Handle with (faith-based) care

It is safe to say that spiritual forces have always played a major role in the provision of health care in Africa. They have, to be sure, been far more atavistic in the past, when the role of dark and mysterious powers was held to be prominent in the causes and cures of disease.

While much of Africa has moved to a more scientific understanding of the treatment of disease, faith-based health care doesn't appear to have lost its prominence, though the form it now takes is more often as the deliverer of health care.

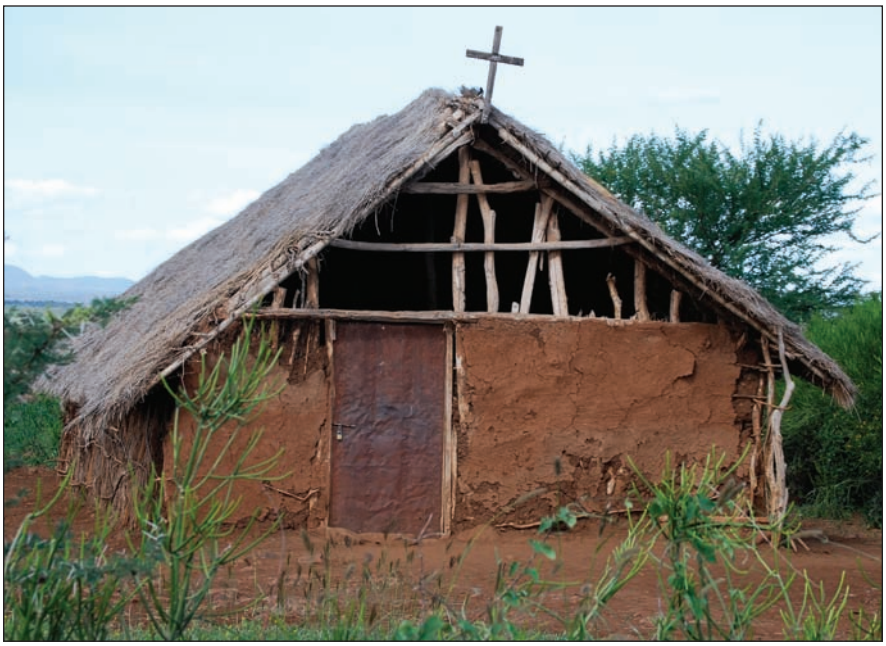
There are tens of thousands of faith-based organizations (FBOs) delivering health care in Africa, representing a wide array of denominations and delivering a host of services, according to a report from the Tony Blair Faith Foundation, *Global Health and Africa: Assessing Faith Work and Research Priorities* (www.faithsact.org/sites/default/files/elfinder/Documents/Reports/Global%20Health%20and%20Africa%20Report_Full%20Report.pdf).

"Perhaps 75 to 80 percent or more are Christian and between 5 to 10 percent, Muslim, with the remaining share representing efforts by Baha'i, Hindu, Jewish, and other faiths."

About 75% of African governments provide financial support to the FBOs, either through service contracts, direct grants or the secondment of staff, the report adds, while also noting that it raises such concerns as whether such funding is "unfair to private self-financing providers" and whether the spending actually benefits the poor.

A recent report from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Interfaith Health Program at Emory University in Atlanta, Georgia, indicated that FBOs play an absolutely essential role in the care of patients with HIV and orphans.

Such groups often are the only ones that provide care in rural and often hard-to-reach populations, states



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The church is closely linked to medicine in Africa, where tens of thousands of faith-based organizations from a wide array of faiths deliver health care.

the report, *A Firm Foundation: The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS* (www.pepfar.gov/documents/organization/195614.pdf). "In Tanzania and Kenya, FBOs provide more than 40 percent and 60 percent of health care services, respectively."

The report, which emerged from a regional forum involving 98 leaders from 58 different FBOs in Kenya, Rwanda, Tanzania, and Uganda, and experts from government agencies in the four countries and the United States, led to recommendations for engaging FBOs to strengthen African health systems, especially in fighting epidemics.

Among the recommendations were the need to "capitalize on the trust that has developed between FBOs and local communities to build stronger, more comprehensive, integrated HIV-prevention efforts built not on stigmatization but on unconditional love; develop the capacity for FBOs to advocate for improved healthcare for all citizens and hold governments accountable," as well as to "develop and make widely available mechanisms to support the organizational development of FBOs."

The report and others like it, however, also point to several underlying trends in the roles and responsibility of FBOs in Africa: a change in their traditional relationship with governments and an increasing reliance on often-ambiguous contractual arrangements.

There are risks therein, as well as signs of a fracturing in the relationship between government and FBOs, often over those financing matters, leading some FBOs to consider bailing from the provision of basic health care services in favour of becoming specialized facilities treating specific diseases like AIDS and funded by international agencies such as PEPFAR, according to a study conducted by the Institute of Tropical Medicine in Antwerp, Belgium.

The institute assessed health contracting between FBOs and governments in Cameroon, Tanzania, Chad and Uganda and found that there is "a

real risk of disintegration of the current partnership dynamic between the public and the faith-based sector in sub-Saharan Africa."

"Current contracting experiments between the public and faith-based health sectors face great difficulties," states the study, *The difficult relationship between faith-based health care organisations and the public sector in sub-Saharan Africa* (www.anglicanhealth.org/Resources/PDF/AHN%20resources/Faith%20and%20health%20care/Medicus%20Mundi%20Africa%20faith%20based%20health%20care.pdf). "Awareness of crisis, particularly among public sector actors is, however, low."

Deficiencies included "a lack of preparation. Agreements arrive as innovations at the peripheral level of the health systems, they are not built upon lessons learned in previous experiments, and they are seldom accompanied by adequate training or coaching. Second, there are the shortcomings of the contracting documents themselves, marked by incompleteness and poor integration in existing frameworks, further aggravated by the absence of revision mechanisms. This leads to a heterogeneous contracting landscape — sometimes in contradiction with existing policies — where nonharmonized types of agreements coexist. Third, all country-cases reveal a strong dichotomy between the central and the peripheral level of the health system, further fragmenting the contracting landscape and pointing at the incomplete and immature character of health system decentralization processes. This negatively affects contracting experiences by impairing the follow-up of agreements, the set-up of structural responses to address the difficulties met, and the overall capitalization of experience. Eventually, the scarcity of financial and human resources is hardly alleviated by the signature of agreements. Governments do not always respect their commitments, or do so to a limited extent only. Facilities therefore need to compensate financing gaps on their own or rely on external resources, which are increasingly more limited."

Some experts say that a failure to resolve the financial and accountability issues may compromise some of the value-added and intangible benefits that FBOs bring to Africa.

It's often difficult to quantify, notes John Blevins, lead author of the PEPFAR report and associate research professor with the Interfaith Health Program at Emory University. For example, he says, the charitable organization Nyumbani, supported by the Children of God Relief Fund, provides HIV primary care to more than 5000 children and their families in informal settlements and is "a great example of being able to leverage the resources of the faith-based sector to build effective partnerships with government, donors, and multinational organizations."

Others laud more intangible benefits. The Malawi Interfaith Association, for example, has mobilized key faith groups such as Muslims and Christians to develop programs, including interfaith national prayers, to confront HIV/AIDS, says Robert Ngaiyaye, the association's executive director.

Such approaches often have widespread community support, says Mike Mugweru, secretariat officer, with the Kenya-based African Christian Health Associations Platform. "There are 31 Christian Health Associations in 26 African countries and these are inspired by their faith to get more involved in health. Because Christian Health Associations address physical, psychosocial, and spiritual dimensions of health, they have the confidence and trust of the communities they serve more than government health institutions."

But Blevins cautions that the involvement of religious bodies in health care in Africa can be a double-edged sword. "Sometimes FBOs can do very good programs that don't have stigma attached to them. And sometimes FBOs or some religious leaders may actually speak very directly in ways that contribute to stigma, and so we recognize that in relation to stigma and HIV, FBOs can hurt or harm, or they can heal."

Mugweru argues the contribution that FBOs make to the training of health care workers is often unappreciated. The Christian Health Association of Kenya, for example, owns 23 medical colleges and six universities and is the primary trainer of health workers in the country, he notes.

In some countries, FBOs are also the primary providers of health care, particularly in rural areas. The Christian Health Association of Malawi, notes Executive Director Rose Kumwenda-Ngóma, runs 172 health facilities, primarily in remote areas, while providing health care to more than four million people. It does so under an agreement with the government that covers the salaries of 8500 health workers in exchange for the provision of free health care to poor Malawians.

In Uganda, a similar memorandum of understanding limits FBOs from charging health care fees that are higher than those levied by private-for-profit health facilities, says Dr. Mwanje Nuru Nakintu, executive secretary of Uganda Muslim Medical Bureau, which runs 63 rural facilities. None have the salaries of health workers reimbursed, however, so "financial sustainability is a challenge. Because sometimes we have to subsidize or waive fees for patients because they cannot afford them."

Kumwenda-Ngóma says there's a need for more comprehensive financing arrangements between governments, international donors and faith-based health providers. "If they [government and donors] support faith-based organizations in terms of financial, human, and informational resources, it will help a lot in the engagement to promote health care in Africa." — Bernard Appiah, College Station, Tex.

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