



## EXECUTIVE SUMMARY

### APPRECIATING ASSETS: MAPPING, UNDERSTANDING, TRANSLATING AND ENGAGING RELIGIOUS HEALTH ASSETS (RHAS) IN ZAMBIA AND LESOTHO

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#### OVERVIEW

Urgent efforts are needed to encourage greater collaboration among public health agencies and faith-based organizations (FBOs) if the goal of moving towards universal access to HIV treatment, care and prevention services is to be achieved by 2010, according to a major study commissioned by the World Health Organization.

The study found that FBOs play a much greater role in disease prevention, care and treatment than previously thought in sub-Saharan Africa. The African Religious Health Assets Program (ARHAP) report estimates that between 30 % and 70 % of healthcare services in Africa are owned by faith-based organizations. The report concludes that greater coordination and better communication is urgently needed between FBOs and the formal public health programmes of governments and other health care agencies.

The ARHAP study is the first to use participatory workshops coupled with

global information system (GIS) technology to map “religious health assets” (RHAs) in Africa: hospitals and clinics, community congregations, support groups, intermediary bodies, pressure groups, media and traditional healers that contribute to health and well-being in the region. (GIS technology uses satellite signals to draft precise maps which plot the exact location of a RHA).

Focusing on four provinces in Zambia and three in Lesotho—two countries with heavy burdens of poverty and disease—the researchers identified 500 religious and partner organizations providing HIV/AIDS services or RHAs. About 350 of these RHAs work at the local level, and have until now been “hidden” or overlooked by national policy-makers, and, in some cases, even their own religious organizations.

Nonetheless, many of the those who took part in the mapping workshops, ranked very highly the level of tangible (care and material support, for example) and intangible (namely, spiritual

encouragement) health care services provided by the FBOs. The study concluded that these faith-based health care providers could assist greatly in overcoming common barriers to scaling up HIV services, such as overly centralized services and a lack of coordination between different health programmes.

## **BACKGROUND**

A global effort is now underway to stem the tide of HIV by working towards universal access to HIV treatment, care and prevention services by 2010. WHO is leading the health sector response, and forging new partnerships with religious entities.

Until now, however, relations between public health and religious entities addressing HIV have often been marked by discord. In the past, public health leaders have frequently criticized FBOs for opposing key prevention measures like the use of condoms. On the other hand, religious leaders argue that despite their important contribution to health care, they are often excluded from important decision-making consultations and largely overlooked by major international donors.

To help bridge this divide, WHO asked a team of researchers to identify, map and assess religious health assets that could be marshalled in the fight against HIV in Lesotho and Zambia. Both countries are burdened by extreme poverty and disease, including HIV prevalence rates of 23.2% and 17%, respectively in 2005. Christian

hospitals and health centres provide about 40% of health services in Lesotho and around 30% of them in Zambia.

## **STUDY APPROACH**

The pilot study was undertaken by partners in the African Religious Health Assets Program (ARHAP) at the Universities of Cape Town, KwaZulu-Natal, and Witwatersrand in South Africa and researchers from the Rollins School of Public Health at Emory University in Atlanta. The research blended qualitative and quantitative information from participatory workshops with data from WHO's Public Health Mapping and GIS Programme and its HealthMapper and Service Availability Mapping (SAM) programmes.

Special research tools known as PIRHANA (Participatory Inquiry into Religious Health Assets, Networks and Agency) were developed for the workshops, which were held at the community, provincial/district and national levels in the two countries between November 2005 and July 2006. The workshops attracted about 360 participants, including many religious and health leaders.

The researchers worked from the premise that religion, health and wellbeing are deeply influenced by local context—and cannot be understood as a single, simple cultural variable. They also employed a holistic African perspective, which considers health, religion, cultural norms and

values as part of an indivisible “healthworld”. This term is derived from the Sesotho word *bophelo*. Sesotho is the main indigenous language of Lesotho, but the researchers discovered that the concept of a “healthworld” was also very similar to Zambian concepts of health and religion.

The study is based on the assumption that these holistic perspectives define the health seeking strategies of many Africans, and it argues that the failure of health policy makers to understand the influence of religion in African 'healthworlds' could seriously undermine efforts to scale up health services.

## KEY FINDINGS

The study reveals these key points:

- Religion is ubiquitous in Lesotho and Zambia, though FBOs providing health care services are often overlooked by public-health decision-makers.
- Religion, health and wellbeing are strongly influenced by local culture and experience. For those seeking to engage RHAs, religion cannot be viewed as a single, simple cultural “variable” - the “one size fits all” approach will not work.
- Religious engagement in efforts to respond to HIV and other diseases has increased greatly in the last decade, particularly since 2000. Opportunities exist for much greater dialogue between organizations of

different faiths and the private and public sectors.

- FBOs provide tangible support (care and material support, for example) and intangible support (spiritual encouragement, knowledge, etc).
- Governments and public health leaders must expand their understanding of health and engage FBOs and their partners in the scaling up of HIV services, or universal access will not be achieved.

## LESOTHO: SUPPORT GROUPS, TRADITIONAL HEALERS PLAY MAJOR HEALTH ROLE

Researchers held community and “leadership” workshops in three health service areas of Lesotho, a country with a population of 2 million. The team also held a national workshop in the capital Maseru. In all, a total of 163 people participated in the workshops: farmers, housewives, unemployed people as well as traditional healers, church leaders and hospital administrators.

The workshops revealed that ordinary Basotho, the dominant cultural group, perceive their struggle for health and wellbeing (*bophelo*) as part of a larger struggle dealing with political uncertainty, poverty and costly health services. When participants were asked to identify factors that contribute to health and wellbeing they responded, in this order of importance: first, water and drought; secondly, food and hunger; and tied for thirdly, church/ religion and farming. Health provision

and education were far behind, in fifth and sixth place.

The Lesotho workshops also revealed that self-initiated community support groups, independent of churches and the public health system, are among the most important health-care providers in communities. Few have easy access to formally-trained doctors. Their members tend to be women, many of whom are deeply religious, though of various religions, and they draw on their own resources to feed, clothe and care for patients.

“Their greatest assets include trust and cultural and linguistic familiarity,” the researchers conclude, “which are essential assets when reaching out to Basotho infected and affected by HIV/AIDS.”

The study also draws attention to the ambiguous, yet important, role of Basotho traditional healers. On the one hand they are isolated from public and Christian health networks. On the other hand they remain an important feature of both the religious and *healthworlds* of many communities in Lesotho, particularly in remote mountainous, rural areas.

### **ZAMBIA: RELIGION IS UBIQUITOUS AND A MAJOR CONTRIBUTOR TO PUBLIC HEALTH**

The researchers held nine workshops in Zambia, which has a population of 10.5 million. No less than 85% of Zambians identify themselves as

belonging to a major religion, the vast majority Christianity, but also Islam, Hinduism and Baha'i.

The 195 participants included representatives of different faiths, FBOs and nongovernmental organizations as well as pastors, business owners, housewives and traditional healers. The discussions revealed that there had been a proliferation of FBOs providing HIV services since the mid-1990s, and subsequent worsening unemployment and erosion of public services. About 84% of the religious entities mapped through these workshops were engaged in some aspect of HIV prevention, care, treatment or support.

Many of the participants gave high ratings to the services and financial support provided by the religious entities addressing HIV, and said that these were superior to those provided through the state sector.

The most highly-rated religious entities included home-based care groups, churches, mosques and orphanages. These were praised for their effectiveness in caring for the sick; providing treatment and health education; and addressing poverty (for example, the digging of wells and income generating projects).

Participants also highlighted the talent of these RHAs in networking with other organizations; their level of leadership; good financial management systems; presence among the poorest people; and commitment to caring for their

caregivers.

Participants in the workshops also said that these religious entities had an “overwhelming desire to be more effective against HIV/AIDS”.

One researcher commented: “Like housework in the economy...which is absolutely foundational to economic life yet almost never shows up in standard economic analyses...religion is so overwhelmingly significant in the African search for wellbeing...and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people’s lives.”

## RECOMMENDATIONS

The report calls for greater dialogue and action between religious and public health leaders in the following areas:

- *Developing religious and public health literacy:* Formal courses, joint training and shared materials to improve understanding between FBOs and public health agencies;
- *Respectful engagement:* Expanding community workshops (as used in this study) to engage more FBOs in community health work; and bringing together religious and public health leaders in “Executive Sessions“ to encourage long-term collaboration in policy-making and project implementation ;

- *Coordinating religious and health systems:* Extending the use of health mapping to identify FBOs that could help in scaling up services; strengthening community support groups and religious entities and further linking them to nearby state-run hospitals, clinics, and dispensaries; supporting the increase of agencies that mediate between religious entities and the public health system; and
- *Further collaborative research:* Extending the participatory mapping used in this study to other African countries and low- and middle-income regions of the world; and further examining the nature of intangible (spiritual encouragement, knowledge and moral formation) health assets revealed in this report.