Faith-Based Models for Improving Maternal and Newborn Health

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access
Access to clinical and community maternal, neonatal and women's health services

ACKNOWLEDGMENTS

AUTHORS:

Sarla Chand, IMA World Health
Jacqui Patterson, ActionAid International USA

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ACCESS PROGRAM REVIEWERS:

Koki Agarwal, JHPIEGO
Patricia Daly, Save the Children
Paul Derstine, IMA World Health
Patricia Gomez, JHPIEGO
Joseph de Graft-Johnson, Save the Children
Juliet MacDowell, JHPIEGO

EXTERNAL REVIEWERS:

Rajnikant Arole, Comprehensive Rural Health Project
Shobha Arole, Comprehensive Rural Health Project
Franklin Baer (Consultant)
Gary Gunderson, Emory University
W. Meredith Long, World Relief
Nahed Matta, U. S. Agency for International Development
Jodi McGill, Presbyterian Church, USA
Paul Mkandawire, Church of Central Africa, Presbyterian
Juliana Yartey, World Health Organization

CONTRIBUTING EDITOR:

Alisha Horowitz, JHPIEGO

EDITORIAL ASSISTANCE:

Dana Lewison, JHPIEGO

GRAPHIC DESIGNER:

Jamie Wolfe, JHPIEGO

PRODUCTION ASSISTANCE:

Youngae Kim, JHPIEGO

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
CCAP	Church of Central Africa, Presbyterian
CHA	Christian Health Association
CORP	Community-Owned Resource Person
CRHP	Comprehensive Rural Health Project
ECC-DOM	Eglise du Christ au Congo (Congo Church of Christ) Medical Office
FBO	Faith-based organization
IPT	Intermittent preventive treatment
IPT 1	First dose of intermittent preventive treatment
IPT 2	Second dose of intermittent preventive treatment
ITN	Insecticide-treated bed net
MHT	Mobile health team
MIP	Malaria in pregnancy
MNH	Maternal and newborn health
MOH	Ministry of Health
NGO	Nongovernmental organization
NRHM	National Rural Health Mission
SBA	Skilled birth attendant
TB	Tuberculosis
UMC	The United Methodist Church
USAID	U. S. Agency for International Development
VHW	Village health worker
WHO	World Health Organization

EXECUTIVE SUMMARY

Faith-based organizations (FBOs) play a crucial role in increasing access to maternal and newborn health (MNH) services worldwide. In developing countries, faith-based health care facilities provide a significant percentage of health care services. With networks that reach even the most remote communities, many FBOs are well positioned to promote demand for and access to MNH services.

Partnerships among FBOs and other stakeholders are critical in promoting and delivering improved MNH services. Such partnerships increase the quality and quantity of services, as well as access to them, and ensure their sustainability—influencing behaviors at the community, family and individual levels. FBOs are important partners of the public health systems in most countries, especially in Africa, and recognition and support of a country's FBOs can lead to improvements in the entire national health care sector.

FBO health networks and community- and congregation-based health programs provide a wide spectrum of clinical and outreach services. The malaria prevention program of the Synod of Livingstonia, Malawi, illustrates how congregations can be mobilized to promote behavior change to improve health and save lives. Every village has one or more faith communities, which provide a strong foundation for positive change.

This brief explores some FBO health networks and facility-based services in Uganda and Tanzania. A pilot project in the Kasese District of Uganda illustrates how Protestant, Catholic and Muslim health care providers and communities can work together from household-to-hospital levels to improve health outcomes. In addition, the brief describes community health programs focusing on behavior change—in particular, the World Relief Care Group Model in Mozambique.

The contributions of FBOs to the development of successful, replicable and sustainable models of comprehensive health care are also highlighted in this brief. One such example is the Comprehensive Rural Health Project (CRHP) in Jamkhed, India, which has empowered communities to take health into their own hands. The CRHP has had a significant impact in Jamkhed, and its influence has also expanded beyond India's borders. Another example is the SANRU Project in the Democratic Republic of Congo, a decentralized comprehensive health system that has provided leadership in the development of health zones for more than 30 years.

Building meaningful, effective partnerships among FBOs, governments and donors will not only strengthen and expand health services, but will also enable the world to achieve the health-related Millennium Development Goals, and help save the lives of mothers, newborns and children worldwide.

INTRODUCTION

Faith-based organizations (FBOs) play a crucial role in increasing access to maternal and newborn health (MNH) services throughout the household-to-hospital continuum of care. FBOs represent not only different religious affiliations, but also diverse models of health care delivery. Few studies have assessed the type and extent of health care delivery by FBOs. In the developing world, however, faith-based health care facilities provide a significant percentage of health care services. In Sub-Saharan Africa, for example, faith-based facilities provide up to 70% of the region's health care services (Dimmock 2005; World Health Organization 2007). In other parts of the world, FBOs manage 10–30% of national health sectors. It is estimated that more than 90% of these FBO facility- and community-based programs offer MNH services. FBOs that have historically provided integrated and comprehensive care are now struggling to maintain their systems because of decreased support from traditional faith-based partners overseas; challenges in recruiting and retaining human resources; and donor-funded vertical programming, which emphasizes achieving results in a short time for narrowly defined interventions versus long-term integrated programs.

FBOs provide health and education services through hospitals, health facilities, and medical, nursing, midwifery and allied schools, as well as community-based programs and congregations of local churches, mosques and temples. With networks that reach even the most remote communities, many FBOs are well positioned to promote demand for and access to MNH services that are culturally sensitive. FBOs also influence the attitudes and behaviors of their constituents.

Partnerships among FBOs and other stakeholders are critical in promoting and delivering improved MNH care services. Such partnerships increase access to services and ensure their sustainability, and influence behaviors at the community, family and individual levels. FBOs are important partners of the public health systems in most countries, and recognition and support of a country's FBOs can lead to improving the entire national health care sector.

During the development phase of this brief, it became clear that there is limited information about faith-based health care delivery and that much needs to be done to build this knowledge base. Even though FBOs have been providing health care for over a century, little has been written about them. FBOs should become proactive in writing, publishing and sharing, through various channels, their knowledge, successes and challenges.

This brief highlights the contributions of FBOs to health care by focusing on a few FBO program models that, despite multiple challenges, have been effective in improving MNH outcomes. It also explores how building

meaningful partnerships among FBOs, ministries of health (MOHs) and donors will strengthen and expand health services, and enable the world to achieve the health-related Millennium Development Goals. To add to the dialogue, recommended actions for all stakeholders—FBOs, policymakers and donors—are presented at the conclusion of this brief.

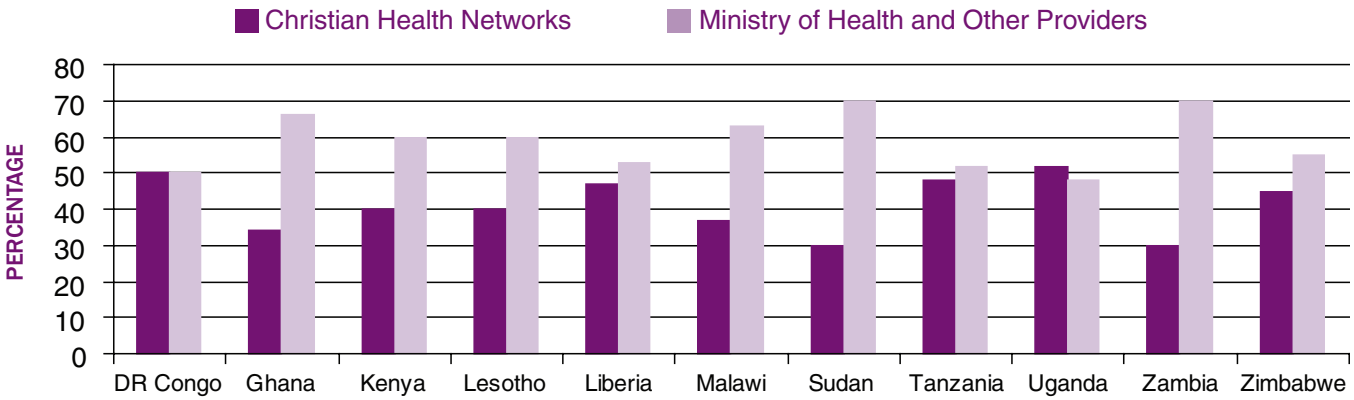
SUCCESSFUL MODELS OF FAITH-BASED ORGANIZATIONS FOR MATERNAL AND NEWBORN CARE

FBO Health Networks

FBOs are a diverse group representing different religious affiliations. Figure 1 presents data from a variety of sources, and depicts the role that FBOs, namely, Christian Health Associations (CHAs)—a network of Christian health facilities—play in the national health sector in a number of African countries. In addition to the CHAs, health networks of other faith groups—such as the Aga Khan network, Bakawata, Hindu Mandal and Ahamadiya—are also contributing to the National Health Sector.

FBO health networks and community- and congregation-based health programs provide a wide spectrum of clinical and outreach services. Congregation-based programs have grown from catering to the health needs of members only to reaching out to their neighborhoods and special needs groups, such as immigrants, migrants and refugees. Following are examples of some FBO health networks and facility-based services in Uganda and Tanzania.

FIGURE 1 | Contribution of Christian Health Networks in Selected African Countries



The Kasese District, Uganda. The ACCESS Program collaborated on a pilot study in the Kasese District in Uganda with three FBOs—the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Catholic Medical Bureau—to increase uptake of intermittent preventive treatment (IPT), using the focused antenatal care (ANC) platform, to prevent malaria in pregnancy (MIP). In 2003, at the national level, the uptake of IPT 1 was 35%, IPT 2 was 27% and the use of insecticide-treated bed nets (ITNs) was 5% (WHO and ACCESS Program 2006). However, at the FBO facilities, IPT uptake was better than the national average (Table 1).

The pilot study was conducted through already existing structures and systems, thereby strengthening them and building their capacity in focused ANC, MIP and project management. The pilot study's objectives were to increase:

- Uptake of IPT
- Use of ITNs among pregnant women
- Capacity among providers to deliver focused ANC services
- The number of pregnant women coming early (first trimester) for ANC

TABLE 1 | Key Project Indicators in the Kasese District Pilot Study

KEY PROJECT INDICATOR	BASELINE	ENDLINE
Percentage of ANC clinic staff trained in MIP in the last six months (including IPT and counseling on ITNs for pregnant women)	2%	100%
Percentage of pregnant women who received ITNs or purchased ITNs during ANC	0%	27%
ANC attendance in first trimester	0%	5%
Percentage of pregnant women who received first course of IPT under direct observation	43%	94%
Percentage of pregnant women who received second course of IPT under direct observation	28%	76%
Percentage of pregnant women who reported sleeping under an ITN the previous night at second ANC visit	37%	14%*

**This drop in ITN use most likely is due to the fact that the endline assessment was conducted during the very hot season and the baseline during the cooler months, when women are more inclined to sleep under a bed net.*

Despite the intervention's short duration of nine months, provider attitudes improved significantly, and the method of directly observed treatment to ensure compliance was implemented. At the community level, Community-Owned Resource Persons (CORPs) accepted their responsibility in motivating women to go for ANC early in pregnancy. There was also increased commitment by community leaders to promote safe motherhood behaviors. The key project indicators in Table 1 illustrate this model's effectiveness and results-oriented approach.

Uganda is well positioned to scale up its programs to prevent and control MIP. The Kasese project showed that much can be gained in a short time. To replicate the Kasese successes, it will be important to ensure advocacy with the district health teams and the community, and the training of different groups, including providers, CORPs and religious leaders. In addition, follow-up support supervision should be used and sustained throughout scale-up. Addressing skilled care and community awareness at the same time is very important and leads to informed demand for high-quality services. While the pilot study in the Kasese District focused on the faith-based sector, the District Health Officer took an active role in exploring scale-up and replication throughout the district. The MOH's participation was a key component of the project's success and provides a strong foundation for Uganda to build upon in future programs.

Kibuli Hospital—Kampala, Uganda. Kibuli Hospital, one of the urban health units under the Uganda Muslim Medical Bureau, is a 140-bed facility that offers a variety of clinical services, including obstetrics/gynecology and family planning. The hospital has a high patient load from the surrounding Muslim population. Most patients are referred to the hospital by smaller health facilities in the vicinity. As a referral hospital, it receives a high number of cases with complications, including obstructed labor, retained placenta and postpartum hemorrhage. The hospital averages 350 births per month. A comprehensive nurse training center that graduates 30 nurses annually has been created by the hospital. The City Council Health Division awarded Kibuli Hospital "Best Performer of the Year 2004/2005" for cleanliness, outreach and community services leading to reduced maternal mortality. The maternal mortality rates at this facility are lower than those of public health facilities nationwide (Kibuli Hospital 2005).

Shree Hindu Mandal Hospital—Dar es Salaam, Tanzania. Shree Hindu Mandal Hospital, part of the Hindu Mandal network, is a 24-hour hospital serving almost 300 outpatients daily. With more than 250 staff, the 60-bed inpatient unit offers specialty care, including maternity, surgical and pediatric services. The hospital handles an average of 200 births per month,

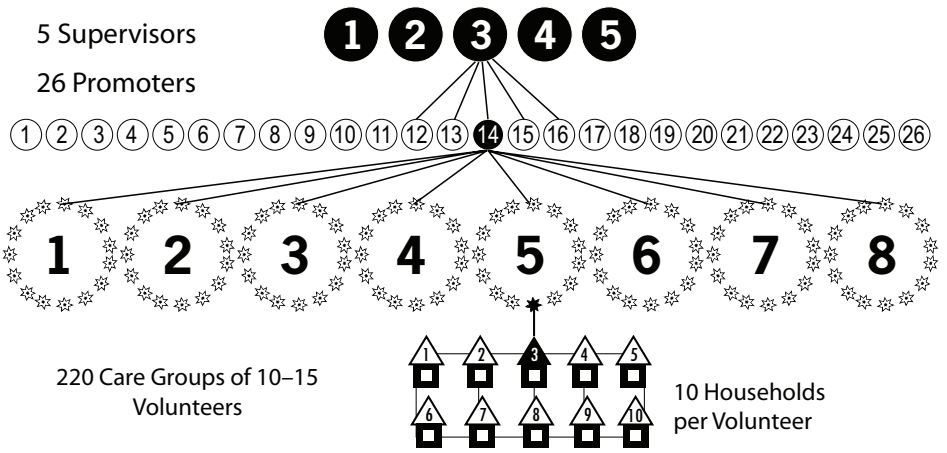
and deals with complications, including prolonged labor and postpartum hemorrhage. The hospital is known for its evidence-based pediatric care and its success in handling many newborn complications.

In terms of services specific to MNH, in addition to those described above, the facility provides voluntary counseling and testing for HIV, and almost all female clients consent to this testing. Most women choose to exclusively breastfeed, but there is little follow-up by the facility since there is no community outreach program. The Government of Tanzania subsidizes immunizations so that they are free to patients, and also provides ITNs through the Hati Punguzo National Voucher System.

Community Health Programs Focusing on Behavior Change

World Relief Care Group—Mozambique (multiple communities). World Relief developed the Care Group Model in rural communities of Mozambique—Vurhonga Projects I, II and III[1]—to address some of the gaps in achieving sustainable impact by engaging a network of community health volunteers, and training them in "care groups" as behavior change agents. These volunteers implement culturally relevant approaches and learn how to combat dehydration, facilitate the practice of birth spacing, and follow good nutrition and hygiene habits. They also learn the importance of breastfeeding, vitamins, iron supplements and immunizations. Each volunteer then shares her newly acquired knowledge with at least 10 of her neighbors. With this approach, the volunteers spread life-transforming information in one of the most effective ways possible—mother to mother.

FIGURE 2 | Care Group Model



Source: World Relief 2004 (Graphic by Baer).

By recruiting a high number of volunteers, the Care Group Model involves the entire community (Figure 2). Every household with a child under five or a woman of childbearing age is visited regularly by a

[1] All Vurhonga health projects took place in Gaza Province and were of similar focus. Vurhonga I (1995–1999) in Guija and Mabalane Districts; Vurhonga II (1999–2003) in Chokwe District, which is highlighted in this report; and Vurhonga III (2004-2009) in Chibuto, Chicualacuala, Chigubo, Massangena and Massingir Districts.

Care Group volunteer, which establishes the project's credibility, achieving a multiplier effect and providing "saturation coverage" in the project areas.

Vurhonga II evaluations revealed that World Relief Care Groups—through education and behavior change interventions—reduced the overall mortality rate of young children by more than 50% through increasing the use of life-saving bed nets from >1% to 85%. In addition, rapid treatment-seeking for pneumonia symptoms increased from 2% to 99%, and the number of malnourished children receiving enriched porridge grew by 45%.

TABLE 2 | Project Results from Chokwe (1999–2003)

	BASELINE	ENDLINE
ANC visits	30%	90%
Delivery by trained provider	66%	85%
Increased food consumption during pregnancy	45%	82%
Exclusive breastfeeding	10%	70%
Knowledge about prevention of sexually transmitted infections/HIV/AIDS	0%	53%
Use of family planning methods	7%	29%
ITN use for children under 5	>1%	85%

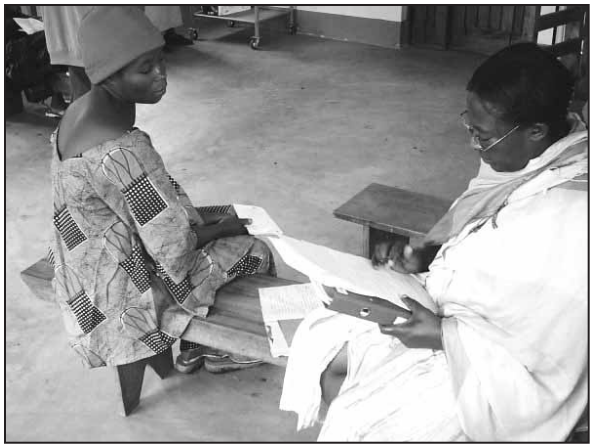
Impressive results were achieved by the project in the Chokwe region for several indicators, as shown in Table 2. In addition, there was a 47% reduction in the infant mortality rate and a 62% reduction in the mortality rate of children under five years of age (Edward et al. 2007).

The Vurhonga projects also worked with religious leaders and formed pastoral care groups. Even though these groups do not visit individual households, they are a critical link with the community and play an important role in sharing health messages. Vurhonga II's final report found that the attendance rate among pastoral care groups was 70%—well above the target of 60%. In addition, 72% of mothers who attended church during the past month reported that they heard a health message, exceeding the target of 50% (World Relief 2004).

The Care Group Model's success generated interest within the provincial MOH and donor community to scale up the model. The model has demonstrated success in other World Relief child survival programs in Cambodia, Malawi, Rwanda and other countries. In Malawi, for example, the number of women using ITNs increased from 8.5% to 60%. Furthermore, the number of women exclusively breastfeeding until six months after birth increased from 35% to 95% in the Mzimba and Rumphi Districts of Malawi.

Congregation-Based Health Programs

Local congregations (churches and/or mosques) promote women's and children's health through their women's groups. Similarly, their youth groups are an effective channel for promoting appropriate reproductive health messages. The U.S.-based model of having a parish nurse or congregational health leader within congregations has taken root in several developing countries. They use behavior change messages to help monitor the health of members and encourage them to get regular checkups. Many congregations promote health care-seeking behavior and reach out to the community by organizing health fairs, well-child clinics and other activities. Retired nurses and doctors who are members of the congregation play important roles in mobilizing their congregations to develop these activities. For example, in Kenya and Uganda, Aga Khan Health Services has a special program through which they mobilize the communities, as well as members of the mosques, to both promote and deliver health interventions in communities.



IMA World Health/William Clemmer

Engagement with religious leaders and members of religious organizations places the MNH agenda squarely with the public, where these topics must be discussed and addressed for any meaningful change to take place. Furthermore, clergy (priests and *Imams*) often need to answer questions from their congregations and communities about health in general and reproductive health-related issues specifically. Religious leaders also provide pre-marriage counseling to youth. Therefore, well-informed and mobilized religious leaders can bring about significant and lasting change in their constituencies.

Congregations can also serve as program managers and implementers for the communities their members represent. Women's and youth groups in the congregations provide some of the most effective channels for sustainable behavior change interventions. One example of this is the malaria prevention program implemented by the Synod of Livingstonia described below.

Congregation-Based Malaria Prevention Program of the Synod of Livingstonia, Malawi. The Synod of Livingstonia's malaria prevention program was established in 2000 and provides the following:

- Health education about prevention and early treatment of malaria
- ITNs at subsidized prices to pregnant women and children five and under
- Re-treatment of nets
- Follow-up services for pregnant women and children who have had malaria

The program was implemented in 26 of 150 Church of Central Africa, Presbyterian (CCAP) congregations, primarily in hard-to-reach areas along the lake shore of northern Malawi and in the interior of the country, specifically the Chitipa region near the Tanzania border. This region, politically and historically, has received fewer services than other areas of the country. The Synod Health Department trained women from the congregations to deliver messages about malaria prevention and treatment.

In 2004, a post-intervention survey about malaria prevention and treatment was conducted in 43 villages with 1,035 respondents who were either pregnant women or caretakers of children under the age of five. The survey highlighted the program's successful outreach efforts (transfer of knowledge and availability of ITNs), with a high percentage (81%) of the respondents aware of the benefits of sleeping under a mosquito net. In addition, there was a significant increase in the percentage of respondents who reported having nets in their homes. The results also suggest that there are reasons, in addition to people's knowledge about malaria transmission and prevention, that still influence their decision or ability to purchase mosquito nets or ITNs. These barriers must be identified and removed to enable widespread use of ITNs for malaria prevention.

Christian Health Association of Kenya/Joseph Oyongo

This congregation-based malaria prevention program is a good example of how congregations can be mobilized, both to promote prevention messages and to implement interventions, such as making nets available to people in their homes and places of worship, and identifying other determinants of health-related behavior. The program also mobilized and built capacity of women's groups in the selected congregations.

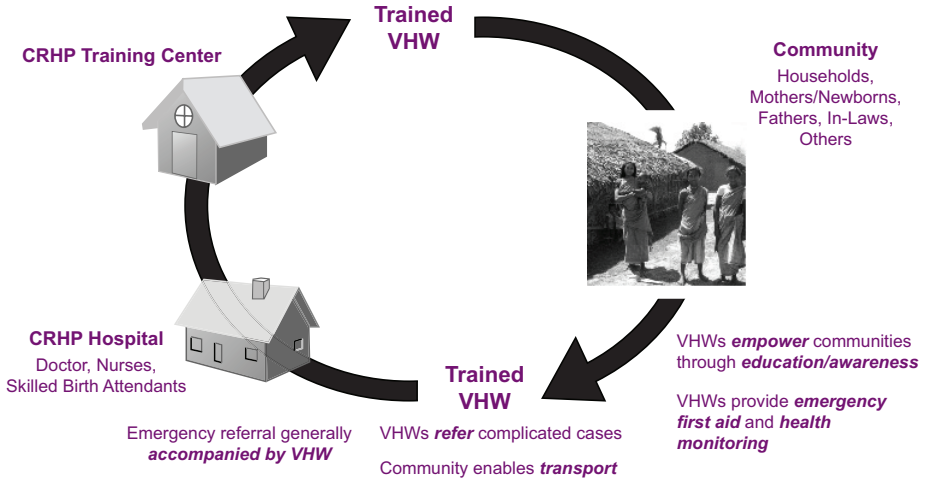
Comprehensive Health Care

There are numerous examples of FBOs that have successfully implemented variations of a comprehensive health care model in different parts of the world. Two such examples follow.

Comprehensive Rural Health Project (CRHP)—Jamkhed, India. The CRHP, founded in 1970 by Rajnikant and Mabelle Arole on principles of integration, empowerment and equity, has developed a successful model (Figure 3) that has empowered communities to take health into their own hands through the leadership of village health workers (VHWs). The founders and CRHP's board of directors are Christian, as are some of the staff. Christian principles of justice and service are the foundation of

CRHP's work, and provide an alternative model to the society's inequitable caste system. The Aroles set out to work with the poorest of India's poor and established themselves in Jamkhed, one of the most impoverished areas of Maharashtra. They have deliberately targeted their services to women, low castes and the destitute—India's most marginalized populations.

FIGURE 3 | CRHP Jamkhed Referral Model



Over 30 years, more than 300 villages, with a combined population of 500,000, were eventually participating in the CRHP through the selection, training and support of VHWs, as well as through the formation of community-based organizations, such as farmers' clubs, women's clubs, adolescent girls' groups and other self-help groups. It was never intended that the project would stay permanently in any one village. As villagers take on more responsibility and conditions improve in a particular village, active project work stops there and starts in a new village.

Currently, the CRHP covers 175 villages and also works in the tribal areas of Maharashtra, Arunachal Pradesh and Andhra Pradesh. The Aroles put into practice their belief that health is a fundamental human right, and the CRHP provides essential, socially acceptable, universally available, participatory and affordable health care, making it a sustainable, replicable and successful program.

The following components—in addition to the comprehensive and integrated approach to health—have made the CRHP a success:

- The VHW is a volunteer selected by her community, and acts as a local agent to promote positive health and social change. She is trained in basic health issues, community development and organization, communication skills and personal development by the CRHP training team. Many VHWs are also trained as skilled birth attendants.
- The mobile health team (MHT) is composed of a nurse, social worker, doctor and paramedical workers. The team visits the project villages

periodically to provide support and facilitate development activities. The MHT also serves as the liaison between the village and health center.

- Jamkhed Hospital is a secondary care facility. It provides low-cost, high-quality emergency, medical, surgical and outpatient care for the 1.5 million people in the surrounding area. Each year at the hospital, about 20,000 outpatients receive treatment, 250 high-risk/referred deliveries are managed and 400 surgical procedures are performed. The hospital acts as a referral center for health problems that cannot be handled by VHWs (Arole et al. 2005).
- By 2005, the Institute for Training and Research in Community Health and Population had trained more than 2,000 international (representing nearly 100 countries) and 5,000 national health and development workers from the government, nongovernmental organizations (NGOs) and FBOs. The training institute continues to train both domestic and international health and development workers, and is affiliated with public health schools in England and Australia.
- The project recognizes the importance of a multi-sectoral approach to improving health and provides support to the communities on agriculture, infrastructure, education and micro-finance, as well as other areas.
- The project has enabled close cooperation among community members from different castes, religions and economic backgrounds, and led to improved services and community members' ability to access services in the project villages.

The training of VHWs has been Jamkhed's most important activity. The VHWs are trained in Jamkhed to then work in their own villages. After their training is complete, only their travel expenses are covered when they return to the project training center for problem-solving discussions and additional input. At the training center, the day begins with spiritual messages and prayers. Motivational and spiritual content forms a significant part of the center's learning methodology both during training and follow-up sessions.

The VHWs from villages where the project is no longer active continue to receive ongoing training and consultation as needed. The present 25 villages have been active for five to 10 years and are the foundation for training programs for people from other parts of India and

FBO LEADERSHIP | The Aroles

Rajnikant and Mabelle Arole have received numerous awards in recognition of their work, including:

- 1988 Winner of the National Council of International Health Award (now known as the Global Health Council Award)
- 1990 Padma Bhushan National Award for Social Service, the highest civilian honor from the President of India
- The Magsaysay Award—considered to be the Asian Nobel Prize
- 2004 Mother Teresa Memorial National Award for Social Justice

TABLE 3 | Impact of CRHP on Key Health Indicators in Project Villages

YEAR	1971	2004	INDIA 2004
Infant mortality rate			
n/1,000 live births	176	24	62
Crude birth rate			
n/1,000	40	18.6	23.9
Maternal health			
Antenatal care	5%	99%	64%
Safe delivery (by trained VHWs)	<5%	99%	43%
Family planning	<1%	68%	41%
Children under 5			
Immunization (DPT/Polio)	5%	99%	70%
Malnutrition (weight for age)	40%	5%	47%
Chronic diseases			
Leprosy prevalence/1,000	4	<0.1	0.24
TB prevalence/1,000	18	4	4.1

Source: Jamkhed Web site.

other countries that want to start similar programs. The data in Table 3 are from the 25 active villages in the project (Jamkhed Web site).

A comparative study on emergency obstetric care in CRHP villages and two other successful projects in South Asia was carried out in 2001 (McCord et al. 2001) and concluded that CRHP project village communities are receiving appropriate and strong support and education from the VHWs. The study's authors wrote, "…while accessible hospital back-up for home delivery is essential, great progress toward reduction of maternal and perinatal mortality can be made long before a 90–100% rate of hospital delivery is achieved."

Strengths and Impact of Jamkhed

Although the CRHP was not started by a church organization, but by two individuals of deep religious faith and care for humanity, several churches and FBOs—including Lutheran World Relief, The United Methodist Church, The Presbyterian Church, USA and the Council of Evangelical Churches of Latin America—have embraced and helped implement this multi-sectoral and integrated model of health care in a number of countries in Africa, Latin America and Asia. The CRHP provides practical training (hands-on training in the project villages and the hospital) with active community involvement, focusing on classroom technical knowledge and development of values. Christian values of love, humility, hope, faith and compassion are nurtured and strengthened in all trainees.

The CRHP in Jamkhed has shown that a value-based approach to mobilizing community members is vital to successful community health care. Community groups help cut across social barriers and religious differences; work in partnership to make sure health services are available; and assess the local health situation, analyze the gaps and take necessary action. They also raise resources within the community and seek funding from government programs, bank loans and other micro-finance sources.

The VHWs organize and mobilize communities by visiting households and passing on valuable health information. They also work directly with women's, youth and farmers' groups. Through community interaction, people are made aware that their actions—both as individuals and as a community—directly affect their health. They also learn about harmful cultural practices such as discrimination against women. The more information community members receive, the more they can make positive changes for their own health and that of their families.

IMA World Health/Sarla Chand

In addition, when people have ailments that cannot be treated in the community, they are referred to the hospital. Hospital staff are trained to be skilled providers and to give care in a respectful manner. The welcoming and caring attitude of the hospital and mobile clinic staff encourages people to seek health care without delay.

The CRHP has improved maternal and child health in Jamkhed. It has:

- Promoted a comprehensive approach to health and empowered the community to improve infrastructure, water quality, hygiene and the like through a multi-sectoral approach by changing its behavior and accessing its own resources, as well as developing capacity to access resources offered by the government, banks and NGOs.
- Introduced participatory decision-making at the community level by encouraging community meetings in the village, and by working with the women's and youth groups separately to develop their skills so that they can participate fully in the community meetings.
- Empowered women—through transferring of health knowledge and enabling them to develop negotiation and decision-making skills—to take responsibility for their own and their families' health, as well as to access health care services promptly, as evidenced by positive changes in key health indicators.
- Mobilized the community to emphasize beneficial traditional practices and eliminate harmful ones.

The CRHP—primarily through word of mouth of its successes in transforming the health status of communities—has motivated hundreds of organizations to promote primary health care throughout India. Currently, 200 community-based programs in the NGO sector use the services of 100,000 female VHWs. In addition, the Government of India started the National Rural Health Mission (NRHM), chaired by the Prime Minister.

The NRHM has adopted many of the elements of the CRHP model for this country-wide program.

The CRHP's influence has also expanded beyond India's borders. The United Methodist Church (UMC) has promoted the CRHP in Latin America, particularly in Bolivia, Brazil, Honduras and Venezuela. UMC-trained participants from Africa have promoted the CRHP approach in that country, and small programs in disenfranchised communities have sprung up—particularly in Angola, the Democratic Republic of Congo, Liberia, Mozambique, Sierra Leone and Zambia.

SANRU Project—The Democratic Republic of Congo. SANRU ("santé rurale" means rural health) is an example of a decentralized comprehensive health system—a partnership between the MOH and the Eglise du Christ au Congo (Congo Church of Christ) Medical Office (ECC-DOM). In the Democratic Republic of Congo, 50% of hospitals, including 62 Protestant church hospitals, are owned and managed by local churches. The ECC-DOM has provided leadership in the development of health zones for more than 30 years. For example, the ECC-DOM managed the Basic Rural Health SANRU I/II Projects (1981–1991) on behalf of the MOH and the U. S. Agency for International Development (USAID) to provide development assistance for 100 of Congo's 306 health zones (Kintaudi, Minuku and Baer 1997). A typical health zone includes a population of 150,000 people, 200 villages and 20 health centers.

FBO LEADERSHIP | Dr. Kintaudi

Under the leadership of Dr. Ngoma Leon Kintaudi, who was named a Global Health Hero by *Time Magazine* in 2005, the original SANRU projects have evolved into the SANRU Program, and currently include a portfolio funded by USAID, the World Bank and the Global Fund, totaling more than $10 million annually.

In 1975, the MOH, in consultation with churches and NGOs, adopted the concept of decentralized health zones and primary health care—eventually leading to the development of pilot health zones. Protestant and Catholic Church health services were the catalysts for this process. The mission hospitals of Vanga, Kimpese Karawa, Wembo Nyama and Nyankunde, for example, pioneered the concepts of community-based health care programs and pilot health zones. Their work became the foundation of a national health plan to create 300 health zones. By 1984, there were 87 functional health zones recognized by the MOH, 70% of which were co-managed by Protestant and Catholic health services (Baer 2007). Today, FBOs not only provide 50% of health services in the country, but also co-manage approximately 40% of the health zones.

The political unrest in the Congo in 1991 disrupted the development of health zones, but not the ECC-DOM's support to continue their important work. In 2000, the ECC-DOM partnered with IMA World Health and received funding for a SANRU III Project to begin rebuilding the health zone system. This Project strengthened primary health care interventions, which include the MOH's basic package of services (vaccinations, growth monitoring and ANC), and services for malaria, HIV/AIDS, nutrition/ vitamin A, water/sanitation and endemic diseases such as TB and onchocerciasis. IMA World Health has also leveraged supplemental funding from its members and other partners, including Pfizer, Merck and Abbott, to support the country's efforts to strengthen the health care system. These partnerships have resulted in more than $15 million of in-kind assistance.

SANRU's integrated and systems-strengthening approach has resulted in major achievements. The approach is based on the framework of a three-dimensional, integrated health system that includes: 1) primary health care interventions—activities selected in consultation with the community; 2) support components (e.g., financial sustainability, information systems, training and supervision) that facilitate the delivery of program interventions; and 3) capacity building at each level of the health system, including referral facilities, health system administration and the like. This approach includes a very practical "Appui Global," meaning global support, assistance package of approximately $100,000 per year for priority interventions and support systems, for example, for routine vaccination programs, malaria and maternal health care.

The SANRU approach has been based on working with and through existing FBOs as partners with the MOH rather than as parallel competitors. The network of FBO hospitals and health centers is considered to be part of the public rather than private sector, and is fully integrated with health zones, which in many cases are co-managed by FBOs (Baer 2007).

SANRU's successful results in improving maternal and newborn care are shown in the figures and table that follow (Clemmer, Kintaudi and Minuku 2006).

As of September 2005, half a million ITNs have been distributed in SANRU Health Zones and more women and children are using them. A study in the health zone of Oicha, for example, demonstrated an important decrease in anemia, malaria cases, deaths, low birth weight and neonatal mortality (Baer 2007). However, much remains to be done in this area since malaria is still one of the leading health problems in the country.

FIGURE 4 | Increase in Prenatal Care—SANRU-Assisted Health Zones

Percentage of population accessing CPN (prenatal) clinics in SANRU-assisted health zones from 2001 to mid-semester 2004 (50/56 health zones reporting)

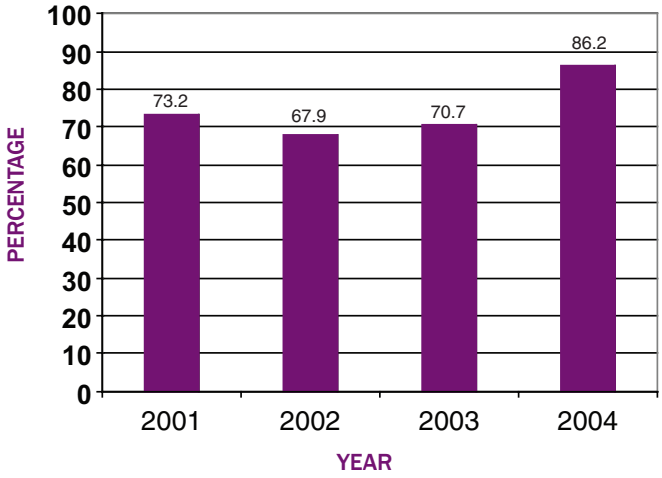
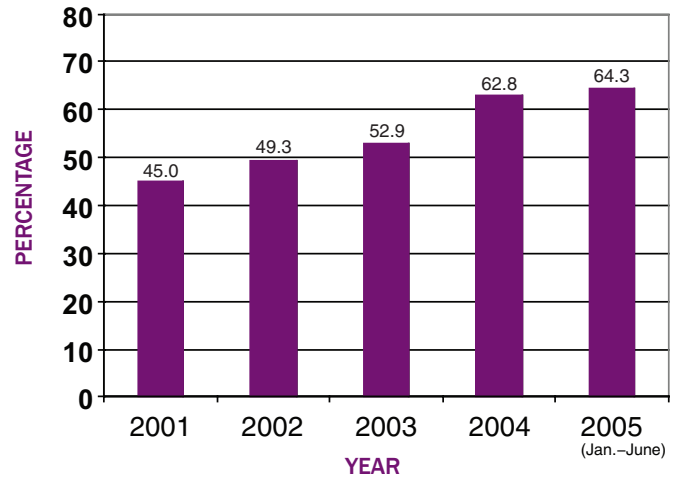


FIGURE 5 | Increase in Assisted Births—SANRU III Project

Births assisted by skilled birth attendants (SANRU III Project—2001–2005)



The SANRU story encompasses 25 years of learning. Important lessons learned from the SANRU III Project's evaluation provide a good summary of the key elements of SANRU's strategy and success over the years. They include the following (Miatudila, Kidinda-Shandungo and Baer 2006):

- FBO-managed health facilities should be treated as a public sector resource rather than a private sector resource.
- FBOs and NGOs can establish important management precedents for developing health systems.
- Building health systems in collaboration with FBOs can result in accelerated development.
- Decentralization in collaboration with FBOs requires administrative flexibility across geographic regions.
- FBOs can play an important role in health systems management, in addition to health services provision.
- FBO networks and umbrella groups can be effective coordinators of national programs and projects.
- FBOs, unlike many private voluntary organizations or NGOs, are permanent resources that can contribute significantly to the sustainability of health systems in times of crisis.

In particular, SANRU's success illustrates the potential of FBOs and the important role that FBO networks like the ECC-DOM can play as grants managers for umbrella projects that are able to tap into funding from major donors.

TABLE 4 | Significant Change in Critical Health Indicators after SANRU Program Interventions in the Oicha Health Zone, Democratic Republic of Congo

Health Indicators and Birth Outcomes			
	2003	2004	Change
Anemia in children under 5	12.8%	8.6%	-32.4%
Malaria cases in children under 5	51.9%	33.6%	-35.2%
Deaths in children under 5	1.1%	0.4%	-62.2%
Low birth weight	22.8%	17.0%	-25.4%
Neonatal mortality	1.7%	1.1%	-22.8%

CONCLUSIONS

- A country's extensive networks of hospitals, health centers, dispensaries, pre-service training institutions, and community- and congregation-based FBO health programs are a valuable national asset, and provide a critical link in ensuring access to health care, especially for rural and marginalized populations. The examples in this brief illustrate that FBOs play a significant role in MNH care—providing clinical care, as well as critical outreach in the communities they serve. FBOs offer compassionate care through well-organized programs and facilities that are better equipped and managed than the public facilities. They also reach out to populations who otherwise would not have access to health care. However, FBO health care programs are in jeopardy because of increasing difficulties in recruitment and retention of skilled providers, especially in remote and difficult-to-reach areas.
- FBOs—both national FBO health networks and religious leaders—can be effective partners in developing sustainable systems. National faith-based health networks should be defined, recognized and promoted as not-for-profit public sector partners of MOHs, rather than as a private sector competitor. All development partners should promote this perspective, including donors, the ministries, NGOs and FBOs. It is an opportune time for governments, especially in Africa, donors and FBOs to review their health care funding policies and develop a system that has universal health care as its guiding principle.

- Some FBO-managed programs have access to limited funding to strengthen infrastructure—funding that is not available to government facilities. This funding can provide supplemental and complementary assistance to the development of health care systems. FBOs must be transparent about their support mechanisms and engage with their governments in partnerships built on trust and accountability.
- The health networks of national FBOs can play a key role in the co-management of decentralized umbrella health systems with the MOH, as is the case in the Democratic Republic of Congo. In some cases, these networks also serve as effective channels for the management of donor funding, as in Zambia. In most countries, FBO health networks, if engaged in training and resource allocation, can be effective partners of the MOH in bringing about positive changes in key health indicators.

CHALLENGES

The Importance of Public/ Private Partnerships

At the 2007 Partnership for Maternal, Newborn and Child Health forum in Tanzania, the Tanzanian Minister of Health shared his experience during the malaria epidemic in the Kagera region. There are 13 hospitals in the region, only two of which are run by the government. Many people who had malaria during the epidemic sought care at government facilities instead of going to nearby FBO hospitals because they could not afford to pay the nominal fee charged there. Meanwhile, the government hospitals were over capacity. The Minister stressed the importance of governments and FBOs working together to develop better systems so that people can access appropriate health care close to home.

In the 20th century, churches had a significant influence on the evolution of global health systems, strategies and priorities. Prior to governments taking charge of the health systems, it was the faith-based groups that led the establishment of health care systems and institutions. However, despite a myriad of health care providers, both in the public and private sectors, adequate and appropriate health care is still a distant dream for many around the world.

Experience has shown that FBOs play a significant role in health care delivery in many countries—especially those with limited resources—and are key to achievement of the Millennium Development Goals. Governments must commit to working together with FBOs toward the common goal of achieving health care for all, recognizing that FBOs bring their unique experience and resources, including strong linkages with communities, to the table.

RECOMMENDATIONS FOR STRENGTHENING PARTNERSHIPS AMONG FBOS, POLICYMAKERS AND DONORS

For Faith-Based Organizations

- Document and disseminate information through mapping, monitoring and evaluation, and publishing in professional journals.
- Strengthen partnerships among FBOs of all faiths with governments, international institutions, secular health agencies and other stakeholders.
- Participate actively in national and global policy development and mechanisms for resource allocation and decision-making.
- Strengthen capacity in management, leadership development and financial stewardship.
- Advocate for improved health care services for all through facility strengthening and equitable human resources recruitment and retention policies.
- Strengthen values of justice, equity, medical ethics, care and compassion in the FBO health care system and integrate them within the country's health care system, while providing leadership in researching and practicing the spiritual dimensions of health.
- Develop a resource base so that the poor and marginalized are not turned away because of an inability to pay for services.

For Policymakers

- Examine the potential of FBOs through health system assessments and planning at the country, regional, district or local level, especially the role of national FBO health networks.
- Engage FBOs—through a participatory decision-making process—in policy development; identification and distribution of resources; co-management of health districts or health zones (e.g., the SANRU model in the Democratic Republic of Congo); and development of implementation plans that lead to a strong national health sector.
- Promote development of a national strategic plan to encourage healthy behaviors that utilizes the reach, holistic service, compassionate care, trust and sustainability of FBO providers and religious leaders to engage individuals, families and communities.
- Endorse a joint decision-making process that strengthens and enables both public and FBO pre-service educational facilities to incorporate evidence-based concepts in their curricula.
- Develop a national HR plan that implements human resources reforms that do not undermine the FBO health care networks, but strengthen the entire national health sector.

For Donors

- Support MOHs to build capacity of national faith-based health networks (e.g., Christian Health Associations and various Islamic health networks) and help strengthen collaboration in the co-development and co-management of an integrated health system.
- Increase funding for integrated MNH programs.
- Support training, recruitment and retention of health professionals equally for governments and FBOs—thereby strengthening health care for all.
- Advocate with governments around the world on equitable recruitment policies that do not drain national assets from developing countries.
- Support MOH and FBO health networks to promote and deliver the holistic and integrated programs that are their strengths.

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FOR INFORMATION:

The ACCESS Program
JHPIEGO
1615 Thames Street
Baltimore, MD 21231-3492
Tel: 410.537.1800
www.accesstohealth.org

OUTSIDE COVER PHOTO CREDITS *(from left to right)*:

DEMOCRATIC REPUBLIC OF CONGO: A nurse with a newborn.
IMA World Health

DEMOCRATIC REPUBLIC OF CONGO: A happy mother and her newborn.
IMA World Health

The ACCESS Program is the U.S. Agency for International Development's global program to improve maternal and newborn health. The ACCESS Program works to expand coverage, access and use of key maternal and newborn health services across a continuum of care from the household to the hospital—with the aim of making quality health services accessible as close to the home as possible. JHPIEGO implements the program in partnership with Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and IMA World Health.