

THE COMPARATIVE NATURE OF FAITH-INSPIRED HEALTH CARE PROVISION IN SUB-SAHARAN AFRICA

Strengthening the Evidence for Faith-inspired Health Engagement in Africa, Volume 2

Edited by Jill Olivier and Quentin Wodon

November 2012



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Edited by Jill Olivier^a and Quentin Wodon^b

^a School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa

^b Education Department, World Bank, Washington, DC, United States

Collection prepared in support of the World Bank's work on private service delivery in human development.

Abstract: As African governments, donors, and a wide range of organizations increase their efforts to reach the Millennium Development Goals (MDGs) and set the agenda for the post-MDGs era, the role of non-state providers of health care is gaining new attention. In Africa, the largest non-state networks of providers are often faith-inspired. But how important is the role of faith-inspired institutions (FIIs) in health care provision in Africa? How substantial are their market share and reach to the poor? How affordable are the services provided by FIIs to households? How satisfied are households with these services? What are some of the interesting and innovative experiences that have been documented in terms of FIIs providing quality services to underserved populations? Beyond facilities-based care, which types of non-institutionalized initiatives emerge out of communities of faith that are generative of health? How can these initiatives be mapped, understood and leveraged for better health and development? The objective of this edited series of three World Bank HNP Discussion Papers is to gather tentative answers to such questions. This second volume focuses on the satisfaction of users with faith-inspired providers and their comparative nature versus public and private secular providers.

Keywords: Health, private providers, faith, religion, satisfaction, comparative advantage, Africa

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Correspondence Details: Dr. Quentin Wodon, World Bank, 1818 H Street NW, Washington, DC, 20433. Email: qwodon@worldbank.org.

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THE COMPARATIVE NATURE OF FAITH-INSPIRED HEALTH CARE PROVISION IN SUB-SAHARAN AFRICA: A BRIEF OVERVIEW

Jill Olivier and Quentin Wodon
University of Cape Town and World Bank

INTRODUCTION

This is the second volume in a three part series on strengthening the evidence for faith-inspired engagement in health in sub-Saharan Africa. One of the driving characteristics of the emerging literature on faith, health and development, is a discourse on the ‘comparative advantage’ of faith-based organizations (see Haddad 2011, Olivier and Wodon 2012, and Wodon 2013). In the earlier stages of the debates in this area, many advocated for the (then) poorly recognized ‘faith sector’. This led to quasi automatic arguments that faith-inspired institutions had characteristic strengths which made them suitable partners. Especially in the advocacy and grey literature on the faith-based response to HIV/AIDS, authors made prominent lists about the ‘comparative advantages’ or ‘value-added’ of ‘faith-based organizations’. For example, it was argued that they had reach into communities, trust, and untapped resources – and many anecdotes suggested that communities preferred faith-inspired providers, that they perceived a higher quality of care there, and that patients would walk for miles, passing other (often cheaper public) health facilities in order to receive care from a faith-inspired provider.

The main challenge with these claims of ‘comparative advantage’ is that they are poorly evidenced. Not only is there limited comparative studies on any of these issues, but the catch-all category of ‘faith-based organization’ tends to create difficulties – being inclusive of everything from a local religious leader to a high level hospital – and therefore making it impossible to prove or disprove many of these statements. It could be argued that without the backing of sound evidence and data, such claims quickly raise suspicion and distrust, especially at a policy level, and arguably now work against the original advocacy-intentions such statements were utilized to engage.

In this volume, we draw together various practice and research perspectives that begin to probe some of these assumptions from different angles. The authors look more closely at recent work and evidence about the specificity of faith-inspired health care, its ‘value-added’ or ‘comparative advantage’ – and also some of the strategies that are being undertaken by faith-inspired health providers based on their particular understanding of what these comparative advantages are, and how they are operationalized.

As with the previous collection in this three-volume series of HNP Discussion Papers, our purpose in the series is to ‘round up’ various analytical perspectives and emerging research on faith engagement in health in Africa from a range of researchers and practitioners from the ‘North’ as well as the ‘South’. What is shared is a common interest in uncovering what might be distinctive about faith-inspired health initiatives and institutions. While we mainly focus on Africa, the questions that are raised are likely to

be of interest for other regions of the world as well. The authors of the various chapters rely on different kinds of research strategies and perspectives. Some of the offerings are full-length analytical articles, reporting on new evidence, and others are shorter ‘notes’ summarizing recent work and perspectives. The work of World Bank authors has been deliberately interspersed with those of other academic and practitioner partners in order to provide a more layered perspective. It should be mentioned that there are continued and unresolved debates relating to the appropriate terminology best applied to ‘faith-inspired institutions and initiatives’ (also called faith-based organizations, religious entities and the like). As editors we have not standardized the use of terminology in each contribution, as the varied usage reflects the complexity of the issue and the variety of interests which intersect at this point.

OVERVIEW OF VOLUME TWO

This collection consists of ten papers which engage on whether there is evidence of a ‘comparative advantage’ or ‘comparative nature’ of faith-inspired health care.

The first article, “*Satisfaction with faith-inspired health care services in Africa*” by Olivier, Tsimpo and Wodon, looks at patient service satisfaction, which has become a critical concept, utilized both in the assessment of quality of care and to predict a range of health-related behaviors and outcomes. It is often stated that patients prefer to walk past a nearby public facility to walk to a faith-inspired facility located further away as a result of higher satisfaction with faith-inspired providers. The authors therefore question what evidence is available relating to patient satisfaction with FIIs in the African context in comparison with other providers – and in particular public providers. The paper first reviews what evidence there is in the literature that might cast light on the comparative satisfaction of patients with FII-health services in Africa today. It then presents new evidence from household surveys in six African countries: Burundi, Niger, Mali, Ghana, Senegal and the Republic of Congo. Overall, the results suggest clearly that satisfaction with the services provided by FIIs is higher than with those provided by public facilities. The authors consider several of the related factors that influence satisfaction, but note that there is still much left to be discovered about the internal values and characteristics of faith-inspired services which might make them comparatively different from other public and private providers.

Applying a different lens and approach, in “*Building on the strengths of people who congregate*”, Gunderson and Cochrane turn the focus towards religious health assets that lie within ‘congregations’ of faith-inspired individuals and communities – and how these can be leveraged for health systems strengthening. They argue that hundreds of thousands of congregations or what they call ‘faith-forming entities’ (FFE) are found in neighborhoods everywhere. They probe the nature of such an entity, and ask what are the strengths of congregations, and which strengths might be of significance for the health of the public? They note that what is often obscured is the mystery of how a congregation functions over time, remaining generative and resilient amid contexts rife with multiple health and other challenges. They identify eight strengths of congregations that express themselves not in mechanical operations or managerial techniques, but in patterns of

complex human relationships. These strengths are: accompanying, convening, connecting, storying, giving sanctuary, blessing, praying, and enduring.

The next two chapters report on qualitative fieldwork carried in the summer of 2010 in Burkina Faso and Ghana on why some households do choose faith-inspired facilities for health care. In chapter 3, Gemignani and Wodon look first at why some households rely on traditional as opposed to modern health providers, and next within modern providers, at why they choose faith-inspired as opposed to public facilities. While there is overall a preference for modern care in the areas of the study, many households still rely on traditional healers for specific health issues. As to the choice between public, private secular, and faith-inspired modern providers, the preference for faith-inspired clinics and hospitals appears to be driven by lower out-of-pocket costs and perceived higher quality of service. Faith-inspired facilities are well regarded in their surrounding communities and patients are willing to travel significant distances to receive care from those facilities. Potential concerns related to proselytism and family planning services appear not to be severe, in that proselytism is limited, and the opposition to family planning seems much stronger in the population than in the personnel of the facilities, even if denominations differ in their approach to the issue. Although faith-inspired providers vary in size and religious affiliation, they share a similar goal of offering affordable services to the poor, and doing so in a way that fosters closer relationships between individuals, communities and the healthcare system. Their approach helps in expanding options for care, especially among those who feel marginalized in the public health system.

In chapter 4, Shojo, Tsimpo and Wodon report on a similar qualitative data collection exercise carried in Ghana, while also relying in part on data from the country's latest multi-purpose integrated survey which identifies separately faith-inspired providers in the health module questionnaire. The two questions investigated by the authors about the services provided by faith-inspired health care providers are: how satisfied are patients with the services received; and why are patients choosing faith-inspired providers for care? The quantitative survey data suggest that the level of satisfaction with the services provided by faith-inspired facilities is similar to that for public facilities, but lower than for private non-religious facilities. However, the qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit. Indirectly this suggests that the satisfaction with and quality of services provided by faith-inspired providers may actually be higher than suggested simply by the household survey data, at least in the areas chosen for qualitative data collection. At the same time, patients do mention some areas for improvement including in terms of availability of medicines and equipment.

Next, Major Dean Pallant, the International Health Services Coordinator for The Salvation Army (TSA), describes in chapter 5 the role and operations of TSA which operates health services and programs in 124 countries around the world. In "*Global health provision for development*", Pallant notes that TSA explicitly defines itself as an international movement and an evangelical part of the universal Christian Church with a mission to preach the gospel of Jesus Christ and meet human needs without

discrimination. The author describes a reflective process from within TSA, which has sought to better understand how to reconcile this faith-based mission with the contextual concerns of health service delivery in development contexts. For example, TSA is wrestling with the tension between hospital-centricity and the demands of primary health care. Pallant argues that religious groups can benefit from a more clearly articulated faith-based strategy to maximize their contribution through health and development initiatives – and that such articulation also needs to be respected by state, market and NGO partners.

Following this, in *“Emerging practices of faith-based organizations addressing human resources for health”*, Dieleman, Hilhorst and Utrera report on a collaborative study that examined the practices of faith-inspired health providers who are facing the crisis of human resources for health (HRH) in Africa. The authors note that health system performance and achieving the MDGs for health requires that qualified health care providers are available and can perform adequately. However, there is a critical shortage of health care providers in sub-Saharan Africa, and this crisis is hitting faith-inspired institutions (FIIs) particularly hard. Many FIIs are organized into national Christian Health Associations that decided, in 2005, to share experiences on creative ways to recruit and retain staff and other emerging innovations around HRH practices. The Netherlands-based international NGO Cordaid supported this initiative by developing a ‘linking and learning’ program around HRH to facilitate exchange and joint reflection. This paper outlines some of the main lessons from this program which sought to document and analyze emerging practices developed by FIIs to improve their HRH situation. It highlights that FIIs are actively experimenting with different strategies at the local, regional and international levels to improve health worker performance.

Community-based organizations provide important health services, especially in countries with poorly-developed health sectors. But community health responses are poorly understood and most are not linked to district health systems. The next article by Foster, Maphosa and Kurebva in chapter 7 describes the HIV responses of local churches in Zimbabwe and suggests how health sectors may link more effectively with community- and faith-based health initiatives. Based on a study in 2008, they describe an initiative to map and strengthen faith- and community-based HIV responses through establishing care networks linked to health centers in Mutare, Zimbabwe. While no community-based organisations were identified in this remote, under-served area, nearly all churches in the study implemented several HIV-related activities.

Chapter 8 by Cochrane, Thomas and Schmid tells the story of an integrated community response to HIV/AIDS in rural South Africa. When state roll-out of HIV treatment was sporadic or non-existent, Masangane, a faith-based program affiliated to the Moravian Church, was initiated in response to the evident pastoral needs of people in Matatiele and Shiloh in rural Eastern Cape, South Africa. Contrary to skeptics, it demonstrated that a rural, community-based program could deliver care and support to those infected or affected by HIV and also could initiate and sustain a multi-year antiretroviral therapy (ART) program. The South African state has since initiated a more comprehensive roll-out of HIV treatment in place and Masangane no longer operates in such a rarefied context. However it remains relevant to a comprehensive, integrated response to the

pandemic, and offers insight into the role and potential of community level, faith-oriented initiatives in health. The paper summarizes the case study evaluation conducted in 2005, which sought to better understand Masangane as a replicable exemplar of development practice in the field of health.

Another contribution to the literature on the involvement of religious organizations in the fight against HIV/AIDS in sub-Saharan Africa is provided in chapter 9 by Agadjanian who focuses on the role of religious organizations in HIV/AIDS-related activities in a predominantly Christian area in southern Mozambique. The analysis is based on several years of fieldwork in the area that included a survey of religious congregations and collection of qualitative data. The analysis shows that church-based activities have been focused primarily on HIV prevention, with relatively little involvement in the provision of care and support to HIV/AIDS-affected individuals or in advocacy on their behalf. Greater formal involvement of religious organizations in effective HIV/AIDS-focused activities is hampered by lack of resources and ideological and organizational tensions among churches and their leaders. At the same time, less formal, small-scale activities, that are typically carried out by church female volunteers and are often not directly sponsored by church leadership, provide vital, even if limited and unsystematic, support to HIV/AIDS-affected families, especially in most impoverished rural areas.

The last chapter in the collection is devoted to how a multilateral development organization has conducted work on faith and development in recent years, including by recognizing their specific 'comparative nature'. Karam describes in chapter 10 the direction the UNFPA has taken in engaging with faith-based organizations as cultural agents of change for the Millennium Development Goals (MDGs). Karam notes that UNFPA is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA's mission statement is to support countries in using population data for policies and programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect. The note outlines why UNFPA's working modality leads automatically to engagement with local faith-based organization and provides some current examples of this work, concluding with lessons learned and recommendations for engagement.

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CHAPTER 1

SATISFACTION WITH FAITH-INSPIRED HEALTH CARE SERVICES IN AFRICA: REVIEW AND EVIDENCE FROM HOUSEHOLD SURVEYS

Jill Olivier, Clarence Tsimpo and Quentin Wodon
University of Cape Town and World Bank

Patient service satisfaction has become a critical concept, utilized both in the assessment of quality of care and to predict a range of health-related behaviors and outcomes. What can be said about patient satisfaction with faith-inspired institutions (FIIs) in the African context in comparison with other providers, and especially public providers? Our objective in this paper is first to review what evidence there is in the literature that might cast light on the comparative satisfaction of patients with FII-health services in Africa today. Second, we present new evidence from household surveys in six African countries on satisfaction rates. Overall, the results suggest that satisfaction with the services provided by FIIs is higher than with those provided by public facilities.

INTRODUCTION

In 1986, World Bank authors noted in a report on the African health sector that: “*In Nigeria and Uganda, mission hospitals and clinics have medicines and other supplies when public facilities do not. In Malawi, consumers walk miles past nearly free government health centers to get to mission clinics that charge many times as much...*” (World Bank 1986). After three decades of African health sector crises and reforms, such sentiments remain strong: it is typically believed that nongovernmental organizations (NGOs) and in particular *faith-inspired institutions* (FIIs) are preferred by users. Of course, it is widely recognized that FIIs are varied, and often have structural and quality concerns of their own. However, as in the 1986 World Bank report, there remains a perception that health-seekers often ‘prefer’ FIIs – sometimes because FIIs are located in rural and hardship areas in which there are no other services, but also in communities in which there are now (possibly cheaper) public services available.¹

Indeed, there is a fairly strong discourse which argues that faith-inspired health care institutions have characteristic comparative values that enable them to provide better services to the population they serve, especially the poor. Similarly it is argued that FIIs have characteristic ways of operating, of providing ‘compassionate care’, or motivating their workforce differently. However, there is very little systematic evidence on such

¹ This area of inquiry is a terminological minefield. Within the broad classification of public vs private – there are many varieties. Private is often split into private-for-profit and private-not-for-profit (PNFP). PNFP is also sometimes called ‘nongovernmental (NGO) or ‘voluntary’ – and in the case of faith-inspired institutions: ‘church providers’, ‘mission providers’, ‘faith-based organizations’ and the like.

comparative advantages (or in some cases disadvantages) of FIIs versus other providers – including public, private-for-profit (PFP), or other nongovernmental (NGO) or private-not-for-profit (PNFP) providers – especially the kind of evidence that can be utilized at a policy level. There *is* a steadily increasing body of literature which compares the quality of public and private providers in development contexts (see Berendes et al 2011). However, this literature most commonly groups FIIs together with other providers (‘private’ or ‘NGO’). This of course makes sense from an aggregate perspective – but it does not enable any resolution of the questions about whether FIIs have a comparative advantage or disadvantage as a result of their faith-inspired or faith-affiliated nature. And it is even harder to assess whether the quality and operational differences often suggested, if they can be documented at all, are rooted in the FIIs’ religious nature or practice, or other aspects of their culture which are not necessarily strongly tied to their faith.

The issue of comparative difference is complex – and needs to be addressed from a number of different angles as can be seen in other papers of this collection. It is beyond the scope of this particular paper to address all the different elements of comparative quality (for example, comparing structural, technical and competency measures) – although this is certainly where such discussion must lead.

In this paper, we address just one element: what can be said about patient service satisfaction with FIIs in the African context *in comparison with other providers*. Patient satisfaction has become a critical concept, utilized both in the assessment of quality of care and to predict a range of health-related behaviors and outcomes. There are significantly fewer assessments of patient satisfaction in developing countries than there are elsewhere – and certainly not enough in Africa where quality and service provision is so varied. Berendes et al (2011) provide a useful systematic review of studies which examines in a comparative way the quality of public and private ambulatory health care in low and middle income countries. In such literature, patient satisfaction is usually utilized as an outcome or process indicator relating to quality measures.

However, there is still an ongoing search for appropriate and reliable methodologies for measuring quality and also patient satisfaction. As Abiodun (2010) says, “*Satisfaction, like quality, is a multidimensional construct...overall service satisfaction is a construct with multiple indicators at the attribute level...*” As will be discussed in the literature review below, satisfaction is measured in many different ways - sometimes based on just a few indicators (such as willingness to return to that same facility for the same health problem), but more often as part of a more complex analysis which integrates multiple quality and contextual factors (for example, tracking the patient’s exposure to a number of different service attributes such as cost, equipment, medication, attention from doctors, courtesy, convenience of location, or layout of facilities).

Bekeke et al (2008) demonstrate this more complex perspective, saying: “*Studies have shown that, satisfied patients are more likely to utilize health services, comply with medical treatment, and continue with the health care providers...Satisfaction is related to more partnership building, more social conversation, courtesy, clear communication and information, respectful treatment, length of consultation, cleanliness of facility, drug*

availability and waiting time. Measurement of patient satisfaction involves multi-dimensional aspects of patients' opinion on health care, identifying problems in health care, and evaluation of health care.” Furthermore, patient satisfaction is particularly challenging being based on patient perceptions or their subjective understanding of the care received. When based on exit interviews (as is most common), there are unavoidable elements of self-selection bias among patients, that is, patients who choose to go to a particular facility are more like to be satisfied with the quality of care than the population as a whole, since those who are not satisfied are more likely to have sought care elsewhere (see Levin et al 1999).

Our objective in this paper is somewhat more modest than some of these more complex satisfaction analyses. We review what evidence there is that might cast light on the *comparative satisfaction of patients with FII-health services in Africa* today. In order to do this, we first systematically review the available literature – seeking out studies which comment on patient satisfaction, with data that distinguishes FIIs from other PNFP providers. Although there is a great deal of anecdotal and policy-level opinion about the comparative satisfaction with FIIs in Africa – there is little systematic evidence – and it is therefore necessary to parse out such findings from studies which are more broadly focused. Secondly, we present new evidence from household surveys to add a further layer to this discussion. For that part, we checked on the availability of data identifying faith-inspired providers in the main multi-purpose national surveys implemented in approximately 30 African countries. In about half of the surveys that we examined, there was enough information on the type of provider consulted by households to identify separately public, private faith-inspired, and private (non-FI) providers. And in six of those surveys, questions were asked to household members relating to whether they were satisfied with the services that they received from their provider, and if not, what the reasons for this dissatisfaction might be (with specific potential reasons provided). We present these findings for the six countries below (see also Wodon, 2013). However, this must be understood as a measure of broad popular satisfaction with health services based on household survey data. We present this here to add to the broader literature and discussion about the comparative characteristics of FIIs, recognizing the limitations of the measures we use.

It is also important to note that throughout this discussion we mainly address health facilities (hospitals, clinics, and health centers) – rather than the broader universe of often faith-inspired health providers such as traditional healers, faith healing ‘clinics’, or even chemical dealers. In the final section, we discuss a number of key issues that are suggested in the broader literature as being important characteristics of FIIs that are linked to satisfaction and quality - such as ‘compassionate care’, the availability of pharmaceuticals, and the suggested successful payoff being implemented by some FIIs between higher cost and higher satisfaction. There is, of course, a lot of heterogeneity among FIIs in the cost charged to patients - some FIIs are cheaper than public facilities, while others are more expensive - but the question is, when FIIs are more costly to households whether this is compensated by higher quality.

LITERATURE REVIEW: COMPARATIVE PATIENT SATISFACTION WITH FIIs

Digging out literature on patient satisfaction with faith-inspired health services in Africa is something of an adventure. Standard and systematic review methods do not reveal a substantial literature. Widmer et al (2011) have just released a systematic review of literature on the role of faith-based organizations (FBOs) in the area of maternal/newborn health care in Africa over a twenty year period (1989-2009) and found only six articles meeting their criteria. They do report, however, that based on the findings in these six articles, while “*maternal/newborn health services provided by FBOs were similar to those offered by governments...the quality of care received and the satisfaction were reported to be better.*” Schmid et al (2008) similarly conducted a broader scoping literature review on faith-inspired health care in sub-Saharan Africa, and noted a dearth of data and evidence which directly compared the scope or quality of faith-inspired health services (with FIIs usually ‘hidden’ among NGO or PNFP providers).

Overall, the absence of substantial comparative studies on quality or utilization of FIIs in Africa means that the main discourse on the comparative advantages or disadvantages of FIIs often appears to be anecdotal or at least not obviously tied to evidence-based analysis. We do not want to impose a particular bias on this discussion – but if you base your conclusions on the ‘grey literature’ of organizational and practitioner reports and best practice experience, public statements and conference presentations – then there is indeed a plethora of anecdotes and qualitative insights which report wide-spread preference for FIIs in Africa, including higher levels of patient satisfaction (see examples in the discussion below). Unfortunately, the data or more systematic evidence that might support such widely-held sentiment is largely absent, or severely outdated – especially considering the crises and reforms African health systems have faced in the last thirty years. This literature is also greatly fragmented, so that estimates across countries remain plagued by comparability issues. In table 1 we list some of the studies which have been identified as containing some comparative information on patient satisfaction in relation to FIIs in Africa.

Table 1: Sample of studies with elements relating to ‘comparative satisfaction’ with FB-health providers in Africa

Author-state	Focus	Method	Finding relating to ‘comparative satisfaction’
1994 Gilson et al <i>Tanzania</i>	Community satisfaction with PHC services evaluated in the Morogoro region of Tanzania.	<u>Focus groups/qualitative interviews</u> : In each village: 3-6 key informants, 3-6 focus groups, 20 mothers and discussions, including perceptions about quality.	Church health care was generally perceived to be better than government care – but also considerable variation in community judgments and clear signs of poor quality church care.
1994 & 1995 Wouter et al <i>Senegal</i>	Relationships between quality of care and efficiency in the public and private sectors in Senegal. Adds survey data relating to quality of care to data collected in field surveys in Niger and Senegal.	<u>Mixed-method (surveys/exit interviews)</u> : Comparative study based on provider, patient and household surveys (1992-1994). Nationwide sample of 95 (3 public hospitals, 23 health centers, 46 health posts, 23 health huts) and 57 private health facilities (30 Catholic health posts, 13 company clinics, 6 for-profit clinics, 8 ‘other clinics’). Patient quality perceptions from 20 patients and medical staff in each facility.	In private sector, for-profit and Catholics offered best care. Differences between patient and provider perceptions of satisfaction (patients more satisfied with care-received than providers were with care-rendered.) Overall patient satisfaction was high. In <i>public facilities</i> , over 80% of patients satisfied; except for hospitals (65%), 80% willing to return; 60% of staff perceived care to be average or below. In <i>private facilities</i> , almost 100% client satisfied with the exception of ‘other clinics’; and staff perceived care to be good.
1995 Bitran <i>Senegal</i>	Study testing relative efficiency of non-governmental private sector provision of health services in Senegal.	<u>Mixed-method (surveys/exit interviews)</u> : 46 public health posts vs 30 catholic health posts – various quality indicators (structure and process measures) including patient exit interviews on service satisfaction	Private providers highly heterogeneous but tend to offer better quality services with higher patient satisfaction. Catholic health posts were significantly more efficient than public and other private facilities, with higher drug availability, and similar patient fees to public.
1995 Kanji et al <i>Tanzania</i>	Testing whether voluntary agencies provide better quality of care than public facilities for primary curative outpatient services in Dar-es-Salaam.	<u>Mixed-method (surveys/exit interviews)</u> : Sampling included 28 government facilities versus 15 PNFP/voluntary facilities (Catholic, Protestant and Muslim). Various aspects of quality – including patient exit interviews on service satisfaction.	Better clinical performance, interpersonal conduct and overall user satisfaction for PNFP providers as compared to government providers (although many PNFP consultations were outside established clinical practice).
1999 Levin et al <i>Uganda</i>	Evaluates provider and consumer costs of maternal health services, along with selected quality indicators at health facilities and among community practitioners in Masaka District of Uganda.	<u>Mixed-method (surveys/exit interviews)</u> : Data relating to quality indicators collected in 1998 from 4 health facilities (1 public and 1 mission hospital, 1 public and 1 mission health center) and among community practitioners (17 private midwives and 20 TBAs) in Masaka District. Includes observation, provider interviews and (128) client exit interviews.	Overall impressions are satisfactory – with client satisfaction higher in the mission hospital and health center. Clients at the mission health center rate all aspects of their visit in the highest category. This may be related to the presence of a doctor, and perceptions that care from a doctor and more availability of drugs are preferable to care from a midwife or nurse (may be related to patients according higher value to the services received because of higher fees.)
2003 Levin et al <i>Uganda, Malawi, Ghana</i>	Compares costs of maternal health services in three Anglophone countries.	<u>Mixed-method (surveys/exit interviews)</u> : Case studies plus client exit polls on costs and quality for maternal services at 1 public and 1 mission hospital; and 1 public and 1 mission centre in each country.	In all three countries the (6) mission facilities generally score higher on process indicators and client satisfaction than did the (6) public facilities.
2003 Lindelöw et al <i>Uganda</i>	Baseline survey on Ugandan health sector to validate data and check for discrepancies in reporting.	<u>Mixed-method (surveys/exit interviews)</u> : Baseline survey (in 2000) of 155 PHC facilities (81 public, 30 PFP, 44 PNFP). The 44 PNFP facilities include 25 Catholic, 11 Protestant, 1 Muslim, 2 SDA, and 5 NGO). 1617 patient exit polls for qualitative	Satisfaction was found to be higher in private non-profit facilities (many of which are faith-inspired) than in public facilities in areas such as friendly service, information about ailment, prompt attention, and information about charges.

Author-state	Focus	Method	Finding relating to 'comparative satisfaction'
2003 Mliga <i>Tanzania</i>	Relationship between quality of care and organizational structure of services in four types of health providers in Tanzania is examined: 1 public and 3 church denominations: SDA, Lutheran, and Catholic.	measure of performance. <u>Mixed-method (surveys/exit interviews)</u> : Study carried out in Iringa and Arusha regions in 1996. 51 health facilities owned by the government (16), Lutheran (15), Roman Catholic (15), and (5) SDA church denominations were surveyed. Includes technically derived scores of quality (professional observation) and client evaluations of quality (patient interviews).	On technical measures and medicine stocks, church facilities performed better than public. Satisfaction rates were highest for clients of Lutheran facilities; then public; then SDA. Catholic facilities received favorable technical measures, but were least favored for a return visit. Clients valued the service provided by public facilities relative to the cost of those services, followed by the Catholics, then Lutherans. SDA services were thought to be too expensive (matching actual cost differences).
2006 ARHAP <i>Zambia, Lesotho</i>	Mapping study of faith-based health and HIV/AIDS activities in Lesotho and Zambia (2005-2006)	<u>Focus groups/qualitative interviews</u> : Mixed method study including 16 community focus-groups: 9 health-seeker and 7 health-provider (358 indiv.) Perceptions of community satisfaction gathered through participatory ranking, interviews and questionnaires.	Community focus groups consistently ranked local faith-based facilities higher – usually described as a result of additional quality of 'compassionate care'.
2009 Bazant & Koenig <i>Kenya</i>	Women's satisfaction with delivery care in a cluster or informal settlements in Nairobi	<u>Household surveys</u> : Data of 1266 women who delivered in health facilities (2004/2005): 63% gave birth in a nearby private facility, 31% in a public hospital, 2% in a public health center, 4% in a mission hospital located 20 km away.	Women's delivery care expenditures varied by facility type, with the cost of delivery at the mission hospital significantly higher (5 times the median expenditure at private facilities). However, dissatisfaction was greater among women who gave birth at government hospitals than at private facilities in the informal settlements. The mission hospital received the highest satisfaction ratings, "most likely reflecting the high-cost provision of care that was affordable to few women"
2010 Nwabueze et al <i>Nigeria</i>	Comparative assessment of patients' satisfaction with ambulatory HIV/AIDS care in a Catholic secondary hospital and public tertiary hospital in Anambra State.	<u>Mixed-method (surveys/exit interviews)</u> : A descriptive comparative cross-sectional study based on interviews of 300 PLWHA-patients sampled from the two facilities.	More patients complained of a bad attitude of staff at the Catholic (SCBH) facility but overall patients' perception of care by all staff was significantly higher at the Catholic facility than the public one. Rating of patient satisfaction drivers like waiting time, confidentiality, hospital structure and environment were higher in the Catholic facility. Overall patient satisfaction with HIV/AIDS services was rated higher in the Catholic facility, despite more concerns about higher user fees.
2011 Babikako et al <i>Uganda</i>	Cross-sectional evaluation study (2007-2008) of satisfaction of adult TB patients attending public and private (Christian) hospitals for TB treatment in Kampala.	<u>Mixed-method (surveys/exit interviews)</u> : Evaluation comparing satisfaction of adult TB patients at Mulago (the national TB center, and a tertiary public teaching hospital) and Mengo (a private Christian hospital with TB clinic, under the UPMB umbrella) - to understand how patient satisfaction differs by hospital setting.	Patients at public hospitals experienced significantly lower levels of satisfaction with technical quality of TB care, responsiveness to patient preferences and patients' understanding of potential problems of TB medicines. Differences in satisfaction suggest differences in public/private delivery with private healthcare possibly more patient-centered.
2011 Lievens et al <i>Ghana</i>	Study focused on health worker incentives in Ghana.	<u>Focus groups/qualitative interviews</u> : Some qualitative interviews with patients.	Quality of care judged higher in NGO facilities by both users and health workers: waiting times are generally shorter and staff is less absent. Transport for outreach activities is more

Author-state	Focus	Method	Finding relating to 'comparative satisfaction'
2011 Makinen et al <i>Ghana</i>	Ghana health sector assessment	<u>Household survey</u> : GLSS4&5 household surveys (and community focus groups)	available; staff is competent, has a positive attitude, is respectful towards patients. No significant difference found between provider types in relation to patient satisfaction. Consumers usually choose self-financed private providers for quality services, customer service, and short waits; Ghana Health Service providers for quality services, low prices, and availability of doctors; and Christian Health Association of Ghana providers for quality services, availability of doctors, and more courteous service.
2012 Gemignani and Wodon <i>Burkina Faso</i>	Satisfaction with services and reasons for choosing faith-inspired providers, comparing public, Christian and Islamic facilities.	<u>Focus groups/qualitative interviews</u> : In each of six faith-inspired facilities in two areas (one urban, one rural), in-depth interviews with patients and clinic/hospital staff plus other key informants, as well as community focus groups.	Better satisfaction with faith-inspired providers; one key reason for choosing faith-inspired facilities is lower cost of service, especially for Catholic providers due to lower cost for the poor. Other key reason is better service and relationships between clinic staff and patients.
2012 Shojo et al <i>Ghana</i>	Satisfaction with services and reasons for choosing faith-inspired providers, comparing public, Christian and Islamic facilities.	<u>Mixed methods</u> : Household survey analysis as well as focus groups and qualitative interviews faith-inspired facilities in two areas (one urban, one rural); this included in-depth interviews with patients and clinic/hospital staff plus other key informants	Quantitative analysis of household survey does not suggest substantial differences between public and faith-inspired providers, but qualitative data suggests better satisfaction with faith-inspired providers, mostly due to better service and relationships between clinic staff and patients.

Source: Authors' compilation.

Note: We only list those studies which make a clear comparison between FII and public/other private providers – we do not include those that mention FIIs as a major part of the NGO sector under discussion, but without delineating this in the findings. We also do not include all studies which might distinguish FIIs, but do not directly address satisfaction, but might address issues related to quality measures (structural, technical or competence). See Berendes et al 2011 and Widmer et al 2011 for useful systematic review of these issues.

HIGHER SATISFACTION FOR FAITH-INSPIRED SERVICES

As noted above, the wide variety of methods and focus make comparison of these studies challenging. Speaking broadly, most of the studies which do contain some kind of comparative element observe higher levels of patient satisfaction with care received at FIIs: this is the case between FIIs and other kinds of private providers, but even more strongly so between FIIs and public (government) providers. We have listed the studies by year in Table 1, since it is important to assess satisfaction in relation to the changes that African health systems have undergone in the last few decades.

There is also some question as to whether the higher satisfaction or user preference is a historic hang-over from a previous era when mission-based providers were the mainstay of most African national health system, or whether that relevance and satisfaction is still prevalent today, given the more diverse health-seeker options available in many places. Another study not listed in table 1 by Bratton (2007) explores the determinants of public satisfaction (or dissatisfaction) with health and education services – reviewing health services in 18 African countries utilizing the Afrobarometer survey (of 2005). Bratton is not surprised that overall, given the high disease burden in these countries, 51 percent of all respondents had some problem with their health services, especially in rural areas, including longer waiting times and a lack of medicines. Interestingly, when asking about where responsibility for health services should lie – while in most countries the majority said the state, in Tanzania and Malawi, almost half the adult population stood ready to experiment with mixed public and private approaches. Bratton (2007) concludes that “*We suspect that these unusually liberal sentiments reflect mass disenchantment with the poor performance of government ministries in these countries, the availability of alternative providers like traditional healers and non-governmental organizations, and nostalgia among older people for the days when missionaries provided most social services.*” Bratton is one of the few who raise the issue of ‘nostalgia’ in relation to mission services and how this might impact on perceptions of satisfaction with FIIs today – and certainly this is an area requiring more enquiry.

However, even the more recent studies described in Table 1 still indicate higher levels of patient satisfaction with FIIs than public services. For example, this is apparent in the two recent studies which directly compare a faith-inspired facility against a public facility – although both seem to select the FII more as a private provider, and less because they happen to be faith-inspired. Nwabueze et al (2011) compare patients’ satisfaction with ambulatory HIV/AIDS care in a Catholic secondary hospital and public tertiary hospital in Nigeria; and Babikako et al (2011) compare the satisfaction of patients receiving TB services at a tertiary public teaching hospital and a private Protestant hospital in Kampala Uganda. Both of these fairly different studies found significantly higher levels of patient satisfaction at the faith-inspired facility than the public facility – even though in both cases the FII was a lower level facility with less structural or technical assets (such as equipment). Babikako et al (2011) conclude that the observed differences in satisfaction suggest differences in public-private healthcare delivery, and that this might be a result of the private care being more ‘patient-centered’. Nwabueze et al (2010) conclude that this supports the view that interpersonal issues, such as health workers’ concern for the

patient rate significantly higher than the medical sophistication of the facility, saying: *“This is aptly demonstrated here where NAUTH Nnewi, a federal government tertiary health institution with all her sophisticated equipment and array of specialists and reputed to be the best in comprehensive HIV/AIDS care in the south east Nigeria, is found trailing behind SCBH Onitsha, a resource-constrained faith-based secondary health institution in almost all the measured domains of patient satisfaction.”*

Of course, it is impossible to stress enough that there is high variety among FIIs – both within countries and in comparison across countries (see Schmid et al 2008). This is raised repeatedly in the studies in Table 1, where noted higher patient satisfaction for FIIs is followed by caveats that FIIs are often structurally weak and have huge organizational differences which impact on varied quality and satisfaction (Gilson et al 1994a, Mliga 2003, Wouter 1994). For example, based on a comparative study of providers in Senegal, Bitran (1995) found private providers to be highly heterogeneous - noting that although private providers tended to offer better quality and more efficient services (in particular an important group of Catholic health posts), *“policies to expand the role of the private sector need to take into account variations in types of providers, as well as evidence of both high and low quality among them.”* This variation makes broad scale comparisons possibly misleading. However, since we are seeking to gather as many different threads which relate to the issue of comparative patient satisfaction with FII services in Africa, we will now consider just some such surveys followed by further discussion of these concerns.

NEW EVIDENCE FROM NATIONAL HOUSEHOLD SURVEYS

As mentioned above, while there are many statements about FIIs providing better quality services resulting in more satisfied patients, much of the evidence comes from qualitative work and small scale surveys. The empirical evidence obtained from large nationally representative data sets remains thin. As can be observed in Table 1, we find only a handful of studies which utilize survey data in relation to health service satisfaction which also have some comparative evidence on FIIs (see Bazant and Koenig 2009, Lindelöw et al 2003, Makinen et al 2011, Sojo et al 2011). This may be due in part to the fact that Demographic and Health Surveys (DHS) do not typically distinguish between faith-inspired and ‘non-religious’ providers of care, and these are the surveys that researchers often use for applied empirical work on health in developing countries. That is, DHS distinguish between public and private providers, but not between faith-inspired and other providers within the private category. Yet other types of surveys can be used to assess the satisfaction of patients with the services received from different providers. The advantage of such surveys is that one may also look at satisfaction according to the socio-economic profiles of the users of services – say by quintiles of well-being based on measures of household consumption.

For this paper, instead of using DHS data, we checked on the availability of data identifying faith-inspired health providers in the main multi-purpose surveys implemented in approximately 30 African countries. In about half of these surveys, there was enough information on the type of provider consulted by households to identify

separately public, private non-religious, and private faith-inspired providers. And in six of those surveys, a question was asked to household members as to whether they were satisfied with the services that they received from their provider, and if not, what were the reasons for not being satisfied (with specific potential reasons provided). The list of the six countries and surveys is provided in table 2 (most surveys are based on the CWIQ survey design piloted by the World Bank, where CWIQ stands for Core Welfare Indicator Questionnaire, which has been translated in French as QUIBB or *Questionnaire des Indicateurs de Base du Bien-être*). While all of the countries are from West or Central Africa where the CWIQ-QUIBB survey program has been more active, they represent both stable and post-conflict countries, as well as countries where the market share of faith-inspired providers is substantial (in Burundi and Ghana especially), and other countries where that market share is much smaller. Thus, while it cannot be claimed here that the results are necessarily representative of sub-Saharan Africa as a whole, they are nevertheless representative of a diverse set of countries.

Table 2: Selected countries with household surveys identifying FIIs

Country (survey name)	Year of implementation	Country (survey name)	Year of implementation
Burundi (QUIBB)	2006	Niger (QUIBB)	2005
Ghana (CWIQ)	2003	Republic of Congo (QUIBB)	2005
Mali (QUIBB)	2006	Senegal (ESPS)	2005-06

Source: Compiled by the authors.

In table 3, data are provided as to the satisfaction of users with the services received in the six countries nationally, as well as for urban and rural areas and by quintiles of well-being, with each quintile accounting for twenty percent of the population, from the poorest to the richest.² In some of the countries, NGOs are included in the same category as faith-inspired providers. The two categories are aggregated in table 3, but the market share of NGOs is significantly smaller than that of faith-inspired providers, so that the category represents for the most part these faith-inspired providers. Although poverty estimates vary between countries, in most countries the bottom two or three quintiles can be considered as representing the poor.

The evidence from the six countries suggests that FIIs do appear to enjoy higher satisfaction rates than public facilities. Looking at the population as a whole, the satisfaction rate among faith-inspired providers is five percentage points above that of public providers in Burundi and Niger, while it is higher by 15 points in Mali, and more than twenty points in Senegal and the Republic of Congo. Only in Ghana is the national satisfaction rate comparable for faith-inspired and public facilities. In many of the countries, faith-inspired providers also do better than other private providers, although the differences tend to be smaller. In some of the countries, the differences in satisfaction rates are larger for the poor, suggesting that faith-inspired facilities may make special efforts to provide better quality services to the poor (we return to this below when

² The quintiles are based on measures of consumption per capita or per equivalent adult normalized by poverty lines accounting for differences in cost of living between areas within a country, in order to ensure consistency with poverty measurement techniques.

discussing the reasons for non-satisfaction in each country). Also, in several countries, satisfaction rates are higher in urban than in rural areas, and tend to increase with the quintile of well-being of households. This is not surprising given that urban dwellers and households who are better off tend to have more and better options for care than the rural poor.

Table 3: Satisfaction rates with the services received, selected countries (%)

	Residence Area		Welfare quintile					All
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Burundi 2006								
Public	46.6	37.8	36.8	35.5	37.5	35.1	44.0	38.0
Faith-inspired	47.4	43.0	46.6	43.7	34.6	48.1	42.6	43.2
Other private	47.7	39.3	34.9	41.8	43.3	35.9	43.2	40.0
Total	47.2	38.6	37.7	37.7	38.3	36.6	43.7	39.0
Ghana 2003								
Public	73.4	73.2	70.6	75.7	75.0	73.0	72.1	73.3
Faith-inspired	73.1	72.9	67.2	76.0	74.3	73.0	74.4	72.9
Other private	83.2	83.8	83.2	85.7	84.3	82.5	82.3	83.5
Total	78.5	78.9	77.2	81.0	79.9	78.0	77.8	78.7
Senegal 2005								
Public	71.1	57.8	67.1	65.8	58.5	63.2	65.9	64.0
Faith-inspired	86.9	86.6	92.8	86.2	79.3	85.9	90.9	86.8
Other private	71.9	66.1	66.7	64.1	65.4	70.9	74.0	69.2
Total	71.8	61.0	67.7	65.6	61.0	66.3	69.2	66.2
Republic of Congo 2005								
Public	68.0	62.1	69.6	68.0	60.6	63.3	67.3	65.7
Faith-inspired	89.5	91.3	80.6	100.0*	79.2*	89.4*	100.0*	90.0
Other private	87.1	85.7	85.4	83.8	88.4	87.7	86.8	86.5
Total	78.4	75.4	78.3	77.1	74.6	77.1	78.5	77.2
Niger 2007								
Public	90.7	91.8	93	96.1	91.7	92.3	87.6	91.5
Faith-inspired	91.9	97.3*	97.3*	100.0*	100.0*	98.6*	76.2*	96.1
Other private	92.7	93	96.5	93.2	93.5	89.5	93.1	93
Total	91.2	92.5	94.6	94.5	92.9	91.1	90.1	92.3
Mali 2006								
Public	67.7	60.8	55.1	63.5	60.4	65.9	67.3	63.7
Faith-inspired	45.6*	85.0	53.6*	100.0*	100.0*	85.2*	0.0*	78.7
Other private	75.6	78.7	84.2	82.0	76.7	66.8	76.7	77.2
Total	70.2	66.1	67.2	69.3	65.1	66.4	70.3	67.8

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

On the basis of the reasons declared by households for not being satisfied, it can also be shown that in all countries, the fact that the cost of service was perceived as too expensive is the main reason for lack of satisfaction (we discuss the results on cost in the section immediately below). After cost, the second main reason for non-satisfaction is long waiting time, again in virtually all countries. This was an issue for 11.5 percent of patients in Burundi, 11.2 percent in Mali, 10.5 percent in Senegal, 8.2 percent in the Republic of Congo, and 3.9 percent of patients in Ghana (in that country, the complaint ranks third after unsuccessful treatment). On this issue, FIIs do not seem to have a

demonstrable comparative advantage. In some countries, complaints about long waiting times are higher among faith-inspired facilities than among public facilities, but in other countries, the reverse is observed. As for the other reasons why some households declare being unsatisfied, sample sizes among faith-inspired facilities are often too small to be able to make a valid comparison with public facilities.

COST, QUALITY, AND PATIENT SATISFACTION

Based on the household surveys outlined above, additional analysis suggests that for all countries, cost of service (as too expensive) was perceived as the main reason for lack of satisfaction with health services received. Cost is mentioned as an issue for 37.9 percent of patients in Burundi, 18.0 percent in Senegal, 13.1 percent in Mali, 11.4 percent of patients in Ghana, and 10.4 percent in the Republic of Congo. In Mali and Burundi, but not in the other three countries, cost is also mentioned more by households in the bottom quintiles of well-being than by household in the top quintiles, which makes sense.

What is striking, though, is the fact that in four of the five countries, cost is mentioned as being less of an issue for faith-inspired facilities than for public facilities. In the Republic of Congo, 14.6 percent of patients in public facilities declare that cost is an issue, versus 6.5 percent in faith-inspired facilities. In Burundi, the two corresponding figures are 37.9 percent for public facilities, versus 30.6 percent for faith-inspired facilities. In Mali, the comparison is 16.9 percent to 6.0 percent. Finally in Senegal 19.6 percent of users of public facilities complain about cost, versus only 2.9 percent in faith-inspired facilities. For Ghana by contrast, the proportion of users who complain about cost is similar in both types of facilities (it is actually slightly higher in faith-inspired facilities at 14.4 percent versus 13.2 percent in public facilities), but this is also the country where there are no substantial differences in overall satisfaction rates between public and faith-inspired providers. Thus, the evidence is strong that lower cost – probably through efforts to make care affordable for the poor – plays a key role in the higher satisfaction rates obtained by faith-inspired facilities (this was also found in qualitative work for Burkina Faso; see Gemignani and Wodon 2012). Note that in three of the five countries, complaints about cost were higher in other private facilities than in the faith-inspired sub-sector. The comparison with private facilities is however more problematic because more households going to private facilities may have formal insurance systems that reduce out of pocket costs.

In the broader literature reviewed, cost appears frequently as a key issue impacting on relative patient satisfaction and user preference.³ There is some difference, however, between studies which note that patients are more satisfied with FIIs *because of lower patient costs*, and those that note that patients are more satisfied *despite higher patient costs*. As noted above in the introduction, the latter explanation is certainly prominent at the discussion level about the perceived comparative advantages of FIIs, although in our

³ Mliga (2003) provides an interesting comparison between government, Catholic, Lutheran and SDA providers in relation to cost and satisfaction, which we do not unpack here, but does hint at significant variation between cost, satisfaction and perceived value for money.

data set for the six countries, the first explanation may well dominate. Still, the question of whether some households may prefer faith-inspired facilities despite higher cost is indeed interesting. There are certainly many such observations. For example, in Uganda during a discussion on the comparative quality and satisfaction with FIIs, a representative of the WHO noted that “...in many cases clients expressed their ‘vote’ for PNF services by making use of them despite their cost and even when there was a public facility ‘less than 100m away’” (stakeholder participant in Schmid et al 2008). Based on data from the 1993/94, 1995/96, and 1996/97 national household and community surveys in Uganda, Hutchinson (2001) found that both the poor and the nonpoor tend to prefer curative care from nongovernmental organizations (NGOs – mainly FIIs in Uganda) and private providers, even over less expensive government care, and even though government health units outnumbered all other providers roughly two and a half to one. Hutchinson (2001) notes that “*price, distance and government ownership all decrease the likelihood that the nearest modern facility will be used for curative care when ill...The result for government ownership supports the data presented earlier that individuals prefer private and NGO health care providers over government providers.*”

Indeed, most of the studies in table 1 (with one exception) indicate that even in cases where FIIs cost more to the patient than public services (which is frequent) – they are still preferred with higher patient satisfaction rates. For example, Levin et al (2003) compare costs of maternal health services Ghana, Uganda and Malawi, and find that in all three countries, “...the six mission facilities generally score higher on process indicators and client satisfaction than did the six public facilities...” – with both structural and process quality indicators generally better at the mission hospital than at the public hospital in all three countries. In addition, while there was no major difference between public and faith-inspired hospitals in the availability of drugs and equipment, for health centers, FIIs had better equipment in two out of the three countries, and clients were more likely to have received prescribed drugs at FIIs than public facilities. However, at these same health centers, in both Malawi and Ghana, the cost of cost of maternal health services was 30 percent higher at mission- than public health centers. The authors concluded that this higher cost was likely because more labor time and materials were used in service provision – therefore relating to higher quality and also satisfaction. That is, the mission hospitals in all three countries had more appropriate staffing for the number of maternal health services that they provided, and in the mission health centers used more materials than in public health centers. Therefore, although the studies noted that FIIs had many of the same inefficiencies as public facilities (such as underutilization of services), FIIs in this sample provided maternal health services at the same or better level of quality than public facilities, with costs that were slightly higher in health centers (but often lower in hospitals) – but with generally higher levels of satisfaction.

Bazant and Koenig (2009) quantify women’s satisfaction with delivery care in informal settlements of Nairobi, Kenya. Of the 1,266 women who delivered in health facilities (2004/2005), 63 percent gave birth in a nearby private facility, 31 percent in a public hospital, 2 percent in a public health center, 4 percent in a mission hospital located 20km away. The women’s delivery care expenditures were by far the highest at the mission hospital (KSh.5100 versus the KSh.1100 at private facilities, KSh.1800 at government

hospitals, or KSh.800 at government health centers – with US\$15 at 74 KSh./US\$1). However, the mission hospital received the highest satisfaction ratings (then private, then government hospitals, which had the highest dissatisfaction levels). Bazant and Koenig et al (2009) conclude that this higher satisfaction with the mission facility most likely reflects the high-cost provision of care that was affordable to fewer women.

The studies in table 1 also frequently note a higher availability of medicines in the same FIIs which receive higher satisfaction rates. In Tanzania, Mliga (2003) found that clients visiting public facilities did not receive the medicines that were prescribed to them: *“Church health facilities seem to have been better stocked with medicines than government facilities. Clients experienced the least difficulties in getting medicines at Lutheran facilities, then Roman Catholic followed by Seventh Day Adventists.”* In Senegal, Bitran (1995) found that while fees per patient were similar between public and Catholic health posts, the latter had higher drug availability (fewer stockouts of drugs, equipment and supplies, see also Wouter 1994). Bitran notes that while patient fees were similar, the Catholic health posts had higher staff costs (because they used more qualified doctors), and higher drug costs per patient – but also the highest labor productivity (visits per health worker per day). Bitran concludes that Catholic facilities provided higher quality health care than the public sector while supplying services to patients of similar social and economic status.

Of course, we cannot expand on this too far – as many FIIs in Africa have noticeable difficulties stocking and supplying medicines (see Gilson et al 1994). However, in the studies that are available, the higher patient satisfaction often appears to be linked to better availability of drugs/medicines. Some authors note that this may relate to the fact that some health seekers feel that the prescription of drugs is necessary for treatment – that is, satisfaction is directly related to whether drugs were received (or a prescribing doctor was available) – and that a consultation without prescribed drugs might be viewed as a waste of time. For example, Nshakira et al (1996) conclude that many users will choose a health facility where they expect to find drugs all the time, such as private clinics. Levin et al (1999) make a similar observation – when finding that the two mission health facilities studied in Uganda had more drugs available and perform more lab tests than the public health facilities. Only about half of the clients at the public facilities said that they had received prescribed drugs at the public facilities, while all mission clients said they had received the drugs prescribed for them. The mission facilities here tended to have significantly higher costs to patients – and also higher satisfaction *“...(with) client satisfaction higher in the mission hospital and health center. Clients at the mission health center rate all aspects of their visit in the highest category. This may be related to the presence of a doctor, and perceptions that care from a doctor and more availability of drugs are preferable to care from a midwife or nurse.”* Levin et al (1999) also note that this may be related to the fact that patients accord higher value to the services received *because of the higher fees.*

Given the limited evidence, we are not able to go too much further in unravelling the bundle that is comparative quality and satisfaction with FII’s services, and our understanding of how frequently reported higher comparative satisfaction with FIIs may

relate to other aspects of quality care (such as cost, the availability of medicines and the like) is at best partial. There is, however, one further aspect which is raised repeatedly in the limited literature – and that is how patient satisfaction might possibly be tied to staffing and the nature of the relationship between patients and staff, and the care they provide - especially where staff and their provision of care are said to be intrinsically religious in nature or motivation.

COURTESY, TRUST AND PATIENT-CENTEREDNESS

There is another aspect widely described as a comparative value of FIIs which impacts on patient satisfaction – which is much harder to understand or quantify. That is the internal ‘intangible’ religious values specific to FIIs which might impact on the quality of care, and therefore on patient satisfaction.⁴ While not speaking about FIIs or religion, Abiodun (2010) has noted that while studies have documented the importance of tangible elements of health care service, “...customers’ satisfaction derived from their perception of quality of service may be derived from their assessment of the intangible elements associated with the interaction between the customers and the health personnel during care. These intangible elements include such aspects as responsiveness, courtesy, competence, and access and availability of physicians and other hospital staff...Other process characteristics...included care givers’ expressions of empathy...communication and interpersonal aspects of health caring have been found to rank most in importance to health care customers...” The available literature strongly suggests that FIIs might be achieving the suggested higher satisfaction as a result of such ‘intangible’ elements of satisfaction.

Courtesy is an increasingly important concern. Bratton’s (2007) Afrobarometer respondents counted lack of respect just as highly as long waiting times, high fees or shortage of medicines as reasons for not choosing a particular facility. In their study on the TB services in Uganda, Babikako et al (2011) note the strikingly higher levels of satisfaction in private (Protestant) hospital relative to the public facility. They note that the public facility got significantly lower scores on patient responsiveness – and suggest that the private FIIs “*may be more patient-centered compared to public institutions thus generating high satisfaction levels.*” In an assessment of the Ghana health sector by the World Bank, Makinen et al (2011), utilize GLSS4&5 household surveys and support this with community focus groups in Ghana. While they did not find significant differences between provider types in relation to patient satisfaction (there was a generally high level of satisfaction seen everywhere), consumers noted “*more courteous services is a distinguishing feature of CHAG (Christian Health Association of Ghana) providers.*” A similar result was obtained in Ghana by Sojo et al (2012).

Of course, issues of respect, courtesy, empathy or patient-centeredness are not unique to FIIs, and are concerns for health care more generally. What is critical is to know whether such ‘intangibles’ can be understood as they operate in FIIs in a systematic manner – that

⁴ See Schmid et al (2008) for discussion on what these ‘intangible religious health assets’ might be and how they might operate.

is, as a systematic characteristic of FIIs. Significant work has been done on the importance of ‘trust’ in health systems (see Gilson et al 2005). Gilson and colleagues have noted the importance of trust at an interpersonal level, influencing patient judgments about provider attributes and their technical competence, “...judgments (that) are influenced by whether providers are rude or courteous, demand bribes or not, treat some people preferentially over others, listen to the patient’s explanation of their complaint or give the patient too little time” (Gilson 2005). However, Gilson continues and notes that “...building a trustworthy health system is not simply about training providers to listen and talk empathetically to patients. Much more importantly, it requires the development of institutions that demonstrate the norms of truthfulness, solidarity and fairness—and that influence the range of actors (patients, providers, managers, insurers, etc.) linked through a health system.” Unfortunately, at this time to our knowledge, there has not yet been substantial work on whether there are characteristic system-wide or institutional characteristics in FIIs that result in higher patient satisfaction levels or quality, and this is another area which could benefit from urgent attention.

The issue of ‘intangible’ issues relating to satisfaction can be approached from other angles. For example, it has been suggested that faith-inspired staff are differently motivated to provide high quality care. Considering health worker motivation in Ghana, Lievens et al (2011) note that while basic salaries are the same in NGOs (which are mainly FIIs) as in the public sector, allowances are more common: “*Health workers usually live on the premises of the facility and have a comparatively heavy workload. Performance expectations are high, and supervision and workplace norms are strict. Health workers are unanimous that workers in the NGO sector are the most committed ones and are very patient-centered. The quality of care is judged higher in NGO facilities by both users and health workers. Waiting times are generally shorter and staff is less absent. The quality of care is generally judged higher in NGO facilities, by both users and health workers. Transport for outreach activities is often available; staff is competent, has a positive attitude and is respectful towards patients. Waiting times are generally shorter, and staff is less absent.*” As one rural service seeker in this study said, “*I prefer to go to the mission hospital because the nurses in the public hospital in this area abuse me whenever I visit the facility. When you go to a mission hospital the nurses are fine and don’t abuse you. They also still attend to patients when nurses or doctors are on strike.*”

Of course, higher workloads tend to impact negatively on courtesy – as one senior nurse in the Lievens et al (2011) study noted when she moved from a mission facility to a public facility that the staff there were less respectful: “*But later when I also worked there for some time I learned to appreciate their behavior. The workload was so high.*” However, in contrast, another senior nurse noted, “*I know one nurse who works at the mission hospital, she arrives in the morning and sometimes stops at 9pm, and the following morning she is there again.*” This sentiment that health workers in FIIs are motivated to work harder, even in hardship areas is strong. Reinekka and Svensson (2010) have argued that in Uganda, there was an altruistic effect to be found in FIIs which motivated staff to work longer for less pay. Serneels et al (2010) looking at health worker motivations to work in rural areas in Rwanda and Ethiopia find that health

workers with higher intrinsic motivation (measured as the importance attached to helping the poor), religious affiliation, and if they had grown up in a rural area - were significantly more willing to work in rural areas. The religious affiliation was demonstrated through a local bonding scheme operated by the Adventist community in Rwanda, and training that encourages rural service by a Catholic NGO in Ethiopia. *“Among these results, the effect of motivation stands out as a particularly strong and robust finding...the results on religious affiliation underline the important role of faith-based institutions in the health sector in Sub-Sahara Africa, and both the Rwanda and Ethiopia cases offer examples to inspire future policymaking. Of these three factors that affect health workers’ willingness to work in a rural area, rural background is the more tangible, while the role of intrinsic motivation, and the context specific role of faith-based institutions, deserve more attention in future analytical work.”*

Comparing health worker motivations in Uganda, Luboga et al (2011) note that a good working environment is more important than the level of health worker compensation. As one participant stated: *“Actually people are not looking for money when they go away (migrate), they are looking for good working environment...Take an example, people are working in mission hospitals, when you want to do a surgery, things to be done are there, when you have done your good surgery the nurses will follow up the patients very well and you become satisfied that the patients have recovered, you have come to a diagnosis with the all things that are required and you treat the patients and they recover very well. And those people are there not because they are given a lot of money - the health staff in mission hospitals is given half the pay of the nurse in public units - but they are there because the environment is good.”*

There are again many unanswered questions about faith-inspired health systems: how quality of care and patient satisfaction emerges from the staff motivation and interpersonal care, or how the working environment (and institutional characteristics) affects the staff and the patients. Speaking broadly, it is often suggested that staff in FIIs tend to be more courteous, more patient-centered, and more respectful – even if they are working longer hours for less pay than in public facilities. However these are all more in the nature of tantalizing hints at some comparative differences than strong conclusions about either operational differences, or how the internal values or ‘intangibles’ potentially impact on satisfaction and quality – none of which can be proven here.

Finally, there is one related question to address, and that is whether our current methods of evaluating quality and satisfaction are adequately designed to pick up on internal or intangible factors that are *religious* in nature – which may provide some causal link between these elements of perceptions of satisfaction and quality of care. Qualitative studies tend to pick up on this issue more easily. For example, in an evaluation study of the Moravian-affiliated Masangane HIV/AIDS program in rural South Africa, health-seekers described a perceived satisfaction and higher quality of care at this FII (as opposed to the public provision of ART). While describing standard measures of good quality, health-seekers also described the greater credibility of the program by virtue of its affiliation with the Moravian church (for example, less corruption). In addition,

health-seekers described the actual ART as enhanced due to the way it had been integrated with the Moravian daily devotional practices (Thomas et al 2006).

Similarly, in an HIV/AIDS mapping study in Zambia and Lesotho (ARHAP 2006), community health-seekers were asked to rank (through participatory processes) the various health providers in their communities. In all communities, FIIs were consistently ranked higher, based on a number of different perceived quality aspects. For example, in Chipata, Zambia, despite the general hospital being more central, all participants preferred Mwami Seventh Day Adventist and St Francis hospitals to Chipata General Hospital. This was attributed to a combination of better facilities and better care, relating to staff having a greater purpose in their work. As one community member said, *“People prefer to go to the SDA hospital, rather than the general hospital because the facilities are better. There is excellent care there as well. The personnel give encouragement and pray for you, and that will give you more confidence and encouragement that you will get well there...that doesn’t happen at the general hospital, nobody will pray for you there.”* In the regional workshops, which included the public and private providers, one of the participants noted, *“...some of the people die (at Chipata General) because of lack of attention. There is also negligence at the general hospital, the nurses are just there for a career, they have no heart for the patient...”* (participant, Chipata Regional, 2006).

In fact, in all the community focus group workshops in this study, the most significant factor that was consistently attributed to the preference for and satisfaction with FIIs – was framed in religious terms: as the readiness to ‘pray with’ or tendency to provide ‘compassionate care’. In Livingstone, Zambia, community health seekers argued that compassionate care was the main difference between faith-inspired and government hospitals. *“The difference is that the care done by church organizations is done with care, compassion and love, with encouragement - but in government hospitals, people just do it for money - no compassion, love or care”* and *“In government hospitals, people are treated professional, without emotional attachment, but religious organizations treat the person as an individual, they provide more quality care”* (participants, Zambia, 2006).

And in a different study, also in Zambia, key informants and focus group participants (including government and NGO stakeholders) focus group discussions showed a general perception that people preferred to go to FIIs because of a better quality of care in FIIs in Zambia, which was noted as being deeply rooted in religious aspects integrated into the care. As one participant said, *“...many people have a need for prayer, spiritual care to be part of the treatment they receive; coming to a mission hospital that will be provided...This gives a sense of security as they undergo their procedure, a feeling that they are experiencing this in God’s presence.”* It is therefore interesting to note that while there are several large scale studies in countries such as the USA on how religiously-infused health care impacts on patient satisfaction (see Williams et al 2011), there is barely any of that kind of research conducted in the African context – a context where religion is more frequently counted as a core part of the patients’ everyday life and experience.

Again, it is dangerous to push some of these issues too far – especially if they are portrayed as only relating to FIIs. There are certainly motivated (and religiously motivated) staff working in public and private-for-profit facilities. As one community participant, who happened to be a nurse in a public hospital, exclaimed during the ARHAP (2006) study: “*we also pray with our patients!*” However, qualitative observations about the comparative differences of the compassionate care provided at FIIs are made repeatedly, and it certainly would be important to understand if and how such intangibles impact on healthcare provision at a systematic level. For example, whether there are patterns of religiously infused care that impact on patient satisfaction (even in strained African health systems); whether a holistic approach to healing is encouraged in FII facility environments therefore impacting on perceptions of satisfaction; or whether a religious mandate to serve the poor might impact on quality of services to the poor. Such questions, of whether FIIs have a comparatively higher satisfaction as a result of a specific kind of *religious* characteristic (e.g. that is different to other PNFPs), remain elusive. While health seekers continue to be vocal about these differences in qualitative studies, our current methods and measures of quality and satisfaction are not entirely adequate to pick up on whether there might be some faith-inspired intangible link between perceived higher quality and more technical and structural quality measures.

CONCLUSION

There are a number of related issues we have not been able to adequately address here. For example, whether there are satisfaction differences between rural and urban health services – an important concern for FIIs who are often perceived to be particularly important in rural and hardship areas. We have also mainly (inadvertently) addressed Christian FIIs here, simply because there are few studies which address Muslim or other providers in any sort of comparative way. There are only some hints available that Muslim providers might enjoy some of the same high levels of satisfaction. For example, in a descriptive report on FII child and maternal health, Chand and Patterson (2007) note a high satisfaction with Kibuli Hospital, an urban health unit under the Uganda Muslim Medical Bureau. “*The hospital has a high patient load from the surrounding Muslim population...The City Council Health Division awarded Kibuli Hospital ‘Best Performer of the Year 2004/2005’ for cleanliness, outreach and community services leading to reduced maternal mortality. The maternal mortality rates at this facility are lower than those of public health facilities nationwide.*” Gemignani and Wodon (2012) in Burkina Faso, as well as Shojo et al (2012) in Ghana also find evidence towards higher levels of satisfaction in Islamic than in public facilities, much in the same way as what is observed with Christian facilities. We also do not adequately address the wider range of health-engaged FIIs, focusing here mainly on formal health facilities. There are several studies which point to higher satisfaction and user preference with other kinds of providers, for example ‘faith clinics’ working as birth attendants in Nigeria with a religious character (Adetunji 1992).

Still, having trawled through a number of different studies and teased out some aspects relating to comparative perceptions of satisfaction with faith-inspired health provider

services and care, triangulated, the evidence points in a clear direction. Based on these studies, and the results of the national surveys we have added here, there are strong indications that patients and health-seekers are still showing strong satisfaction with and preference for faith-inspired health facilities in Africa. Although the evidence is still patchy – and certainly requires a substantial amount of work before any policy-level action can be taken – there is enough in these studies to suggest that these perceptions of higher satisfaction are not a nostalgic hang-over for mission-based health services of the past. The perceptions are too strong and consistent for that, and nostalgia is not enough to make people in dire circumstances carry friends and family past (often) cheaper government facilities. There is a lot left to be understood about what faith-inspired health providers are, how they operate, and what internal values and characteristics they might have that make them different to other private providers, but there is a strong case to be made that something different is going on which urgently needs closer consideration.

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CHAPTER 2

BUILDING ON THE STRENGTHS OF PEOPLE WHO CONGREGATE

Gary Gunderson and James R. Cochrane⁵

Wake Forest University and University of Cape Town

Hundreds of thousands of congregations or what we might call ‘faith-forming entities’ (FFE) are found in neighborhoods everywhere. Here we probe the nature of such an entity. What, of significance for the health of the public, are the strengths of congregations? Lost most to view is the peculiar mystery of how a congregation functions over time, remaining generative and resilient amid contexts rife with multiple health challenges. We identify eight strengths of congregations that express themselves not in mechanical operations or managerial techniques, but in patterns of complex human relationships. The life they express may vary over time and location, but the patterns can be discerned.

INTRODUCTION

What is the nature of ‘faith-forming entities’ (FFE) found in neighborhoods in the USA and Africa, India or South America? What, of significance for the health of the public, are the strengths of congregations? Similar to other kinds of social organizations in some ways, congregations are also unlike them. Even when they do many things that other organizations do, it is in ways that are specific to their nature. Looking at an FFE as a social service entity or affinity group obscures as much as it discloses. Lost most to view is the peculiar mystery of how a congregation functions over time, remaining generative and resilient amid contexts rife with multiple health challenges.

The point can be made by contrasting the view on violence from what many see as the heartbeat of a hospital, the emergency room with that of a congregation. In many places violence is a leading cause of death among the young or, more quietly, among older people (suicide), and violence accounts for a large fraction of what is seen in the ER. Here the hospital helps survivors of violence, yet knows almost nothing about the causes or modalities that might prevent it. The answer to violence is understood better by what we would call ‘pastoral intelligence’ working beyond the personal or individualized therapy at the level where people congregate around their religious faith. Here the answer looks more like a youth choir than an ensemble of therapists or surgeons. The life of any one person of faith is the fruit of a multi-generational congregate history, however much the unique gifts of a particular leader might express that history in particular neighborhoods and institutions. A congregation, and not just its leaders, has deeply

⁵ This note is an abbreviated extract from a book by the authors entitled ‘*Religion and the health of the public*’ and is printed here with permission.

woven strengths. In their own right, congregations are, for this reason, seminal religious health assets.

We can, in response to such a claim, anticipate complaints about the obvious weaknesses of these same congregations. Anyone who has ever observed, much less served in a congregation, understands that. This is also often captured in the scriptures or knowledge of every faith tradition. To acknowledge weakness or failure is one thing - simply to ignore strengths or accomplishments is another thing entirely. We need a logic model that, despite their obvious frailties, brings into view the strengths in the social structure of FFEs that persist and generate new possibilities, even healthy ones, and that do so repeatedly, often over multiple life-spans.

The frailties of FFEs can be explained, in terms of organizational development, as weaknesses of leadership, training, or management. Social scientists, similarly, find it recreationally easy to dissect congregations of all faiths for their awkward fit into modernity, while offering to repair their failings. The shortcomings may also be analyzed as the side effects of an inadequate self-understanding vis-à-vis the positive or emancipatory trajectories of a particular religious or faith tradition. FFEs can produce ill-health, stigmatization, exclusion and pain—a naïve view of faith or religion would be counter-productive, and there are certainly enough studies or commentaries that demonstrate what many would regard as the negative characteristics of religion.

But none of this adequately accounts for the persistence of the contribution to health of many FFEs. It is precisely this that is the most useful thing to know, in order to align their assets with others, for the health of the whole community. FFEs are most productively understood, analyzed, and engaged in terms of their strengths, that which enables and expresses the social life that flows through and around them as permeable webs of trust, rooted in a wider environment in which they find their life. They are in this respect nurturing entities, and they raise up boundary leaders who are on transformative, healing journeys of life.

The strengths of congregations we identify below must be understood as holistic, and as fractal. They represent identifiable patterns. Though often expressed through individuals that play roles in the life of the entity, they are not contained merely in one person, not even the clerical leader. The social entity in this case is seminal, and the personal derivative or expressive of it. Just as personal health primarily proceeds from the social even if expressed in personal choices, experiences and outcomes, so it is with the strengths of the congregation.

WORKING FROM STRENGTHS

At least eight strengths can be meaningfully distinguished. In themselves, and taken together, these strengths enable those who lead congregations (and often others outside them) to build their capacity to act in ways that generate assets, rather than liabilities, for health. The eight strengths are the strength to accompany, to convene, to connect, to ‘story,’ to give sanctuary, to bless, to pray, and to endure. Our purpose in introducing these eight strengths aims at avoiding the all too common over-simplification of how congregations function in relation to the health of the public. The strengths named, which we describe below, may be characteristic, but they are not part of a recipe book - they are non-linear and organic. They express themselves not in mechanical operations or managerial techniques, but in patterns of complex human relationships. The life they express may vary dramatically over time and location, but the patterns are discernable.

HISTORY OF THE CONGREGATIONAL STRENGTHS MODEL

The eight-fold model of congregational strengths has a particular history, located in the early years of the Interfaith Health Program begun at The Carter Center and funded by the Robert Wood Johnson Foundation in discussion with the Centers for Disease Control and Prevention (CDC). During the 1990s, the curiosity of public health professionals continually expanded to include health conditions far from the classic public health interest in infections, towards those rooted in human behavior, including the determinants of that behavior that require social, political, and environmental explanations. This inevitably drove a renewed appreciation for the potential role that community partners of all kinds could and should play in applying evidence-based, preventative science to the enduring health challenges of communities, one type being faith entities. In this context, William Foege (1999, see also Foege et al 1985) explained that the convergence of faith and public health could make possible a very particular vision: *“It is not impossible to dream of thousands of congregations working alongside public health, sharing an understanding that health is a seamless whole – physical, mental, social, spiritual – that poverty and illiteracy and addiction and prejudice and pollution and violence and hopelessness and fatalism are forms of brokenness, diseases that require the deployment of both their assets in building whole, healthy communities.”*

The challenge was and is more complex than simply activating religious networks with their congregations. The issue is how the particular, and often peculiar, social form of religious affiliation we call a ‘congregation’ could be understood and then linked in any useful and sustained way to the public, science-driven health agencies. These agencies, because they think bureaucratically or see, ‘like a state’ (Scott 1998), instrumentally and functionally, usually do not grasp the way congregations actually work or express their particular contributions. The idea of the strengths of congregations was thus a clear attempt to probe beneath the functional approach and apparatus of polity and legal structures, and to explore the ways in which this social form offered assets relevant to the health of communities complementary to those of public agencies. The set of eight strengths was thus conceived in relation to heightened concerns about the functionality,

reach, and effectiveness of formal health systems and health services. While they were framed in the context of USA public health policies and practices, they are clearly not specific to American congregations, nor are they confined to any one religious or faith tradition.

UNDERSTANDING THE CONGREGATION

The systematic study of congregations has engaged the minds of some of the most well-known students of religion, including the earlier, seminal work of Richard H. Niebuhr (1965). It has provided a generation of scholars with tools of analysis that have helped to illuminate many aspects of congregational reality but have generally lacked a satisfying paradigmatic framework with which to work. The recent history of the field goes back to the landmark multi-volume study of *American Congregations* by Wind and Lewis (1998a, 1998b). In some cases the approach is appreciative (Ammerman 2005, Ammerman et al 1998), in others objectively curious (the analysis of mega-churches by Thumma and Bird 2009), in still others baldly utilitarian (Cnaan and Boddie 2002, who see congregations as social service providers with useful credibility; or the analysis of 'medical religious partnerships' by Bennett and Hale 2009). From its inception, however, much of this scholarship was seen as 'practical,' that is, complementary (at best) to the more traditional focus on the systematic study of the theological ideas of faith.

In *Deeply Woven Roots*, Gunderson (1997), wondering about the role of faith in forming and sustaining human communities that are healthy, also answered in theological terms that: "If there is any hope at all, it is that God intends the renewal of the whole world. Congregations are a tool for that greater purpose, not themselves the point." Here, going beyond views of the congregation as a weak, frail, and complicated link in the logic chain of health, he articulated that we "*need a new understanding of how faith groups are integral to communities, not separate; how their strengths integrate with those of other institutions...*" (Gunderson 1997). The concept that congregations have social strengths relevant to the health of communities is a weaving of streams of thinking that have emerged from the fields of religion and public health. The eight-fold strengths model was developed in part to prevent premature conclusions about congregations that result only in a functionalist or instrumental focus on techniques, messages, and tasks that seem to outsiders, including public health agencies, the only valuable thing about congregations, which are often reduced to places for spirituality or venues for the delivery of health messages.

Public health professionals are often surprised at how ubiquitously congregations already do work relevant to the health of communities. Congregational leaders are equally surprised to learn how much of what they do 'naturally' is relevant to the health of the public. Because their activity in caring for individuals is so 'normal,' reflecting deeply held historical norms, they do not think of their work as advancing or sustaining community systems of health that could be deliberately improved. Despite these practical and intellectual disconnections on both sides, the fact is that both sets of people are interested in social scale, complex and dynamic patterns or determinants of health and well-being over life-spans. To a remarkable degree, they flow within conversational

range of each other, but along parallel courses. Their common, mutually informing discourse about the interface of knowledge that lives between them is what has mostly been missing.

Congregations are formed by people of faith, but people of faith are formed by and through congregations. In that sense, it is best to think of congregations as ‘faith-forming entities’ (FFE), nomenclature that may seem odd to those accustomed to the widespread use of the term ‘faith-based organizations’ (FBOs), really a subset of the categories of non-profit organizations (NPOs) or non-governmental organizations (NGOs). ‘Faith-forming’ forces one to focus on the primary dynamic which produces what matters in congregations - those texts, rituals, beliefs, stories, songs, memories, expectations, and the like which shape both individual members and the ethos and practice of the group. FFEs are the seminal religious health assets from which other forms of assets derive, some highly structured in form (clinics, social service agencies) and others far less so (prayer circles, orphan care groups).

We live in what Bauman (2000, 2006), in contrast to the ‘solid modernity’ characteristic of earlier industrial society, calls ‘liquid modernity,’ his term to capture changing forms of association, technologies and modes of communication that mirror large shifts in modern social and political organizational patterns. Yet in every society, despite the proliferation of other social forms, the presence of an intricate array of FFEs continues. People continue to congregate for reasons of faith and spirituality, and congregations remain relevant to the health of vast numbers of individuals, families, neighborhoods, and their societies. And as a sympathetic empirical study by Levin and Idler (2010) suggests, *“there is a need to recognize the direct link between religion, health and healing which is not mediated through the medical profession.”*

The idea that congregations have strengths suggests how alignment between religion and public health might be approached. Understanding the strengths of FFEs also suggests what not to do and why organizational practices imported from secular norms are likely to be useless or damaging to the FFE and detrimental to the community outcomes to which their vitality and strengths are relevant. One cannot use faith without understanding the way that FFEs live and have their effect.

THE EIGHTS STRENGTHS OF CONGREGATIONS

Accompanying

People gather, they congregate. And in the most basic sense, the gathered people accompany each other through their journey of life, even to the end. They show up in times of dependency and celebration, in lament, learning, and loss. The acts of accompaniment are a part of membership. Membership is usually bound by an explicit bond of covenant, spoken and marked by rituals of entry. Less formal ways of membership grow organically through patterns of association that also build webs of relationship and accompaniment. One experiences accompaniment as the fruit of human association, as an affirmation of commonality, not dependency. One is of the company and thus, appropriately, is accompanied. The FFE has the peculiar strength of generating

such associations across bounds of race, blood, class, party, and even distance that are crucial to the health of the community (Gunderson 1997). As Ammerman et al (1997) put it: “*Religious congregations, including the small groups they house and sponsor, are then a space of sociability where real commitments are made (even if temporary and partial) and where persons are thereby formed and transformed. Congregations are not best described merely as the product of individual choices. They are social realities sui generis. While people may shop for the congregation that best fits their individual tastes, the resulting group is usually not merely a collection of individual consumers but a community...*”

Congregations are not merely aggregations of autonomous individuals making rational choices designed to secure individual benefits, but socially created and sustained over generations. People form companies of companions who accompany each other through their lives. To be sure, especially in ‘liquid modernity’, congregations are not always associated with specific geographical spaces in which all their members live. Easy to notice in stable, archetypal small communities, congregations are also the most visible form of accompaniment in the radically new kinds of translocal and transcultural networks of new immigrants growing on the suburban edges of liquid cities like Cape Town or Atlanta (Cochrane 2009, Levitt 2004). And even if messages and presentations may be absorbed privately via Internet, cassette tapes, videos and other contemporary media, they are first and last physical spaces in which people gather. Life and health are social and thus dependent on social spaces.

This is most useful precisely where cultures and livelihoods are most at risk, most in motion and least established. Religion may be seen as a critical element in transnational flows, contributing to the formation of multiple and hybrid identities on the borderlands where two or more lifeworlds mingle. In the Atlanta suburb of Doraville, for example, residents continue to use their churches as the places to negotiate their way in a context of segregation. Doraville's newest residents, who face multiple forms of discrimination, also turn to churches not only for refuge but also for places that provide the space and symbolic and material elements with which to engage a public sphere from which they are often excluded. But these newer residents keep links with wherever they left, finding in their churches support for the “*formation and maintenance of transnational, transregional, and translocal ties that shape the ways in which they negotiate the city's often inhospitable landscapes*” (Vásquez and Marquardt 2003).

Even if congregations like these are malleable spaces, they establish networks of relationships that hold many capacities, not necessarily at all confined to clergy. Vásquez and Marquardt describe Luz Maria, an undocumented Mexican immigrant to Atlanta, who cleans homes for a living. But her vocation is her work as the organizer of the Mission's chapter of St. Vincent de Paul. Her dedication to this work has earned her the status of unofficial matriarch of the church. Why do people feel ‘at home’ there? “*Here,*” she says, “*it feels like the town square [plaza del pueblo]. We come, we get to know each other, we mingle with each other. We listen to the word of God, but we also develop friendships ... It's like a vision of a plaza where people from all countries encounter each other*” (Vásquez and Marquardt 2003). Luz Maria's role is an expression of the

congregational strength of accompaniment, of being in the company of people who are not simply servicing each other, but participating in each other's lives.

Congregations provide social supports such as accompaniment that are powerful precisely because they are not professionalized, but built on the efficacy and intelligence of non-professional actors, protecting community agency in the process. This is not trivial. As McKnight (1996) notes about the ironic trap of poor communities held down first by circumstances, and then again by the weight of development professionals trained and paid to administer service technologies to them: "... *the invisible message of the interaction between professional and client is, 'You will be better because I know better' ... Through the propagation of belief in authoritative expertise, professionals cut through the social fabric of community and sow clienthood where citizenship once grew.*" Both the form and the function of congregations hold open the social space for people like Luz to bring life through the expectation that they will accompany others around them and the belief that this is part of their membership in such a religious community.

Convening

Finding some way of getting people into one place where health issues can be discussed is not always easy, especially if civic or other accessible venues are not readily available. But it is important to the practice of public health and to the ability of its practitioners to be able to convene groups of people. Very often those outside the social network a congregation represents seek to engage that network. They will usually ask congregational leaders to convene a gathering to this end. Their authority, however, is not simply individual, but deeply derivative of the social structure of the congregation itself. As Cnaan and Boddie (2002) note, congregations play the role of providing a venue for the community "*where people can interact with others whom they trust and care for.*" They open space, often foreclosed in resource-poor or politically repressed situations, where community, municipal, state, national, and international issues can be discussed. An example of the power of convening is the story of the Nikolai Church in Leipzig under Pastor Christian Führer. In February 1988, he invited fifty people advocating for the right to leave East Germany to hold their meeting at the church. About 600 turned up, and increasing numbers of people began to attend his regular prayer sessions. More and more people followed at prayers and the vigils until, in May 1989, the authorities decided to block any traffic going to the church. Despite this and beatings and arrests in Leipzig and other East German cities at the time, on October 9, 1989, at least 70,000 people turned up to the Monday Demonstration, chanting, "*We are the people.*" Pastor Führer's influence, among others, critically ensured that the protest was nonviolent. This confused the police, whose sharpshooters were everywhere waiting to unleash the violence that would break this movement, and they received no useful advice from Berlin, so the march through the streets of Leipzig simply went ahead. The authority of the rulers was broken. On the next Monday, there were 120,000 people, and on November 9 the Berlin Wall fell. Leipzig's movement was not alone, but it was decisive (Führer 2009).

Such power to convene, if very seldom as massively important, historically timely, or on such a scale, is not nearly as rare a capacity of congregations as one such iconic story might lead one to think. Cnaan and Boddie (2002) argue that "*The voluntary coming*

together of people as a group in a respectful and reflective manner distinguishes the congregation as a unit of social intervention from any other institution in the community.” The point is that FFEs like congregations are mostly no longer part of the command structure of society: *“Nobody has to come when the church calls or do what the mosque says. But amid the decline of many other unifying social structures, it can convene. It has capacity to bring together people across lines that frequently divide; such as profession, economics, race and self-interest”* (Gunderson 1997).

Connecting

Congregations, as social phenomenon that tend to persist in time and space with more resilience than most other social organizations, represent stable networks of connections independent of any individual members that pass through. They also often connect to other existing pools of social capacity in other networks and organizations. The strength to connect is especially valuable at the level of community systems, where it creates social capital to create new entities and access to resources and services that already exist. But it also generates the social imagination necessary to create social forms that do not yet exist.

While the power to convene focuses on bringing people together, connecting is marked by creating links across which resources, assets, power, and knowledge flow. Sometimes, as Vásquez and Marquardt showed in Chamblee-Doraville, the connections mature into wholly new organizations that become part of the community's organizational infrastructure. *It is easy to forget where the organization came from, how the meaning and purpose were formed, where the leadership was raised up. Once these connections become visible and stable in the form of a new association, they are easy to name. They are visible products of what some now call social capital* (Lin et al 2001). *This economic term helps mark the relational phenomenon as something valuable, in the same way we speak of religious health assets. But the economic language also distracts from the underlying generative dynamic that produces new connections among animate beings. Even on Wall Street, capital is just money until somebody has an idea. If one wants to build a community, one does not start with social capital: “A social infrastructure is just a skeleton until it has compassion and discernment. These are what breathe life into the connections...”* (Gunderson 1997). In many communities, congregations connect together and to larger networks of institutions through leaders who form social webs. Ammerman (2005) notes: *“The typical congregation can touch the lives of many people, but its most direct impact ... is likely to be limited to a relatively small and local circle where emergency assistance can be rendered, the precepts of faith shared and support and enrichment provided ... when congregations want to reach beyond their own local community or want to do more than their own limited resources make possible, they work through other organizational channels.”*

Some public health scientists emphasize the way religious communities create social friction, but Ammerman (2005) shows that it is rare for congregations to stand alone: only 3 percent of congregations have no network of partners. Most congregations are permeable networks with multiple, flexible ways of linking people, ideas, resources, social, and political capital relevant to the functioning of the social whole of which they

are part. They connect across and in the interstices of social and political borders. Vásquez and Marquardt (2003) indeed show that borders and borderlands are crucial to understanding religion in a global setting: *“On the one hand, religion generates hybridity, opening, in the same ways borderlands do, liminal spaces of transcultural creativity and innovation. For no matter how rigid they might be and how hard the nation-state and elites work to maintain them, borders are always permeable.”*

Denominations are and have been the most common form of network partnership among congregations for at least a century, according to Ammerman (2005). And, she notes, the average congregation supports about five service organizations beyond whatever the congregation does on its own or through denominational affiliates. 73 percent of the congregations in her study have at least one connection to an organization that works for the health, education, and cultural enrichment of people beyond their members. Significantly, many of the community partners congregations connect to and through are not explicitly religious and many are impossible to classify neatly at all. In the U.S. context, *“almost no service organization is without a religious presence of some sort, nor is any organization - no matter how apparently religious - utterly without secular influences. Almost by definition, when charitable intentions take organizational form they are at once both sacred and secular”* (Ammerman 2005).

Connection creates new intelligence and new efficiencies relevant to health at community level. One example: Memphis has long been a destination for medical students, about one third coming from other countries, and many have stayed. The neighborhood north of Summer Road is much like any other working class area except for one thing, the *Masjid jāmi* (community mosque) and its stream of members from countries all over the world. Many of its founders came to Memphis as students, built it, its school, and now a free clinic established with the Islamic Medical Society but open to all, everything as expressions of their faithfulness. In the constant ironies of faith-based healthcare, the clinic secretary is a redheaded Methodist who enjoys being in a faith-based ministry providing competent care. The medical professionals within the *Masjid* also connect with other faith-based institutions, including Methodist Hospital. The personal connections of faith woven in the *Masjid* create a safety net for hundreds of patients, including referral patterns strong enough to carry those without insurance who otherwise find access to care difficult. The Methodist Hospital has established a policy that waives hospital charges when a physician acting out of their own faith forgoes their charges, irrespective of which particular tradition generates that faith. These multiple kinds of connections are clearly a strength of the *Masjid* congregation, whose members display a special intelligence regarding health and ways and means of caring for the health of individuals, families and the whole polis within which the *Masjid* has its life. It is an intelligence that looks for synthesis and synergy and that sees health as a whole.

Connections as produced among and by congregations also produce some efficiency of resource flows. People can get what they need because the resources are made visible and accessible across their networks. Some connections assume institutional form on a significant scale, linking hundreds of congregations of all traditions, as in the Greater New Orleans Federation of Churches described by Cnaan and Boddie (2002), a

sophisticated structure that enables a network of congregations to offer extensive and ever-mutating programs for education, training, elder care, grief counseling, advocacy, adult literacy, food, shelter, a cable TV channel, health initiatives, and prison ministry. The Federation describes itself as a bridge that links “*the spiritually concerned and the socially concerned,*” and it functions by “*connecting the religious, social, political and economic communities of New Orleans in order to serve the needs of the whole city*” (Cnaan and Boddie 2002). The Federation extends, though it does not replace, the smaller scale intimate connections that congregations develop and sustain, across which caring is expressed. Sometimes, indeed, these connections are capable of withstanding a hurricane and are there to help the community grow back when almost all is washed away. If accompaniment is the root asset for individuals, connection plays the same role for the health of social wholes. Cnaan and Boddie wrote their study three years before Katrina came ashore scattering institutions and drowning buildings by the square mile. Congregations survived that, and provided a kind of trellis on which life could grow back, using their existing connections and their strength as life demanded.

Storying

One of the mysteries of health is why people continually make choices against the best data and advice. We are increasingly awash in information and advice, much of it contradictory or highly contested. New communications technologies make it easy to find technical answers quickly. What we are often missing is the larger story within which we can understand ourselves. To think of this as a story is a crucial move that shifts us away from data to narrative. And it pulls us toward the essential role of FFEs: “*The challenge of where to find unifying, trustworthy stories confronts business, government and leaders of all kinds as they discover that it is quite literally true that where there is no vision the people perish*” (Gunderson 1997). People make choices in the context of a larger story that makes the world coherent, even when not fully articulated. Humans tend to locate themselves in relationship to other people, to time and circumstances, and even to their own bodies, by means of stories. In the context of hermeneutic philosophy, Ricoeur (1984) calls this ‘emplotment’, the narrative and historical weave within which we are able to interpret the world around us and our lives within it. The power to ‘story’ can of course be used by religious leaders simply to protect proprietary language or as tool for domination (as religious sacred writings often themselves point out), but handled with humility, it can be like water in the desert.

Nothing is more characteristic of FFEs than their strength to story - it is how they express and nurture their other strengths. Ammerman’s extensive work on congregations convinces her that congregational life is grounded in stories: they incorporate past, present and future, recount action, and build on relationships, current and intergenerational. “*What congregations make possible is a meeting ground where new, shared stories evolve*” (Ammerman 2005). It is now widespread in secular public health circles to ask clergy to disseminate health messages that carry credibility by being spoken from the pulpit. But the strength to story is deeper, if less predictable, because the stories with traction are those that arise out of the congregational life itself.

Nowhere is this more telling than in the history of the relationship between faith congregations and HIV/AIDS. Canon Ted Karpf, later in the World Health Organization, tells the story of a young man suffering from AIDS who came to his parish hall, asking if he could die there in safety. He had found no other place that would have him (Karpf 1989). Out of this and similar experiences (he used the burial liturgy, for example, to mark the passing of one of his parishioners from AIDS well before most people had heard of HIV), Karpf and his congregation built a narrative for living that took him over the next decades into congregations in many other parts of the world, telling the story, encouraging others into it, and thereby advocating for practical change to meet the pandemic. And these stories of caring also offer up a witness: *“Those of us who have worked daily with persons living with AIDS have seen nobility of spirit, courage of heart, power of the will, patience in the midst of suffering, and genuine holiness”* (Karpf 1989).

The strength to story is not just the strength to speak, but also the strength to hear and then to participate in the story as it unfolds in the lives within caring distance. The congregation is a social space in which stories emerge, find, give, and transform life - though not always. As Rosalyn Carter once noted, the first word religious leaders should say to those living with mental illness is one of apology, because congregations have often been the last bastion of the worst stigmas that persist in our society (Carter 1999). Recognizing a strength is not to ignore the weaknesses that are part of the ambiguity of congregations or any form of social life, including the much-used term ‘community’. The power of story is to turn descriptions and abstract ideas about social life into human realities, whether of hope or tragedy. Wendell Berry (199) argues that those who hope for community must dispense with childish wishes or complaints. It takes an adult familiar with the ambiguities and disappointments of lived social life to get the story right, and thus move beyond the facile complaints: *“What is wanting ... is the tragic imagination that through communal form or ceremony, permits great loss to be recognized, suffered and borne, and that makes possible some sort of consolation and renewal”* (Berry 1990). As Mrs. Carter recognized in the context of the mentally ill, a true story of the relationship between the mentally ill and communities of faith is complex, tantalizing, disappointing, tragic and hopeful all at the same time.

Giving sanctuary

FFEs usually have spaces in which public worship is held that we may call sanctuaries. The concept of religious health assets is designed in part to bring attention to their intangible and social nature, but people of faith also tend to build tangible things that stand for generations. Ancient cities such as Istanbul, Delhi and Canterbury are defined by their religious structures. And in many streets with almost no name at all, the FFE has the largest meeting room in the neighborhood. Space matters. As the story of Canon Karpf above indicates, even those people most cruelly stigmatized have a reasonable expectation that a house of worship might be a safe place to enter and find protection, and though not always, often it is so. The space sends many important clues to people about whether it is safe for those on a life journey, safe for difference.

For example, the Episcopal Church of the Incarnation in Atlanta before the mid-1960s was located predominantly in a white area. Now, however, the area is predominantly

black, with a distinctly mixed economic status. As the population changed, so did the churches. Some new ones were built, some old ones changed hands, and some, like Incarnation, were transformed, creating an environment that gave people safe space, a sanctuary, where they can express their identities and their diversity (see Ammerman et al 1997). Space matters. Sometimes even when confused about *what* to believe, people know *where* they believe, which holds them in social relationships where meaning can grow. One of us teaches bible study to a group who began to meet as a class of young married couples more than five decades ago, in the same room. Almost everything in their world has changed, all of which they have witnessed together, washed in tears from time to time, and just as often in laughter (Gunderson 1997). The other had dealings for some while with a socially active base community in a shack settlement in KwaZulu Natal, where its work was shaped by conversations which took place in a protected space that was more than necessary in the face of threats of the Apartheid state and its local proxies (Cochrane 1999). For words to become deeds, they need a place where they can come alive and be embodied; stories need sanctuaries at their heart too, especially those that are risky or dangerous or filled with costly consequences.

Congregations as sanctuaries have both proximate and distal implications for health. To be sure, they offer valuable venues for dissemination of health information and health services such as blood pressure checks or counseling, perhaps to model testing for HIV or prostate cancer. But health messages and services also gain from the trust engendered by what has gone on in that space before, during and after any such activity, from stories that can be safely told and take form, and from other meetings in which people experience their social membership in a community of meaning and accompaniment - a sanctuary built and sustained by repeated, mutually witnessed, personal, and social transformation. Whatever their ambiguities that must be critically considered and taken into account, an intrinsic strength of congregations is that they can and often do offer safe and trusted spaces upon which one may build.

Blessing

In the health professions, including health education, many think that congregations and religious leaders have powers of persuasion, even coercion, that direct behavior in ways that are all too often negative or that carry direct and indirect deleterious health effects. Condemnation seems common, and stigma is one result. HIV, for example, is too frequently described as a sin, a punishment from God, a sign of poor faith. No doubt this is part of the ambiguous jumble of religious life, and there is enough literature to criticize it. Once again, our methodology begins with the question of assets or strengths. As Ken Pargament has shown, a sense of condemnation is not good for health. He, Koenig and others studied 596 people hospitalized for a variety of illnesses, all fifty-five or older, and all saying either that they felt unloved, abandoned, or punished by God, or that the devil's work was responsible for their problems. Such negative beliefs put patients at increased risk of death, 19-28 percent of these patients being more likely to die during the two-year study period than the control group (Sherwood 2009).

The opposite of condemnation is the strength to bless. Essentially, blessing another (or oneself if need be) means to affirm rather than condemn, and to offer one's presence,

physically or in spirit, in support of that affirmation. Blessings are healthier than religious warnings, scolding or negative rules. This embodied strength, close to, but different from, the power of forgiveness, is one root of the transformational evidence for the changes in identity, ideation, and behavior that is so crucial to life-span health, especially in patterns of community.

While those who seek to enlist FFEs in targeted campaigns or social programs to get people to do certain things ('get your H1N1 vaccine') or stop doing other things ('just say no') are often disappointed, they might better grasp the power to bless and its effects: "*Blessing sets people free, free to change, to untangle from their bondage. But blessing never prescribes, dictates or manipulates*" (Gunderson 1997). One might, of course, ask what good freedom is in the face of a killer virus or a threatening illness. Koenig says religious beliefs help everyone, but that they are especially valuable to those who often have "*nowhere else to turn*" nor "*the resources available to survive*" (Sherwood 2009). For these vulnerable people, even when a challenge seems impossible, religious beliefs can sustain them through almost anything, in amazing ways, Dr Koenig says gleefully (Sherwood 2009). This strength is found not in disembodied, abstract faith, but faith mediated through the physical human relationships found in an FFE that provides for the social integrity of the blessing. Blessings that produce the liberty that produces health cannot be bought or sold, only given and accepted gracefully, where a community provides a place for embracing the full complexity of life, where one is welcome, forgiven, hoped for and included (Gunderson 1997).

Praying

Congregations have strengths that are useful for many things, but as Ammerman (2005) points out, "*Congregations are fundamentally religious organizations. That is such a common-sense assertion, but the perception of what congregations are about is often distorted by all the talk about them as deliverers of social services, builders of social capital, mobilizers of political constituencies, or even producers of culture.*" They nurture spirituality and faith by means of corporate worship to engage in the rituals of their faith, they teach and educate people through the course of their members' lives, and most have some way of encouraging individual decision of commitment to their faith (Ammerman 2005). People of faith, when they congregate, are present to each other as individuals and a social body sharing what they experience and understand as holy or sacred. 'Prayer' is the simplest possible name for a very long and deep menu of means to evoke and celebrate the presence of the holy in their lives. Formal prayers offered up by an ordained person in full ecclesiastical regalia is prayer. But so is the silent candle-lit witness offered by clergy at the site of handgun deaths on the streets of Alameda County or by a mélange of people in St George's Cathedral in Cape Town in the struggle against Apartheid.

Health education messaging in a congregation can focus too sharply on the rational instructions and underestimate the critical importance of the social phenomenon. The whole phenomenon is the message, not just the health science. Similarly, prayer abstracted from its social embodiment or location in a healthworld is readily turned into a mere therapeutic technique done well or badly. Much significant literature on the health effects of prayer reflects this reductionism, and most of it, in our opinion, lacks a

theoretical context in which to understand the limited, even contested, association between prayer and health outcomes.

More important is the fact that the actual practice of prayer nearly always emerges in some form where people gather in faith. The faith entity creates the space in which prayer is made credible and thus accessible to individuals even when they are not active members of a particular congregation. Pilgrimage sites, for example, may appear to be mainly special physical spaces, but they are also profoundly social in genesis and affect. The Sunday school class of older people who have met for decades mentioned above meets in a bland room, its dominant feature a cork bulletin board. The board is totally unremarkable until one comes close enough to read the dozens of clippings, notes, pictures, articles, cards and reminders of who the members are, who they love enough to pray for, how long they have traveled together - in prayer, directed not just toward God, but toward each other, reminding them of who to visit, touch, call, and feed.

Prayer, precisely because it is a social practice at the boundary between physical and spiritual, private and public, fear and belief, hope and mystery, also illuminates the (sometimes bizarre) relationship between religion and liquid modern reality. Vásquez and Marquardt (2003) begin their exploration of globalization and the sacred with a story that takes place in a Florida strip mall in Clearwater, where people gather to observe what they perceive to be an in-breaking presence of the holy in the form of reflections on the windows of a building that represent the Madonna. Here there is no normal congregation, of course, and that makes a difference. Instead there were the two of them, local residents, the “occasional curious out-of-towner,” members of the national and international media, volunteers working with a lay Catholic organization based in Cincinnati dedicated to interpreting and spreading ‘Mary’s messages’ through their Internet site, transnational Mexican immigrants who saw the Virgin reflected in the bank windows as Our Lady of Guadalupe, French, German, and Australian pilgrims on their way from other pilgrimage sites like Medjugorje and Conyers, Georgia, and tourists on their way to Disney World in Orlando (Vásquez and Marquardt 2003). Prayer and those practices in the borderlands of the holy turn weird when abstracted from the FFE whose social bonds provide context.

The opposite story of healing prayer is found in the many congregations that open their doors to prayers of blessing to those whose daily work drains their spirit, like teachers, nurses, and social service workers who live on the bleeding edge of social problems and tend to wear down. Thus the Free Synagogue in Evanston, Illinois, holds a monthly prayer and healing service for social service workers, Christian, Jewish, or otherwise. The service is focused on silence and meditation. Using powerful, nearly universal symbols, the service begins with the lighting of a candle and includes a brief meditation on the theme of light (Greene 1994). This is prayer as the most, not least, common denominator of those who live in service of others, and is a strength of congregations.

Enduring

Among the most remarkable strengths of congregations is that they last, often much longer than any other kind of place of meeting or gathering. They are not only

generational but intergenerational. While its practices and theology inevitably shifted in multiple ways, the parish retains its congregational strengths, in potential if not always in practice. Congregations are durable. The nature of congregations is, however, changing in many ways that also need to be understood to grasp the manner in which their strength to endure may display itself. Though many still are, an FFE no longer needs to be physically rooted in one place. Indeed, many congregations today are spread across different spaces and sometimes even virtual. Congregational studies have yet to come to terms with this fact, a consequence of the compression and dispersal of space and time, driven by new means of communication, that we call globalization (Castells 1996, Harvey 2000).

Vásquez and Marquardt (2003) thus call for a deepened and extended stress on ‘lived religion’ in congregational studies that can account for the increasingly common fluidity, conflict, and paradox within religious localities, where religion is repeatedly de-territorialized and re-territorialized: “It is not that locality and face-to-face encounters do not matter anymore, but rather that they have become more unstable, stretched, and shot through with hybridity and disjunctures.” This is to pay attention to the ways in which congregations are borderlands and not necessarily fixed entities. But as their studies also show, along with many others, fluid, shifting, liquid congregations do not lose their capacity to endure (see for example Levitt 2003, 2004).

Congregations or FFEs are social spaces in which humans bring and live their actual lives. Social is not the opposite of personal, for congregations still provide the space, real or virtual, within which the personal exists, changes, and adapts over time. Congregations are living fields of social soil, which, even better than ‘capital’, hold and nurture ever emergent life, including the passing - even dying - of its temporary but intimately attached members. As Ammerman et al (1997) point out, congregations function in community to nurture the life of the social whole even when its structure passes away leaving its ‘social capital’ to be reclaimed and invested in other social structures that emerge into the ecology of the community. Like other forms of life, any particular faith entity is durable but not eternal. Even its passing, however, is not an end, properly understood, for it usually sits within the strength predicated in the story of the faith it holds to, so that what truly lives in congregations is in fact more lasting than their particular embodiments.

STRENGTHS FOR THE JOURNEY: ACCOMPANYING THE PEOPLE

The core assumption in our discussion is that the social precedes (without replacing) the personal, in both faith and health. A second recurrent claim is that we are in motion, maturing in faith, evolving in health through space, time, and a thick fabric of relationships. To say that life is a journey is not a metaphor but a reasonable description of how persons experience health or the lack of it through shifting social and geographical locations and circumstances from birth to death. Some traditions see the journey as circular and find meaning in the cycle, while others describe a linear path made meaningful by its *telos*. Both faith and health languages fail when used to describe events, interventions, medical management strategies, services, and ‘outcomes’ as a

disconnected clutter of singularities; they are best understood as parts of a sequence, a narrative, a fractal stream of causation and influence, a history of a journey.

Whatever the social and political context, the health sciences increasingly recognize that health is life-span phenomenon in which access to specific medical services form a small fraction of what determines the quality of health life along the way. While the traditional medical 'history and physical' focused on diseases and their proximate determinants, such as smoking and genetics, the best science now values the long term affect of social location and deeply embedded identity, security, love, intimacy, confidence, and optimism - all qualities better suited to describe a journey rather a service. And that journey is rarely taken alone. FFEs are organized around the life stages of journeys that people predictably take - pre-school, adolescence, young couples, older women, and so on - while many congregations also organize around disruptive life passages such as divorce, retirement, living with cancer, or substance dependence. The best-known rituals, weddings and funerals, draw people toward sacred spaces, even if they are removed from regular participation in the life of a congregation. These are landmarks on a journey of meaning.

What difference might it make to those living in the world of providing health services to realize that their activities are part of social journeys? Recently, examining national patterns among the elderly of their journey out of a hospital, researchers discovered that 19.6 percent of these journeys cycled back into the hospital within 30 days, mostly because of a failure to follow simple medical advice and protocols, or because of missing social supports such as transportation to follow-up medical appointments, or even more minor causes. The cost to Medicare for these unplanned rehospitalizations in one year (2004) was \$17.4 billion (Jencks et al 2009).

Just as an individual gains the possibility of efficacy by way of a trustworthy narrative of the journey through life, so too an organization providing some kind of service gains power by seeing the story of those it intends to help. Concretely, a service provider, such as a hospital, gains intelligence beyond its limited competence by paying attention to the journey of its patients before and after they enter its space. It is remarkable how little attention such science-based institutions pay to where their patients come from and go to, and the unpredictable behavior of patients around their own healing (called 'compliance'). Hospitals are so confused, says Dr. David Hilton (2006) that they mistakenly refer to patients as 'inpatients' when they are actually estranged from their normal way of life. The hospital is 'out', not the patient, just as a fish is not normally 'in' the boat. Health for both depends on a quick return to their normal environment.

A hospital or clinic tuned to the journey of those humans who pass through on their way through life would pay special attention to the journey of their patients, with a special curiosity about the critical weeks before and after admission. This would make any need for hospital care identifiable earlier, increase the chances of manageable care in the development of any disease or illness, and render the visit less costly and fraught with fear. It would include paying attention to their pathways back to the social networks where their healing could be completed. On either end, the provider of specific services

would necessarily be interested in how to align itself with other organizations in their patients' lives that offer relevant services and advice, creating mutually supporting processes and better meeting their own goals.

Trying to pull any one living thread from the tangled journey only illuminates how interwoven they are in reality. It is much easier to live in this weave than to map it, or even name all the threads. But if one can identify congregationally related patients (which requires a conscious relationship between congregation and hospital), as increasingly happens at Methodist Healthcare in Memphis as more congregations (almost 350 as of early 2011, in its Congregational Health Network) and their members 'sign up', one can pay attention to the relationship between the patients and congregations in specific neighborhoods admitted to one of its hospitals.

The growing CHN data for Methodist Healthcare in Memphis, comparing the lives of those members who become its patients with others who are not part of the CHN program, show dramatically positive differences for CHN patients matched for diagnosis, gender, age, and race. The differences extend to such fundamental things as mortality, cost, and premature readmission - three of the golden rings pursued by hundreds of millions of dollars invested in electronic technology and platoons of highly qualified specialists. The CHN patients come in the same door as others, sadly mostly through the emergency room, see the same doctors and have a comparable length of stay. The significant difference is that the CHN patients are more systematically connected to the network that primarily cares for them - their faith community. Nothing medical differs; the only difference is the link to the FFEs that accompany them, entities that are able to convene care teams and connect the social webs within which they find what they need (Cutts and Gunderson 2009). This is one place where we see how FFEs embody a story of membership that is not just about dependency and frailty, but includes safe sanctuary, from hospital to home, relieving basic fears of isolation and violation. They offer up the confidence of liberating blessing at a time of traumatizing vulnerability. And, of course, they pray, marking the journey as a sacred one in life and not just a slow entropic decline. These strengths echo the causes of life, but also make them accessible, participatory, and practical.

Such strengths of the FFE or congregation are evident in patterns that cross lines of theology, class, and culture. They are visible in African villages and in poor and rich, black and white and brown parts of Memphis. They are evident in entities echoing with the Koran, Isaiah, Revelations and oral lore of African traditional religions. Indeed, one of the most important implications of the eight-fold model of strengths is that it helps those standing in one stream of faith (or none!) to see another stream as an asset for health without stripping it down to instrumental manipulation. Leaders who are able to do so find the greater depth of field keeps more of the assets in focus and thus amenable to alignment. Imagination moves beyond simplistic functionalism toward vitality, even in breaking, broken, and broken-open communities. Such 'boundary leaders' are more comfortable with the dynamic fluid complexity common to turbulent human systems.

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CHAPTER 3

HOW DO HOUSEHOLDS CHOOSE BETWEEN HEALTH PROVIDERS? RESULTS FROM QUALITATIVE FIELDWORK IN BURKINA FASO

*Regina Gemignani and Quentin Wodon*⁶
The World Bank

This paper provides results from qualitative fieldwork conducted in 2010 in Burkina Faso to understand the factors that lead households to rely on traditional as opposed to modern health providers, and within modern providers, on faith-inspired as opposed to public facilities. While there is an overall preference for modern care, households still rely on traditional healers for specific health issues that they encounter. As to the choice between modern providers, faith-inspired clinics and hospitals are perceived as being characterized by lower costs and higher quality of service than public facilities. Faith-inspired facilities are well regarded in their surrounding communities and patients are willing to travel significant distances to receive care from the facilities. Although these providers vary in size and religious affiliation, they share a similar goal of offering affordable services to the poor and doing so in a way that fosters closer relationships between individuals, communities and the healthcare system. Their approach and services thus helps in expanding options for care, especially for those who feel marginalized in the public health system.

INTRODUCTION

Significant progress has been made in Burkina Faso in the area of health service provision. The government's 10 year health sector program initiated in 2001 has led to improvements including the construction of health facilities, expanded services including vaccinations, the reduction or elimination of fees for many maternal and children's health services, and the distribution system for essential drugs (World Bank 2009). These actions are likely to have contributed to a better health status of the population. For example, between 2002 and 2008, the rate of assisted childbirth rose from 27 percent to 49 percent, the overall utilization rate for health services increased from 27 percent to 49 percent, and significant gains were made in the areas of vaccination and infant mortality (WHO 2009, USAID 2009).

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Yet despite substantial gains, the country still faces many health challenges. There are still high rates of unassisted deliveries and high maternal mortality. Malnutrition rates have apparently increased over the last decade, and the capacities of district health teams are seen as insufficient to adequately address pressing health needs. In describing problems on both the demand and supply sides of health services, WHO (2009) states: *“The utilization rate of health services remains low due to the weak quality of care and the persistence of financial and cultural barriers...Current capacities...(do) not permit them to fully implement priority health interventions in order to attain the Millennium Development Goals in health.”*

In this context, all efforts that contribute to improving access to health care for the population are crucial, including those of faith-inspired institutions (FIIs). In many countries, FIIs play a significant role in overall health service delivery, often accounting for 30 percent to 40 percent of hospital beds. In the case of Burkina Faso, their role is less imposing in terms of market share. A study by the Ecumenical Pharmaceutical Network (EPN 2005) noted that *“...the church health sector is extremely small...(with only) 44 registered church-related health structures in Burkina Faso in 2003 (only an estimated 2.3 percent of all healthcare structures were run by faith-inspired organizations). The majority of these are thought to be small health posts.”* The EPN (2005) also noted the need *“...to develop a cross-denominational overview of the Burkina Faso church health service provision and its role in the supply of health care in Burkina Faso.”* Nevertheless, even if small, the role of FIIs is still significant for the communities they serve.

According to WHO (2009), there are currently 272 for-profit private health providers in Burkina Faso and a smaller number of non-profit providers. Of the non-profit institutions, approximately 60 are faith-inspired (a slightly higher number than reported by the EPN study), including 35 Catholic, 18 Protestant and seven Muslim facilities. While the faith-inspired facilities operate in most cases independently from the government, they are integrated within the national health system and receive various forms of support, in material resources (e.g. vaccines, mosquito nets) as well as human resources (e.g. training of personnel and salaries for a limited number of government health workers). They are also subject to quarterly inspections from district health officials. Some faith-inspired facilities are large as is the case for Christian hospitals in the capital city of Ouagadougou. But the majority of facilities tend to be smaller clinics and hospitals often serving rural populations or populations in unincorporated urban areas. These facilities may have the status of a CSPS (*Centre de Santé et de Promotion Sociale*), the first-line health facilities responsible for providing basic outpatient, maternity and pharmacy services, or a medical center with operating capability (CMA, *Centre Médical avec Antenne Chirurgicale*).

The objective of this paper is to assess the factors that lead households to rely on faith-inspired providers in Burkina Faso, and how they see the performance of those providers (see also Wodon, 2013, on the context for the study). The paper is structured in three sections. In section 2, we discuss how households chose between traditional as opposed to modern health providers. The analysis suggests an overall preference for modern care

among households, but many still rely on traditional healers for specific health issues. Next, in section 3, we look at how households choose among modern providers between faith-inspired as opposed to public health facilities. The results show that faith-inspired facilities are perceived as providing higher quality services at a lower cost than public facilities. Finally, in section 4, we discuss briefly how the users of facilities see the issues of proselytism and family planning.

The analysis is based for the most part on qualitative data collected in 2010 in two areas in Burkina Faso (one rural, one urban). A semi-structured questionnaire was used to interview 48 patients in three rural and three urban faith-inspired facilities (eight client interviews in each facility)⁷. Two of the clinics were Catholic, two Protestant, and two Islamic, and the selection of patients for the interview was made to also ensure diversity of faith affiliations. The questions focused on patients' views and motivations concerning healthcare, their evaluation of the faith-inspired health centers and the comparison with their experiences in public centers. Interviews were conducted by a Burkina Faso based research team in French and local languages. Semi-structured interviews were also conducted with clinic leaders, and in addition 24 focus groups were held in both rural and urban areas. Finally, to set the stage, Section 2 also includes a brief analysis of part of the health module of the nationally representative 2007 QUIBB (in French: 'Questionnaire Unifié des Indicateurs de Base du Bien-être') survey.

SEEKING CARE AND CHOOSING BETWEEN MODERN AND TRADITIONAL PROVIDERS

Any discussion of health care provider choices in Burkina Faso must mention the coexistence of multiple care modalities that characterize health seeking in this country as in many other parts of sub-Saharan Africa (Schmid et al 2008, Korling 2005). Traditional medicine remains an important alternative mode of care in Burkina Faso and a pluralistic approach to health prevails, with several different types of care existing side by side, and patients often relying on multiple sources of care. Household decision making in health is shaped by religious and cultural beliefs as well as social and circumstantial factors related to the illness. A particular modality may be used alone or in combination with other approaches. Many of the respondents in our fieldwork described this eclectic approach. For example, one leader in a Catholic clinic stated: "*What one notices more and more is not a rejection of modern care but its association with other types of traditional care.*" In order to discuss the decision by individuals and households to seek care and the choice made between modern and traditional providers, we start in this section by providing context through basic statistics about the type of care that patients rely on based on the nationally representative 2007 QUIBB survey. Thereafter, findings from the qualitative fieldwork are presented to better explain what drives patients to rely on modern or traditional care providers.

⁷ This is admittedly a small sample size, but we were more interested in in-depth analysis than statistical representativeness. Because assessments of facilities by respondents were converging to a very large extent, we are confident in the findings obtained from the interviews.

Basic statistics from the national QUIBB survey

The health module of the 2007 QUIBB survey asks for each household member whether the person was sick or injured in the last 15 days, and what sort of sickness/injury the person suffered from. Ten types of illnesses and injuries are identified: Fever/malaria; Diarrhea; Accident; Dental problem; Skin problem; Eye problem; Stomach pain; Coughing; Ear/nose/throat problem; and others. It can be shown that fever/malaria is the most common type of illness, affecting close to half of the population, but eye problems appear to be very frequent as well, which is a bit surprising. Other illnesses or injuries frequently reported include stomach pain and coughing. Diarrhea has a smaller incidence among the population as a whole, but it affects small children substantially. The data also suggests that there are few differences in reported incidence of illnesses between urban and rural areas, as well as between quintiles of well-being based on an index of asset wealth, but it must be kept in mind that this is self-reported, and it could be that the threshold to report an incident may be higher for the poor.

What is more important for the purpose of this paper is whether individuals seek care when ill or injured. Table 1 shows the extent to which this is the case. Slightly less than two thirds of those ill or injured (62.4 percent) consulted with a health service provider of any type. Economic status was an important factor in the decision to seek care, since only 53.1 percent of those in the lowest quintile had a consultation, compared to 70.7 percent in the top quintile. Low utilization of health sector services is thus a widespread problem that has received a significant amount of attention in Burkina Faso. For example, De Allegri et al (2010) analyze women's utilization of prenatal and childbirth services after the implementation of policies to reduce user fees for these services. They show improvements in utilization rates but also considerable variability across religion and ethnicity. The authors suggest the need for further research to understand the reasons for continued avoidance of formal healthcare services. They state that the quality of maternal care services "*may shape women's decision to use ANC and to seek skilled attendance at birth... Beyond the equipment and the staff available, important differences in quality of care persist depending on the motivation and attitude of the single providers.*" In other research, Mugisha et al (2004) looked at the problem of initiation and retention in the area of formal health services in Burkina Faso. They found that while many commonly cited factors influence initiation of the demand for services (these factors include income level, education, urban residence, etc.), the only predictor of retention is the perceived quality of care. Nikiema et al (2010) examined the low utilization rate of antenatal care in Burkina Faso and found that low quality of care may be the main reason for this problem.⁸ As will be discussed in the next section, it is probably because of the perceived quality of care that they provide that faith-inspired facilities are found to be preferred by households when seeking care.

⁸ The quality of care concerns discussed by these researchers are similar to those discussed in this paper and include communication issues, time available for consultations, and quality of information provided to patients during consultations, among others (see also work by Korling 2005 on public health services in Niger.)

Table 1: Decision to seek care and place of consultation in last 15 days, 2007 (%)

	Sex		Residence		Well-being – Quintiles					All
	Male	Female	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Decision to seek care										
Whole population	5.9	6.6	9.3	5.6	4.4	5.1	6.1	6.6	9.1	6.2
Population sick/injured	62.9	62.0	65.4	61.4	53.1	56.6	61.2	65.9	70.7	62.4
Type of provider										
Traditional/Marabout	14.8	11.7	4.8	16.1	18.8	21.5	18.0	7.8	6.3	13.1
Private doctor/pharm.	3.5	3.8	11.3	0.9	0.7	1.3	1.6	2.5	8.5	3.6
Nurse, ‘sage-femme’	1.7	3.6	4.4	2.2	2.4	0.6	1.7	3.3	4.3	2.7
National hospital	2.7	1.9	6.9	0.6	0.6	0.0	0.6	1.9	5.7	2.3
Regional hospital	3.8	3.6	8.9	1.9	2.5	1.8	3.7	2.9	5.9	3.7
CMA/CM	14.0	15.2	25.6	10.8	10.1	8.9	10.8	18.4	20.1	14.7
CSPS	56.0	56.1	28.2	65.9	63.5	64.1	62.6	59.9	40.9	56.1
Private Cabinet/NGO	3.2	3.6	9.2	1.4	0.9	1.3	0.7	3.3	7.7	3.4
Traditional ‘matronne’	0.1	0.2	0.1	0.2	0.0	0.5	0.1	0.0	0.2	0.1
Other	0.2	0.3	0.6	0.1	0.5	0.0	0.1	0.0	0.5	0.2
All	100	100	100	100	100	100	100	100	100	100

Source: Authors’ estimates using 2007 QUIBB survey.

While the QUIBB survey questionnaire does not identify separately faith-inspired health care providers, information on the type of facility used for consultation is available. Table 1 shows that 56.1 percent of those who had a consultation in the past 15 days visited a CSPS, 14.7 percent went to a CMA and 13.1 percent visited a traditional healer or marabout. Formal healthcare options are thus more popular than traditional forms of care. We will discuss in much more detail the factors that lead to the choice of care between Western-style medicine and traditional healers in the next section using our qualitative fieldwork data.

What about the satisfaction with the services received? Table 2 suggests that satisfaction with private doctors and pharmacies, as well as nurses and sage-femmes tends to be very high, but is lower with (mostly public) national and regional hospitals, CMAs/CMs, and CPSPs, and indeed also private cabinets and NGOs. The lowest satisfaction rate is that for regional hospitals, at 68.8 percent. Importantly, satisfaction tends to be lower among the poor than among better off individuals. Although in some cases the sample sizes are small, this suggests that there may be issues with the quality of the services provided in many public facilities, both large and small.

Table 2: Satisfaction with the services received for formal providers, 2007 (%)

	Sex		Residence		Well-being - Quintiles					All
	Male	Female	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Private doctor/pharm.	96.1	90.4	91.3	100.0	100.0	84.1	81.7	95.8	94.2	92.9
Nurse, sage-femme	83.7	100.0	98.2	93.3	100.0	100.0	100.0	84.6	98.4	95.3
National hospital	69.9	88.0	78.6	75.0	-	-	100.0	73.6	81.2	77.9
Regional hospital	64.7	72.5	69.4	67.8	58.1	80.3	71.7	69.6	67.6	68.8
CMA/CM	77.3	76.9	78.6	75.8	72.4	73.5	78.1	71.3	82.6	77.1
CSPS	79.9	81.2	72.3	81.9	74.2	84.0	79.2	77.8	86.9	80.6
Private Cabinet/NGO	89.0	75.9	79.9	85.4	22.7	100.0	78.3	83.7	82.8	81.6

Source: Authors’ estimates using 2007 QUIBB survey.

To sum up, three main conclusions emerge from this brief analysis of the QUIBB survey. First, cost seems to be an important barrier to care, given that the probability of seeking care when injured is significantly lower among the poor. Second, individuals tend to choose formal providers of care for treatment, although traditional forms of care remain present. Third satisfaction with the main public facilities such as regional hospitals, CMAs and CSPS tends to be lower than with other formal care providers. In what follows, we explore these issues in more detail using results from the qualitative fieldwork conducted in 2010. We start in the rest of this section with the decision to seek care and the choice between formal and traditional providers, and continue in the next section with the comparison of faith-inspired and public facilities.

Results from fieldwork

The plurality of options for care appears clearly in our qualitative fieldwork. The sample may suffer from a slight bias toward formal health care since the study was clinic-based. But even then, the role of traditional providers emerges clearly. When asked about their choice of providers, respondents suggested that formal providers were most popular with all respondents (100 percent) ranking nurses as one of the top three health practitioners they most often consult when ill. But this was then followed by traditional healers/marabouts (52.1 percent), herbalists (37.5 percent) and doctors (35.4 percent). A second question asked respondents to list the type of care that they would pursue if treatment in faith-inspired facilities was not successful. Almost all (95.8 percent) said that they would pursue treatment in a secular clinic/hospital (the vast majority of providers in Burkina Faso) while 68.8 percent said that they would visit a traditional healer. Other common answers were informal drug merchant (39.6 percent), another faith-inspired provider (39.6 percent), herbalist (35.4 percent), and pharmacist (29.2 percent).

What about perceptions of quality or efficacy? When we asked respondents how they would evaluate the efficacy of different types of care, modern care was viewed as the most effective, followed by botanical medicine, traditional healers and spiritual healing practices (table 3). While Western health care approaches are seen as the most effective, the respondents have a high regard for botanical medicine and traditional healers. There was little difference here between urban and rural respondents and urban respondents were only slightly less likely to view traditional healers as very or somewhat effective (66.7 percent compared to 79.2 percent).

Table 3: Perceived effectiveness of different healthcare approaches (%)

	Very effective	Somewhat effective	Neutral	Not very effective	Not at all effective
Modern medicine	85.4	14.6	0	0	0
Botanical medicine	62.5	37.5	0	0	0
Traditional healer	33.3	39.6	20.8	6.3	0
Spiritual healing (e.g. prayer)	35.4	22.9	37.5	4.2	0

Question: What is the degree of efficacy of the following approaches in improving a patients' health?

Source: Authors.

A more notable divergence between urban and rural areas was however found when respondents were asked whose opinion they most trusted – a doctor or a healer. Here, all of the urban respondents said they would be more likely to trust the opinion of a doctor,

compared to slightly more than half of rural respondents. Rural respondents said that they were ‘unsure’ whose opinion they would be more likely to trust (table 4).

Table 4: Choice of Advice to Follow between Western and Traditional Medicine (%)

	Urban	Rural	Total
Traditional healer	0	4.2	2.1
Doctor	100.0	54.2	77.1
Don’t know	0	41.7	20.8
Total	100	100	100

Question: If a doctor and a traditional healer gave you contradictory advice for the same health problem, whose advice would you choose to follow?

Source: Authors.

Table 5 digs a bit deeper in the perceptions about Western and traditional medicine and shows the level of agreement with various statements relating to health care choices. Again, while there is a preference for Western medicine, few respondents see traditional healers as ineffective (only 16.7 percent overall), and over 90 percent state that there are some problems that can only be treated by a healer. Perceptions are similar for urban and rural respondents and for Muslim and Christian respondents as well. Rural respondents were slightly more wary of health problems caused by Western medical treatments and a third (versus 12.5 percent in urban areas) agreed with the statement that modern medicine endangers community health. In addition, about one fifth of respondents had a fatalistic view toward illness, stating that medical advice is not helpful.

In the in-depth interviews, when we asked respondents whether the use of traditional medicine varies by factors such as ethnicity, gender or religion, they emphasized instead a pluralistic approach that is widespread among the population and involves a large degree of consensus and conscious decision making. The following three quotations (by Christian respondents) illustrate this approach: *“Those who consult a traditional healer are not a particular social group. It is everyone – even myself. We go there for those diseases which, through experience, we’ve learned cannot be treated at the hospital. We know our diseases and for which ones we should go to the hospital. For example, malaria, diarrhea, treatment of wounds, cholera, meningitis, vomiting, coughs, and colds – the hospital can treat all of those”* (patient, Protestant clinic); *“This CSPS has existed for decades... Its utility is known, and its services are useful in saving lives and improving our health. However, it is better to look at health problems on a case-by-case basis. There are those for which modern drugs are effective and those which are best treated by traditional healers. We have come to use all the various services, modern and traditional, because God gave a little of his science to each and, according to the illness, it is necessary to try the different possibilities. We say that someone who is ill doesn’t know ‘to which saint they should devote themselves’ (in French: ‘à quel saint se vouer’)”* (patient, Protestant clinic); *“For issues concerning health, all types of approaches are accepted in order to resolve the problem. You can see that even on television and radio, they speak about traditional healers. The healers have their own knowledge and their drugs are effective”* (patient, Catholic religion).

Table 5: Perceptions about Western and Traditional Medicine

Respondent category	Totally agree or agree	Neutral	Disagree or totally disagree
Treatment in this hospital/clinic is better than that of traditional healers			
Urban	87.5	0	12.5
Rural	75.0	6.3	18.8
Christian	80.8	3.9	15.4
Muslim	73.7	10.5	15.8
Total	75.0	6.5	18.8
Traditional healing has no effect			
Urban	12.5	12.5	75.0
Rural	20.8	4.2	70.8
Christian	26.8	7.7	61.5
Muslim	5.3	10.5	84.2
Total	16.7	8.3	72.9
There are some health problems that only traditional healers can cure			
Urban	87.5	0	12.5
Rural	95.8	0	4.2
Christian	92.3	0	7.7
Muslim	94.7	0	5.3
Total	91.7	0	8.3
Modern medicine endangers the health of the community			
Urban	12.5	4.2	83.3
Rural	33.3	4.2	62.5
Christian	26.9	0	73.1
Muslim	21.1	10.5	68.4
Total	22.9	4.2	72.9
The advice of health professionals cannot help prevent disease because health/illness are not under human control			
Urban	20.8	8.3	70.8
Rural	25.0	4.2	70.8
Christian	26.9	3.9	69.2
Muslim	33.3	0	66.7
Total	22.9	6.3	70.8

Source: Authors.

Certain illnesses were listed by respondents as particularly suited to treatment by healers such as marabouts, diviners (*fetichers*), and herbalists rather than through Western medicine. These included mental health problems, sexual dysfunction and infertility, skin problems, genital infections, fractures, hernia, hemorrhoids, jaundice, and poisonings. As suggested by Shaikh and Hatcher (2004), health seeking behavior is often complex, and *“traditional beliefs tend to be intertwined with peculiarities of the illness itself and a variety of circumstantial and social factors.”* We found ample evidence of this complexity as respondents described the varied health care choices they make. Several Christian health center administrators also described working with healers in order to streamline care for their patients, in recognition of the significant role of traditional medicine. Most often the collaborators are herbalists or those traditional healers who are well known and respected: *“There are healers with whom we collaborate. They refer patients to us and we also refer patients to them. We complement each other. But as for the healers who perform evil acts of sorcery...we don’t work with them and we advise patients not to consult them”* (administrator, Protestant clinic). *“I believe that they often do good work. Although we are medical professionals, we sometimes also go there to*

consult them. One example is the health issues of the children – diarrhea is not well treated through modern drugs, but with herbal teas and decoctions, they can quickly be cured” (nurse, Muslim clinic).

Although the religious leaders, including Muslim, Christian and Protestant do not promote belief in the healing power of ancestors and spirits, there did not seem to be a lot of controversy around these practices in the centers we visited. The healers have strong support from the communities and have a widely accepted approach to healthcare. Rather than co-opt the idea of ‘traditional healing’ and define it in biomedical terms as is sometimes the case, health center personnel expressed a tentative acceptance of healers and their practices, though as shown in the first quote above, there are limits to this tolerance. The patients who we interviewed did not make such distinctions between types of healers; the only healers which are avoided are those known to be ‘swindlers’ with high prices for services. The respondents often distinguish between traditional healers who are ‘charlatans’ or ‘swindlers’ and influenced mainly by material gain and ‘true healers’ who perform their services for free or for small fees. Herbalists are also very popular.

When we asked respondents about Christian and Muslim religious leaders’ views concerning traditional healers, as well as about the spiritual nature of religious healers, we were given the following responses that suggest a somewhat harmonious cohabitation with few problems: *“The true healers are religious and believe in God who has given them the power of healing. They are in service for the good of the community” (patient, Protestant religion). “Their role is much appreciated. Since long ago, we have owed our health and well-being to them. However, the religious leaders advise us to go only to the good healers because some are only involved in a business activity. Whereas the true healers are like the personnel of this CSPS - they are not running a business, they want just to save lives” (patient, Muslim religion). “Most of the religious leaders get along with and appreciate [the traditional healers]. But there are certain religious leaders among the Christians and Moslems who prohibit their followers from visiting them...But overall, the populations visit them without the interference of the religious leaders” (administrator, Muslim religion). “Generally the traditional healers are our customary leaders, therefore they are very influential in our village. The religious leaders do not have a problem with this and they often benefit from the care. We are a community, we have our traditions and religion does not divide us” (patient, Catholic religion). “Unlike the new wave of swindler-healers, the true healers are very respected in the community. We know their importance, their utility, and the religious leaders are among their patients” (patient, Catholic religion).*

Still, healers treat illnesses in ways that for some in the medical profession are less effective than Western approaches. One example is that of bonesetting, where health center administrators are concerned with potentially harmful infections and express a preference for those healers who ‘negotiate’ with Western medicine, for example by enabling staff to take and look at x-rays. As one nurse explained it: *“For anything related to a fracture, people do not attend the clinic.... What is better is when the healers go to [the CMA] where they negotiate by having an x-ray. They combine both. When the x-ray*

is made, they will look at it, treat it traditionally, and then come back two months later for a follow-up x-ray” (nurse, Protestant clinic). However, in some cases, the popularity of traditional approaches to health care can be problematic as some individuals simply avoid being treated at health centers - even when they offer high quality and affordable care.

Some of the factors affecting health center attendance more generally in Burkina Faso, such as education, economic status, and distance also matter. Our qualitative research suggests that one group with lower rates of attendance is that of men. Many men explained that the faith-inspired centers are “*for women and children.*” The following comment from a male respondents illustrates this attitude: “*The majority of the modern treatments help the women and children. We, the men, have our own practices using traditional medicine – plants. We find it more effective. This is especially true for a farmer. These are essential medicines for him that can reinvigorate him quickly and for a long period. If he becomes accustomed to the tablets and injections, he will be hospitalized all the time, his storehouse will always be empty, and he will meet with famine.*” At the same time, other men are aware that such attitudes are problematic: “*It is when the disease forces you to lie down that you start to take precautions...Here we like to say that a true man can’t be hospitalized. The man must be able to endure disease and hunger. He must overcome them or die. One likes to say of a man who is morbid that he did not receive anything from his ancestors – he is without protection...He can consult a healer discreetly and follow the treatment without the village being alerted. But as soon as you frequent the health center, everyone knows that so-and-so is sick...[However] the men should be made more aware of this clinic and encouraged to have consultations.*” The reluctance of some men to access services at these health centers is important in the care and prevention of disease for half of the population and may not be evident due to the greater focus on the more well-known barriers affecting women’s care. In the case of faith-inspired clinics where more women are now attending, some of the inherent gender biases affecting men’s health become more obvious.⁹

Another example of lower attendance at the faith-inspired centers is that of conservative Muslim men and women. Several individuals stated that men belonging to the Wahhabi movement may sometimes prevent their wives from attending Christian health centers, even if they have few other affordable options. One woman attending a Catholic clinic stated: “*Often our husbands do not like us to come to this center if they are Wahhabi. They don’t like to see the sisters living like that, without marrying and they think that they will speak to us about their religion...It is said that life came before the religion. If my religious values could provide my care, I would not come to this center, but it is the center which provides relief. I am allowed to pray here. When I’m in the center and it is time for prayer, I make ablutions and pray without a problem. I already explained that to my husband, but there are certain men who still oppose that their wives attend the center although they do not have the means to go to [CMA].*”

⁹ For a fuller understanding of the gender boundaries that prevent men from accessing health services, queuing up with women for these services, and accompanying wives on reproductive health visits, see work by Bila and Egrot et al (2009).

Respondents pointed out that some Muslim women are required to be accompanied by their husbands when they visit health facilities (but this depends on the man's willingness to go and availability). There are also problems in regard to prenatal care and childbirth, since many obstetricians and gynecologists are male and there are proscriptions against women receiving this type of care from men. This is illustrated by the following quotes from Muslim women: *"In our area, the CSPS has sent a man to provide maternity services, and after that the center was no longer well attended. We prefer to give birth in the village. Maternity services are the work of women; it is not good for a man to deliver a woman"; "It is mainly the Wahhabi women who cannot remove their clothes except in front of their husband or if they are being consulted by a birth attendant/midwife"; "The problem is mainly at the CMA, because in the maternity wards at the hospitals, we must deal mainly with men. It is not part of our practices for a man who is not your husband to ask you to remove your clothes."* This avoidance of childbirth services did not occur at the faith-inspired health centers we visited, since all have women personnel in maternity wards. But this does not mean that some do not avoid the centers due to religious beliefs and values.

Another issue is the low utilization of certain services. One of our respondents declared, *"Whites cannot treat certain illnesses"* and many held the view that certain Western approaches are inferior to traditional care. We already gave the example of bone setting, but another commonly mentioned example was the treatment for jaundice. Similar issues were reported at the various centers although the particular illnesses varied, depending on local context. Personnel at all of the centers described cases where they felt effective services were avoided. One key issue was the avoidance of vaccines. The following two quotations illustrate two opposing views on this topic: *"There are people who do not believe in the effectiveness of certain drugs. Let us take the case of vaccination... We always have low levels of realization in tetanus vaccinations because there are people who tell women that it will make them sterile. There is a need to sensitize people about the advantages of modern care and especially vaccinations"* (clinic administrator); *"It is the utility of a preventative medication which we don't understand – why it is necessary to search everywhere for someone who is healthy in order to administer a vaccine... But what causes the most controversy is the fact that the preventative care brings illness. That is what happens to our children. When the health workers visit to give them strange medicines, the children start to vomit and to have a fever"* (male patient).

Religious and cultural beliefs about health and disease were often mentioned here, especially regarding the idea that vaccination can weaken natural immunities and make a person more rather than less vulnerable to future illness. Some said that vaccination is also thought to weaken the strength of traditional medicines against disease. There are taboos around vaccination as well. For example, clinic personnel in one village described how their vaccination campaigns had to account for the fact that those women living to the west of the vaccination site would not bring their children for vaccination. These beliefs with linkages to traditional religion are intertwined with rumors about sterilization campaigns surreptitiously carried out through the vaccination of children. One Muslim respondent stated: *"Among Muslims, some like to hide our children so that they do not*

receive their drugs against polio because it is said that the Whites want to decrease our capacity to procreate. By taking these products, one will not be able to make many children.” Polio vaccinations were said to be the most controversial, because of the side effects experienced by some children who are vaccinated. However, all vaccination campaigns were seen by health center administrators to be a difficult and time consuming process.

CHOICE BETWEEN PUBLIC AND FAITH-INSPIRED PROVIDERS

In the previous section, we looked at attitudes towards modern and traditional care providers, as well as some of the concerns that remain about Western medicine. In this section, we focus on the choice of modern care provider for those who choose to rely on such services. That is, once households have decided to seek care in formal Western-type facilities, we ask: what are the reasons for using faith-inspired services and the perception of those services as compared to public health care options? Several questions in the qualitative fieldwork aimed at understanding the perceived advantages of faith-inspired health centers at both the individual and community level, and the ways in which faith-inspired care stood apart from care provided by the public sector. We consider first the perceived advantages of faith-inspired providers at the individual level, and next the advantages that the presence of a faith-inspired facility may bring to a community.

Advantages of faith-inspired providers for individuals

Table 6 suggests that the most important advantage of faith-inspired health providers for those who use them is the lower treatment cost (mentioned by 87.5 percent of respondents), followed by the good relationships between personnel and patients (60.4 percent), and the overall quality of care (31.3 percent). Smaller proportions of respondents identified other advantages including the religious affiliation of the center (14.6 percent), the inclusion of spiritual healing practices (12.5 percent), the availability of infant and children’s health and nutrition programs (10.4 percent), convenient location (10.4 percent), and the superior skills of personnel (8.3 percent). When asked to make a comparison with public health centers, respondents again focused on cost and quality with 54.2 percent saying that a major difference between the two types of providers is cost, 72.9 percent noting the good relationships with personnel, and 27.1 percent mentioning the overall quality of care. Another 18.8 percent of respondents noted the accountability of personnel in faith-inspired centers, especially regarding fair pricing practices.

Table 6: Advantages of faith-inspired healthcare for the patient (%)

	Faith-inspired healthcare – advantages for individuals	Faith-inspired healthcare – comparison with public sector
Lower costs of treatment	87.5	54.2
Good relationship between personnel and patients	60.4	72.9
Quality of treatment – general	31.3	27.1
Religion – general	14.6	14.6
Religion – spiritual healing	12.5	8.3
Location	10.4	4.2
Infant/child health programs	10.4	6.2
Personnel skilled	8.3	10.4
Accountability	8.3	18.8

Note: Multiple answers allowed. First question: What are the advantages of faith-inspired clinics/hospitals for patients, when compared to public clinics/hospitals? Second question: How would you compare your experience in this clinic/hospital with your experience in public clinics/hospitals in this area?

Source: Authors.

The issue of cost is both very important for the population, and complex to understand because faith-inspired facilities typically benefit less than public facilities from funding from the Ministry of Health. What enables faith-inspired facilities to be low cost must therefore be related to additional funding or support that the facilities receive from other sources. The advantage of being low cost, and what makes this financially sustainable are discussed in a companion paper by the authors (Gemignani and Wodon 2012). In what follows, we focus on the apparently higher quality of services provided by faith-inspired facilities, as compared to public facilities.

In making comparisons with public facilities, respondents referred to both public hospitals (CMA) and clinics (CSPS). Respondents emphasized that while they may have a CSPS closer to their home, they still prefer to travel longer distances to the faith-inspired provider. This was due to both cost and quality, as table 6 attests. Two respondents stated, *“We have a CSPS in [town], but we travel 17 km to come here because we know that we will have better information about our illness and we won’t need to pay for expensive medications.”*; *“We have a CSPS in [town] but the head nurse is never there since he’s always in displacement to the city. When I learned about this religious center, I brought all my family members here because I have the guarantee that we will be well accommodated and our means will enable us to look after ourselves.”*

Patients were highly satisfied with the services offered at the faith-inspired health centers. They made heartfelt statements about the care at the centers and the benefits to their well-being. One man visiting a Catholic clinic stated: *“It is said that when you take shelter in the shade of a tree after a long walk under the sun, you realize the utility of the tree and the fact that God sustains you by providing you with such conveniences. It is similar when you are sick and meet somebody who can really care for you. You see them like a savior. For us, this center is an invaluable treasure.”* One of the aspects of care most often mentioned and appreciated was the worker-patient relationship. Communication is seen as central to the respondents’ views of quality services – being able to understand the health worker and in turn, to be listened to and understood, came up many times. Patients appreciate that staff at faith-inspired facilities do spend the time needed for

patients to be seen and listened to. The style of communication is a large part of this as is the issue of language. Respondents appreciated the fact that personnel in the faith-inspired centers often have at least a working knowledge of the local language, whereas this was sometimes absent from the public health facilities, especially the larger hospitals. *“[At the CMA]...time for the consultation is very short. From the first words, the health worker believes they understand the problem and writes an ordinance. Here, one is welcomed, has time to explain the reason for the visit, and is listened to closely”* (male patient, Catholic clinic).

Communication matters in general in terms of setting the tone in the health center: *“When you attend this health center, what you notice immediately is a certain aspect which reminds you of the village. You see people moving about, entering and leaving, greeting and exchanging news. The director for example when not in his office is always surrounded by people conversing with him. There is really a community life where everyone knows one another”* (male patient, Protestant clinic). But it also matters at a very practical level, for example through the ability of personnel to communicate in local languages: *“These private clinics are closer to the communities and more accessible because they are generally located inside the communities and the personnel are very motivated and friendly...The religious aspect of these private clinics attracts the community and creates trust because people feel great confidence in all that is attached to God and religion. The fact that the personnel are welcoming and speak the local language creates bonds of friendship and fraternity and fosters good communication between the patients and the workers”* (female patient, Muslim clinic).

The fact that the facilities are run at the community level, and that trust exists with the population, is also important, *“Since the time of my first childbirth, I’ve come here for the weighing and the care of my children. The hospital is very close and I know most of the midwives and nurses who work here. There is familiarity and a good atmosphere...I trust the midwife who is kind and experienced. I believe this woman can help me and can look after me when I suffer from health problems”* (female patient, Muslim clinic). Staffs at faith-inspired facilities are seen as more dedicated, for example in terms of a higher likelihood of actually be present in the facility, even late at night: *“At [CSPS], to which I have easy access, I’ve noticed a regular absence of the nurses in their stations, in addition to their indifference toward the suffering of a patient, even if it is a child. On the other hand, here... the reception is already proof that the worker who receives you is completely prepared to treat you. Also, the diagnosis is explained simply so that you are able to understand your illness. They explain everything to you, whereas at [CSPS], they can give you an ordinance without saying one word about your illness”* (male patient, Protestant clinic); *“Even late at night, a member of the community has access to this center for care in the event of disease; the personnel are available 24 hours a day. I often have the impression that it is our village which set up the center and those which work there are members of our community. There are no barriers”* (male patient, Catholic clinic).

The literature on faith-inspired services often makes reference to the compassion and holistic nature of the care provided, as well as the respect with which patients are

attended to. In all the centers, respondents emphasized the open, trusting, and respectful environment, at times in contrast with public health facilities. A number of respondents explained the difference by describing how patients may be yelled at or scolded in public clinics and hospitals. The frequency and severity of these reprimands were seen as offensive and in stark contrast to the more patient-centered environment of faith-inspired care. *“There is compassion and pity for patients, especially for those patients who have no resources to pay for this care. Medicine is provided, but also counseling about the illness. This allows us to sleep better at night, because we feel reassured.”* (male patient, Protestant clinic); *“I have attended this center for more than 30 years and I have never heard of a case of death related to the negligence of the personnel. I have never seen a worker at this center shouting at a patient. Even if the worker is tired, they make themselves available to the patient. All of those who work here are notable for their singular desire to serve, help, and relieve the patients”* (male patient, Protestant clinic); *“When you are received, you are listened to closely, informed about your illness, and advised about your treatment, and you remember this person who consulted you, her seriousness and interest for the work that she does and the effect of her actions on the recipient. One feels in this sister the will to overcome illness when it is found in the body of another... Human warmth is very present in this center. There is a true closeness between the patients and the sister and her colleagues. One is spoken to, touched and accepted. This human warmth does not exist at [CMA], only distance and rejection...”* (male patient, Catholic patient); *“In the sisters’ center, one is accommodated well and treated respectfully...A patient has the opportunity to converse with the health worker, describing the illness, and when s/he is mistaken or does not understand well, s/he is not threatened. The health personnel helps us to locate the pain and explains everything about the disease and how to treat it. When one is timid, they encourage us to speak and they try to give us confidence”* (male patient, Catholic clinic).

Some respondents went further to describe the marginalization of the poor that may take place in some public health centers, and related this to the lack of ability of the poor to pay the costs of care. Recounting prior experiences, respondents felt that those without resources are likely to be neglected in some public institutions and unable to receive quality care. *“Elsewhere, especially at [CMA], I often see the personnel shouting at the patients and ridiculing them”* (male patient, Muslim clinic); *“At the CMA, they do not have patience. Even with adults, they are not obstructed from threatening and shouting”* (female patient, Catholic clinic); *“In [CMA], when someone is not agreement with something they say it openly and often in an excessive way”* (male patient, Catholic clinic); *“I have four children... I had to give birth in a secular CSPS and there I suffered a lot... I have a bad memory of these places not only because of my suffering, but the midwives also shouted at me. Since that experience, I decided to leave that place and I discovered this medical center”* (female patient, Muslim clinic); *“Here the midwife chats with everyone and there is no barrier between the patients and the nurses.... It is not the case in certain secular hospitals such as [CMA], where the personnel are unpleasant and always have a stern expression. The midwives insult and shout at the expectant mother. Even those who need to give birth are abused and insulted. When I was pregnant with my second child, I was insulted by a midwife. That day I waited 3 hours and the midwife didn’t want to receive me and, when I entered her office, she told me that she did not*

authorize me to enter and began to insult me. The personnel of these hospitals are not at all welcoming with the patients” (female patient, Muslim clinic); “When I come here I feel more at ease because the nurses are kind. They are also Muslims and they fear God....Whereas elsewhere, especially in the CSPS, the patients are neglected and sometimes maltreated. If you are poor and have no money you don’t count; you are marginalized and scorned” (female patient, Muslim clinic); “If you are poor, it is necessary to know someone to be well accommodated and to have a consultation. If not, you are completely ignored. People pass and pass by again. No one is concerned about your problem... For this reason, we thank God all the time for having given us this center, Before this center, one could easily die of a small disease for lack of care since one must have means to receive care at the CMA” (female patient, Catholic clinic).

For health center administrators, fostering a positive relationship with patients is a priority in the provision of services. For some, like religious sisters, empathy, understanding and consideration is part of their own personal approach that they bring to their position. Others describe learning this approach on the job: *“Compared to my experience in the other CSPS, I can say that here the patient is king because time that one grants to him for the consultation is relatively long...There is a gift of oneself, an availability of the personnel. I will admit that when I came to this center, I was reformed in regard to my level of conscientiousness. The sister always reminds us that we are here to save lives. It is necessary to try our best, because it is not our fault if we fail but it is our fault and it is even a crime if we don’t try our best... It is here at this clinic that another kind of training took place in my young career. Instead of just managing a patient’s care, it is necessary to show compassion, love, and tenderness. This is 50 percent of the cure” (male nurse in Catholic clinic). This special relationship and attention may also help to influence in a positive way the health behaviors and choices made by the patients themselves: *“All of the people who work in this center are much appreciated. That is why it why the sisters can influence us; it is because we have respect for them and not fear” (male patient, Catholic clinic).**

Advantages of faith-inspired providers for the community

Respondents were also asked questions as to whether faith-inspired facilities provided any special benefits for their community. As expected, some of the same answers as those observed when looking at benefits for faith-inspired individuals came up again. For example, as shown in table 7 the lower cost of treatment came up first in terms of the gains for the community of having a faith-inspired facility (mentioned by 62 percent of respondents). But other advantages identified for communities were new, such as general improvements in community health due to greater attendance (41.7 percent), improved antenatal and postnatal care (22.9 percent), availability of nutritional programs (22.9 percent) and a stronger attention by faith-inspired health care providers to social and economic issues (20.8 percent).

Table 7: Advantages of faith-inspired healthcare for the wider community (%)

Advantages	Share of respondents citing an advantage
Lower costs of treatment	62.5
Improvements in community health – general	41.7
Improved care for women and infants (antenatal and postnatal care)	22.9
Nutritional programs	22.9
Attention to socioeconomic problems	20.8

Note: Multiple answers allowed. Question: What are the advantages of faith-inspired clinics/hospitals for the local community, when compared to public clinics/hospitals?

Source: Authors.

Although many faith-inspired facilities are small, they offer a broad approach to care, providing not only outpatient services, but also follow-up care, counseling, as well as food and material aid on occasion. Many facilities are involved in community services focusing on preventative care, often working with community members to build support and reach more families in order to inform them about good health practices. At one rural Catholic clinic, these activities were described as follows: *“Today health is not just about looking after patients but also about prevention, in order to reduce the demands on the health system. We have developed advanced mobile strategies which consist in being off-site in the communities discussing health issues such as how to prevent malaria and dehydration, diseases due to lack of hygiene, and identifying children who are slipping toward severe malnutrition”* (administrator, Catholic clinic); Or, as a nurse explained it: *“To my knowledge, this is the first center in our zone to integrate social and medical care. We make home visits to follow up with the patients and to detect social cases. Some of these we refer to Action Sociale [social services]”* (nurse, Catholic clinic).

Faith-inspired services are also viewed as contributing to improvements in community health through increased use of the facilities. Even in the less remote study sites where other health care options are available, the work of the faith-inspired clinics was said to have caused a significant increase in clinic attendance: *“Previously, one was satisfied with [herbal medicine]. If the illness became very serious, that is when people sold their chickens or cereals to mobilize funds for their care. There were many cases of death during the periods of meningitis, cholera, and malaria. But now, since the center came, the health of the poor has improved. Our children receive immunizations because we regularly attend the center and the sisters show us how to take care of our children. And the men are the happiest, since they no longer have to spend money on the health care of their wives and children”* (female patient, Catholic clinic).

In their discussions of community advantages, respondents highlighted the special programs offered at faith-inspired centers for women’s and children’s health, especially maternity services and child nutrition. Such programs were said to be well-attended and seen as being of great benefit to the community: *“Most of the women in our village who have small children spend the day at the center. In the morning, the sister gives us the ingredients to make porridge, and at midday we prepare rice. We help the sisters with all their work. We sweep the courtyard and the buildings of the center, we wash the uniforms of the personnel, and in the evening we retire to the village. We train our families with the help of the sisters and their colleagues...I can say that among the women who attend*

this health clinic, no one can say today that she doesn't know the utility of breast-feeding until 6 months, or the utility of the mosquito net, or the importance of hygiene. Come to our village. If you visit the household of a woman who attends this clinic, you will see that she prepares her drinking water well, that the meals are prepared safely, there is a well-attached mosquito net, and clean children" (patient at Catholic clinic); "The real problem for our children is hunger. This is the entryway for disease... We women have noticed that since the sisters began receiving us at the center and giving milk, porridge, and rice to the children, they no longer fall ill. For me, the true vaccine is food" (patient at Catholic clinic).

In addition to facility-based care provided to women and children, it was common for respondents to mention non-facility based programs addressing issues such as reproductive health, child nutrition, hygiene, HIV/AIDS prevention, malaria prevention, and immunization. Community workshops, home visits, and other off-site activities were found in four of the six facilities visited. Again, women respondents had a very positive view of these efforts: *"I know of villages where the women are trained to help their sisters with their pregnancies. Some are even trained as midwives. They lead small workshops with groups of women to give them advice on their pregnancy, the health of the expectant mother, and the health issues of children. The center trained these women and in return, they help their sisters in the village" (Protestant clinic); "Today I know a lot about how to care for myself when I'm expecting, how to take care of a newborn, and which healthy foods a mother should prepare for her children's good physical growth. This is because the nurses explained it to me and I listened well" (Protestant clinic); "The sisters have had to work a lot on women's mentalities and we've seen that it's very beneficial, especially as it is a question of being able to give birth without dying or seeing the baby die. Before one would lose a pregnancy and link that to sorcery. But now, thanks to the work of the sisters, the pregnancy takes place without a problem, one gives birth without a problem, and the baby is healthy" (Catholic clinic); "The center distributes food provisions for the community during periods of famine, and organizes community education for the women. The sisters show us simple techniques for the care of the children for example how to prepare the pulp of mijola, how to put shea butter in the nostrils of the children during the period of meningitis, how to wet a piece of cloth and cover the child in order to lower a fever, how to use mosquito nets when putting the children to sleep...The benefits of this center for our community are priceless" (Catholic clinic); "Today everyone in the village understands that if one wants to keep their health and to be able to have the energy to farm, transport crops, and go to the market, it is necessary to sleep under a mosquito net because malaria kills many people...It is also necessary to be immunized against meningitis and to accommodate those who protect our children against polio. Nobody in our village is opposed. From this, we have our health and longevity. All of that is thanks to the activities of the sisters' health center" (Catholic clinic).*

The work of faith-inspired centers helps to reduce barriers faced by women in accessing care. Not only are costs reduced, but women are also provided with a caring and supportive environment. Special programs aimed at the specific health needs of woman and their young children are emphasized and the efforts are paying off in the large

numbers of women who rely on the centers for treatment and for ongoing guidance on preventative care. Here are two more examples of positive feelings for the services received: *“I saw children returned to life thanks to the center’s actions. It was not easy to save them because there was no flesh left on their bones...breathing was difficult. I can say that it is a rebirth for these children. The religious leaders say that it is a resurrection, and it is indeed miraculous to see today these children who walk and play. If it was at the CMA, we would have already mourned them”* (Catholic clinic); *“The maternity services here have restored to women the pleasure of giving life without suffering. There is also a center for child nutrition which has made it possible for some women to keep their children, whereas before these children died of malnutrition.”* (Protestant clinic); *“There are no women in our village who give birth without medical help... Now, all the women go to the center to give birth and there are no longer complications and deaths. Also, children who lose weight and become very thin are identified by teams of women from the center and then referred to the center to be nourished”* (Catholic clinic).

Areas of potential concern

The analysis so far suggests a higher level of performance in faith-inspired facilities than in public facilities. This does not mean however that all is well, and that there are no areas for improvement. For example, in terms of the management and capacity of the health centers, several problems were mentioned by respondents, including a lack of personnel and consequent long waiting periods. The percentages of respondents reporting various problems were as follows: long wait for treatment (54.2 percent), insufficient staff (54.2 percent), problems with facilities and equipment (20.8 percent), and lack of certain services (e.g. x-rays, blood transfusions) (31.3 percent). The problem of limited staff seemed especially acute in the Muslim centers where over 90 percent of patients complained about this problem, as compared to about a third in the Protestant and Catholic centers. Still, these problems are likely to be encountered as well in public facilities, even though we do not have data here to make this case.

Another issue is the difficulty for health centers to promote the use of family planning services. This is perhaps less due on the ground to the theological orientation of specific facilities or their affiliation to a specific faith, than to cultural and religious opposition to family planning in much the population, and especially among men (so that the difficulties in promoting family planning are also likely to be encountered in public facilities, but it is nevertheless useful to document them here). Still another issue that is much more specific to faith-inspired centers is the risk of proselytism, and how such activities, to the extent that they take place, are viewed by patients. We briefly discuss both the issue of proselytism and that of family planning in this section.

Proselytism

Is proselytism a major issue at faith-inspired facilities? Religion is to some extent part of the services offered at faith-inspired clinics and hospitals. But for the most part in the facilities surveyed, participation in religious activities is on a voluntary basis, and seen positively: *“Since the center is run by people of faith, prayer is integrated with health care. However, it is not an obligation for the patients to take part in these practices.*

Because of the testimony of certain patients who link the success of their treatment to the pastor's prayers, there are many patients who visit the pastor and this is normal because people are willing to try everything when they are ill. In our birthplace, we are taught that all types of prayer are welcome because 'it is not known in whose mouth will be found the good blessing' (Muslim respondent, Protestant clinic).

Workers at some Protestant health centers are known to discuss aspects of faith, pray for patients, or recite verses from the Bible. But religion is not of primary focus and is limited to what one leader describes as the sharing of basic 'small amounts of religious information.' Patients of all religions visit the centers and health services are focused on providing care that will be acceptable to this diverse clientele. For those patients who are interested, the faith-inspired facilities do provide a range of services from religious counseling to spiritual healing practices. As a leader at a Protestant clinic explained it: *"In each center we have a pastor who shares the word of God with groups of patients. The health workers also share their faith with the patients and we pray for the patient. Often times when a patient is cured, s/he will return to visit the pastor. We do not hide our faith from our patients but we do this only with their agreement"* (administrator, Catholic clinic). Patients' views of this approach are mostly positive. As a respondent explained: *"For 50 years I have attended this CSPS... In the time of the first missionaries, evangelization was more common. They spoke to the patient about the Lord and wanting to save his soul...but one was not obliged to accept in order have the care. It doesn't disturb me that somebody speaks to me about his religion as long as the decision rests with me. I understand the evangelization as educating men and women to have love for others"* (Muslim respondent, Protestant clinic).

Within any particular faith-inspired health center, both Muslims and Christian respondents expressed positive views about the quality of the care received. When we asked about their willingness to seek care at a clinic or hospital of a different faith than their own, almost all respondents said that the religious affiliation of the clinic was not a major concern. The decision of where to seek health care was based on issues of cost and quality, rather than religious affiliation. Many respondents also confirmed that the health centers are attended by people of all faiths and that different religious groups are made to feel welcome. As one patient at a Protestant clinic stated, *"It is health which we seek. Religious conflicts are for those who are not in the hospital, those who do not have health problems."* Similar comments were expressed by many others: *"They accommodate us like their brothers and their sisters; they are full of kindness. The center functions like a place of worship and there is no place for spite and bad intentions"* (Muslim respondent, Catholic clinic); *"The center is known and appreciated by everyone. Muslims, animists, everyone speaks about this center and the work of the sisters"* (Catholic respondent, Catholic clinic); *"At the beginning, the Muslim patients avoided this center because they thought that only the Christians were entitled to care, but now there is a great multitude. Everyone comes to be looked after here"* (Catholic respondent, Catholic clinic); *"It is true that I am a Muslim, but when I am ill, or someone in my family is ill, I do everything to get to a clinic, without taking religious affiliation into account"* (Muslim respondent, Protestant clinic); *"When I am sick I don't choose where to go as a function of my religion. I choose to go anywhere where there is healthcare and especially modern"*

healthcare...” (Catholic respondent, Protestant clinic); *“I don’t even realize there is this aspect of the center [religious affiliation]. Except for the presence of a pastor, nothing suggests that this center is run by Protestants. Even the Imams are authorized to come and pray for patients if they wish”* (Catholic respondent, Protestant clinic).

The question as to whether religion and spirituality should be a part of the care provided at the health centers elicits mixed responses. While 61.5 percent of Christians and 21.4 percent of Muslims were in favor of this, 30.8 percent of Christians and 42.1 percent of Muslims said that they would prefer not to see religion integrated with care (7.7 and 36.8 percent were undecided). In Protestant centers, where more religious activities are offered as part of care being provided, respondents were mostly tolerant but emphasized that participation should be voluntary. For example, one Muslim patient who had a positive experience in the Protestant clinic said that he saw religious proselytizing as a “minor defect” of the care offered: *“I don’t approve of having prayer in the rooms of those who are hospitalized. This is a minor defect that can be corrected, because we know that Muslims, Catholics, Protestants, Animists, everyone - can attend the medical centre for a health issue. I notice that the Protestants always have had this propensity to want involve others in their religious family.”* Furthermore, even if Muslim respondents had many good things to say about the Christian centers, we were also told that some Muslims with more conservative beliefs or views did not attend the center due to religious differences.

Family planning

A second area where concerns arise as to the ability of health centers to perform a useful function relates to family planning services. All the centers visited were engaged in family planning counseling to some extent. Catholic centers, whose focus on child malnutrition has prompted their attention to family planning, mainly promoted the rhythm method, while others offered broader options (condoms, pills, injections, implants). Some Protestant and Muslim facilities also offered counseling and workshops related to HIV/AIDS prevention and treatment. These programs were said to be controversial from the point of view of the local population however. This was especially a problem in rural areas. In the following quotations, the leaders of the three rural clinics describe the problems they are facing in providing these services: *“We are in a rural environment and birth control messages are difficult to impart. We opened [a nutritional health center] in order to help the mothers of children, not to see their children dying. Just imagine, when an infant should still be nursing, their mother is already carrying another pregnancy. Early weaning plunges the child into a state of acute malnutrition with a high risk of death”* (leader, Catholic clinic); *“Family planning messages are not listened to at all...Men do not use condoms and women are not authorized to adopt contraceptive methods. The problem of malnutrition will persist as long as planning does not become a reality. However, the subject is very delicate because it relates to intimacy among couples”* (leader, Catholic clinic); *“According to the women patients, when they return with the [birth control] pills to the house, their husbands find the pills and throw them away. The women are interested in planning because they are conscious of their sufferings, but it is the men who are opposed”* (leader, Protestant clinic).

The patients who we interviewed discussed in detail the preference for large families. Both Muslims and Catholics also described the substantive ways in which religious beliefs and practices influence opposition to family planning. During interviews and focus group sessions, men of both groups provided similar arguments that planning goes against the will of God and that to practice birth control is to challenge or deny the existence of God. Members of both of groups also described the widespread belief that promoting birth control encourages immoral sexual behavior among youth and in the broader society. Among Muslim respondents there was also strong opposition to family planning discussions initiated from outside of the community. A Muslim religious leader stated: *“One can plan according to the interests of the family. Islam does not prohibit planning if it is decided together and is in the interest of the family. But now if somebody comes from outside and comes to impose it on you, to tell you to stop the births, this is prohibited by Islam.”* In sum, the fact that family planning continues to be a very sensitive topic poses difficulties for the faith-based health centers. While the clinic and hospital personnel see it as a crucial step in achieving improved community health, there are many conflicts with social, cultural and religious realities including men’s role as decision-maker, women’s opportunities to negotiate power and prestige through childbearing, and perceptions of autonomy and self-determination.

CONCLUSION

The objective of this paper was to answer three questions. First, what are the factors that lead households to rely on traditional as opposed to modern health providers? Second, within modern providers, how do households assess the performance of faith-inspired and public facilities? Third, are there specific areas of concerns with the work of faith-inspired facilities regarding especially proselytism and family planning? The analysis suggests an overall preference for modern care even though households still rely on traditional healers. In addition, faith-inspired facilities are perceived as being of significantly higher quality (especially in the patient-health worker relationship) and cheaper than public facilities. Finally, potential concerns related to proselytism and family planning service appear not to be too serious, in that proselytism is limited, and the opposition to family planning seems much stronger in the population than in the personnel of the facilities, even if various denominations differ in their approach to the issue.

As is often the case with qualitative work, our sample for the analysis presented in this paper was small, and we could suffer from a selection bias in favor of faith-inspired facilities given that we interviewed only patients attending these facilities. Nevertheless, it appears that in the facilities that we visited, cost and cultural barriers to the use of formal health care are being addressed through efforts to create a welcoming and supportive care environment. Ways of speaking to patients, the ability to work within the local cultural context, and attention not just to disease but to a patient’s sense of wellbeing all appear to play a central role in shaping what patients ultimately view as higher quality services in faith-inspired facilities than in public facilities. Leaders across the different faith groups described this aspect of their work as a “strength” which they bring to the health care sector and recognized it as something which is valued by the

public, including the poorest members of society, and which draws patients to their services. A user of one of the facilities summarizes well these perceptions: “*I am widowed and it is thanks to this center that my children and I have access to health care. The sisters here accommodate us well. They listen to you closely, and seek to understand your health and social issues...Illness is not something you wish for, but I can say that the illnesses of my children no longer make me worry since their treatment is not a concern. It is written that the Lord never abandons the widow and the orphan. It is the sister who reminded me of this*” (female patient, Catholic clinic).

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CHAPTER 4

SATISFACTION WITH AND REASONS FOR CHOOSING FAITH-INSPIRED HEALTH CARE PROVISION IN GHANA

Mari Shoyo, Clarence Tsimpo, and Quentin Wodon¹⁰
World Bank

This paper relies on household survey data as well as qualitative fieldwork to answer two questions about the services provided by faith-inspired health care providers in Ghana: how satisfied are patients with the services received?; and why are patients choosing faith-inspired providers for care? The quantitative survey data suggests that the level of satisfaction with the services provided by faith-inspired facilities is similar to that for public facilities, but lower than for private non-religious facilities. The qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit. Indirectly this suggests that the satisfaction with and quality of services provided by faith-inspired providers may be higher than suggested by survey data. At the same time, patients mention some areas for improvement including in terms of availability of medicines and equipment.

INTRODUCTION

Faith-inspired providers of health services, many of which are affiliated with the Christian Health Association of Ghana (CHAG), play an important role in Ghana (e.g., Boateng 2006, CHAG 2008, Dieleman and Hilhorst 2009, Ghana-MoH and CHAG 2006, Olivier et al 2012, Rasheed 2009, Salisu and Prinz 2009, Makinen et al 2011, Miralles et al 2003). Anecdotal evidence suggests that the quality of faith-inspired health service providers is often higher than that encountered in government led facilities. This may be one of the reasons why the occupancy rates of faith-inspired facilities are also often higher than those of public facilities, and this is indeed the case in Ghana with the facilities federated by CHAG. Yet solid evidence is often lacking to confirm that the quality of faith-inspired services, or at least its perception among users, is indeed better.

In this paper, we use both household survey and qualitative in-depth interview data to first assess the extent to which patients are satisfied with the services provided by faith-inspired providers, and second the reasons that are invoked by patients for

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choosing faith-inspired providers of health services as compared to other providers. While CHAG plays an important role among faith-inspired providers, clinics and hospitals are also associated with Islamic organizations such as the Ahmadiyya Movement. Both Christian and Muslim facilities will be considered.

The limited existing research in Ghana on satisfaction rates with the health services received and the reasons for choosing specific providers suggests relatively few differences between various types of providers. Based on an exit poll carried at different types of facilities, Makinen et al (2011) find that the main reason for choosing public, private-for-profit, and CHAG facilities is the same: all the facilities are perceived as providing good quality care, although the proportion of patients mentioning that reason is lowest for CHAG at 41 percent, and highest for public facilities at 45 percent. The second main reason is the fact that the facility is nearest to the patient's home - this ranges from 18 percent of patients for CHAG to 26 percent for public facilities. Among other reasons, the low cost of some facilities is mentioned more often for CHAG than it is for other providers. The study also finds high and similar rates of satisfaction for the various types of providers. Yet when inquiring about the distinguishing features of various providers, low cost tends to be cited most for public facilities, while courteous service is associated with CHAG, and shorter waiting times is mentioned as an advantage of private providers.

Following up on Makinen et al (2011), this paper relies on household survey data and qualitative fieldwork to answer two questions about the services provided by faith-inspired health providers in Ghana: how satisfied are patients with the services received?; and why are patients choosing faith-inspired providers for care? Section 2 presents our data and methodology. Sections 3 and 4 provide the key results in terms both of the satisfaction with the services provided, as well as the reasons for choosing a specific facility, with a focus on Christian and Muslim clinics. The quantitative survey data suggests that the level of satisfaction with the services provided by faith-inspired facilities is similar to that for public facilities, but lower than for private non-religious facilities. The qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit. Indirectly this suggests that the satisfaction with and quality of services provided by faith-inspired providers may be higher than suggested by survey data. At the same time, patients mention some areas for improvement including in terms of availability of medicines and equipment. A brief conclusion follows.

DATA AND METHODOLOGY

This paper relies on both quantitative and qualitative data for assessing the role of faith-inspired health providers in Ghana. The quantitative evidence was obtained from the analysis of two nationally representative household surveys. The first survey is the Ghana Living Standards Survey (GLSS5) implemented in 2005-06. The GLSS is a multi-purpose household survey covering demography, health, education, employment, migration, housing, agriculture activities, non-farm self-employment, household expenditures, durable goods and, remittances and other incomes. The 2005-06 round was administered to around 36,500 individuals grouped into 8700 households. This nationwide sample is deemed representative at the level of the ten regions. The second survey is the large sample (50,000 households) 2003 Core Welfare Indicator Questionnaire (CWIQ) survey. Both surveys distinguish between faith-inspired and other types of providers when asking about care sought by individuals. The data from both surveys may appear to be a bit dated given that substantial progress has been achieved in health care provision in Ghana since the surveys were implemented, but they are still instructive in assessing the satisfaction with faith-inspired providers as well as what leads households to choose them at an aggregate level, but acknowledging the limits of multi-purpose household surveys for such work.

Given that this paper relies in part on household survey data, it is legitimate to ask whether the identification of faith-inspired providers by households in the surveys is reliable. One way to do this is to look at the market share of faith-inspired providers in the surveys, and compare it to administrative data. As discussed by Olivier and Wodon (2012), the market share of faith-inspired providers in the two surveys is fairly similar, but lower than is commonly assumed in Ghana on the basis of administrative data on the share of hospital beds or facility survey data on the consumption of pharmaceuticals that is accounted for by faith-inspired organizations. But a large part of the difference in market shares can be explained by the fact that the surveys cover virtually all of health care provision in Ghana, while data on hospital beds and pharmaceuticals are related only or principally to the services provided by hospitals, which themselves account for only a third of the total number of consultations according to the surveys. Thus, while it could be that the market share in the surveys is underestimated, this may not be as serious a problem as one might think, and Olivier and Wodon (2012) also discuss why even if there were a bias, this need necessarily not affect comparative work using these surveys on the characteristics of faith-inspired, other private and public providers.

In addition to the analysis of the CWIQ and GSSL5 surveys, qualitative research was conducted between April and June 2010 through interviews with patients (four male and four female patients at each clinic/hospital), the directors of the clinic/hospital and doctors. The providers were selected with district health officials on the basis of their being located in areas where both public and faith-inspired providers were available in order to allow patients to discuss the advantages and disadvantages of different types of providers and explain the reasons why they chose specific providers. The faith-inspired providers contacted

for the qualitative field work can themselves be categorized in two groups: Christian and Islamic. Due to limited resources, only patients and staffs from faith-inspired clinics/hospitals were interviewed. Table 1 provides basic data on the six clinics/hospitals selected for the qualitative study. The clinics/hospitals A-1 to A-4 are managed by Christian organizations; those labeled B-1 and B-2 are managed by Islamic organizations. Of the four Christian clinics/hospitals, three belong to CHAG. In Islamic clinics, while the B-1 clinic does not belong to any broader association of providers, the B-2 clinic receives support from a foreign faith-inspired organization. As the table shows, there is substantial variation in the areas of care provision in which each clinic/hospital works, as well as in the number of staff in each facility, which is useful to assess whether common tendencies can be uncovered across providers that differ in size and coverage of services provided.

The core data from the qualitative work comes from in-depth interviews carried for each of the six faith-inspired providers. A semi-structured questionnaire was used to interview parents using the facilities (eight patients per facility, four women and four men). Each interview took from one hour to one hour and a half, and focused in large part on the perceptions of the providers by parents and the reasons that led them to choose one provider versus another. Quantitative statistics will be presented in percentage terms from those interviews, but it must be emphasized that the sample is small (a total of 48 parents were interviewed). A separate semi-structured questionnaire was also administered to managers of the faith-inspired care providers (or owners in the case of a private faith-inspired school) as well as to the doctors. Additional interviews were conducted with key informants, such as officials from the Ministry of Health.

Table 1: Characteristics of Sampled Clinics/Hospitals for the Qualitative Field Work, 2010

Health Facilities		Partnership	Religious organization	Areas in which clinic/hospital works							Number of staff					
				General health	Reproductive health	Pre- and postnatal care	Children's health	Disability	Care of the elderly	Mental health	HIV/AIDS	Doctor/Specialist	Nurse/Mid wife	Health Assistant	Other	Total
A-1	Christian	CHAG	Catholic Church	○	○	○	○			○		4	13	11	15	43
A-2	Christian	None	Rural for Christ International Ministries	○			○					1	1	1	0	3
A-3	Christian	CHAG	Catholic Church	○	○	○	○					0	4	2	8	14
A-4	Christian	CHAG	Church of Pentecost	○	○	○	○				○	8	3	3	8	22
B-1	Islamic	None	Islam	○	○	○	○			○	○	1	5	0	9	15
B-2	Islamic	Kwait IC clinic	Islam	○	○	○	○			○	○	1	3	1	4	9

Source: Authors based on qualitative fieldwork data.

A few basic statistics on the characteristics of the patients that were interviewed are given in Table 2. Among patients in Islamic clinic/hospitals, slightly more than half had registered with or were covered by a health insurance scheme, while the proportion in Christian clinics/hospitals was higher, at two thirds. The most common reasons for not being registered with NHIS mentioned by patients were that such registration was perceived as “not useful” or the patients had “no knowledge of any scheme” or the “premium is too high”. The share of patients unemployed at the time of the interviews was similar in both Islamic and Christian clinic/hospitals at about 10 percent. Data on monthly income suggest that on average patients in Christian clinics/hospitals were slightly better off than patients at Islamic clinic/hospitals, and those data are consistent with the levels of schooling registered, as well as with the higher insurance coverage among patients at Christian hospitals. About a fourth of patients in Islamic clinics/hospitals were not Muslim and the proportion of patients in Christian clinics/hospitals that were not Christian was a bit smaller, but of a similar order of magnitude. Again, those data are not representative of the characteristics of patients using various types of faith-inspired facilities nationally; they simply provide some pointers as to the characteristics of the patients interviewed in our qualitative field work.

Table 2: Patient Characteristics in Faith-Inspired Facilities, 2010

Occupation	Patients in Islamic clinics/hospitals	Patients in Christian clinics/hospitals
NHIS		
Registered	56.2%	68.8%
Occupation		
No job	12.5%	9.4%
Wage earner	6.3%	18.8%
Monthly income		
No income	6.3%	9.4%
Mean income	113.6 GHC	118.2 GHC
Final education		
No education	18.8%	12.5%
JSS +	40.0%	65.6%
Religion		
Muslim	75.0%	18.8%
Christian	18.8%	78.1%
Other	6.3%	3.1%

Source: Authors' calculations based on qualitative fieldwork data.

One of the parameters that may affect the choice of a specific provider is the cost of that provider. As we will see, cost indeed appears to be one of the main complaints observed in the 2003 CWIQ survey, but that survey was implemented before the major reform of the healthy system in Ghana that led to the creation of the National Health Insurance Scheme (NHIS) in 2004. The NHIS was introduced precisely as an effort to increase the access to and affordability of health care, especially for the poor. The scheme has led to smaller out of pocket payments at the time of our qualitative work in 2010 than was the case at the time of the implementation of the CWIQ survey, at least to the extent that individuals are

covered by the scheme. Looking at each clinic/hospital in our sample in table 3, it appears for example that all sampled patients of A-1 Christian hospital were registered with the NHIS, while 50 percent of sampled patients in B-1 Islamic clinic were covered. Data on consultation fees, travel cost, travel time, and time spend at the clinic/hospital were obtained and vary according to the clinic/hospital with some charging higher fees, but for most of the facilities the fees are relatively low, probably in large part thanks to the introduction of the NHIS. This suggests that cost would be a smaller issue in 2010. Other useful background data are provided in table 3. Mean monthly income varies by clinic/hospital. While it is at 155.0 GHC in A-2 Christian clinic, it is at 78.1 GHC for A-4 Christian hospital. As for the travel time to the facilities and the cost of such travel, differences are also observed. For example patients of B-1 Islamic school live relatively closer while patients in A-1 Christian hospital live much further away.

Table 3: Basic Statistics by Clinics/Hospitals, Qualitative Field Work, 2010

	Health facilities	Partnership	Monthly income	Health insurance holder	Consultation fee	Cost to travel to the clinic or hospital and return	Time to travel to and from the clinic or hospital	Time spend at the clinic or hospital
A-1	Catholic	CHAG	108.3 GHC	100%	2 GHC	2.2 GHC	63.1 mins	296.3 mins
A-2	Catholic	None	155.0 GHC	25%	5 GHC once	0.05 GHC	31.8 mins	43.8 mins
A-3	Catholic	CHAG	128.8 GHC	75%	1 GHC	1.1 GHC	21.7 mins	90.0 mins
A-4	Pentecostal	CHAG	78.1 GHC	75%	6 GHC	2.6 GHC	29.8 mins	185.0 mins
B-1	Islamic	None	111.3 GHC	50%	5 GHC	0.4 GHC	15.0 mins	52.5 mins
B-2	Islamic	Kuwait clinic	116.7 GHC	63%	1 GHC	0.5 GHC	16.5 mins	98.1 mins

Source: Authors' calculations based on qualitative fieldwork data.

SATISFACTION WITH SERVICES

The data from the household surveys used here cannot be used to measure the quality of the care provided by various providers. But it is feasible with the 2003 CWIQ survey to measure subjective levels of satisfaction with the care received (similar data are not available in the GLSS5). The survey asks whether individuals had any type of dissatisfaction with the care received, as well as the reasons for dissatisfaction, and it can be assumed that households who said that they did not have any problems with the care received were satisfied. As shown in Figure 1 and table 4, nationally the satisfaction rate is at 73 percent for both faith-inspired and public facilities, versus 83.5 percent in non-religious private facilities (which also tend to be more expensive). There are few differences between public and faith-inspired facilities in terms of the reasons for non-satisfaction, although there is a slightly higher proportion of patients using faith-inspired providers that consider care as too expensive, while there is a higher proportion of patients using public

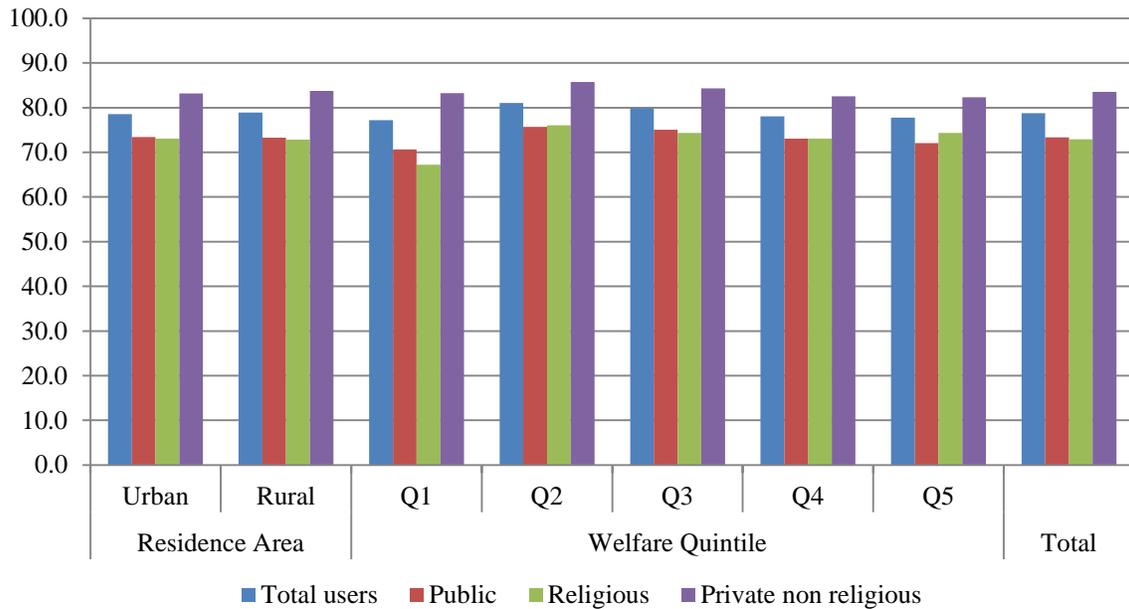
facilities who complain about a lack of medicines. Still, overall, even if it must be emphasized that subjective perceptions on satisfaction with the care received have limits for assessing the quality of care (especially if different facilities tend to reach different types of households in terms of their levels of well-being, but this tends not to be the case too much for public and faith-inspired facilities), the quantitative evidence suggests similar levels of satisfaction among faith-inspired and public providers.

Table 4: Satisfaction and Problems Encountered, 2003 CWIQ (%)

	Residence Area		Welfare Quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
All facilities								
No problems (satisfied)	78.5	78.9	77.2	81.0	79.9	78.0	77.8	78.7
Facilities were not clean	0.6	0.5	0.5	0.7	0.5	0.4	0.5	0.5
Long waiting time	4.9	3.1	3.2	3.1	3.4	4.4	4.8	3.9
No trained professionals	0.7	0.7	0.8	0.7	0.6	0.8	0.7	0.7
Too expensive	12.9	10.3	10.4	9.8	10.5	12.5	12.9	11.4
No drugs available	5.1	3.9	4.5	3.4	3.9	4.8	5.2	4.4
Treatment unsuccessful	4.3	7.7	9.2	6.3	5.9	5.3	5.6	6.3
Poor staffing attitude	1.4	1.3	1.4	1.1	1.1	1.5	1.6	1.4
Other problems	0.2	0.3	0.3	0.2	0.3	0.3	0.2	0.3
Public facilities								
No problems (satisfied)	73.4	73.2	70.6	75.7	75.0	73.0	72.1	73.3
Facilities were not clean	1.0	0.8	0.8	1.2	0.8	0.5	1.0	0.9
Long waiting time	8.3	5.7	5.8	5.6	6.2	7.9	8.0	6.8
No trained professionals	1.1	1.2	1.6	1.3	1.0	1.0	1.0	1.1
Too expensive	13.8	12.8	13.1	12.4	11.8	13.7	14.6	13.2
No drugs available	7.0	5.7	7.1	5.3	5.6	5.9	7.3	6.3
Treatment unsuccessful	5.6	8.5	10.1	6.8	6.7	5.9	7.3	7.2
Poor staffing attitude	2.5	1.9	2.0	1.8	1.7	2.3	2.7	2.2
Other problems	0.2	0.4	0.4	0.3	0.4	0.3	0.2	0.3
Faith-inspired facilities								
No problems (satisfied)	73.1	72.9	67.2	76.0	74.3	73.0	74.4	72.9
Facilities were not clean	0.1	0.4	0.0	0.8	0.3	0.1	0.4	0.3
Long waiting time	6.1	6.0	8.1	3.6	5.3	3.6	9.0	6.0
No trained professionals	1.3	1.6	0.7	2.1	1.2	2.9	0.7	1.5
Too expensive	17.6	13.1	17.3	12.0	14.9	14.0	13.4	14.4
No drugs available	3.9	3.9	4.3	2.5	3.0	4.6	4.9	3.9
Treatment unsuccessful	6.3	8.4	10.6	8.5	7.1	9.2	4.0	7.9
Poor staffing attitude	1.2	2.2	2.0	2.5	3.1	1.0	1.4	1.9
Other problems	0.6	0.4	1.0	0.2	0.9	0.0	0.3	0.5
Private non-religious facilities								
No problems (satisfied)	83.2	83.8	83.2	85.7	84.3	82.5	82.3	83.5
Facilities were not clean	0.3	0.2	0.3	0.2	0.3	0.3	0.2	0.2
Long waiting time	2.0	0.9	0.7	1.0	1.0	1.6	2.1	1.3
No trained professionals	0.4	0.3	0.3	0.2	0.2	0.5	0.4	0.3
Too expensive	11.9	8.1	7.6	7.5	9.1	11.4	11.6	9.7
No drugs available	3.6	2.6	2.5	2.0	2.6	3.9	3.6	3.0
Treatment unsuccessful	3.2	7.0	8.3	5.7	5.1	4.6	4.4	5.4
Poor staffing attitude	0.5	0.8	0.8	0.5	0.5	0.8	0.8	0.7
Other problems	0.2	0.2	0.2	0.1	0.1	0.3	0.3	0.2

Source: Authors' estimation using CWIQ 2003 survey.

Figure 1: Satisfaction of Users by Provider Type, CWIQ 2003



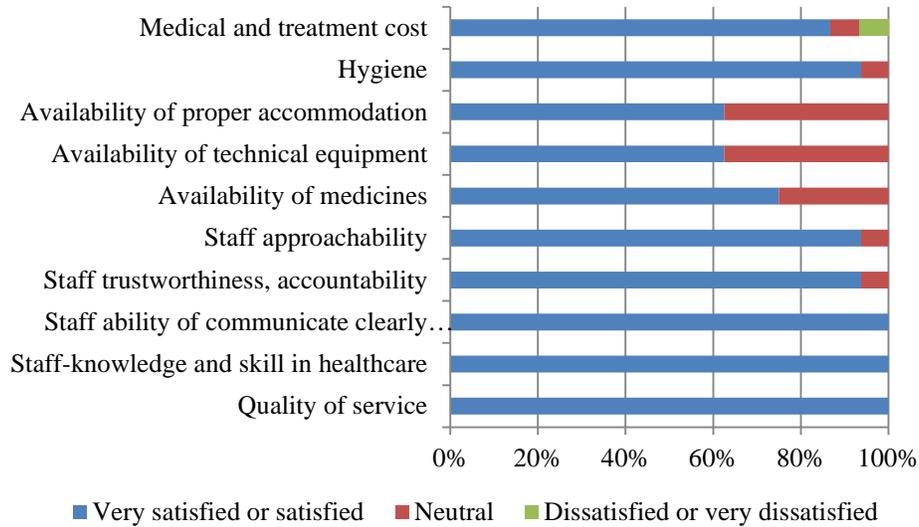
Source: Authors' estimation using CWIQ 2003 survey.

As mentioned in the previous section, the creation of the National Health Insurance Scheme (NHIS) in 2004 and its implementation as of 2005 has reduced significantly the out of pocket costs of care for households, since many procedures are now paid for by the scheme directly to the health facilities. It is thus likely that cost is less of an issue today than it was at the time of the CWIQ survey, at least for the estimated two thirds of the population that is registered today in the scheme. This is a positive development, but some issues remain. All directors of CHAG facilities interviewed for this study cited delays in receiving funds from the scheme as well as insufficient amounts received as issues which affect their cash flow as well as their ability to deliver their services smoothly. As the Director of a Christian hospital explained, *“the idea of the NHIS is perfect. It is good for the poor and brings clinic to certain standard. But delivery has some problem. Our workload increased. It put stress on our finance because payment does not come regularly. I have doubt of the long-term viability of the NHIS. Many complained that the NHIS delay the reimbursements for more than two months.”*

Returning to the analysis of the satisfaction of households with the services received at faith-inspired facilities, as was the case for the survey data from the 2003 CWIQ, the data from the qualitative fieldwork suggests relatively high satisfaction rates with the services received, albeit with some caveats. Figures 2 and 3 suggest that patients were highly satisfied with the quality of the staffs, the hygiene in the facilities, and their cost (again, this is explained in large part by the introduction of the NHIS), with rates of satisfaction near 100 percent. However, satisfaction rates were lower regarding the availability of proper accommodation, technical equipment, and medicines, with the situation apparently being more

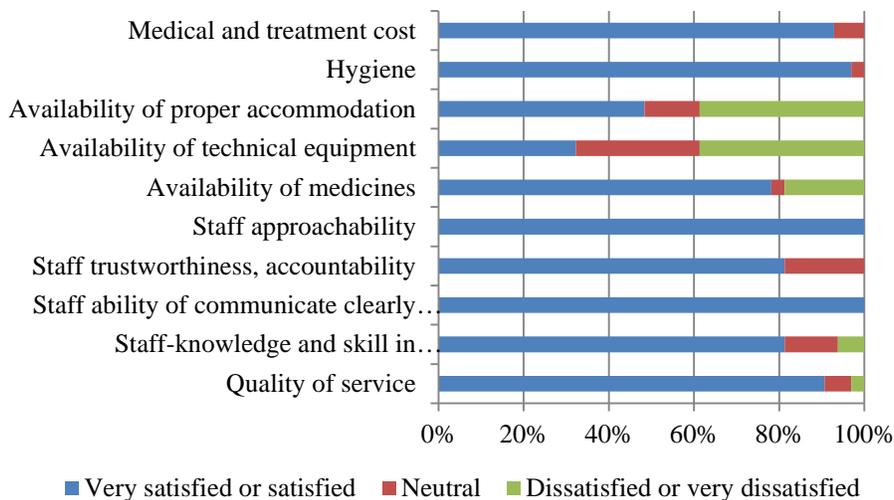
difficult for the three clinics and hospitals not yet accredited with the NHIS. Patients using Christian clinics/hospitals were also found to be less likely to be satisfied with the level of availability of various resources than patients using Islamic clinics/hospitals, but given the very small sample size, one should not try to infer too much from the differences between the two types of faith-inspired providers.

Figure 2: Satisfaction of the Interviewed Patients in Islamic Clinics/Hospitals



Source: Authors' calculations based on qualitative fieldwork data.

Figure 3: Satisfaction of the Interviewed Patients in Christian Clinics/Hospitals



Source: Authors' calculations based on qualitative fieldwork data.

REASONS FOR CHOOSING FAITH-INSPIRED PROVIDERS

We now turn to the reasons for choosing health care providers in Ghana, starting again briefly with the survey evidence, and then using the more detailed and nuanced results from the qualitative field work. Because of the way in which questions are asked in the survey questionnaire, data from the GLSS5 tend to better identify faith-inspired facilities than the data from the 2003 CWIQ. Looking at the basic statistics presented in table 5, differences are relatively small in terms of the market shares of public, private religious, and private non-religious providers among the various religious groups, and it is likely that some of the differences observed are related simply to the location of the facilities, rather than to specific choices made by households. Regression analysis on the drivers of the choice of provider confirms that neighborhood effects are much more important than faith affiliation for choosing one or another provider.

Table 5: Market Share of Alternative Providers by Religious Group, 2005-06

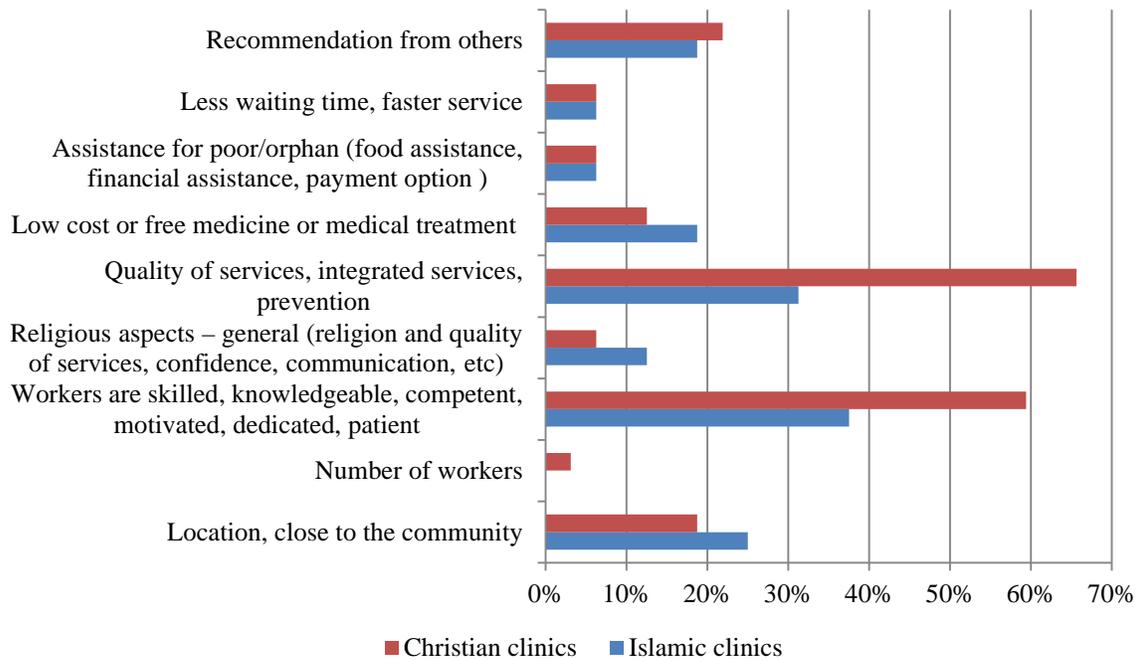
	Catholic	Protestant	Evangelical	Muslim	Other religion	Total
Public	72.9	71.4	67.1	76.2	72.1	70.7
Private religious	6.1	7.5	9.0	6.6	3.1	7.5
Private non-religious	20.9	21.1	23.9	17.2	24.9	21.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Authors' estimation using GLSS5 2005-2006.

Note: Consultations at hospitals, clinics, and maternity houses only.

The qualitative work also confirms that faith affiliation is not a major reason for choosing faith-inspired care providers. Questions were specifically asked to the patients as to why they chose the faith-inspired providers they used (multiple motivations were allowed). As shown in Figure 6, among patients in Christian clinics/hospitals, two thirds (65.6 percent) responded that quality of service was the main reason for choosing the clinic/hospital; 59.4 percent mentioned that workers are skilled, knowledgeable, competent, dedicated, and patient; in short they appreciated the quality of the staff. A third common answer (21.9 percent) was “recommendation from others”. For the patients in Islamic clinics/hospitals, the most common answer (37.5 percent) was “quality of workers” followed by “quality of service” (31.3 percent). Twenty-five percent mentioned “location” (25.0 percent). Overall, quality service, and especially the respect provided to patients appears to be a key reason why patients rely on faith-inspired hospitals, as a few quotations help illustrate: *“I get a lot of relief at religious clinic since nurses are very kind and treat patients with dignity. I think staff here are working by faith. Their services are done for mankind because they are God-fearing”* (Male Christian patient, Christian hospital); *“Here we are treated with respect. They listen to us well and understand all of our problems. They take their time to talk to us in a polite way. You don't regret spending your money at this hospital. Even if they don't have all the equipment, the way they handle makes me feel comfortable”* (Female Muslim patient, Islamic clinic); *“I have heard that they are a top quality hospital and they are very serious with their work and they treat patients with care and respect”* (Male Christian patient, Christian hospital).

Figure 4: Main Reasons for Choosing the Clinic/Hospital



Source: Authors’ calculations based on qualitative fieldwork data.
 Note: Multiple answers allowed.

While quality and respect are important for choosing faith-inspired hospitals, religion itself is much less important, with only 6.3 percent of patients in Christian clinics/hospitals and 12.5 percent of patients in Islamic clinics/hospitals respectively mentioning that religion was a key reason for their choice. When asked whether their religious beliefs and values affect their choices regarding healthcare for themselves and their family, nine in ten patients respond that this is not the case in terms of choosing health care providers. This emerged clearly from the interviews: *“I am Christian but came to this Islamic clinic not because of my religious beliefs but because the clinic works well”* (Female Christian patient, Islamic clinic); *“I will seek health care from even a Christian health facility if that is of high quality but not go to a traditional priest”* (Male Muslim patient, Christian clinic); *“My religious beliefs do not affect my choice of health care for me and my family. I am Moslem and I have been attending a Catholic clinic in the past, so religion doesn't matter to me. Any clinic where I can receive effective medical care, I will go”* (Male Muslim patient, Islamic clinic).

We also asked patients if they would be willing to use health care services at a clinic grounded in a faith different from their own. As shown in Table 9, again nine in ten patients would not mind using services at a clinic grounded in a faith different than their own, as illustrated through the following quotes: *“If they will take good care of me to get well, I don't care what faith is behind them”* (Male Christian patient, Christian hospital); *“I use Islamic clinic here even though I am Christian because I believe that it is providing gravity health care and not about changing me to Moslem”* (Male Christian patient, Islamic clinic).

Table 6: Patients' Values and Choice of Health Care Service

Questions	Patients who use a clinic that belongs to a different religion	Patients who use a clinic that belongs to the same religion
Do your religious beliefs and values affect your choices regarding healthcare?	Yes: 0 %	Yes: 10.8%
Are you willing to use health care services at a clinic which is grounded in a faith different from your own?	Yes: 100%	Yes: 89.1%
Do you think that the health clinic/hospital should provide spiritual guidance and counseling to the patients?	Yes: 18.1%	Yes: 33.3%

Source: Authors' calculations based on qualitative fieldwork data.

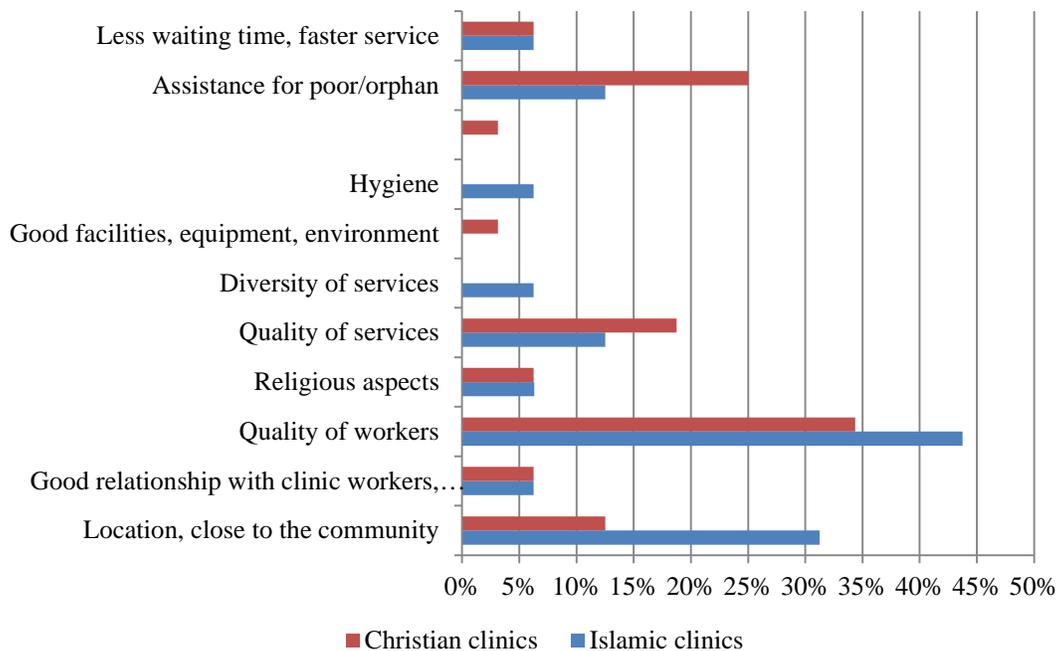
The desire to serve communities as a whole also emerges clearly from the interviews conducted with the Directors and staff of the clinics and hospitals. As the Director of a Christian hospital explained it, *“First a maternity clinic was established in 1946 by the bishop of Accra. Then in 1977, the hospital registered to the government. We serve all mankind. We accept patients who belong to different religion. The vision of the national catholic health services is to provide high quality health care in the most effective, efficient and innovative manner, specific to the needs of the communities we serve and at all times acknowledging the dignity of the patient.”* Or as a doctor at an Islamic clinic shared *“there was no clinic around here before. We established this clinic to assist poor community in this area. Most of the people in this area are Moslem, but our target population is entire community. We accept everyone...Personally I am Christian, but I am working at Islamic clinic as a doctor. I don't care the patients' religion. Whatever they believe, we are fighting for our own goal to support the people's health”* (Doctor at an Islamic clinic).

Finally, to get at the question of the role of faith in the choice of facility still in a different way, we asked patients to share the advantages that they see in using faith-inspired clinics or hospitals. As shown in Figure 7, in Christian facilities a third of patients cited “quality of workers” as the main advantage of the facilities, followed by “assistance for the poor” (25 percent of respondents) and “quality of service” (19 percent). Among patients in Islamic facilities, the most common answer was “worker’s skills and quality” (44 percent) followed by “location” (31 percent). Two other reasons were mentioned: “Assistance for the poor/orphans” and “quality of service” by 12.5 percent of respondents. The availability of assistance for the poor, while not a leading criterion for the choice of provider, was also mentioned by facility staff. As a Director at an Islamic clinic explained, *“What is the target population of this clinic? It is not by us, it is not by religion. Elders come, youth come, children come, and pregnant women come... any kind of category. Majority of people who come to this clinic are Moslem, but we have non-Moslem too. They are Christian or believe traditional religion. Also we have both poor and somehow middle income group. Majority of the patients are actually poor. That is one of main reason of establishment of this clinic. People are facing financial problems, unemployment and deprivation. Their monthly income is low.*

We try as much as possible to subsidize our services.” But as far as religion is concerned, in most cases respondents mentioned that it was not in itself a key reason for their choice of health care provider, and the fact that no discrimination takes place on the basis of religious affiliation was in fact appreciated by patients: *“Members of the local community can come here anytime because there is always a doctor available and there is no discrimination”* (Female traditional religion patient, Christian clinic).

The data also shows that all of the sampled clinics and hospitals in the qualitative fieldwork do accept patients who belong to different religious denominations, and as mentioned earlier some doctors or health staffs actually belong to a different religious denomination than the one to which their clinic or hospital is affiliated. As to the patients, when they did mention the importance of values, faith, or religion, this was done typically in general terms as a good influence overall, rather than in partisan terms: *“As an Islamic community this clinic is seen as a good model of what Islam can do for Moslems. It is providing health care as well as spiritual care for the people”* (Male Muslim patient, Islamic clinic); *“They try to increase the faith of patients who come to this clinic, so it is good. It boosts the moral of patients and increases their faith. Even though I am Moslem, I like it so much”* (Male Muslim patient, Christian clinic).

Figure 5: Advantages of the Faith-inspired Clinic/Hospital You Selected



Source: Authors’ calculations based on qualitative fieldwork data.
 Note: Multiple answers allowed.

CONCLUSION

This paper has explored the role of faith-inspired health service providers in Ghana, with a focus on two questions: what is the level of satisfaction of patients with the services received? And what is the motivation of patients for choosing faith-inspired providers? Quantitative survey data suggest that satisfaction rates with the services of faith-inspired and public providers are similar, and lower than those observed for private non-religious facilities, which may be related in part to the higher cost of the services that they provide.

The picture that emerges on satisfaction from the qualitative work is slightly different. First the issue of cost, which came out strongly in the 2003 CWIQ survey as a problem in all types of facilities, does not appear to be as important in the qualitative fieldwork, and this may be due in part to the introduction of the NHIS which has reduced out of pocket payments. Second, even though we do not have comparative qualitative data on public providers, the qualitative data suggests that the satisfaction with the services received in faith-inspired facilities is high, including in areas such as respect paid to patients. Subjective satisfaction does not measure quality per se, but it is an important indicator and it appears indirectly from the qualitative data that faith-inspired facilities may have a comparative advantage at least in terms of the attention paid to patients. More data would be needed to confirm this, but it is encouraging for faith-inspired facilities. It also appears that faith-inspired facilities try to help the poor afford the cost of care. Finally, and this is also related to the question of quality, religion itself does not seem to be a key factor for the choice of faith-inspired facilities. Many patients use services from clinics and hospitals that are affiliated with a different faith from their own, and the main reason for the choice of facility is precisely the perception that they provide services of quality.

This study has been exploratory and descriptive in nature, and it was not meant to generate specific policy recommendations. But it is clear that as a staff from the Ministry of Health put it, *“non-state service providers are our partners. They play an important role in delivering health care services to the Ghanaian. Thanks to their great effort, we, Ghanaian are trying to improve our quality of the health services. We still need more collaboration.”* One of the objectives of Ghana’s national health policy is to foster closer collaboration and partnership between the health sector and communities, other sectors and private providers of care, including not only organizations such as CHAG but also traditional healers. As mentioned in the introduction, CHAG signed a memorandum of understanding with the government. As a Director at a Christian hospital explained it, by acting as an umbrella body for Christian facilities, CHAG gives a voice to these facilities not only for negotiating with the government, but also for sharing ideas and experiences.

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CHAPTER 5

GLOBAL HEALTH PROVISION FOR DEVELOPMENT: THE SALVATION ARMY'S EXPERIENCE

Dean Pallant¹¹
The Salvation Army

The Salvation Army operates in 124 countries around the world and defines itself as an international movement, an evangelical part of the universal Christian Church with a mission to preach the gospel of Jesus Christ and meet human needs in his name without discrimination. Salvation Army health services include 29 general hospitals, 25 maternity hospitals, 19 other specialist hospitals, 56 specialist clinics, 135 health centers, 64 mobile clinics and more than 15,000 local congregations almost all of whom have a community service program. This paper considers what it means to reconcile a faith-based mission with the contextual concerns of health service delivery in development contexts. It argues that religious groups can benefit from a more clearly articulated faith-based strategy to maximize their contribution through health and development initiatives – and such articulation also needs to be respected by state, market and NGO partners.

INTRODUCTION

People in the USA associate The Salvation Army with bell-ringers at Christmas while in Britain the stereotype is brass bands playing carols or hostels for homeless men. In Zimbabwe, Papua New Guinea, Bolivia, Ghana, the Democratic Republic of Congo and many other less economically developed countries the public associates The Salvation Army with health care, schools, churches and, of course, uniforms. Today the Salvation Army operates in 122 countries around the world with an annual expenditure in the USA alone of more than \$2.5 billion. The Salvation Army (2009) defines itself as, “an international movement, an evangelical part of the universal Christian Church” with a mission to “preach the gospel of Jesus Christ and meet human needs in his name without discrimination.” Health services include 29 general hospitals, 25 maternity hospitals, 19 other specialist hospitals, 56 specialist clinics, 135 health centers, 64 mobile clinics and more than 15,000 local congregations almost all of whom have a community service program.

The Salvation Army is a faith-based organization. FBOs are receiving attention in the global quest for better health for the world’s poorest people. Research into the reach and

¹¹ Major Dean Pallant is the International Health Services Coordinators for The Salvation Army (International). He shares this appointment and work with his wife, Major (Dr) Eirwen Pallant, a primary health care physician. A more detailed version of this argument can be found in: Pallant ‘*Keeping Faith in Faith-Based Organisations*’ (2011) – this version is printed with full permission.

effectiveness of FBOs has noted between 30 percent and 70 percent of health institutions in Africa are “*in the hands of religious entities*” (WHO 2008). In a recent survey in sub-Saharan Africa, 82 percent of people surveyed preferred FBOs to non-faith groups (DFID 2009). Partnerships with faith-based groups are increasing but as Olivier (2010) notes, “*there is concern that “enthusiasm for partnership has run ahead of the knowledge of the nature, scope and scale of religious entities and religious response, not to mention their unique characteristics that may demand a specific strategy.”*”

FBOs already make a significant contribution to the task of improving the health of the poorest people, but can do better. FBOs certainly require a specific strategy and this paper seeks to discuss some of their defining characteristics, highlight issues influencing the work of FBOs and make proposals for going forward. A specific strategy to maximize the contribution of faith-based health and development initiatives needs to be better understood and articulated by religious groups themselves, as well as being respected by state, market and NGO partners. The starting point is that FBOs should not merely adopt objectives and policies set by politicians and government officials; nor simply determine program priorities and methods according to the funding criteria of the world’s wealthiest people; nor embrace the business models of large commercial health providers. Although the actions of state and market inevitably impact FBOs, the direction and character of an FBO should by definition, be determined by its faith - with its theology an acknowledged influence. Gifford (2009) analyses the extent to which the Kenyan Church is engaged in the ‘development business’ and notes very few FBOs in Kenya “*seem interested in even asking whether there is any specifically Christian way of, or contribution to, development.*” Such secularization of development institutions does not reflect lived reality of Kenyan or African lives – where secular values hold little sway. We will argue below (using The Salvation Army health services as our example), that the more FBOs are faithful to their faith tradition, the more effective their contribution in the global fight against poverty will be.

A CHALLENGING TASK REQUIRED A SPECIFIC METHODOLOGY

In October 2007, The Salvation Army embarked on a review of its global health services in order to develop a more cohesive international vision and strategy. Senior leaders had expressed concern that many Salvation Army hospitals and clinics in economically developing countries were declining in their quality of service and were not financially sustainable. There was some internal disagreement on how these challenges should be met. In the past 25 years, The Salvation Army withdrew from almost all hospital-based health care in the USA, Canada, UK, Australia and New Zealand. Leaders justified these actions on the grounds of increasing cost, the threat of lawsuits and conflict with state grant makers and regulators over human life ethics. Community-based healthcare was fundable, less risky and perceived to be more effective and sustainable.

A number of influential western voices were recommending the closure of all Salvation Army hospitals and clinics around the world. Members of The Salvation Army in the global south overwhelmingly disagreed with closure proposals. Leaders and employees argued there continues to be an important role for faith-based health institutions in

serving poor and marginalized people through institutional, church and community-based health ministry offering a continuous chain of care from home to hospital and back. They could not, however, offer a financially viable means of achieving this ambition.

The reviewers were tasked with assessing the current situation, determining a strategy and then implementing it. This was not only a standard organizational evaluation of health services – but was also described as ‘reflection-in-action’ (see Schön 1991), and grounded in the methodology of practical theology (see Pattison and Woodward 2000). Between October 2007 and August 2010, Salvation Army health programs in more than 30 countries were visited and reviewed – including hundreds of interviews with Salvation Army staff and other stakeholders discussing the current state and future hopes for faith-based health ministry. The focus was on investigating the challenges facing FBOs who sought to improve the health of the poorest people in the developing world and the competing visions being proposed by governments, for-profit organizations, non-governmental groups as well as faith and non-faith community-based groups.

INFLUENCES SHAPING FAITH-BASED HEALTH INITIATIVES

The review highlighted the varying contribution of the market and state to improving the health of the poorest people and the lack of awareness of FBOs in appreciating the impact of market and state upon their work. While the Salvation Army health ministry stretches across continents, the experiences of state-dominant health models such as in Zambia were of limited comparative value in South Asia where the impact of commercialization in health care came as a surprise.

Polanyi’s (2001) analysis of the transformation of Britain after the Industrial Revolution demonstrates the dynamics of market and state upon the health of the poorest people. Polanyi (2001) argues that before the Industrial Revolution markets were nothing more than “*accessories of economic life*” – but afterwards, all transactions received a monetary value, which he considers a mistaken assumption resulting in “*an economy directed by market prices and nothing but market prices.*” Other scholars have highlighted similarities between this description and the challenges facing developing countries today. Historically, communities and economies in the developing world were embedded in society through concepts of reciprocity, exchange and redistribution but are now experiencing rapid transformation caused by forces of economic globalization. Currently, millions of rural people are losing access to land and do not have property rights. Urban dwellers do not fare better with a lack of secure employment destabilizing society; increasing competition and deregulation keeping wages low and unemployment high, coupled with access to health services, water, sanitation and education being patchy and expensive (Stewart 2008). This is a reminder of the limitations of markets; the importance of relationships in developing a healthy society, and the contribution of political ideas and organizations in protecting people against unbridled commodification.

The influence of forces shaping the effective functioning of the state is also significant. Reich (2002) argues, in developing countries the state rarely has a robust capacity to deliver health care due to it being reshaped by multiple forces acting simultaneously:

“From above, the state is actively constrained by agreements promoted by international agencies and by the power of multinational corporations. From within, the state is being reshaped by increasing trends toward marketization and by problems of corruption. From below, the state’s role is being diminished by the expansion of decentralization and by the rising influence of nongovernmental organizations.”

The review of The Salvation Army health services in Haiti, DRC, Pakistan and PNG emphasized the complexity of FBOs working in the context of a failed state. It emphasized that FBOs need to take care not to undermine the importance of a functioning state. Public health disasters in failed states illustrate the importance of the state in improving the health of the poorest people. No matter how fragile the state, FBOs and NGOs should seek ways to strengthen the capacity of the state.

It is not only the state that is being reshaped by multiple forces acting simultaneously. Similar forces shape FBOs and NGOs. The term ‘institutional isomorphism’ is used in organizational studies to describe the process of increasing homogeneity in the forms and practices of organizations as they engage with other organizational fields where interaction, awareness, information, and structures of domination and coalition are shared (Di Maggio and Powell 1983). Proponents of neo-institutional theory argue that when disparate organizations engage in a common industry they become structured through organization-field forces such as market competition, state regulation, or professionalization and, often, emerge with strikingly similar forms and practices (Swartz 1998). Such a process is particularly significant for an FBO engaging in health ministry in a contested and crowded space, where pressures might alter their identity.

The process of institutional isomorphism is not inevitable. Smith and Sosin (2001) argue that if FBOs make conscious choices – regarding, for example, the sources of resources, the groups they partner with, or the way they apply authority – they are able to shape organizational character. This shaping is dependent on the degree to which faith is ‘coupled’ with these choices – the less the FBO is coupled to the faith community, the more the FBO will be coupled to ‘secular society’. Excavating the underlying moral frameworks upon which FBOs make those choices is foundational in understanding the extent of such coupling.

The forces shaping the character of people and organizations need to be acknowledged and analyzed. The contribution of FBOs to the task of improving the health and development of the poorest people is not merely its institutional footprint in hard-to-reach communities. FBOs do not simply offer a distribution network to deliver anti-malaria bed nets or participate in immunization campaigns. FBOs can make a more important contribution when they are orientated by their particular faith tradition. There are many examples of faith developing and sustaining character, values and virtues. Reservoirs of faith are essential in developing resilient households and socially cohesive neighborhoods with the capacity to enable the flourishing of healthier people. The experience of Salvation Army health ministry during the past 125 years evidences this argument.

THE EXPERIENCE OF THE SALVATION ARMY

The Salvation Army was founded by William and Catherine Booth in 1865 in the poverty-stricken East End of London, England. It experienced rapid growth throughout the British Empire with a mix of evangelical revivalism combined with non-discriminatory social action. The Booths were Methodists and adherents of John Wesley's teaching but concluded the Christian Church in London was ineffective in engaging with the poorest members of society. The new 'Salvation Army' with its military-styled uniform and structure caught the spirit of the Victorian age and attracted large numbers of the poorest people. It gave them an identity, hope and a task.

Unlike some revivalist evangelical movements of the time, The Salvation Army did not merely focus on 'saving souls' but articulated the holistic nature of the human person as 'body-soul' created by God. Booth received financial and political support from governments and corporations who were alert to unrest among the poorer sections of European society. More than 100 years ago, free marketers (such as Cecil John Rhodes) and governments supported social regeneration projects using faith-based solutions. The Salvation Army were willing to work with the establishment and gained credibility by helping the poorest people escape from unemployment, alcoholism, gambling, poor housing, poor access to finance and social determinants of health.

In 1890, Booth set out his plan for social regeneration in *Darkest England and the Way Out*. It was a scheme for the re-embedding of social relations against the forces of the unregulated market in Victorian England. Central to the process of building what Booth termed, "*self-helping and self-sustaining communities*" was a role for institutions. Booth developed a range of institution-based solutions including schools, children's refuges, centers for the mentally ill, workshops for the unemployed, hostels for men and women, labor bureaus, the poor man's bank, the poor man's lawyer, and model suburban villages. Booth argued that the institutions which sustain the upper and middle classes and the poor in rural areas, should also be available for the poor in the cities.

The Salvation Army also established church congregations, as key in sustaining the faith aspect of the work and the effectiveness and resilience of the organization. Salvationists learnt the importance of habits and practices in worship such as "*meeting people, acknowledging fault and failure, celebrating, thanking, reading, speaking with authority, reflecting on wisdom, naming truth, registering need, bringing about reconciliation, sharing food and renewing purpose*" (Hauerwas and Wells 2004). The habits and practices of a particular faith tradition are highly significant in energizing and sustaining the participation of FBOs in building a better society.

Booth's plan for The Salvation Army was similar to other faith-based approaches for social development. In the 19th and early 20th century, the growth of the Church in many developing countries was linked to education and health care services (Grundmann 2005). The first missionaries concluded "*preaching without healing was a most inadequate way of interpreting the Gospel*" (Garlick 1943). Neither Hinduism nor Islam had developed institutional health services for the poor as an expression of their faith and

the dedication of the missionaries impressed the local people (Garlick 1943). Christian denominations such as the Catholics, Anglicans, Methodists and Presbyterians embarked on an extensive expansion of institutions such as schools, clinics and hospitals across the world – often in collaboration with colonial rulers.

However, since the 1960s there has been a waning of interest in Christian hospitals by the Western Church. Currently, most mission hospitals in Africa and Asia are run by national staff and many are struggling to survive due to a lack of resources and, in some cases, management skills. In other instances, denominations have withdrawn completely and handed the institutions back to the government. Many justifications have been given for western donor withdrawal from mission hospitals in developing countries. Evans (1999) identifies: *“The recent paradigm shift in the Two Thirds World is moving health care delivery from the hospital-based medical missionary movement model towards an integrated health-and-community based model, empowering people to be responsible for their own health. The reasons for this shift are (1) the exorbitant cost of establishing and sustaining health institutions; (2) alternative sources of health care provided by government and private organizations in many countries; (3) the difficulty by a number of countries in managing large medical institutions that exceed local competency levels and specialities; and (4) the shift in North American missiology from building institutions to empowering and enabling people in preventative health care based on a holistic, communitarian view of health.”*

It is widely accepted that large faith-based hospitals seeking to serve the poorest people in the developing world are economically unsustainable – a problem facing many different denominations (see Crespo 2001). An independent, interdenominational investigation into Christian mission hospitals in developing countries identified six issues threatening their future: lack of vision and leadership, staffing, community relationships, finance, cultural conflicts, and technology (Crespo 2001). It is necessary to note that despite these criticisms, the state health institutions in developing countries are often perceived by the users to be even worse, and most commercial providers offer services that are unaffordable for the poorest people. Pressure is being exerted on faith-based health services to align with global and national health systems and strategies, and partnerships are obviously necessary. However, the more pressing issue experienced by field workers is not simply aligning with strategies but implementing them. There are many excellent strategies on the shelves and many workshops for health workers, but little evidence of sustained improvement in the health of the poorest people.

TWO KEY ISSUES TO MAXIMIZE THE CONTRIBUTION OF FBOs

Two issues stand out as means to maximize the contribution of FBOs to the global task of improving the health of the poorest people. First, it is important to clarify the goal: what is a healthy person? Secondly, how can faith-based hospitals and clinics support the development of healthy persons?

It has been noted that faith traditions tend to approach the health of the individual more broadly than liberal individualistic models – where trust is placed in the capacity of

science, human rights and the inevitability of human development – as well as rational choice (MacIntyre 2007, Plant 2004). The Salvation Army tradition is based on a richer conception of human personhood. For example, the Christian theological understanding of ‘who we are’ is grounded in the belief that God created man and woman in his own image (Genesis 1:26). *“Healthy persons’ in this tradition are people created by God as integrated ‘body-soul-in-relations”*, who do not overvalue or undervalue their individuality, but understand themselves and other humans as unique gifts, made in the image of God with capacity for relationships. Such ‘healthy persons’ should develop a particular relationship with their immediate locality (family, friends, neighborhood, nation), and all humanity. However, ‘healthy persons’ live in a fractured world that is in ongoing need of redemption. Based on this faith tradition, redemption is possible through the work of Christ, and sustained by the institution of the church and the habits and practices of faithful people. This is the ‘big story’ that shapes the actions of The Salvation Army. This does limit opportunities to build partnerships with groups who are orientated by a different story. Nor does it advocate a sectarian, isolationist position, but rather one that explicitly acknowledges the contribution of particular faith traditions.

As noted earlier, many faith-based hospitals and clinics serving the poorest people are struggling. Most health institutions accessible by poor and marginalized people are under-funded and needing urgent reform. However, there is little appetite for institutional reform and some of this reluctance stems from the de-institutional shift in western society. Institutions lost credibility in the 20th century as the structures of modernity came under scrutiny from ‘post-modern’ thought. Institutions such as churches, hospitals, governments, corporations and the nuclear family became viewed with suspicion as the capacity to abuse power was better appreciated. One response to the loss of trust in institutions has been a rise in the popularity of community-centric solutions.

Up until relatively recently, the institutions of ‘family’ or ‘household’ were the focus of attention for community-based health initiatives. The 1978 Alma Ata Declaration called for a primary health care (PHC) emphasis referring to the importance of individuals and families in the community. In most low-income developing countries, the household remains the most important producer of health. However, in the 30 years since Alma Ata the emphasis has shifted away from the institutions of ‘family’ or ‘household’ towards the term ‘community’ – which is difficult to define and lacks a specific institutional foundation within which to embed relations. Admittedly, accessing households and defining families is not straightforward either, particularly in the chaotic neighborhoods where the poorest people often live. However, the adoption of less defined concepts such as community, capacity building and social cohesion without an institutional focus is extremely fluid. The underlying presumption is that autonomous rational individuals will make their personal choices and there is little need for institutions.

This paper does not propose a return to the institutions of modernity but neither does it endorse the romantic illusions of de-institutionalized community capacity. ‘Institution’ may be a dirty word to some, however, in the cause of the health of the poorest people, there needs to be a reimagining of the contribution of institution. It is more than the buildings, although physical presence is important. Institutions can play a key role as

building blocks of a more complex space that FBOs should promote against what Bretherton (2009) calls “*the totalizing, monopolistic thrust of the modern market and state that seek to instrumentalize and commodify persons and the relationships between them.*” Without such institutions, people struggle to have the opportunity for dialogue, free from government or commercial imperatives. Such spaces are essential if people are to have the space and time to listen to each other and develop mutual trust (Bretherton 2009).

Refounding hospitals and clinics is no easy task. Hospitals, particularly in sub-Saharan Africa, have been demonized by health planners. Hanson et al (2002) describes them as the “*consumers of excessive resources, magnets for patients whose needs would be better met elsewhere, and as inefficient dinosaurs whose activities should be reined in.*” There is justification for such a view. Three central hospitals in Zambia together with 19 second-level referral hospitals (of which The Salvation Army hospital at Chikankata is one), consumed approximately 40 percent of the Zambian health budget in 1998. However, there is also significant resistance across the world to shifting resources away from hospitals. As Arbuckle (2000) argues: “*It is naïve to assume life can proceed without institutions. People cannot govern without political institutions, earn an income without economic institutions, Institutions are simply stable, orderly patterns of behavior which persist and crystallize in the course of time and to which people become attached as a result of their role in the formation of identity ... Morally good institutions, however, can become corrupt when the founding story is lost and nothing matters but that the institution continues no matter what the human cost.*”

As argued earlier, a ‘big story’ is of critical importance in ensuring the power within institutions is appropriately orientated. This is one of the key contributions of faith – every faith has a ‘big story’. Each promotes a vision of ‘health’ even though they are not all are the same. They need to be articulated or else a different meta-narrative will be adopted.

REIMAGING A FUTURE FOR INSTITUTIONS

The role of health institutions in supporting the health and development of the poorest people needs urgent, collective attention. The Salvation Army has decided to keep some hospitals and clinics but will reposition them toward supporting PHC for the poorest people, and resist pressure towards high-tech specialization and commercialization. The World Health Organisation’s recent attempt to reinvigorate the PHC agenda is welcomed and, in light of the WHO strategy, our hospitals will prioritize health interventions with ‘relational’ dimensions as close to the family as possible. In other words, medical conditions that benefit from long-term relationships as against those which generally require short-term, high technology interventions. The following list of health conditions will be prioritized: addictions, diabetes, end-of-life care, eye care, HIV/AIDS, hypertension, infectious diseases, leprosy, maternal and child health, mental illness and nutrition. All of these benefit from community- and institutionally-based interventions, predominately at the level of PHC. They are all best responded to with an integrated, continuous chain of care from home-to-hospital-and-back supported by people of faith at

every link of the chain. A new model of integrated faith-based health ministry has been well received by Salvation Army practitioners around the world. In this model, the institutions (of clinic-hospital) provide a hub for a web of relationships with others including place of worship and households. Most of the cost of repositioning Salvation Army health institutions is being met by selling land which is no longer required in the shift from large ‘mission compounds’ to small, quality, focused clinic-hospitals.

There are risks in developing congregation-based health services. First, the instrumentalization of health services is a particular risk for churches engaging in ‘direct health care’ services. The ‘instrumental’ attitude manifests itself in the congregations wanting to “...‘do something’ about the plight of ‘the poor’ rather than commit to deep relationships with people” (De Gruchy 2003). Thus, it is critically important that congregation-based health ministries (and other FBO health services) appreciate the faith works of the poor themselves as they find their agency and identity in the task of improving their own health.

Developing the capacity of clinic-hospitals, churches and households is not a quick and easy task. It requires leaders who are committed to building relationships, and worshipping congregations who are able to sustain the faithful character of clinic-hospitals. Such a move opens up opportunities for congregation and clinic-hospitals to engage with families and individuals in prevention, health promotion, home care, and rehabilitation initiatives as people take greater responsibility for their health. FBOs, like The Salvation Army, have existing institutional infrastructure as well as a theological imperative to participate in integrated health services.

TAKING FAITH SERIOUSLY

Central to the above discussion is the argument that FBOs should take their faith seriously, and that other actors working for the health of the poorest people should give FBOs the space to do so. Some may argue this promotes a privileged position for faith, but we contend making space for faith contributes to the strengthening of civil society. Others similarly propose appreciation of the interrelated roles and functions of FBOs and the liberal state. Bane et al (2005) argue: “*Because so much of religion’s contributions are good for democracy and because these contributions are anchored in faithful religious practices ... creative initiatives to strengthen the intrinsic religious practices of faith communities will also serve the instrumental aims of helping to strengthen pluralist civil society and participatory democracy.*”

This is a constructive starting point that seeks to find areas of mutual interest between the secular liberal state and the faith community by allowing different ends (*telos*) to be attributed to the same action by different groups. The FBO is enabled to rely on ‘faithful religious practices’ with the understanding that the results are acceptable because they strengthen the instrumental aims of the state and wider society. Bane et al (2005) identify six interrelated roles for FBOs working within a liberal democracy: fostering expression, forming identities, creating social bonds, shaping moral discourse, enabling participation,

and providing social services. They leave service provision to last, believing that this is given too much focus, to the exclusion of other roles.

In the past three decades The Salvation Army has become particularly aware of the dangers of dependency. Our experience confirms that service provision is required in some situations – but it should always act as a catalyst for the development of deeper relationships, greater capacity and long-term development. Shifting practice away from the ‘provider’ mindset has taken time. One helpful approach has been to increase the use of facilitation methods such as Participatory Action Research (PAR) and Community Counseling. Acknowledging the resources of faith increases the impact of such facilitation methods - a practice we term ‘Faith-Based Facilitation’ (FBF)¹² which helps people think, talk, explore and respond to their issues in the light of faith. This results in the development of healthier people and communities who enjoy deeper relationships. FBF is a way of working, not a new idea, but one that needs to be habitually remembered and practiced. Such an explicitly faith-based approach explicitly acknowledges and applies the resources of faith.

CONCLUSION

This paper makes two main arguments: Firstly, FBOs need to be given space to be what they are: Faith-Based Organizations. This does not preclude partnerships with others orientated by a different tradition. Indeed, the process of hearing other traditions and reflecting on one’s own is vital for the task of improving the health of the poorest people. Secondly, institutions should not be bypassed. Institutions such as households, clinics, hospitals and churches need to be orientated by a ‘big story’ which legitimates, forms and sustains them. Existing FBOs need to improve the quality of their health ministry, but this will not be achieved by recreating the ‘missionary era’, nor by the state and market co-opting FBOs to their ends. The experience of The Salvation Army is that paying attention to the habits and practices that sustain faith-based institutions is important, especially as a means to strengthen ‘community’ in development contexts.

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¹² See *Building Deeper Relationships using Faith-Based Facilitation* - www.salvationarmy.org/fbf

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CHAPTER 6

EMERGING PRACTICES OF FAITH-BASED ORGANISATIONS ADDRESSING HUMAN RESOURCES FOR HEALTH

M.A. Dieleman, T. Hilhorst and J. Utrera¹³
Royal Tropical Institute and CORDAID

Adequate health system performance and achieving the Millennium Development Goals for health, requires that qualified health care providers are available and can perform adequately. However, there is a critical shortage of health care providers in sub-Saharan Africa, and this crisis is hitting faith-based organizations (FBOs) particularly hard. Many FBOs in sub-Saharan Africa are organized into national Christian Health Associations. In 2005 several of these highlighted shared challenges with respect to human resources for health and decided to share experiences on creative ways to recruit and retain staff and other emerging innovations around HRH practices. The Netherlands-based international NGO CORDAID supported this initiative by developing a 'linking and learning' program around human resources for health to facilitate exchange and joint reflection. This article outlines some of the main lessons from this program which sought to document and analyse emerging practices developed by FBOs to improve their HRH situation.

INTRODUCTION

Faith-based organisations (FBOs) run a large number of health facilities, ranging from training schools and hospitals to community-level health posts. It has been estimated that in Anglophone sub-Saharan Africa (SSA), faith-based facilities provide 30-70 percent of the health care services, mainly in underserved areas such as rural, remote areas and urban slums (Dimmock 2005). Adequate performance of health systems (and achieving the Millennium Development Goals for health) requires that qualified health care providers are available and can perform adequately (WHO 2006, WHO 2000). However, there still is a chronic shortage of health care providers in sub-Saharan Africa (WHO 2006, Chatterjee 2011). Although efforts are currently underway to improve the human resources for health (HRH) situation, progress remains slow. For example, of the 57 HRH crisis countries, 45 (79 percent) have an HRH plan, but evidence shows that only 55 percent are implementing these plans (Van den Broek et al 2010).

It can be argued that this HRH crisis is hitting faith-based health providers (FBOs) particularly hard. Firstly, FBO facilities tend to be located in remote, rural, and hardship areas – generally less favored locations for health care providers. Moreover, the

¹³ The authors acknowledge the contribution of the original authors of the 6 case studies: Adjei S., Maniple, E., Dokotala, T.B., Mpoza K., I., Pamba, P.M., Pearl. We are grateful for the support of The Directorate General for International Cooperation of the Netherlands Ministry of Foreign Affairs and Cordaid for the development of this project. Text in this article is drawn from the publication *Quest for Quality* (Adjei et al 2011).

generalised scarcity of human resources results in competition over already limited numbers of qualified staff between public, private-for-profit, and private-not-for-profit (FBO) providers. FBOs often lose out as they sometimes lack the financial resources to match salaries, allowances and other non-financial incentives that are offered in the public sector and by NGOs and private-for-profit sector (TWG 2006). The public sector has been able to improve its remuneration packages through donor funds and debt relief, while International NGOs often offer a much higher remuneration package and more favourable working conditions (WHO 2010, Southall et al 2010). For health facilities to continue to function and provide quality care, especially in underserved areas, FBOs need to develop sustainable approaches to address these human resource management challenges.

Most health care providing FBOs in SSA are organized into Christian Health Associations (CHAs) – national level networks of faith-based health providers and facilities. In 2005, CHAs noted that FBOs in Anglophone Sub-Saharan Africa faced a shared crisis with respect to human resources. They decided to more actively share experiences and innovative practices around HRH, such as sharing creative ways to recruit and retain staff (TWG 2006). The Netherlands-based international NGO Cordaid¹⁴ supported this initiative by developing a ‘linking and learning’ programme around HRH to facilitate joint learning. This article describes some of the outcomes of this program - the cases described here all implemented for at least one year, and dealing with a range of issues such as improving working and living conditions of health workers, task-shifting, enhance performance of managers, or advocacy for more resources.

The main aim of the applied Linking and Learning Program for HRH was to build capacity within participating FBO’s to address the HRH crisis by monitoring experiences with HRH interventions, developing case studies and putting these into context. Furthermore, the program emphasized the production and publication of case studies and outputs by the FBO partners themselves, in order to raise awareness at a policy level about the challenges faced by FBOs and their efforts to improve the performance of HRH workforce, especially in underserved areas. Partners from four countries took part: Kenya, Uganda, Ghana and Tanzania. The program began with two workshops utilizing a conceptual framework to design and analyse HRH interventions, using a system’s approach.¹⁵ During which, participating FBO’s systematically documented their cases, followed by a series of feedback events. These case studies were supported by additional desk review and data collection – conducted in the months between the workshops. The analysis and writing-up was also facilitated by the Royal Tropical Institute (KIT), which brought additional expertise on HRH. The full joint learning program took a year and

¹⁴ Cordaid funds health care programmes of FBO partners that work at community level, provide first line health care services, and that have strong presence in rural areas and urban slums.

¹⁵ The framework visualised a “theory of change” on how implementation of HRH interventions are expected to generate outputs in terms of improved motivation, improved staff retention, increased production of staff etc. These in turn result in the outcome of the intervention in terms of measurable improvements with respect to the availability, productivity, responsiveness and/or competence of health workers. These outcomes of the intervention influence effects, defined in terms of improved service delivery, measured by for instance increased availability, improved access and improved quality of services. Improved service delivery contributes to an improved health status (the impact of the intervention).

resulted in the publication “*Quest for Quality*” (2009), some of which is summarised below.

CASE STUDIES ON INNOVATIVE PRACTICES FOR HRH

There were innovative practices shared through this joint learning program. For example, the National Catholic Health Services (NCHS) in Ghana focused on improving performance of health workers in rural areas by directly supporting health worker through a retention scheme. The Ugandan Catholic Medical Bureau (UCMB) had a similar focus, and created a new cadre of ‘pharmaceutical assistants’ to fill a gap in pharmacy personnel in rural hospitals. The Christian Health Association of Malawi (CHAM) strengthened knowledge and skills of local health facility managers through a performance improvement program for hospital managers and accountants. The Ugandan Martyr’s University (UMU) set up a master’s training program on health services management aimed to strengthen management, including HR management, at local facility level. In Tanzania, with support from partners, the Christian Social Service Commissions (CSSC) developed a geographic information system on health services and human resources, aiming to strengthen its knowledge and skills to negotiate and discuss HRH policies with different stakeholders. Lastly, at the global level, a Technical Working Group on HRH was established among the Christian Health Associations, with the aim to lobby and advocate work with respect to HRH issues among FBO’s and exchange of knowledge and experiences regarding HRH interventions and policies. In the next section we describe just two of these cases in more detail.

National Catholic health services in Ghana: health workers retention

The global policy recommendations on increasing access to health workers in remote and rural areas provides an analysis of the current evidence on factors related to retention, emerging practices, the process to be followed when developing retention interventions and how to monitor and evaluate such interventions (WHO 2010). Improving health worker retention is a major goal in under-served areas and the focus of many FBOs interventions. Retaining more staff contributes to building an institutional memory, which in turn is likely to positively influence productivity and responsiveness. Interventions aiming to retain staff in rural and remote areas are particularly important.

Factors influencing an individual’s decision to leave are multiple, context-specific, change over time and are gender specific. Lehmann et al (2008) showed that single strategies are often used to address retention problems, whereas the underlying reasons why health care providers and managers accept and remain in a post have shown to be more complex. Comprehensive approaches (or ‘bundles of HR interventions’) are likely to yield better results (WHO 2010). For example, multi-faceted HR interventions address the preparation for rural practice during pre-service training, targeting people with a rural background for recruitment and providing professional and community support for rural health workers (Dieleman and Harnmeijer 2006, WHO 2010). Interventions to improve HR retention thus need to address the range of influencing factors simultaneously. These could aim to: improve HR and deployment policies, and develop specific policies for rural recruitment; develop rural training and bonding schemes; address job satisfaction by

improving working conditions, HRM practices, offering financial and non-financial incentives, make possible professional development, include activities and regulations to mitigate the impact of HIV/AIDS at the workplace; improve living conditions, for instance by providing housing; and address the needs of specific groups: allow flexible working hours for health service providers with young children or sick relatives; offer specific arrangements for HIV-positive health care providers.

By 2005, the shortage of key health professionals in Ghana had reached acute levels, especially in faith-based health sector. NCHS observed a growing trend of staff attrition amongst doctors, pharmacists and nurses. Newly-trained staff did not report to their duty stations; those already working were leaving their posts in growing numbers, often without prior notice to the employer; and staff who requested leave did not return. FBO leaders believed that most staff were moving to public sector facilities in urban areas to fill the vacancies created by the migration of large numbers of professionals to Europe and the Americas. By 2005 the staff attrition problem was becoming so acute that almost half of the NCHS facilities were under threat of closure due to staff shortages. The NCHS therefore commissioned a study on this phenomena, interviewing the majority of the remaining NCHS staff. This study found that staff needs and expectations varied: for doctors and pharmacists, financial incentives per se were not the most important factor for continuous service - access to professional training, career and personal development were often considered more important. Some doctors wanted to hold managerial positions, which they felt was more likely to happen in the public sector than in NCHS. A few doctors complained about interference by religious authorities in their professional work. Critically, it was felt that the HRH crisis had become worse as the remaining staff were increasingly over-burdened by heavy workloads. In addition, at the same time, the increased workload carried by fewer staff meant that more over-time, resulting in an increase in total staffing costs.

Based on this, NCHS opted for a multi-faceted intervention to address retention, deciding to move beyond financial incentives alone. Interventions implemented were:

- training to strengthen technical skills and knowledge of NCHS workforce
- competence building of staff through in-service and post-graduate training for health workers, on-the-job-training by visiting professionals and training for managers
- pre-service sponsorships for medical students with a binding agreement that the student joins NCHS after graduation
- skills transfer programmes to enable non-health professionals to perform tasks that do not require technical skills
- promotion of voluntary inter- or intra-diocesan transfers, with the aim to stimulate interest for serving employees who desire to be relocated and improve the skills mix
- offering an end-of-service package, improving allowances and salaries, and allocation of new staff by government through a Memorandum of Understanding with the Ministry of Health.

By 2007, several doctors had accepted pre-service sponsorships and many (103) nurses and medical assistants had benefited from other sponsorship programs. The University of Ghana Medical School assisted the NCHS with identifying students for sponsorship – in

particular those who were prepared to work in rural areas. In addition, almost all NCHS medical and assisting staff had received in-service training, and management teams have received a basic two-month residential course and an annual retreat to discuss HR practices. It was noted that overall, the process of building management capacity was slower than expected, possibly as a result of a generally weak capacity at a management level as opposed to the required competencies. It was common that clinicians who had never had any management training were heading management teams. It was noted that this meant that HRH intervention materials needed to be extremely detailed. There was also a noted difficulty with joint decision-making and implementation.

A further impact study of these staff retention activities within the NCHS was begun in 2010. The preliminary results show a worsening situation in terms of retention, especially for doctors, but an improvement of availability for all other cadres. NCHS has improved its ability to attract staff – however, most staff do not stay for more than five years. One explanation is the desire for specialization among newly qualified doctors and nurses combined with more availability of training opportunities. The study also reveals that, unlike in 2005, doctor's salary and financial incentives have become more important as reasons for leaving. A separate institutional staff satisfaction assessment was carried out in 2010 in all hospitals. Both show a high satisfaction level for hospital staff, but poorer among clinic staff. The NCHS has therefore changed its approach by introducing staff wellness and satisfaction activities in its program of work for 2011 with a special HRH focus for clinic staff. The NCHS experience therefore highlights that effective HR interventions have to be based on a continuous reassessment of expectations and strategies. Consistently though, it is noted that improved financial rewards alone is not sufficient, as some employees value access to training and other non-financial incentives even more than money.

Ugandan Catholic Medical Bureau: Task-shifting to improve Pharmaceutical Services

Currently, the main strategies promoted to improve the number of health workers are: to increase or improve pre-service training, introduce task-shifting and to recruit unemployed or retired workers. With respect to pre-service training, most African countries currently lack sufficient schools and faculties, equipment and internship places to assure quality teaching. For instance, the whole of Africa has 66 medical schools whereas Europe and the Americas have respectively 412 and 441 (WHO 2006). Many FBOs are involved in pre-service training to increase the number of mid-level and lower level cadres – although to understand the full extent of this would require more systematic research. They may have their own training institutes (such as UCMB in Uganda) and provide scholarships, often with bonding agreements (such as NCHS in Ghana). Faith-based providers have found that increasing the number of health care providers by expanding pre-service training is an effective strategy. It is also noted that further attention must be paid to the preparation of rural students for pre-service training as they often lack sufficient qualifications to enrol in the programs of health training institutes (as was experienced by Cordaid partners in Malawi and Tanzania, see Van den Broek 2009). Language skills and school fees which often act as a barrier to the education of health professionals – also require urgent attention.

Another approach to expand the human resource capacity is through task-shifting, when some tasks are shifted to less specialized health care providers (WHO 2007). This type of cadre tend to be less scarce and more willing to work in hardship areas. Positive results have been obtained by training non-physician clinicians in diagnostic and clinical tasks that used to be part of the tasks of medical doctors (Mullan et al 2007). Huicho et al (2008) showed that health workers with shorter pre-service training provided equivalent and sometimes better integrated management of childhood illness services compared to those with longer pre-service training. Zachariah et al (2008) describe successful implementation of HIV and AIDS services by lower level cadres. Several experiences in task shifting have been undertaken by FBOs in the past, although few have been documented – or are recognized outside the FBO systems. The following example describes a task-shifting intervention applied by the Uganda Catholic Medical Bureau (UCMB).

UCMB represents the health services of Roman Catholic Church (RCC) in Uganda, which is comprised of 19 dioceses. There are in total 27 hospitals, 11 health training institutions and 236 lower-level health facilities. In all, 7,525 health workers are employed, of whom 4,782 work in hospitals (data of 30th June 2007). UCMB provides about 40 percent of the FBO health infrastructure, 17 percent of outpatient department services (OPD) services and 35 percent of deliveries (UCMB et al 2007). While there has been no noticeable net reduction in the UCMB workforce, the number of certain health cadres leaving has increased markedly since 2004, especially for nursing cadres. Another cadre noted to be in short supply was pharmaceutical staff. Only three out of 27 UCMB hospitals could afford a qualified dispenser. The other 24 hospitals lacked the financial capacity, and were providing pharmaceutical services either through nurses or others without any pharmaceutical training. There was frequent exhaustion of supplies, inefficient management of the essential drugs scheme, problems with procurement, poor drug dispensing and poor records management.

In the early 1990s the health sector in Uganda introduced an Essential Drugs Scheme to which all health facilities had to comply, including the FBOs. However, this was difficult without appropriately trained staff. To address this, the UCMB created new complementary cadres of staff to support pharmaceutical service delivery – retraining current staff (mostly nurses) and formalizing the informal task-shifting that had already occurred. This decision was based on the advice of an international technical advisory group (TAG), comprising of the five church secretariats in East Africa and the Pharmaceutical Programme at the University of Western Cape. The TAG proposed to introduce a new cadre: *pharmaceutical assistants* (PA), through a regional training program, which was awarded by a certificate in pharmacy. The two-year PA training (PAT) was established in 1995 as a joint venture of the church health programs in East Africa – to meet the immediate training needs of Kenya, Tanzania and Uganda who would pilot the training. The curriculum was developed based on the knowledge, attitudes and skills outlined by the TAG under guidance from the Mission for Essential Drugs and Supplies, Joint Medical Store and the Ecumenical Pharmaceutical Network

and in consultation with other training institutions including the universities in the three countries.

Since then, 51 pharmaceutical personnel have been trained for Uganda (37 aligned with UCMB facilities). Although UCMB has sought to have this training recognized by the appropriate government ministries and corresponding professional regulatory authorities, PAT graduates were never given appropriate recognition by the Ministry of Public Service in Uganda. This became a preoccupation of the trainees. In addition, the entry conditions often hampered access, and there was a clear need for further professional development of trainees. In addition, not enough attention was paid to other HR management aspects such as salary, career structure and entry levels, as the staff concerned were already employed. On completion of studies, the newly trained pharmaceutical assistants were offered a salary increment to match the increased responsibilities. Their job description was based on the training curriculum, but did not mention explicitly which tasks were shifted from the dispensers to the pharmaceutical assistants. Financial sustainability of the PAT program is a concern with over 90 percent of the program income from grants from two donors – and few of the PAT trainees or facilities in a position to pay the full fees if donor support was withdrawn. Other funding options and possibilities for diversification have to be pursued. However, in Uganda, all 27 hospitals of the Catholic Church now have at least one trained person in the area of pharmacy: either as pharmacist, dispenser or pharmaceutical assistant. In fact, the failure to get formal recognition from the government bodies contributed to the retention of the PA graduates in FBO health facilities because they cannot find comparable employment in non-UCMB facilities. But recognition remains an important issue that is still being pursued – as are other areas relating to HRH which could potentially benefit from task-shifting.

Several important lessons can be learned from the UCMB case: new tasks for cadres need to be carefully planned and included in job descriptions, as FBO facilities are increasingly integrated into national health systems, new cadres need to be embedded into the existing job categories of the Ministry of Health. In this way, these new positions are incorporated into the existing salary structures and staff have opportunities for career development (promotion, in-service training, even mobility - see also WHO 2007). Any attempts at task-shifting should involve all stakeholders from the outset: the professional regulatory bodies, professional associations, government Ministries, FBOs, denominational bodies and UN agencies so alliances are formed and credibility is established. In addition, HRH can be improved through the utilization of retired or unemployed health workers – which requires further negotiations with other ministries on adjustment of public sector budget ceilings and recruitment restrictions in order to allow the ministries of health to employ additional staff.

DISCUSSION: IMPROVING HEALTH WORKER PERFORMANCE

Quality of care is to a large extent determined by staff performance. This is a combination of health workers' competencies, their productivity and their responsiveness to patients' and the health system's needs. Competency, productivity and responsiveness

are influenced by a number of interrelated factors, such as having appropriate knowledge, skills and attitudes, being present at work, working conditions, job satisfaction and motivation, and being accountable to management and clients. The improvement of health facility management is important for staff performance, as has been highlighted by the case studies. Inadequate management has a negative influence on service performance and can damage health care providers' motivation and performance. The case studies of UMU in Uganda, CHAM in Malawi and NCHS in Ghana (described in detail in the report) all indicate that one of the main problems in the health sector is that managers of health care facilities often lack appropriate skills and knowledge. As the cases show, a major reason for this situation is that medical doctors or other health professionals often manage health facilities. Pre-service training of these professional health cadres tends not to include training in management competencies. There is thus an urgent need to create a critical mass of trained managers to assure that human resources are managed appropriately at different levels in the system. Training of managers should not only focus on management of resources, but also on policy and strategy development, lobbying and advocacy skills.

In-service training or continuing education is used mostly to improve performance of health care providers and managers. However, experience has shown that in-service training does not guarantee improvement of performance, although it is important for updating knowledge and skills (Dieleman and Harnmeijer 2006). Integrated approaches are likely to be more successful, which include developing procedures and tools and setting up peer support and supervision. The work of CHAM in Malawi around strengthening hospital management is an example of such a comprehensive approach. The CHAM focus is on improving the performance of hospital managers and accountants through institutional capacity building instead of just offering a one-off training course. The Financial and Material Management Improvement Program uses a combination of job aids, training, coaching and individual distant support (by e-mail and telephone exchange), peer support and supervision after training. They developed also manuals and procedures.

In areas with a high HIV prevalence, special attention needs to be paid to mainstreaming HIV/AIDS activities, such as infection control, training for dealing with HIV-positive patients and colleagues, and regulations assuring access to care and treatment of HIV-positive health care providers in workplace policies. When implemented appropriately, these can reduce stigma and discrimination of HIV-positive health care providers and fear for infection and enable HIV-positive health care providers to continue their work. Guidelines to deal with HIV/AIDS at the health workplace exist (ILO/WHO 2005), but the results of these interventions have not yet been properly documented. The various underlying factors for poor performance need to be identified first before designing appropriate strategies. These should be context-specific and could include:

- Addressing the living conditions of health workers in rural areas or the needs of specific groups, such as female health workers or workers in specific age groups
- Activities at health facility level, such as specific quality assurance and performance improvement interventions, based on local problem analysis

- Changes in payment systems (for instance contracting-out of services), decentralisation of human resources management functions, community participation in health care management and strengthening accountability mechanisms
- Development or improvement of human resources management activities, such as implementing performance-based incentives, conducting supportive supervision, providing in-service training and improving leadership and management

DEVELOPING AND IMPLEMENTING HRH INTERVENTIONS

Creating space for innovation and change: FBOs often have long-standing relationships with external funding agencies (many of whom are also faith-based, which sometimes gives them the freedom to experiment with innovative approaches as described here. The challenge is how best to select priorities, involve all stakeholders and ensure sustainability of these interventions. This requires the alignment of FBO-initiated HRH interventions with national HRH interventions and their integrating in the health system. Achieving change also requires a process - of analysis, reflection and ‘change-making’ – for which a safe space must be protected and management skills developed.

Selecting HRH interventions: Four of the six interventions described here (NCHS, CHAM, UCMB and UMU) emerged as a result of other studies. NCHS interviewed staff to identify reasons for attrition and then addressed the findings through their intervention; CHAM implemented a study among hospital staff prior to the development of their program; UCMB based theirs on the results of an international study to assess pharmaceutical services in church health facilities; and UMU developed a Master’s programme for health managers, based on an external evaluation of their existing Master’s in Hospital Administration. It should be stressed that this is not the norm or even common practice. Indeed, Lehman et al (2008) concluded that there is limited evidence of retention interventions being developed on the basis of results from baseline studies; and it has been noted that effective sharing of experiences across Christian Health Associations and faith-based facilities has not developed sufficiently.

Stakeholder involvement: A consistent lesson of the more successful strategies is the involvement of all key stakeholders in the formulation and implementation of HRH interventions (Dussault and Franceschini 2006). All the cases described in this study have involved a wide range of stakeholders: NCHS asked for feedback from health workers; CHAM interviewed and involved hospital managers; UCMB developed the pharmaceutical assistant training in collaboration with FBOs outside Uganda; for the UMU masters’ program, both UCMB and the Ministry of Health were involved in curriculum design; and CSSC developed the HRIS system in consultation with its partner-organizations and stakeholders. The huge variety of stakeholders to be taken into consideration makes decision-making complex and time-consuming. However, most FBOs have become accustomed to dealing with a wide range of stakeholders, for example they maintain extra connections to their churches, denominations, networks and faith-based funders, each with their own requirements and interests. Whether HRH interventions are implemented depends on the owners of the individual facilities (often churches), and integrating the HRH interventions in the overall plans of the member-

facilities. This makes alliance-building to support decision making in these facilities important.

Mapping interests and influence: Mapping and analysis of the interests of stakeholders, and how they influenced (positively or negatively) the selection and implementation of HRH interventions are required. This would help produce a better understanding of which interventions would be more acceptable, feasible and sustainable. However, analyzing the opinion of key stakeholders on the planned intervention and mapping their influence was not common practice among the participating FBOs; and FBOs did not sufficiently assess whether all key stakeholders were actually consulted as planned. The UCMB case, for example, demonstrates that regulatory bodies and the Ministry of Health were not facilitating the integration of the pharmaceutical assistant in the professional cadre of pharmaceutical personnel as anticipated, which caused major challenges to the intervention. This is in line with other findings and may affect sustainability and institutionalization of interventions (Dussault and Franceschini 2006). More attention for stakeholder analysis would help in developing strategies on how to better accommodate the different interests.

Gendered HRH interventions: The involvement of health workers in developing and implementing interventions is especially important for success. However, the category 'health care workers' consists of several subgroups with different needs (such as gender, different professional cadres, difference in age). Gender differences are prevalent in the workplace; gender and power relations are likely to play a role in decision-making regarding HRH issues. Gender especially appeared to be a neglected issue in most cases described here. UMU analyzed gendered differences of participation in their training, did not seem to act on this information: no targeted strategies were developed to increase enrolment of female health care providers in their courses. Some FBOs are working on making their Human Resource Management more gender-sensitive, but more insight is needed on the gendered-dimension of HRH – especially in FBOs. For example, there is a need for gender-disaggregated data in order to identify the division of labour between men and women at management level, among regions of the country, and across primary, secondary or tertiary level or in the provision of informal and formal health service provision. It is equally important to understand the difference in perceptions between female and male health care providers on location of work, motivational and discouraging factors, and required support. These insights will allow for the formulation of more gender-sensitive HRH interventions (George 2007).

Involving health workers and patients: More attention needs to be paid to the involvement of patients in interventions to improve performance of health workers. For instance, feedback from patients on the service given by health care providers can increase their responsiveness to patients' needs, which can in turn improve motivation. Health care providers also have the obligation to provide quality services. Opportunities need be created to include communities in accountability mechanisms towards improving performance of social services in general and of health care providers and their managers in particular. Valuable experiences with accountability towards communities are gained in Mali (Lodenstein et al 2007). The extent to which HRH interventions can be

implemented according to plan depends on the decision-making power of the organization that developed the HRH intervention, and the influence of other stakeholders.

Financial resources for HR and sustainability of interventions: Over the years, FBOs have experienced a decline in donor funds and become more dependent on user fees. This shift makes it difficult for FBOs to offer attractive remuneration and allowance schemes, and thus match working conditions and incentive packages offered by government and private institutions. This is leading to problems attracting new staff, high staff turnover and more work pressure on remaining employees. In response, FBOs are exploring extra funding opportunities from government and global initiatives to hire staff, pay salaries or provide salary top-ups. Given that FBOs have limited resources, financial incentives should be complemented with non-financial incentives such as housing, in-service training, appreciation by managers and rotation between facilities.

Improved financial planning: Three out of the six interventions studied face problems regarding their sustainability. For example, the program in Malawi depends on external funding, with donor funding not yet secured and the Ministry of Health not yet actively engaged; UCMB is not able to integrate the new cadre they created into the existing professional categories, nor is the program financially sustainable; and the TWG has not been prioritized by the participating CHAs. Alignment of HRH interventions between FBOs and national agendas needs to be discussed for each intervention, and the risks of non-alignment need to be seriously weighed. Adequate financial resources for sustainable implementation need to be considered (Dieleman and Harnmeijer 2006). To avoid sudden depletion of funds, an estimation of required funding, technical support and possible commitments by partners is needed. Plans also need to be made also for future financing and capacity needs for sustaining implementation without external support.

Monitoring and evaluation: The designs of the HRH interventions described here are mostly based on logical and pragmatic arguments, with implicit assumptions about expected results. One of the lessons has been that expected results of these HRH interventions must be made explicit in advance – this in turn would make it possible to develop appropriate monitoring and evaluation (M&E) systems. Such knowledge can assist policy makers and planners in deciding on the up-scaling of interventions. In the cases described here, although innovative projects, the assumptions about expected results were not made explicit, nor were M&E methods and indicators well defined. Consequently, the FBOs have difficulties in documenting progress and in assessing results. Most have the *impression* that their interventions have worked well, but they cannot demonstrate to what extent achievements of the various approaches are in line with expectations in terms of improving retention and motivation, availability, productivity, responsiveness and competency of health workers or managers. The lack of solid M&E for HRH is a general constraint. Too often little evidence is available on what works and what does not (WHO 2006). There is an urgent need among FBOs to build capacity on M&E for interventions addressing health workers and to exchange (existing) tools, methods and indicators. The first step for FBOs is to better monitor and evaluate progress of different HRH interventions, using indicators related to the expected results

and other assumptions made from the beginning. This will require the use of qualitative and quantitative methods and appropriate record keeping at facility level.

CONCLUSION

FBOs are clearly active in experimenting with different strategies, as the various cases show. They cover important part of rural and remote areas in Sub-Saharan Africa, where the HRH crisis is often the most severe. These cases show that FBOs' try to develop and implement interventions at local, regional and international levels to improve health worker performance and thus access to and quality of care. Sharing and documenting these experiences is important, as they contribute to the knowledge-base on HRH interventions. The case studies also highlight the importance of advocacy and lobbying to attract more recognition for the contribution of FBO to health services delivery, put HRH problems faced by FBOs on the agenda, and to assist FBOs to build strategic alliances for HRH solutions. Skills building among FBOs for advocacy and lobbying seems to deserve a high place on the agenda of action among FBOs.

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CHAPTER 7

FAITH UNTAPPED: LINKING COMMUNITY-LEVEL AND SECTORAL HEALTH AND HIV/AIDS RESPONSES

Geoff Foster, Talent Maphosa, and Frank Kurebva

Mutare Provincial Hospital, District Medical Officer, and Ernst and Young

Community-based organizations provide important health services, especially in countries with poorly-developed health sectors. But community health responses are poorly understood and most are not linked to district health systems. This article describes the HIV responses of local churches in Zimbabwe and suggests how health sectors may link more effectively with community- and faith-based health initiatives.

INTRODUCTION

Community participation in health is a fundamental human right. The Alma Ata Declaration defined primary health care as essential health care made accessible to families in the community through their full participation. It noted that ‘*people have the right and duty to participate individually and collectively in the planning and implementation of their health care*’. Benefits result from linking community and health sector responses. These include:

- increased numbers of people from underserved areas accessing clinical services
- better follow-up and adherence to treatment of patients with chronic illnesses
- better understanding by health workers of the socio-economic determinants of health
- improved quality and increased coverage of community-level health activities (WHO 1978, Richter and Foster 2006).

Formal health sectors interact with communities through outreach services, community health committees, and clinic health worker involvement with traditional birth attendants, community health workers and other volunteers. But community-level groups, organizations and committees frequently initiate and implement their own health-related activities. These groups vary considerably in their make-up, functioning and degree of engagement with health structures. The heterogeneity of community health activities makes community-owned health initiatives difficult to characterize. But one characteristic is undisputed – their pervasiveness. A nine-country study sponsored by the World Health Organisation found over 500 community groups implementing health activities in two districts in Nigeria and Senegal (WHO 1994).

A subsequent study confirmed that women's, youth, religious and traditional groups, termed ‘local civil society organizations’ (LCSOs), undertook considerable health development activities. LCSOs contributed to health development but their activities were poorly recognized and under-supported by health sectors (Laris et al 2001). LCSOs

engaged in health activities frequently complain about the growing distance between themselves and the formal health sector.

Civil society health responses have proliferated in sub-Saharan Africa as a result of the impact of HIV/AIDS. Community safety net initiatives such as credit associations, burial societies and cooperatives have modified their *modus operandi*; new LCSOs that meet the needs of particular groups affected by the epidemic have also been established (Foster 2005a). Support groups for people living with HIV/AIDS and home-based care initiatives for the chronically ill represent important new community-based health responses (Foster 2009). Mapping of orphan and vulnerable children support initiatives in four Ugandan districts identified one per 1,300 people, suggesting over 20,000 OVC initiatives throughout the country (Nshakira and Taylor 2008). One group, noting the extent and impact of community-initiated HIV responses, concluded: “Many years from now, when the history of the global HIV epidemic is written, self-help and community support initiatives will receive their proper recognition as the unique contribution of the African continent” (SAT 1999). But studies suggest that referral and close interactions between community home-based care responses and formal health care facilities are uncommon, confirming previous conclusions that linkages between health sectors and civil society health initiatives are lacking (Ogden et al 2004).

Most community-level HIV/AIDS responses globally may be implemented by faith-based organisations. Some 5,000 faith-based groups supported children, people living with HIV/AIDS, and the chronically ill through home care initiatives in Lesotho. A mapping study in Zambia found that congregations and religious support groups constituted the majority (63 percent) of community-level organizations with health activities; faith-based groups represented 71 percent of all organisations with an HIV response. Of 96 congregations and religious support groups surveyed, 88 (92 percent) offered one or more HIV-related service (ARHAP, 2006). Surveys of HIV responses by churches in other countries with severe epidemics suggest most churches have developed an HIV/AIDS response, as shown in Table 1 below (UCAN 2003, Weekes 2007, Yates 2003).

Table 1: National Surveys of Church HIV Responses

Country	Nr local churches surveyed	Churches with HIV response (%)	Level of HIV response (%)			Churches receiving external funding (%)
			Basic	Developing	Full-scale	
Namibia	95	87	32	38	30	21
Uganda	223	68	68	28	5	28
Sierra Leone	353	34	53	37	10	23
Total	671	53	55	34	11	25

Source: UCAN (2003), Weekes (2007), and Yates (2003).

Most research on community participation in health has focused on structures established by government health systems. Less attention has been given to the nature and impact of community health initiatives, how they interact with the health sector, and how they can

be strengthened. This study was conducted as the first phase of a multi-country project designed to strengthen community-level HIV initiatives through the establishment of community care networks linked to government health clinics in southern Africa.

METHOD

Zimbabwe has a population of some 12.6 million people. The major religious affiliations are Christian (78 percent) and traditional ethnic (19%). It was estimated there were 25,689 Christian congregations in Zimbabwe in 2000, about one church for every 500 people (Mandryk, 2010). The city of Mutare and its surrounding rural district have a population of 417,845 and are served by a network of 48 health centers. The study was conducted in late 2008 when the Zimbabwean economy had collapsed as a result of an inflation rate that reached 230 million percent and mass unemployment of over 90 percent.

The goal of this initiative was to strengthen faith- and community-based HIV responses through establishing care networks linked to health centers. The first phase aimed to map all faith- and community-based organizations in the catchment areas of two clinics in Mutare district. The district health executive purposively selected two adjacent rural health centers to pilot the initiative because each had a qualified nurse and were in areas not receiving support from a development project. The clinics served a combined population of 15,165 in 33 villages in a remote, poverty-stricken, drought-prone area with a large population of independent Zionist and Apostolic spirit-type churches.

Clinic staff were requested to identify all faith- and community-based groups, committees and organizations in their catchment area and invite them to send representatives to meet with researchers at the clinic. Trained data collectors interviewed each representative using a previously piloted questionnaire and obtained details about each organization and their HIV-related activities. A focus discussion was held with each group that indicated general willingness to establish a community care network to meet regularly at each clinic. Care network committee representatives were elected by each group. Collected data was subsequently analyzed and the results were discussed with both community care committees that engaged in strategic planning of network activities.¹⁶

RESULTS

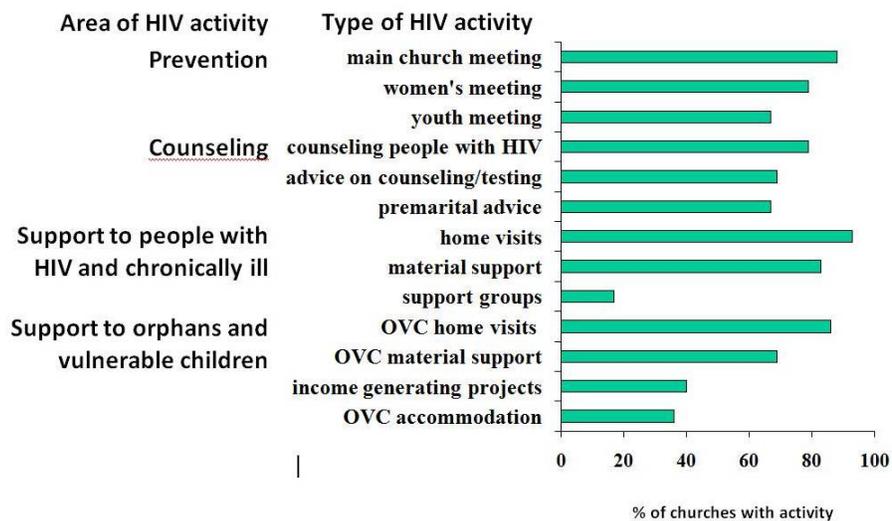
Respondents were requested to identify other local faith- and community-based organizations not present at the assessment meetings. No other organizations were identified through this process. Around each clinic, 21 Christian churches and no other community-based or faith-based organizations were identified in either catchment area. There was one church per 360 people in the area of the study; 65 percent of churches were affiliated to a religious umbrella body while 35 percent were

¹⁶ The Faith to Action project was initiated by the Kellogg Foundation in 2008. The project aimed to establish pilot projects in Zimbabwe, Mozambique and Lesotho during the first year, leading to possible expansion thereafter. The project was terminated in November 2008 following the abrupt cessation of contracts with southern African partners by Kellogg Foundation and the closure of its African office.

independent. Churches had memberships of between 10 and 200 adult members; denominational churches had an average of 76 members while independent churches averaged 69 members.

Ninety-five percent of churches were engaged in HIV activities; only two, both African independent churches in which members held a worldview that included exclusive spiritual causation of disease, had no HIV/AIDS activities. Churches with HIV responses engaged an average of 13 volunteers in their activities. No church involved a paid member of staff who was ex. Churches were involved on average in 9 HIV activities (Fig. 1). The most common activities, implemented by over 80 percent of churches, were: counseling people living with HIV/AIDS; material support for affected households; home visiting of orphans; home visiting of the chronically ill; and HIV prevention in both women’s and main church meetings. Less common activities implemented by less than 40 percent of churches were: income generating projects; HIV support groups; and accommodation for orphans and vulnerable children (OVC)

Figure 1: Prevalence of HIV-Related Activities Amongst 42 Churches in Zimbabwe



Source: Authors.

The main motivations underlying church involvement in HIV activities were to provide comfort (47 percent); to serve God (17 percent); and to reduce the spread of HIV (12 percent). Churches’ most common objectives in developing their HIV responses were to reduce the spread of HIV infection (36 percent) and to provide more material support (24 percent) or money (12 percent) to beneficiaries. Churches requested material support, especially food and clothing (27 percent); training in HIV care and prevention (26 percent); money (22 percent); and networking (14 percent) in order to develop their HIV activities. Three-quarters of churches relied exclusively on contributions by their members to support their HIV responses. Less than ten percent of churches received contributions from outside their community. Less than ten percent had an office, a bank account or a telephone. If churches were to receive additional financial support for their HIV activities, they would use this to provide material support (48 percent) and to

facilitate income generating activities (29 percent) for beneficiaries. Only 20 percent of churches with HIV activities were networked with another organisation that provided them with financial or technical support for HIV activities.

DISCUSSION

This study sought to identify all community-based health and development responses in the catchment areas of two rural health centres. No community-based organisations (CBOs) were identified in this remote, under-served area of Zimbabwe. This contrasts with findings from studies in other countries where CBO HIV responses are common (see ARHAP, 2006). A Ugandan mapping study that identified CBOs supporting vulnerable children found that 65 percent had received external support in the form of financial or material assistance (Nshakira and Taylor 2008). External support contributes to the establishment of new CBOs and enables existing CBOs to continue functioning. Zimbabwe's economic crisis was associated with reduced availability of external sources of support and this may account for the absence of CBOs observed in the study.

Religious bodies offer the most extensive, best-organised and most viable network of community organisations in sub-Saharan Africa (Foster 2005b). This study identified a high prevalence of religious congregations, suggesting the resilience of congregations and faith networks that are self-supported and driven by religious calling in the face of severe adversity.

Nearly all churches in this study implemented several HIV-related activities. Most responses operated at a basic level with activities implemented on an occasional, reactive basis, relying almost completely on church volunteers and depending on the contributions of members for resources. In studies from other countries, the majority of HIV responses by churches were noted to be "basic", utilising the efforts of volunteers who were members of the church and with little formal HIV/AIDS program infrastructure (Table 1). Some churches had "developing" responses with programmes in which small-scale funds were raised for HIV activities. A few churches had "full-scale" responses, accessing substantial funds to operate systematic programmes with dedicated professional staff (UCAN 2003). This study did not attempt to measure whether the responses of churches were effective in mitigating the impact or preventing the spread of HIV.

Most churches wanted to develop their HIV activities to prevent the spread of HIV and help more people affected by the epidemic. Churches most commonly requested external assistance in the form of material support (food, clothing or medicines) or money, the former twice as frequently as the latter. This might be explained because the study was conducted when the cash economy in rural Zimbabwe had virtually ceased to function. Churches may also prefer material support which is easier to administer than cash, given their limited financial administration capacity.

Churches frequently requested assistance for training in this study. Studies from Namibia and Mozambique found that churches requested training more frequently than financial

resources, indicating churches' strong voluntarism and philanthropic motivation (Foster 2011, Yates 2003). Practical difficulties exist in delivering appropriate training to large numbers of low-capacity organisations such as churches. Training may be more accessible when provided through community care networks linked to local clinics.

A few churches in the study, mostly those with better established HIV activities, had received technical support from religious umbrella bodies, non-governmental organisations or government structures. Studies of churches in Namibia and Uganda also found that three-quarters or more were not networked with any organisation that provided them with support for their HIV activities. Linkages between churches with HIV responses and the health sector are poorly developed throughout sub-Saharan Africa. Most churches were willing to join local community care networks that might meet together regularly at government health institutions to receive training and support and might help them develop their HIV activities. This was despite the fact that the churches represented a broad range of religious perspectives, including marginal and independent Christian sects. There are advantages in establishing community care networks of faith- and community-based organisations that are linked to health clinics.

1. Care networks enable regular contact between health services that are administered by district health executives and community members; this promotes community participation in health care provision and helps achieve one of the principles underlying primary health care provision
2. Care networks enable appropriate training and support to be delivered to large numbers of organisations implementing health and HIV-related activities. This can enable small organisations to scale up their activities and increase the effectiveness of their activities. Local networks can facilitate appropriate learning from peers rather than from external organisations. Congregations may expand their "basic" HIV responses into "developing" initiatives or even "full-scale" projects through strategic planning, monitoring system development, mobilisation of financial and human resources and organisational development. Networking with health sectors and non-governmental organisations may enable local organisations to incorporate principles of best practice and align their activities with public health priorities (Foster 2010).
3. Care networks allow the development of new initiatives that can help meet people's health needs. Many of the problems that cause high morbidity and mortality, such as malnutrition, maternal and early childhood mortality and HIV/AIDS, are difficult to solve by improvements to formal health sectors alone. These problems demand engagement with affected communities and families so that these conditions may be effectively prevented and treated. Large numbers of small organisations currently engage in health-related activities in uncoordinated and unsupported activities. When such initiatives are networked together and partnered with health sectors and external organisations, it is possible to develop more appropriate responses that can be scaled up through the health sector delivery systems. One example of an innovative solution that emerged from this study was the establishment of community "funds" providing emergency food and financial assistance that could be drawn upon by member

organisations in the event of an health crisis, such as acute food shortage or medical emergency requiring transport costs and medical fee provision. Individually, churches lacked the capacity to operate emergency funds but care networks were deemed appropriate implementers of this service for community members.

CONCLUSION

Throughout the last few decades, civil society health responses have proliferated. States have adopted primary health care declarations enshrining principles of community participation in health activities. But few health care systems have attempted to tap the health resources that surround their institutions by incorporating community-level organizations into health care provision. Faith- and community-based organization resources are largely untapped by formal health sectors. Yet clinics are well positioned to serve as nodes around which networks of surrounding community groups can connect together and link to the formal health sector. This study of religious organizations in eastern Zimbabwe demonstrates the potential of a model of linked community and sectoral health provision that could be replicated in countries with under-developed health care provision and lead to improved health outcomes for populations.

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CHAPTER 8

MASANGANE: AN INTEGRATED COMMUNITY RESPONSE TO HIV AND AIDS IN RURAL SOUTH AFRICA

James R Cochrane, Liz Thomas and Barbara Schmid
African Religious Health Assets Programme

When state roll-out of HIV treatment was sporadic or non-existent, Masangane, a faith-based program affiliated to the Moravian Church, was initiated in response to the evident pastoral needs of people in Matatiele and Shiloh in rural Eastern Cape, South Africa. Contrary to sceptics, it demonstrated that a rural, community-based program could deliver care and support to those infected or affected by HIV and also could initiate and sustain a multi-year antiretroviral therapy (ART) program. The South African state has since initiated a more comprehensive roll-out of HIV treatment in place and Masangane no longer operates in such a rarefied context. However it remains relevant to a comprehensive, integrated response to the pandemic, and offers insight into the role and potential of community level, faith-oriented initiatives in health. This report summarizes the case study evaluation conducted in 2005, which sought to better understand Masangane as a replicable exemplar of development practice in the field of health.

INTRODUCTION

As South Africa emerged from apartheid, alongside the expected challenges of reconstruction and development, it found itself overwhelmed by the HIV pandemic. The political freedom of democracy and the growing confidence that came with the dismantling of the apartheid system was dampened by high levels of poverty and inequality, increasing deaths from AIDS complications, and concern at the country's capacity to respond to the pandemic. Beyond issues of political buy-in and leadership, key concerns for health practitioners and policy-makers, regarding inequity in access and the capacity of the health system, revolved around:

- Lack of staff, especially trained staff, to be able to implement the program
- Long distances and high costs for those needing to get access to ARVs in more remote areas
- Long waiting lists in the state health system for those needing ARVs
- The impact of a vertical ARV program (with a lack of adequate horizontal integration) on the morale and capacity of the staff of the public health system at a primary care level
- Concern regarding the integration, sustainability and scaling up of the program and its potential to undermine the health system

Masangane (isiXhosa for 'let us embrace one another') is a faith-based response to the impact of HIV and AIDS on local communities in the Eastern Cape province of South

Africa, served by pastors of the Moravian Church. Beginning with HIV awareness programs, it subsequently expanded its operations to provide an integrated response to HIV and AIDS through prevention, treatment, treatment literacy, mentoring of treatment, orphan care, and other support for those infected and affected by HIV. At the time of the research in 2005, Masangane had a staff of four: a treatment manager and coordinator, an orphan care coordinator, a counsellor, and an administrator. All other activities were coordinated through a body of volunteers.¹⁷ Crucial to the ability of Masangane to win the confidence of those it sought to serve was (and remains) the fact that the primary community workers were all openly HIV positive. Masangane serves all who come to it, and not only members of its affiliate Moravian Church, nor only Christians. Equally crucial to Masangane are the networks that sustain it, from the commitment of donors, many religious themselves (e.g. church-related aid agencies or local congregations in other countries), to private doctors, to professionals from *Médecin Sans Frontières* (MSF) and the Treatment Action Campaign, and the Moravian church.

ARHAP's study of Masangane was predicated upon certain specific goals, and a unique approach to the subject. The goals of the study were to describe the activities of the Masangane ARV programme, consider the views of various stakeholders, evaluate the impacts of this faith-based organization, and assess the 'value added' of its services as a result of it being faith based. The study also explored the practices of beneficiaries of the ART program in their regular use of multiple health systems - biomedical, traditional, faith – simultaneously or consecutively. Important to understanding both the study and its results is the conceptual framework used by ARHAP, where Masangane is framed as a 'religious health asset' (RHA), and also as a repository of varying RHAs at another level.¹⁸

METHODOLOGY

A mixed method case study design was used, as elaborated in Table 1 below. Qualitative methods were supplemented with a questionnaire developed to quantify and understand the views and circumstances of the beneficiaries of the project.

The survey showed that of the respondents: half were heads of households, nearly two-thirds were unemployed, and a similar number had lived in the area for more than five years. Self-rated health status data shows that two-thirds of men regarded their health as good, while almost three-quarters of the women believed their health to be fair or poor. Chronic illness was widespread, and about one third of the households surveyed had experienced a death in the previous year.

¹⁷ Subsequent to this evaluative research, the state supported 20 community health workers to be linked to Masangane.

¹⁸ This RHA framework is briefly described in the companion chapter in this collection. For the sake of brevity, this Note utilizes the term 'faith-based organization or initiative (FBO/I)'.

Table 1: Tools used in the Masangane evaluation study

Tools	No.	Interviewees
Key informant interviews, semi-structured	16	Funders, doctors, decision makers in Masangane as well as selected health seekers
Additional unstructured interviews	6	Traditional healers and family members of clients
Health seeker (“client”) questionnaires	77	59 Masangane clients on ARVs and 18 not on ARVs, 77% of the total of 100 Masangane clients
Focus groups	2	One support group in Matatiele and one in Shiloh
Participant observation		Multiple HIV support group meetings, visits to households identified from the health seeker questionnaires

Source: Authors.

Most interviews and the participant observation were conducted by Xhosa-speaking field workers; other team members spent a week in the area. Interviews were digitally recorded, transcribed, translated, and analyzed. Researchers also had access to documentary records, annual reports, photographs and published pieces on Masangane. The multiple methods used in obtaining data helped to build up a complex picture for the research team, adding to the validity of the findings. The client or health-seeker survey was carried out using a structured questionnaire, incorporating: socio-demographic profile of the respondents, self-reported health and mental health, religious beliefs, health seeking behavior, and where appropriate, experiences of using ARVs and Masangane’s services. Standard questions were used as much as possible, including validated measures for self-reported health and mental health (see the WHO’s SRQ20 questionnaire). ARHAP also developed specific questions suited to its conceptual framework, to explore the ‘value added’ of Masangane as an FBO/I, participants’ plural health approaches, and the impact of plural health systems on their health seeking behavior.

RESULTS

The results of this research reflect the state and status of Masangane as of 2005. While the program is ongoing, certain details have changed since then and are not incorporated in this article. What has not changed are the factors identified in ARHAP’s research that are relevant to understanding Masangane as an exemplar of faith-based responses to health at a community level. We thus retain the present tense in describing Masangane in what follows.

Masangane’s *continuum of care* includes a very successful treatment program serving up to 100 people, operated in partnership with private doctors and run by a treatment coordinator, herself on ART. Key to their success is getting those who are very ill onto ARVs quickly, and the use of an effective treatment literacy program, modeled on the MSF approach. Adherence to ARV drugs in the program is also very good. According to the beneficiaries this is in important ways associated with several factors:

- Linking the routine of taking the drugs to an existing daily bible reading ritual
- Given crucial hope and encouragement by strong support groups and treatment supporters

- challenging stigma theologically through enlightened leadership in the Moravian and other faith communities in the area
- being welcomed, “embraced”, supported and encouraged in their ART regimen

The Masangane treatment program is complimented by its orphan support initiative and HIV awareness educational work in local communities, and in Matatiele, by home based care provided by Noncedo, a partnering community-based organization. The activities are managed by a small team who have been able successfully to negotiate funding with church-based agencies in Europe and the USA, manage the resources astutely, and simultaneously maintain a high standard of care. Masangane can justifiably be regarded as a vital *community health asset*. The impact of Masangane extends from the improved health and well-being of the clients to their acceptance in the community where stigma has been reduced. Beneficiaries not only participate in treatment support groups that offer a sense of belonging, fellowship and dignity, but also often volunteer to work in the broader community.

Masangane as a program has been able to preserve and manage a connection to the teaching, values and structures of the religious tradition within which it is embedded while maintaining a scientific approach to the actual treatment it offers. To be able to call on the resources of its religious tradition, and yet remain open to new possibilities in responding to AIDS, to offer a Christian embrace to those with HIV – wherever they come from – and draw them into a well-controlled bio-medical treatment program, is no mean feat. In this regard, its *faith-based character* adds considerable value, difficult to measure, yet very clearly an important part of its success.

The *diversity and plurality of health-seeking approaches* among Masangane health seekers is common. Mixing strategies while on ART is a controversial, even dangerous matter. But it is more often than not the norm in the context in which Masangane works, perhaps even pervasive, and it has its own logic. People mix health strategies and systems for various reasons: desperation, frustration, ease of access, competing claims of effectiveness or lack of trust in public institutions. Most of the respondents said that they did use, or would like to use, multiple health systems, whether concurrently or sequentially. Masangane itself might be seen as resting primarily on ‘Western’ ways of dealing with AIDS and this is certainly true in respect of its treatment practices and protocols. But it also represents something that has become increasingly part of public health thinking, namely, the need for a far more holistic response to illness and disease. In the case of Masangane, this includes its comprehensive range of responses to prevention, care and support beyond its bio-medical activity. The clients see considerable benefit in being associated with Masangane because of the importance it gives to the integration of their Christian belief system with healing, to the point where they regard its ARVs as more effective than the identical drugs provided in the public health system.

What appears to be highly valued is the integration of providing drugs to address the physical condition of the body with the person’s belief system and social context, referred to as the spiritual and social body. From a ‘Western’ medical perspective, what is valued could be described as the integration of the physical healing (control of the virus with

ARVs) with the psycho-social aspects of the individual as well as re-integration/re-acceptance into the community. When asked about the impact on well-being (*impilo*) on faith (*inkolo*), over two-thirds reported that it played a major positive role.

Table 2: Importance of faith in coping (%)

<i>Role of faith in:</i>	<i>Not important at all</i>	<i>Always & Very very important</i>
Giving me hope for the future	3.6	75.0
Helping me make meaning in my life	10.9	72.3
Helping me survive	6.9	77.5
Giving me a sense of belonging	12.5	66.1

Source: Authors.

Contrary to widespread perceptions that religion or faith places strong constraints on people's behavior and attitudes that might produce negative outcomes for health interventions, the Masangane clients showed surprising levels of freedom in this respect.

Table 3: Importance of faith (negative influence) (%)

[Share in Col 2 included in totals of Col 3]

<i>% Role of faith in:</i>	<i>not important at all / sometimes important</i>	<i>very very important</i>
	<i>not important at all</i>	
Making me feel uncomfortable about my sexuality	42.6	66.0
Stopping me carrying out rituals	55.4	69.4
Raising taboos	58.0	70.0

Source: Authors.

Indicating a mix of religious practices, half (56 percent) said they sought ancestral guidance, and just under a third (29 percent) reported the use of 'muti' (traditional medicines) themselves. Traditional rituals were used by nearly two thirds of the respondents (62.7 percent) and a quarter (25.5 percent) consulted 'sangomas' (herbalists and diviners) while 15.3 percent said that they were sangomas themselves.

Assessment of Masangane as viewed by external stakeholders

Rural access: While the conditions of rural isolation and poverty create challenges to the provision of reliable ART service, Masangane has developed a program and methodology that copes with many of these constraints in an exemplary fashion.

Speed of treatment response: Masangane uses its access as an FBO and its local knowledge to provide fast entry into ART with good support structures already in place.

Follow-up and monitoring: Follow-up, effective local support and education and counseling services make Masangane a preferred provider for health-seekers.

Adherence: Masangane is able to offer close monitoring services for ART, resulting in generally very high levels of adherence.

Support groups: An intensive ‘buddy’ support system based on high levels of personal commitment enables Masangane as an FBO/I to offer services otherwise felt to be lacking but necessary for continued adherence to ART. This however could be a limitation for scaling up.

Volunteers and assistants: The strength of Masangane as an FBO/I is evidenced in its capacity to draw significant numbers of volunteers and treatment assistants at low cost. Also a limitation unless resources can be accessed to sustainably cover the costs of the volunteers, it is still the case that costs in this case are relatively low compared to the costs of employment in public ART programs generally.

Range of activities: Masangane’s ability to offer a comprehensive integrated response to HIV and AIDS, linking ART to counseling, training, orphan support, treatment literacy, education and awareness, and support for various treatment protocols and procedures, is a positive indication of its strength as an FBO/ I. A lack of adequate pastoral counseling may be a weakness.

People still die: Masangane as a single FBO/I cannot address the scale of the problem, and its replicability is crucial to scaling up any overall FBO/I response to complement the State ARV program. But replicability is not all. Advocacy to public health agencies and policy makers for a massive increase in treatment allied to an integrated, locally based and rooted set of organizations and structures, such as Masangane, is perhaps the more critical contribution.

Core group actors: Organizational tensions arise through personality clashes, different understandings of positions and tasks, and shifting lines of authority, responsibility and accountability – over time and as personnel and procedures change – a reality that may be regarded as ‘normal’ for NGOs, CBOs and FBOs. Masangane is heavily dependent on a small number of key people, and when these people are no longer there, its sustainability and modus operandi are critically at risk. Succession plans and a move away from dependency on a small number of key individuals, especially evident after the death of Rev Mgcoyi under whose leadership the initiative had started, is a key problem to be solved. Yet, key ‘community mediators’ are vital to the success of such projects or programs, and this mediating role itself is part of the reason FBO/Is (or NGOs) work well. The importance of key mediators fits with social capital theory, through which they may be understood as the critical ‘bridging capital’ people who fill ‘social holes’ (where needed ties do not exist) that would otherwise make an initiative or intervention that much weaker.

Faith values: The enduring faith tradition within which Masangane sits and out of which many of its personnel operate is part of its strength.

Ties or partnerships: Though Masangane, in terms of employed personnel, is a small project, the ties it has to other agencies, to international bodies (including churches in this case), and to private health practitioners is a central feature of its ability to respond well beyond what one may expect from a FBO/I. Key have been the links to agencies with a

depth of experience in raising HIV awareness and in the provision of ARV treatment as well as MSF's empowerment approach.

Management: Attempting to offer more than it might be possible to deliver, an effect of a “charity mindset” in FBO/Is, raises difficult issues of sustainability, but this must be read in relation to equity in a context of historical dispossession and relative poverty, especially in the Eastern Cape. When ‘big funds’ flow into poor churches, tensions invariably arise over who has access to them, who takes decisions about them, and – most importantly – who benefits from them. Tensions around money, authority, decision-making, procedures and representivity, for example, may be seen as typifying FBO/I relationships, especially where the institution to which a local organization of initiative is linked (the Moravian Church, in this case) is relatively poor or cash-strapped and a struggle for resources emerges.

Individual FBO/I versus host institution: Faith-based initiatives such as Masangane, often begin as informal individual or local pastoral interventions (a common feature of what it means to engage in practical ministry). If they gain strength and resources, shift into becoming organizations with formal structures, this changes their institutional and operational character, which is likely to generate tensions around authority, status, and the like that must be managed. Similarly, funding opportunities for FBO/Is (obviously very significant in the current climate of HIV/AIDS funding) are not without serious ambiguities: The possibility of funds opens up the potential for contestation over the control of the money and its use, not least between a particular initiative such as Masangane and its host or parent body, in this case the Moravian Church. The tensions that arise can threaten the viability of the project, its management integrity and its ethos.

Limited finance: Rural communities are especially disadvantaged in being able to gain access to treatment and ongoing follow up, attending support group meetings due to the out of pocket transport expenditure and other indirect costs. Despite the recently acquired vehicle, the sustainability of treatment to people living in rural areas remains a critical cost for Masangane and an inequitable barrier to service for those living in remote rural areas.

The ‘value-added’ of a FBO/I offering ART

Access to communities and to potential clients: The link of an FBO/I to a broader based religious body which has existing local presence, such as a church denomination in the case of Masangane, offers opportunities for strong local access (to congregations, for example) based on trust in the motives, commitments and ideological foundations of those who act on behalf of the FBO/I – thus, the FBO/I is likely to reach potential clients through by different paths to other agencies.

Advocacy through access: Through its access as an FBO/I to local congregations and related groups, Masangane is able to advocate for greater openness about and understanding of HIV and AIDS, and to work thereby against stigma; similarly, it can play an advocacy role among local doctors to encourage them to offer their services in innovative ways.

Motivated, committed staff and volunteers: The ‘value added’ by the faith of the FBO/I workers is reflected in the attitudes they bring to the task: Commitment, passion, caring, willingness to work hard for little compensation, in order to make a difference to the lives of others. Faith leaders are able to be instruments of hope to those in need.

Liturgy, rituals, love and care: The performative (liturgy and ritual) and affective (love and care) dimensions of religious or faith community life, which bind people together in ways that they regard as vital, function positively to guide health behavior (e.g. adherence to treatment protocols as in Masangane’s use of Moravian twice daily devotional readings to govern the taking of ARVs) and provide needed care and support. FBO/Is may be able to support ARV treatment and other health practices through the use of rituals that provide religious legitimization of treatment and undermine stigma.

Spiritual support: The faith-based roots of FBO/Is provide particularly rich resources, languages, performative practices and idioms to engage with and sustain the intrinsically ‘spiritual’ encounter that people experience in support groups, making it more durable and lodging it in an enduring tradition. In socio-psychological terms, the dynamics of ‘belonging’ are enhanced and have the potential, at least, to anchor this belonging over time (that is, through incorporation into a history of belonging) and through space (that is, in relation to other groups linked to the same religious tradition).

Reach out to the marginalized and neglected: Given that HIV/AIDS invokes taboos, evokes stigma, and provokes marginalization of people known to be HIV positive, a faith tradition that encourages its adherents to respond positively to those who are marginalized and neglected can be a potent tool for action appropriate to that vision, as is the case with Masangane as an FBO/I consciously relating itself to an exemplifier such as Jesus.

Inclusivity: It is considered especially valuable that an FBO/I such as Masangane is, as part of its self-identity, inclined to welcome all and sundry in a health delivery context where many people feel pushed from ‘pillar to post’.

Credibility: FBO/Is such as Masangane, in their interventions in health, are able constructively and effectively to draw on the credibility offered by their host or affiliate religious body because it is (often, though not always) generally more trusted than many other institutions in society in local contexts. This includes their ‘power to speak’ to people – a huge potential – and the enabling environment provided by the host or affiliate religious body.

Norms, values and rules: Norms, values and rules in FBO/I environments often carry weight; and even if this is so only to the extent that individuals accept them, it remains a potentially important dimension of how health interventions, including ART, are delivered or received. Though there is room here for abuse, so too is there and for gain, Masangane being an example of the latter.

What is clear from our study is that the interface between religion and health needs to be comprehended as a complex whole, and that this needs to be embodied in policies and practices that generate an alignment of best practices between health systems and religious bodies, initiatives or institutions.

This is both a strategic and a development imperative for the public health system if health interventions are to be accepted and sustainably and deeply embedded in local communities. Similarly, it is imperative that religious leaders and bodies sharpen their own understanding of the interface between religion and health as a complex whole. One outcome of this may be that they train their personnel as professionally as possible in order to maximize their contribution to health in society.

CONCLUSION

Greater cognizance in strengthening health systems needs to be taken of:

- The critical role that a faith dimension has on treatment, especially the value for clients of the integration of the faith component into treatment and support group activities
- The potential shown through the Masangane case for FBO/Is, in partnership with the State ARV program, to provide for some aspects of an ART program that are very time-intensive such as treatment literacy, stabilization on treatment, support groups, and monitoring adherence
- The infrastructure, influence and respect FBO/Is often have in communities, and thus their potential contribution to addressing stigma and mobilizing for treatment
- The need to assist in the education and training of religious leaders so as to be able to mobilize these important religious assets for health gains
- It is *not* suggested in any way that FBO/Is and their like should be seen or treated as a substitute for what the state and the public health system should and could do.

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CHAPTER 9

RELIGIOUS ORGANIZATIONS AND THE FIGHT AGAINST HIV/AIDS IN MOZAMBIQUE

Victor Agadjanian¹⁹
Arizona State University

A large literature has been devoted to the involvement of religious organizations in the fight against HIV/AIDS in sub-Saharan Africa. This paper adds to this literature by focusing mainly on challenges faced by religious organizations in HIV/AIDS-related activities in a predominantly Christian area in southern Mozambique. The analysis is based on several years of fieldwork in the area that included a survey of religious congregations and collection of qualitative data. The analysis shows that church-based activities have been focused primarily on HIV prevention, with relatively little involvement in the provision of care and support to HIV/AIDS-affected individuals or in advocacy on their behalf. Greater formal involvement of religious organizations in effective HIV/AIDS-focused activities is hampered by lack of resources and ideological and organizational tensions among churches and their leaders. At the same time, less formal, small-scale activities, that are typically carried out by church female volunteers and are often not directly sponsored by church leadership, provide vital, even if limited and unsystematic, support to HIV/AIDS-affected families, especially in the most impoverished rural areas.

INTRODUCTION

Religious organizations are ubiquitous and vibrant elements of the societal landscape in sub-Saharan Africa. Given the scarcity of resources and the weakness of state and secular non-governmental institutions in much of the sub-continent, religious organizations are well positioned to tackle a variety of social and health problems plaguing sub-Saharan countries, and especially rural and small urban communities. Religious organizations have a long record of engagement with health issues throughout the sub-Sahara, but it is the HIV/AIDS epidemic that has brought this engagement to the fore of the scholarly and public attention. Numerous accounts highlight religious organizations' role in prevention education and in provision of HIV/AIDS care and support (Olivier et al 2006, Trinitapoli and Weinreb 2012). However, the cross-national evidence also suggests that religious organizations' involvement in efforts aimed at mitigating the impact of the pandemic faces various challenges (Agadjanian and Menjívar 2011, Agadjanian and Sen 2007, Haddad et al 2008). The literature has focused in particular on how religious

¹⁹ The data used in this paper were collected as part of a collaborative project between Arizona State University (USA) and Eduardo Mondlane University (Mozambique), which was funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, USA (grant #R01HD050175)

organizations' stance regarding HIV/AIDS may have contributed to HIV/AIDS-related stigma and discrimination (Keikelame et al 2010, Mbilinyi and Kaihula 2000, Regnerus and Salinas 2007, Zou et al 2009) and on some religious organizations' negative or ambivalent attitudes toward condom use (e.g. Casale et al 2010, Garner 2000, Pfeiffer 2004).

This paper summarizes achievements and challenges in religious organizations' involvement in the fight against HIV/AIDS in Gaza province of southern Mozambique, where HIV prevalence is estimated at around 25 percent (Ministry of Health 2010). Like much of the sub-continent, Mozambique, a poor nation of some 23 million in southeast Africa, is characterized by a dazzling kaleidoscope of religious faiths and organizations. Whereas about one-third of Mozambique's population profess Islam (with Muslims concentrated mainly in the northern part of the country) most of the rest of Mozambicans, especially those in the country's south, on which this report is focused, belong, at least nominally, to Christian churches. As elsewhere in the sub-Sahara, Mozambique has registered a rapid growth and proliferation of Pentecostal-type churches, which stress miracle healing through direct interaction with and intervention from the Holy Spirit (Agadjanian 1999, Seibert 2005). The so-called Zionist churches, initially imported to Mozambique from South Africa, have seen a particularly spectacular expansion, accounting for about 35 percent of religious affiliation in southern Mozambique (National Statistics Institute 2009). In the context of rural society in particular, where alternative forms of public participation and expressions are scarce, religious organizations are important vehicles of spiritual and social self-realization, especially for women, the overwhelming majority of active church participants.

The paper builds upon an earlier study of successes and challenges of religious organizations' involvement with HIV/AIDS (Agadjanian and Sen 2007) and presents the results of a survey of religious organizations and of several years of related research in both urban and rural areas among a variety of religious organizations. The survey, conducted in 2008-9 covered all religious congregations that could be identified in Chibuto District, a typical, largely agricultural district of Gaza province with a population of about 200,000. In all, the survey interviewed leaders of 678 different congregations. Reflecting the denominational composition of the district's population and the typical size of congregations of different denominations, almost half of all the survey respondents, 46 percent, were from Zionist churches. Leaders of other Pentecostal churches constituted the second largest group, 19 percent. Mainline Protestant (e.g., Anglican, Presbyterian, or Methodist) leaders and leaders of Apostolic churches made up 15 and 11 percent, respectively. Leaders of Roman Catholic congregations were the smallest group, 8 percent: although the share of Catholics in the population is somewhat bigger, Catholic congregations tend to be larger and therefore fewer than congregations of other denominations. Only two of the interviewed leaders were Muslim, and they are excluded from the analysis. The survey instrument covered various aspects of congregation structure, membership, and activities, and also included several questions dealing directly with congregation involvement with HIV/AIDS.

The focus of this paper is, among other matters, on HIV/AIDS-related themes invoked by leaders during religious services and on their attitudes toward condom use, as reported in the survey. It should be noted that because surveyed leaders typically wanted to present a positive image of their congregations (which is typical of similar surveys), misreporting of HIV/AIDS-related activities cannot be ruled out. However, the question on HIV/AIDS-related activities was designed so as to solicit a spontaneous listing of such activities; the responses to this question allow gauging the relative priorities attributed by religious leaders to various HIV/AIDS-related matters. In addition to the survey data, insights are synthesized, obtained from qualitative data gathered through in-depth interviews and focus group discussions with religious leaders and rank-and-file members alike in the same district. In-depth interviews were carried out between 2007 and 2011 and the focus groups, involving representatives of congregations from both the rural and urban parts of the district, were conducted in 2009.

RESULTS

The overwhelming majority of the surveyed religious leaders, 83 percent, had spoken about HIV/AIDS at least once during main religious services in the several months preceding the survey. This percentage did not vary appreciably across five largest denominational categories (see Table 1). The surveyed leaders were asked to name specific HIV/AIDS-related themes that they had addressed in their congregations; they could list up to six different themes. The analysis of the themes showed that religious leaders talk to their congregations primarily about prevention. Among more specific themes, faithfulness to marital partners (including reduction of partnerships outside marriage) was the most common one: 60 percent of all leaders, with relatively little variation across denominational types, reported having talked to their congregations about the importance of avoiding extramarital partnerships. Premarital abstinence, a message targeting congregation youth was invoked by 20 percent of religious leaders, ranging from a low of 12 percent among Pentecostals to a high of 26 percent among Catholics. Just over one-half of the respondents, 51 percent, said they had talked about “prevention” in general, which in that context could mean all standard ABC (“Abstain, Be faithful, and use Condoms”) components.

Despite a widely held notion that religious leaders tend to oppose condom use, 27 percent of the survey participants spontaneously mentioned condoms as a form of prevention about which they had talked during services in their congregations. Interestingly, Catholic respondents were most likely to mention condoms (32 percent). When asked specifically about their church attitudes toward condom use, than two-thirds of the survey respondents (67 percent) said that their religious organizations approved of the use of condom by unmarried couples to prevent HIV. Across denominational groups, the approval of condoms in non-marital relationships ranged from 59 percent among Catholics to 71 percent among Apostolics. In comparison, condom use within marriage to prevent HIV transmission had a much lower approval rate, 39 percent. The denominational variation in this rate was not large—from 35 percent among leaders of mainline Protestants to 43 percent among Pentecostals.

Table 1: Selected HIV/AIDS-related topics, by denominational categories, Survey of religious leaders, Chibuto, Gaza, Mozambique, 2008 (%)

	Catholic	Mainline Protestant	Apostolic	Zionist	Pentecostal	Total
<i>HIV/AIDS-related topics mentioned by congregation's leader during church services in past several months</i>						
Any HIV/AIDS-related topic	79	87	88	80	85	83
Any HIV prevention topic	76	83	79	77	77	78
Marital fidelity as prevention	53	65	59	64	52	60
Premarital abstinence as prevention	26	20	31	19	12	20
Condoms as prevention	32	25	24	27	28	27
Avoiding cutting and piercing tools	15	16	7	16	14	14
HIV testing	50	36	45	37	37	39
HIV stigma and tolerance	6	5	10	9	8	8
Care for HIV+ individuals	12	5	2	9	8	8
Support for ARV treatment	18	16	14	12	11	13
<i>Church approval of condom use</i>						
Approves condom use by unmarried couples	59	67	71	69	63	67
Approves condom by married couples	38	35	36	40	43	39

Source?

How effective are these religion-based prevention messages? Although direct evidence is lacking, in-depth interviews and field observations identified several factors that may limit the effectiveness of these messages. First, these messages are typically religiously-framed variations of the messages spread by the secular HIV/AIDS prevention campaigns. In this sense, religious leaders can hardly offer a more convincing argument in support of prevention than the arguments to which the population is continuously exposed through radio broadcasts, posters, billboards, and countless *palestras* (public lectures, in Portuguese). Second, the religious prevention messages are often diluted broader messages about the importance of a strong family bond and of love, trust, and respect among spouses. As a result, these messages may lose their focus and urgency and offer little practical guidance for reducing risks of infection in real-life situations where abstract moral instructions on marital fidelity are not easily realized. Third, these messages may not be reaching individuals who should hear them most. The overwhelming majority of church attendees are married women; a message that exhorts female church members to be faithful in marriage but does not reach their husbands, who are typically more likely to have extramarital relations than their wives, is likely to be of limited impact. Finally, the prevention message aimed at church unmarried young members may be detached from the reality of young people's lives outside the religious realm. The idea of unconditional premarital abstinence articulated by many religious leaders is at odds with the constraints and pressures that young people must confront and negotiate on a daily basis. Moreover, with an inexorable erosion of the institution of marriage in southern Mozambique as elsewhere in sub-Saharan Africa, the very notion of "premarital" sexual partnership becomes blurred. As our research in the study area has

shown, a growing share of “marriages” are not formalized in any way - either through traditional bridewealth payment or through a civil or religious ceremony.

Despite their limited influence on church members’ preventive behavior, religious-based messages might still serve as an effective psychological tool of organizational mobilization. Forcefully articulated by religious leaders, many of whom are skillful and passionate orators, these messages paint HIV/AIDS as an enemy of the entire congregation thereby nurturing the sense of organizational belonging and, by extension, of personal loyalty to congregation leaders.

Whereas the actual impact of most of religious prevention messages on reducing members’ exposure to HIV risks is questionable, there are two areas where the HIV prevention efforts of religious organizations may make a real contribution to HIV prevention. One is avoidance of non-disposable or unsterilized cutting or piercing objects, such as razor blades and syringes. Fourteen percent of surveyed leaders claimed to have addressed the matter during religious services. Although this emphasis may stem partly from the religious leaders’ attempts to discourage their congregation members from using services of witchdoctors and other traditional health care providers, where unsterilized blades are often reused for cuts and incisions performed as part of treatment, the message may indeed heighten congregation members’ awareness of non-sexual forms of transmission, which typically do not receive much attention in the secular prevention narrative. Another area where churches may be quite effective is in mobilizing members to get tested for HIV. In the survey, 39 percent of leaders spontaneously named HIV testing as an HIV/AIDS-related topic that they had spoken during services in their congregations, with this share being particularly large among Catholics, 50 percent. The leaders’ exhortation to get tested may benefit in particular the younger, unmarried congregation members of both sexes. However, this exhortation may be redundant for the majority of the congregation leaders’ audience - married women of reproductive age - as a growing number of those women undergo routine HIV testing during antenatal care. And tellingly, while the importance of testing figured so prominently in the surveyed leaders’ HIV prevention repertoire, only one percent of them had mentioned in congregation services that individuals who tested positive should take measures to avoid transmitting the virus to others.

While prevention messages are frequently heard in religious congregations, problems and challenges facing by individuals who are already HIV+ are much less talked about. Most surprisingly, only eight percent of the respondents said that they had urged their congregation members not to discriminate against HIV-positive individuals. This low percentage does not, of course, imply that church leaders are indifferent to issues of tolerance and inclusion, but it does suggest that secrecy surrounding the disease greatly constrains what could be one of the most pertinent messages by faith-based organizations in a society ravaged by the epidemic. Matters surrounding provision of care and support to HIV-affected individuals and families and matters pertaining to treatment of HIV patients were invoked more often than anti-HIV stigma but were still much less talked about than those related to prevention. Thus, only eight percent of the surveyed leaders reported having ever talked during congregation services about providing care to HIV+

patients (with a range from two percent among Apostolics to 12 percent among Catholics), whereas the need to encourage HIV-infected individuals to seek or to adhere to medical advice or antiretroviral treatment was mentioned by 13 percent of respondents (ranging from 11 percent among Pentecostals to 18 percent among Catholics).

There may be several reasons for this contrast in the frequency of the prevention and care/treatment messages. Whereas the prevention argument is straightforward and fits well with religious emphases on moral rectitude, articulating and deploying relevant and effective activities aimed at provision of care and support to HIV-affected individuals, beyond prayers for their health, is a much more complex task, which often requires specialized knowledge. Most religious leaders have very limited knowledge of health matters in general and of HIV/AIDS in particular. And unlike prevention messages, which need little more than religious leaders' rhetorical talents, provision of care and support to individuals and families affected by HIV requires considerable pecuniary and material resources, which most congregations do not possess. The lingering stigma of HIV and the correspondingly low disclosure of the seropositive status further hinder articulation and implementation of these activities. Finally, provision of care and support to individuals and families afflicted by HIV (or any other illness, for that matter) may often involve crossing organizational boundaries; reaching out to people who belong to other congregations may be viewed with suspicion and even resentment by other religious groups in a crowded and competitive religious marketplace.

Several efforts to overcome ideological and organizational tensions among religious organizations have been made in the district. Thus a district chapter of the regional organization called *Tshembeka* ("Being trusted" in Changana, the main local language) was created in the district's capital by leaders of some two dozen churches to coordinate assistance for HIV/AIDS-affected families, and specifically for children orphaned by AIDS. The organization, however, has remained confined to the small group of initial members from the district's capital and its activities have depended on the availability of outside funding. Several similar attempts at coordinating HIV/AIDS-focused activities across religious organizations have been made in other parts of the district (often transcending the district boundaries), but they have also been small-scale and sporadic and have had limited impact. Some of the district's religious congregations have been involved in the regional- and national-level organizations such as the Christian Network for the Fight against HIV/AIDS, which was set up in 2007 and has its national headquarters in Mozambique's capital Maputo, some 200km south of the district. Yet, due to lack of funds and organizational and logistical difficulties, the Network has done little more than organizing meetings of the leaders of participating churches and occasional *palestras* in churches to promote prevention.

Formal interchurch coordination of HIV/AIDS-related activities therefore lack clearly defined targets and strategies and is often hampered by suspicion and, at times, overt animosities among religious leaders involved who often compete for influence and for the limited outside resources available. At the same time, our fieldwork suggests that on the ground, considerable, even if loosely organized, efforts are being undertaken by *activistas* (volunteers) of individual congregations. Most of these volunteers are married, divorced,

or widowed women who are often driven by their own experiences and worries regarding HIV/AIDS (Agadjanian and Menjívar 2008) and whose outreach and care provision activities are typically coordinated by church women's groups. These activities are often carried out outside of direct control of congregation leaders (who are typically males) and even outside of their knowledge. However, the lack of direct, official sanction on the part of the church leaders may actually help these activities as they are less likely to be interpreted as church-sponsored events aimed at proselytizing. These activities include spiritual support, personal care, and help with household chores. Importantly, these activities are not explicitly focused on HIV/AIDS: their targets are the sick and the needy regardless of the causes and clinical manifestations of their afflictions. The broad umbrella of misfortune and suffering is, in fact, best suited for cases where the diagnosis is unknown or is hidden by the afflicted or their family members to avoid association with HIV/AIDS. Yet, as the HIV/AIDS is increasingly accepted as a *mavabyi ya tiko* (disease of the land, in Changana) and the related stigma recedes, volunteer work by church women's groups may evolve to target more HIV/AIDS-specific and in particular what looms as the biggest challenge of the current stage of the epidemic in rural Mozambique and similar settings—ensuring universal access and maximum adherence to antiretroviral treatment.

CONCLUSION

In conclusion, evidence gathered in southern Mozambique points to a high level of community trust in religious organizations and to these organizations' ability to mobilize and deploy committed and energetic volunteers. These assets can enable religious organizations to make major contributions to the fight against HIV/AIDS. However, while acknowledging the potential of religious organizations, policy-makers should also be aware of internal and external constraints that circumscribe the realization of this potential. While much of the literature has focused on ideological controversies, such as the interpretation of HIV/AIDS as god's punishment or some churches' opposition to condoms, our research has brought attention to organizational barriers hindering religious organizations' effective involvement with HIV/AIDS. Religious leaders' concerns about enhancing their congregations' financial base and strengthening their members' loyalty and the competition among religious leaders for potential converts and for social and political influence may compromise the scale and effectiveness of religious organizations' participation in the fight against HIV/AIDS in Mozambique and comparable resource-limited high HIV-prevalence settings. Policy makers seeking to take advantage of religious organizations' potential and especially to harness their rank-and-file members' dedication, initiative, and energy, should take these organizational constraints into account.

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CHAPTER 11

THE UNITED NATIONS POPULATION FUND'S LEGACY: ENGAGING FAITH-BASED ORGANIZATIONS AS CULTURAL AGENTS OF CHANGE FOR THE MDGS

*Azza Karam*²⁰

The United Nations Population Fund

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA's mission statement is to support countries in using population data for policies and programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect. This article outlines why UNFPA's working modality leads automatically to engagement with local faith-based organization and provides some current examples of this work, concluding with lessons learned and recommendations for engagement.

INTRODUCTION

Over the last decade, there have been several broad claims made about the attitude of international agencies and institutions to local faith communities and faith-based organizations (FBOs). However, UNFPA's methods of engaging with FBOs have been evolving over the last few decades. UNFPA's strategy for engagement identifies points of alignment between UNFPA's principles and aims and the activities of many FBOs, who are viewed as cultural agents of change. The concern now is less about *why* UNFPA is dealing with local FBOs, and rather *how* such engagement can be systematically and deliberately strengthened within the broader framework of ensuring culturally sensitive human rights-based approaches.

WHY THE SPECIFICITY OF UNFPA LEADS TOWARDS ENGAGEMENT WITH FBOs

UNFPA is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA's mission statement is to support countries in using population data for policies and programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and

²⁰ This article, although describing the work of UNFPA, contains the opinions of the author alone, and does not necessarily reflect those of the Fund, its staff, Executive Board members or of any other Member State. A more detailed version of this article was previously published as Karam (2010).

respect. As a means of understanding UNFPA's working modality, it is important to highlight five unique aspects of the Fund and its work:

1. UNFPA is the UN body which provides a comprehensive package of services simultaneously, for and about reproductive health as well as broader population dynamics. This is a critical part of its mandate and distinguishes it from other international agencies working on various specific aspects of health, gender or statistics and information gathering. This mandate can be described as one that covers human welfare from before conception to the moment of passing.
2. UNFPA has been given the task of implementing goals that touch on the most sensitive and intimate spheres of human existence, including reproductive health and rights, with all the incumbent complexity of gender relations and gendered identities, sexuality, and related population issues. This means that whether it is counting people, or making everyone count, UNFPA has to deal with many cultural and social taboos, intricately connected to political and economic challenges.
3. UNFPA has invested in systematically developing, training, and successfully testing a unique three-pronged programming methodology: combining gender equality, cultural sensitivity and the human rights based approach to programming.²¹ These 'integrated development approach' trainings have been provided to various regional UNFPA staff, as well as to several entire UN Country Teams.
4. UNFPA's work with FBOs is grounded in its commitment to acknowledging and proactively *integrating culture into development processes*. Culture, defined by UNFPA as the contextual dynamics which both influence and are impacted upon by the way people think, believe and behave (UNFPA 2008), is acknowledged by the Fund to be a key feature of human development. Changing attitudes, behaviors and laws, especially those dealing with gender relations and reproductive health, has proven to be a long-term and complex task. Appreciating the contexts of work and changing mindsets can be more difficult than providing services. This has been proven, time and again, to be especially true when lives are bound by centuries-old traditions and complex cultural constructs, in ever-changing political contexts.
5. Since 2002, UNFPA has invested in setting up a *Global Interfaith Network for Population and Development*, with 5 regional offshoots. The Interfaith Network, with over 500 registered FBOs in a Directory made available to all development partners, is also a forum for sharing of news and information.

²¹ A human rights-based approach to programming (HRBA) is one that is built on a consensus achieved by all the United Nations system which requires consciously and systematically paying attention to human rights in all aspects of program development. It strives to secure the freedom, well-being and dignity of the people within the framework of essential standards and principles, duties and obligations, and with the provision of mechanisms to guarantee that entitlements are safeguarded and attained. As a backdrop to its broader mandate on peace and security, and on human development, human rights are a foundational and guiding 'doctrine' for the Organization's work and accountability.

CULTURE MATTERS

UNFPA's work on culture is built on the experiences documented by many of its 100+ Country and Regional Offices. Each experience of engaging with cultural agents of change, and accepting the inevitability of cultural dynamics as key to positive social, political, economic and legal transformation, affirms that for any process of human development to be sustainable and effective, it has to be aspired to, driven towards, and established, from within.

In 2002, UNFPA sought to consolidate its initiatives to systematically mainstream culturally sensitive approaches into programming efforts by documenting case studies of how culture mattered; who the agents of change are; providing 'tools' for programmers and trainings for its own staff. A greater emphasis was advocated to work with communities and local agents of change – engage in dialogue, listening, sharing knowledge and insights, and jointly planning the way to move ahead. The principles underlying this approach required understanding the cultural dynamics in each society where UNFPA works and the positive, as well as the challenging cultural values, assets, expressions and power structures.

This translates into working with FBOs, indigenous communities, and other community-based structures as partners in development and human rights. The engagement of these partners in addressing reproductive health and gender issues has gone beyond changing individual attitudes and behaviors. It has also placed reproductive health and rights issues on the agenda of many FBOs, and discussions once considered taboo have been moved into the public arena. For example, family size, early marriage, violence against women, wife inheritance, female genital mutilation and cutting, and reproductive services and rights are now being discussed openly, from the pulpits of a village church, mosque or temple.

LESSONS LEARNED FROM WORKING FROM WITHIN CULTURES

UNFPA undertakes culturally sensitive approaches in diverse socio-cultural contexts. A number of lessons learned have emerged, as the following illustrates:

Communities can be encouraged to incorporate universally recognized rights into their own realities through joint community dialogues and sharing of evidence on how human rights and gender issues contribute to the well-being of men, women, children and families.

Promoting behavior change often begins by identifying individuals who have the capacity and legitimacy to motivate and mobilize communities. Partnering with local 'agents of change' is an invaluable strategy in gaining wider acceptance and ownership of programs.

Effective negotiation requires an understanding of the interests of diverse stakeholders - from political leaders to the myriad civil society organizations, cultural leaders and the

private sector. Until their interests are clearly understood, it will be difficult to find common ground.

Gaining the support of agents of change and local power structures is often necessary before engaging effectively with communities. One way to do this is by presenting evidence-based data on issues of concern to the community. Such information can help defuse potential tensions by focusing on the shared goal of people's well-being. Once trust develops, discussions can be expanded to more sensitive issues.

Avoiding value-laden language can help create neutral ground in which understanding and support for program objectives become possible. Just as *carefully developed advocacy campaigns*, closely tailored to the cultural context in which they are launched, make it easier to deal with sensitive subjects. These campaigns, when they reflect a clear understanding of the views of both allies and potential adversaries, and draw from sources that are popular within a given culture, have proven to be effective communication tools that support national processes. In Muslim contexts, using Islamic references in advocacy campaigns has helped to dispel suspicions and promote local ownership, just as working with faith-based leaders across the Christian communities has provided a means to counter stigma and discrimination among people living with HIV in many contexts.

THE CASE FOR ENGAGEMENT WITH FAITH-BASED ORGANIZATIONS

The case for working with FBOs, as one community among many cultural agents of change, is no longer a matter of discussion, but rather, one of considered, systematic and deliberate engagement of like-minded partners. There is clearly an important parallel faith-based universe of development, one which provides an average of 30 percent of health care and educational services in many developing countries, with these figures rising significantly in contexts of conflict and natural disasters. UNFPA (2008) acknowledges: “...at a time when basic needs are becoming increasingly harder to provide for more than half of the world's population, we can no longer avoid acknowledging these parallel faith-based development interventions which reach so many and provide so much. Many are critical venues for outreach, resources, and service delivery.”

UNFPA recognizes that the world of FBOs is filled with a diversity of mandates, missions, expertise, services, modality of work, among other things. Similarly, the Fund has had to acknowledge that religions themselves are a vast and complex tapestry, as is reflected in the plurality of FBOs. Amongst this world are friends of the MDGs and the ICPD. And it is to these friends – with a legacy of engagement and service provision – that the Fund turns to – and views as part of wider civil society partners.

UNFPA's definition of FBOs refers to faith-based or faith-inspired, legally registered non-profit/non-governmental organizations, which are working to deliver a range of services in and around the ICPD areas – in a manner that is in line with the human rights mandate of the United Nations. It is important to note that several of UNFPA's Offices in

the field, have engaged with religious leaders (of congregations and heads of religious institutions proper) as a means of 'working with the faith-based communities'. Increasingly, however, the Fund is advised to distinguish between religious leaders and human rights-oriented FBOs with a track record of delivering services which can be traced, monitored and evaluated, as per any non-governmental institutional partnership.

The legacy of engaging FBOs as cultural agents, actually began in the 1970s with the partnership between the Fund and the University of Al-Azhar in Egypt (Sunni Islam's foremost academic and religious authority) to set up the International Centre for Reproductive Health and Population Studies. Since then, the partnerships have evolved in different countries, with the specific aim of reaching out to constituencies which have arguably, the most impact in changing the mind-sets of the larger population. Much of this outreach was done on the premise that religious communities were therefore critical agents of change, and a great deal has been accomplished through these partnerships (see UNFPA 2005 and 2008).

However, much of this work from the 1970s was ad hoc and rarely documented, evaluated, or indeed, framed within a policy context. Systematization of such outreach, the provision of training and guidelines to all staff at UNFPA and sister UN agencies through select UN Country Teams only occurred with the strong endorsement and guidance from the senior most management of the organization. The latter being a critical feature of the success of cultural mainstreaming, as it has been with many key developmental issues.

PRINCIPLES OF PARTNERSHIP WITH FBOs

In its *Guidelines for Engaging FBOs as Cultural Agents of Change* (UNFPA 2008b), principles and policy considerations for engagement are outlined.

1. Strategic issue-based alliances: focusing on the common ground (instead of divisive aspects) allows consideration of joint efforts to achieve the ultimate objectives captured in UNFPA's mission statement. This is realistic when focusing on specific issues. The common ground is a critical building block of these partnerships. UNFPA has found that leaders of faith-based and interfaith organizations are open to discussing reproductive health, if issues are addressed with care and sensitivity. It is clear that women's equal rights, and reproductive rights in particular, are not usually the issues which generate consensus among religious leaders – and especially not publicly. Nevertheless, UNFPA recognises the importance of rallying those within the faith-based communities who are already supportive of the common goals and targets embodied in the ICPD PoA and are reflected in and reinforced by the MDGs, and have ongoing programmes to that effect. One effective approach is to use scientific evidence, on issues such as infant and maternal mortality, violence against women, and HIV and AIDS prevalence rates for instance, to tap into ethical positions. Each engagement is predicated upon certain circumstances and needs, and may well be time-bound. This is a valid and necessary aspect of any strategic alliance, which also requires at least anticipating, a mutually respectful and agreed upon, exit strategy.

2. *A level playing field:* While UNFPA recognizes the differences between its mandate and approach and those of FBOs, it nevertheless seeks to cooperate as equal partners, depending on each other's comparative advantage and respective strengths. This entails that neither side is utilized or instrumentalized, but both are relevant agents of action based on their different, and in many instances, complementary strengths. While the partnerships sought within the FBO community are expected to share the objectives of the ICPD-linked MDGs, UNFPA respects that they would reach these objectives differently – using their own language, networks and *modus operandi*. UNFPA acknowledges that the diverse languages and methods require mutual understanding and sensitivity.

3. *Diversity of outreach:* UNFPA ensures that its outreach is multi-faith and balanced according to the religious diversity within communities, nations and globally. This is often made explicit in the terms of reference of the programs. One of the lessons learned is that this multi-faith outreach approach cannot be implicit. UNFPA also recognizes that in order to identify like-minded partners and continuously enhance the working modality and programme delivery, working with already established multi-faith organizations and communities which already work on an inter- and intra-faith basis is critical.

4. *Clarity, accountability and consistency:* As with any other partnership, UNFPA sets out clearly (in Memoranda of Understanding, joint proposals, or other project documents) the concrete outcomes expected of the joint endeavours. How the partnership falls within the parameters of its own Strategic Plan, defines joint mechanisms of accountability, monitoring and evaluation. Moreover, the engagement with FBOs needs to be consistent, not a one-off, event-oriented alliance which creates false expectations. An engagement that is designed with a collective sense of ownership and responsibility for specific outcomes in mind, is also one that is sustainable. Together, clarity, accountability and consistency are essential for building the trust necessary to establish a legacy of realistic partnerships.

5. *Throughout these partnerships,* UNFPA maintains two important dimensions *and* targets of its commitment which significantly enrich the experience and inform its policy considerations:

- *South-South engagement:* Within each region, and amongst its five regions (e.g. Africa, Arab States, Asia and Pacific, Eastern Europe and Central Asia, and Latin America and the Caribbean), there is much scope for knowledge sharing, creation of knowledge networks, and the strengthening of alliances.
- *Global perspectives, comparisons and continuity:* There is much to be said for a continuous feedback loop where the national, regional and the global/international enrich one another. Such knowledge and comparison of engagements at the national, regional and international levels, i.e. feedback loops, enable better appreciation of FBO interventions as well as UNFPA strategies, as well as grounding and sustainability of the partnerships formed.

LEARNING FROM THE JOURNEY, AND LOOKING AHEAD

An important realization from the mapping of FBO engagement undertaken by UNFPA from 2006-2008, is that even where Headquarters can be too hesitant to engage with the faith-based sectors, most of the country or field-based offices have done so anyway. This was a natural evolution not necessarily always mandated by policy, but in most instances, because the realities on the ground required it, and it was strategic to realize the developmental objectives.

Generally speaking, UNFPA-supported programs have been able to reach some of the most vulnerable and marginalized communities through partnerships with FBOs as well as other civil society partners. Some churches, mosques, schools, health units, income-generating projects and youth organizations already have country-wide networks that are being built upon. Working with these networks lends a credibility and familiarity to new initiatives, and reduces the perception of changes being imposed by external actors. This is especially important where initiatives seem threatening to community values.

Targeting specific areas of collaboration in areas where both partners have common objectives is another strategy that has proven to be effective on the ground, UNFPA has found that FBOs are open to discussing (if they are not already working on) reproductive health and rights, if issues are addressed with care and sensitivity.

As per the principles of engagement noted above, UNFPA's global headquarters is keen to harvest the lessons learned and support national development processes in general, a feature which is applied to partnering with FBOs in particular. To that end, UNFPA convened and launched, in October of 2008, the Global Interfaith Network for Population and Development (see UNFPA 2009b). What came to be known as the *Istanbul Consensus* outlines the commitments that UNFPA and its faith-based partners made.

FBO partners have also provided UNFPA with several recommendations, covering general advocacy, building joint technical capacities, as well knowledge creation and management. A subsequent Policy Roundtable with internationally-based FBOs, convened in August of 2009, affirmed the Fund's Guidelines for Engagement and narrowed the range of areas to focus on till 2015, to maternal health and violence against women.

This focus is not meant to exclude other areas of partnership. In fact, an important UNFPA partner, UNAIDS, already has developed an elaborate *Strategic Framework for Engagement with FBOs on HIV/AIDS* (UNAIDS 2009). This framework lays out in detail the areas and range of complex activities which AIDS irrevocably connects to, and as such provides an excellent framework for UNFPA's work in many of its own reproductive health areas.

Examples of UNFPA Partnerships with FBOs in Africa

In *Mauritania*, UNFPA supported scaling-up of a grassroots initiative by the *Mauritanian Midwives Association* to combat sexual violence against women, bringing it to national scale in collaboration with the government. The initiative yielded significant results, including reports of reduced incidences of rape, increased reporting, and improved responses by the police and community, in addition to incorporation of a component on sexual violence against women and children in the annual work plan of each Ministry. Key to this success was working with religious leaders known to be progressive and flexible, and who viewed the endeavor as being in-line with Islamic principles.

In *Rwanda*, UNFPA sensitized members of Protestant, Catholic and Islamic religious groups, known as *Religions Against AIDS*, to raise awareness on gender, sexual and reproductive health and rights.

In *Sierra Leone*, UNFPA is supporting faith-based partners and local groups of young people by providing reproductive health services, basic health care, psychosocial support and counseling, HIV prevention education, occupational training and skills development. The Fund also organized its reproductive health awareness sessions within the largest women-attended church in Free Town.

REACHING OUT TO FBOs: LEARNED SKILL, STRATEGIC POLICY DECISION, AND CONUNDRUM

There are many lessons learned for UNFPA in its legacy of partnerships with FBOs, but some have an immediate impact on the Fund's long-term strategic engagement. It was already noted above that the world of religion is complex and varied, as is the reality of FBOs. Try as we can to narrow down the domain to health service providers with a like-minded attitude (on and for human rights), to develop guidelines, to document the lessons and cases of success, and to develop indicators, the challenges remain in language, attitudes, perceptions of each other, and even in tempo of discussions and activities. But most of all, a major challenge resides in the global political dynamics. Dealing with these different approaches requires significant skills on the part of all staff. Simple acknowledgement of the importance of partnering with NGOs and FBOs, is not an automatic qualification in the skills required to identify, document and, most critically, negotiate with these partners - especially when no two are alike.

Then there is the conundrum: on the one hand, we must continue to advocate for partnerships, not only because these are critical service providers to the growing numbers of humanity's needy in times of dwindling resources, but because these are critical agents of change with moral, social and economic impact. On the other hand, the lines between religion, politics and social advocacy, are becoming increasingly blurred in contemporary realities where religion has become a force to be reckoned with – and its agents are not always saints (see Karam 2004).

What can we say for instance, to those who will maintain that the same relief service providers may be engaged in supporting communities from within which grow, or who

have connections with, radical elements?²² What is the argument to be made when the same FBOs which are providing life-saving services, may also be proselytizing their religious dogmas? How can we maintain a line between health-care service provision and political activism, if that demarcation becomes increasingly difficult to draw on the ground? Which one of us has the resources to keep track of each and every non-governmental counterpart over time, and to trace changes in attitudes, range of activities, and shifts therein? These are rhetorical questions. Because the answers are obvious: we can, we do and we will endeavor to train our staff appropriately, but we must realize that on our own, we cannot do all that it will take to strengthen the partnerships. There are inevitable fault lines. At the very least, we have to coordinate our outreach internally, and externally.

Partnerships with FBOs requires collaboration with UN sister agencies – that is, a system-wide reservoir of deliberations, systematic monitoring and evaluation, and support - as well as by leveraging key trusted FBO partners as advisors and advocates. Without a doubt, supporting each other, or trying to, will require deliberate communication efforts within the UN agency – which, regardless of the size of the organization, is not always easy. Moreover, a means of communication and information exchange among and across all of those who are reaching out to the same set of FBOs as partners, is critical. This lesson continues to be learned by UNFPA at the national, regional and global levels.

There are a range of successful cases where cooperating with other UN agencies, around a shared task with FBOs, has proven helpful to all, including the FBOs themselves. For example, an initiative pioneered and supported by UNAIDS to convene a high level summit of religious leaders on AIDS, together with two FBOs,²³ resulted in an unprecedented constructive dialogue and engagement not only with and between the religious leaders, but also with people living with HIV as well as Intravenous Drug users organizations. The Summit, which resulted in a progressive Statement signed onto by all the leaders gathered - a feat which would have been impossible to obtain a few years earlier - was a testament to how UN agencies and FBOs can partner towards a shared objective constructively and with important and far-reaching results.²⁴

Inter-Agency collaboration around FBO engagement has become a mantra within UNFPA, and a rationale for investing significantly in ensuring a common platform and means for sharing of ideas, results of engagement, FBO networks, and more. To that end,

²² By ‘radical’ here it is meant for instance, those who advocate against any means of family planning and decry any attempt to provide comprehensive reproductive health care services as ‘anti-religious’ and/or may even urge that those who provide such services should not receive any governmental support. Other examples are those who advocate against the work of the UN as ‘a tool for foreign domination’ and may even go so far as to blow up its buildings and kill its own staff in the process.

²³ The two specific FBOs here are the Ecumenical Advocacy Alliance and the Dutch Catholic development organization – Cordaid. The initiative was strongly supported by the Dutch government, which has also been a strong backer of cultural outreach, following the examples of the Swiss government pioneers (as far as UNFPA is concerned), as well as the Swedish, Spanish and German governments.

²⁴ See <http://www.e-alliance.ch/en/s/hiv aids/summit-of-high-level-religious-leaders/>

the *Inter-Agency Task Force on FBO Engagement* is comprised of at least ten such partners,²⁵ with differing levels of membership and commitment. While this mechanism has some ways to go to gain as much credibility and present a record of joint engagement on a par with other such Inter-Agency mechanisms, the mere fact that it exists today is a testament to the importance of the issue of partnerships with FBOs within the UN system.

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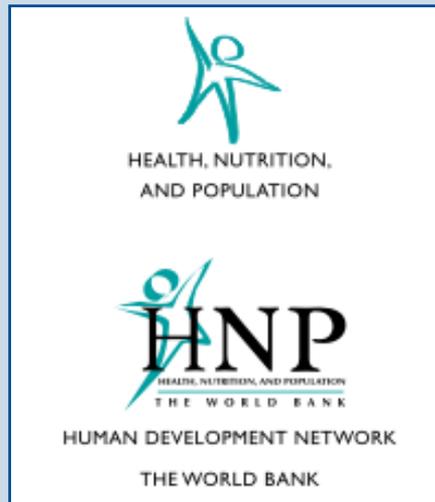
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²⁵ See listings of UN and multilateral partners at <http://www.unfpa.org/public/pid/1352> and <http://www.unfpa.org/public/publications/pid/4974>



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THE WORLD BANK

1818 H Street, NW
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