Half a Century Young: The Christian Health Associations in Africa

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World Bank

November 2012

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Christian Health Associations (CHAs) – umbrella networks of faith-inspired health providers – have become a solid presence in the collaborative environment of African health systems. Established through sometimes trial-and-error attempts to draw together disparate faith-based health providers who were disconnected from each other, and also unaligned with national health systems, CHAs have evolved into a particular kind of collaborative effort with a very specific role. CHAs now network faith-inspired health providers and facilities; advocate for a proper recognition of their work; negotiate with governments; build capacity among members; and in some cases now channel and report on substantive funds. In this paper we provide a brief recounting of the history of the CHAs and how they were established, as well as a basic typology of CHAs according to three (highly stylized) conceptual stages of their development. This is followed by a discussion of some of the challenges facing CHAs today, based on self-reports from the CHAs.

INTRODUCTION

Over the last fifty years, Christian Health Associations (CHAs)[1] – umbrella networks of faith-inspired health providers – have become a solid presence in the collaborative environment of African health systems. Established through sometimes trial-and-error attempts to draw together disparate faith-based health providers (also sometimes called mission-based providers or church health services) who were not only disconnected from each other, but also unaligned with national health systems, CHAs have evolved into a particular kind of collaborative effort – and have established a very specific role for themselves: networking faith-inspired health providers and facilities; advocating for a proper recognition of their work; negotiating with governments; building capacity among members; and in some cases now channeling and reporting on substantive funds.

CHAs do not operate in a vacuum, so to understand the challenges they face, one must also understand some of the broader challenges facing national health systems as a whole. Such challenges include under-resourcing, the difficulty of operating in hardship areas, the Africa-wide human resources for health (HRH) crisis, the impact of HIV/AIDS,

[1] This area of interest is a terminological minefield. Our main focus in this article is the Christian Health Associations (CHAs) which are also sometimes called national faith-based health networks (NFBHNs). The members of these CHAs are called many different things in different contexts. Usually clustered as private-not-for-profit (PNFP) providers, they are sometimes called 'mission-based providers' (MBPs), 'church health services' (CHS), or the non-descriptive 'faith-based organizations' (FBOs). Importantly these are *facility-based* providers of 'modern'/biomedical health care services.

challenges relating to corruption, or the lack of management capacity. Despite ambitious restructuring, and health and development goals which have been set to reduce the burden of disease and poverty-related illness, health systems in many African countries are overstretched, understaffed and under-resourced. In addition, many of the countries in which CHAs operate are 'fragile' and face severe economic and political challenges. Some are experiencing prolonged conflict (e.g. Liberia, Sudan and Uganda) while others have experienced economic isolation (e.g. Zimbabwe). These crises have jeopardized national public health care and essential social services, and in many cases, the CHAs and their members have evolved in response by filling public service gaps.

Several recent studies have shown that CHAs have a unique collaborative place and role in national health systems – particularly in the context of the weak health systems in which they often operate. Better data has been collected on the work of CHAs, including their relationships with governments and public health service providers. Many CHAs have also begun to improve their information and reporting systems, and (as a result) have become more visible in national surveillance systems. In addition to this emerging background information, this article builds on the findings of four main sources (and as such these will not be referenced directly again): (1) A questionnaire-based survey of CHAs in Africa which was circulated to CHA representatives at their 4th Biennial CHAs Assembly in Kampala Uganda in 2009 and then followed-up at the 5th CHA Assembly in Accra Ghana in 2011, to identify challenges and opportunities for maintaining and strengthening their role within national health systems; with responses received from 18 networks in 16 countries of sub-Saharan Africa (Dimmock 2011).[2] (2) A study by ARHAP for the Bill and Melinda Gates Foundation in 2008 which conducted desk review on national faith-based health networks (NFBHNs) in 24 SSA countries, with more detailed primary data collection on CHAs in Uganda, Mali and Zambia (Schmid et al 2008). (3) A study by ARHAP for Tearfund and UNAIDS which also gathered primary data on CHAs in Kenya, Malawi and the Democratic Republic of Congo (Haddad et al 2008). And (4) results from a series of papers prepared at the World Bank on the market share, reach to the poor, cost, and satisfaction vis à vis the services provided by CHA member institutions (see Olivier and Wodon 2012 in this collection).

It is important to note that there is no standard list of CHAs. Ultimately, we are focused here on those entities which have self-selected themselves as 'CHAs', as can be seen in their presence at CHA meetings, or as members of the newly formed African Christian Health Associations Platform (ACHAP).[3] These are all national-level networks of faith-inspired health providers, although they have critical differences. Many CHAs have formed as a 'health desk' of a national Christian Council or denominational body; some have broken away and become nongovernmental organizations (NGOs) in their own right, while others remain an arm of a broader network of organizations. CHAs also have very different membership structures: sometimes the health facilities (e.g. the hospitals)

[2] Including Benin, Cameroun, Central African Republic, Chad, Ghana, Kenya, Zambia, Ethiopia, Lesotho, Malawi, Sudan, Tanzania, Togo, Uganda, Zimbabwe and Liberia. Countries with CHAs not reporting include DRCongo, Nigeria, Sierra Leone and Senegal.

[3] see www.africachap.org

are the members, sometimes the members are the supporting congregation or churches, and some CHAs have included NGOs and community-based organizations (CBOs) as members as well – so long as they are engaged in health service provision. Therefore, while some CHAs are directly engaged in the management of health services, others exist mainly to build capacity among members. This also demonstrates the constant tension in the literature and data, which often blurs the work of the CHAs and the challenges facing them, with that of their members.

This paper specifically addresses CHAs, not the 'faith sector' more broadly in each country, which typically includes a much broader range of health-engaged faith-inspired institutions (FIIs). We have also not included other non-Christian NFBHNs, the most prominent example being the Uganda Muslim Medical Bureau (UMMB) which was established in 1998 and is said to network 5 hospitals and over a hundred health centers (and works in strong collaboration with the Protestant and Catholic NFBHNs in Uganda). Neither have we included some of the denominational and regional networks who sometimes participate as CHAs, but are not national-level networks of health providers. For example, in South Africa, where mission hospitals were nationalized by the government in the 1970s, networks such as the South African Catholic Bishops Conference and the South African Council of Churches play a CHA-like role, coordinating large numbers of health-engaged faith-inspired institutions and initiatives. Similarly, in Swaziland, where there is no functional CHA, the Swaziland Church Forum on HIV and AIDS plays this role, with several denominations, hospitals and clinics affiliated. Indeed, there are a large number of substantial faith-inspired national and regional networks (denominational, pharmaceutical, interfaith, HIV/AIDS councils and the like) which in some contexts function almost as CHAs do.

The paper is structured as follows. In section two we provide a brief recounting of the history of the CHAs and how they were established, together with a discussion how CHAs have had to adapt to changes in funding sources since the 1960s. In section three we present some of the main characteristics of CHAs today, introducing a basic typology of the CHAs according to three highly stylized conceptual stages of their development (emergence, professionalization and integration). We recognize that this is an area of investigation that is notoriously lacking in systematic data. Even the basic estimates of the comparative presence of the CHAs in national health systems provided here should be considered with caution - they represent an attempt to establish some baseline (sometimes based on disparate data), rather than definitive estimates.[4] We also acknowledge that no two CHAs are alike, even within a specific stage of the 'life cycle': with characteristics shaped by their history and country context. Some are loose networks (sometimes newly formed or fragile), while others are strongly organized collaborative with direct partnerships with governments or donors - for example, CHAZ is a primary recipient of The Global Fund to Fight AIDS, TB and Malaria (GFATM) in Zambia. Still, despite such differences, CHAs do share certain challenges, and we provide this basic typology to assist in framing the discussion of key challenges faced by CHAs in sections three and four that follow. Some challenges, such as constrained funding or human resources, are

[4] See Olivier and Wodon (2012) in this collection which describes this evidential landscape in more detail.

logically shared with other (non-religious) health providers, yet may impact CHAs differently. Other challenges tend to be more specific to CHAs and their members, such as concerns about historical funding sources, and fundamental questions as to whether the core intentions of CHAs' members (such as the desire to provide quality health services to the poor), might be under threat.

A BRIEF HISTORY OF CHAS AND THE CHALLENGE OF FUNDING

CHAs have different historical trajectories (see Annex 1): some have evolved as a health desk to a Christian Council, others have formed more recently based on the example of other CHAs in Africa. Yet an important influence in the shaping of the CHAs came in the 1960s, with the Christian Medical Commission (CMC) of the World Council of Churches (WCC). One account of that era comes from James McGilvray, the first director of the CMC, and a missionary who began this work by encouraging the churches in the Philippines to form a coordinating body of faith-based health work in 1958. In his seminal 1981 booklet, *The Quest for Health and Wholeness*, McGilvray describes the ground-shaking events for church health services in this time (1960s-1980s): the changes brought by African independence and changed missionary contexts, and the efforts to re-imagine the role of church health services. The proceedings of a CMC meeting in 1968 describe the crisis facing the Church's healing ministry as follows: "*Today, many of these (church) institutions suffer from multiple problems: steeply rising costs, limited staff, inadequate administrative systems, and obsolescence. There are crippling limitations of resources with which to meet those problems. These institutions often function in isolation, not co-ordinating their activities with each other or with government. Governments meanwhile develop plans for providing universal health care, but neither do they take into account nor benefit from a representative voice from the churches, because there rarely is such a representative voice…the orientation of hospital work toward the service of only those who come to the institution, rather than reaching out to serve all in a surrounding community, has meant that many in need have not been served at all...a re-orientation of Christian medical work is obviously required*" (in McGilvray 1981).

These concerns turn out to be somewhat 'prophetic' or at least still very relevant today. From 1963-1964, McGilvray, with national church bodies, conducted surveys of church-related health services in several countries (McGilvray 1981). These led to a series of key meetings, commonly called the Tübingen meetings (although not all were held in Tübingen, Germany) led by the CMC and designed to shape new thinking on church-based health provision. The surveys generated significant collaborative interest, and also what would become pioneering national estimates of medical facilities contributed by church health providers: "43 percent of the national total in Tanzania, 40 percent in Malawi, 34 percent in Cameroon, 27 percent in Ghana, 26 percent in Taiwan, 20 percent in India, 13 percent in Pakistan and 12 percent in Indonesia". Importantly however, McGilvray then adds, *"however, one should not read too much into the above ratios because, at the time of the surveys, this church-related sector was a very disparate group which, with few exceptions, had no collective existence."*

These efforts in the 1960s highlighted the importance of establishing collaborative networks or bodies to address a lack of collective existence, and in particular a lack of representation at the national level. This was particularly important as countries began to move towards independence – as a result of which national health systems were being reassessed and there was a greater need for church health providers to be represented and negotiate together as a group. This led to the formation of several CHAs. For example, in the case of the CMC-led 'Tübingen' meeting of April 1967 in Legon, Ghana, it was *"…resolved to form an Association of church-related hospitals and clinics which would co-ordinate all church-related medical programs both Catholic and Protestant...This body would represent a united voice in negotiations with the government and would make a concerted effort to employ Ghanaian doctors in its hospitals and give high priority to the training of nationals…It was also decided that…churches should explore new avenues of service in community health as distinct from…the individualistic approach through curative medicine as practiced in hospitals."* From this meeting a coalition, formed as a voluntary professional association, was formed in 1967: the Christian Health Association of Ghana (CHAG).

A similar process occurred in Uganda (1955-1957), Cameroon (1957) and Malawi (1966) - see Annex 1 for more detail about these formative events. More CHAs followed in the 1970s: Zambia (1970), Democratic Republic of the Congo (1971), Zimbabwe (1973), Nigeria (1973), Lesotho (1973-1974), Botswana (1974), Sierra Leone (1975), Liberia (1975), and Rwanda (1975). Other CHAs have since been established in Benin (1985), Kenya (1987), Central African Republic (1989), Mali (1992), Tanzania (1992), and Togo (1994). More recently, the Christian Health Association of Sudan (CHAS) has been developing (2004-2008), and there are new partnerships growing in Senegal and Ethiopia. It is important to note that these establishment dates are specific to CHAs (or CHA-like networks), and are not reflective of the historical presence of church health services or other kinds of denominational networks in these countries. Some CHAs were formed when other bodies were renamed or reshaped, and of course, many mission-based providers have been present in these countries since (pre)colonial times.

Since the first CHAs were established, church health services have seen the context or landscape around them change dramatically (discussed below). While it is extremely difficult to generalize about all countries in Africa – or the development of all CHAs – broadly speaking it is useful to mention that colonial administration structures had an important impact on church health providers. Distinct patterns can be seen between church health services (and their CHAs) depending on the colonial administration from which they emerged. For example, it has been acknowledged that Anglophone and Francophone countries experienced distinctly different health system management, different attitudes towards missionary health and education activities, and as a result different inherited modern health systems, with Francophone systems being noticeably 'weaker' than Anglophone counterparts. Another significant common factor for church health services was that alongside the independence movement in Africa in the 1950s and 1960s was a similar movement to indigenize churches (Green et al 2002). In some countries, this resulted in a shifting of the ownership and management of the 'mission-

based' health facilities from the international bodies to the national denominational churches.

While it may be difficult to generalize about financial support for all CHAs – crudely put, church health services and their CHAs have experienced a significant ebb and flow of financial resources, with much of the last half century spent scrambling to tap into and become accustomed to new funding pools and sources. In many African countries, church health providers expanded facilities significantly in the first half of the twentieth century. Based on a 1996-1997 survey of CHAs in 11 countries (9 in Africa and 2 in Asia), Asante et al (1998) found that the peak founding years of the surveyed hospitals were 1930-1967 (with a decline towards 1967). In Ghana, for example, independence from colonial administration resulted in the rapid expansion of church health services – with many new church health facilities built after 1957, including the hybrid 'agency hospitals' established in the late 1950s and built by the Government in *"…what were then rural areas, and handed…over to religious organizations to run…despite being funded by government, (these) were able to reflect the religious nature of their Churches"* (Rasheed 2009).[5]

However, at the same time, many church health services also started to see a decrease in external funding flows from originating traditional sources such as those historic relationships with international denominational bodies (see McGilvray 1981, Ewert et al 1990). Importantly, they also saw a decrease of 'in-kind' contributions of equipment, drugs, and externally funded technical staff such as long-term medical missionary staff (Green et al 2002, McGilvray 1981). Van Reken (1990) notes that medical mission has leveled off since 1925, and gradually decreased since then. Not only has international mission declined, but there has also been a shift from long-term postings to short-term assignments. CHAs have noted that medical missionaries not only brought skills but also created a strong north-south partnership bringing other resources and some budgetary relief for hospitals (CSSC 2007). The shift to short-term mission has had a severe impact on church health services and CHAs, not only in relation to reduced financial support and partnership (thus threatening the sustainability of church health services), but also in an increased burden on local management.

Since independence and with intensification in the 1980s, governments (and international donors) started to implement different plans and strategies for strengthening health care – all of which church health services and CHAs have had to adjust to. For example, health sector reforms such as those led by the International Monetary Fund and World Bank, the new divisions of the health system into 'sectors' (e.g. public, private-for-profit, private-not-for-profit), and different strategies to implement universal health care (e.g. making public health services free, or implementing user fees), have all impacted on church health services who had traditional ways and means of operating and recovering costs. Since the 1980s, new funding avenues also appeared for church health providers, but it is

[5] This raises an important point. In many countries, there are different kinds of 'hybrid' facilities – jointly owned or managed between different partners (between different denominations, or between government and church health services).

unclear to what extent CHAs and their member facilities were initially able to tap into them given that the expansion in multilateral and bilateral development assistance was mainly directed at governments. Atingdui (1995) does note that the 1980s and 1990s *"…saw significant growth, especially at local levels, of charitable, relief, and development activities carried out by nonprofit organizations affiliated with the Catholic, Presbyterian, Anglican and Methodist Churches"* - however, it is unclear whether such growth relates to the church health services, or rather the 'faith sector' NGO activities more broadly.

As a consequence of changing sources of support, church health providers have increasingly sought government funding in order to survive. This has not been a simple shift, as Green et al (2002) note, many church health providers found it extremely difficult to shift away from a structure *"…where the majority of external income comes from those motivated to promote religious activities, to one where there is a greater contribution from secular sources such as bilateral and multilateral donors, international NGOs and national government as well as user charges."* Many individual faith-inspired institutions are still reluctant to align themselves with the government, for example in terms of the priorities that they should adopt in their activities (Green et al 2002, Schmid et al 2008). We do not assess the funding patterns here further, but it is important to note that these shifting funding landscapes and the need for renewed (and more technical) relationships with governments have strongly established the role and function of the CHAs.

THE CHAS TODAY: BASIC DATA AND TYPOLOGY

CHAs were conceived as national umbrella networks of Christian health providers - mainly tasked to draw together the various Christian health providers so as to improve coordination of services, reduce duplication, and, perhaps most importantly, provide a more consolidated platform from which church health providers can dialogue and collaborate with the government. There are a number of similarities among all or most CHAs, namely: (1) The CHAs are the umbrella body and as such do not usually 'own' or manage the health facilities themselves; (2) The member facilities are usually classified as private-not-for-profit (PNFP) providers, although there are outliers; (3) The nature of the member facilities' operations is more 'public' than 'private' in that they customarily state a mission to provide quality health services to all – especially the poor in hardship areas; (4) CHAs and their members state a mission of being engaged in health care provision as motivated by their faith and Christian values (e.g. a Christian mandate to serve the poor as a concern of justice and equity)[6]; (5) Characteristically, CHAs and their members are simultaneously engaged in a complex arrangement of many different networks, including at the national, civil society and denominational levels; and (6)

[6] Asante (1998) notes five fundamental principles are commonly cited in Christian healthcare provider's mission statements – and highly valued by all CHAs: Should be dedicated to the promotion of human dignity and the sacredness of life; Should assist all in need, with a preferential option for the poor and marginalised; Are meant to contribute to the common good; Should exercise responsible stewardship; and should be consistent with the teachings and moral principles of the church.

CHAs and their members are usually engaged in many different kinds of health and development-related activities, not only medical service delivery.

The core functions of a typical CHA include: advocacy (for example, for planning and policy making); communication and health information; technical assistance and training; capacity building or institutional strengthening (for example, strategic planning, organizational development, human resource management); resource mobilization and administration; research; monitoring and evaluation (monitoring and evaluation, establishing standards); joint procurement (for example, drug procurement) and equipment maintenance. Typically, each CHA has a secretariat that is responsible for liaising between the church health services and various Government ministries and other partners to address these core functions. Clergy, health professionals and representatives from Ministries of Health (MOH) often participate in the managing boards of the CHAs. In turn, the more established CHAs are usually represented on a number of Government and civil society committees and boards.

Each CHA member is usually also part of a complex web of historical and institutional relationships: with local communities, as well as local, national and international institutions. In fact, a key role of CHAs that is not commonly highlighted is their role in managing and negotiating a complex array of relationships and initiatives – especially in relation to representing and simplifying these to outsiders and stakeholders. CHA members also typically have very different communication and decision-making processes which it takes significant (and unacknowledged) skill to coordinate. CHA secretariats (as umbrella networks) do not always have the full authority necessary to ensure that members act appropriately, especially with regards to the submission of plans, budgets, and financial statements – requiring ongoing internal negotiation. For example, in the case of Ghana, Rasheed (2009) notes that each denominational group within CHAG has its own decision-making and communication arrangements: *"…the Presbyterians have the best scope to coordinate implementation among their members. Within their group, policy and funding are decided upon centrally and regionally. The Catholics operate using a fully decentralized system, with each diocese in charge of local policy and funding. All in all, coordinating the various entities for decision making is far from simple, and depends on the political and technical acumen of the representatives of each…"* Rasheed (2009) concludes that CHAG's Secretariat requires more capacity to coordinate these complex relationships.

While each CHA is unique, we find it useful to characterize the various CHAs according to their level of development, which turns out to be closely related to the level of development of the country in which a CHA operates, at least on average. This is illustrated in table 1, which provides basic data on the CHAs as well as broader country characteristics, as well as in table 2, which provides perhaps what could be considered as the simplest possible conceptual typology of the CHAs according to three stages in their development: emergence, professionalization, and integration (explained below). Note that in tables 1 and 2, the data on the CHAs is based in part on a recent internal survey of CHAs conducted by Dimmock (2011). We included most of the CHAs in the table, apart from those which had missing facilities data. Countries not included that do have a CHA

(albeit newly formed) include Angola, Burkina Faso, Ethiopia, Niger and Senegal. Some basic information on all CHAs, including those not listed in tables 1 and 2 is provided in the annex.

The CHAs that tend to be least developed – for example the less active CHAs, or the CHAs that do not have a MOU with their MOH – tend to be located in countries that have very low income levels (as measured by GDP per capita in purchasing power terms) and/or have been affected by conflict and weak governance. More generally, on the basis of the data in table 1, the basic typology presented in table 2 distinguishes between CHAs according to three stages in their life cycle: emergence, professionalization, and integration. Emergence indicates that the CHAs are still in the process of being formed, or are at a latent stage of activity if formed. Professionalization suggests a movement towards a stronger role for CHAs in a country, together with more formal relationships with the MOH, as well as an important role in capacity building for member facilities. Integration reflects a stage where faith-inspired facilities tend to be fully integrated in national health systems, so that the role of CHAs can shift from securing funding to exerting broader influence. We are not suggesting that all CHAs need to go through these three stages, indeed, some of the countries listed as being at the integration stage may not have gone through an obvious multi-year CHA professionalization stage, and some of the CHAs listed in the professionalization stage already undertake functions that are more akin to the integration stage. Still, the typology begins to illuminate how CHAs' priorities may differ under different circumstances.

Professionalization

Consider first the group of countries with low levels of income characterized as being in a stage of professionalization, in some cases already very advanced. These are the core members of ACHAP, the CHAs that were among the first to be established, and which tend to have an especially high (self-described) share of health provision in their countries, with these figures typically based on a perceived comparative share of hospital beds or facilities.[7] Most CHAs in this group already have an MOU with their respective Ministries of Health, or are in the process of negotiating one. These are also countries were the number of CHA facilities per million inhabitants is the highest; with a high ratio of hospitals to health clinics; and a similarly high ratio of training facilities to the sum of CHA hospitals and health clinics. Although life expectancy in these countries is not higher than in fragile states (in part due to HIV/AIDS), the number of hospital beds per 1,000 inhabitants and spending on health care is higher than in fragile states, and this is also the case at the margin for the number of physicians per 1,000 inhabitants. Because these CHAs are well-established and professional, but at the same time still receive limited funding from the state in many countries, one of their key objectives is to secure better financial (and other) support from MOHs, which is why MOUs are indeed so important. This focus on securing support is represented in table 2 by the arrow emerging from the CHAs towards external stakeholders, but returning to internal stakeholder since the bulk of the support that is requested from the state is to help fund the care provided by

[7] This measure tends to overstate the share of all health care accounted by CHAs, see Olivier and Wodon (2012).

member facilities. However, some of the best managed and most advanced CHAs in this group also aim to exert a broader influence on their countries' health policies and practices, for example, as is the case of CHAG in Ghana.

Emergence

Consider next the group of countries characterized as 'fragile', due either to conflict or major problems of governance leading to a 'failed' state. Most of the countries in this group have very low levels of income in part due to conflict, although Sudan has been faring better, mainly due to oil (for Zimbabwe, recent data on GDP per capita adjusted for purchasing power parities are not available). Some of the CHAs in this group were established early, but often did not 'take off', in part because of conflicts which disrupted the ability to organize and perhaps also reduced the need to negotiate with the state (in several of these countries, the state almost gave up its role in health care provision during conflict periods, which led in some cases to a very prominent role an 'market share' for faith-inspired health providers, as is the case in the DRC). Other CHAs, such as Chad and Sudan, were established much more recently. Typically, with the exception of the DRC, the market share of CHAs in health care is lower in fragile states than in the low income group, and a higher share of services are provided through health centers than hospitals, at least in terms of the number of facilities and probably because many of these countries have large rural populations (Zimbabwe being an exception, but that country started from a much higher income base until recently). The countries are also characterized by a lower availability of facilities per million inhabitants (again, with the exception of Zimbabwe) as well as a lower number of beds or physicians per thousand inhabitants. The CHAs in these countries have a more limited number of training facilities available in comparison to other CHA facilities, but this does not mean that they play a smaller role in this area given that the ability of governments to train health care professionals is limited in fragile states. Because in many fragile countries CHAs have been constrained in their development by conflict circumstances, a key priority at this time is basic internal organizing, which is necessary when aiming to secure better support from the state (and donors). This is represented in table 2 by an arrow emerging from the CHAs and going towards their internal stakeholders.

Integration

The third group, consists of middle income countries with small populations. These CHAs often do not have formal MOUs with the state, and typically the facilities operated by faith networks in these countries are already well integrated (and funded) in national health systems. The CHAs in the three countries in this group were created later than those in the low income group, perhaps because in middle income countries with better developed health systems there was less immediate need for the creation of CHAs in order to negotiate support from the state. The CHAs networks in middle income countries also tend to have a smaller market share of health care (bed) provision, again possibly because of better provision by the state. As a result, these countries also have a smaller number of CHA hospitals and health centers per million inhabitants than is the case in the low income group. The ratio of hospitals to health clinics among CHA facilities is higher in these countries, probably because the countries tend to be more urbanized, but the CHAs do seem to play a key role in the training of health personnel as suggested by the

ratio of training to other CHA facilities which is as high as in the low income group. In terms of broader health systems characteristics, not surprisingly these are countries were the number of beds and physicians per thousand inhabitants is highest, with also much higher levels of spending on health per capita. Yet life expectancy is not necessarily higher, in large part due to the burden of HIV/AIDS especially in the cases of Lesotho and Swaziland. It is difficult to highlight the main priority of the CHAs in these countries as data are less available than is the case in low income countries. However, we can surmise that to the extent that the CHA member facilities are already well integrated into national health systems, possibly a priority could (or should) be to exert influence on the countries' broader health policies and practices, for example in order to help disseminate/share the 'comparative values' that tend to characterize faith-inspired health care. This is represented schematically in table 2 by an arrow going from the CHAs towards external stakeholders, and especially government agencies.

One should not read too much in this very basic typology – and there are important differences between CHAs within the three groups. Other countries where CHAs are being created or considered are not included in the typology, and this is especially the case for Francophone (and Islamic-majority) countries where the market share of faith-inspired facilities tends to be much lower, and the historical circumstances of health care provision were very different. What the data in table 1 and the typology in table 2 seek to illuminate is that there is not only a lot of diversity between CHAs, but also common characteristics and challenges that are worth considering. The priorities associated to the three groups of countries in table 2 tend to reflect a quasi-natural process through which after organizing internally, and after securing external support for their services, CHAs would then shift to a different agenda related to influencing health policies and practices on the basis of their core values and experiences. This also suggests that there is potential for CHAs in the stages of 'professionalization' to assist those in the stages of 'emergence', based on lessons learned through experience. Although the challenges at the three stages of the life cycle of CHAs are different, in the next section we raise challenges that have been identified as important to all CHAs (although most clearly identified by the core group in the stage of 'professionalization').

Table 1: Basic Data on CHAs and Selected Health Indicators by Country, Circa 2010

Country	MoU	Year est.	PPP GDP per capita in US$ (2009)	Self-declared CHA market share (beds)	Number of CHA hospitals (1)	Number of CHA health centers (2)	Number of CHA health care facilities (1)+(2) per million inhabitants	Ratio of CHA hospitals to health centers (1)/(2)	Number of CHA training facilities (3)	Ratio of CHA training to health care facilities (3)/[(1)+(2)]	PPP health spending per capita in US$ (2005)	Number of beds per 1,000 inhabitants	Life expectancy at birth (years)	Number of physicians per 1,000 inhabitants	Population (millions)
DRC	-	1971	319	50%	89	600	10.4	15%	20	3%	31	0.80	48	0.11	66.0
Liberia	-	1975	396	10%	6	67	18.5	9%	3	4%	53	0.70	59	0.01	4.0
CAR	-	1989	757	20%	2	62	14.5	3%	19	30%	32	1.20	47	0.08	4.4
Sierra L.	-	1975	808	30%	-	-	-	-	-	-	106	0.40	48	0.02	5.7
Togo	-	1994	850	20%	3	39	6.3	8%	0	0%	57	0.85	63	0.05	6.6
Chad	Yes	2009	1300	-	8	130	12.3	6%	2	1%	94	0.43	49	0.04	11.2
Sudan	-	2008	2210	30%	4	-	0.1	-	-	-	161	0.70	58	0.28	42.3
Zimbabwe	-	1973	-	35%	80	46	10.1	174%	15	12%	56	-	45	0.16	12.5
Fragile		1987	949	28%			10.3	8%		8%	73.8	0.72	52.2	0.09	
Malawi	Yes	1966	794	37%	27	142	11.1	19%	10	6%	50	1.10	54	0.02	15.3
Rwanda	-	1975	1136	40%	-	-	-	-	-	-	102	1.60	51	0.02	10.0
Mali	-	1992	1185	2%	-	-	-	-	-	-	66	0.57	49	0.05	13.0
Uganda	Yes	1957	1217	12%	42	491	16.3	9%	19	4%	115	0.39	53	0.12	32.7
Tanzania	Yes	1992	1362	42%	89	815	20.7	11%	24	3%	68	1.10	56	0.01	43.7
Zambia	Yes	1970	1430	40%	36	110	11.3	33%	9	6%	68	1.90	46	0.06	12.9
Lesotho	Yes	1973	1468	40%	8	72	38.7	11%	4	5%	133	1.33	45	0.05	2.1
Benin	Yes	2002	1508	40%	6	20	2.9	30%	28	108%	65	0.50	62	0.06	8.9
Ghana	Yes	1967	1552	42%	58	104	6.8	56%	10	6%	104	0.93	57	0.09	23.8
Kenya	Yes	1963	1573	-	74	808	22.2	9%	24	3%	68	1.40	55	0.14	39.8
Nigeria	-	1973	2203	40%	147	2747	18.7	5%	28	1%	136	0.53	48	0.40	154.7
Cameroun	Yes	1957	2205	40%	30	150	9.2	15.4%	3	1%	122	1.50	51	0.19	19.5
Low inc.		1972	1495	37%			15.8	20.3%		14%	93.7	1.11	52.6	0.10	
Swaziland	-	1998	4998	-	3	27	25.3	11%	1	3%	312	2.10	46	0.16	1.2
Namibia	-	1978	6410	-	6	-	2.8	-	-	-	384	2.67	62	0.37	2.2
Botswana	-	1974	13384	18%	2	6	4.1	33%	2	25%	1341	1.81	55	0.34	1.9
Middle inc.		1983	8264	18%			10.7	22%		14%	678.9	2.19	54.3	0.29	

Source: Compiled by the authors based on data from CHAs and World Bank Development Indicators database.

Notes: Countries are ranked by PPP GDP in US$ in 2009. Sudan and Zimbabwe are included in group 1 despite higher GDP levels because of the conflict in Sudan and the situation in Zimbabwe. Mali is included in Group 2, but not included in average statistics for that group. Blank cells indicate that data are not available.

Table 2: Typology of CHAs according to their state of development

	Stage 1: Emergence	Stage 2: Professionalization	Stage 3: Integration
List of countries (ranked by increasing level of GDP per capita)	Fragile: DRC; Liberia; CAR; Sierra Leone; Togo; Rwanda; Sudan; Zimbabwe	Low income: Malawi; Rwanda; Uganda; Chad; Tanzania; Zambia; Lesotho; Benin; Ghana; Kenya; Nigeria; Cameroon (plus Mali)	Middle income: Swaziland; Namibia; Botswana
Country average characteristics	PPP GDP pc: $949 Life expectancy: 52.2 Bed rate: 0.7 per 1,000 Physician rate: 0.09 PPP Health sp. pc: $74	PPP GDP pc: $1,479 Life expectancy: 52.6 Bed rate: 1.1 per 1,000 Physician rate: 0.10 PPP Health sp. pc: $94	PPP GDP pc: $8,264 Life expectancy: 54.3 Bed rate: 2.2 per 1,000 Physician rate: 0.29 PPP Health sp. pc: $679
CHA average characteristics	Year established: 1987 Share with MOU/Eq.: 1in8 National (bed) share: 28% (Ho+HCs)/million: 10.3 Ho/HCs: 8% (excl. Zimb.) Training/(Ho+HCs): 8%	Year established: 1972 Share with MOU/Eq.: 9 in 12 National (bed) share: 37% (Ho+HCs)/million: 15.8 Ho/HCs: 20.3% Training/(Ho+HCs): 14%	Year established: 1983 Share with MOU/Eq.: 0 in 3 National (bed) share: 18% (Ho+HCs)/million: 10.7 Ho/HCs: 22% Training/(Ho+HCs): 14%
CHA Priority: Internal stakeholders (member facilities) CHAs External stakeholders (government, donors, etc.)	Organizing	Securing Support	Exerting influence (also valid for advanced CHAs from low income countries)

Source: Compiled by the authors based on data from CHAs and World Bank Development Indicators database.

CHALLENGES FACED BY CHAS AND FAITH-INSPIRED MEMBER FACILITIES

Having described in broad terms the history of the establishment of the CHAs and their current characteristics, we now shift to some of the challenges they face. Although the CHAs in Africa clearly operate in very different funding and health contexts, representatives of CHAs do point to several shared challenges. This is evident in the broader emerging literature, as well as from a small survey of CHAs carried out by Dimmock (2011) from which the quotations in this section are taken.

Increased demand equals increased strain on health providers

Church health providers commonly state that they have recently experienced greatly increased demand (for health services) which in turn has put added pressure on them and the health system. This is both in relation to those countries with stronger systems (such as Ghana, where the implementation of a national health insurance has had positive

impact, but has also placed greater strain on the providers), and those in more fragile contexts, such as Zimbabwe. As ZACH/Zimbabwe notes, as a result of the instability and isolation the country has experienced, *"…partners lost confidence and moved to neighboring countries with vibrant economics…The demand for health increased due to poverty and increased disease burden. The demand for health care meant that hospitals needed to increase their capacities to provide services, however due to poor economic performance critical shortages…forced hospitals to scale down and provide basic care."*

Human resources for health crisis

All church health providers share the challenges of a continental-wide human resource crisis, especially in relation to human resources for health (HRH). All of the CHAs indicate difficulties in competing with governments and international NGOs for staff. Several say that a competitive salary is the best way to retain staff, but that this is also one of the greatest challenges. At the same time CHAs have successfully implemented (sometimes innovative) incentive strategies such as continuing education for staff, and motivation such as giving credit where credit is due, and good working conditions. As stated by UPMB/Uganda: "*Unfortunately we are not in a good position to compete favorably with government, INGOs and NGOs. Salaries in these sub sectors are much higher than in our network…(however) professional staff get more job satisfaction working with us because facilities and drugs are available*." A particular problem for the CHAs and their members is the loss of long-term medical mission staff. However, CHAs have become heavily engaged in the human resource crisis, through negotiation with government (see below), and also through engagement in a CHA-HRH technical working Group.

Reduced funding from traditional sources

Even today, CHAs continue to feel the effects of a reduction in traditional sources of support and funds from affiliated religious groups in the West. For example, CHADCath notes, "*Yes, the funding is getting more and more difficult…The general opinion is that there are other countries in Africa suffering a lot (more)…*", and CHADProt similarly says, *"…the funding that we get from our Christians partners from Europe (decreased) during the last year. They say that people in Europe don't give more money like the last past years and ask us to focus on the local opportunities of fundraising*." There are many other such examples of how the loss of traditional funding sources continues to hurt the church health providers and their CHAs. For example, Boateng (2006) notes that CHAG facilities find their financial sustainability seriously threatened due to increased demands for services against declining donations from traditional sources, sometimes uncertain support from government, and low cost recovery in member facilities.

Targeted funding not allowing for long-term or core activities

All CHAs and their members now find themselves heavily dependent on local and international donor support – and increasingly dependent on conditional grants and targeted project funding. (Ironically, this trend has further weakened their relationship with traditional church partners). In Uganda, for example, the UCMB reported that 49 percent of their funding during 2007/8 was comprised of project funds: "*It is true that donor (project funds) are increasing…(but) 80 percent were for HIV/AIDS only. So I*

cannot really say the main work of the hospitals is depending on donor funds." CHAs note the difficulties and detrimental effects that targeted funds (especially HIV/AIDS funds) have on broader health provision. For example, CHAM/Malawi note: "*Yes, funding for projects has increased, but funding for core programming has decreased."* CHAZ/Zambia reported that project-funded donors are often more interested in short-term technical inputs than in long-term investment in developing local human resource capacity. This places additional stress on under-staffed health programs and encourages competition within the health sector. UCMB/Uganda, CHAK/Kenya, CHALe/Lesotho and ASSOMESCA/CAR all expressed caution with regard to the need to balance attention given to administering specific project funding with the priority tasks of providing integrated and essential health services. The demands of reporting and accountability for donor funding have also increased – stretching the capacity of church health providers and increasing the role of CHAs in capacity building.

Government support, responsibility and cost recovery

A key role of CHAs has become the negotiation of appropriate and sustained support from government. Several CHAs are now heavily dependent on government subvention for covering payroll and operating expenses within their facilities (for example, CHALe/Lesotho, CHAZ/Zambia, CHAM/Malawi, CHAS/Sudan). The CHAs have played an important role in the negotiation between church health services and the governments – especially in relation to proving the significance of the church health services to the governments. Dimmock (2011) surveyed CHAs about the likelihood of their handing services over to government, and what this would mean to denominational bodies or churches. Most of the responses were strongly against this notion – also noting that most governments did not have the capacity to manage CHA facilities in addition to their own. They also cited the trust local communities had in church health services, and that transfer of the facilities to governments would mean a loss of credibility in the broader healing ministry of the church. For example, CAM/Cameroon: "*In Cameroon, the churches were the first in the area of health. People trust us a lot. It will be very difficult to accept (a very big failure).*" However, some CHAs noted that it was increasingly difficult to maintain independent health services in the current financial climate – and that it was mainly their poor experiences of handing over services and their fear that whoever took over would do a worse job, with poorer quality or not serve the poor as well, which kept them engaged. Says UCMB/Uganda: "*This is not an option, at least for the foreseeable future. We believe we have a duty as Christians to fulfill the mission of Christ…People in situations of instability would be the greatest losers as Churches have provided resilience to health care for them when everybody else left or could not.*"

Erosion of Christian values

Most importantly, a constant challenge, relating to all of the above is that CHAs and their members feel that it is increasingly difficult to maintain their Christian mission and values in the face of new constraints and integration with public and private services. This is felt broadly, in terms of searching for financial sustainability to continue to be oriented towards the poor (private urban hospitals are certainly more profitable). For example, UCMB/Uganda notes "*…the poor rural hospitals are more dependent on the*

conditional grants from government…Drops in (primary health care conditional grants) are increasingly forcing facilities to try to increase user fees. In turn this affects the principles of our mission, universality and preferential option for the poor." This tension is also felt in relation to new partnerships and conditional support of governments and donors – which often have a different 'vision' or operational culture. CHAK/Kenya notes: "*We must resist the temptation of getting donor funding from sources that would compromise our faith and values. We have to be firm with government on the minimum acceptable standards for our values.*" This challenge is also felt in relation to operational decisions, such as the kind of staff that gets hired. CHAZ/Zambia expressed a perceived erosion of Christian values in the services of their members. This was related to the shortage of professional staff and relaxation of recruitment criteria reflecting religious values. UPMB/Uganda noted that "*The biggest threat to values lies in the secondment of staff to our health facilities. These staff are often recruited and then deployed by government with no consideration whatsoever for the values and work ethics of the receiving faith-based institution…their social values and work ethic are sometimes in conflict with the organizational culture of the institution to which they have been deployed*."

Clearly, the above list of challenges suggests that CHAs and their members are operating in complex and apparently rapidly changing circumstances. However, it is rather disconcerting to note that many of the above challenges were already raised in the 1960s, and have still not been resolved. For example, McGilvray's (1981) account raised most of the challenges in relation to the nature of church health services, their role in facilities-based versus PHC/preventative care, what it means to be a 'Christian' provider, whether it is possible to bear the costs of a 'pro-poor' mission, whether church health providers are sustainable given new financial constraints, and queries about evidence of their 'value-added' in modern health systems. What has changed, however, is the strengthening presence of the CHAs in this negotiation, especially in the group of middle income countries outlined earlier. In these countries, CHAs have become active in negotiating these challenges to partners and in working to mitigate these effects – both directly and indirectly.

ROLE OF CHAS IN NEGOTIATING, CHANNELING AND RAISING SUPPORT

In this last section, we consider the relationships between CHAs and their external stakeholders, and especially the negotiations taking place between CHAs and MOHs (in particular, focusing on the CHAs at the stage of professionalization characteristic of the low income countries group - where securing support from the state is paramount).

The issue of financial and other forms of support (such as capacity building) is important not only for the CHA member facilities, but also for the CHA secretariats themselves – and is often a distinctly different fund-raising endeavor. When CHAs were asked how they ensure their own future financial viability (CHAs specifically, not their members), they indicate the following strategies: developing business plans, reducing staff, cutting expenses, outsourcing some services, negotiating with government for additional support – and interestingly, many CHAs are now engaging in direct income generation to support

the CHA (secretariat) activities. For example UPMB/Uganda and CHAK/Kenya have both investment properties that provide some revenue, and others are involved in guesthouses, office rental, drug supply and distribution, and corporate health service contracts.[8]

The increased engagement with government and donors (and attendant donor requirements) has cemented the role of the CHAs, in terms of their unique position in negotiation with government and partners, and building technical capacity in their members. It is important to note that this role for the CHAs has been developed gradually, with much trial and error, and continues to evolve. Internally, negotiating the role of the CHA has caused some tensions, especially with regards to whether the CHA holds funds and is involved in the management of health facilities or whether it mainly builds capacity and channels resources to members. This was experienced in Kenya, where the role of the CHA has been renegotiated several times. CHAK/Kenya: "*From 1946 to the early 80s CHAK received and channeled grants from MOH/Government Budget to Protestant Church health facilities. In the mid-80s to mid-90s CHAK enjoyed huge funding from international donor partners including bilateral partners and experienced uncontrolled growth in response to donor funding. The pressures of fulfilling donor demands gradually shifted its role to implementation to the extent that it at times worked in competition with member health facilities. In 1996, CHAK underwent a major paradigm shift from an implementer to a facilitator. Priority was refocused on advocacy, capacity building, networking, communication and facilitation.*" In Zambia, CHAZ has evolved from being an umbrella network, to now being a primary recipient of the Global Fund, even receiving the bulk of Global Fund support for Zambia in 2006 (58 percent committed, and 56 percent received), and in turn dispersed money to *"411 local FBOs to fight AIDS, 73 local FBOs to fight TB and 75 local FBOs to fight malaria"* (GFATM 2008). At the start of the Global Fund grants in 2003, CHAZ had 23 employees and by the end of 2008 had 82 employees.[9]

The role of negotiator of partnership between the national government and respective church health providers is perhaps the most significant role that has evolved for CHAs. There is some evidence that several of the CHAs in the professionalization (low income group) have managed to establish strong collaborative relationships with government, evidenced by successful and ongoing negotiation around issues such as financial support and human resources (see examples below). Several studies indicate that in the case of HIV/AIDS multisectoral collaboration, some CHAs hold a stronger collaborative relationship with government than other FBOs and NGOs thanks to a dual pathway to government, through the Ministry of Health (in relation to their medical response, e.g.

[8] CHAs have also become significantly involved in negotiation and operation of pharmaceutical provision. (e.g. CHAZ/Zambia, CSSC/Tanzania, BUFMAR/Rwanda, ECC/DRC, CHAM/Malawi). Other medical supply organisations include: Mission for Essential Drugs and Supply (MEDS) – jointly owned by CHAK/Kenya and KEC/Kenya; the Joint Medical Store (JMS) – a joint venture of UCMB/Uganda and UPMB/Uganda; ASSOMESCA/CAR which operates a regional drug distribution agent system in the Central African Republic, with customers (church member groups) in CAR, DRC and the Congo; and CHANPHarm operated by CHAN in Nigeria (Schmid et al 2008).

[9] See www.theglobalfund.org

ART), and also through national AIDS councils as a civil society representative. "*Although the CHAs and their members face various critical challenges such as financing and workforce concerns…these associations are exemplars of the positive impact of collaboration, networking and resource sharing…in countries that do have such national faith-based health networks, there is stronger collaboration between FBOs, as well as between FBOs and secular groups - in particular a stronger advocacy role with government. The NFBHN appears to be a valuable type of FBO that draws together different faith-health activities, and provides support in a variety of ways*" (Haddad et al 2008).

The evolution of relations between CHAs and governments is demonstrated by the negotiation surrounding the establishment of MOUs between CHAs and their national governments (usually the Ministries of Health). We specifically mean those MOUs which frame and lay down the terms of a specific relationship between the CHAs and that government (not standard legal policies outlining the roles of NGOs or private sector providers more generally). As outlined in Table 3 below, these MOUs characteristically formalize the relationship between the CHA and the government; acknowledge the important work of the CHA members; and often formalize some level of reciprocal partnership and support (such as waivers on import taxes for medicines and supplies, budgetary or human resource support, and access to training opportunities).

These MOUs are indicative of the collaborative role that CHAs are increasingly playing – as chief representative and negotiator of groups of church health providers. There are also several examples of CHAs successfully negotiating their way through specific crises. For example, several networks (e.g. CHAM/Malawi and CHAG/Ghana) have negotiated service contracts at the district or local level, or have agreed on 'designated District Hospitals' (e.g. CSSC/Tanzania, UCMB/Uganda and ZACH/Zimbabwe) through which church hospitals, subsidized by government, act as public hospitals. Several CHAs continue to negotiate on the issue of human resources – for example, curtailing the inappropriate secondment or 'luring away' of staff, or negotiating access to government training opportunities for church health staff. These relationships however require continuous negotiation. That is, the presence of an MOU does not automatically result in stronger practice – or adherence to the terms of the MOU. To improve adherence to the MOU, some countries have also established joint committees, including government representation on managing Boards (for example, CHAM/Malawi and CHALe/Lesotho) or have an official in the Ministry of Health assigned to liaise with the private sector (CHALe/Lesotho).

Most CHAs have reported that the process of establishing the MOU was important in identifying and aligning the relationship between the Ministries of Health and CHAs. In Ghana, this relationship is held up as one of the most positive examples of public-private partnership in the country. Indeed, the rest of the private sector is described as feeling left out of the mainstream government thinking and planning (Rasheed 2009, Makinen et al 2011). Rasheed (2009) describes the gradual strengthening of the CHAG-MOH relationship as follows: *"CHAG worked with government, gaining trust and proving its usefulness. In particular, CHAG participated in restructuring exercises within the health*

sector, represented FBOs within the SWAP, and helped with mapping services including describing the extent of the human resource crises. CHAG worked with government to work out strategies to ensure health service coverage for rural areas and conceptualize national health insurance policies. CHAG also substantively increased collaborations with government in training. It was during the administration of 2003-2006/7 when things finally came together." The relationship between CHAG and the MOH was strengthened slowly over time, and the MOU is reflective of the fact that CHAG has sought and secured a seat at the Ghanaian health policy table (Rasheed 2009).

Even though described as comparatively strong (especially in comparison to Christian Health Associations in other African countries), the relationship between CHAG and the MOH should not be taken for granted, or assumed to be without its own tensions and obstacles. For example, Dovlo et al (2005) describes the context in which the national health insurance scheme (NHIS) was initiated by the MOH and notes that at that time CHAG tried to initiate a dialogue on health insurance but failed to get an audience before the NHIS law was passed. However, there appear to be more positive examples than negative, and the fact that such tensions are openly expressed suggests that the collaborative relationship between CHAG and the MOH includes a healthy degree of debate that goes beyond surface-level 'dialogue'. This is just one country example, but generally CHAs have to continue to work to maintain good partnerships, proving the 'value' of their members to the broader system.

Also, despite this stronger role, CHAs (as a function) still face significant internal challenges. For example, reporting on a CHA meeting in 2006, Mandi lays out the main challenges as being: lack of co-ordination among CHAs when lobbying since they usually approach governments independently and not as a united front; CHAs do not have adequate lobbying or negotiating powers; there is a lack of trust between governments and CHAs; CHAs fear that if they partner with governments, they will be absorbed and lose their identities; and that governments view church health providers as direct competitors rather than partners (Mandi 2006).

Table 3: MOUs between CHAs and governments in Africa

Country- CHA	*MOU*	*Status*
Benin - AMCES	no	Have agreement with government as an "NGO of public utility" since 2008.
Cameroon - FEMEC	yes	MOU signed 2007: monitored through a committee with representatives of Protestants, Catholics, others and the MOH. Further negotiations underway (draft proposal for state assistance).
CAR - ASSOMESCA	no	A convention signed 1995: used to get drugs, equipment, and vehicles from abroad without paying taxes, but no longer in effect.
Chad - Catholic	yes	MOU signed 1994: to cooperate with the NHS, including the importation of drugs without paying any import tax (formally renewed annually)
Chad - Protestant	yes	MOU signed 2006: for the importation of medicines and supplies without taxes. 2008 further contract signed for support of hospital running costs.
Ethiopia - CHAE	no	New CHA
Ghana - CHAG	yes	MOU signed 2003, with administrative addendum in 2006 - – indicates shared responsibilities and some government financial assistance
Kenya - CHAK	no	MOU in development - awaiting government review and finalization.
Lesotho - CHALe	yes	Service agreement in 2002, MOU signed 2007: Monitored through agreed structures in different committees (e.g. HR, quality, legal) – but no predetermined frameworks with indicators.
Liberia - CHALi	no	Not in development.
Malawi - CHAM	yes	MOU revised in 2002: indicates government's responsibility to provide health services to the nation, and CHAM's role to complement the Government's efforts. Towards this end, the government undertakes to provide financial assistance to CHAM units, monitored through CHAM-MOH quarterly review meetings.
Sudan - CHAS	no	Government said MOU not necessary – advised CHAS to get legal status in order apply for government funding and service agreements. (Status obtained 2008)
Tanzania - CSSC	yes	Two MOUs signed in xxx: Service agreement on the provision of health services, database sharing, joint supervision and joint review.
Togo - APROMESTO	no	MOU has been designed, but not signed by government.
Uganda - UCMB	no	MOU in being developed – after legal framework for PPPH policy approved by Cabinet.
Uganda - UPMB	no	But collaboration with government on health service provision and capacity support is advanced.
Zambia - CHAZ	yes	MOU revised in 2004: government provides 75% of the CHA facilities running costs, seconds almost all health professionals and supplies essential medicines. CHAZ in the sector advisory group and in various other committees (e.g. NAC and CCM of the Global Fund) as well as in health-related statutory bodies and overall planning and budgetary processes.
Zimbabwe - ZACH	no	MOU drafted and waiting on Management Board Review and inputs from MOHCW.

Source: Authors' compilation, based in part on Dimmock (2011), Schmid et al (2008), and Haddad et al (2008)

THE NEXT HALF CENTURY FOR CHAS – WHICH WAY FORWARD?

Maintaining and strengthening health systems will necessitate effective and efficient partnerships within the health sector, and beyond. It will call for increased intersectoral cooperation (rather than competition), regarding the scarce human and financial resources. It will also require the identification, resourcing and rational use of religious health assets, both tangible and intangible, to positively impact health outcomes. Now, perhaps more than ever before, it is vital to align public health policies with primary health care (PHC) principles and objectives to promote equity, access and fair health for all. Despite the numerous challenges currently facing African CHAs and their members, these associations will likely remain the primary partner to government health services for a long time to come.

We have outlined several challenges facing CHAs and their members – some challenges that are contextual, and some which are specific to what church health providers are trying to be. In all this, the developing role of the CHAs as a particular collaborative function has been demonstrated as key. This function is very much in line with what was imagined in the 1960s. However, what does this mean for the future – and for what CHAs might need to become in the future? We have named several important functions, such as continued and improved capacity building, negotiation, and skills building. The literature and the CHAs themselves outline two other functions that may become even more important in the future.

Wrestling with the weightier questions

It is clear that CHAs are seen to be centrally involved in wrestling with the weightier questions about the role, function and sustainability of church health services. Said differently, CHAs have become the forum for consideration of what it means to be a faith-inspired health provider in modern health systems. The CHA annual meetings have replaced the function of those other mechanisms such as the CMC for engagement with these concerns. CHAs have been tasked by their members, not only with operational issues such as funding or capacity-building, but also with some of the more difficult questions about the role of the church in health, the potential of (re)orientation towards PHC, or weighting community health and health promotion versus hospital-based care.

Technical assistance, information gathering and sharing

It has been widely noted that many church health providers lack the information systems and the necessary capacity to document their work. We cannot judge whether this capacity is less or more than other public or private providers. Suffice it to say that this is a significant need – and one that CHAs are seen to play an important role supporting their members. This is not only relating to M&E, but also to the ability to evidence the work they do, and also utilize information systems to improve their own work. There are also clearly many lessons that need to be shared between CHAs – for example, on how they deal with these challenges named above. So far, this sharing (between CHAs) has mainly occurred at annual meetings, and supported by outside partners.

The CHAs tend to have a few key partners with whom they work in relation to technical assistance (for example the development of information systems). It was concerning that when the African CHAs were asked who knew of technical assistance (TA) available to CHAs and who accessed such – specifically from country partner offices (e.g. EU, World Bank, UN agencies) of the 14 CHAs that responded (Dimmock 2011), only 8 knew of TA available to CHAs. For example, CHAM/Malawi noted TA was available in Malawi, but not to CHAs; CHAS/Sudan noted TA was only available to the government; and CHAZ/Zambia noted that TA was seen to be available, but that "*the Association has not yet accessed this support*". Only two CHAs had accessed TA in the past: UCMB/Uganda noted that they usually did not access TA, but had done so in the past, for example *"…from a European partner in developing proposal for EU funding in the past*"; and ZACH/Zimbabwe was the only CHA who noted they were currently gaining TA by "*working with UN agencies, World Bank, GFATM, European Union*".

During the CHAs Assembly in Tanzania in January 2007, a significant step was taken, when it was agreed that a continent-wide platform for African national associations should be established: the African Christian Health Associations Platform (ACHAP). Its objectives are to enhance advocacy, facilitate technical assistance and support, networking and communication of ideas for coordination and capacity building (the hub of which is mobile, and currently hosted in Kenya by CHAK). Fundamentally, what this platform represents is an acknowledged need to share information, experiences and best practices among CHAs. This need is supported by the available literature, which reiterates the importance of 'evidence-based' advocacy if CHAs are to take the role of negotiator further (see Olivier and Wodon 2012). While some CHAs would see the ACHAP platform as taking on the main information gathering role, there is still not enough capacity in the platform for this to happen.

In addition, the country-specific information gathering role (as potentially played by the CHAs) cannot be supplanted by a regional structure, simply because while there are certainly shared traits between CHAs, they operate in highly context-specific environments. For example, we have focused mainly on national level collaboration here, but there are also urgent questions being asked about the role of church health providers and CHAs at a district and local level – especially as countries increasingly decentralize health services. District-level collaboration requires a whole different range of partnerships and functions, and different system of information gathering and support. This means that each CHA needs to become increasingly involved in data gathering and information system building and also negotiate the partnerships necessary to build this capacity when necessary (for example reaching out to partners for TA or to universities for research support). This also means an increased role for CHAs in 'chronicling' their experiences, from their negotiations with particular partners, to highlighting best practices of their members.

Given the rapid development of CHAs and the lessons they have learned over the last half century, another potentially powerful task for CHAs (and the new platform) might be to take a more proactive role in sharing these lessons with a broader range of networks, in particular the emerging non-Christian NFBHNs. In Ghana, for example, the Islamic

health providers have a much smaller market share of facilities – and also a significantly weaker relationship with government, even though some hospitals function as district hospitals (Miralles et al 2003). They are also clustered in areas in which the CHAG providers are not. This might certainly be an opportunity for CHAG (and other CHAs) to take on a stronger role of inter-faith collaboration.

Supporting innovation and flexibility

Another potential function for attention of the CHAs might be increased support of innovation and flexibility. Many church health providers have been noted as being particularly innovative: in the way they respond to need with limited resources, in the ways they connect with community, or the health-providing traditions and operations that have been built over decades of in-context trial and error. Many church health providers could also be considered to be 'rural health specialists', advising others (including government) on what it takes and means to operate health services in hardship areas. However this role is not properly documented or recognized. Another concern which has been raised as CHA members become increasingly integrated into national health systems (surely a good thing) – is that they may be losing some of their characteristic strengths in the process. For example, Gilson et al (1997) noted that church health providers *"tend to enjoy greater flexibility, adaptability and innovativeness than government providers because they are not governed by rigid bureaucratic procedures."* Gilson et al argued that while increased collaboration and contract compliance with the public sector makes it easier for governments to integrate private providers in national systems, it may also impose constraints that affect the very nature of the private sector, including its flexibility and innovativeness. "*Formalizing the government/church relationship through contracts may, thus, change the nature of church providers and so undermine some of their comparative advantages over government"* (Gilson et al 1997). This means that a potential function for CHAs might to take on the challenge of protecting the innate flexibility and innovativeness of church health providers (even while negotiating with government for improved integration), and partnering with others to document and demonstrate this more effectively.

CONCLUSION

These suggestions of potential areas for future focus emerge from the CHAs themselves (it is certainly not for us to say what role CHAs should play in the future). The CHAs have benefitted from increased attention over the last half century. They have established a particular and important role for themselves – especially in African health systems which require constant negotiation and intricate collaboration between a variety of public and private providers. The challenges and suggestions above all hint at an *increasingly* complex role for CHAs going forward – and a role which will require more diverse and complex capacities for CHA staff. When CHA members sometimes respond that they 'just want to get on with the healing' – the CHAs are then handed the task of looking forward. This role extends beyond that of an 'umbrella network' which organizes meetings or facilitates dialogue between partners, and beyond that of a standard intermediary organization which channels funds or builds technical capacity among members. In resource constrained environments, it now seems that it is the CHAs which

have mainly been tasked (by their members) with the role of looking forward beyond immediate need – to take the longitudinal view of where faith-inspired health providers should be in the next fifty years.

REFERENCES

Asante, R. K. O. 1998. *Sustainability of Church Hospitals in Developing Countries: A Search for Criteria for Success*. Geneva: World Council of Churches.

Atingdui, L. 1995. "Defining the Nonprofit Sector: Ghana", in L. M. Salamon and H. K. Anheier, editors, *Working Papers of the Johns Hopkins Comparative Nonprofit Sector Project*. Baltimore: The Johns Hopkins Institute for Policy Studies.

Boateng, J., H. Surnye, A. Mensah, B. Boateng, P. Nyarko, N. Munguti, and J. H. Bratt. 2006. "Costs of Reproductive Health Services Provided by Four CHAG Hospitals, Frontiers in Reproductive Health Program and Family Health International Supported by USAID.

Boulenger, D., B. Keugoung, and B. Criel. 2009. "Contracting Between Faith-based and Public Health Sector in Sub-Saharan Africa: An Ongoing Crisis? The Cases of Cameroon, Tanzania, Chad and Uganda." Antwerp, Institute of Tropical Medicine, Study commissioned and published by the Medicus Mundi International Network.

Christian Health Associations at Crossroads (CSSC). 2007. "Christian Health Associations at Crossroad Toward Achieving Health Millenium Development goals." *Christian Health Association's Conference, 16-18 January 2007, Dar es Salaam.* Tanzania: (CSSC) Christian Social Services Commission, pp.1-28.

_____. 2007. "Christian Health Association's Conference Planning Document." Tanzania: (CSSC) Christian Social Services Commission.

Dimmock, F. 2007. "Faith-Based Health Networks in Africa." Paper presented at Christian Connections for International Health Annual Conference, Washington, DC.

_____. 2011. "Maintaining and Strengthening Religious Health Assets: Challenges Facing Christian Health Associations in the Next Decade." In B. Schmid, J. R. Cochrane, and T. Cutts, eds., *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, Cluster Publications: Pietermaritzburg.

Dovlo, D. Y. 2005. "Social Dialogue in the Health Sector: Case study Ghana." *Sectoral Activities Programme, Working Paper Series*, WP 234, Geneva: International Labour Office, World Health Organization.

Ewert, D. M., and A. Merrill, editors. 1995. *A New Agenda for Medical Missions*. MAP International.

GFATM. 2008. “Report on the Involvement of Faith-based Organizations in the Global Fund.” The Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva, Switzerland.

Gilson, L., J. Adusei, D. Arhin, C. Hongoro, P. Mujinja, and K. Sagoe. “Should African Governments Contract Out Clinical Health Services to Church Providers?.” In S. Bennett, B. McPake and A. Mills, eds., *Private Health Providers in Developing Countries: Serving the Public Interest?*, London and New Jersey: Zed Books.

Green, A., J. Shaw, F. Dimmock, and C. Conn. 2002. “A Shared Mission? Changing Relationships Between Government and Church Health Services in Africa.” *International Journal of Health Planning and Management* 17: 333-353.

Haddad, B., J. Olivier, and S. De Gruchy. 2008. “The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC.” Cape Town: Africa Religious Health Assets Programme.

Makinen, M., A. Sealy, R. A. Bitran, A. Adjei, and R. Munoz. 2011. “Private Health Sector Assessment in Ghana.” *World Bank Working Paper Series* No.210.: World Bank, Washington, DC.

Mandi, F. 2006. “Planning, Development and Supporting the Faith-based Fealth Workforce.” African Christian Health Associations' Human Resources for Health Mini-Forum, Nairobi, Kenya, The Capacity Project and Medicus Mundi Int.

McGilvray, J. 1981. *The Quest for Health and Wholeness.* Tübingen: German Institute for Medical Mission.

Miralles, M. A., F. Aboagye-Nyame, et al. 2003. « Access to Essential Medicines: Ghana, Strategies for Enhancing Access to Medicines Program.” Arlington, VA: Center for Pharmaceutical Management, Management Sciences for Health.

Olivier, J., and Q. Wodon, 2012. “Estimating the Market Share of Faith-Inspired Health Care Providers in Africa: Comparing Facilities and Household Survey Data.” In J. Olivier and Q. Wodon, eds, *The Role of Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships.*, HNP Discussion Paper, World Bank, Washington, DC.

Rasheed, F. 2009. “Collaborations Between Public Health Systems and Faith-Based Organizations: Memorandum of Understanding Between the Ministry of Health and the Christian Health Association, Ghana.” Programme on Partnerships and UN Reform - World Health Organization, Geneva.

Schmid B., E. Thomas, J. Olivier, and J. R. Cochrane. 2008. *The Contribution of Religious Entities to Health in Sub-Saharan Africa.* Cape Town: African Religious Health Assets Programme.

Van Reken, D. E. 1990. "Medical Missions and Development of Health.", in D. M. Ewert and A. Merrill, editors. *A New Agenda for Medical Missions,* MAP International: 23-24.

ANNEX: Basic information for Christian Health Associations in Africa

Country	Full name	DOB
Angola	**CICA: Conselho das Igrejas Cristãs em Angola [Council of Christian Churches in Angola, Christian Medical Commission]**	
Establishment and Members: Established in 1977 as an ecumenical institution with the purpose of being the Angolan faith community's guiding institution, and prophetic voice of its member institutions towards local and international governments. CICA's mission is to contribute to the peace process and to strengthen ecumenism in Angola. ~ 20 church members CICA Work: provides guidance and technical assistance in community assistance and development, literacy, vocational training, community health (including HIV and AIDS), development of youth, ecumenical co-operation, and peace education and reconciliation.		**1977**
Benin	**AMCES-Bethesda: Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin ['Association of Private Church Medical and Social Works in Benin'**	
Establishment and Members: In 1985 the 'Association of Private Church Hospitals of Benin' (AHPOC) with was established – later instituted as AMCES the 'Association of Private Church Medical and Social Works in Benin'. There were five initial facility-based members (hospitals). There are now ~20 members with 30 related health facilities. AMCES Work: AMCES' focus is to promote and foster cooperation, understanding, exchange of information and experience, consultation among members and with the Beninese government and all governmental or non-governmental national and international; to organize collaboration; solve common problems; promote work of all non-profit providers; and defend the moral and material interests of its members. Websites:www.amces-benin.org · In Cameroon, ECMA was also created as a platform to coordinate all private, non-profit providers – religious (Catholic, Protestant and Muslim) and secular (association and NGOs) members. · Bethesda is a faith based hospital that was started in Benin in 1990 by the Council of Churches of Benin with an aim to "improve the physical and social wellbeing of the individual and the family at accessible and reduced rates". Website: http://www.bethesdabenin.org/		**1985**
Botswana	**AMMB: Association of Medical Missions for Botswana**	
Establishment and Members: Established in 1973-1974, AMMB began as an ecumenical arm of the Botswana Christian Council – before developing as an association in its own right. Work: AMMB is a loose association of Christian health facilities.		**1974**
Cameroon	**CEPCA: Conseil des Eglises Protestantes du Cameroun [Council of Protestant Churches of Cameroon – Health Department]**	
Establishment and Members: CEPCA was established in 1941 (as FEMEC), with its Department of Health established in 1957 and reconstituted as CEPCA in 1968. A federation of 11 protestant churches and missions, managing 30 hospitals, 150 health centers and 3 nurse training schools. CEPCA Work: CEPCA has several departments, including those focused on education, women and communication. The Department Health assists churches in the management of health facilities, organizes seminars on hospital management of certain diseases, distributes grants when the state gives, serves as a link with the ministry.		**1957**
CAR	**ASSOMESCA: Oeuvres Médicales des Eglises pour la Santé en CentrAfrique**	
Establishment and Members: Established in 1989 as an ecumenical collaboration with 16 member groups: 8 Protestant and 8 Catholic. Participating members now include Lutherans, the national work associated with Baptist Mid-Mission, Grace Bethren, Catholic, Swiss Pentecostal, Apostolic, Swedish Baptist and a few independent groups. Work: ASSOMESCA coordinates and builds capacity among members – and operates a drug distribution system in CAR, with customers (church member groups) in CAR, DRC and Congo.		**1989**

Chad **AEST/UNAD-sante: Union Nationale des Associations Diocésanes de secours et développement**

Establishment and Members: Newly forming collaborative **2009**

DRC **ECC-DOM: Eglise du Christ au Congo - Direction des Oeuvres Médicales & SANRU**

Establishment and Members: The Protestant Church of Zaire (currently known as ECC – *Eglise du Christ au Congo)* came into existence in 1971 with around 60 member communities. At the same time, a medical office, the *Direction des Oeuvres Médicales* (DOM) was created to coordinate the health work of the ECC members and to serve as the liaison with the Ministry of Health. In 1999, in a major move, the DRC Ministry of Health formally turned over responsibility for health care in 60 zones (of a total of 306) to a coalition of mostly faith-based non-governmental health organisations – with ECC-DOM as implementing partner (the project named SANRU (Projet Santé Rurale). ECC currently co-manages 65 of the 515 health zones in the DRC, with more than 50 hospitals and several hundred dispensaries. The ECC network of 64 member communities includes Anglican, Presbyterian, Evangelical, Baptist, Pentecostal, Methodist and Mennonites. **1971**

Health Work: Through its member communities, ECC-DOM provides community-base health care, hospital and dispensary-based care. ECC also plays an important collaborative and networking role, uniting most protestant congregations and health efforts.

- SANRU includes ECC-DOM as well as the Salvation Army, Kimbanguist Medical Department, and the Catholic church. website: www.sanru.org

Ethiopia **CHAE: Christian Health Association of Ethiopia**

Establishment and Membership: *CHAE is currently in the formative stages. Other* **new**

- Also networking in Ethiopia is CRDA (Christian Relief and Development Association) – established in 1973 as an umbrella organisation of 212 NGOs and FBOs. Said to coordinate around 89 hospitals and several hundred lower units). Today it focuses on development, capacity building, advocacy and networking.
- Also networking is EECMY-DASSC (The Ethiopian Evangelical Church Mekane Yesus Development and Social Service Commission) website: www.eecmydassc.org.et/health.htm

Ghana **CHAG: Christian Health Association of Ghana**

Establishment and Members: CHAG was founded in 1967 as Voluntary Professional Association. CHAG is open to any Christian church-related medical institution in Ghana, which is recognized as such by the Ministry of Health. *Founding members:* Ghana Catholic Bishops Conference, Christian Council of Ghana, Ghana Pentecostal Council. *Institutional members:* the hospitals and clinics, which belong to the founding members and share in the responsibilities and benefits. *Associate members:* other Church-related institutions which share in the aims and objectives of the association and share only some limited benefits and responsibilities. *Facilities:* 152 institutions: 56 hospitals, 83 primary health care bodies and 8 health worker training centres - most belonging to the Catholic church, then the Presbyterians, and then the SDAs. **1967**

CHAG Work: CHAG is an umbrella organization that coordinates the activities of the Christian Health Institutions and Christian Churches' Health programmes in Ghana. It is a body through which all or most of the Christian Church related health facilities/programmes liaise with the Ministry of Health to ensure proper collaboration and complementation of the government efforts at providing for the health needs of Ghanaians. Main activities: policy analysis, advocacy & lobbying, capacity building of members, networking & public relations (or public image building), translating government policies in operational terms for members to implement.

website: http://www.chagghana.org

Kenya **KEC: Kenya Episcopal Conference (CHC: Catholic Health Commission)**

Establishment and Members: Although Catholic health care provision in Kenya dates back to the early 1900s – KEC was founded in 1957, with the CHC established in 1967. The Catholic Health Commission provides oversight and co-ordination of 456 Catholic health facilities affiliated to 25 Catholic Diocese in Kenya – as part of the church's social and pastoral mission. These include 53 hospitals, 82 health centres and 311 dispensaries. In addition, the Church has Community Health Programs that offer Mobile Clinics, HBC and care for OVC. **1957** **1967**

KEC-CHC work: CHC provides oversight, advocacy, lobbying and representation, capacity building, networking, and management to its members. CHC member facilities provide a holistic and wide range of preventive, rehabilitative and curative health services and programs. website: www.kec.or.ke

Kenya **CHAK: Christian Health Association of Kenya**

Establishment and Members: CHAK's history dates back to the 1930s when it was established as a Hospitals' Committee of the National Council of Churches of Kenya (NCCK) - as an umbrella organisation of health facilities or programs owned by Christian denominations or missionary groups who were providing health services in Kenya. Re-constituted as a non-profit organization (CHAK) in 1987 – membership includes 33 affiliated Protestant church denominations, responsible for 455 facilities - 25 hospitals, 48 health centres, 324 dispensaries, 10 nursing training colleges and 58 church health programs. **1930** **1987**

CHAK Work: CHAK's core functions on behalf of its members are advocacy & representation, capacity building, health care technical services, technical support, networking, communication and HIV/AIDS programs. CHAK member facilities provide a wide range of preventive, rehabilitative and curative health services. website: www.chak.or.ke

- CHAK and KEC jointly own MEDS (Mission for Essential Drugs and Supplies) - which provides essential drugs and medical supplies, as well as training of church and other not-for-profit health facilities in the management and appropriate use of drugs. "MEDS' current clientele of more than 1,500 health facilities in Kenya and other countries (Sudan, DRC, Ethiopia, Somalia, and Tanzania)
- CHAK was recently appointed to host the first secretariat for the African Christian Health Assocations Platform (ACHAP)

Lesotho **CHALe: Christian Health Association of Lesotho**

Establishment and Members: In the 1960s, physicians from various mission hospitals began meeting to discuss common problems, and in the 1970s the Christian Council of Lesotho and Oxfam advocated a more formal organization. The Minister of Health also urged a more formal association in 1973, and in 1974 CHALe was founded as a voluntary association of Christian churches providing not-for-profit health care services to the Basotho, particularly in hard to reach places around the country. Members include**:** The Anglican Church of Lesotho, Assemblies of God Church, Bible Covenant Church, Lesotho Evangelical Church, Roman Catholic Church, and the Seventh Day Adventist Church of Southern Africa. These manage around 72 health centres and 8 hospitals. **1974**

CHALe Work: CHALe assumed operational responsibility for health services in 8 of 18 health service areas. CHALe's service programme comprises of three components: capacity building, primary health care and medical services, infrastructure improvement – as well as several projects including: HIV/AIDS prevention and control programme, primary health care programme (MCH/FP, nutrition, environmental health), child protection, rural health development and rural clinic improvement programs.

Liberia **CHALi: Christian Health Association of Liberia**

Establishment and Members: Founded in 1975, is an ecumenical umbrella body of Liberian churches involved in the health sector. 6 hospitals, 67 health centres. **1975**

CHALi Work: CHALi supports members work in several fields, namely: drug supply, PHC, capacity building, water and health, family education and HIV/AIDS control. CHALi is currently being revitalized with a new constitution and strategic plan being drafted.

Malawi	**CHAM: Christian Health Association of Malawi**	
Establishment and Members: CHAM was established in 1966 as the 'Private Hospitals Association of Malawi' - following a meeting of the WCC and church leaders in Malawi. In 1991 the Association changed its name to CHAM to reflect its Christian identity and its focus on broader health ministry. Membership consist of 18 different Catholic and Protestant churches and church organizations (i.e. ecumenical and interdenominational organizations that operate health facilities). There are also 12 associate members, and facilities are currently at 27hospitals, 142 health centres and 10 training institutions. CHAM Work: CHAM works for the improvement and expansion of health facilities, facilitation of inter-denominational cooperation, collaboration with government and other organisations, the development and coordination of training programs including nursing schools, the provision and coordination of support services. website: www.cham.org.mw		**1966**
Mali	**APSM: Association Protestante de la Santé au Mali (Association of Evangelical and Protestant Groupings of Mali)**	
Establishment and Membership: An associate member of the AGEMPEM, the APSM (Association of Evangelical and Protestant Groupings of Mali, *Association Protestante de la Santé au Mali)* was established in 1992 by the Health Personnel of the Protestant Churches and Missions in Mali. It is non-political, inter-denominational, non-profit, nongovernmental organization – set to serve all the people of Mali and also evangelical Christians. APSM Work: APSM's objectives are to encourage its members to provide quality health care to the Malian population, and facilitate the coordination of the medical activities of the churches and missions. The APSM designs, amongst others, literacy and health education programmes for women and children. In the area of HIV/AIDS, APSM undertakes prevention exercises, and has produced information and awareness-raising documents in Bambara, the most widely-spoken national language. website: www.apsmmali.org		**1992**
Namibia	**CCN-ECN: Council of Churches in Namibia**	
Establishment and Members: Formed in 1978, CNN is an ecumenical body that is focused on religious, education and social concerns. Members manage around 8 hospitals in Namibia.		**1978**
Nigeria	**CHAN: Christian Health Association of Nigeria**	
Establishment and Members: CHAN was established in 1973 by founding members: The Catholics Bishops Conference of Nigeria (CBCN); The Christian Council of Nigeria (CCN); and The Northern Christian Advisory Council of Nigeria (NCMAC) to facilitate cooperation between Member Institutes (MIs) and to help build capacities in order to better serve the Health needs of Nigerian population. Members include ~400 registered Member Institutions (MIS) operated by 15 denominations. These manage 147 hospitals, around 3000 community facilities, and 28 training centres. CHAN Work: As an umbrella network, CHAN works to coordinate and assists the health services of its members. Primary Health Care Services (PHCS): activities include training of village health workers and traditional birth attendants, nutrition, immunization, maternal and child health care, growth monitoring, water and sanitation, management training for various health workers of different levels, HIV/AIDS and STD control and AIDS care activities, holistic health care activities and program development, a resource centre with a bookstore. CHAN also manages a drug supply service, CHANPHARM – which is responsible for essential drugs importation, production and supply to member institutions. Website: www.channigeria.org		**1973**

Rwanda	**BUFMAR: Bureau des Formations Médicales Agréees de Rwanda [The Office of Church-affiliated Health Facilities in Rwanda]**	
Establishment and Members: Established in 1975, BUFMAR is an umbrella organisation that represents both the Catholic and Protestant churches and their health facilities and programmes throughout Rwanda. It is comprised of 24 Christian churches and services with 120 health facilities. Church-affiliated health facilities represent 45% of hospitals and 35% of primary level care facilities (health centres, dispensaries, health posts). BUFMAR work: BUFMAR coordinates and supports member facilities.		**1975**
Senegal	**EPSCM: Eglise Protestant du Senegal Commission Medicale**	
Establishment and Members: A newly established Protestant umbrella group in Senegal. Still in formation.		**new**
Sierra Leone	**CHASL: Christian Health Association of Sierra Leone**	
Establishment and Members: Established in 1975, members are heads of churches and health institutions. Facilities include hospitals and health centres		**1975**
Sudan	**CHAS: Christian Health Association of Sudan**	
Establishment and Members: CHAS has been slowly forming since 2002, with initiating members such as the Sudan Council of Churches, and reshaping the function of older Health Desks and Health Secretariats (CEAS - Church Ecumenical Action in Sudan – has recently been taken over by CHAS). The task to facilitate the establishment of CHAS became more visible in 2004 with technical and financial support from ICCO and later EED and Caritas Australia. The envisaged goal is to evolve CHAS from a network of Christian health organizations into a legally registered entity that functions fully as a Health development arm of the Sudan Council of Churches. *(Note, the Sudanese context and the role of CHAS is rapidly changing – especially in South Sudan where international NGOs are currently rehabilitating health facilities destroyed during the civil war.* CHAS work: Still forming, the vision is that CHAS will support Christian health care program with technical support, budget proposals, financial management, the provision of medical supplies. www.chasudan.org		**2008**
Tanzania	**CSSC: Christian Social Services Commission**	
Establishment and Members: Established in 1992, The Christian Social Services Commission is an umbrella body that brings together the Tanzania Episcopal Conference (TEC), representing the Catholic Church, and Christian Council of Tanzania (CCT), representing about 14 Protestant Churches and 10 Church related Organizations. CSSC coordinates 89 hsopitals, 815 health centers and dispensaries, and 24 training centers. CSSC has two executive organs, the Christian Medical Board of Tanzania (CMBT) and the Christian Education Board of Tanzania (CEBT) for health and education respectively. CSSC work: CSSC is involved in fostering ecumenical cooperation in matters regarding social services provided by Tanzanian Churches, lobbying and advocacy with government towards improving the environment for provision of church related services among other things. CSSC is also involved in education through the establishment of various schools. website: http://www.cssc.or.tz		**1992**
Togo	**APROMESTO: L'Association Protestant des Oeuvres Medico-sociales du Togo [The Protestant Association Medico-Social Works of Togo]**	
Establishment and Members: Established in 1994, bringing together 7 churches of the Christian Council of Togo. Facilities include 3 hospitals and 39 HC/lower units. APROMESTO work: Co-ordinating the action of the health centres and hospitals belonging to these churches, sensitising the faithful in the struggle against AIDS, train the nursing personnel and resolving the health problem through concerted actions. APROMESTO encourages the team of health facilities to establish a psychosocial care unit and draw up AIDS projects in order to address the epidemic more effectively.		**1994**

Uganda UPMB: Uganda Protestant Medical Bureau

1957

Establishment and Members: Established in 1957, UPMB is an umbrella, private, not-for-profit, Faith Based Organisation (FBO) of Protestant Churches and Church-related organizations involved in Health care in Uganda. Originally established to provide co-ordination and collaboration between medical care institutions affiliated to the Protestant churches in Uganda and the Ministry of Health – it then became the official channel for disbursing government grants-in-aid to the hospitals, evolving into a national umbrella organisation. Facilities include 15 Hospitals, and 251 HC/lower units, and 7 training institutions.

UPMB work: SUPMB is involved in advocacy and lobbying for policy on behalf of its members, capacity building, publicity and networking and support and supervision.

website: http://www.upmb.co.ug/

Uganda UCMB: Uganda Catholic Medical Bureau

1955
1956

Establishment and Members: Established in 1955-1956, with the main purpose of overseeing the procurement of medical drugs and equipment and distributing aid provided by the colonial government to the voluntary health sector. With the establishment of the Uganda Episcopal Conference, UCMB became the technical arm of the Conference's Health Commission with co-ordination of health units organised on the intermediate (diocesan) and national levels. Facilities managed are: 27 hospitals, 240 HC/lower units, 12 training institutions.

UCMB work: The UCMB invests in human resource management, financial management, health management information systems, assistance to dioceses to compile strategic plans, and quality improvement by adopting a gradually more sophisticated accreditation system called "faithful to the mission". The strengthened capacity pays off in an improved performance at unit level (in terms of utilisation, cost, quality of care) and a better negotiation position with the MoH at central and local level. website: www.ucmb.co.ug

- In 1979, the Catholic Medical Bureau and the Protestant Medical Bureau jointly established a drugs' procurement agency: the Joint Medical Stores. The JMS is now an autonomous organisation in whose Board sit the representative of the founding bodies (the UPMB and the UCMB).

Zambia CHAZ: Churches Health Association of Zambia

1970

Establishment and Members: Founded in 1970 (then as CMAZ: The Churches Medical Association of Zambia) through the merging of the Medical Committee of the Christian Council of Zambia and the health department of the Zambia Episcopal Conference, following a recommendation by the World Council of Churches. CHAZ acts as an umbrella organization, representing the interests of church administered health institutions in Zambia. Membership includes hospitals, health centres, faith based organizations and community based programs – in total 135 affiliates representing 16 different Catholic and Protestant churches. Facilities include: 30 hospitals and more than 36 hospitals, 81 HC/lower units (+ 29CBOs), and 9 training institutions

CHAZ work: The stated mission of CHAZ is to be committed to providing technical, administrative and logistical services for affiliate members to serve communities with holistic quality health services that reflect Christian values, so that people live healthy and productive lives. CHAZ provides members with representation and advocacy, administrative and logistical support, technical support, and resource mobilization assistance. website: www.chaz.org.zm

Zimbabwe	**ZACH: Zimbabwe Association of Church Related Hospitals**	
	Establishment and Members: Founded in 1974, ZACH is the ecumenical medical arm of Christian churches in Zimbabwe – registered as an NPO or public voluntary organization. ZACH is accountable to the Heads of Christian Denominations (HOCD) in regard the running of Church Health Institutions/Hospitals. Facilities include 80 hospitals, 46 HC/lower units, and 15 training institutions ZACH work: ZACH represents the link between Head of Christian Denominations (HOCD), Ministry of Health and Child Welfare (MOH & CW) and other Health Providers and Agencies. Objectives include the promotion of Christian medical care; to facilitate and co-ordinate cooperation between member institutions and the Ministry of Health & Child Welfare and partners; to coordinate the planning, implementation and evaluation of projects and programmes; to assist member institutions in staff recruitment and development; to source funds and support; to assist member institutions to enhance their management capacity; to keep member institutions abreast and updated on management trends of Health delivery.	**1973**