="http://www.kec.or.ke">www.kec.or.ke</a></td>
<td>53</td>
<td>393</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td>CHALe</td>
<td>1973</td>
<td></td>
<td>40%</td>
<td>8</td>
<td>72</td>
<td>4</td>
</tr>
<tr>
<td>Liberia</td>
<td>CHALi</td>
<td>1975</td>
<td></td>
<td>10%</td>
<td>6</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>Malawi</td>
<td>CHAM</td>
<td>1966</td>
<td><a href="http://www.cham.org.mw">www.cham.org.mw</a></td>
<td>37%</td>
<td>27</td>
<td>142</td>
<td>10</td>
</tr>
<tr>
<td>Mali</td>
<td>APSM</td>
<td>1992</td>
<td><a href="http://apsmmali.org">http://apsmmali.org</a></td>
<td>2%</td>
<td></td>
<td>Many CB projects</td>
<td></td>
</tr>
<tr>
<td>Namibia</td>
<td>CCN/ECN</td>
<td>1978</td>
<td>Not available</td>
<td>6</td>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>CHAN</td>
<td>1973</td>
<td><a href="http://www.chan">www.chan</a> nigeria.org</td>
<td>40%</td>
<td>147</td>
<td>247 + 2500 CBHS</td>
<td>28</td>
</tr>
<tr>
<td>Rwanda</td>
<td>BUFMAR</td>
<td>1975</td>
<td></td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td>EPSCM</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>CHASL</td>
<td>1975</td>
<td></td>
<td>30%</td>
<td>Not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>CHAS</td>
<td>2008</td>
<td><a href="http://www.chasudan.org">www.chasudan.org</a></td>
<td>30%+</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>SCFHA</td>
<td>1998</td>
<td>Not available</td>
<td>3</td>
<td>27</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>CSSC</td>
<td>1992</td>
<td><a href="http://www.cssc.or.tz">www.cssc.or.tz</a></td>
<td>42%</td>
<td>89</td>
<td>815</td>
<td>24</td>
</tr>
<tr>
<td>Togo</td>
<td>APROMESTO</td>
<td>1994</td>
<td></td>
<td>20%</td>
<td>3</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Uganda</td>
<td>UPMB</td>
<td>1957</td>
<td><a href="http://www.upmb.co.ug">www.upmb.co.ug</a></td>
<td>12%</td>
<td>15</td>
<td>251</td>
<td>7</td>
</tr>
<tr>
<td>Uganda</td>
<td>UCMB</td>
<td>1956</td>
<td><a href="http://www.ucmb.co.ug">www.ucmb.co.ug</a></td>
<td>20%</td>
<td>27</td>
<td>240</td>
<td>12</td>
</tr>
<tr>
<td>Zambia</td>
<td>CHAZ</td>
<td>1970</td>
<td><a href="http://www.chaz.org.zm">www.chaz.org.zm</a></td>
<td>40%</td>
<td>36</td>
<td>81+29 CBOs</td>
<td>9</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>ZACH</td>
<td>1973</td>
<td></td>
<td>35%</td>
<td>80</td>
<td>46</td>
<td>15</td>
</tr>
</tbody>
</table>
NOTE: * Based on physical assets (e.g. numbers of health institutions) Information in this table was obtained in June 2009, via email or conversation with CHA officials in each country. In the cases of Angola, Botswana, Mali, Namibia, Senegal, Sierra Leone, and Swaziland, formal responses had not yet been received at the time of writing.

**FUNCTION, MANDATE AND COMPARATIVE ADVANTAGE OF CHAS**

It should be noted that many of the countries included in the study have faced, and continue to face, severe economic and political challenges. Some are experiencing prolonged conflict (for example, Liberia, Sudan and Uganda) while others have experienced economic isolation (such as Zimbabwe). These crises have jeopardised national public health care and essential social services. In many cases, the religious communities have responded to fill public service gaps.

The core functions of the CHAs include:
- Advocacy (for example, for planning and policy making)
- Communication and health information
- Technical assistance and training
- Capacity building or institutional strengthening (for example, strategic planning, organisational development, human resource management)
- Resource mobilisation and administration
- Research
- Monitoring and evaluation (establishing standards)
- Joint procurement (for example, Mission for Essential Drugs and Supplies or MEDS, and Joint Medical Stores or JMS) and equipment maintenance

Typically, each association has a secretariat that is responsible for liaising between the religious entities providing health services and various government ministries and donors to address the core functions. Clergy, health professionals and representatives from ministries of health participate in the managing boards of many CHAs.

Five fundamental principles are commonly cited in Christian healthcare (Asante 1998:9). Often reflected in vision and mission statements of Christian health institutions generally, and consistently highly valued by all CHAs, they include that CHAs:
- Should be dedicated to the promotion of human dignity and the sacredness of life;
- Should assist all in need, with a preferential option for the poor and marginalised;
- Are meant to contribute to the common good;
- Should exercise responsible stewardship; and
Should be consistent with the teachings and moral principles of the church.

With respect to state-run health services, the comparative advantage of religious networks (dioceses, synods and other denominational structures) lies in their membership numbers, geographic coverage and relational connectedness with communities. Africa-wide assemblies of CHAs are held biennially and networking has developed among them. The CHAs Assembly in Tanzania in January 2007 agreed to establish a continent-wide platform for African national associations (ACHAP). Its objectives are to enhance advocacy and facilitate technical support, networking and communication of ideas for coordination and capacity building (see its bulletins at www.africachap.org). In addition to ACHAP, a technical working group on Human Resources for Health was established that has conducted health-worker retention studies in several countries with the support of the Capacity Project of USAID.

Alignment within the health sector is especially important in times of crisis. As personal incomes decline, additional stress is placed on public services, including subsidised, private not-for-profit health services. During the past four decades, the relationship between government and faith-based health services across sub-Saharan Africa has been formalised and strengthened through the establishment of CHAs. A critical feature of the evolving relationships has been the development of memoranda of understanding (MoUs).

Ten of the 18 networks surveyed have agreements or MoUs with their governments. Several networks (for example, CHAM/Malawi and CHAG/Ghana) have negotiated service contracts at district or local level, or have agreed on ‘designated District Hospitals’ (for example, CSSC/Tanzania, UCMB/Uganda and ZACH/Zimbabwe) through which church hospitals, subsidised by government, act as public hospitals. Under the MoU, some governments provide CHAs with a waiver on duty for medicines and supplies, budgetary or human resource support, and access to training opportunities.

In practice, there have been problems with inconsistent representation in meetings and lack of commitment in monitoring the partnership. To improve adherence to the MoU, some countries have established joint committees, including government representation on managing Boards (for example, CHAM/Malawi and CHALE/Lesotho) or have an official in the Ministry of Health assigned to liaise with the private sector (CHALE/Lesotho). Most CHAs have reported that the process of establishing the MoU was important in identifying and aligning the relationship between the Ministries of Health and CHAs.

One example of a partnership between a CHA and the health department having had an impact in improving human resources for health can be seen in Box 1 below (Kankye 2009), which outlines the experience of CHAG/Ghana and that country’s Ministry of Health.
The implementation of the policy that guided the MoU in Ghana ended in 2006, after which CHAG conducted a study to assess the extent to which the policies of the government of Ghana impacted the delivery of health services of its network members. The outcome of the study is intended to guide the development of future human resource (HR) policy options and to strengthen CHAG’s capacity to remain a key partner in the delivery of health services throughout the country.

The study found some measure of success for government policies:

(a) **Retention of Human Resource (that is, with regard to trained staff):** The Ministry of Health was to provide career development avenues by increasing opportunities for further training, providing access to fellowships for eligible staff of all categories at all levels and encouraging, supporting and recognizing essential non-clinical programmes. Through Vehicle Hire Purchase Schemes and additional remuneration for duty per hour, the policy has reported a high retention of staff, increased workforce productivity and increased motivation as a result of enhanced salaries.

(b) **Equitable distribution of health professionals to benefit deprived areas:** The Ministry of Health was to pay a rural allowance amounting to 30-50% of basic salaries to doctors and other staff working in rural areas, providing staff with viable housing ownership schemes, encouraging mission or NGO hospitals to run more satellite clinics in the rural areas where they operate. As a result, CHAG hospitals have seen an increase in infrastructural investment in nursing training schools and an increase in the ratio of professional to non-professional nursing staff in hospitals. The study recommended that CHAs analyze the impact of government HR policies on their staff, evolve their own HR strategies and implementation plans and gather and use evidence for engagement with their health ministries.

This section has presented the historic significance, the geographic coverage and the inter-relationships characterizing much of Christian health work in Sub-Saharan Africa. We have examined some of the ways in which Christian health care is unique and how the challenge of partnering with governments has been met in various countries. The following section will explore the threats to and future viability of CHAs highlighted by the survey.
CURRENT AND FUTURE THREATS

When CHAs listed the threats to their mission and values, many recognised the potential negative influence of the conditional support of government or donors. Those associations with MoUs with their governments have negotiated for protection of their mission and values. The Uganda Protestant Medical Bureau (UPMB), which does not yet have a MoU, reported that its government has occasionally seconded staff to church hospitals without respect for religious values. This practice can lead to a demoralisation of staff and an undermining of Christian principles and motivation.

Several CHAs expressed a similar concern with non-governmental donors. Some donors have reportedly influenced the hiring of experienced technical staff for temporary projects, without regard to Christian values in the workplace or critical service demands. In addition, many professional staff members employed at church hospitals have been enticed into higher-paying employment with donor-funded projects elsewhere.

All CHAs are dependent on local and international donor support for their coordination activities. In recent years, due to the decline of donor support globally, CHAs have become increasingly dependent on conditional grants and project funding. This trend has weakened their relationship with traditional church partners. Several CHAs are heavily dependent on their government subvention for covering payroll and operating expenses within their facilities (for example, CHALe/Lesotho, CHAZ/Zambia, CHAM/Malawi, CHAS/Sudan). UPMB/Uganda and CHAK/Kenya have investment properties that provide some revenue for covering secretariat administrative expenses.

Most CHAs, however, are reliant on donor partners for their primary support via designated project funding. In Uganda, for example, the UCMB reported that 49% of their funding during 2007/8 was comprised of project funds (80% of these funds were designated for HIV and AIDS programmes). Reporting and accountability requirements of donor funding can be burdensome and the continuity of funding uncertain. CHAZ/Zambia reported that project-funded donors are often more interested in short-term technical inputs rather than long-term investment in developing local human resource capacity. This places additional stress on under-staffed health programmes and encourages competition within the health sector. CHAZ/Zambia also expressed a perceived erosion of Christian values in the services of their members. This was related to the shortage of professional staff and relaxation of recruitment criteria reflecting religious values. This trend should challenge the church to reiterate its call to compassionate, holistic health ministry and encourage more committed Christians to join the health professions and, in particular, the church-owned facilities.
When CHAs were asked how they ensured their future financial viability, they indicated these strategies: developing business plans, reducing staff, cutting expenses, outsourcing some services, negotiating with government for additional support, increasing local resource generation (for example, guesthouses, office rental, corporate health service contracts) and competing for global funds and international project funding. UCMB/Uganda, CHAK/Kenya, CHALE/Lesotho and ASSOMESCA/Central African Republic all expressed caution with regard to the need to balance attention given to administering specific project funding with the priority tasks of providing integrated and essential health services.

FUTURE STEPS AND PROSPECTS

We suggest that in order to strengthen and maintain Christian healthcare in Africa during the next decade, CHAs must focus on three broad areas:

1. **Advocacy**—focused on health equity, justice and stewardship of resources (corporate governance);
2. **Partnerships**—community, church, health authorities and donors;
3. **Strategic planning**—re-focusing on primary health care (PHC) and social determinants of health.

**Advocacy**

Because issues of justice and equity are at the heart of the Christian mandate to serve the poor and Christian activists may be well positioned to take on the liberal ‘laissez-faire doctrine’ that has failed to address ongoing inequality and dire health problems of the world’s poor (Gutierrez, in Farmer 2005:142). Indeed, Farmer (2005:139-159) has suggested that public health professionals could learn from the insights gleaned from liberation theology as well as from its praxis.

The healing ministry of the church to the needs of the poor is one of the most noticeable expressions of the compassion of Christ. The poor are socially invisible and often out of reach, but religious movements involved in these communities have ‘intimate acquaintance with the suffering of the poor’ (ibid: 142). The church must lead efforts to reach invisible and marginalised groups and must be appropriately supported in its efforts. Religious leaders and health workers, inspired by their faith, must actively campaign at the highest political and social levels to ensure that all policies and budgets are assessed for their potentially direct and indirect impact on health equity, sustainability and social justice. They are well positioned to reveal injustices and take on the task of ‘conscientization’ highlighted by Farmer (ibid: 143).

An essential prerequisite for effective advocacy in this regard is information. Evidence and data with appropriate, current, complete and accurate statistics and analyses are vital for advocacy purposes. It is
important to present effectively the evidence that will raise awareness, build respect, and enlighten key religious and government authorities.

One example of such information that might be used for advocacy purposes is the mapping of Religious Health Assets in Africa that has been conducted by ARHAP (De Gruchy et al. 2006). ARHAP used participatory techniques to collect information and to objectively identify and characterise community health assets. These assets can have both direct and indirect impacts on the underlying causes of poor health in the community. CHAs should promote in their daily work the collection and presentation of accurate data to inform and support the efforts of those best placed to advocate for improved and more efficient health care for all.

**Partnerships**

Maintaining and strengthening public health services will require a concerted effort. Governments will find that engaging CHAs and other faith-based organisations in health care partnerships can significantly increase public health value and reduce health inequity. Alignment of state or public health systems with those of CHAs and other faith-based organisations will greatly improve efficiency and effectiveness. But what value can CHAs and their member institutions add to health partnerships?

Perhaps, most important are the linkages between church and community, and ecumenical links between religious groups (for example, religious leaders are often leaders in their communities so inter-faith links at leadership level become viable).

Church structures provide an alternative health network to that of state health infrastructure. As Reinikka and Svensson (2003) show in their comparative study in Uganda, religious, non-for-profit healthcare providers, in this case, provide better care than government facilities, although the latter sometimes possess better equipment. The ‘altruistic concerns,’ they claim in ‘working for God’ make for a more effective health care strategy.

Care may be provided for those who are otherwise marginalised, such as vulnerable populations in rural areas. Referring again to Reinikka and Svensson (2003), their findings indicate that religious-based health services generally employ people at a rate below the average market wage, thus enabling them to charge lower prices for their services in favour of the poor.

- The contributions of CHAs to partnerships include: Access to committed community volunteers through church groups; for example, home-based care workers, community health workers and community-based rehabilitation volunteers.
- Training and development of health workers; for example, the South African Christian Leadership Assembly project in South Africa
Mobilising Religious Health Assets for Transformation

accesses and trains community health workers, utilizing its community ties, experience and external funding (Cruse 1997:9-10).

- Flexibility to test new methods, strategies or research; for example, health financing, human resources and HIV and AIDS prevention and care methods. Schmid et al. (2008:50-51) comment on the fluidity of religious-based health care, which is able to respond to the needs of community members by adapting its own practices accordingly. This flexibility, which is not always or easily available to bureaucratically organised state facilities, should be further harnessed by CHAs to try out and advise on possible new approaches.

- Credibility, which is built around practical experience; for example, influencing social health and lifestyle behaviour changes.

- Experience in co-ordinating technical support services; for example, pharmaceutical systems such as MEDS and JMS.

CHAs and their members provide these and other services to varying degrees. Careful monitoring and resource inputs of these associations are urgently required in order to maintain quality and expand the reach of these public services.

Some of the weaknesses in health services provided by churches and other faith-based organisations include irregular and inadequate financial support, severe health workforce shortages, insufficient numbers and distribution of skilled staff for administration, accounting, and programme management, lack of infrastructure maintenance, poor reporting performance, lack of monitoring and evaluation mechanisms and poor management and governance.

Successful partnerships require the promotion of servant-leadership models, which assume that goals can be met through careful alignment and implementation by all who share a common vision. As such, planning, visioning and developing strategies must be done collectively. Working together will help to achieve universal coverage. Partnership calls for interdependence, trust and respect, with accountability and regular communication. Partnerships are critical for realigning and strengthening health care systems. CHAs and churches should embrace the opportunity through partnership to influence health holistically.

Strategic Planning for Health

It was in 1975 that the World Health Organization, with significant vision and input from the Christian Medical Commission, outlined seven principles of primary health care or PHC (CMC 1990:13). The following year, a methodology for PHC was offered as a means to achieving ‘Health for All by the year 2000.’ In 1978, at the World Health Assembly in Alma-Ata, a resolution was endorsed that launched PHC as a global movement (Bandy 2008). But there have been significant shifts, with important consequences, in the policy focus and implementation of PHC in the subsequent three decades (see Table 2 below for more details).
In their World Health Report of 2008, the World Health Organization again identified and prioritised the Primary Health Care approach for the strengthening of health systems. The Report (WHO 2008) states that health inequalities in all countries are ‘politically, socially and economically unacceptable.’ In May 2009, delegates to the 62nd World Health Assembly unanimously reaffirmed their commitment to four broad policy directions for reducing health inequalities and improving health for all, namely, tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health (WHO 2009). Not only do health authorities have the moral obligation to make careful policy design decisions, but they, as well as CHAs and all other health providers, have an urgent need to re-focus strategically on PHC reforms.

What are the implications of these reforms for CHAs and their members? As reported earlier, the majority of Christian health services serve rural communities. These are areas where churches and congregations can provide integrated, people-centred support. The determinants of health inequality will necessitate a first response at community level; in other words, access to health care by all. This is where servant leadership in strategic partnerships and responsible stewardship (or governance) of limited health resources are most important.

Strategic planning as a management tool is generally carried out to fine-tune systems and target resources to increase efficiency. It is critical now to review and adjust policies and plans to equitably expand health access and improve performance indices.

**Conclusion**

While this chapter has focused on the provision of Christian health care, it should be noted that there are other religious traditions and African traditional practices that also play a role in provision of community health services.
Table 2. Shifts in Policy Focus of PHC over Last Three Decades (WHO 2008:xv)

<table>
<thead>
<tr>
<th>Early attempts at implementing PHC</th>
<th>Current concerns of PHC reforms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended access to a basic package of health interventions and essential drugs for the rural poor</td>
<td>Transformation and regulation of existing health systems, aiming for universal access and social health protection</td>
</tr>
<tr>
<td>Concentration on mother and child health</td>
<td>Dealing with the health of everyone in the community</td>
</tr>
<tr>
<td>Focus on a small number of selected diseases, primarily infectious and acute</td>
<td>A comprehensive response to the expectations and needs of people, spanning the range of risks and illnesses</td>
</tr>
<tr>
<td>Improvement of hygiene, water, sanitation and health education at village level</td>
<td>Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards</td>
</tr>
<tr>
<td>Simple technology for volunteer, non-professional community health workers</td>
<td>Teams of health workers facilitating access to and appropriate use of technology and medicines</td>
</tr>
<tr>
<td>Participation for the mobilization of local resources and health-centre management through local health committees</td>
<td>Institutionalized participation of civil society and local communities in policy dialogue and accountability mechanisms</td>
</tr>
<tr>
<td>Government-funded and delivered services with a centralized top-down management</td>
<td>Pluralistic health systems operating in a globalized context</td>
</tr>
<tr>
<td>Management of growing scarcity and downsizing</td>
<td>Guiding the growth of resources for health towards universal coverage</td>
</tr>
<tr>
<td>Bilateral aid and technical assistance</td>
<td>Global solidarity and joint learning</td>
</tr>
<tr>
<td>Primary care as the antithesis of the hospital</td>
<td>Primary care as co-ordinator of a comprehensive response at all levels</td>
</tr>
<tr>
<td>PHC is cheap and requires only a modest investment</td>
<td>PHC is not cheap; it requires considerable investment, but it provides better value for money than its alternatives</td>
</tr>
</tbody>
</table>
health care (especially in the western Sahel region). ARHAP, in its case study in Mali, for example, noted the significant role of religious leaders (predominately Muslim) in health promotion activities (Schmid et al. 2008:161). In some countries, inter-faith groups are collaborating on HIV and AIDS programmes, as for example, the Zambia Interfaith Networking Group on HIV/AIDS, the Inter-Religious Council of Uganda, the Malawi Interfaith AIDS Association, the Lesotho Inter-religious AIDS Consortium, and the Kenya Inter Religious AIDS Consortium. In addition, there are numerous international, faith-based organisations that also play a significant role in health and development (for example, World Vision, Norwegian Church Aid, Catholic Relief Services, Christian Aid and Islamic Relief Worldwide).

Alignment between church and other religious health providers and government is obviously important. For centuries, Christians, motivated by their faith, have been committed to serving the poor. Evidence of this commitment is found everywhere—from urban slums to remote communities—where the Church has established places of worship, schools, clinics, hospitals and other such structures serving social needs. The Church often provides health and social services, such as counselling, home-based care and primary health care in areas where there are no such government services. In these cases, the Church should be supported and resourced in order to maintain and strengthen its efforts and delivery of health care to local communities.

Despite the numerous challenges currently facing African CHAs and their members, these associations will likely remain the primary partner to government health services for a long time to come. By concentrating on both PHC principles and aligning religious health assets with public health systems, improvements in achieving health equity and health quality can be achieved.

REFERENCES


Kingma, Stuart, Marion Morgan, Frank Winnubst & Daleep Mukarji. 1994. 'Coordinating Agencies, Churches Working Together for Health.' *Contact* 137.


