COMMITMENT, CONSCIENCE OR COMPROMISE: THE CHANGING FINANCIAL BASIS AND EVOLVING ROLE OF CHRISTIAN HEALTH SERVICES IN DEVELOPING COUNTRIES

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ABSTRACT

This research investigates the changes in the operations of CHSs (Christian health services) in developing countries, particularly their funding bases, relationships with their respective governments, and the extent to which these have resulted in changes to the socioeconomic characteristics of their users. Three main areas of study are woven together: the history of medical mission, health service management and its response to the pressures of the last half-century, and the role of non-state providers in a comprehensive health care system. Evidence was assembled from interviews with officials of twelve UK based mission organisations, a survey of CHSs in thirteen countries, and case studies of CHS provision in Malawi and India based mainly on extensive interviews with selected stakeholders.

The research confirmed that funds received by CHSs from mission organisations have declined and are now more often in the form of project funding. CHSs have, for the most part, continued to provide services for the poor in a variety of ways: first, by providing low cost services; second, by developing hi-tech tertiary services, the profits from which subsidise services for the poor; and third, by working more collaboratively with governments, for which they receive varying degrees of financial and other support.

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ACRONYMS AND ABBREVIATIONS

AIC	African Initiated Church
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARHAP	African Religious Health Assets Programme
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral (medication)
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
BJP	Bharatiya Janata Party (in India)
BMS	BMS World Mission (previously the Baptist Missionary Society)
BSc	Applies to a nurse who is a Bachelor of Science nurse graduate
CCIH	Christian Connections for International Health
CF	Christian Fellowship (as in Christian Fellowship Hospital)
CFH	Christian Fellowship Hospital (as at Oddanchatram)
CGHS	Central Government Health Scheme (in India)
CHA	Christian Health Association
CHAD	Community Health and Development Programme (at CMC, Vellore)
CHAG	Christian Health Association of Ghana
CHAI	Catholic Health Association of India
CHAK	Christian Health Association of Kenya
CHAM *1	Christian Health Association of Malawi
CHS	Christian Health Service
CIM	China Inland Mission
CMAI	Christian Medical Association of India
CMC-PNG*2	Churches' Medical Council in PNG
CMC-Vellore	Christian Medical College (as at Vellore)
CMC-WCC	Christian Medical Commission (set up by the WCC)
CMS	Church Mission Society (previously Church Missionary Society)
CNI	Church of North India
C of E	Church of England
CONCH	College of Nursing Community Health Programme (at CMC Vellore)
Columban	Missionary Sisters of St Columban
CSI	Church of South India
CSO	Civil Society Organisation
CWM	Council for World Mission
DFID	Department for International Development (UK)
DHO	District Health Officer
DHS	Diocesan Health Secretary
DIAFEM	German Institute for Medical Mission (Tübingen)
DIP	District Implementation Plan
DOTS	Directly Observed Therapy Short Course (for TB treatment)
Dr	Doctor
EHA	Emmanuel Hospital Association
EHP	Essential Health Package
EMMS	Edinburgh Medical Missionary Society

ESIS	Employees State Insurance Scheme (in India)
EU	European Union
FBO	Faith Based Organisation
FFF	Female Education, Family Spacing and Food Supplementation
FP	Family Planning
FPO	For profit organisation
GDP	Gross Domestic Product
GHS	Government Health Service
Global Fund	Global Fund to fight AIDS, Malaria and Tuberculosis
GOBI	Child Growth Monitoring, Oral Rehydration, Breastfeeding and Immunisation
GOI	Government of India
GOM	Government of Malawi
HHD	High Human Development
HIPC	Heavily Indebted Poor Countries
HIV	Human Immuno-Deficiency Virus
HSA	Health Surveillance Assistant
HSR	Health Sector Reform
ICC	Inter-agency Cordination Committees
IMC	International Missionary Council
IMR	Infant Mortality Ratio
JMJ	Jesus, Mary and Joseph Religious Order
LAMB	Integrated Rural Health and Development (Bangladesh)
LCECU	Low Cost Effective Care Unit (at CMC Vellore)
LEB	Life expectancy at birth
LHD	Low Human Development
LMS	London Missionary Society
MCH	Maternal and Child Health
MD	Medical Director
MDGs	Millennium Development Goals
MHD	Medium Human Development
MMM	Medical Missionaries of Mary
MMS	Medical Mission Sisters
MoH	Ministry of Health
MOU	Memorandum of Understanding
MPRS	Malawi Poverty Reduction Strategy
NFP	Not for profit
NHS	National Health Secretary
NGO	Non Governmental Organisation
NSO	Non-state Organisation
NSP	Non-state Provider
NRHM	National Rural Health Mission
OPD	Outpatient Department
PHC	Primary Health Care
PMS	Pontifical Mission Societies
PNG	Papua New Guinea
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper

PWM   Partnership for World Mission
RBM   Roll Back Malaria
RCH   Reproductive and Child Health
Rev   Reverend (title of an ordained Christian priest or minister)
Rt Rev   Right Reverend (title of a Bishop)
RUHSA   Rural Unit for Health and Social Affairs (at CMC Vellore)
SAP   Structural Adjustment Programme
Sn   Staff Nurse
Sr   Nursing Sister or Religious Sister
S-SA   Sub-Saharan Africa
St   Saint (as applied to the name of a Christian building, e.g. St Stephens')
STI   Sexually Transmitted Infection
SWAp   Sector Wide Approach
SWOT   Strengths, weaknesses, opportunities and threats
TB   Tuberculosis
TBA   Traditional Birth Attendant
UNDAF   United Nations Development Assistance Framework
UNDP   United Nations Development Programme
UNFPA   United Nations Population Fund
UNICEF   United Nations Children's Fund
USAID   United States Agency for International Development
USPG   USPG–Anglicans in World Mission (previously known as United
         Society for Propagation of the Gospel)
VHAI   Voluntary health Association of India
VSO   Voluntary Service Overseas
WB   World Bank
WCC   World Council of Churches
WHO   World Health Organisation

Notes
*1 The term CHAM is used ambiguously in Malawi. For clarification in this thesis when CHAM is followed by (CHS) it refers to CHS facilities. When it stands alone it refers to the CHAM organisation.
*2 The acronym CMC has three distinct meanings. For clarification in this thesis CMC is followed by –PNG, -Vellore, -WCC to distinguish them

The two and three digit numbers appearing in brackets refer to section and subsection numbers, unless stated otherwise.

CHAPTER 1

INTRODUCTION

Christian organisations are significant providers of health services in many low income countries, and have been since colonial times, although their roles and modes of operation have had to change in response to changing circumstances since independence. They have had to respond to medical, demographic, epidemiological, political and economic changes, but it appears that the most significant influence on their operations has been changes in their funding bases and their relationships with their respective governments. It has been suggested that in response to these changes, their commitment to continue providing services has sometimes wavered and that the original moral imperative to provide services to the poor has been undermined, leading to compromise on the original motivation for and types of provision. Through an in-depth examination of Christian health service provision in Malawi and India, external influences on providers will be identified and their relative importance assessed, and the implications of changing circumstances for their commitment, motivation and provision evaluated. Not only will this research make a contribution to knowledge about a particular important group of non-state service providers in the health sector, it will also contribute to understanding of the factors that influence non-state provision and its relationship to state provision.

1.1 Motivation for this Research

The motivation for this research arose from the author's eight years experience as National Health Secretary managing the Anglican Church CHS (Christian Health Service) in PNG (Papua New Guinea), during which time he chaired the CMC-PNG (Churches' Medical Council) working group which formulated CHS policies, drew up conditions of service for

CHS health workers, and prepared background documents for negotiating an MOU (memorandum of understanding) with the PNG government. The CHSs in PNG, which collectively provide approximately 45% of all health services (4.3), work in close collaboration with their respective provincial governments and, through the CMC-PNG, with the national government. The MOU formalised the relationship between the government and CHSs, specifying the support and services to be provided by each to the other. Initial investigation of the CHSs' contribution in other countries identified a dearth of systematic and reliable data on their contribution to national health provision, a lack of analysis of their characteristics and responses to changing circumstances, and exclusion of any specific consideration of faith-based service providers in attempts to theorise the relationships between state and non-state providers.

1.2 Aims and Objectives

The overall aim of this research is to assess and explain the extent to which changes in the circumstances in which CHSs operate, and particularly changes in their funding bases and their relationships with their respective governments, have resulted in changes to their values and operations, and the socioeconomic characteristics of their users. Four objectives were identified to meet this aim:-

1)   To determine the extent and nature of current CHS provision in specified developing countries of S-SA (Sub-Saharan Africa), South Asia and the Pacific (South-Western Pacific islands).

2)   To ascertain the changing policies of selected mission organisations in the UK and how these have affected the funding of CHSs in their partner countries.

3)   To ascertain and explain the changing nature of the relationship between governments and CHSs and assess their impact on the nature and extent of services provided.

4)   To ascertain and explain the changing funding bases of CHSs and their effect on the socioeconomic characteristics of users of CHSs.

For purpose of this research 'mission organisation' includes both mission agencies which operate independently, but on behalf of a church denomination and the mission sections of those churches which operate their own mission and overseas support functions.

1.3 Background to the Research

Several factors combined in the second half of the C19th to accelerate the development of medical mission, from which the current CHSs evolved (2.4.2). Mission organisations recognised that doctors and nurses were needed to provide medical support to their missionaries who were suffering high levels of morbidity and mortality from working in inhospitable conditions overseas and later acknowledged, in some cases reluctantly, that medical missionaries often had access to communities which remained closed to other missionaries. The bacteriological discoveries at the end of the century also meant that medical missionaries, who were inspired to ease the suffering of people overseas, had effective treatments to offer. For the next half-century, and more, the expansion of Christian mission saw the establishment of new churches accompanied by church schools and health facilities.

By the middle of the C20th the former colonial countries were starting to gain independence and the mission churches in those countries were gaining autonomy from their founding churches (2.5, 3.2.3, 4.2). As a consequence the newly independent churches inherited large networks of hospitals and other health facilities, often greater in number than the

governments' own provision. A high proportion of these were in rural areas, where there was frequently no government health service provision or government infrastructure. By the 1960s the churches were expressing concern about the increasing cost of operating these institutions and whether the imposition of user charges, which had become necessary, was preventing them from meeting the health needs of the poorest sections of their populations. As a result the Tübingen Consultations and national surveys (4.4) were initiated to explore these and other issues including the relationship between the increasingly professionalised CHS and their respective church organisations. There were two particular positive outcomes: First, acceleration of the establishment of CHAs (Christian Health Associations), which improved the cooperation of denominational CHSs with each other and with their respective governments, and second, the promotion of PHC (Primary Health Care).

By the last quarter of the C20th it was becoming apparent that despite the medical, technological and epidemiological advances taking place the disparity in the health status both between low and high human development countries and between the poor and non-poor populations in those countries was widening (3.3.1). One of the reasons for this was believed to be underperformance of the health sector. Governments, as well as CHSs, were facing escalating costs of the networks of institutions they had inherited. The consequence for CHSs in several countries was the closure of many of their health institutions. As a result of cooperation between the World Council of Churches and the World Health Organisation, PHC was endorsed as the means of achieving 'Health for All by the Year 2000' (4.4). Despite professional and political resistance, PHC has persisted, although it never reached its full potential.

There have been several initiatives during the last three decades that had the potential for advancing closer working relationships between governments and CHSs, but which have not always been fully grasped. From the 1980s the components of what came to be known as Health Sector Reform were the favoured approaches for tackling underperformance in the health sector (3.4.2). These broadly comprised government decentralisation and the promotion of alternatives to state funding and provision, which presented opportunities for the negotiation of service contracts or partnerships between governments and CHSs. SWAps (Sector Wide Approaches) (3.4.2.3) were developed in the early 1990s as a means of avoiding duplication and fragmentation of effort by channelling all resources through a common mechanism in support of governments' strategic plans. Although they were designed to benefit NSPs (non-state providers), including CHSs, as well as government services, this does not always occur. Furthermore, a number of donors, including the Global Fund (3.4.3) undermined their success by operating separate budgetary systems. After the turn of the millennium there was further impetus for governments to engage with a wide range of NSPs, including CHSs, in the campaign to achieve the Millennium Development Goals (3.4.3).

1.4 Methodological Approach

Two points became apparent at an early stage of this research. First, that the exploration of CHSs does not fit neatly into a single area of study and second, the dearth of academic literature on either the history or the current operation of CHSs, which further endorses the need for this research. The literature review, therefore, pursued three main areas of study. First, in order to provide an understanding of the origins and context within which early CHSs evolved, the history of mission is briefly sketched, focusing particularly on medical mission (chapter 2), which laid the foundations for CHSs. Second, the major changes and initiatives,

which had the potential to influence the delivery of all contemporary health services in developing countries, are identified. These include medical, technological, epidemiological and demographic changes, the attainment of national independence and international development initiatives, and are reviewed in chapter 3. Third, in order to locate CHSs within the wider health sector context, and to identify factors that influence relations between governments and NSPs, material on the contribution of NSPs to the health sector is reviewed with particular reference to CHSs (3.4.2.2 and chapter 4). The literature review led to the formulation of the conceptual framework (5.2) and the following hypothesis:-

'The necessity of seeking alternative funding sources has resulted in changes in the types of provision of CHSs in contemporary developing countries, their users, and their relationships with governments' (5.3).

The research aim specified above (1.2) seeks to test this hypothesis through four research questions, corresponding to the objectives, which were formulated to substantiate or disprove the hypothesis:-

1)   What is the current contribution of CHSs to the total health service of their respective countries and to what extent do they cooperate with each other?

2)   How and why have the policies of mission organisations in the UK changed; how have these affected their relationships with, and support given to, their developing country partner churches and their health services; and what is the impact of CHSs' religious heritage on their service provision?

3)   What is the nature of relationships with, and support given by, governments to CHSs and how and why have these changed?

4)   How have CHSs responded to these changes; what impact have these changes had on

        the search for alternative sources of funding, the nature and extent of services

        provided, and their users; and what are the reasons for the continued existence of

        CHSs?

The second question also includes support given by mission organisations in other countries

from the perspective of the CHSs. Further investigation of these is beyond the scope of this

thesis.

A qualitative rather than a quantitative approach is deemed appropriate as the main emphasis

in the research is investigating the opinions; interpretations; beliefs; values; attitudes and

relationships of respondents rather than the collection of statistical data, and this also allows

some flexibility to make adjustments to suit different circumstances (5.5.1). Some initial data

was obtained from those mission organisations and overseas CHAs, CHSs and church

organisations with websites that were known and could be accessed, although the data

provided was usually limited and not always in a form which was useful to the research. For

example some Anglican diocesan websites barely mention their health services and the CHS

websites are often limited to information designed for medical students seeking elective

experience. In a few cases it was possible to obtain annual reports and/or strategic plans either

as hard copies or on-line.

There are three strands to the research (5.5.5). First, mission organisations are investigated to

identify whether they have had any change in relationships with, or support of, developing

country CHSs, and if so why (5.5.5.1).   In order to provide a reasonably comprehensive and

systematic overview within the time and resource constraints, twelve UK based mission

organisations were selected from denominations which were active in mission during the colonial era (appendix 2). Face-to-face interviews, using a topic guide (appendix 9), were conducted between November 2007 and November 2008, with senior officers of twelve mission organisations (appendix 2). This had the advantage of enabling relevant points to be pursued in greater depth. Second, CHSs which evolved from mission churches after independence in Commonwealth countries in S-SA, South Asia, and the Pacific are studied to investigate their extent, funding sources and relationship with their respective governments (5.5.5.2). The principal reason for selecting these regions and countries was the anticipation that because of their cultural ties to the UK they would have a concentration of CHSs related to UK based mission organisations and also that it would be possible to communicate in English (5.4).

It was only possible to obtain data from overseas CHAs or denominational CHSs by sending a semi-structured questionnaire through e-mail or the postal system (appendices 9 and 10). These were sent from April 2006, as contacts for CHAs were identified, but several reminders were needed to elicit any response from many CHAs and it was often difficult to obtain further clarification of points. Usable data was received from only thirteen countries by April 2008 (appendix 3).

For the third strand, two countries were selected for in-depth study in order to pursue the issues of their extent, funding and relationship with their governments in greater detail, and also to gain a range of perspectives on the nature of the services provided and their users (5.5.5.3). Malawi was selected as a mainly Christian country in S-SA in which it was reported by CHAM (Christian Health Association of Malawi) that it was the sole CHA in

Malawi and is working closely with the government. India was selected because of its major differences from Malawi including its Asian location with a minority Christian population, and in which it was reported by CMAI (Christian Medical Association of India) that there are separate Protestant and Catholic CHAs, and limited cooperation with the government. The reported different structures and relationships of CHSs with their CHAs and with their respective governments are important because their possible effects on CHSs service provision and their users is a principal focus of the research. The interviews were carried out in Malawi between 17th November 2006 and 20th January 2007 (appendices 4 and 5), and in India between 28th February and 8th May 2007 (appendices 6 and 7).

The starting point in both countries was the CHAs, from which information was obtained first, about their role, responsibilities and relationships with both their governments and CHSs, and second, about the extent and nature of CHSs in the country. With the help of the CHAs decisions were made about the selection of CHS health facilities to be visited taking account of the potential for different experiences due to their different types, denominations and geographical regions. Eight CHS health facilities were visited in Malawi and eight in India (maps 6.1 and 6.2) to reflect these differences. To seek different perspectives on the issues being researched interviews were conducted, using topic guides, with managers, staff and patients. To gain perspectives from outside of the CHS, interviews were conducted with community members, church officials, Muslim and Hindu faith leaders (India only), development organisation officials, government hospital officers and other government institution officials (limited in India)(appendices 4, 5, 6, 7, 11 and 12).

1.5 Structure of the Thesis

This thesis is divided into eight chapters. This introduction is chapter 1. The literature review is divided between three chapters: The origin and development of Christian medical mission (chapter 2); contemporary health service development (chapter 3); and post-colonial CHSs (chapter 4). The research framework, including the conceptual framework and methodological approach, is explained in chapter 5. The results of the main empirical research are divided between chapters 6 and 7. Although there is some overlap between the results of the questions, chapter 6 addresses first, research question 1 by exploring the background of the countries researched, their health status, health services, particularly services provided by CHSs, and a description of CHS facilities researched in India and Malawi. Second, research question 2 is addressed by exploring the UK based mission organisations, particularly their relationship with, and their funding and health sector support of their overseas partner churches, the management of denominational CHSs in Malawi and India, and their religious orientation. Chapter 7 addresses first, research question 3 by exploring government health programmes in Malawi and India; the relationships between CHSs and governments including the roles of CHAs and the involvement of CHSs in the formation of policy and service planning; government support of CHSs including funding and service agreements; government regulation of CHSs; and cooperation between government health services and CHSs. Second, research question 4 is addressed by exploring sources of CHS funding, including financial support from overseas partners and user fees; the socioeconomic orientation of CHSs; and the reasons for the continued existence of CHSs. The conclusions are discussed in chapter 8.

CHAPTER 2

THE ORIGIN AND DEVELOPMENT OF CHRISTIAN MEDICAL MISSION

2.1 Introduction

This is the first of three chapters that follow the progression of CHS (Christian health services) from their early mission beginnings to the present time. For purposes of this thesis health and healing are confined to 'Western style' allopathic medicine, and discussion excludes consideration of spiritual healing or traditional medicine, except where mention is helpful for clarification. The thesis also deals primarily with Christian mission in S-SA (Sub Saharan Africa), South Asia and the Pacific (South-Western Pacific Islands), all of which were subject to substantial British influence during the colonial period. Latin America is generally excluded because of its closer historical and cultural ties with Spain and Portugal.

This chapter considers how the biblical roots and worldwide growth of Christianity, which today is the largest faith claiming 1.9 billion adherents worldwide (Clarke and Jennings 2008), resulted in many newly independent countries inheriting a network of Christian (previously referred to as 'mission') health services. Chapter 3 will deal with the medical, technological, epidemiological, demographic, political and economic pressures on contemporary health services generally, and chapter 4 will explore how post-colonial Christian health services have responded to the joint challenges of their mission inheritance and the health sector pressures.

Well into the C20th, and beyond, it was common for mission health services to be the only source of Western-style medical or nursing assistance in many communities in developing

countries, particularly in rural areas, but, despite their very significant contribution around the world, mission health services have received negligible attention from either academic study or mission historians (Grundmann 2005). The authoritative *'Transforming Mission'* (Bosch 1991) scarcely mentioned medical mission. Much of the available literature on the topic would best be described as the biographical or autobiographical experiences of particular medical missionaries, which are subjective in nature. *'Heralds of Health'* (Browne et al 1985) and *'Sent to Heal'* (Grundmann 2005) are exceptions, and the latter book has the advantage of its recent publication. Grundmann (2005), however, explains that his desire to use original documents limited his primary concentration to the C19th Protestant initiatives because of the high volume of material to examine.

This chapter is not intended to be a comprehensive history of medical mission but aims to highlight some of the significant milestones in its introduction and growth, commencing with the foundation and development of Christian mission (2.2), and continuing with the socioeconomic orientation of mission organisations (2.3); the introduction and development of medical mission (2.4); Christian ecumenism, autonomy of national churches and national independence (2.5), and concluding with a discussion of the ways in which mission organisations raised funds for their work and the effects of the difficulties they encountered (2.6).

2.2 Foundation and Development of Christian Mission

The missionary mandate for Christians to propagate the Gospel, convert the "heathen" and establish new churches was based on their conviction that salvation could only be achieved through following the teaching of Jesus Christ (Bosch 1991) and His instructions to his

disciples (Neal 2004): "Go, then, to all peoples everywhere…teach them to obey everything I have commanded you" (Matt 28:19). Following the C4th conversion of Constantine, Christianity became the state religion of the Roman Empire, after which the next millennium saw the general spread of Christianity throughout the known world (Bosch 1991). The responsibility to spread the religion was endorsed by the Treaty of Tordesillas in 1494, which ruled that Spain and Portugal should Christianise the people in the countries they colonised, thus developing the modern concept of mission (Grundmann 2005). British Protestant missionary societies began to emerge in the C18th, starting with SPG (Society for the Propagation of the Gospel) which was granted its Royal Charter in 1701 (Thompson 1951, O'Connor 2000), followed by others towards the close of the century, initially working mainly in particular geographical areas (box 2.1).

Year	Society	Initial Countries of Mission
1701	Society for Propagation of the Gospel	North America, West Indies
1786	Methodist Missionary Society (1818 Constitution)	West Indies
1792	Baptist Missionary Society	India
1795	London Missionary Society	Pacific, China, Southern Africa
1796	Glasgow Missionary Society	Southern Africa
1796	Scottish Missionary Society	Southern & Western Africa
1799	Church Missionary Society	Africa, East Asia
1857	Oxford and Cambridge Mission ((later Universities Mission) to Central Africa	Central Africa

(Dates are not always precise because of the way in which some missionary societies evolved rather than being established on a specific date)

Box 2.1 Missionary Societies: Year of Origin and Initial Country of Work (Sources: Davey 1951, Herklots 1961, Goddard 1967, Wilkinson 1991, Carey 1992, Anderson et al 1994)

The C19th expansion of western domination and the associated spread of Christianity across the world was paralleled by growing agnosticism, indifference, secularism and anticlericalism at home (Latourette 1954). At the start of the C19th more than 90% of Christians lived in Europe or North America, but by the end of the C20th, Christians living in Africa, Asia, Latin

America and the Pacific increased to around 60% of the world total (Walls 2001). Thus the missionary movement can be seen as one of the earliest forces of globalisation (Stanley 2001).

2.3 The Socioeconomic Orientation of Mission Organisations

Mission organisations commonly experience two particular tensions. The first tension, which is explored in the context of medical mission in the next section (2.4), is between evangelising and serving the poor. The second tension, which is explored in this section, is between the perceived mandate of mission organisations to minister to the poor and their identification with the non-poor.

Christians take Jesus' priority to evangelise and serve the poorer and otherwise disadvantaged members of society (Davey 1985, Nazir-Ali 1990, Bosch 1991, Nazir-Ali 1995) as a moral imperative to positively discriminate in favour of the poor (Taylor 1990). However there is often ambivalence in how this professed bias is executed. On the one hand churches have a long tradition of charitable giving, support of welfare work among the poor, foreign missions and overseas aid (Cof E 1985, Paterson 1993), often where no other help is available. However there are three particular constraining factors. First, actions to help the disadvantaged may be limited if the 'givers' perceive that their own security is threatened (Sheppard 1983, Cof E 1985, Nazir-Ali 1990, Bonk 1991) resulting in their retention of control, thus reinforcing the dependence of the poor (Sheppard 1983). Second, mission organisations sometimes experience a conflict between their 'Christian duty' towards the poor and their perceived expedient of gaining the acceptance and support of local elites to enable churches to grow. In India, for example, dalits and hill tribes accounted for the majority of conversions (Kim and Kim 2008), but some missionaries saw the conversion of marginalised

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people as a discouragement to the evangelisation of higher castes that, it was hoped, could bring about changes in society (Nazir-Ali 1990, Kim and Kim 2008).

Third, despite the conviction of, and sacrifices made by many missionaries, they often demonstrated an inconsistency between the heavenly values they preached and the worldly values they practised (Bonk 1991, Ingleby 2006). In Africa, for example, compared with themselves, missionaries were seen by indigenous Africans as wealthy, but unwilling to share what they had with the poor (Nthamburi 1991). Many missionaries displayed attitudes of racial, cultural and linguistic superiority; religious insensitivity; identification with the powerful; and unwillingness to relinquish control, which led critics to interpret their mission as an arm of colonialism (Bonk 1991).

2.4 Introduction and Development of Medical Mission

This section traces the development of medical mission from the healing ministry of Jesus and the founding of Christian hospitals (2.4.1); the C18th and C19th initiation and expansion of medical mission (2.4.2); the influence of medical mission (2.4.3); relationship with indigenous culture (2.4.4); and religious ministry (2.4.5). The section concludes with the formation of mission hospitals and PHC (primary health care) (2.4.6) and health worker training (2.4.7).

2.4.1 The Founding of Christian Hospitals

Compassion for the sick, and healing, particularly of vulnerable people, was central to Jesus' ministry (Lambourne 1963, Asante 1998, WCC 2005) and is described on 26 occasions in the Gospels (Davey 1985). He expressly charged his disciples to heal as well as preach at every opportunity (Asante 1998).

The first Christian hospitals were founded in Caesarea and Constantinople during the C4th AD. By 500 AD they had been established in most cities throughout the Roman Empire. In medieval Europe monasteries advanced the art of nursing the sick, pioneering clean water supplies, sanitation and good nutrition, as well as providing rest for travellers (Williams 1985). Hospital building gained impetus during the C11th and C12th to provide care for the Crusaders along the routes to Palestine, and accelerated in England during the C12th and C13th with the establishment of St Thomas' and St Bartholomew's in London (McGilvray 1981). Christian compassion saw the operation of 326 leprosy homes in Britain and 2000 in France, but the Reformation caused many Christian hospitals and charitable institutions to close (Davey 1985). It was the C18th Evangelical Revival which ignited the next wave of concern for the underprivileged, resulting in the establishment of 145 new hospitals between 1700 and 1825 (Davey 1985).

2.4.2 The C18th and C19th Initiation and Expansion of Medical Mission

Despite the centrality of healing in the ministry of Jesus and his disciples, the development of medical mission was impeded, first, because of the 4th Lateran Council ruling in 1215 that clerics should not practice medicine, to avoid the risk of accidental homicide, and second, because Canon law forbade religious sisters from practising midwifery. The first overseas missionaries who were recorded as practising medicine were the C16th Jesuits and Franciscans (Bonk 2007). It was not until 1819 that the first reference was made to a designated medical missionary, who was working with the New Zealand Maori on behalf of CMS (Church Missionary Society), and not until 1834 that Peter Parker, the first fully trained doctor and theologian, travelled to China and, with colleagues, founded the first Medical Missionary Society there in 1837 (Grundmann 2005). Parker inspired the founding of EMMS

(Edinburgh Medical Missionary Society) in 1841, which promoted acceptance of the role of the Christian doctor in the missionary strategy of UK churches (Wilkinson 1991) and the establishment of other medical mission societies in Europe and North America, including the Medical Missionary Association in London in 1878 (Grundmann 2005).

Although not all churches were initially enthusiastic about setting up medical missions, the number expanded, first, because non-medical missionaries, often the wives of missionary ministers, were called upon to treat the sick who appeared at the missions (Pearson 1996). It was increasingly recognised that, because of the tropical climate, illness and accidents in their own families and the isolated communities where they were stationed, missionaries could not carry out their work effectively without medical help (Davey 1951, Ibemesi 1982, Davies 2007). Second, the reason for the slow acceptance of medical mission was that it was not until the C19th discoveries of bacteriology, antisepsis, anaesthesia and public health that 'Western' medicine had anything significant to offer, and was seen to be effective where local remedies had failed (Bonk (2007). As missions extended into previously unexplored territory and medical treatment became accepted as a necessary part of mission, communities built churches, schools, hospitals, dispensaries and aid posts as occurred in PNG (Papua New Guinea) (Kettle 1979).

Despite the gradual change in the attitude of mission societies towards medical mission, it was not until 1901 that the MMA (Medical Mission Auxiliary) was set up to support the medical work of BMS (Baptist Missionary Society) (Stanley 1992); and 1911 before SPG formed its Medical Missions Department (Thompson 1952). By 1910 medical mission was sufficiently established for a separate Medical Missionary Conference to be held alongside the Edinburgh

Missionary Conference, which helped churches to understand their healing ministry
(Wilkinson 1991).

Over 3,000 doctors and nurses left Britain to work in overseas mission between 1850 and
1950 (Davey 1985). From 1900 to 1923 the total number of serving missionaries increased
from 13,000 to 20,500, during which period the percentage of medical missionaries, including
nurses, remained constant at 10.5% of the total. Mission Boards were impressed that in 1900
medical missionaries treated 2.5 million patients, which was eleven times as many patients
per missionary as pupils per missionary taught in schools (Grundmann 2005).

China	31.1%
India	26%
Other Asia	9.4%
Africa	10.6%
Near East	6.4%
South America	2.9%
North America	2.9%
Oceania & Australia	3.1%
Missions to the Jews & Seaman	7.1%
n=770 (physicians only)	

**Table 2.1 Location of Medical Missionaries
in 1900 (compiled from Grundmann 2005)**

Almost 30% of the 154 British and 128 North American missionary societies were involved
in medical mission by 1900, compared with 17% of the 82 continental European societies. Of
the 770 known medical missionaries in 1900, excluding the Catholic Church which did not
recognise medical mission work as such until the second quarter of C20th, nearly 60%
worked in India and China, but less than 11% worked in the whole of Africa (table 2.1),
where medical mission had started later (Grundmann 2005). Well into the C20th and beyond,

it was common for mission health services to be the only source of Western style medical or nursing assistance in many communities, particularly in rural areas.

2.4.3 The Influence of Medical Mission

Very little has been written about colonial government health services and their relationship with mission health services. Neither Browne et. al (1985) nor Grundmann (2005) do more than mention this in passing. In many countries the early mission health services preceded not just government health services, but the existence of colonial governments themselves. Browne (1985) suggested that there are many instances of mission hospitals inspiring governments to provide health care. Davey (1985) noted that the Christian influence in government medical services was usually greater in Africa than in Asia because of the general absence of other religions and the cohesive effect on expatriates of the severe consequences of the hyperendemic malaria.

The degree of cooperation between church denominations varied between different countries. In those where there was a high level of accord, churches and their associated medical missions were established in different rural areas. This limited conflict between them and with the colonial health services, which were generally located in the administrative centres as in PNG (Kettle 1975, Hand 2002). However, where accord was lower, such as at Chengtu in China, disagreements arose between the seven different denominations operating health facilities in the city (Grundmann 2005).

In the countries in which they worked, medical missionaries often took the lead in many different ways: not just the transfer of the medical practice they had learned in their home

countries, but establishing public health systems, nursing and medical education (2.4.7),

professional regulatory bodies, and carrying out clinical research (Grundmann 2005). Their

pioneering achievements in tropical medicine and public health (Grundmann 2005) impacted

on the government health services in the countries concerned as well as the mission health

services (Browne 1985).

2.4.4 Medical Missionaries and Indigenous Culture

Despite their good intentions, the work of medical missionaries was not always accepted nor

appreciated by the local communities they were seeking to help, partly due to their different

concepts of health and disease. There was often a gradual process, aided by improved

education, of appreciating the effectiveness of Western medicines and surgery, as described

by Gelfand (1984) in South Africa. Indigenous communities do not always forsake their

traditional healers entirely with the advent of modern medicine and in many countries

traditional medicine persists alongside modern medicine.

In many Asian countries, Muslim and some Hindu women were prevented from seeking

treatment from male physicians, because of purdah requirements, and were attended only by

the local traditional midwife during childbirth, resulting in high mortality (Thompson 1951,

Fitzgerald 2000). In 1867 the first women's medical mission in India, the Delhi Female

Medical Mission, was established. By 1877 the mission was treating annually over 6,000

women and children in the dispensary and over a thousand in their own homes, and was the

forerunner of St Stephen's Hospital, Delhi (Thompson 1951, Fitzgerald 2000). In recognition

of this need to provide female medical missionaries, the CIM (China Inland Mission) founded

by Hudson Taylor in 1866 broke new ground by sending single women to China (Steer 2001),

and a number of Zenana medical missionary organisations were formed in England from 1880 (Grundmann 2005).

2.4.5 The Religious Ministry of Medical Mission

Section 2.4.2 suggested reasons why mission organisations had not generally recognised the need for medical mission until the third quarter of the C19th. Even then some missionary societies, such as CMS, were reluctant to engage in medical mission, except to help missionaries and their families, because they feared that it would detract from their more important evangelistic work. It was the opportunity to gain access to previously forbidden Muslim areas which persuaded CMS to enter this field. Nevertheless, its medical committee, established in 1885, stipulated that its medical work should always be subordinated to its spiritual mission (Murray 1985, Thomson 1985, Grundmann 2005).

The fears of the mission societies were soon proved to be well founded. In 1874 BMS recalled its first medical missionary from China, because he refused to engage in evangelistic preaching alongside his medical work (Stanley 1992). The growing demand for their professional skills and their increasing professional confidence resulting from the scientific advances of the late C19th increasingly left medical missionaries with insufficient time for religious work. This led to tension between their view of themselves as primarily physicians because of the immediate medical necessities, and the higher priority given by mission societies to evangelism (Grundmann 2005). However, contemporary accounts show that missionary zeal was often no less amongst the medical missionaries, it was simply that the new medical and bacteriological discoveries gave them a growing confidence that God had entrusted this scientific knowledge to them to share with suffering people in other parts of the world (Grundmann 2005). Increasingly mission societies recognised the benefit of medical

work in making people more receptive to the gospel because, despite a professionalised view of medical missionaries' roles, the increasing confidence in medical work did create opportunities for spiritual work which would otherwise not have been possible (Thompson 1951, Price 2003, Grundmann 2005).

Several writers have reported instances of patients deliberately choosing to attend mission hospitals because they appreciated the hospitals' spiritual and compassionate ethos, sometimes in preference to a government hospital, which may be free and better resourced (Davey 1951, Ibemesi 1982, Gelfand 1984, Pearson 1996, Fitzgerald 2000). Sometimes the Christian practice of ministering to both the body and soul led to conversion of patients to Christianity, particularly those who had recovered from their illness (Ibemesi 1982, Gelfand 1984). However conversion does not necessarily occur, as people of other faiths often ask Christians to pray with them in time of need, without any change of faith occurring (Nazir-Ali 1990).

2.4.6 Establishment of Mission Hospitals and Primary Health Care

For much of the C19th and C20th medical mission became synonymous with mission hospitals, mainly because the most effective treatments, such as surgery, required the controlled environment of a hospital, which was usually a small building adapted for the purpose (Grundmann 2005). Dispensaries, some as outstations of hospitals, were also important, because of their lower cost and greater accessibility than hospitals, but also because they served a much greater number of people, who were seen by mission organisations as mission contacts (Grundmann 2005). Many of these dispensaries became, in the course of time, the hubs of PHC services (Grundmann 2005). Their help was often

enlisted by colonial governments in their preventive programmes because of their contact with local communities, particularly in rural areas as Schulpen (1975) reported occurred in Tanzania.

However, mission organisations were often hesitant, because of the huge financial consequences, to erect and maintain mission hospitals (Stanley 1992). Instead, they considered the relative merits of providing an efficient well equipped hospital or developing travelling medical patrols, as illustrated by Woods (1992) in China. To improve general standards of health and deal with problems early, many medical missionaries, such as Ida Scudder in India, developed village outreach. This most commonly included maternal and child health services, basic medical services, improving nutrition and hygiene (Ibemesi 1982, Paterson 1993, Pearson 1996), and sometimes community, economic and agricultural development (Ibemesi 1982, Paterson 1993). There continued to be a tension between the spiritual and social work of the church because although the great number of hospitals and schools built by missionaries provided a much needed service, the impression was sometimes created that the mission enterprise was performed by a mighty transnational religious corporation, and in India missionaries became increasingly perceived as managers of schools and hospitals (Buhlmann 1991).

2.4.7 Health Worker Training

Much of the early pioneering work in health worker training was also carried out by medical missionaries, initially on an informal basis. This became increasingly formalised as schools of nursing and medicine were established and national registration boards formed, which drew up the training syllabus, administered examinations and regulated the professions (Schulpen

1975, Pearson 1996). By the end of the C19th, 651 indigenous medical personnel, of whom over one third were women, were being trained in at least 67 institutions headed by medical missionaries (Grundmann 2005). By 1925, there were estimated to be over 600 indigenous physicians, constituting one third of the total missionary physicians, and nearly 5,500 indigenous nurses and attendants, five and a half times as many as their overseas counterparts (Grundmann 2005). As late as the 1940s, 80% of nurses in India were Christian girls who had trained in church-related institutions (McGilvray 1981), and during the same period, Christian institutions in China provided 60% of medical services and most of the medical and nursing training (Woods 1992).

2.5 Christian Ecumenism, Autonomy and National Independence

The start of the C20th was marked by the three interrelated and concurrent movements towards unity between Protestant churches, the autonomy of churches in developing countries and national independence. This section traces how the part played by the international missionary conferences as a vehicle for unity led to calls from the newer churches for greater autonomy. The move towards national independence is dealt with at the beginning of chapter four (4.2).

Initially, relationships in Britain between the Established Church and the 'dissenting churches' and the lack of cohesion between the Protestant churches affected relationships between overseas missions (Davey 1951, Latourette 1954), exacerbated by tensions between Protestants and Catholics and between missions of different national origin (Schulpen 1975). The beginning of the Ecumenical Movement was marked by the World Missionary Conference in Edinburgh in 1910 and subsequent establishment of the IMC (International

Missionary Council) in 1921 (Murray 1985, Nazir Ali 1995). At the first World Conference on Faith and Order at Lausanne in 1927, V.S.Azariah, the first Indian bishop, argued for greater Christian unity in the mission field. However, it was not until 1947, the year of India's independence and three years after Azariah's death, that Anglicans, Methodists, Presbyterians and Congregationalists united to form the Church of South India, followed by moves to greater unity in North India, Sri Lanka, Pakistan, Bangladesh, parts of Africa and China (Davey 1951, Herklots 1961, Kim and Kim 2008).

Frustration in many African countries with the failure of Western churches to recognise indigenous customs in church liturgy and theological differences had, by the end of the C19th, prompted many Africans to form AICs (African Initiated Churches), which were independent of missionary control (Kim and Kim 2008). Usually associated with religious revival or nationalism, the first half of the C20th saw the emergence of indigenous churches in a number of Asian countries, including the Philippines, Korea and China (Kim and Kim 2008).

The 1910 Edinburgh Conference, which had been hailed as a major landmark in the journey towards Christian unity, highlighted tensions between the older Western churches and the newer churches in the developing world. All except 17 of the 1200 delegates were from Western countries. Bishop Azariah articulated the increasing nationalist consciousness by entreating overseas missionaries to abandon their well-intentioned paternalism and transfer responsibilities to Indians in a spirit of friendship, cooperation and support (Herklots 1961, Murray 1985). This was to be a recurrent theme at the 1928 IMC conference in Jerusalem, and again in 1938 at Tambaram, which was the first conference to be attended by equal numbers from the older and younger churches. Although it was accepted that the relationships

between the newer churches and the older Western churches should change from paternalism to partnership, with adequate preparation for handover of responsibility (Neill 1986), the newer churches believed that the resulting changes were superficial, and that they were still regarded as lacking the experience to operate autonomously (Bosch 1991).

At the 1958 Ghana IMC conference it was eventually accepted that distinctions between the older and newer churches were no longer valid and that all churches everywhere were involved in mission. This change of attitude was endorsed by the merger of the IMC into the WCC (World Council of Churches) in 1961, but despite the intent for the newer churches to have equal status with the older churches, final decisions continued to be made in the West, due to the reliance of the newer churches on the older churches for financial support (Bosch 1991).

2.6 Funding Issues

This section starts by considering the financial basis for mission societies generally, followed by the more specific situation of medical missions.

The problem of seeking financial support for mission is not a new one. St Paul needed to seek help from the newly established Macedonian and Corinthian churches for the impoverished church in Jerusalem (Herklots 1961). The earliest C18th and C19th missionaries often raised their own funds or relied on their family and friends for financial support. As churches became more supportive of mission they raised funds from their congregations through specific appeals and subscription schemes (Stanley 1992, Murray 1985). The historical accounts of different missionary societies attest that the willingness of the Western churches

to fund overseas mission has always been precarious, varying between opposition, apathy, worries about financial deficits, and generous enthusiasm (Davey 1951, Murray 1985, Stanley 1992, Steer 2001). As the indigenous churches gradually became autonomous during the C20th, their financial situation became even more unstable because of inadequate preparation for independent management coupled with a decline in financial support from their Western partner churches, which was exacerbated by their loss of overseas missionary personnel (Stanley 1992).

At the inception of medical missions during the middle of the C19th facilities and treatments were usually basic. Overseas churches and personal friends were the major, and often the sole sources of funding for building projects and sometimes operational costs (French 1954, Ibemesi 1982, Gelfand 1984), but this usually depended on missionaries spending a significant proportion of their home leave visiting churches to raise awareness and encourage giving (Wilkins 1987, Pearson 1996, Steer 2001). Funding medical mission was an ambiguous issue. On the one hand it was a cause of constant anxiety for most mission organisations, particularly as costs increased due to the need for new buildings and facilities, and rising prices for drugs and other medical supplies. However by the end of the C19th they were able to benefit from donations from businessmen who had grown rich through expanding trade (Thompson 1951), and medical mission often benefited from philanthropic support not always forthcoming to other missionary ventures (Grundmann 2005).

From the end of the C19th some medical missionaries introduced fees for health care, first, as a contribution towards the cost of the care, and second, as some medical missionaries believed, to increase patients' appreciation of their treatment (French 1954). However,

frequently medical missions had been established in areas where people were too poor to pay more than a minimal fee, which made only a minor contribution to the costs (Schulpen 1975, Ibemesi 1982, Gelfand 1984). At times of financial exigency, particularly when money was needed for a particular project, more affluent patients, including private patients, were sometimes encouraged because they could afford to pay higher fees (French 1954), although this could jeopardise the treatment of poorer people who had greater needs (Stanley 1992).

Initially colonial governments made only ad hoc contributions to the early medical missions, usually for a particular capital project (Ibemesi 1982, Pearson 1996). In some countries, they later assisted with operational costs, particularly where a need recognised by the government was being met. If and when these grants were paid more regularly, mission health services were able to expand, improve their services, increase health worker training and extend their outreach to more isolated areas (Gelfand 1984, Wilkins 1987).

The combination of financial difficulties experienced by mission organisations and increasing costs of providing health services forced many mission organisations, such as BMS in 1925, to cut costs by simplifying their structures and devolving their management, including the introduction of self-supporting status to mission hospitals. It also encouraged greater partnership with colonial governments. Government funding for mission health programmes brought to the fore tensions over the legal, professional and financial accountability of medical missionaries to the government and their mission organisation, as well as the degree of their autonomy (Stanley 1992). Issues of funding and partnership with governments in the post-colonial era are pursued in chapter four.

2.7 Summary

This chapter has shown the centrality of mission and healing to the Christian ministry, and that at the end of the C18th the surge in overseas mission took place, partly because of the opportunity provided by colonial expansion and partly because of increasing motivation to offer Christian salvation to the 'heathen' (2.2). It was another fifty years before the combination of four interrelated factors prompted the acceleration of medical mission:-

► Missionaries found that their work was seriously impeded by the effects of tropical climates on their own health and that of the communities in which they were working.

► The bacteriological discoveries of the late C19th started to make Western medicine more effective than local cures.

► There was a philanthropic desire to ease the suffering of people overseas.

► Mission organisations increasingly recognised that medical mission could contribute to the pursuit of evangelisation (2.4.2).

Often it took the successful treatment of an influential person before Western medicine became accepted by indigenous communities, but this did not necessarily preclude the simultaneous use of traditional and Western medicine. This parallel use of traditional and Western medicine has continued into the C21st. When female medical missionaries became available, they were able to build on the work of religious sisters, wives of missionaries and deaconesses, who had been able to treat and care for Muslim and Hindu women in Asian countries, particularly during childbirth (2.4.4).

In many countries medical missionaries were the first to practise Western style medicine and in many areas they were the only providers until national independence and beyond. Medical

missionaries also pioneered the identification and treatment of a number of tropical diseases, as well as instituting public health measures, running outreach clinics in rural areas and establishing medical and nursing training, all of which had an influence later on the services established by the governments of newly independent countries (2.4.3, 2.4.4, 2.4.7).

Medical mission shared with mission generally tensions between serving the poor and gaining the support of those in authority (2.3), difficulties in securing sufficient financial support (2.6), interdenominational rivalry, devolution of responsibility from Western partners to indigenous churches (2.5) and, associated with the latter, the financial burden of managing increasingly expensive hospitals. Medical mission created a huge network of hospitals and clinics worldwide, within a church infrastructure, and with overseas links, which faced new pressures as the C20th progressed. These pressures prompted searches for new sources of financial support and new relationships, particularly with newly independent governments and international donors, which will be further explored in chapter four and will be an important influence in constructing the conceptual framework and research questions for the current research. The political, economic and epidemiological pressures facing all health services will be dealt with in chapter three.

CHAPTER 3

CONTEMPORARY HEALTH SERVICE DEVELOPMENT

3.1 Introduction

In order to understand the context within which post-colonial CHSs (Christian health services) operate it is necessary to first, develop an awareness of their medical mission roots, from which they have evolved and which were explored in chapter two; second, recognise the influences which have affected the development of all contemporary health services, within both the state and non-state sectors, which are explored in this chapter; and third, understand how post-colonial CHSs have responded to the joint challenges of their mission inheritance and general health sector pressures, which will be explored in chapter four.

This chapter commences with two key factors that have affected contemporary health services in developing countries: major medical, technological, epidemiological and demographic changes and the attainment of national independence (3.2). Section 3.3 explores the extent of health status disparities between countries at different levels of development and the factors contributing to underperformance of the health sector in the countries at the lower end of the development scale, which is where CHSs are most prevalent. The chapter continues by identifying a series of international initiatives to improve health sector performance, which possibly have had an effect on the contribution of CHSs to the national health services in their respective countries (3.4).

3.2 Changes Affecting the Health Sector

CHSs do not operate in isolation from the rest of the health sector and are, therefore, likely to be affected either directly or as a consequence of the pressures affecting the state sector. This section first identifies the effects that medical and technological advances have had on the health sector (3.2.1). It next considers the impact of epidemiological and demographic changes (3.2.2) and finally the impact of national independence (3.2.3).

3.2.1 Medical and Technological Advances

The last half century has seen unprecedented improvements in global health, with the eradication of smallpox, the near eradication of conditions such as poliomyelitis and leprosy, and major reductions in the incidence of measles (World Bank 1993, WHO 1996). Disease patterns change as countries develop and become more affluent, from high mortality, but preventable, infectious and childbirth related diseases to the long term chronic conditions of old age. At the same time, the pressure on and consequential costs of health services increase because these latter conditions are more expensive to diagnose and treat (Berman 1995, Peters et al. 2002). This situation is exacerbated by the emergence of new diseases such as AIDS, improved diagnosis, and the discovery of new treatments, which are frequently expensive because of the technology and drug costs involved. In addition, as people become better educated, they become increasingly knowledgeable and have rising expectations of what a health service should provide. This 'social transition' (Peters 2005) increases the potential for health interventions which have only marginal benefit (Berman 1995) and increases pressure from the urban middle class for high technology and costly hospital services, often provided at the expense of the less affluent, creating an 'epidemiological polarisation' (Berman 1995) between the affluent and the poor (Green 2007).

3.2.2 Epidemiological Changes and Demographic Transition

The increased pressure on health services may be exacerbated because of the demographic transition, during which a population equilibrium with a high birth rate and high death rate, particularly amongst young children, is replaced by an imbalance when the child mortality rate reduces because of improved nutrition, improved water supply, immunisation, and health care provision, and the population rises exponentially because of the increased reproductive capacity. Eventually families reduce the number of their children to take account of the increased survival, until there is a return to equilibrium (Farmer and Miller 1991). At the stage of high birth rates, the population may increase by 2.5-3% per annum, which can result in a population doubling time of 24-27 years (Farmer and Miller 1991), causing pressure on maternal and child health services, which tend to have high unit costs. Additionally, almost half of the population are frequently under 15 years of age (UNDP 2008) which, together with an increasing elderly population, is likely to cause a high dependant-producer ratio, resulting in services for a high number of dependants being funded by a small number of producers (Green 2007).

3.2.3 Independence and the Establishment of National Health Services

The second half of the C20th saw many previously colonised countries gradually achieving independence, starting with India and Pakistan in 1947 and the first African countries a decade later. The governments of many newly independent countries in Africa and Asia were enthusiastic to provide comprehensive health services to their populations, both to demonstrate their newly found legitimacy and as a reward for public support during the struggle for independence (Semboja and Therkildsen 1995). In some countries, such as Zambia, their new constitutions provided for free health services to all, but between 1965 and

the1980s, despite initial improvements, services declined, particularly in rural areas (Turshen 1999). Reasons for decline included political instability, civil war, poor education, rapid population growth, limited economic resources, lack of preparation by the withdrawing nations and the inherited territorial boundaries which divided people from the same historic background (Kim and Kim 2008).

Experience has shown that only those countries that have been able to invest a minimum of 5% of their GDP in health have been able to sustain comprehensive state provision (Peters et al. 2002).

The situation was exacerbated by the disproportionately large share of available budgets allocated to urban prestige health facilities, some of which were established by governments in their enthusiasm to provide high quality healthcare (Hall and Taylor 2003), and some of which had been inherited from colonial administrations. According to Turshen (1999), at the turn of the millennium, Malawi and Tanzania, for example, still spent over 90% of their health budgets on hospitals, and Zambia allocated 40% of its recurrent resources to the university teaching hospital in Lusaka.

3.3 Health Sector Underperformance

As CHSs constitute a significant proportion of health service provision in some of the poorest countries (4.3), it is possible that some of the factors contributing to underperformance of the sector generally also apply to CHSs. Table 4.1 shows examples of countries at the lower end of the HDI (human development index), in which CHSs generally provide between 30% and 50% of total health services. It is likely, therefore, that CHSs are both affected by and contribute to the health status and health sector performance of their respective countries. This

section will examine the extent of health disparities between countries at different stages of development (3.3.1), and identify some of the factors contributing to health sector underperformance (3.3.2).

3.3.1 Extent of Health Disparities

Life expectancy and infant mortality are two common proxy measures of a country's health status and are combined with adult literacy in the compilation of the UNDP (United Nations Development Programme) HDI (Human Development Index). Table 3.1 illustrates substantial differences between the LEB (life expectancy at birth) of 75.7 years for people in high human development (HHD) countries, compared with 47.9 in low human development countries. The difference is even starker for IMRs (infant mortality ratios) which are 13 per 1,000 live births for HHD countries compared with 108 for LHD countries. Whilst there was little difference in the improvement rate in LEB between the two groups between 1970-5 and 2000-5, IMRs fell by 70% during the same period in the HHD countries, but by only 30% in the LHD group, indicating a much slower rate of improvement in the latter.

Countries' Human Development Status	Life Expectancy at Birth			Infant Mortality Rate		
	1970-5 (years)	2000-5	% Increase	1970 (per 1,000 live births)	2005	% Decrease
High	69.4	75.7	9	43	13	70
Middle	56.6	66.9	18	106	45	58
Low	43.7	47.9	10	155	108	30

Table 3.1   Life Expectancy at Birth and Infant Mortality Rates (UNDP 2008)

Such country comparisons can mask the health disparities within low and middle income countries, where under-5 mortality rates are on average 2.3 times higher amongst the poorest fifth of people than amongst the richest fifth (World Bank 2004). Children are

disproportionately represented amongst the poor because low-income families tend to have more children than richer families (UNICEF 2005). Castells (1998) referred to these poor and 'disconnected' persons, who are effectively excluded from participation in the global economy, as the '4th world'.

In addition to the availability and performance of the health sector, other factors outside the immediate control of the sector have powerful influences on health such as material deprivation, social marginalisation, education, food supply, housing, and environmental hazards. Action to improve these requires collaboration with other sectors (WHO 2003).

3.3.2 Contributing Factors to Health Sector Underperformance

Complex interrelated factors constrain poor countries from improving the health of their poorest people. The first factor is related to economic resources. Not only is the GDP per capita for low human development countries much lower than in the high human development countries, $US1,112 compared with $US23,986 (UNDP 2008), but the proportion allocated to the health service is much lower, typically less than 4% of GDP (UNDP 2004). Green (2007) affirmed that generally the lower the GNP, the lower the percentage of GNP spent on health. The consequence is that the governments of the poorest countries are the least likely to have available resources to support CHSs.

The situation was exacerbated first, by the global recession of the 1970s and 1980s, which resulted in low or negative growth rates in many developing countries, and second, by international debt repayments, which in Africa amounted to an average of US$43 per person in 1994 compared with US$35 spent on health and education (Turshen 1999). In real terms,

government health budgets in S-SA (Sub-Saharan Africa) and many Latin American countries decreased by 50% during the 1980s (Bennet 1992), with the consequence that, at a time when unemployment-related poverty and ill health caused higher demands on the health service, the sector suffered a severe funding deficit (Green 2007). A further set of factors relate to ineffective management, planning, and accountability (Gilson and Mills 1995, Tarimo and Webster 1996, Gov of PNG 2000, Collins et al. 1999, Mills et al. 2001, Peters et al. 2002), caused by failure of governments to:-

►   Plan services, set priorities and hold managers to account.

►   Effectively coordinate and regulate activities and resources.

►   Devolve operational management and train managers to be effective.

►   Monitor the quality of services provided and ensure accountability to service users.

►   Reallocate resources from the treatment of diseases and conditions which affect a minority of the population, to activities which prevent ill health and treat people in greatest need.

However, it is not just governments at fault. Even where postcolonial governments recognised the need for health sector planning, not everyone viewed this endeavour positively: Whilst governments might see it as a means of ensuring that resources were available for health workers to provide services for patients, doctors sometimes regard it as interference with their clinical freedom, and some administrators view it as a bureaucratic exercise requiring them to produce complex planning documents bearing little relationship to the needs or aspirations of their catchment populations (Green 2007).

A further cause of failure by health sector planners was the insufficient attention given to the assessment of future human resource needs, particularly bearing in mind the labour intensive nature of the work and the extended period necessary for training professional staff. For human resource planning to be meaningful, it must not just take account of epidemiological and demographic trends, but also of the government's planning priorities; the budget available to fund it; and predicted recruitment to the non-state sector (Green 2007).

The overall workforce deficit may be exacerbated first, by a shortage of health workers who are willing, motivated and committed to working in rural areas, where a high proportion of the poor live. An Indonesian study found, for example, that doctors needed to be paid several times their current salaries to work in remote areas (World Bank 2004). Second, the difficulties are often compounded by ineffective management: health workers in rural Honduran health centres were found to have worked only 77% of the possible days in the week before a team visit (World Bank 2004), and demotivation may occur due to lack of medical supplies, poor conditions of service, or inadequate supervision (Green 2007). This situation is often exacerbated by corrupt practices, such as health workers charging informal payments particularly to poor patients, misusing funds, or misappropriating supplies from free public clinics for use in fee-paying private clinics (World Bank 2004). The poorest communities may be underserved either because services intended for them are appropriated by privileged minorities (Parmar 1979) or because services are not as well provided in areas inhabited by poorer people or as responsive to their needs (Bennett and Gilson 2001, World Bank 2004, Khan et al. 2005). This tendency for the people in greatest need of services to be the least likely to receive them has long been recognised and was termed the 'inverse care law' by Tudor Hart (1971). More recently, an analysis of 30 countries showed that the use of

health care interventions is consistently lower among people living on less than $1 a day than among richer groups (World Bank 2004).

Despite the major contribution made by NSPs (non-state providers), including CHSs, data is poor on their size, number and activities in some countries and little regular interaction or joint planning has been established by governments because of the logistic difficulties of identifying who to involve and then bringing them together (Palmer 2006). The government's oversight role as policy developer and regulator of the location, type, quality, professional standards, service pricing, and possibly equity of services has generally been neglected (Green 2007, Peters et al. 2002). The reasons include first, the scattered nature of small scale providers; second, the lack of provider data; and third, the inadequacy of resources allocated for defining and monitoring measurable outputs (Palmer 2006).

3.4 International Initiatives to Improve Health Status and Health Sector Performance

Because of the general lack of improvement in the health status of postcolonial developing country populations, there have been three main thrusts to improve the performance of their health sectors: first, the Alma Ata Declaration and the promotion of PHC (3.4.1); second, the adoption of components of HSR (health sector reform) (3.4.2); and third, the MDGs (Millennium Development Goals) and the Global Fund to fight AIDS, Malaria and Tuberculosis introduced at the turn of the millennium (3.4.3). All of these initiatives had a potential influence on CHSs, particularly where it was necessary for governments to obtain the support of all health sector providers.

3.4.1 Alma Ata Declaration and Primary Health Care

By the 1970s it had become apparent that the morbidity and mortality of rural communities were failing to significantly improve, and in consequence, there was increasing awareness that the achievement of health needed more than physician-centred care in hospitals, many of which were geographically and financially inaccessible to the poorest communities, particularly in rural areas (Zakus and Lysack 1998, Hall and Taylor 2003). This recognition coincided with a review by WHO (World Health Organisation) of basic health care programmes to poor rural communities in China, Tanzania, Sudan, Venezuela and PNG (Hall and Taylor 2003) and collaboration between the WCC (World Council of Churches) and WHO (4.4), which inspired the joint WHO/UNICEF conference in Alma-Ata, Kazakhstan in 1978. At the conference, health ministers worldwide agreed a major policy statement on achieving 'Health for All by the Year 2000' through PHC.

The components of PHC emphasise the accessibility of services to everyone according to their need; that health is an individual and community responsibility; and that there should be an intersectoral approach that applies appropriate technology and is appropriate to the available resources (Tarimo and Webster 1996). After the Alma-Ata Declaration, PHC was enthusiastically embraced by African governments as a means of expanding health services (Turshen 1999), and became the official health sector policy of most developing countries (Green 2007). 'Alma-Ata' formalised a growing belief that basic health needs could only be met by greater involvement of local people themselves (Zakus and Lysack 1998), an approach consistent with Brinkerhoff's (2002) principle of subsidiarity, by which people's needs are best met by 'units of social life' closest to the individual, and only when needs cannot be met in this way should higher/larger units intervene (3.4.2.2). Thus decentralisation, as a vehicle

for increasing community participation, came to be seen as part of PHC, and in some minds a prerequisite for PHC. In their review of Health for All initiatives in 17 developing countries, Morley et al. (1989) concluded that political commitment to equity and community participation was a major factor in achieving health improvement. However, the achievement of genuine community participation turned out to be more complex than initially anticipated, with less predictable outcomes (Zakus and Lysack 1998, Morgan 2001). Nevertheless, it is now mainstreamed into developmental health thinking, as evidenced by the World Bank adopting the concept (Morgan 2001).

However, Green (2007) argued that the full potential of PHC was not realised for a number of reasons. First, there was confusion between the terms 'Primary Health Care' and 'Primary Care', which led to PHC being perceived as no more than the transfer of services from hospitals to community locations, rather than seeing both hospitals and primary care facilities as essential parts of a health service network. This misconception caused resistance from some professional and commercial interests. There was also political resistance because the emphasis on equity, participation and empowerment was seen by some as a threat to existing power structures. Much of this opposition was demonstrated by insufficient resources being allocated to fully implement the strategy.

One result of the resistance was the promotion of vertically led 'selective PHC', in which centrally driven interventions target particular causes of morbidity and mortality. Typically, these include GOBI (child growth monitoring, oral rehydration, breastfeeding and immunisation) and FFF (female education, family spacing and food supplementation) programmes. Although these initiatives may be effective in the short term, they have two

major limitations: First, because they are selective, externally imposed and fail to address the multiple causes of ill health, they are contrary to the essential ethos of PHC (CMC 1979 (a), WHO 2003, 2005). Second, without national and local capacity building these top-down, supply-driven approaches risk failure when political priorities or donor assistance change (UNICEF 2005). Furthermore, studies in Haiti, Thailand, Ghana and India failed to demonstrate that these selective approaches were any more cost-effective than comprehensive PHC (Turshen 1999). A more recent assault on PHC came from the World Bank (2004), which acknowledged the obvious benefits of PHC, but argued that the difficulty of staffing and maintaining a large network of primary health centres in remote areas make it more practical, until government capabilities improve, to ensure that poor people can reach government hospitals, than to take facilities to poor people.

The promotion of PHC tended to polarise supporters of community health, who emphasised the provision of accessible services for the poor, and the scientific and technological fraternity, who primarily served the more affluent. However, this generalisation oversimplifies the issue by overlooking the importance of referral hospitals in treating conditions which cannot be dealt with at community level and the need to optimise the use of resources by providing basic services in lower level facilities (Paterson 1993). This polemic was also expressed in the debate between the CMC (Christian Medical Commission)-WCC (World Council of Churches) and CHSs, which is dealt with in section 4.4. Both WCC (2005) and WHO (2008) have recently renewed their endorsement of PHC and the importance of an integrated approach to healthcare between health professionals, individuals and communities and between PHC, secondary and tertiary care. WHO also advocated adaptation of the approach to the needs of particular communities and broadens its focus by proposing

health sector reforms to improve equity, make health systems people-centred, improve leadership and develop public policy to promote and protect the health of communities.

3.4.2 Health Sector Reform

During the late 1980s, many countries worldwide were experiencing increasing pressures on their health services and declining health budgets. This came at a time when neo-liberal, market-driven economics were gaining worldwide popularity and spawned what came to be known collectively as HSR (health sector reform). It was believed by health economists that efficiency, equity and effectiveness could be improved by reducing the bureaucracy which was believed to be inherent in the direct provision of services by national governments, instead, encouraging decentralised government, enhancing the role of for-profit and not-for-profit private providers, and seeking new approaches to financial generation and management (Berman 1995, Collins et al. 1999).

Whilst countries with stronger economies were more able to view the introduction of HSR positively, developing country governments often viewed HSR as a standard package of imposed austerity measures associated with conditionality of international lending imposed by the World Bank (Turshen 1999, Collins et al. 1999) and a component of SAPs (Structural Adjustment Programmes) requiring public expenditure control (Sahn and Bernier 1995, Gilson and Mills 1995).

The implementation of HSR brings into sharp focus two political ideologies regarding the provision of health care: reliance on comprehensive state provision and the market, which assumes that consumers are able to make informed and rational choices and that providers

have free entry and exit into and out of the market, resulting in optimal efficiency (Hsiao 1995). Supporters of the second view, including the World Bank, first emphasise the need to avoid the inefficiency and lack of accountability to users believed to be characteristic of direct state provision by allowing market forces to determine the production and allocation of health care (Bennett 1992). In addition, they argue that state intervention should be restricted to ensuring the provision of public goods such as communicable disease control, reproductive health, health promotion and training; correcting for market failure; and providing a safety net for communities excluded from the private sector by geographical distance, lack of finance, lack of facilities, or social factors (Peters et al. 2002), which is often the prevailing situation for poor communities in developing countries.

The alternative view is based on two principal arguments: first, that consumer choice is limited because of imperfect information about price, location, quality and the benefits of alternatives, exacerbated by the technical nature of diagnosis and treatment (Moran and Batley 2004); and second, that health care provision cannot be left to markets, but is the duty of government as a component of social justice (Turshen 1999). Widespread adherence to this principle is demonstrated by the fact that every country has endorsed at least one treaty encompassing health-related rights (WHO 2003).

The following sections discuss three main components of HSR: government decentralisation (3.4.2.1), non-state health provision (3.4.2.2) and alternative sources of funding (3.4.2.3), all of which may increase the opportunities for CHSs to participate more closely with governments.

3.4.2.1 Government Decentralisation

Many newly independent governments inherited from their colonial administrations centralised structures which they in turn reinforced to consolidate their control over state structures. However, before very long it was realised that central government structures are remote and bureaucratic and there was a move towards greater decentralisation. It was believed that decentralised government would transfer decision making, resource allocation and service provision closer to the communities being served. Thus it was seen as an attractive policy not just to supporters of neoliberal economics but also to supporters of PHC (World Bank 1993, Gilson and Mills 1995), because as well as providing new opportunities for local income generation and increasing efficiency, it was seen as a means of improving equity and intersectoral collaboration (Green 2007, Collins 1994).

The expectation of improving public accountability, equity, efficiency and responsiveness to local needs by devolved control over resources has not always been realised, for four main reasons. First, some districts may lack the managerial capacity to manage health service provision as well as develop policy and ensure citizen oversight, which is likely to disadvantage those districts in their ability to access funds, exacerbating inequity between districts (World Bank 2004). Second, ministry officials often continue to exert power by 'quarantining' for specific purposes a proportion of districts' financial allocations, thus limiting the autonomy of districts (Kapiri et al. 2003). Third, assets are sometimes misused and priorities distorted by local elites (World Bank 2004). Finally, administrative costs are likely to increase because economies of scale are reduced and there may be duplication of services (Gilson and Mills 1995).

3.4.2.2 Non-State Health Provision

Arguments for the greater involvement in health provision of NSPs include beliefs about their greater managerial efficiency, flexibility and cheaper cost, as well as political preferences, including strong encouragement from the World Bank and UN agencies (Rosenbaum 2006). There is also an argument that the release of governments from some of their direct provider responsibilities enables them to give greater focus to other aspects of health care, such as the identification of health needs, regulation and quality assurance, some of which are dealt with later in this section.

NSPs comprise all providers outside the public sector, whether they operate on for-profit or non-profit principles, and include individual practitioners, firms, citizen-based organisations, NGOs and FBOs (faith based organisations) (Batley 2006). NGOs are often favoured by international agencies because of an assumption that they are better able to reach the poor (Lewis 2001). Although FPOs (for-profit organisations) and NFPOs (not-for-profit organisations) are generally differently motivated, there is considerable heterogeneity within each of the groups, thus whilst some NFPOs, for example, operate on a more or less commercial basis, others depend heavily on external subsidies (Bennett 1992).

In studies of five countries (Bangladesh, Malawi, Nigeria, Pakistan and South Africa), the non-state health sector was shown to contain a wide diversity of providers, ranging from corporations operating hospitals at one end of the continuum to small informal providers such as traditional healers and unqualified drug dealers, at the other end. Whilst NSPs consistently provided the majority of primary contacts with the health system overall, a higher proportion of the poor went to lesser qualified NSP practitioners than the non-poor (Palmer 2006). Other

studies have shown an inverse relationship between state and non-state provision, suggesting that either NSPs fill the gap left by the state (Bennett 1992, Mallya 2007) or the state and NSPs complement each other by recognising their respective strengths and weaknesses (Salaman and Anheier 1999).

Two particular problems often arise from the involvement of FPOs: first, a loss of specialist personnel from the public sector to more lucrative posts in the for profit sector, which may mitigate against cost reduction in the latter (Bennett 1992, Rosenbaum 2006); and second, activities are more likely to be focused on curative care, which is the most profitable part of the market, leaving the issues of prevention and long term care to the state (Turshen 1999).

The greater involvement of NSPs in health provision requires governments to establish effective coordination and regulatory mechanisms to facilitate the optimum delivery of services and avoid distortion, duplication or omission. Governments have sought to achieve this either through control systems or by facilitation through coordination, contracting or partnerships (Palmer 2006). Some governments attempt to control the provision of health care through accreditation, backed by monitoring visits, registration with medical councils or other government agencies, and ensuring compliance with regulations regarding the standards of premises and equipment. As shown in section 3.3.2, such regulation is often more by omission than commission, particularly in the for-profit sector. There are difficulties in defining measurable outputs and carrying out inspections of scattered small scale providers. There is usually little incentive for medical councils to enforce government regulation by exposing the failings of their members (Moran and Batley 2004, Palmer 2006). Current

experience suggests that control-orientated regulation is more likely to be effective when it is accompanied by incentives such as financial resources, training or government cooperation (Gilson et al. 1994, Palmer 2006).   Regulation of NGOs may be easier than of FPOs because of their willingness to work with governments, their similar motivations and the possibility of establishing NGO umbrella groups (Gilson et al. 1994), including CHAs (Christian Health Associations) (4.4). Such associations have attempted to negotiate the conditions under which NGOs and CHSs operate; as well as improving coordination, cooperation and sharing of resources and information; and participating in national policy making and planning on behalf of the NGOs and CHSs they represent.

Governments encourage the cooperation and involvement of NSPs by adopting various forms of contracting, which range from a service being funded and provided by government through the award of a one-off contract to an NSP at one end of the continuum to co-production involving various forms of joint funding and joint provision by government and NSPs at the other (Batley and Larbi 2004). Palmer (2006) added an additional distinction between long term contracts or subsidies, typically for service delivery in rural areas, which are characterised by a degree of interdependence, and newer contracts between government and NGOs for a specific project, using donor funds. The intentions of contracts are first, to specify the service to be provided and second to encourage competition, but in practice only a limited number of organisations compete for any particular contract (Moran and Batley 2004). Experience suggests that complete privatisation is rare. Governments are more likely to pursue two particular courses of action: first, to liberalise regulations, which facilitates growth of the private sector and second, to develop contractual relationships under which NSPs take

on operational roles but with the government retaining ownership and control (Bennett 1992, Batley and Larbi 2004).

Contracting out of non-clinical services has been relatively successful, but contracting out clinical services to the non-state sector is more problematic because, at least in the early years, systems of management information, pricing and negotiation were not well developed (Bennett 1992, Musgrove 1995). McPake and Banda (1994) identified some tentative initiatives using different arrangements for contracting clinical services to non-state organisations in Zimbabwe, South Africa, Mexico and Pakistan. They group these into three broad models:-

►   Block contract under which a specific amount is paid for an unquantified service.

►   Cost and volume contract under which a specific amount is paid for a quantified workload.

►   Cost per case/day/service contract under which a rate is fixed per item of work.

The second and third models require clear specification of outputs, but when outputs are difficult to specify, governments may prefer to contract services to NGOs rather than FPOs, because NGOs are perceived to be committed to high quality or because their religious or ideological orientation is thought to enable them to better serve certain groups (World Bank 1997). Moran and Batley (2004) refer to the informal trust-based arrangements under which governments pay block grants to CHSs as 'relational' contracts.

In many countries governments are developing partnerships as a more collaborative approach to encouraging the cooperation of NSPs (Collins et al. 1999). The less competitive aspect of

partnerships may be favoured by NGOs as morally superior to contracts, and by governments and international donors as a more effective means of achieving strategic direction; involving and coordinating multiple actors; and improving efficiency, responsiveness and public relations in public service provision (Brinkerhoff 2002). Brinkerhoff argues that the prime motivation for seeking a partnership is to access resources which the other partner has in greater abundance. These may include finance, skills, information, contacts or credibility. She develops this theme by defining two dimensions of partnership (box 3.1): the extent of mutual objectives, processes and interdependence; and the extent to which the partners maintain their own organisational identity through their core beliefs and values.

		Mutuality	
		Low	**High**
Organisational Identity	**High**	Contracting	Partnership
	Low	Extension	Co-optation and Gradual Absorption

Box 3.1 Dimensions of Partnership (Brinkerhoff (2002)

At one extreme, a true partnership may exist, with maximum mutuality and separate organisational identity, and at the other, one organisation is seen as an extension of a more dominant organisation, with little independent identity. Klijn and Teisman (2003) observed that although actors enter partnerships because they cannot achieve their objectives without resources which are possessed by other actors, there are a number of factors which militate against success, including different rules followed by, organisational structures, and values of

participating organisations; reluctance to relinquish control and demarcation lines between domains; and a lack of commitment to each other. Governments have increasingly established partnerships with CHSs, where they exist, through CHAs, as discussed in sections 4.4 and 4.5.3.

3.4.2.3 Alternative Sources of Funding

All health service providers, both state and non-state, must decide how their services should be funded. Governments can raise funds through taxation, although many of those in developing countries often have difficulty in mobilising adequate resources because revenues may be low due to high poverty levels and low levels of participation in the formal labour market (Green 2007, Bennett and Gilson 2001). An important part of HSR was the pursuit of more individually based sources of funding, including the payment of charges by users and health insurance, which are discussed in the following paragraphs. However, because of the limitations in the amount of revenue raised in this way, many developing country governments continue to rely on overseas aid, which is discussed in the final part of this section.

Several reasons have been given for the introduction or increase in direct user charges for health care. These include the reduction of public expenditure as a component of HSR (Collins et al. 1999); improving cost effectiveness by controlling costs and inessential demand (World Bank 1987, Green 2007); improving efficiency by using a differential payment system to deter patients from bypassing primary care clinics to go directly to the hospital outpatients' departments (Green 2007, Gilson and Mills 1995); and providing accessible funds for health facilities to improve services as recommended by the Bamako Initiative, agreed by African

Ministers of Health in 1987 (World Bank 1993). The difficulties CHSs have faced with this issue will be discussed in section 4.5.2.

The intention of the Bamako Initiative was to capture financial resources from users to be administered by locally elected committees for improving services, including the availability of generic drugs and giving incentive payments to health workers. This model was based on the premise that even poor households are willing to contribute towards the cost of more reliable and better quality health services (World Bank 1993). Experience has demonstrated both benefits and disadvantages to this approach. For example, when user fees were retained by health facilities in Cambodia to improve quality, there was greater utilisation of the facility by poorer patients than of those facilities that did not charge fees and had not experienced improvements (Gilson and Mills 1995).

However, other studies contradict this finding: when user fees were introduced at a District Hospital, also in Cambodia, the more affluent patients travelled greater distances to the hospital because of its better quality of care, but more than half of the patients claimed an inability to pay and a proportion of the poor and vulnerable were deterred from seeking care at the hospital (Jacobs and Price 2005). Services may be further distorted against unfavoured groups by local elites when communities take charge of health services, as a study in Benin, Guinea and Mali discovered (World Bank 2004). A Kenyan study demonstrated also that disparities widened between the more and less affluent districts (Gilson and Mills 1995).

Several studies have demonstrated that user charges disadvantage the poor, first, because payments represent a higher proportion of their income, which also tends to be less secure,

than that of the non-poor. Second, the poor are more likely to suffer chronic and disabling illnesses requiring long term treatment for which they have insufficient income to pay (Green 2007, Turshen 1999, Mills et al. 2001). Bennett and Gilson (2001) assert that the introduction of user fees has nearly always resulted in a decrease in service utilisation with a disproportionately negative effect on the poor.

In order to avoid the exclusion of poorer patients from health care, various systems of subsidising their health care have been attempted, including the provision of vouchers, reducing or exempting poor patients from the full cost and health insurance. Health insurance is dealt with later in the section. Two particular difficulties are encountered in providing subsidies, including vouchers: first ensuring that the level of subsidy is sufficient to achieve its intention of not excluding poor patients and second, that they benefit the genuinely poor. (Gilson and Mills 1995, World Bank 2004). A study in Thailand, for example, found that one third of beneficiaries were not poor, and half of the poor did not benefit (World Bank 2004).

Reasons why the poor fail to benefit from subsidies might include a systematic bias against poor people, as occurred in Zimbabwe, where earnings had to be verified by a social worker, who was located up to forty kilometres away (Turshen 1999); the application of criteria in a way that causes stigmatisation; or a financial disincentive to the health facility to award exemptions (Bennett and Gilson 2001). Thus the determination and application of the criteria for exemptions are not matters of administrative detail, but fundamental policy issues because of their effect on equity (Green 2007). A further study in Cambodia demonstrated greater impartiality when an equity fund is administered by a well respected group not involved in the management of the health facility, such as the local Pagoda Committee (Jacobs and Price

2005). There is thus a balance to be achieved between the positive and negative effects of user charges, which must be weighed against the level of revenue generated and the administrative costs of collecting them, particularly in poor rural areas.

Because of the potential high cost of health treatments and the disadvantages of individual user charges highlighted in the paragraphs above, health insurance has been promoted in some countries as a means of pooling the risk. However, several difficulties have been encountered in implementing commercial health insurance in developing countries. Because insurance schemes assume low risk and ability to contribute, they exclude many people resulting in a two-tiered system that includes the affluent minority, but excludes the poor majority (Hsiao 1995). Additional problems in some countries, particularly in Africa, are that health service coverage is poor and a high proportion of people earn low incomes or do not work in the formal sector (Turshen 1999). National Insurance systems funded by employers and employees and based on income rather than health status suffer similar problems because of the low proportion of the population in formal employment (Green 2007).

Further disadvantages of commercially operated schemes are the high administrative costs (Hsiao 1995), the potential for over-provision of easily provided well remunerated services (Green 2007) and two examples of market failure: first, adverse selection by well informed consumers, which militates against the intention of risk pooling, and second, moral hazard, in which patient demand is increased to a point where its marginal cost outweighs the marginal benefit (Hsiao 1995). Some countries have implemented HMOs (health maintenance organisations) as a means of correcting market failure by accepting pre-payments to provide all necessary services, including preventive services, to a defined population, thus providing

an incentive to prevent illness (Hsiao 1995). If everyone contributes, it avoids adverse

selection, but this is problematic for poor communities, members of which are unable to make

the pre-payments.

Because of the difficulties in raising funds from other sources, as illustrated in the foregoing

paragraphs, many developing countries depend on aid from better resourced countries, in the

form of grants, loans, equipment, supplies or technical assistance, without which many state

run services would seriously deteriorate (Semboja and Therkildsen 1995). However, loans

and grants usually reflect the donors' interests and concerns (Gilson and Mills 1995), and

come with conditions on utilisation, monitoring and reporting (Green 2007), resulting in

dependence and deference to donors (Sogge 2002), and a reduction of accountability to local

citizens. This may compromise state sovereignty (Gilson et al. 1994, Sogge et al. 1996), for

which Wood (1997) coined the phrase 'franchise state'. In some instances, competition and

resentment can develop between governments, which may see themselves as the more able

and legitimate providers, and NGOs and FPOs, which may appear to be favoured by

international donors (Rosenbaum 2006).

To overcome some of these problems, attempts have been made to provide funding through

partnership arrangements between donor agencies and state and non-state agencies within

specific developing countries. WHO, for example, has initiated a number of partnerships with

other health agencies and NSOs, including its Global Programme on AIDS in 1986 and the

Roll Back Malaria (RBM) programme in 1998. In the mid-1990s, donors transferred their

support to a new UNAIDS programme partly because of their demand for a more multi-

sectoral approach, and also because the RBM programme, which had brought together over

90 diverse organisations as partners, was increasingly suffering from a lack of clarity in relationships and responsibilities (Yamey 2002). Further problems with these PPPs (public/private partnerships) include the tension between the donors' needs for quick results and the need for longer term capacity building in countries with weak health systems, and the lack of coordination with other initiatives such as SWAps (Sector Wide Approaches), and the World Bank's poverty reduction strategies linked to debt relief for HIPCs (heavily indebted poor countries) (Yamey 2002).

SWAps emerged in the early 1990s because of increasing concerns that traditional project oriented approaches and vertical disease specific programmes (3.4.1) were tending to result in fragmentation and duplication of effort, as well as potentially weakening government capacity and local ownership. The intention was that funds from all donors are put into a 'common basket' and allocated to support the respective government's strategic plan. Zambia, for example, adopted a SWAp in 1993, but it has not achieved the anticipated success principally because several donors, including the Global Fund and PEPFAR ((US) President's Emergency Plan for Relief), have not channelled their funds through the SWAp basket, and continue to operate their own separate budgetary and accounting systems (Chansa, et al. 2008).

3.4.3 'Millenium Initiatives'

By the arrival of the year 2000, it was acknowledged by international health and development agencies that the target of 'Health for All by the Year 2000', declared at Alma Ata in 1978 (3.4.1), had not been reached. The 2001 Human Development Report (UNDP 2001) summarised some of the factors contributing to the continued high morbidity for poor people.

Of the 4.6 billion people in developing countries, 1.2 billion people live on less than $1 a day; 2.4 billion lack access to basic sanitation; 968 million lack access to improved water sources; 854 million are illiterate; 325 million children do not attend school and 11 million children under 5 years die each year from preventable diseases. Lee Jong-wook (2005), the then Director-General of the World Health Organisation, claimed that seventy million mothers, their newborn babies, and numerous children, who represent the potential for societies' future wellbeing, were excluded from health care.

Reduce by half the number of people who:-
      Live on less than $1 a day
      Suffer from hunger
      Are without access to safe drinking water
Achieve universal completion of primary schooling
Achieve gender equality in access to education
Reduce maternal mortality ratios by three quarters
Reduce under-five mortality rates by two thirds
Reverse the spread of HIV/AIDS, Malaria and other major diseases
Develop a global partnership for development

Box 3.2 Millennium Development Goals (UNDP 2001)

In 2000, 189 countries endorsed the UN Millennium Declaration, which set out specific, quantified and monitorable goals for development and poverty eradication by 2015 (box 3.2). Some of these address health issues directly and others, such as those aimed at poverty reduction and improved education, address health issues indirectly. The links between poverty, education and health are well established and a commitment to improving health necessitates a commitment to the other two (Braveman and Gruskin 2003). Recognising this, the World Bank, since 1999, has required plans for reducing poverty in the form of PRSPs (Poverty Reduction Strategy Papers) from HIPCs seeking debt relief (Stewart and Wang 2003). It soon became apparent that the results were not matching the good intentions and

that at the current pace, most regions of the developing world would not reach the MDGs (Millennium Development Goals) by 2015 (World Bank 2004). This situation has been exacerbated by the recent global economic crisis which has resulted in decreases in financial aid to poorer countries. Thus, despite some successes such as the overall increases in primary school enrolments and decreases in under-5 child mortality, progress towards the goals has slowed and even reversed in some areas (UN 2009). Whilst there is a need for political commitment to pro-poor economic growth, redistribution of resources and social protection policies within the countries concerned, the UN Secretary General stressed the need for additional international assistance to achieve the MDGs (Ki-moon 2009). However, there is an alternative view held by some, including the poor themselves, that sustainable poverty reduction is only achievable by a change in the economic order which facilitates what they perceive as a more equitable approach to international trade and debt (Taylor 2003, Taylor 2004). The necessity of including faith groups in initiatives to achieve the goals is increasingly recognised, and is discussed further in section 4.5.1.

The Global Fund was introduced in 2002 as an international PPP to fight AIDS, Malaria and Tuberculosis, which together account for six million preventable deaths annually (Global Fund 2007). In an attempt to avoid the mistakes of previous initiatives, the Global Fund allocated over one third of its funds towards capacity building, aimed at in-country ownership, and attempted to establish a clear management process involving governments and CSOs (civil society organisations), including FBOs, at all levels. Up to 2009, 600 grants have been made to 140 countries, totalling over US$10 billion. 56% of allocated funds have been spent by government institutions, and 32% by NGOs (Global Fund 2009).

3.5 Summary

This chapter commenced by noting the major improvement in health status which has occurred worldwide due to demographic, epidemiological, medical and technological changes and the impact that this and national independence have had on the health sector (3.2). These changes have also had consequences for CHSs specifically, which are discussed in sections 4.2 and 4.4. Section 3.3.1 highlighted the disparities in health status within and between countries at different stages of development. Many of those countries with the lowest health status are those in which CHSs provide significant proportions of the health services. Whether this fragmented approach to health service provision contributes to underperformance of the sector, or whether CHSs are improving the situation in areas where government services are either absent or ineffective is explored in chapter 4. The discussion in this chapter indicates that the problems might not be so much that of the presence of a range of providers, which is encouraged by HSR (3.4.2.2), but lack of joint planning, weak regulatory systems and resource scarcity (3.3.2).

Three major initiatives to improve health status and health sector performance were explored in section 3.4. The first of these was the general endorsement of PHC (3.4.1) as a means of achieving 'Health for All by the Year 2000', intended to provide a more accessible health resource to people who are not easily able to access hospitals for either financial or geographical reasons. Whilst both governments and CHSs have supported the PHC concept, often enthusiastically, there has also been political and professional resistance, mainly because it was perceived as a threat to the *status quo*, rather than recognition that both PHC and a range of health institutions are necessary as part of a comprehensive network.

Although there was, and still is, widespread implementation of PHC, it has never reached its full potential, and has been weakened by vertical programmes, which were argued to provide quicker and more cost effective results, although this assertion has not been clearly demonstrated. The vertical approach was again adopted for the 'Roll Back Malaria' programme in 1998 (3.4.2.3) and the Global Fund in 2002 (3.4.3), both of which, despite their attempts to work with local partners, could be seen to undermine the coordinated approach attempted by SWAps (3.4.2.3). Opponents of vertical approaches argue that sustainable health improvements are unlikely to be achieved without the participation of local people themselves (3.4.1) and tackling the root causes of ill health, particularly material deprivation and social marginalisation, which require collaboration with other sectors (3.3.2, 3.4.3).

The prevalence of HSR as the favoured approach to improve health sector performance came about as a manifestation of a universal change in political ideology characterised by reducing state involvement in direct service provision, government decentralisation and promoting alternatives to state funding (3.4.2). The first and second of these presented opportunities for CHSs to develop relationships with local government, with whom they can negotiate contracts or partnerships. This is further explored in sections 4.3, 4.5.2 and 4.5.3. Many of the problems faced by governments in funding their services (3.4.2.3): in particular the difficulty of implementing user charges without discriminating against the poor and introducing insurance schemes in communities in which a high percentage of people have low or irregular incomes have been identified in this chapter. These issues are explored with respect to CHSs in sections 4.5.2 and 4.5.3.

The final initiatives discussed in this chapter are those introduced at the turn of the millennium, of which the global fund has already been mentioned. The other major initiative was agreement on the MDGs (3.4.3), which have several positive features. First, as well as tackling specific health factors such as maternal and under-5s mortality, they also address the causes of ill health such as poverty and lack of education. Second, they define monitorable targets, and thirdly they were supported by 189 nations in the UN Assembly. Although, current evidence indicates that the goals are unlikely to be achieved by 2015, significant progress has been made.

The role of CHSs in the initiatives identified in section 3.4 will be further explored in chapter 4 and will assist in the formulation of the conceptual framework for the current research (5.2).

CHAPTER 4

POST-COLONIAL CHRISTIAN HEALTH SERVICES

4.1 Introduction

This is the last of three chapters tracing the development of CHSs (Christian health services) from their historical origins to the present day. Chapter 2 explored the introduction and development of medical mission as the precursor of present day CHSs and chapter 3 outlined the main milestones in the development of contemporary health services. This chapter draws on this background, together with the recent history of CHSs, particularly from the WCC (World Council of Churches) perspective, to examine their current position and some of the challenges they face.

This chapter commences by considering the effect of national independence on CHSs (4.2) and the extent of CHSs (4.3), followed by a summary of the outcomes of a series of investigations into the current and future role of CHSs carried out over a period of 40 years by the WCC. It draws particularly on the work of McGilvary (1981), Asante (1998), CCIH (Christian Connections for International Health), and ARHAP (African Religious Health Assets Programme) (4.4). The chapter concludes with consideration of four sets of issues faced by contemporary CHSs, namely the role of religion in their operations, funding, coordination of CHSs and their relationships with governments, and the socio-economic orientation of CHSs (4.5).

4.2 National Independence

Section 3.2.3 referred to the gradual achievement of independence by many previously colonised countries in the C20th starting with India and Pakistan in 1947 and later the African nations. Because many of the leaders of the newly independent governments were educated in mission schools, they were often appreciative of the churches' contribution to health and education provision (Schulpen 1975, Kim and Kim 2008). However, some, particularly in Africa, were initially hostile to mission health services. This resulted from anti-religious feelings and a trend towards secularisation, combined with many governments' belief that their legitimacy depended on fulfilling their pre-independence pledges of providing free social services to everyone. In some countries (e.g. Zaire), governments imposed restrictions on the involvement of religious organisations in society (Stanley 1992). In other countries health and education services were nationalised, although there was generally a less restrictive attitude towards CHSs in remoter areas (Schulpen 1975, Semboja and Therkildsen 1995).

Section 3.2.3 highlighted some of the difficulties that constrained post-colonial development, including political instability and in some countries civil war; section 3.3.2 identified some of the causes of health sector underperformance including inadequate accountability, management and regulation; and section 3.4.2 discussed the impact of HSR (health sector reform) including the move to decentralised government and the implementation of structural adjustment policies.

Missions were often equivocal towards the emerging independent governments. Relations with colonial governments had sometimes been difficult and many missions had supported the independence movement (Schulpen 1975), and were supportive of the emerging governments

(Kim and Kim 2008). However, as the democratic and socialist aspirations of many African countries evolved into authoritarian regimes, the churches found themselves in the invidious position of incrementally condoning authoritarian policies, as occurred in the churches' support of the 'Ujamaa villagisation' programme after the 1967 *Arusha* Declaration in Tanzania (Schulpen 1975, Jennings 2008). In some countries the churches' support later turned to opposition: in Malawi, for example, the churches caused Hastings Banda, who had in 1971 been declared 'President for Life' of the one-party state, to resign in 1994 (Ross 1998).

4.3 Extent of CHSs

This section briefly refers to the historical context of CHSs, then explains the difficulty of quantifying their extent and finally notes the dearth of research and literature on their work. As shown in chapter 2, many of the missionaries arrived at their overseas destinations over 100 years ago, often predating the formation of the states concerned. They worked principally in rural areas, serving the most vulnerable populations (Gilson et al. 1994). From the end of the C19th medical missionaries established health services (2.4.2) in areas which usually were not served by other health service providers because the populations were sparse and scattered over wide areas, with inadequate communication and access, and where residents had insufficient income to pay for services, resulting in their dependence on external support (Asante 1998). By contrast, colonial governments tended to concentrate their health services in their administrative centres. At the time of independence, missions provided the majority of the health services in many countries, particularly in Africa (Jennings 2007).

Marshall and Van Saanen (2007) affirm that there is no single database of faith based health institutions. Therefore, in order to build up a general picture (Table 4.1), it was necessary to draw on a number of references. It is recognised that the table has three imperfections. First, the sources were compiled by different authors in different contexts and are not strictly comparable. Second, there is a problem of definition: some references count the number of beds and some count the number of facilities, which skews the proportions towards either services with large urban hospitals, or services with networks of small rural facilities. This problem is compounded by not taking account of bed occupancy or clearly defining the term health facility.

Country	CHS as % total NHS	Number of CHS Hospitals	CHS beds as % total NHS beds	Health Centres Dispensaries	Training Schools
Ghana	40	49	33	79 HCs	5
Kenya	40	14 (34%)	20	20 HCs 180 Dsps (Prot)	
Lesotho	40	9		75 HCs	4
Malawi	35	18 + 10 Rl Hls		120	6
Nepal			26		
Nigeria			33		
PNG	45				
Tanzania	48	(40%) DDHs 17			
Uganda	50	44	20	308	
Zambia	30	30 + 66 Rl Hls (53%)			
Zimbabwe	45	79		46	
Key Column 2 – Number of CHS services as a percentage of national health services Column 3 – Number of CHS hospitals. Figures in brackets are CHS hospitals as a percentage of all hospitals. Rl Hls are specified rural hospitals, which have lower medical and technical support than hospitals. DDHs are Designated District Hospitals. Column 4 – Number of beds in CHS facilities as a percentage of beds in all facilities. Column 5 – Number of CHS health centres (HCs) and dispensaries (Dsps). Prot = Protestant. Column 6 – Number of CHS health worker training schools.					

Table 4.1 Examples of Extent of Christian Health Service Provision
(World Bank 1993, Gilson et al 1994, Semboja and Therkildsen 1995, Asante 1998, Lewis 2001, Gov PNG 2001, Green et al 2002, Mallya 2007)

Third, the references are drawn from a 15-year period and the situation is dynamic, with established health facilities closing or transferring their ownership and new ones opening. Acknowledging these imperfections the table is useful as a general guide, because the extent to which more accurate figures can be obtained through the current research is unclear. Table 4.1 suggests that CHSs constitute a substantial proportion of the total health provision in many countries, reaching over one third in some, particularly in S-SA (Sub-Saharan Africa). As well as providing dispensaries, health centres and hospitals, some of which are designated by the respective government as district referral hospitals, CHSs provide health worker training schools.

However, despite their significant contribution and long history, not only are CHSs often ignored in government health planning and funding processes (Green et al. 2002), and disregarded in official documents, but there is little research or discussion on their contribution, including their relationship and interface with other health institutions or with the public sector (Green et al. 2002, Grundmann 2005, Marshall & Van Saanen 2007, ARHAP 2007). It was not until the late 1990s that development studies and development agencies started to pay attention to the contribution of FBOs (Faith Based Organisations) (Rakodi 2007, Clarke 2008, and see discussion in 4.5.1).

4.4 Reviews of the Role and Operations of CHSs

During the initial post colonial period, when Western churches were transferring control to churches in the newly independent states (2.5), there was a high level of optimism over the prestige institutions the newly autonomous churches were inheriting. However, the transfer was accompanied by a reduction in expatriate personnel working in church education and

health services, which also resulted in a decline in overseas financial support. This occurred at a time when many newly independent governments were working towards the state provision of comprehensive health services. The medical and technological advances and epidemiological and demographic changes, discussed in sections 3.2.1 and section 3.2.2, did not just increase the costs of providing CHSs, but the consequential increased professionalisation of the service was perceived by some churches to be causing a separation between themselves and their CHSs. These factors prompted the WCC (World Council of Churches) to question first, whether CHSs continued to have a role; second, if so what was the nature of the role; and third, whether CHSs were sustainable, particularly as there had been a steady decline in the number of CHS facilities worldwide (McGilvray 1981). This concern over the future of CHSs prompted the WCC with the German Institute for Medical Mission at Tübingen in Germany to initiate the Tübingen 1 and Tübingen 2 consultations in 1963, the National Surveys, Satellite Consultations and establishment of the CMC-WCC (Christian Medical Commission).

The Tübingen Consultations (appendix 1.1) marked a significant and long overdue landmark in the evolution of CHSs because there had been no major discussion by the churches on their health ministry since the World Missionary Conferences at Edinburgh in 1910 and Tambaram in 1938 (Newbigin 1965) (2.5). The National surveys of church-related medical programmes (appendix 1.2) were initiated at the end of 1963 to identify the relevance of CHSs to the work of the churches and the health programmes of the government and other agencies. Until this time, CHS facilities operated independently of each other with no common identity. Little was known about where they were located or what they did (McGilvray 1981). Three particular initiatives emerged from the Tübingen 1 Consultation and National Surveys: the

establishment of CHAs (Christian Health Associations), a series of satellite consultations and the formation of the CMC (Christian Medical Commission)-WCC and its cooperation with the WHO (World Health Organisation).

The 1960s saw increased impetus to the formation of CHAs in several African countries, some of which represented all denominations, while others separately represented Catholics and Protestants (Green et al. 2002). In Malawi, for example, the Private Hospitals' Association, and later CHAM (Christian Health Association of Malawi) brought together 26 different church organisations. As in many other developing countries, the CHA provided a common voice and a means to develop cooperation and coordination, with each other and with the government, in planning, service provision and training, which led to a greater awareness of national needs and increased emphasis given to community health and preventive services (McGilvray 1981). A survey carried out in 1999 demonstrated that the responsibilities of African CHAs included negotiating funding agreements with their respective governments, provision of specialist advice and engagement in policy formulation, which consolidated the position of CHSs and strengthened their negotiating position with their respective governments (Green et al. 2002).

The satellite consultations launched in 1967 mainly dealt with theological issues related to of the churches' understanding of healing and the CMC-WCC (appendix 1.3) was established in 1968 to investigate the most appropriate ways for the churches to fulfil their healing role and promoting national coordination of church-related medical programmes (McGilvray 1981, WCC 1990). This resulted in the formation of a Joint Standing Committee in 1974 to work cooperatively with WHO, the major outcome of which was the acceptance by the World Health Assembly in 1975 of the principles of PHC (3.4.1). The resistance of the general

health sector to the implementation of PHC was discussed in section 3.4.1, but the promotion of PHC by the CMC-WCC caused a major rift with the churches because of a failure to recognise the importance of secondary care in supporting PHC programmes (McGilvray 1981, Paterson 1993).

Because of the continued concern over the future of CHSs, two further investigations were conducted under the sponsorship of the WCC. The first (appendix 1.4), was the investigation of the sustainability of 43 church hospitals in nine African and two Asian countries initiated in 1995 that identified that the thriving hospitals were likely to be more effectively managed, less likely to be located in economically deprived areas, provided a better service and were more likely to give fee exemptions to poorer patients (Asante 1998). The second (appendix 1.5), was a questionnaire survey conducted in 2000 by CCIH (Christian Connections for International Health) that reiterated many of the concerns identified in the earlier WCC reviews. The overall picture derived from these studies is one of an increasingly expensive health service which is unaffordable by the poorest patients, facilities out of touch with their local community, failure to cooperate with the government sector and in which the least satisfactory hospitals are badly managed and lack a shared sense of direction with their Church organisations, both in-country and overseas. In some cases, respondents complained that their Church was not only failing to financially support its health facilities, but rather tended to see them as a source of income. Many of these issues will be further explored in the current research. Finally, the ARHAP (African Religious Health Assets Programme), established in 2002, is taking a different approach (appendix 1.6) by establishing what religious health assets exist and what faith based initiatives do best.

4.5 Key Issues of CHSs

There are four key interrelated and overlapping issues which emerge from the literature on, and reviews of, CHSs, which are discussed further in the following sections and which provide the basis for the construction of the conceptual framework (5.2) and research questions (5.3). These are religious issues, including the relationship between CHSs and their respective denominational church organisations (4.5.1); the change in levels of funding of CHSs by traditional partners and their search for new sources of finance (4.5.2); coordination of CHSs and their relationships with governments (4.5.3); and the socio-economic orientation of CHSs (4.5.4).

4.5.1 Religious Issues

This section deals first with the relation between religion and development of which health development is a part. This is followed by an exploration of the factors associated with the distinctiveness of CHSs and the tensions experienced by churches in relation to the operation of their increasingly professionalised health services. Finally, the changed relationship between CHSs and their Western church partners is considered.

The development movement has until recently ignored the potential contribution of religious organisations, for which Rakodi (2007) suggested a number of reasons. First, their religious beliefs and practices are seen by critics to be incompatible with modern scientific knowledge and believed to constrain social change. Second, there are interdenominational tensions. Third, religious organisations are seen to be economically irrelevant and their contributions difficult to measure. Three reasons are given for the recent change in attitude. First, the 'secularisation thesis' which purported that, as societies develop and modernise, the increase

in rational thinking typically associated with the European Enlightenment would erode religious adherence and in consequence reduce the relevance of religious organisations has been refuted (Oliver et al. 2006).   On the contrary, religion continues to be very much entwined with people's community life in many countries (Oliver et al. 2006, Jennings and Clarke 2008), not just in developing countries, but also in parts of the Western world, principally North America (Hovland 2008). Second, the failure of secular development agencies to achieve the desired reductions in poverty (Haynes 2007) and recognition by governments and development organisations of the need to harness the capacities of FBOs in achieving the MDGs (Taylor 2005, Jennings and Clarke 2008). Third, propagation of the new liberal economics since the 1980s (see discussion on HSR in 3.4.2), accelerated by legislation in the USA in 2001 to end discrimination against FBOs in the award of government contracts. Together these provided opportunities for FBOs to positively respond to privatisation policies (Clarke 2008). Consideration will be given in the current research as to whether CHSs took advantage of this opportunity to seek new sources of donor support or seek more positive relationships with their respective governments.

This more positive approach towards FBOs was marked by a series of conferences at the turn of the millennium between faith leaders and donor agencies organised by the World Bank President and the Archbishop of Canterbury (Haynes 2007, Clarke and Jennings 2008) and led to the formation of WFDD (World Faiths Development Dialogue), which seeks to engage world faiths in the development process (www.wfdd.org.uk). The activities of religious extremists such as the Al-Qaeda attack on the World Trade Organisation buildings in 2001 also raised the profile of religion in the collective consciousness, albeit for negative reasons (Haynes 2007, Clarke 2008).

A number of potential positive influences of religion in development can be identified, including their community roots and networks (Goold et al. 1998) and encouragement of both positive interpersonal relationships and moral behaviour (Rakodi 2007). Rakodi (2007), however, contended that there is a lack of evidence to confirm whether or not religious values encourage particular types of behaviour. It must also be recognised that there is great heterogeneity between different FBOs, and their approach to development. Clarke (2008) advanced two taxonomies, the first of which categorises FBOs according to their form of social engagement. Two categories of particular relevance are faith-based charitable or development organisations, and missionary organisations. The former, such as Caritas and World Vision, directly fund or manage development programmes, including those in the health sector. The latter group have a commitment to the provision of social services as well as actively promoting their faith. The second taxonomy categorises FBOs according to the deployment of their faith in their humanitarian or development programmes as follows:-

►   Passive: faith is subsidiary to broader humanitarian principles.

►   Active: faith is the explicit motivation for action, but there is no overt discrimination against non-believers.

►   Persuasive: faith is the explicit motivation for action, and it seeks new converts.

►   Exclusive: faith is the explicit motivation for action, and it may act against rival faiths.

Development FBOs, such as Caritas, tend to be passive with respect to their faith basis, whereas missionary organisations tend to be active and are often closer to the poor because of their longer-term presence in local communities and more modest lifestyle. However, the distinctions are not always clear, particularly between the active and persuasive categories, which may cause a difficulty for donors attempting to identify whether or not development

funds are used for seeking converts (Clarke 2008). Western official donors have traditionally been hesitant about the relationship between faith and development, regarding religious leaders as being resistant to development programmes which they identify as secular and threatening to their traditional moral values (Clarke and Jennings 2008). Donor wariness of FBOs remains a strong undercurrent of the development discourse and generally restricts their engagement to the select few that fall within the active and passive spheres of action (Clarke and Jennings 2008) and some governments take an apparently ambivalent approach by enlisting the assistance of FBOs in social welfare provision whilst maintaining a distinction between faith and society (Jennings and Clarke 2008).

Many Christian agencies face a dilemma between their commitment to holism on the one hand and separation of their evangelistic and development roles on the other, partly because of a desire to disassociate themselves from the perceived negative colonial images of mission and partly for practical reasons related to increased specialisation within development agencies and increasing their appeal to donors. Whilst some Christian agencies view their service and development roles as inseparable from evangelisation because of their perceived mandate to offer the gift of salvation, other Christian agencies see service and development without the accompaniment of evangelisation as their faith-inspired mission (Taylor 1990, Taylor1995).

Donor concern led the Norwegian Mission Society, for example, to clearly separate its development work from its mission programmes (Hovland 2008). Whilst this has the benefit of demonstrating that their development funds are not being used for evangelisation, at least not directly, it has the unintended consequence of undervaluing the extent to which religion is

embedded in the culture and community life of many communities, particularly in rural areas (Linden 2008). Moreover, it can be argued that to separate social provision and evangelism undermines the very value base that might contribute to the success of a development programme (Hovland 2008). Because of the centrality of religion in people's lives in most developing countries, referred to by ARHAP (4.4), and the respect accorded to religious leaders and FBOs, they are in a strong position to raise awareness and influence behaviour (UNICEF 2005), including on health issues.

McGilvray (1981) raised the question of whether there are factors which distinguish health care provided by CHSs from that provided by secular institutions. He argued that Christian doctors not only experienced difficulty in defining their distinctiveness, but resented having to justify what they believed was self-evident. Although the literature on this topic is limited, a number of commonalities can be identified, many of which apply to other FBOs and distinguish them from comparative secular organisations (Jennings and Clarke 2008). First, Christian health facilities can usually be identified as such from either their name; the presence of a chapel; religious services; crosses, crucifixes or religious texts on the wall and/or the employment of largely Christian staff (Latourette 1954, Wilson 1966, Schulpen 1975, Asante 1998). Section 2.4.5 explored the tension which developed between the often competing medical and evangelisation roles of medical missionaries during the late C19th and early C20th. There continues to be a question of whether this 'religious' environment is simply the motivation for, and the means of, providing a service or is intended as a method of seeking converts: in other words, whether they meet the criteria of Clarke's (2008) active or persuasive categories.

Second, it is suggested that the vocation of health workers, the support they receive, their attitude towards their work and the atmosphere of the hospital are considered to be the main determinants of a hospital's healthcare ethos (Church of England 2000). The particular values attributed to Christian healthcare include love, compassion, trust and treating everyone with dignity (Wilson 1966, McGilvray 1981). It is suggested that this is most obvious when care is given to people who may not be able to access care from elsewhere because of an inability to pay, or are discriminated against because of their age or ethnicity, or their condition carries a stigma such as with leprosy or HIV/AIDS (Asante 1998, WCC/DIAFEM forthcoming 2010). Christian institutions are also seen as providing an environment for patients to die with dignity rather than death being perceived as a failure to be aggressively fought (WCC 2005).

Third, Asante (1998) asserted that the spiritual aspect was perceived to be the most distinctive element of Christian healthcare and observed that the hospitals with the 'best practice' recognised the spiritual nature of everyone and encouraged a spiritual dimension into their care. This was accompanied by a commitment amongst the staff towards helping each other to grow spiritually through prayer, Bible study and weekly staff meetings. The tension between the scientific approach and the spiritual, however, continues to surface. The issue of whether churches' healing ministry should be through prayer and anointing or by the provision of specialist health services was addressed, but not satisfactorily resolved, by the Tübingen consultations and subsequent CMC-WCC initiatives (McGilvray 1981) (4.4). The advance of science and technology resulted in a tendency for the spiritual dimension of healthcare to be overlooked, but the WCC (1990) added spiritual wellbeing to the physical, mental and social dimensions previously proposed by WHO (1948) and suggested that there is increased interest in this dimension of healing. The WCC (2005) further argued that prayer, laying-on of hands,

divine healing, rituals involving touching and tenderness and sharing the Eucharist can have a dramatic effect on healing (WCC 2005).

Fourth, churches often insist that healthcare provided by their CHSs must be consistent with their moral principles (Asante 1998), which can lead to tensions particularly in relation to reproduction, life and death (Lambourne 1983). The importance of controlling the spread of HIV infection has brought the issue of condom use into sharper focus. Although many churches have changed their attitude to condom use from resistance to support (Haynes 2007), some (particularly Catholic agencies) are still unwilling to participate in government campaigns to promote the use of condoms (Green 2007). Some churches continue to label people living with HIV/AIDS as 'sinners' undeserving of forgiveness and ART (Anti-Retroviral Therapy) is sometimes compromised by denominations which promote a belief that cure can be achieved through prayer and faith without any medical treatment (WCC/DIAFEM forthcoming 2010). Churches sometimes object to public funding coming with conditions attached that run counter to their moral teaching, which in turn reinforces the reluctance of public health experts to engage with faith leaders (Marshall and Van Saanen 2007).

Fifth, it is well established that CHSs motivated by their Christian mission have since their origins preferentially provided health services to poor and marginalised communities, often in isolated areas where no other services exist (4.3). There is an argument that the church should only provide healthcare where there is no secular provision (WCC/DIAFEM forthcoming 2010).

Sixth, CHSs usually possess a particular advantage of being rooted in church communities, which provide opportunities for their involvement in PHC programmes (3.4.1 and 4.4), although these have not always been fully realised (WCC 2005). It is recognised that more than three decades after the Alma Ata declaration, there is a need for a revitalisation of PHC, including the multi-dimensional contribution of faith communities (WCC/DIAFEM forthcoming 2010).

Two factors combine to create an environment which constrains church congregations from influencing the operation of Christian hospitals (Newbigin 1965, Gelfand 1984) and constrains senior church leaders from understanding the key concerns of health policy and management (Green et al. 2002): first, the increasing professionalisation of services which Jenkins (1981) argued is often pursued in the interests of the professionals rather than to promote the health of individuals and communities and second, the complexity and cost associated with the increasingly technical nature of diagnosis and treatment. The churches' difficulties in managing complex health services, coupled with increasing state provision, prompts the question of whether the churches should continue to manage their own health institutions. Latourette (1954) questioned, over 50 years ago, whether mission organisations might use their limited resources more productively than by supporting institutions that are only marginally distinctively Christian. Alternatively Christian health workers could work within a secular system (Newbigin 1965) seeking to create structures and systems that will benefit everyone (Murray 1985, Paterson 1993) finding new ways of working in cooperation and giving health workers spiritual and pastoral support to deal with the many stresses confronting them (Wilson 1966). These issues will be explored in the current research.

The achievement of autonomy by developing country churches during the first half of the C20th (2.5) was often slow and acrimonious. In addition the newer churches received little preparation for their new management responsibilities, including the increasingly expensive health and educational institutions they were about to inherit. There were, perhaps, good intentions that the relationship between overseas and newly autonomous churches would change from paternalism to partnership, but as Bosch (1991) pointed out, this was claimed more by the Western churches than the churches in developing countries, because it was difficult to shed the inheritance of the colonial relationship. It was not until the Tübingen consultations began in 1963 (4.4) that the issues associated with the relationship between the Western churches, their developing country partners and CHSs were investigated, albeit inconclusively (McGilvray 1981). The effects of the reduction in funding (4.5.2) and expatriate support from the Western churches on the relationship between CHSs and their Western mission partners will be explored in the current research.

4.5.2 Funding of CHSs

When mission health services were set up, most of the funding was from their home churches (2.6), but by the end of the C20th three factors had combined to cause a decrease in the financial support from these churches:-

► Mission organisations (or their successors) were experiencing decreasing support, both because of declining church congregations and because of the increasing number of givers who favoured other agencies (Taylor 1995).

► CHSs were increasingly administered and staffed by nationals, who lacked the contact with overseas donors (Marshall and Van Saanen 2007), from which CHSs with past or present expatriate staff still benefited (Green et al. 2002).

► The devolution of responsibility from overseas churches often ignored the financial and administrative burdens the national churches were inheriting (McGilvray 1981). These were linked to the high quality medical and educational institutions which they valued highly but were incapable of supporting locally without substantial grants from Western church partners (Stanley 1992).

By the 1990s, only half of the Protestant denominations continued to receive assistance for their medical work from partner churches overseas (World Bank 1995), and this decline was accompanied by an increasing trend for donations to be more "project oriented" (Mills 2001). As a result, the flexibility CHSs had over the use of block grants was replaced by the allocation of defined budgets for specific projects to be carried out and completed within specified time periods. This decline in traditional sources of funding combined with three further factors to exacerbate an already difficult financial situation:-

► The increasing cost of expensive diagnostic and treatment equipment (McGilvray 1981) to meet the demands of medical and technological advances (3.2.1).

► The need to upgrade staff pay scales to reduce the number of staff leaving for more highly paid posts in the government sector, as occurred in Nigeria (Ibemesi 1982) and Uganda (Marshall and Van Saanen 2007), in better funded NGOs (Goold et al. 1998), or overseas.

► The local churches not only failing to financially support their hospitals but, in some cases, seeing them as a source of income (CCIH 2000).

These factors, compounded by an increase in private and government services, resulted in a severe decline in the number of CHSs worldwide (Crespo 2000) but also led to some

exploration of alternative sources of funding, including user fees, government grants, support in kind, donor gifts, pre-payment schemes, and income generation projects ranging from livestock to petrol stations (Green et al. 2002). The benefits and difficulties associated with local financing, including user fees, were discussed in section 3.4.2.3. The difficulties are likely to apply more strongly to CHSs than to GHSs because CHSs are more likely to be located in areas of high poverty and where a high percentage of the population do not work in the formal sector (Asante 1998). Growing financial crises forced CHSs to raise their fees, in some cases to over 65-70% of their income, which both militated against serving the most vulnerable (Stanley 1992) and encouraged a policy of attracting more affluent patients who could afford higher fees, in order to provide services for the poor (McGilvray 1981). Nevertheless, often the costs of treatment in CHS hospitals, even when they are equipped with only modest technology, are beyond the means of the poor (WCC 1990).

The result is that services provided by CHSs are increasingly dependent on funding from their respective governments and secular agencies (Mills 2001, Asante 1998), to the extent that significant parts would cease operation without state-provided resources (Semboja and Therkildsen 1995). As well as giving tax exemptions and providing drugs and supplies (Gilson et al. 1994), governments have increasingly formalised their subsidies to CHSs to keep facilities open and user payments low (Palmer 2006). However government support often involves delayed and unreliable payments, lack of flexibility in their use and unacceptable conditions (Gilson et al. 1994). In addition, as governments develop their own services, grants to other agencies often cease, as occurred with the maternity service in Nigeria (Ibemesi 1982). Financial support from governments rarely matches the level of CHSs' contribution to the health sector. In Uganda, for example, faith-based institutions

provide over 30% of total health care, for which they receive only 7% of the national health care budget, which constitutes 35% of their operating costs. User fees contribute 50% and 15% is from charitable sources (Marshall and Van Saanen 2007).

International donors are another source of funds that can potentially substitute for those previously received from overseas church organisations. Because of the poor performance of some of their own programmes, concern over channelling funding through inefficient or corrupt governments and a perception that NGOs are better able to reach the poor, international donors are tying an increasing amount of aid to contracting initiatives with NGOs (Lewis 2001). However, there are disadvantages as well as benefits attached to international funding: SWAp (Sector Wide Approach) programmes, for example, are intended to improve coordination but the disadvantage for CHSs may be a reduction in the direct donor funds they are able to attract as well as increased conditionality (Green et al. 2002).

Donors may exhibit some ambiguity in their approach by insisting on effective service delivery matched by rapid and honest use of their funds on the one hand, but refusing to fund administration costs on the other, which can lead to weak administrative and financial systems (Carroll 1992). As a result of this and other factors, many churches lack the capacity to adequately deal with the complexities of managing large amounts of overseas funding (Goold et al. 1998), which restricts the level of funding they are able to seek. Two further constraints imposed by international donors are that they tend to control both key policy decisions (Hyden 1995) and financial resources (Goold et al. 1998), but the latter are generally available to fund only capital or start-up projects, rather than recurrent costs (Gilson et al. 1994). The obverse of this scenario is that from the late 1980s onwards, new funding opportunities

opened up to FBOs as a result of HSR measures (3.4.2.2), the liberalisation of donor attitudes to funding FBOs (4.3), the introduction of SWAps and the Global Fund and, after 2000, a new urgency to achieve the MDGs (3.4.3). An issue to further explore in the current research is the extent to which CHSs have taken advantage of these opportunities.

4.5.3 Relationships between CHSs and governments

The achievement of national independence by previously colonised countries and its effects on relationships between newly independent governments and the churches in the second half of the C20th (4.2) can best be described as reciprocal ambivalence, marked by varying degrees of disaffection on the one hand and recognition of their interdependence on the other.

There were varying degrees of cooperation between CHSs and newly independent governments. Some churches were motivated to cooperate by a desire to rescue something acceptable from what they perceived as the inevitability of increased government control. Others were resistant to cooperation, either because of their mistrust of government and their wish to retain their autonomy, or because they still saw health service provision as an evangelistic tool, or because of their belief in the superior quality of their services. A range of strategies were adopted by different churches in different countries. Some CHSs remained independent, some entered into various forms of contractual arrangements with their government, and some became part of an integrated national health service, typically by some of their hospitals being designated as district hospitals, with responsibility for supervising other hospitals and health facilities (Schulpen 1975, Gov of PNG 2000, Green et al. 2002).

As in many other newly independent states, the Tanzanian Government, for example, planned to provide free treatment in at least one hospital in every district, but several districts lacked government hospitals. At independence in 1961, the missions had 287 health facilities, compared with the government's 73 (Jennings 2008). In 1965 five church hospitals agreed to function as district hospitals. Under this arrangement, churches retained ownership of their facilities, but provided free treatment and food in return for additional government grants. Over the next few years, various models of integrated hospitals were pursued by the churches and government. These provided, on an experimental basis, different arrangements for ownership, funding and management (Schulpen 1975). In some other countries, such as South Africa in 1972, governments nationalised all mission hospitals, because the churches had continued to work independently of each other and, constrained by their denominational differences, were unable to put forward any agreed alternative to nationalisation (Gelfand 1984). Nationalisation often resulted in the secularisation of institutions which previously had longstanding Christian traditions (Davey 1985).

Schulpen (1975) carried out a comparative study of church, government and integrated church/government hospitals in Tanzania to assess their relative merits. Church hospitals had the most overseas donations, best quality service and best staff motivation, perhaps related to the higher religious influence, but the level of user fees charged, due to their shortage of resources, militated against their effectiveness as centres for local communities. Government hospitals had the best administration and communication systems, but scored worst on all of the other factors, including levels of bureaucracy. The integrated hospitals, which were owned by the church and received additional government funding in return for an agreed package of services, were found to be best at community outreach. Overall, church hospitals

gave the best service for the least cost, but to the least number of patients, whereas integrated hospitals were the most community oriented and were considered to provide a reasonable standard of care at reasonable cost.

A window of opportunity for the churches to enhance their working relations with governments was opened in the1980-90s by the convergence of two factors: first, the HSR policies (3.4.2), which encouraged the participation of the non-state sector in health provision; and second, the increasing awareness by governments of their limitations in providing comprehensive services without greater collaboration with NSOs (non-state organisations), including CHSs. Government decentralisation may also have assisted in developing the closer relationships necessary for increased cooperation. Governments more readily engaged with NGOs, many of which are CHSs, than with FPOs (for profit organisations) because of the greater similarity in their development objectives and motivation (Green et al. 2002) and a perception that NGOs were less likely to behave opportunistically or fraudulently (Palmer 2006, Mallya 2008). In particular, religious leaders are frequently regarded as the most trusted people (Haynes 2007). In some countries, the churches were encouraged to resume control of health institutions they had previously transferred to the government (Goold et al. 1998).

This closer cooperation was marked by the looser government grants-in-aid schemes being replaced by more formal contracts under which CHSs were paid a proportion of their costs in return for the services they provided (Mills 2001). Whilst this closer cooperation enables governments to steer CHSs into the work they want and encourage a more even spread of services, CHSs risk a potential constraint on their autonomy (Mallya 2008) and an incremental slide to co-optation, whereby they become merely an extension of a more

dominant government (3.4.2.2 and box 3.2). A contractual arrangement provides CHSs with greater funding security as well as opportunities to build trust with government and influence policy (Lewis 2001). However, they may also threaten their individual organisational identity, with a potential loss of their specific attributes and assets, and thus a loss of the very benefits they are able to bring to the partnership, including their ability to adapt to changing circumstances and innovate (Brinkerhoff 2002).

Although a measure of interdependence has developed between governments and church organisations, there may also be mutual distrust. Governments may believe that church organisations use government grants for unintended purposes, as well as having a perception that CHSs are less willing to adopt national policies because of their colonial past, continuing links to overseas churches, ideology or because of a different concept of service provision. CHSs, on the other hand, may manifest their distrust by inadequate reporting to their governments about their resources, particularly donor funds, although this may be to protect their services from financial strains resulting from government subsidies not being paid on time or in full, especially when government funds are in short supply (Schulpen 1975, Gilson et al. 1994, Green et al. 2002, Marshall and Van Saanen 2007).

For governments experiencing a shortage of resources there is a need to work with all available providers to maximise the use of resources and assets, including those of quality and commitment (Green et al. 2002). The challenge for government, with its dual role of regulator and partner, is to harmonise these contributions to benefit everyone, particularly as agencies realise that they are competing for the same resources (Mallya 2008). Nevertheless, situations of extreme need may encourage closer cooperation than would otherwise have existed, such

as in tackling the HIV/AIDS pandemic (Marshall and Van Saanen 2007). The attempts of governments to achieve the MDGs (Millennium Development Goals) and implement Global Fund programmes also provide opportunities for closer collaboration with CHSs (3.4.3).

National umbrella groups were established in many countries to improve coordination, cooperation and sharing of resources, and information between NGOs, and between NGOs and their respective governments, as well as enabling NGOs to negotiate with the government and participate in national policy making and planning (3.4.2.2) (Gilson 1994). This presents a dilemma for CHSs because although such networks may be perceived to have greater influence on the government than NGOs have individually or collectively, they frequently have a dominantly secular ethos. This presents CHSs with a choice between participation and maintaining their faith-based distinctiveness through separate associations: the CHAs (4.4).

Additionally, many churches have an ambivalent attitude towards being considered an NGO: whilst they do not consider themselves ordinary NGOs, they would not want to be excluded from the benefits of NGO status, and are not always very clear at identifying what makes them distinctive (Goold 1998), perhaps because in the largely Christian world in which they previously operated, there was little pressure to do so. In addition, because many governments experience difficulty in executing their regulator role, they may attempt to use NGO associations for this purpose (3.4.2.2). The potential contradictions between promotional, coordinating and regulatory roles may pose dilemmas for the organisations concerned. Governments often rely on CHAs to carry out a regulatory role on their behalf. This issue will be further explored in the case studies of the current research.

4.5.4 Socio-Economic Orientation of CHSs

Section 2.3 illustrated the inconsistency which sometimes occurs between the Christian churches' principle of giving priority to the needs of the poor and their practice. It was this inconsistency which, following the reforming ethos of the second Vatican Council inspired the Latin American Bishops, at their 1968 Medellin and 1979 Puebla meetings, to controversially endorse a 'preferential option for the poor'. This necessitated a change in the approach of the Catholic Church, which had not always opposed the exploitation of the poor and oppressed (Gutierrez 1983, Eade 1997). The effects of this 'Liberation Theology' went far beyond the Catholic Church in Latin America and influenced the mission, policy and value statements of many present-day Christian organisations, which state their commitment to changing a society which allows or causes poverty and injustice (USPG 2002, CAFOD 2004, Christian Aid 2005, Tearfund 2006, Medical Missionaries of Mary 2006, Anglican Church 2006, Methodist Church 2006).

Because of their declared Christian preference for the poor and the deprived, CHSs should, it is suggested, concentrate on providing care for those who have none, rather than increasing the quality and sophistication of care for those who are already well served (CMC-WCC 1979). Parmar (1979) argued that a Christian health institution loses the justification for its existence if its services are so expensive that they exclude the poor, a view endorsed by Paterson (1993), who added that in her view failure to build structures and networks that support the primary aim of serving the poor will result in withdrawal of support from the potential allies of CHSs resulting in widespread closure of their facilities. A Ugandan study confirmed the view that religious not-for-profit facilities were more likely to provide pro-poor services and charge less than for-profit units, and that all religious facilities provided better

quality care than their government counterparts, despite the latter's better equipment, which suggested that they were driven, at least partly, by altruistic motives (Reinikka and Svensson 2002).

However, there seem to be three principal reasons why CHSs may not deliver on their declared priority for the poor. First, because of the buildings they have inherited and their limited resources, some CHSs are restricted to providing services in high cost hospitals and clinics, oblivious of the poverty and disease in the surrounding community (Morley 1979) and precluding basic public health measures which would save many more lives from preventable disease, particularly in the most deprived communities (Foege 1979, McGilvray 1981). In addition, some health professionals believe that the provision of services which are less than the best is unethical (Asante 1998), which may militate against providing lower cost services for the poor.

Second, the assumption that staff working for Christian organisations necessarily share a preference for the poor has been challenged on a number of grounds:-

► Some people are Christians in name only, seeing little connection between their Christian identity and their paid employment, which may result in their vested interests driving them to act against, rather than for, the interests of the poor (Taylor 1996).

► Employment may be sought in NGOs as a means of livelihood rather than an expression of personal philanthropic commitment (Fowler 1995).

► Because of equal opportunities policies some employees of Christian organisations may not share the faith of their employers, resulting in organisational secularisation (Goold et al.1998).

Third, as demonstrated in previous sections (4.4) and discussed in section 4.5.2, economic pressures have caused many CHSs to incrementally adopt financing policies which, perhaps unintentionally, discriminate against the poor, and change their ethos from being needs driven to becoming resource driven (Paterson 1993). This issue will be further explored in the current research investigations.

4.6 Summary

This chapter has explored the ways in which their missionary heritage (chapter 2) has influenced CHSs and the impact on them of changes affecting the health sector generally (chapter 3). When national churches gained autonomy from their overseas church partners, there was a gradual loss of expertise and funding from traditional sources (4.5.2). This coincided with increased professionalisation and cost of operating the health services they had inherited, resulting from medical, technological, epidemiological and demographic changes (3.2, 4.4). In addition, following national independence many post-colonial governments started programmes of developing comprehensive networks of state-run health services. The convergence of these factors prompted churches to start questioning the validity and viability of church-run health services, which led the WCC to establish a series of consultations, surveys and reviews of CHSs (4.4).

The practical results of these explorations by the WCC were limited, primarily because there were at least two agendas operating in opposition to each other. Those church leaders responsible for managing CHS facilities were seeking solutions to the practical problems of balancing their need for income with their mission of providing services to people in need, whilst others were more concerned with pursuing theological definitions of health and bridging the gap between medical professionals and church congregations. However, there were two positive outcomes. First, there was recognition of the need to establish CHAs (4.4) to improve cooperation and communication, both between different CHSs, which had operated independently of each other until this time, and between CHSs and governments. Second, the WCC, through the CMC-WCC, was able to cooperate with the WHO in promoting PHC (4.4), which received subsequent worldwide endorsement at the Alma Ata conference in 1978 (3.4.1). PHC has survived in various forms for the last 30 years, although it has not reached its full potential because it has been perceived both by GHSs and CHSs as a threat to established institutions and has to some extent been overshadowed by vertical programmes. It has, however, received more recent endorsement from both the WCC and WHO (3.4.1, 4.4).

Both GHSs and CHSs face problems of increasing costs and declining resources. Governments have an ability to raise funds to support their health services through taxation, although this may be limited in many LHD countries, because of the low incomes of the population and the high proportion not in the formal labour market. Thus, both GHSs and CHSs have had to seek alternative sources of funding, including health insurance and user fees. Although some governments continue to provide free services, since the Bamako Initiative many now make charges (3.4.2.3). In order to remain financially viable, CHSs have

also reluctantly introduced user fees, which may contribute up to half of their income (4.5.2). There is a severe dilemma for CHSs, which must have sufficient income to operate increasingly costly services, but which may be perceived as losing the justification for their existence if they exclude the poor who may not have sufficient funds to pay for treatment (4.5.4). The possibility of local churches financially supporting their CHSs has also proved to be limited principally because they are located in poor areas. In some cases, the church itself may be short of funds and views the health facility as a source of income rather than vice versa (4.4).

The closure of CHS facilities poses a difficulty for governments as well as CHSs themselves, as CHSs may provide up to 30% (and in a few countries 50%) of all health services, and are frequently located in isolated rural areas where the government may have limited infrastructure (4.3). As a result, the level of support given to CHSs by governments is increasing in many countries. However, it still falls far short of what is needed. In Uganda, for example, FBOs provide 30% of the health care, but receive only 7% of the national health budget. In many areas there is no alternative service to that provided by CHSs which, it is claimed, have a number of advantages over governments as health providers, including their lower cost; contact with difficult to reach groups; priority for the poor; altruistic behaviour; and support of their church organisations, although some of these advantages are challenged in some situations (4.5.1).

The greater involvement of NSOs as part of the promotion of HSR and subsequent endeavours to achieve the MDGs encouraged governments to seek greater cooperation with FBOs, including CHSs. International donors often favour NFPOs because they are perceived

as less likely to behave opportunistically or fraudulently than FPOs (4.5.3). Increased collaboration between governments and CHSs has been further encouraged by international initiatives such as the Global Fund and SWAps, and facilitated by the improved communication between CHSs of different denominations and between CHSs and governments provided by CHAs (4.5.3). However, some CHSs may continue to resist this closer relationship with government because of the perceived risk of co-optation, lack of trust in the integrity of the government (4.5.3) or fear of the possible secularisation of their service (4.5.1).

Chapter 3 highlighted the failure of many developing countries to substantially improve the health status of the poorer sections of their populations and the general underperformance of their health sectors. This chapter has highlighted firstly the significant role played by CHSs in the provision of health services to many of the difficult to reach communities in those countries and secondly some of the constraints that must be overcome for governments and CHSs to collaborate more closely in providing comprehensive health services to their populations.

The issues identified in the last three chapters will be drawn together, in chapter 5, into a conceptual framework, from which the hypothesis and research questions for the current research will be developed.

CHAPTER 5 – RESEARCH FRAMEWORK

5.1 Introduction

This chapter first draws together into a conceptual framework the major factors identified in chapters two, three and four that might influence the way in which contemporary CHSs (Christian health services) operate (5.2), from which the hypothesis and research questions for the current research are developed (5.3). The chapter next defines the geographical and denominational focus of the research (5.4) and concludes with the research methodology (5.5).

5.2 Conceptual Framework

Contemporary CHSs do not fit neatly into a single area of study, but require the interweaving of three main areas of study: first, Christian mission history, with particular reference to medical mission, about which there has been little written except the biographical work of individual medical missionaries and the academic works of Browne et al. (1985) and Grundmann (2005) (chapter 2); second, the development of contemporary health services, the pressures they have experienced and the initiatives taken to improve their performance (chapter 3); and third, the contribution of NSPs (non-state providers) to the health sector with particular reference to CHSs, also about which very little has been written (3.4.2.2 and chapter 4).

The key factors influencing the current provision of CHSs, their users, and their relationships with other organisations can be identified in a conceptual framework (Denzin and Lincoln 1998). As suggested by Miles and Huberman (1994), a graphic display of the main variables, with arrows to indicate these relationships, has been produced in a transition map (figure 5.1)

to help clarify the framework. This is explained below, identifying in brackets which sections

in chapters 2-4 have led to this conceptualisation.
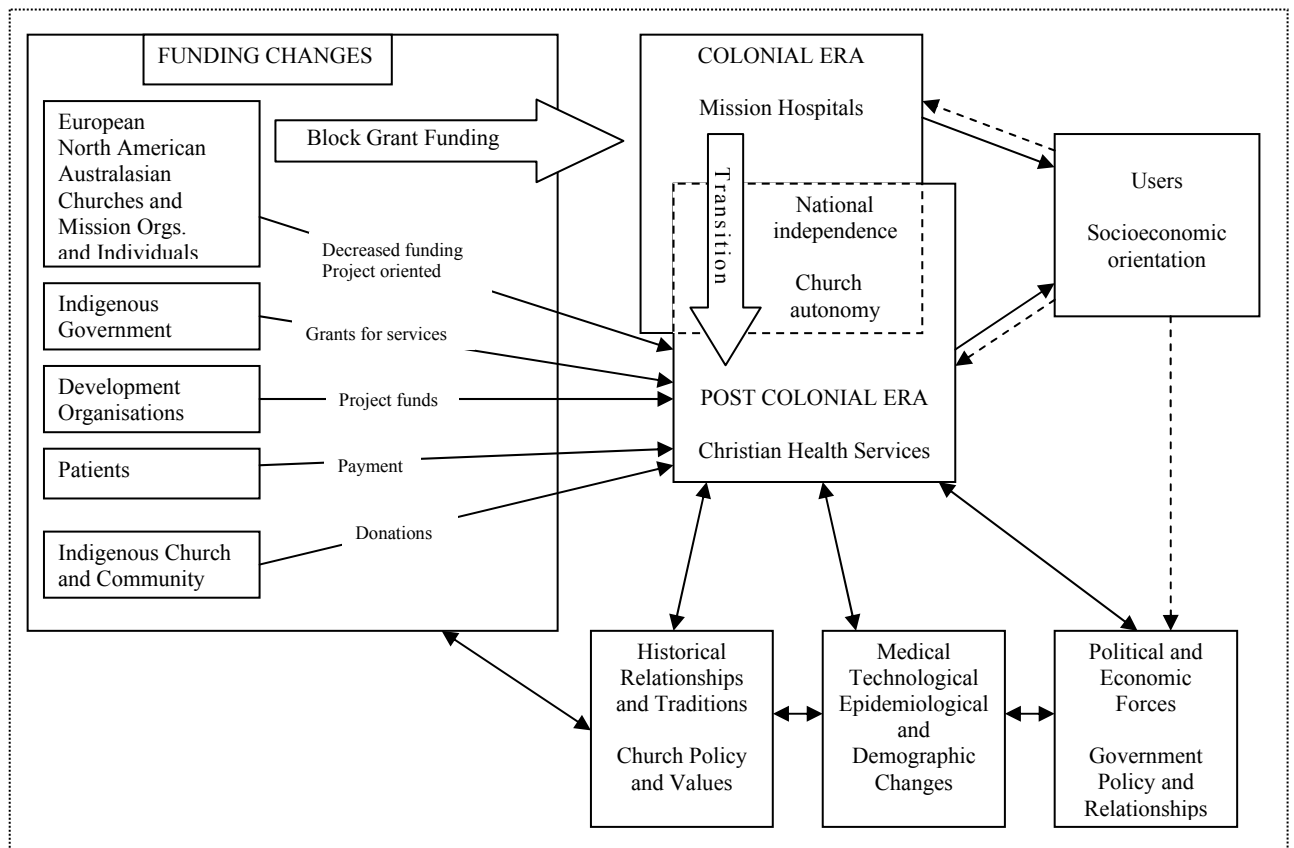
Figure 5.1 CHSs Transition Map

First, the history of Christian mission studies demonstrates that the initial intentions of

mission were to spread the Christian message to people of the developing world (2.2), with a

stated preference for reaching the poor (2.3). Medical mission evolved from this mission

(2.4.2). However, the attitude of UK based churches and mission organisations towards

medical mission was ambivalent. They were able to identify the potential evangelisation

benefits of increased contact with people receiving health services from a church agency, but

they were also concerned that medical missionaries might be distracted from their main task

of evangelisation (2.4.5). The tension between the evangelising and health providing wings of

mission organisations, which continued within national churches after independence was a focus of the Tübingen consultations (4.4) and has continued into the C21st. The extent to which the perceived combination of evangelisation with service is an explanation for the reluctance of some donors (4.5.1) and governments to financially support CHSs (4.5.2-4.5.3) will be investigated in this research.

Concurrent with the previously colonised countries gaining independence, the churches gradually gained autonomy from their partner churches overseas (2.5), which resulted in the evolution of the colonial mission hospitals to autonomous post colonial CHSs, as depicted by the arrow between the two large boxes in the centre of figure 5.1. The broken-line box between the two large boxes illustrates the part played by the achievement of national independence and church autonomy in the countries concerned. Despite becoming autonomous, national churches often continue some of the values, customs, and organisational structures inherited from their colonial partners and remain part of their international denominational network, as occurs in the Anglican Communion. The nature and extent of contemporary relationships between national churches and their original mother churches will be investigated in the research.

With autonomy came a dilemma for both national churches and their UK mission partners. The cost of operating the formers' newly acquired legacy of hospitals, health centres, training institutions and other health facilities, which it is suggested were initially viewed as prestige symbols, increased at a time when the diminished managerial responsibility of Western mission partners was accompanied by reduced financial support, due largely to increasing difficulty in raising funds at the previous level. Post independence churches also felt

frustration because health service provision was becoming more technical and professionalised, which appeared to open a divide between the churches and their CHSs (4.4). The tension was fuelled by the perceived ability of churches' health and educational institutions to attract more financial support than other parts of the churches' work while also adding to the churches' financial burdens. This situation appeared to be reinforced by overseas churches becoming more project oriented and developing country CHSs starting to seek funds from secular development organisations (4.5.2).

Thus for CHSs to survive, existing information indicates that it often became necessary for them to seek alternative sources of funding from secular development agencies, indigenous governments, indigenous churches, local communities and/or user fees. Funding from secular development agencies was apparently dependent on their willingness to support the work of FBOs and the willingness of CHSs to become more project oriented (4.5.2). The issue of cooperation with indigenous governments is dealt with below. Because indigenous churches and CHS facilities were generally located in poor areas (4.3), it is suggested that it is unlikely that either the churches or the surrounding communities are in a position to subsidise the health service to the extent that is needed. The sources from which the CHSs under study sought financial support, the extent to which they were successful in doing so and the implications for their ability to subsidise services in poor areas will be investigated in this research.

The available information indicates that many CHSs tried to improve their financial situation by levying user payments, usually through direct charges for treatments, but sometimes through insurance schemes. The little information available indicates that this is more likely

to be successful in urban than in rural areas, where there are a larger number of more affluent patients who can afford to pay, but in both urban and rural areas it is suggested that poorer patients are likely to experience the greatest difficulty in accessing the service unless the health facility is able to operate a system of fee subsidies and exemptions (3.4.2.3, 4.4, 4.5.2). The adoption of user fees, subsidies and exemptions and their implications for user profiles of CHSs in India and Malawi will be assessed in the study and is illustrated in the large box on the left of figure 5.1.

Second, the study of contemporary health service development demonstrates that the course of the C20th saw health services affected by substantial demographic and epidemiological changes, and medical and technological advances (3.2). The increase in both demand and cost caused by these changes contributed to the underperformance of the health programmes of many newly independent governments (3.3), many of which had sought independence on a mandate which included providing free and comprehensive health services to their populations (3.2.3). It is probable that these changes also affected CHS facilities, both as a result of changes in the number and nature of patients seeking treatment and/or by patients' increased expectations of the availability of the latest diagnostic and treatment technology, the provision of which add both to the costs of individual patients' treatments and the overall costs of operating CHSs. This factor is illustrated in the centre box at the bottom of figure 5.1. The effects of demographic and other changes on the operations and client profile of CHSs in India and Malawi will be investigated in the study.

Third, the newly independent national governments took a variety of approaches towards health services provided by the churches and other NSPs, which included complete

nationalisation, integration with state services, provision of financial and other support to CHSs, or leaving them to continue much as before. The churches are said to have responded in different ways, ranging from cooperation motivated by self preservation, to resistance fuelled by a possible combination of motives including mistrust of government, retention of their autonomy, belief in the superior quality of their services or because they viewed health service provision as an evangelistic tool (4.5.3). The persistence of some of these attitudes, at least in a vestigial form, might account for the differing extents to which governments and CHSs are willing to cooperate with each other. The extent to which the governments of India and Malawi responded in these ways, church reactions, and their contemporary legacies, will be assessed.

From the 1980s, national governments, encouraged by international financial institutions, implemented a number of initiatives to improve the performance of their health sectors. These came to be known as the HSR (health sector reform) movement (3.4.2) and ran parallel with measures to improve political and economic governance more generally. Collectively the measures included SAPs (structural adjustment programmes), which required reductions in public expenditure, cost sharing between governments and users, government decentralisation and greater involvement of NSPs in health service provision, which in the case of CHSs often included increased recognition of the services they were already providing. In many cases, service arrangements between governments and NSPs were formalised by contracts, service agreements or PPPs (public/private partnerships) (3.4.2.2). More recently international initiatives such as the introduction of SWAps (Sector Wide Approaches) (3.4.2.3), the Global Fund and the campaign to achieve the MDGs (millennium development goals) (3.4.3) have emphasised the importance of involving all providers, particularly those which have access to

marginalised communities. The extent to which churches possess substantial infrastructure and networks through which they continue to provide health services, the continued predominantly rural location of those services, and the existence and effects of financial constraints will be examined in this research (4.3).

The greater involvement of NSPs in service provision requires government regulatory mechanisms, which available assessments indicate are frequently ineffective (3.3.2, 3.4.2.2). For CHSs, regulation is often assumed to be provided through CHAs – this assumption will be investigated in the study (4.5.3). In some areas governments and CHSs have been able to work more closely together, but in others this has been difficult. Factors which determine the degree of cooperation appear to include whether the prevailing political climate encourages governments to work with and support FBOs and whether CHSs are willing to pursue government policies. Moves towards greater cooperation seem often to be based on issues such as whether CHSs are serving populations which are not served by GHSs (government health services), whether they are able to provide the full range of services to everyone in a particular community, and the willingness of different denominations to cooperate with each other and negotiate with the government through a CHA (4.5.3). Governments and international donors sometimes have concerns about whether funds allocated for service provision or development are used, either directly or indirectly, to promote the evangelistic aims of churches (4.5.1). The influence of political and economic forces and relationships with governments is represented in the bottom right box of figure 5.1 and their presence, characteristics and influence on CHSs in India and Malawi will be assessed.

All of the above factors have a possible impact on the level and type of services provided by CHSs. This, in turn, may affect the nature, particularly the socioeconomic status, of the users of CHS facilities, as illustrated by the solid arrows to the box on the right of figure 5.1. In a situation where users have a perfect choice between providers, or where providers are held accountable by users, the relationship between CHSs and the users would be shown by a solid line. However, the literature suggests that CHS facilities are often located in areas where there is limited access to alternative facilities (4.3), particularly for people who cannot afford to travel. It is also unlikely that users with limited financial resources would be in a position to exert a great deal of influence either over the management of the CHS or over the political system (3.3.2, 4.4), thus these two relationships are indicated by dotted lines on the far right of figure 5.1, to represent this suggested weak accountability to users. The relative roles and outcomes of these different channels for accountability in India and Malawi will be investigated. There is an assumption that because of the churches' declared priority for the poor (4.4, 4.5.4), CHSs give priority to the poor, but the literature suggests that changes in funding and other policies may militate against this intention being achieved (4.5.2), an assertion to be tested in the country contexts under study.

5.3 Hypothesis and Research Questions

The conceptual framework as set out above suggests a central hypothesis for the study, which has already been set out in chapter 1 and is reproduced below for ease of reference (box 5.1). As noted in chapter 1, testing the hypothesis implies four research questions, relating to the four issues identified at the end of chapter four (4.5.1-4.5.4), although there is some interweaving and overlap of the issues. The questions listed in chapter 1 are reproduced in box 5.1.

The first question is a general one that requires an investigation of the background of the countries researched; the health status of their populations; the structure of their health care delivery systems, particularly services provided by CHSs; a description of the CHS facilities researched in India and Malawi; and their level of cooperation with each other. The second question requires an exploration of the ways in which UK based mission organisations have changed their operational systems, relationships with overseas church partners and policies of support for CHSs and the reasons for the changes. The question also requires an examination of the management of denominational CHSs in Malawi and India, the support they receive from overseas partners, and their religious orientation. The results of the analysis of the data collected to answer these two questions are reported in chapter six.

Hypothesis
The necessity of seeking alternative funding sources has resulted in changes in the types of provision of Christian health services in contemporary developing countries, their users, and their relationships with governments.

Research Questions
1. What is the current contribution of Christian health services to the total health service of their respective countries and to what extent do they cooperate with each other?
2. How and why have the policies of mission organisations in the UK changed; how have these affected their relationships with, and support given to, their developing country partner churches and their health services; and what is the impact of CHSs' religious heritage on their service provision?
3. What is the nature of relationships with, and support given by, governments to CHSs and how and why have these changed?
4. How have CHSs responded to these changes; what impact have these changes had on the search for alternative sources of funding, the nature and extent of services provided and their users; and what are the reasons for the continued existence of CHSs?

Box 5.1 Hypothesis and Research Questions

The third question requires an investigation of government health programmes in Malawi and India, the extent to which the governments and CHSs cooperate and support each other, and the roles of their CHAs. The fourth question implies an exploration of how CHSs have responded to the decline in their traditional funding by seeking alternative funding sources and/or changing the services they provide, the socioeconomic characteristics of their users,

and the reasons for their continued existence. The results of the analysis of data relevant to these two questions are reported in chapter seven.

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5.4 Geographical and Denominational Focus

As this research topic was potentially extensive, it was necessary to impose some geographical and denominational boundaries. Thus, the research primarily focused on health services provided by those denominations which resulted from foreign mission during the colonial era in Commonwealth countries in S-SA (Sub-Saharan Africa), South Asia, and the Pacific (South-Western Pacific islands). These countries were selected because it was anticipated that they would have a concentration of CHSs related to UK-based mission organisations and an ability to communicate in English because of their cultural ties to the UK resulting from missionary endeavour during the colonial period. For the purpose of this research, those denominations which resulted from foreign mission during the colonial era comprise Catholic, Anglican, Methodist, United Reformed (including the Presbyterian and Congregational Churches, where these still operate separately), and Baptist churches. Some basic information relating to more recent missionary denominations was included in the analysis of the contemporary situation, but excluded from the main study.

5.5 Methodology

This section discusses six aspects of the methodology utilised in the design of the research: the choice between a positivist or interpretive methodology in the design of the empirical research (5.5.1); ethical issues (5.5.2); triangulation and generalisation (5.5.3); validity and reliability (5.5.4); conduct of the field studies (5.5.5) and data analysis (5.5.6).

In order to investigate the research questions, three field study strands were pursued, as

illustrated in box 5.2. The first strand investigated the second research question by ascertaining the current and past support given by UK-based mission organisations to CHSs. This involved seeking documentation from and conducting interviews with senior officers of these organisations (appendix 2). Further detail on the approach to this strand is given in section 5.5.5.1.

The main aim of the second strand was to ascertain from CHAs in the countries meeting the criteria identified in section 5.4 whether there was any pattern in the extent and nature of CHSs in their respective countries, coordination between them, their relationships with their respective governments and their receipt of government support, which contribute to answering the first, third and fourth research questions. It was also intended that this overview would provide a basis from which to make a selection for the country studies, but this was not possible in the event because of the difficulty in identifying, contacting and obtaining responses from CHAs. Further detail on the approach to this strand is given in the introduction to section 5.5.5.2. The third strand was the in-country field studies in Malawi and India (schedules in appendices 4, 5, 6 and 7), which contributed to answering all four research questions. Further detail on the approach to this strand and the reasons for selecting Malawi and India are given in section 5.5.5.3.

Box 5.2 also lists the data obtained for each strand, the means of obtaining it, and the sources. Although it was intended that the strands would be sequential, there was considerable overlap between them. This occurred because of time delays in arranging appointments in the UK for strand one, difficulty in identifying some of the overseas' CHAs, and delay or failure in some of the latter responding, which required several follow-ups.

STRANDS	DATA SOUGHT	DATA SOURCES
UK Based Churches and Mission Organisations Churches and Mission Organisations	Policies, overseas links, Relationships, funding	Documents, websites, published data, individual interviews
General Survey of study countries UK Based Linking Organisations	Identifying Christian Health Associations (coordinating organisations) in study countries	Documents, websites, published data, e-mail, telephone
Christian Health Associations	Functions, responsibilities, relationships, funding	e-mail questionnaires, websites
Denominational Christian Health Services (where no response from CHA)	Responsibilities, relationships, service provision, funding	e-mail questionnaires websites
In-Country Studies Key Officers of: Christian Health Associations Church denominations Governments Development agencies Other faiths (India only)	Perceptions of roles, relationships, policies, values, funding, service provision, and users	Interviews, documents
Health Facilities Managers Patients Staff Community	Experiences of roles, relationships, policies, values, funding, service provision, and users	Interviews, documents

Box 5.2 Field Study Strands

5.5.1 Positivist or Interpretative Methodology

To investigate the four research questions it was necessary to consider whether a positivist or

an interpretive methodology would be most appropriate. Positivist social scientists favour the

precise measurements available from experiments or surveys in order to identify causal

relationships between variables. However, the argument that quantitative research is relatively value free and superior in scientific objectivity, because of its use of distinct variables, control and measurement, ignores the extent to which quantitative researchers express their own beliefs in determining the variables to be measured and drawing conclusions from their correlations (Silverman 2002).

Interpretivists, on the other hand, using qualitative methods, recognise the impossibility of achieving total objectivity and emphasise the value-laden nature of inquiry. They attempt to translate the different reality experiences and points of view of people in a way that will generally be understood. Interpretive theory reveals the meanings, values, and rules of living used by people in their daily lives, all of which are regarded as valid (Newman 1994). Cresswell (1998) drew together the main elements of qualitative research as that in which data is collected from a natural setting, is focused on participants' perspectives, and is analysed inductively using expressive language.

For the current research, as shown in box 5.2, a number of secondary data sources were initially explored, such as reports and websites. This was followed by sending semi-structured questionnaires by e-mail and post to CHAs for the second strand. As the major emphasis was on seeking information from a range of subjects related to their opinions, interpretations, feelings, beliefs, values, attitudes and relationships, rather than seeking accurate statistical information, an interpretivist approach using qualitative methods was deemed most appropriate. This also allowed flexibility, when necessary, to modify the issues being explored in the light of experience gained and new information emerging (Huberman and

Miles 1998). More detailed descriptions of the methods used are included under each of the field study strands in section 5.5.5.

5.5.2 Ethical Issues

Consideration was given to the three ethical issues of informed consent, right to privacy and protection from harm (Fontana and Frey 2000). On the first of these issues there is a dilemma between giving respondents sufficient information to enable them to give informed consent to participation without unduly influencing their contribution (Silverman 2000). For health facilities, the hospital director, or other senior manager in smaller facilities, was initially telephoned to gain permission to conduct research in their premises and a letter of introduction was provided by the appropriate CHA. Interviewees at health facilities and in the nearby communities were individually approached by the researcher, accompanied by the interpreter where necessary. They were advised that the purpose of the research was to obtain information, that no specific action was intended as a result and given the opportunity to participate or not. Very few of the respondents approached declined the invitation to be interviewed. In the case of senior personnel in mission organisations, governments, churches and development organisations, the initial request for an interview was made either by letter or telephone. Most of these readily agreed, although a few required a more lengthy explanation before agreeing to be interviewed. Ideally interviewees would have been provided with a copy of their transcript to check, but this was regarded as impractical first, because notes were handwritten and second, the lack of available time due to the need to travel to the next location. However, critical or potentially contentious statements were checked with interviewees for their assent. Those respondents contacted by e-mail or post were able to exercise their choice of whether or not to participate by returning or not returning the

questionnaire. Respondents were requested to indicate with an (x) any statement they wished not to be attributed to themselves (appendix 9). On reflection, it might have been appropriate to include a reminder at the end of the questionnaire requesting respondents to confirm their agreement to their statements being attributed unless they had indicated otherwise.

On the issue of privacy, interviews were conducted in a private room and, as far as possible, out of the hearing of others. Particular care was taken with patients and community members to emphasise that the researcher was not associated with the health facility and that their responses would be kept confidential. The field notes of these subjects were given a unique code, as described in section 5.5.6. The issue of confidentiality was more difficult for managers and senior staff of health facilities and others holding official positions, who could often be identified from the positions they held. It was, therefore, intended initially not to name the facilities researched to protect the identification of individuals involved. However, this would have been an artificial exercise because the facilities would have been identifiable from their descriptions. In the event, none of these subjects took up the offer of anonymity; on the contrary, many were keen to be quoted.

On the issue of protection from harm: as already stated respondents were assured first, of confidentiality, to avoid the risk of negative repercussions, and second, that nothing done in the course of the research would interfere with the treatment given to patients. With regard to the ethical aspects of covert fieldwork (Fontana and Frey 2000), all aspects of the research were fully transparent.

5.5.3 Triangulation and Generalisation

Triangulation in qualitative research was initially regarded as a means of data validation, but is now regarded as an extension and enrichment of the research itself (Flick 1998). Triangulation involves using multiple methods, groups, settings, data sources and media with different biases and strengths (Huberman and Miles 1998), exploring data from different perspectives (Coffey and Atkinson 1996) and double-checking findings, particularly those involving deviations from the general pattern (Denzin and Lincoln 1998).

This research was triangulated by interviewing respondents from different organisations, and from the same organisation, on the same topic, and in the health facilities by interviewing managers, staff, patients and prospective patients (community members). Variances were highlighted and investigated further, including comparison with published data, where this was available. An exception to this approach was the completed questionnaires for the second strand: for a minority it was possible to check some of the data against websites and reports, and some of the data could be cross checked for those countries with more than one CHA, such as Kenya and Uganda. For the others, the only accessible data within the timescale available was that provided by the officer identified (appendix 3).

Generalisation is regarded as an essential requirement of quantitative research, but is unlikely to be appropriate in qualitative research because of the small sample size, its means of selection and the contextual nature of the study (Silverman 2000). The intention in qualitative research is less about generalisation of findings, than the development of new insights (Flick 2002). Although 'multiple actors in multiple settings enhances generalisability' (Huberman and Miles 1998.93), there is a danger of aggregating data from different cases to achieve a

generalisation which does not apply to any particular case (Coffey and Atkinson 1996, Huberman and Miles 1998). Thus, although the current research involves 'multiple actors in multiple situations' no claim is made that the number of cases studied in any of the settings was sufficiently large or representative to generalise to other situations.

5.5.4 Validity and Reliability

Because qualitative research does not share the assumed legitimacy of the scientific methods demanded by positivists, demonstrating validity and reliability are seen to be important (Holloway 1997). Kirk and Miller (1986.21) cited by Flick (2002.221) summarised validity as 'whether the researcher sees what he/she thinks he/she sees', which can be taken to imply whether the researcher hears what he/she thinks he/she hears. Flick (2000) suggests three types of potential error: Type 1 in which a relationship or principle is seen which does not exist, Type 2 in which a correct relationship or principle is missed, and Type 3 in which the wrong questions are asked. Flick (2000) further suggests that validity of knowledge cannot be assessed with certainty, rather knowledge can only be judged for its plausibility and credibility. In the current research, attempts were made to reduce the potential for the first two types of error by assessing whether a particular response was consistent with other responses and if not, whether there was a credible explanation for the inconsistency. Where possible, clarification was sought from confirmatory questions, documentary evidence and checks with key informants. To reduce the likelihood of the third type of error, the questions to be asked were regularly reviewed and discussed with key informants (5.5.5.3). Selecting the wrong cases could be added to this list as a fourth type of error. The procedure for selecting locations and interviewees is discussed in section 5.5.5.

Reliability is variously defined as the extent to which a test or procedure produces similar results either "…under constant conditions on all occasions" (Bell 2005.117), or "…regardless of how, when and where the research is carried out, or the extent to which the instrument is consistent" (Holloway 1997.136). The achievement of full reliability in qualitative research is neither possible nor desirable because "Despite all the methodological controls, the research and its findings are unavoidably influenced by the interests and the social and cultural backgrounds of those involved" (Flick 2000.4). Thus the responses of subjects may be influenced by the personal attributes of both the interviewer and the interviewee including their gender, class, ethnicity, language and age, as well as the motivation of the interviewee for participating and the interviewee's perception of the purpose of the interview.

It is recognised that in the current research it was not possible to fully accommodate all of these factors as the researcher was an older, foreign male and the range of participants was very diverse. Attempts to reduce the effects of some the possible impediments were made in a number of ways. First, the researcher dressed smartly but informally for most of the interviews and more formally when meeting officials of the church, government or development organisations. Second, to balance the gender influence, the notetaker was a woman, albeit a foreign woman. Third, when an interpreter was needed, this was always a young woman familiar with the local culture, who was able to put local women at ease and advise the researcher on cultural norms. Fourth, care was always taken to establish and maintain rapport through the use of body language, explanation of the purpose of the interview and giving interviewees the opportunity to ask questions and freely express themselves (5.5.5.3).

Procedural reliability was increased by all interviews being conducted by the same interviewer and notes taken by the same notetaker, who used a consistent style of recording, and keeping a record of the procedures used for selecting interview sites and the subjects to be interviewed. Consideration was also given to using the same interpreter for all of the interviews in each country. Although this was not possible because of the different languages involved, it was possible to use the same interpreter for all of the interviews in each geographic location.

5.5.5 Conduct of the Field Studies

This section describes in more detail the three strands to the field studies (5.5 and box 5.2): first, interviews with UK based mission organisations (5.5.5.1); second, the general survey of CHSs (5.5.5.2); and third, the in-country studies (5.5.5.3).

The first stage of the field study was to identify the availability of secondary data. For most of the UK-based mission organisations this included annual reports and websites, some of which were identified from telephone contact with their national offices. The Anglican Communion has a particularly useful website listing linked dioceses overseas, with names and e-mail addresses, for each UK diocese. Some organisations such as USPG - Anglicans in World Mission, CMS and the Methodist Church also publish periodicals dealing with mission in their respective denominations. USPG - Anglicans in World Mission (O'Connor 2000), CMS (Ward and Stanley 2000) and BMS (Baptist Missionary Society) (Stanley 1992) have relatively recent published histories.

A number of the CHAs, such as CHAM (Christian Health Association of Malawi), CHAG (Christian Health Association of Ghana), CHAK (Christian Health Association of Kenya) and CMAI (Christian Medical Association of India) have websites with useful data about their respective organisations. Some of the CHS hospitals, particularly the larger ones in India such as St Stephen's in Delhi and CMC (Christian Medical College) in Vellore, have their own comprehensive websites, but many websites are limited to basic information to attract overseas medical students seeking placements for their electives. Published data, such as annual reports and strategic plans, were obtained, where available, from each organisation during the visit to their site.

In conducting interviews consideration must be given to the amount of time available, both for the researcher and the respondent, the topics to be covered, and allowing the respondent to relate their own experiences. Bearing this in mind, the interviews conducted in the UK (5.5.5.1), Malawi and India (5.5.5.3) were carried out using topic guides as the basis for discussion (appendices 8, 11 and 12). These allowed specific topics to be covered whilst limiting researcher impact, but permitting valid interpretations of the respondents' experiences to be expressed (Huberman and Miles 1998). Consideration was given to the alternative approaches to recording respondents' views. The researcher writing notes himself would have had the advantage of being the least intrusive, but the disadvantage of being time consuming and with the probability of missing important quotes. Using a recording device would have had the advantage of enabling the production of verbatim notes, but some respondents find this approach off-putting and there would have been a practical difficulty of carrying numerous tapes and batteries for use in rural areas. It was, therefore, decided to use an assistant to take written notes of each respondent's views. As the assistant was in each case

female, this had the added benefit of encouraging female respondents to feel more at ease (5.5.5.1 and 5.5.5.3).

The general survey of CHSs (5.5.5.2) was conducted using a semi-structured questionnaire (appendices 10 and 11), which allowed respondents to freely reply to the questions. These were sent by e-mail, and by post to those who had not replied or were without e-mail access.

5.5.5.1 Interviews with Officers of UK based Mission Organisations

For the purpose of this research 'mission organisation' includes first, mission agencies which operate independently, but on behalf of a church denomination, as with CMS and USPG-Anglicans in World Mission, that operate on behalf of the Anglican Church; and second, the mission section of those churches which operate their own mission and overseas support functions, as with the World Church Office of the Methodist Church. As noted above, the denominations investigated are the major denominations that had been involved in foreign mission during the colonial era (5.4 and appendix 2).

Data was sought to investigate the second research question of how the policies of UK church and mission organisations have changed and how these changes have affected the funding of CHSs in their partner countries. This was initially explored using data available on the organisations' websites, where they exist, and some was obtained from their mission and values' statements, strategic plans, financial accounts, and annual reports. In some cases this was obtained in advance and in others it was obtained during the interview. There were variations in the willingness to provide such data, although on some occasions, where an initial request had been refused it was given following the interview. As there was difficulty

in easily obtaining historical documents, particularly within the available timescale, some of this information was obtained from published histories. It is acknowledged that these were often based on personal recollections, the authors of which may have a subjective perspective.

Twelve interviews were conducted with officers of the selected organisations (listed in appendix 2), using a topic guide (appendix 8). Some of these interviews were relatively easy to arrange, but others were more difficult either because of the commitments of the officer concerned, including overseas visits, or initial unwillingness to be interviewed. In a few cases additional interviews occurred on the suggestion of another interviewee. Eventually, with persistence, all intended interviews were completed, the results of which are reported in chapter six.

5.5.5.2 General Survey of Christian Health Services

In response to the first, third and fourth research questions, the general survey of CHSs in Commonwealth countries in S-SA, South Asia and the Pacific was carried out to generally explore the extent and nature of CHSs in their respective countries, their coordination, funding, relationships with their respective governments and government support of CHSs. It was apparent that the data gained by this method would be insufficient to adequately respond to the research questions, thus it was decided to conduct in-depth studies in two (initially three) countries and that this overview would provide a basis from which to select the countries to be studied. However, the limited number of CHAs identified, contacted and who had responded within the required timescale, limited the achievement of this intention. An approach to CHAs seemed an appropriate route for the investigation. Basic information was initially sought from websites, where these existed and could be accessed. A semi-structured

questionnaire (appendix 9) was sent to CHAs by e-mail, and by post to those who had not replied or were without e-mail access.

Because there is no easily accessible database of CHAs or CHSs, a variety of means were used to identify them. These included:-

► UK-based churches and mission organisations, including the office of Anglicans in Development at Lambeth Palace. The Anglican Communion website was also particularly useful.

► Christian Aid.

► UK-based linking and recruiting agencies such as:-

Christian Medical Fellowship/Healthserve,   Global Connections,

Partnership for World Mission,   World Service Enquiry.

► An officer at CHAM (CHA of Malawi) helped to locate other CHAs in S-SA, and an officer at CMAI (Christian Medical Association of India) helped to locate other CHAs in South Asia.

For those countries without a CHA, or where the CHA continued not to respond, or where the address of the CHA was unknown, an individual denominational CHS, where one had been identified and its e-mail address obtained, was sent a semi-structured questionnaire by e-mail (appendix 10). In some cases the CHA was identified through a denominational CHS. The number of questions was limited to encourage a response.

There were responses from nine countries in S-SA, five in South Asia and two in the Pacific. No CHS was identified in either Malaysia or Sri Lanka. The Melanesian Mission advised that, with the exception of PNG (Papua New Guinea), the CHSs of most of the other Pacific

countries had been transferred to the government at the time of independence. Of the

countries listed in appendix three, thirteen provided usable data. This activity provided a

snapshot of CHSs, based on the views of those CHSs and CHAs that were successfully

contacted and responded, rather than a representative or comprehensive picture. The results of

this part of the research are reported in chapters six and seven.

5.5.5.3 In-country Studies

The limited data provided by the e-mail questionnaires and requests for clarification or

supplementary information confirmed the need to proceed with conducting in-country face-to-

face interviews. The in-country studies explored research question two from a different

perspective than that in 5.5.5.1 and the other three questions in greater depth, i.e. how CHSs

have responded to the changed funding policies of and relationships with their partner

churches and mission organisations in the UK and elsewhere, and the effects of such changes

on the extent and type of service provided, their users and their relationships with their

respective governments and church organisations.

Although more countries would have been preferable, the available time only permitted two

countries to be studied. The conceptual framework (5.2) refers to the potential significance for

the operation of CHSs of their relationship with their respective governments, their

contribution to national health service provision, the financial support given by governments

and the role of CHAs. These factors were taken into account when making the country

selection. Malawi was selected as a mainly Christian country in S-SA in which it was reported

by CHAM that CHSs provided 37% of the country's health services and that it is the sole

CHA in Malawi and is working closely with the government. India was selected because of its

major differences from Malawi, including its Asian location, with a minority Christian population, and in which it was reported by CMAI (Christian Medical Association of India) that there are separate Protestant and Catholic CHAs, and limited cooperation with the government.

The starting point in both countries was the CHA, which helped with identifying contacts, giving administrative support, providing letters of introduction, assisting with use of its telephone to make appointments and general conveyance of messages. This assistance eased the process in both countries and maximised the use of available time, but was accompanied by the danger of the researcher being identified too closely with the CHA and perceived as acting on its behalf. It was necessary to clarify the researcher's independence at the start of each interview. Fontana and Frey (2000) stress the importance of finding an insider to advise on cultural norms, jargon or language. At the country level this role was performed in Malawi by the Director of Health Programmes at CHAM and in India by the General Secretary of CMAI and the Director of CHAI respectively. At the health facility level this role was variously played by the Medical Director, Nursing Director and Administrator. Much advice and guidance was also given by the interpreters.

Relevant documents, including mission statements, policies, strategic and operational plans, and annual reports, were obtained, where available, to ascertain whether the recorded values, policies and procedures of Christian organisations demonstrated a particular socioeconomic orientation, and whether this is overtly recognised by other organisations. Individual interviews were generally conducted because of the opportunity to explore the issues in greater depth without the views of the specific officer being influenced by the views of

colleagues, particularly where a superior-subordinate relationship was involved. Occasionally, two or more officers were interviewed together where it was judged that the benefits of a joint view outweighed this consideration, or where the respondents felt more at ease being interviewed together. There were two sets of interviews for this strand of the research, first, with key officers at national and local level and second, at selected health facilities, which included interviews in the local communities living close to the health facility locations.

Key officers were interviewed with the help of a topic guide (appendix 11) to determine their perceptions of the current and changing role of CHSs from the perspective of the CHAs, schools of nursing and medicine, different arms of the churches, and development agencies. Representatives of several government institutions were interviewed in Malawi, but in India it was not possible to obtain permission to officially interview government officers, although a number agreed informally to be interviewed. In India, Hindu and Muslim leaders were also interviewed to ascertain their views, because less than 3% of the population are Christian. The majority of intended interviews were conducted (schedules in appendices 4 and 6), but there were some intended respondents with whom it was not possible to arrange an interview, including the Primate of the Catholic Church in Malawi and the Bishop of Delhi Diocese of the Church of North India.

There was limited data available from the CHAs and CHS national offices on the detailed operation of health facilities and their users, therefore, it was necessary to visit a selection of health facilities to gather data. In order to gain as broad a picture as possible it was decided to conduct interviews in six health facilities in each of the two countries. From the databases held by the respective CHAs, the researcher carefully selected facilities of

different types and denominations, in urban and rural locations, in two Malawian regions and three Indian states (maps 6.1 and 6.2). The selections reflected the former mission church denominations with the largest number of health facilities and included health facilities which were regarded by the respective CHA officers as thriving and those experiencing difficulty.

The health facilities in Malawi were:-

Southern Region -

Rural - St Luke's Hospital (Anglican), Pirimiti Community Hospital (Catholic), Mposa Health Centre (Anglican).

Central Region

Rural - Nkhoma Hospital (Presbyterian), Frances Palau Community Hospital (Catholic),

Urban - Chimwalla Health Centre (Presbyterian).

It became increasingly apparent during these early interviews that there were three particular initiatives affecting CHSs: first, the fees and subsidies policy produced by CHAM; second, the service agreements being negotiated between DHOs (District Health Officers) and particular CHS facilities; and third, a financial capacity building project, which was being piloted at specific CHS facilities. As the latter two initiatives were expected to have important service implications for all CHS facilities in time, although none of the hospitals selected were involved at the time of the study, it was decided to include two additional locations, at which interviews were limited to senior staff: St Anne's Hospital (Anglican, rural) and Likuni Hospital (Catholic, urban).

St Anne's Hospital planned to have the first government service agreement. In the event this was finalised much later than planned because of disagreement over the terms; however the

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delay in itself was sufficient reason for exploring the negotiations further.

Likuni Hospital was participating in the pilot financial capacity building project, which involved devolution of designated financial responsibilities. Unbeknown to the researcher in advance, it was also in the process of implementing a service agreement, which added increased benefit to its inclusion.

The health facilities in India were:-

Delhi – CNI (Church of North India)

Urban - St Stephen's Hospital, Sunder Nagri Health and Community Centre.

Tamil Nadu – CSI (Church of South India)

Urban - Kalyani Hospital,

Rural - Ikadu Hospital.

Andhra Pradesh - Catholic

Rural - St Theresa's Hospital, St Ignatius Health Centre

There were two other hospitals, of which the researcher was aware in advance but because they were atypical, were not initially included in the study. However during the course of the interviews, reference was frequently made to them. Both were Protestant, but independent of any denominational structure:-

CMC (Christian Medical College) at Vellore is a centre of educational and treatment excellence that also operates a major outreach programme, provides substantial services for

poor and marginalised patients, is well respected by the government and gives educational support to other CHS institutions.

CFH (Christian Fellowship Hospital) at Oddanchatram operates on Christian fellowship principles, by which members of the fellowship dedicate their lives to the hospital and are paid only a modest living allowance. It was reported by staff in other hospitals that this hospital gave priority to services for the poor and never turned anyone away because they could not pay. It was also reported that staff who had trained or worked in this hospital took the compassion associated with this hospital with them when they worked elsewhere.

As these two hospitals had such an outstanding reputation and were reputed to be successful when others were struggling, it was decided to include them, but because of time constraints, interviews were limited to senior staff.

Thus, interviews were limited to senior staff in four of the health facilities, while in twelve interviews were conducted with managers, staff, patients and residents of communities living within close geographical proximity of the health facility. The purpose of these interviews was to explore the perceptions and experiences of managers, 'hands-on' health workers, and past, current and prospective users of the services. At all of the large hospitals, the researcher was able to sleep and eat in the staff residence, or in the case of the Catholic health facilities, the adjacent convent. In a minority of locations, the absence of available accommodation necessitated travelling to the site each day. Thus in most locations, it was possible to utilise the whole of the day and evening, maximising the opportunity to follow up outstanding issues, as well as providing an opportunity to absorb the ambience of the facility and the surrounding area.

Participants for interview were drawn by purposive sampling as follows:-

a) The outpatients' departments, and maternal and child health clinics, which are the front door of health facilities, and the only health service contact for many patients. Women generally have greater contact with health services throughout their lives than men do, because of conditions related to female reproductive health and their generally greater responsibility for child rearing. Thus interviews were conducted with six male and six female outpatients, and six women attending for maternal and child health services, i.e. antenatal, family planning or child growth clinic, who were selected as they became available after their consultations with the health workers. Patients were approached jointly by the researcher and the interpreter. Most of those approached agreed to be interviewed. The main reasons for declining were that the patient was in a hurry to catch transport, or had an infant who needed feeding.

b) Because of the possibility that the values, policies and socioeconomic orientation of the service are perceived and applied differently by health workers of different ranks and gender, a mix of staff were interviewed. The number interviewed varied according to the size of the health facility and the number of staff employed. At hospitals, the Director, Head of Nursing, Medical Officer, Administrator and Treasurer (depending on the actual staff structure) were interviewed, as well as a senior nurse and junior nurse of each gender, where available, and the health worker responsible for community outreach. The staff establishment was less at health centres, and thus the number of staff interviewed smaller. Senior staff were identified by the positions they held and were usually agreeable to being interviewed. The major constraint was the availability of their time, and for some it was necessary to continue the interview over several sessions. Junior staff to be interviewed were generally selected

according to their gender, position and department and negotiated with the individuals concerned. Some were initially self-conscious, but more relaxed when they were assured of being out of the earshot of others.

c) The communities within the catchment areas of the health facilities comprise past and potential users of the health service, who have valid views on the values and socioeconomic orientation of the health facility. It was useful to explore why community members had, or had not, used the CHS. Because of the family gender relationships in many traditional communities, particularly in rural areas, it was necessary to interview both women and men. Within the time and resources available, it was only possible to interview a small sample of residents: six men and six women were interviewed in each location, in order to provide a reasonably reliable flavour of typical residents' views. The aim was to conduct each interview in the absence of the respondent's husband or wife wherever possible to avoid spousal influence on responses. In most instances this was achieved, particularly in communities where there was separation in the lives of men and women, but in some urban parts of India, it proved to be more difficult.

It was felt that there would be some benefit in identifying the socioeconomic status of the interviewees, who were either current patients or members of the local community and, therefore, potential patients. Although it was recognised that the samples were too small to be statistically significant, individuals' socioeconomic status can be relevant to their views on the services provided by their local CHS facility. For this purpose it was necessary to employ a simple tool to determine whether health service users and potential users were severely poor, moderately poor, or not poor.

In the search for an appropriate tool, the life expectancy and infant mortality figures recorded in tables 3.1 and 6.1 as proxy measures for the health and development status of populations are not an appropriate measure for the status of individual people. Of the four approaches identified by Laderchi et al. (2003) both the monetary and the participatory approaches were rejected. The monetary approach, although it is commonly used as a measure of poverty by UN agencies, was rejected because of the difficulty of quantifying income or expenditure amongst people with a subsistence economy. The participatory approach has the merit of involving poor people themselves in the assessment of poverty within their own community (Chambers 1994), but was rejected because it is very time consuming. The matrix of wellbeing variables produced by Ashley and Carney (1999), which was developed by CARE and accepted by DFID within its Sustainable Livelihoods programme, seemed to be more appropriate. This tool draws on the work of the capabilities and participatory approaches by taking account of a number of factors, which are agreed with local people. The CARE matrix gathers simple information on family size, children in school, food consumption, house ownership, business, assets and husband's occupation.

For the current research the precise category definitions for urban and rural households were modified from the initial definitions in consultation with local people to achieve relevance to the situations under study (appendices 13 and 14). Because a significant number of respondents fell between two categories, two intermediate levels of poverty were added to give a total of five levels as follows: not poor, mildly poor, moderately poor, very poor and severely poor. Sufficient information was collected from interviewees to facilitate subsequent amendment to the matrix categories if necessary. In the event the category of children in school was deleted because education was provided free in both countries and the number of

parents declaring that their children did not attend school was negligible. The matrix was applied retrospectively to patients interviewed at the health facility, with no attempt to pre-select according to socioeconomic status, but prospectively for community members who were selected to represent the different socioeconomic status categories. This was carried out with the help of a community worker and/or community leader who thus had some influence on which individuals were selected. One result was that the socioeconomic status of the interviewees suggested by the 'gatekeeper' did not always match their status as measured by the matrix. This occurred particularly in Malawi, where a higher proportion of the respondents than intended were drawn from the moderately to severely poor categories. It is acknowledged that in these instances respondents' views represent the poorer sections of the communities concerned, but this is not regarded as a major problem as the main focus of the research is to assess whether CHSs are providing services for the poor.

As pointed out by Clendenin and Connelly (1998), the responses of interviewees can be greatly shaped by the approach of the interviewer. This point was borne in mind throughout the field study, and particularly when dealing with junior staff, patients and community members, for interviews with whom it was necessary to employ an interpreter. In each location, a female high school or college student was recruited for two reasons: first, as a female it was anticipated that she would be more likely to establish a rapport with the female respondents; and second, as someone not connected with the health facility, it was considered that she would be seen as less likely to interject her own opinions into the interviews or to breach confidentiality. All key officers and senior staff were able to communicate in English.

The topic guide for this part of the research (appendix 12) was divided into three parts. The first part sought factual data about the health facility, which was normally provided by the Administrator; the second part sought information from everyone on their experiences and perceptions of the particular health facility; the third part sought views on managerial and policy issues concerning the CHS from those respondents in managerial roles and those who had a wider experience of the CHS. The results of this part of the research are reported in chapters six and seven.

A total of 275 interviews were conducted in Malawi and 293 in India (listed in appendices 4, 5, 6 and 7).

5.5.6 Data Analysis

The data analysis followed four stages:-

1. Condensing field texts into analysable units by creating categories (coding)

2. Exploring the codes and categories, including the splitting, linking and creation of new categories.

3. Interrogating the data for patterns, themes, regularities, contrasts, and exceptions.

4. Drawing out conceptual connections and coherence, reflection and theory building.

(Dey 1993, Coffey and Atkinson 1996, Huberman and Miles 1998, Clandinin and Connelly 1998, Flick 2002).

In the current research these stages were pursued as follows:-

1. Condensing field texts

Field texts were created by employing the services of an assistant to write the responses of

interviewees on individualised topic guides at the time of the interview. Each interview and e-mail questionnaire response was later typed individually into MS Word and given a unique code defining its key attributes for ease of retrieval. For example in the code:-

'mw-int-hf-pir-pt-ml-v-op-bk', the component parts define the following characteristics:-

mw = Malawi, int= interview, hf= health facility, pir=name of health facility,

pt=patient, ml=male, v=very poor, op=outpatient, bk= interviewee's initials.

Consideration was given at this point to the possible use of specialised computer software, but three points weighed in favour of continuing with MS Word. First, there is a danger that the specialist computer software can constrain the analysis within its own limitations (Coffey and Atkinson 1996), second, 'qualitative data are particularly resistant to tidy processing methods' (Richards and Richards 1998.211) and third, contemporary word processors have the ability to carry out most of the necessary tasks (Coffey and Atkinson 1996).

2. Exploring codes and categories

New files were then set up under each topic heading and the responses from each interviewee cut and pasted from their personal file into a master file for each topic with responses categorised under the following headings:-

a) Name of each health facility - managers, staff, male outpatients, female outpatients, maternal and child health patients (all female), male community members, female community members.

b) Key officers -schools of nursing and medicine, churches, Hindu and Muslim leaders (India only), development organisations, government, CHA.

3. Interrogating the data for patterns

The topic files were then reformulated identifying themes and grouping together experiences and opinions under each theme. From these groupings patterns, regularities, contrasts, and exceptions were identified.

The views of the managers of each health facility and statements in their official documents were taken as the official position on each of the topics. These were then compared with the responses from other interviews to consider whether the actual experiences of staff, patients, the community and key officers were consistent or at variance with the official intention. There was a constant tension between reducing data at the same time as collecting more (Huberman and Miles 1998) and new ideas, lines of inquiry and analytical possibilities continued through to the writing-up stage (Coffey and Atkinson 1996).

4. Drawing out connections and theory building

The results are presented in chapters six and seven and respond to each of the four research questions, although there is considerable overlap between the responses to the research questions. The main form used is narrative description under each of the topic headings, supported, where appropriate, by verbatim quotations and case examples. The conclusions, models and theory building are drawn out in chapter eight.

Note

For clarification the following points apply in chapters six and seven:-

a)   All verbatim quotes are in italics and inverted commas, and are taken from face-to-face interviews except where stated otherwise.

b) Where a single person from an organisation was interviewed, only the name of the organisation is cited, but where more than one person was interviewed, the person's title is given also.

c) Attribution of interviews to Malawi or India are indicated by –M or –I respectively.

d) When the term 'both countries' is used it refers to Malawi and India.

e) When the term 'all 13 countries' is used it applies to all of the study countries, including Malawi and India.

CHRISTIAN HEALTH SERVICES IN MALAWI, INDIA

AND OTHER STUDY COUNTRIES: THEIR BACKGROUND, CHANGED

RELATIONSHIPS WITH THEIR DENOMINATIONAL CHURCHES AND UK

MISSION ORGANISATIONS, AND RELIGIOUS ORIENTATION.

6.1 Introduction

This is the first of two chapters (chapters 6 and 7) which explore the results from: first, the general questionnaire survey of CHAs (Christian Health Associations); second, the interviews with senior officers of UK mission organisations; third, the interviews conducted in Malawi and India and fourth, data gained from the websites, reports and other published literature of CHSs (Christian Health Services), CHAs and mission organisations where they exist and could be accessed.

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This chapter is divided into three parts. The first part (6.2) provides the political, economic and health sector background in which the CHSs of the thirteen study countries operate. The second part (6.3) responds to the first research question by exploring the current contribution of CHSs to the total health service of their respective countries, including the roles and operations of CHAs. The third part (6.4) responds to the second research question by investigating how and why the policies of UK-based mission organisations have changed; how the changes have affected their relationships with, and support given to, their developing country partner churches and their health services; and the impact of CHSs' religious heritage on their service provision. This part also includes the CHSs' perspective on the support they receive from mission organisations outside of the UK. The issues covered in the responses to these questions are not discrete and some of the material is relevant to other research

questions. These connections will be highlighted in the analysis. As noted in chapter 5, all quotes from interviews are printed in italics and in inverted commas. Where there was a sole person interviewed from the organisation only the organisation name is given. The position of the interviewee is also given for organisations in which more than one person was interviewed.

6.2 Political, Economic and Health Sector Background of the Study Countries

This section comprises three parts, in each of which there is a brief examination of the topic for all 13 countries, followed by a more in-depth exploration for Malawi and India. The purpose of this is to identify the environment within which CHSs operate related to the countries' geographic locations and development status (6.2.1); health status (6.2.2); and health sectors (6.2.3).

6.2.1   Geographic Location and Development Status

Nine of the study countries (table 6.1) are located in S-SA (Sub-Saharan Africa), three in South Asia and one in the Pacific region. Further information on the country selection was given in sections 5.4 and 5.5.5.2. The level of human and economic development is compared using the three indicators of LEB (life expectancy at birth), IMR (infant mortality ratio) and GDP per capita. LEB and IMR are common proxy measures of a country's health status (3.3.1), and are combined with adult literacy in the compilation of the UNDP Human Development Index. According to the HDI, eleven of the countries, including India, are in the MHD (medium human development) group of countries, and two, including Malawi, are in the LHD (low human development) group (UNDP 2008). All of the countries in this study except South Africa can be regarded as some of the poorest worldwide as indicated by their

GDP per capita which is substantially below the average of US$4,876 for all MHD countries. The result of this situation is that not only do these countries have some of the lowest health indicators worldwide (see section 6.2.2), but they are amongst the least able economically to address health problems. All per capita financial figures quoted in this section are adjusted for Purchasing Power Parity.

	Life Expectancy At Birth	Infant Mortality Per 1000 live Births	GDP per Capita (ppp US$)	Health Expenditure per Capita (ppp US$)
Medium Human Development				
Pakistan	64.6	79	2,370	48
India	63.7	56	3,452	91
Bangladesh	63.1	54	2,053	64
Ghana	59.1	68	2,480	95
Papua New Guinea	56.9	55	2,563	147
Kenya	52.1	79	1,240	86
South Africa	50.8	55	11,110	748
Cameroon	49.8	87	2,999	83
Uganda	49.7	79	1,454	135
Lesotho	42.6	102	3,335	139
Zimbabwe	40.9	81	2,038	139
All medium HD	67.5	45	4,876	n/a
Low Human Development				
Tanzania	51	76	744	29
Malawi	46.3	79	667	58
All low HD	48.5	108	1,112	n/a
All high HD	75.7	13	23,986	n/a
Note n/a = data not available				

Table 6.1 Selected figures from Human Development Indices (UNDP 2008)

India and Malawi contrast with each other in several ways including their size, location, population, cultural diversity and economy. Malawi is a small landlocked country in southern Africa divided into three regions and 27 districts. The population is approximately 13.2 million. India, on the other hand, dominates the south of Asia and is surrounded on two sides by sea. It is often referred to as a subcontinent rather than a country because of both its size

and the diversity of its geography, ethnicity, languages and religions (Christian Aid 2005). It has 28 states, each with its own state assembly. With a population of approximately 1.1 billion people, India is the second most populous country worldwide. Whilst Malawi has an annual population growth rate of 2.5% and 47% of the population is under 15 years of age, the comparable figures for India are significantly lower at 1.4% and 33% respectively. A higher proportion of Malawians (83%) live in rural areas than Indians (71%) (UNDP 2008).

The economic inequality indicators demonstrate similar levels of inequality in both countries: the poorest 20% share 7% of income or expenditure in Malawi and 8.1% in India, whilst the richest 20% share 46.6% in Malawi and 45.3% in India (UNDP 2008). The major causes of poverty in Malawi are low land productivity due to rapid environmental degradation and limited access to land, low levels of education, poor health status, which has worsened with the advent of HIV/AIDS, and gender inequalities (WHO 2005b). The most vulnerable people include AIDS orphans; women, who are often restricted by family obligations, particularly those heading households; tenants; estate workers; casual labourers; and the disabled. These groups suffer the additional disadvantages of low literacy, higher child and maternal mortality, greater food insecurity, and poor access to productive assets (DFID 2003).

In India the powerful effects of caste, ethnicity, patriarchy and feudalism have created a degree of social exclusion for particular groups that denies them access to the benefits of the country's development. Dalits and Adivasis comprise almost a quarter of the total population, nearly one half of whom live below the poverty line (Christian Aid 2005). Denial of equal wages and access to basic healthcare and education has led to poor health, low social status, poverty and vulnerability of women. Gender inequality is also manifested in the neglect of

girl children, female infanticide and foeticide, resulting in an imbalance of 927 girls to 1000 boys. An estimated 60-115 million children are working, many in bonded conditions; they suffer severe deprivation and exploitation (Christian Aid 2005).

6.2.2 Health Status

The health status of populations in all 13 countries are at the lower end of the global scale, with lower LEB and higher IMR than the average of 67.5 and 45 per 1000 live births respectively for all MHD countries (table 6.1). Malawi's maternal mortality ratio is reported to be the highest in Africa at 1,120 deaths per 100,000 live births due to poor quality of care; lack of essential medicines, equipment and supplies; shortage of skilled attendants; and a poor health sector referral system. There has been some improvement in infant and under 5 mortality, but the neonatal mortality rate remains high at 42 per 1000 live births, caused by infections, complications during delivery, prematurity and delays in getting to health facilities (GOM 2004, WHO 2005b). The maternal mortality rate in India of 450 deaths per 100,000 live births is less than half that for Malawi (UNDP 2008). Some of the reasons for this are that 69% of rural and 41% of urban women are married before the age of 16 and the median age of first pregnancy is 19.2 years. Only 65% of pregnant women receive antenatal care, 34% have institutional deliveries and 42% receive professional medical care (WHO 2005a).

In India 36% of mortality is from communicable diseases, perinatal and maternal conditions and nutritional deficiencies (WHO 2005a). More than one third of Indian women and almost half of Indian children are malnourished. The major causes of child mortality are acute respiratory infections, dehydration due to diarrhoea, measles, and in some areas malaria (WHO 2005a). The poorest quintile have more than double the mortality rates, malnutrition

and fertility of the richest quintile of the population and inter-state differentials are increasing (Peters et al. 2002). Fewer than half of all Indian children receive the recommended vaccinations at two years of age (WHO 2005a), whilst, in Malawi, high routine coverage for all childhood immunisations has been sustained since 1989, although there was a decline to less than 80% between 1999 and 2002 due to a global shortage of vaccines (WHO 2005b).

There are more than eight million episodes of malaria per year in a population of 11.9 million in Malawi, making it the most commonly reported cause of morbidity and mortality in adults, particularly pregnant women, and children (WHO 2005b), and accounting for 30% of OPD (outpatient department) attendances (GOM 2004). This is followed by chronic malnutrition, suffered by 50% of children under five, due to household food insecurity resulting from poverty, poor weaning and feeding practices, and frequent infections (WHO 2005b). Diarrhoeal diseases, especially in children, and cholera epidemics are common. Tuberculosis increased from 14,322 cases in 1991 to 27,000 in 2004 largely due to HIV infection, estimated at three times higher than it would be without HIV/AIDS (WHO 2005b). In India there are over 1.8 million new cases of tuberculosis and over 1.5 million people contract malaria each year (WHO 2005a).

More than five million Indians are living with HIV/AIDS, although with an average prevalence of 0.9%, compared with 14.1% in Malawi (UNDP 2008), the prevalence is still relatively low by global standards. The prevalence in Malawi ranks as the ninth highest worldwide, with HIV/AIDS-related conditions accounting for over 40% of all inpatient admissions and 15% of households being child headed (GOM 2004). One third of infected people live in urban and two thirds in rural areas. Over 800,000 children under 18 years of age

are orphans. There are huge unmet needs for orphan care, ART (anti-retroviral therapy), access to voluntary testing and counselling, and antenatal care including prevention of mother-to-child transmission. The high mortality from HIV/AIDS is threatening the normal demographic transition from high fertility/high mortality to high fertility/low mortality, and then low fertility/low mortality, referred to in section 3.2 (WHO 2005b).

6.2.3 Health Sectors

The purpose of this section is to first identify the level of financial commitment to the health sector of governments in the study countries, and then to identify the health sector structures and systems within which CHSs operate in Malawi and India.

Health expenditure per capita in the study countries ranges from US$29 in Tanzania to US$147 in PNG (Papua New Guinea), with the exception of South Africa with US$748 per capita (table 6.1). The health expenditure per capita in India at US$91 is substantially higher than the US$58 in Malawi. No average health expenditures per capita are given in the UNDP indices, but the difference is apparent when these figures are compared with those for richer nations. For example, the comparable figure for the UK is US$2,560 per capita, and US$3,294 for Iceland, which had the highest human development ranking (UNDP 2008).

The conceptual framework referred to underperformance of the health programmes of many newly independent governments: even today only 54% of Malawi's rural population have access to formal health services within a five kilometre radius, resulting in nearly half of the population either not seeking treatment, seeking treatment from a traditional healer, or having to travel over five miles for treatment. 60% of health facilities are operated by the GHS

(government health service) and 38% by CHAM (Christian Health Association of Malawi) affiliated organisations. Fewer than 10% are resourced to deliver the EHP (Essential Health Package), which includes OPD (outpatient services), FP (family planning), immunisation and maternity services. Financial barriers to improving services exist, particularly in CHAM facilities, where as a result user fees are levied, posing a serious threat to equity amongst the rural poor. The poorest households spend 7.4-10% of their annual consumption on health care. Approximately 25% of health expenditure is from government funds, 30% from donors, 19% from employers' contributions, and 26% from user fees. The government intended that the signing of an MOU with CHAM in 2004 was a significant step towards ensuring that no one is denied access to the EHP through an inability to pay. A further constraint on service provision is the acute shortage of skilled personnel, which is exacerbated by an inequitable distribution in favour of urban and tertiary services, despite 87% of people living in rural areas. This disparity is attributed to the lack of rural accommodation and social and educational facilities. In 2004, 62% of trained health worker posts remained vacant due to a training deficit, retirements, emigration, and mortality due to AIDS (GOM 2004). Malawi has only 2 physicians to 100,000 population compared with 60 in India (UNDP 2008).

Some CHS and GHS hospitals in Malawi have half, or more, of their nursing posts vacant. The matron of the government hospital in Lilongwe affirmed:-

"We have 311 vacant nursing posts from an establishment of 534, resulting in one nurse looking after70 patients".

CHS managers explained that an exacerbating factor is loss of staff to posts in NGOs or overseas with better salaries and conditions of service. The favourite description of this phenomenon is *"moving on to greener pastures".* The Lilongwe matron again: -

"The University of North Carolina recruited 80 nurses over the last few years for research and 'Action against Hunger' took 10 registered nurses".

Even though, under the Indian Constitution, the 28 state governments have responsibility for public health and hospitals, the central government is financing national disease control, family welfare and reproductive and child health programmes. The numerous informal providers include several indigenous and complementary forms of medicine. The Primary Health Centres are the core of the rural health service, each providing outpatient services to a population of 30,000, with their associated Sub Centres, each providing outreach services to 5,000 people. Inpatient and more specialised services are provided at Community Health Centres serving populations of 100,000. Referral care is largely provided by District hospitals and medical college teaching hospitals (WHO 2005a).

Unlike Malawi, India has a large private sector, including for-profit and not-for-profit providers. It is estimated that approximately three quarters of outpatient care and two thirds of hospitals are provided by the private sector (WHO 2005a). More than 80% of qualified allopathic doctors practise in the private sector (Peters et al. 2002). It is argued that the private sector, which comprises corporate hospitals at one end of the spectrum and small allopathic and traditional providers, including single-handed practitioners and specialist clinics, at the other, expanded because of widespread dissatisfaction with the public services (Peters et al. 2002). This occurred despite the public services being largely free at the point of use and private hospitals not always having a set fee schedule.

The private sector in India is largely unregulated: most of the numerous informal practitioners are reported to provide a low quality service and are less than fully qualified (WHO 2005a,

Peters et al. 2002). The private non-profit sector includes voluntary organisations, charitable trusts and missions which, since the 1960s, have been broadening their focus from hospital care to include more community health programmes (WHO 2005a). As the government's infrastructure is unable to meet the demands of the epidemiological and demographic transition, there is considered to be an opportunity for increasing the participation of NFPOs (not-for-profit organisations) to help achieve public health goals, particularly in poor performing states and remote areas (WHO 2005). However, this poses challenges.

72% of India's health expenditure is from households through user fees or insurance schemes, 13% from state governments, 6% from central government, 2% from local governments, 5% from employer schemes and 2% from external aid agencies (National Health Accounts of India 2001-2 cited by WHO 2005a). There are two mandatory employment-related health insurance schemes: ESIS (Employees State Insurance Scheme) for specified low income industrial employees and the CGHS (Central Government Health Scheme), mainly for central government employees. A number of companies also offer employment health insurance to their employees (Peters et al. 2002). However, the bulk of funding for the public sector is from general taxation because of the low level of cost recovery from users and the difficulties of operating health insurance because of the low rate of participation in the formal labour market (Peters et al. 2002).

6.3 The Extent and Type of Services Operated by Christian Providers

This section is divided into three parts: first, a general examination of the extent and type of services provided by CHSs in the 13 study countries (6.3.1), second, a general description of

the health facilities researched in Malawi and India (6.3.2), and third, an examination of the roles and operations of CHAs (6.3.3).

6.3.1 CHS Provision in the Study Countries

Quantification of health services is confused by problems of definition (4.3), both of what is included in the definition of a health facility, and what services are actually provided from those facilities. For example, some health facilities have a larger number of beds than others, but their occupancy might be lower. Further, some CHSs operate from small premises but have large networks of outreach services. Another problem in determining the proportion is that once the definition of a health facility or what constitutes a bed has been agreed, it might be relatively easy to calculate the number of CHS and government facilities or beds, but in countries where there is little regulation of private health facilities, the number of these facilities or beds might not be known.

It was not possible to obtain figures for CHSs as a proportion of the total health sector for all of the countries listed in table 4.1. However, the figures supplied in the questionnaire responses indicate that while CHSs provide a broadly similar proportion of the total in most of S-SA and PNG (30-50%), they are estimated to be much less important in South Asia, ranging from 1% of the total in Bangladesh to approximately 10% in India. During the post-colonial period, the proportion of health services provided by CHSs in some countries has changed for a variety of reasons. Increases have occurred in some countries as a result of CHSs expanding their services, or (more recently) governments returning services to CHS that they had previously taken into government control. Decreases have occurred because governments

have nationalised CHS facilities, or facilities have closed due to increases in user fees or

competition with expanding private or government sectors.

Country	Hospitals	Health Centres	Aid Posts/ Dispensaries
Cameroon (Presbyterian only)	5	21	1
Ghana	61	91	0
Kenya (Catholic)	45	92	282
Kenya (Protestant)	25	48	324
Lesotho	8	75	0
Malawi	*41	125	0
Tanzania (Anglican only)	13	20	40
Uganda (Catholic)	27	154	79
Uganda (Protestant)	15	59	184
Zimbabwe	78	48	126
Bangladesh	8	0	3
India (Catholic)	515	795	1251
India (Protestant)	258	16	2
Papua New Guinea	16	305	284

Note

In Cameroon and Tanzania figures were only available for the Presbyterian and

Anglican CHSs respectively.

n/a = figure not available
*includes 20 community hospitals

Table 6.2 Disaggregated health facility figures per country (figures obtained from
questionnaires and websites provided between 2006-08 - see appendix 3)

In all the countries for which disaggregated figures are available, CHSs operate a range of

facilities (table 6.2). Again, there is a problem of definition: for example a facility classified

as a large health centre in some countries is regarded as a small hospital in others and in some

cases there is a tendency to accord facilities higher status by giving them higher level titles.

Thus these figures can only be regarded as a rough guide. The table does not list the large

number of social welfare projects provided as part of facility programmes which, because of their varying nature, are difficult to compare between countries.

The figures generally suggest an inverse ratio between the size of facility and the number of that type of facility, i.e. dispensaries and aid posts, which are the smallest types of facility, are the most common, and there are fewer hospitals, which are the largest types of facility. This is consistent with a policy of encouraging patients to attend the lowest level of facility, with referral to a higher level facility if necessary. However, there are exceptions: The CHSs in Cameroon (Presbyterian Church), Lesotho and Bangladesh have few or no dispensaries, which suggests that patients are either seeking lower level services from elsewhere, or are attending a higher level facility than is necessary. The ratio between health centres and aid posts in PNG is possibly the result of the government reclassifying the previous category of health sub-centres to health centres. The Protestant CHS in India appears to operate fourteen times as many hospitals as health centres, although many of these hospitals have fewer than 20 beds and would be more correctly designated health centres.

In addition to operating health facilities, many CHSs have different types of outreach programmes, which most commonly comprise MCH (maternal and child health) clinics at which antenatal mothers are examined and children under 5 are immunised and monitored for their growth and development. Additionally, some operate community based health care in which village volunteers are trained and supervised by CHS health workers. The advent of HIV/AIDS has seen the development of VTCs (Voluntary Testing and Counselling Centres), many of which are not located at formal health facilities but operate within communities.

6.3.2 Description of Health Facilities Researched in Malawi and India

Interviews were carried out in a total of sixteen CHS health facilities of different types and denominations, and in different states and regions, in India and Malawi. The selection of facilities for the study has been explained in section 5.5.5.3. In this section the location and brief description of each facility is given.

As noted in chapter 5, in Malawi (Map 6.1) three health facilities in the Southern Region were studied: St Luke's Hospital (Anglican), Pirimiti Community Hospital (Catholic) and Mposa Health Centre (Anglican), all of which were in rural locations but accessible by public transport, and initially three health facilities in the Central Region: Nkhoma Hospital (Presbyterian) and Francisco Palau Community Hospital (Catholic), both of which are rural but on a main public transport route to Lilongwe, the capital of Malawi and Chimwalla Health Centre (Presbyterian) which is in a semi-urban area on the outskirts of Lilongwe. Likuni Hospital (Catholic) and St Anne's Hospital (Anglican) were also visited. Likuni, which is in a semi-urban area on the outskirts of Lilongwe, was selected because it was participating in the financial capacity building project initiated by CHAM, the aims of which were described by the project coordinator as:-

"... developing financial skills to enable devolution of financial management and accountability to individual CHS facilities. Personnel who have been trained are bonded for three years to ensure that their health facility benefits from the project".

St Anne's was visited because it planned to have the first government service agreement, although in the event it was not the first because of a dispute over the terms of the agreement.

MALAWI

Tunduma
Chitipa
Chisenga
Karonga

ZAMBIA

CHITIPA

KARONGA

LAKE

Nyika Plateau
Katumbi
RUMPHI
Bolero
Rumphi

NORTHERN

Ekwendeni
Chikwina
Kafukule
Mzuzu
Euthini
Nkhata Bay

MZIMBA
Chintheche
Mzimba
MALAWI
Edingeni
Chizumulu
Likoma

Lundazi

UNITED REPUBLIC
OF
TANZANIA

Francis Palau
Community Hospital

KASUNGU

M A L A W

Lake Nyasa

Kasungu
Nkhotakota

MOZAMBIQUE

Likuni Hospital

CENTRAL
NTCHISI
Ntchisi
St Anne's Hospital

Mponela
Chipata
MCHINJI
DOWA
Dowa
Mchinji
Chilobwe
SALIMA
LILONGWE
Salima
Makanjila
Namitete
Lilongwe

Chimwalla HC

Nathenje
Chipoka
Monkey
Bay

DEDZA

Nkhoma Hospital

Dedza
MANGOCHI
Mandimba

MOZAMBIQUE

Mangochi
Lake
Malombe

Mposa HC

NTCHEU

SOUTHERN
Lake
Chiuta

Ntaja
MACHINGA

St Luke's Hospital

Ntcheu
Balaka
Liwonde
Machinga

Pirimiti
Community
Hospital

Nero
ZOMBA
Domasi
Nambazo

MWANZA
Zomba
Lirangwe
Namadzi

Mwanza
Lanzu

BLANTYRE
Chiradzulu
Phalombe

Blantyre
CHIRADZULU
MULANJE

Chikwawa
THYOLO
Mulanje

Thyolo
Milange

CHIKWAWA
Thekerani

N'gabu

Tete

NSANJE
Bangula

Zambezi

Nsanje

ZIMBABWE

Legend:
- National capital
- Regional headquarters
- District headquarters
- Town, village
- Airport
- International boundary
- Regional boundary
- District boundary
- Main road
- Secondary road
- Railroad

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

0 25 50 75 100 km
0 25 50 75 mi

Map 6.1 CHS health facility locations in Malawi

The level and volume of services provided, listed in table 6.3, generally increase with the status of the health facility, although the figures for some categories overlap with others.

Facility	OPs	IPs	ANCs	Dlvries	Oprtions	FP	Under 5s
Likuni Hl	24,722	26,377	33,450	1,917	n/a	snp	n/a
Nkhoma Hl	19,162	12,039	4,859	1,806	1,602	20,096	13,857
St Luke's Hl	18,154	4,168	7,424	1,223	802	3,291	10,098
St Anne's Hl	10,111	5,378	5,360	1,582	2,041	1,276	1,101
Fr Pl Cmty Hl	6,609	5,643	6,199	4,145	snp	snp	2,685
Pirimiti Cmty Hl	3,957	625	5,484	674	snp	snp	4,202
Chimwalla HC	16,306	snp	snp	snp	snp	20,096	5,058
Mposa HC	9,684	snp	3,789	542	snp	1,907	2,763
Gov Central Hl	147,842	24,207	2,859	n/a	n/a	n/a	7,746

Key
OPs   outpatient attendances   IPs   inpatient admissions   Hl - Hospital
ANCs   antenatal attendances   Dlvries deliveries carried out   HC - Health Centre
Oprtns   surgical operations   FP   family planning attendances   Cmty - Community
            performed   Gov   Government   Fr Pl – Francisco Palau
n/a   data not available   snp   service not provided
Under 5s children attending for growth monitoring and/or immunisation

Note – although the above figures are for a 12 month period between 2005-06, the actual period is not the same for all facilities and can only be regarded as a general guide.

Table 6.3 Services provided by selected CHSs and the Government Central Hospital in Malawi, (Sources – annual reports, health facility records and interviews.

The two health centres provide mainly outpatient services and growth monitoring clinics for children under the age of five years, at which they are also immunised. Mposa also carries out antenatal examinations, deliveries and family planning. Chimwalla attracts a relatively large number of outpatients, first, because of its proximity to Lilongwe and second, because of its high quality facilities, which were paid for by a Korean Presbyterian Church which continues to have a presence in the area. However, the health centre contends that it is too busy to carry out antenatal examinations or deliveries, so patients access these services mainly from the government hospital in Lilongwe. Mposa is accessed by a dirt road and supervised by St

Luke's Hospital, which is located in the village of Malossa on the main road to Zomba. Chimwalla is on the main road from Lilongwe to Blantyre and is supervised by Nkhoma Hospital, which was located in the hills by the missionaries to reduce exposure to malaria-carrying mosquitoes, and is accessed by a newly laid tarmac road off the main Lilongwe to Blantyre road.

The two community hospitals have an inpatient facility, in addition to a similar range of services to those provided by the health centres. As in the health centres, diagnosis and treatment is carried out by medical assistants or clinical officers. Because both facilities are Catholic, family planning is not provided, although the government employed HSAs (health surveillance assistants), who work in each locality and have a base in the CHS facilities, do provide family planning services (7.3.4.2). The hospitals provide surgery and employ doctors who carry out a wider range of treatments than the medical assistants and clinical officers at community hospitals. There are also more extensive diagnostic facilities, such as laboratories and radiography, and the capacity for treating larger numbers of patients.

Running parallel to the CHS structure, the government provides a network of lower level facilities and district hospitals, to which CHSs are able to refer. These are under the control of the DHO (District Health Officer). Generally CHS facilities are in different geographic locations from the government facilities and serve different populations. There are also four central hospitals at Mzuzu, Blantyre, Zomba and Lilongwe, which are under the direct control of the MoH (Ministry of Health). The available patient figures for the government's Central Hospital in Lilongwe are included in table 6.3 to provide an added perspective. Allowing for the lack of exact comparability because of the slightly different time periods, the figures

highlight that the government hospital deals with approximately six times as many outpatients than Likuni, the busiest CHS hospital in the study, but the number of inpatients is similar to Likuni and twice the number at Nkhoma, the next busiest facility.

As explained in section 5.5.5.3, the Indian study included two Catholic health facilities in Andhra Pradesh: St Theresa's Hospital and St Ignatius' Health Centre; two CNI (Church of North India) facilities in Delhi: St Stephen's Hospital and the Health and Community Centre at Sunder Nagri; two CSI (Church of South India) facilities in Tamil Nadu: Kalyani Hospital in Chennai and Ikadu Hospital near Tiruvallur; and the two additional facilities in Tamil Nadu: CMC at Vellore and the CFH (Christian Fellowship Hospital) at Oddanchatram.

The two Catholic facilities are both operated by religious sisters who are available 24 hours a day. St Theresa's was initially established as a 'gausha' (maternity) hospital to meet the purdah needs of Muslim and some Hindu women, and had an extension opened in 1999 to treat general medical and surgical patients. The number of patients treated is very small, first, because many people still see it as a 'gausha' hospital, and second, because of the private facilities located nearby. In an effort to increase the clientele, local doctors with private clinics admit and treat their own patients, for which they pay the hospital a fee. Although it is still regarded as a rural hospital, the town of Kunoor has developed around it. St Ignatius' health centre in Gagillapuram village provides a 24 hour outpatient service and beds for inpatients, some of whom are treated for short term acute illnesses while others are longer term elderly patients. There are a small number of elderly residents whose payments help to fund patients unable to pay. The number of outpatients triples when migrant brick workers from Orissa are

camping in the area for six months each year. Their employer makes a standard payment to the health centre for their health care.

Map 6.2 CHS health facility locations in India

St Ignatius provides maternity services, but not under-5s services, which are available at a government health centre three kilometres away. Neither of these Catholic facilities provides family planning (except advice on natural methods), although St Theresa's carries out tubal ligations on women who have had three caesarean deliveries.

Facility	OPs	IPs	ANCs	Dlvries	Oprtns	FP	Under 5s
CMC Vellore	1,434,057	92,248	n/a	7,708	n/a	n/a	50,365
St Stephen's Hl	445,438	38,669		4,043	16,865	n/a	n/a
CFH	380,233	18,955	35,846	2,328	4,475	749	n/a
Kalyani Hl	81,505	7,925	5,921	673	1,353	n/a	3,516
St Theresa's Hl	3,411	3893	n/a	48	651	TL after 3rd caesern only	n/a
Ikadu Rl Hl	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sunder Nagri CHC	42,271	snp	4,655	1,476 in patients homes	snp	185	11,817
St Ignatius HC	12,012	n/a	1,536	78	snp	snp	snp

Key
All figures are numbers per annum
OPs   outpatient attendances   IPs   inpatient admissions   Hl   Hospital
ANCs   antenatal attendances   Dlvries deliveries   HC   Health Centre
Oprtns surgical operations   Gov – Government   Cmty Community
TL   tubal ligation (sterilisation)
FP   family planning attendances
Under 5s children attending for growth monitoring and/or immunisation
n/a   data not available

Note – although the above figures are for a 12 month period between 2005-06, the actual period is not the same for all facilities and can only be regarded as a general guide.

Table 6.4 **Services provided by selected CHSs in India (Sources – annual reports, health facility records and interviews.**

St Stephen's and Sunder Nagri operate under the umbrella of CNI, but enjoy a high level of autonomy. St Stephen's developed from the Delhi Female Medical Mission, which was established in 1867 (2.4.4) as the first women's medical mission in India. It is now a very busy multi-speciality hospital opposite a Metro station in the northern part of Delhi. It has 32 clinical units of different types and three outpatients' departments: one each for general,

private and free patients, treating over 445,000 outpatients and almost 44,000 inpatients each year (table 6.4). Although the hospital is facing increasing competition from the for-profit private sector, it is proactive in developing new services to meet the challenge and has purchased a piece of land on which to build a medical college. Sunder Nagri is funded and staffed by St Stephen's as a service to people who are poor or otherwise marginalised. As well as providing the usual health centre services, it operates a number of specialist clinics and provides social services such as counselling, child to child education, food provision and activities for youth groups.

Kalyani hospital in Chennai and Ikadu rural hospital are operated by CSI, Diocese of Madras (the old name of Madras is still used for legal reasons). Kalyani provides the full range of general hospital services, but has less capacity and financial resources than St Stephen's to face increasing competition from the for-profit private hospitals and clinics opening in Chennai and does not enjoy the same level of autonomy. Ikadu rural hospital is located 3-5 kilometres from Tiruvallur. It was once a thriving hospital, but there has been population migration, leaving Ikadu with a much larger hospital than it needs. The diocese has built a thriving outpatients clinic at Tiruvallur, which operates as an extension of Ikadu. The diocese is trying to resurrect the hospital, but it is only surviving by financial transfers from Kalyani, ordered by the bishop, which might help it in the short term, but adds to the financial pressures faced by Kalyani.

The two additional hospitals in Tamil Nadu were included in the study because of their distinctive approaches to health care. CMC-Vellore is a 2,234 bedded multi-speciality Teaching Hospital treating almost one and a half million outpatients and over 92,000

inpatients per year (table 6.4). It is based on providing high quality medical and nursing education, coupled with clinical excellence using the latest technology, for which patients travel from all over India and beyond. This is coupled with a range of community and basic services directed at people who do not need the full range of services provided by the main hospital. These services include CHAD (Community Health and Development), which also has a base hospital, CONCH (College of Nursing Community Health Programme), LCECU (Low Cost Effective Care Unit), and RUHSA (Rural Unit for Health and Social Affairs). Funds generated from the main hospital provide free and low cost services to people in need.

The CFH at Oddanchatram is operated by the Christian Fellowship, which is a group of Christians, mainly doctors who have committed themselves for life to live simply and serve the poor. Official posts, such as medical superintendent and treasurer, are held in rotation by members of the Fellowship. The hospital has 288 beds, 95 doctors and 120 nurses and treats approximately 1000 outpatients each day. Staff are expected to live a simple life, comparable to the average standard of living of the community they serve. All of the doctors are able to give unlimited charity to patients and no patient is turned away, whether or not they are able to pay.

All of the health facilities researched in both Malawi and India provide some form of outreach service to their surrounding communities. In Malawi each health facility has a broadly defined catchment area for which it provides services ranging from 54 villages for Mposa to 156 for Nkhoma. In India the situation is less structured. CHS health facilities generally provide some form of outreach to selected communities in their vicinity. This ranges from the services of a single religious sister at St Ignatius visiting the migrant brickworkers and people at home

in Gagillapuram, to the services given to 83 village communities by several outreach programmes at CMC-Vellore.

6.3.3   Christian Health Associations

Much of the interface between CHSs of different denominations and between CHSs collectively and their respective governments is conducted by their CHA (Christian Health Association) and in many instances is the main reason for the existence of CHAs. The establishment of CHAs accelerated following the Tübingen Consultations and formation of the CMC-WHO (Christian Medical Commission) (4.4). Prior to 1968, CHAs existed in only five countries, namely India, Uganda, PNG, Malawi and Ghana. Thus the two field study countries of Malawi and India were amongst the earliest countries to establish CHAs. By 1995 the number of countries with CHAs had increased to 16 (CHAM 2005). Examination of the origins of the CHAs in Malawi and India illustrate different motivations for their introduction and development.

CMAI, named the Medical Missionary Association when it was formed in 1905 as an individual member organisation and gradually extended its membership from doctors to other professional groups and from individuals to institutions in 1970. Regional Executive Committees were established in a number of states in 1952, which in most cases functioned as the Medical Committees of their respective church Provincial Councils. CMAI has changed its emphasis several times during its history, often to reflect international priorities of the time (3.4.2.1, 3.4.1, 3.4.2.3), starting with professional pioneering work in leprosy and tuberculosis; followed from 1925 by a focus on medical education, nurse training, hospital management, PHC and preventive medicine; from 1947 training for laboratory technicians,

x-ray technicians and pharmacists; from 1963, a family planning programme; and from 1980

until the present time community based health programmes with a particular focus on

HIV/AIDS. The latter, CMAI asserts, became, at the request of WHO, a national programme

with government support (CMAI 1997).

CHAI was established as the Catholic Hospitals Association of India in 1943, much later than

the establishment of CMAI. As with CMAI it was formed with the purpose of increasing

communication between health professionals, in this case religious sisters operating the 50

Catholic health institutions, that existed at that time, and with the intention of increasing the

quality and quantity of medical service and to uphold Catholic and ethical values in medical

work (CHAI 2003).

In contrast, several respondents reported that the motivation for the formation of CHAM in

Malawi was first, to improve cooperation between denominations that had traditionally

operated in an environment of rivalry:-

"Traditionally, there was rivalry between denominations…" (DFID-M).

"Early CCAP (Presbyterian) missionaries could not settle in certain areas dominated by the British government, which supported the Anglicans, so they settled in very rural areas. Now that CHAM is uniting different denominations there is better cooperation" (administrator, Nkhoma-M).

The second motivation was to facilitate closer working with the government. The popular

Malawian 'folklore' is that CHAM, then known as PHAM (Private Health Association of

Malawi), came about through the personal intervention of the then President, Hastings Banda,

in 1965, a year after independence, to whom the following words are often attributed:-

'I can't work with you unless you all work together' (government paediatrician-M).

McGilvray (1981.33) reports a similar comment from President Banda:-

"…they are all playing in their backyards and they never look over the wall…"

The executive director of CHAM describes its formation as follows:-

"CHAM started in 1965/6 as PHAM, initially based in the Ministry of Health. At that time there were no private hospitals. Later large industrial estates started to provide private health services so PHAM changed to CHAM in 1992 as an exclusively Christian non-profit organisation".

The general survey indicated that CHAs can be categorised in two ways, according to whether they serve all denominations or are separate for Protestant and Catholic denominations, as listed in box 6.1. In some countries, the Episcopal Conference serves as the CHA for Catholic health services. In Uganda there are Catholic, Protestant and Muslim Medical Bureaux, each of which coordinates their own health services, although they affirm that they work cooperatively as the PNFP (private not-for-profit) Sector.

A second difference between CHAs, revealed from the general survey, was that some provide a mainly professional support role for their members and others have a responsibility for coordinating the activities of their member CHSs. The first category, which will be referred to as 'Support CHAs', provide a range of services for their members, which commonly include: fellowship, dissemination of information, education and training, technical services, institutional strengthening, capacity building, and advocacy especially on behalf of vulnerable groups. Countries which have Support CHAs include India, Pakistan and Bangladesh. The general secretary of CMAB (Christian Medical Association of Bangladesh) expresses its function thus:-

"CMAB does not control Christian Hospitals and Clinics. It's a place of fellowship…arranges a scholarship program for medical and nursing students for both

undergraduate and postgraduate studies…and [organises] workshops on Christian leadership and capacity building" (questionnaire).

Country	CHA	Denomination
Sub Saharan Africa		
Cameroon	FEMEC (Federation of Evangelical Churches)	Protestant
Ghana	CHAG (CHA of Ghana)	all
Kenya	CHAK (CHA of Kenya)	Protestant
	KEC (Kenya Episcopal Conference)	Catholic
Lesotho	CHAL (CHA of Lesotho)	all
Malawi	CHAM (CHA of Malawi)	all
South Africa	CATHCA (Catholic Health Care)	Catholic
Tanzania	CSSC (Christian Social Services Commission)	all
Uganda	UCMB (Uganda Catholic Medical Bureau)	Catholic
	UPMB (Uganda Protestant Medical Bureau)	Protestant
Zambia	CHAZ (CHA of Zambia)	all
Zimbabwe	ZACH (Zimbabwe Association of Church-related hospitals)	all
South Asia		
Bangladesh	CMAB (Christian Medical Association of Bangladesh)	Protestant
India	CMAI (Christian Medical Association of India)	Protestant
	CHAI (Catholic Health Association of India)	Catholic
Pakistan	CHAP (Christian Hospital Association of Pakistan)	Protestant
Pacific		
Papua New Guinea	CMC (Churches' Medical Council)	all

Box 6.1 CHAs and the denominations they serve (questionnaires)

The Medical Director of the United Christian Hospital in Lahore, Pakistan describes the functions of CHAP (Christian Health Association of Pakistan):-

"CHAP holds seminars and conferences for the improvement of health services…[and] gives scholarships to deserving medical, nursing and para-medical students" (questionnaire).

The second category, which will be referred to as 'Coordinating CHAs', have, in addition to these support functions, an identifiable role of facilitating and coordinating the provision of quality health services in members' units. Countries with 'Coordinating CHAs' include PNG and most of those in S-SA. Membership of Support CHAs is usually voluntary, but in many Coordinating CHAs there are varying levels of compulsion, including the need for CHSs to register with the CHA to gain government recognition, accreditation or funds (questionnaires). Another distinction between Support and Coordinating CHAs is the extent to

which they are empowered by their members to formulate policies to be implemented by their

member organisations. The enforcement of policies from Support CHAs is generally seen as

optional. In Pakistan, for example:-

"CHAP does not have any legislative authority. Any policy is only a general recommendation to the member institutions" (Questionnaire – MD, UCH)*,*

and in India:-

"There is fragmentation in CMAI because different denominations have their own salary structure and policies. There is no consensus between them" (director, Ikadu-I)*.*

"CMAI produces policies on topics such as AIDS, smoking and sexual determination, which are not mandatory, but [are] strongly recommended as best practice" (assistant secretary, CMAI-I).

On the other hand, there is a general expectation that Coordinating CHAs will formulate

policies for member CHSs to implement, although there are varying perceptions on the degree

of discretion CHSs can exercise in their implementation. The view of CHAM is expressed in

the following quote from the Director of Health Programmes:-

"CHAM policies are mandatory: CHSs must adopt or adapt them. Denominations may have different doctrines, but they must implement CHAM policies within the context of their beliefs. For example, the Fees & Exemptions policy is mandatory. We must have 40% compliance by 2007 & 100% by 2008".

Thus, although CHAM states that it is mandatory for CHSs to implement CHAM policies, it

qualifies this obligation with the options to "…adapt them…" and "…within the context of

their beliefs…" This understanding is confirmed by the Malawi Council of Churches:-

"CHAM policies are generally guidelines for each church to adopt according to its beliefs and doctrines. Some conditions are mandatory, such as the membership criteria of CHAM". This obviously gives some scope for variance, although the degree of variance is not defined.

There is a difference of view between those managing CHSs and external agencies. The CHS

managers generally see CHAM policies as mandatory, whereas some of the external agencies,

such as the EU, VSO (Voluntary Services Overseas) and the National AIDS Council see them as guidelines.

Experience in Malawi suggests that, even if CHA policies are intended to be mandatory, the degree to which they can be enforced varies. CHAM officers argue that successful implementation depends first, on the extent to which individual CHSs are willing to subsume part of their identity within that of the CHA; second, their willingness to cooperate with other denominations and the CHA; and third, the application, by CHAs, of incentives and sanctions such as access to funds, favourable consideration in the allocation of equipment or places on training events, and registration with the CHA through which recognition by the government is obtained.

The general survey revealed that CHAs' own administrative costs are most commonly funded totally or mainly from members' fees. The cost of CHAs' own operations are related to the nature and extent of their operation, necessitating those with higher costs seeking additional funding from international donors, government and/or income generating schemes such as letting real estate, and also sometimes charging member CHSs for writing their project bids and training activities. Many CHAs feel that their funding is insecure, and are continually anxious about the procurement of adequate funds to support the following year's activities. The executive director of CHAM summarised the multi-faceted fundraising strategy it has developed to ensure sufficient ongoing funding:-

"CHAM has a large secretariat of 46 staff funded mainly from donor funds and members' fees, but we are also generating income by letting accommodation and charging for training and administering projects. We are planning to build a private hospital and conference centre to generate income".

Some of CHAM's income raising initiatives give rise to tensions, which were expressed during interviews with Malawian church officers and CHS managers: the building of a private hospital is seen as an unwelcome move into private for-profit health provision; income generating schemes risk an incremental slide away from the CHA's core activity of supporting the CHSs in providing health care; increased membership fees increase the pressure on individual CHSs to find additional funds; and grants from the government or international donors is likely to increase CHAs' accountability to these organisations and reduce the CHA's accountability to its own members. Similar concerns were expressed by some other CHAs responding in the general survey.

Because of the potentially important roles played by CHAs in the relationships of CHSs with each other, with their denominational church organisation and with the government, the different ways in which CHAs operate in Malawi and India is explored here in greater depth. CHAM is a 'Coordinating CHA' serving both Catholic and Protestant CHSs and is governed by a General Assembly through the Boards of Directors and Trustees, who are accountable to both the Malawi Council of Churches (Protestant) and the Episcopal Conference of Malawi (Catholic), which are the joint owners (CHAM 2006). CHSs are currently provided by nine Christian denominations registered with CHAM, of which the largest four operate 93% of CHS facilities (Catholic 55%, Presbyterian 16%, Anglican 12% and Lutheran 10%). The difficulties of definition referred to in section 6.3.1 apply again here: these figures are based on the actual number of operational facilities without regard to their size or level of activity. A calculation based on the number of beds, occupancy, or taking account of outreach activities would possibly produce different figures. Both the number of CHS facilities operating and the

number registered with CHAM are increasing: the latter increased from 106 in 1980 to 167 in 2007.

Inevitably some disagreements still occur between denominations, but it is reported that they are usually resolved without undue difficulty:-

"There is sometimes conflict... due to staff shortage they poach from each other, causing bad feeling. Some denominations offer better top-up [additional remuneration and allowances] than others, in an effort to reduce loss to the city [urban health services], NGOs or overseas" (Malawi Council of Churches).

"Sometimes the understanding of the health service is very different between denominations, but we cooperate with each other and with the government (Presbyterian moderator-M).

"They [CHSs] try to work together, recognising that they may have differences. They mostly have similar problems. Tensions are usually resolved" (VSO-M).

The general view is that different denominations currently work together well under the umbrella of CHAM:-

"There is good cooperation [between denominations]... we respect each other's responsibilities and beliefs" (Anglican provincial secretary-M).

"The chairperson [of CHAM] changes every three years, so all denominations get their turn" (Catholic health coordinator-M).

During preparation for its 2005-2009 Strategic Plan, CHAM conducted a SWOT (strengths, weaknesses, opportunities and threats) analysis amongst its members. Three of the important strengths identified were the partnership between CHAM and the government in health service delivery including the MOU signed in December 2002 that specifies the terms of the partnership; support of CHAM from well established churches and its high level of donor confidence. However, members also identified three categories of weaknesses: first, issues related to the relationship between the CHAM Secretariat and member institutions, including inadequate supervision of units (CHS facilities); second, staffing issues experienced by CHSs

including poor conditions of service, poor staff attitudes, and high staff turnover, resulting in staff shortages; and third, financial issues including the lack of policy on user fees, their unreliable sources of income, and their dependency on donor funds (CHAM 2004).

These weaknesses were to be addressed in the objectives of the Strategic Plan by:-

a) Improving communication and cooperation between CHAM, MoH, Units and donors.

b) Promoting capacity building, institutional strengthening, and quality of health care in CHAM units.

c) Increasing the sustainability of the CHAM Secretariat which is currently 80% donor dependent.

d) Strengthening and expanding PHC and HIV/AIDS activities in CHSs (CHAM 2004).

The strategy was at an early stage of implementation at the time of the study, however some progress had been made through the SWAp programme (7.3.1), negotiation of service agreements (7.3.3), financial sustainability of CHAM (referred to earlier in this section), and the formulation of a user fees policy (7.4.4.3). These are discussed under the appropriate sections as indicated.

Although there is general appreciation amongst its members of the support given by CHAM and its assistance in activities which many CHSs do not have the resources or expertise to carry out for themselves, such as writing policies, organising training events and managing projects, some of the senior managers interviewed felt that their own roles were being eroded by CHAM. They perceived the eagerness of CHAM to perform these functions as a desire to impose uniformity, which the CHS managers viewed as undermining their own authority and autonomy, and in some cases threatening their role, as expressed by a senior CHS manager:-

"There was a meeting in 2003 at which CHAM wanted to do away with Health Secretaries and manage all denominations themselves. CHAM are building up their own organisation and strengthening it, but bypassing denominational managers".

This feeling is reinforced by CHAM having responsibility for determining staffing levels and paying staff on behalf of the government, which some CHS managers consider causes a lack of clarity in the minds of some staff between their accountability to the church which owns the building in which they work and CHAM, which pays their salaries on behalf of the government.

The arrangement in India contrasts sharply with that in Malawi. First, there are two CHAs: the mainly Protestant CMAI (Christian Medical Association of India), which is a related agency of the National Council of Churches in India, and CHAI (Catholic Health Association of India). This division into two CHAs results in greater difficulty in arriving at, or presenting, a unified CHS position, as the following perceptions of both external and internal observers testify:-

"CMAI and CHAI have no cohesive organisation" (UNICEF-I).

"CHAI could strengthen our cause if we could unite on some causes" (general secretary, CMAI-I).

"There is a strong divide between Catholics and Protestants" (Christian Aid-I).

Second, unlike CHAM, as well as having 350 healthcare institutional members, CMAI has individual members, of which there are 4,000. Third, CMAI and CHAI emphasise their roles as fellowship, advocacy, advisory services and educational provisions:-

"CHAI coordinates programmes, facilitates project implementation, helps access project funding [and] provides training courses and a conference venue" (project manager, CHAI-I).

"CMAI is concerned with education, communication and information" (Principal, CMC-I).

"CHAI has sister-doctor forums and forums for nurses and chaplains" (Catholic health commissioner-I).

CMAI does not attempt to coordinate the services of its members, whilst the CHAI director asserts that his organisation manages, on behalf of the bishops, the 25% of Catholic health facilities that are under the authority of dioceses. The other 75% of Catholic facilities are managed by religious orders. CHAI and CMAI differ from each other in several other respects: First, the membership of CHAI comprises a single denomination, whilst CMAI is multidenominational, providing greater opportunity for CHAI to develop a common view with its denominational church organisation and achieve a unified approach:-

"CMAI has much more difficulty [than CHAI] in getting any consensus of vision" (associate professor, JNU-I).

"Catholics are more coordinated." (Christian Aid-I).

The membership patterns of CHAI and CMAI over the last 60 years are also markedly different. By its silver jubilee in 1968, CHAI's membership had expanded from 50 hospitals when it was formed in 1943 to 18 schools of nursing, 307 hospitals and 469 dispensaries, with 121 religious sisters serving as doctors. By 2007 the numbers had again increased to 515 hospitals, 795 health centres, and 1351 dispensaries. As table 6.2 shows, the less costly health centres and dispensaries constitute a much higher proportion of Catholic than Protestant health facilities. Following an evaluation in 1993, CHAI identified its future thrust as the promotion of community health or community-based health care and reformulated the Alma Ata declaration of 'Health for All by 2000' (3.4.1) to 'Health for many more by many more' as its motto (CHAI 2003). This emphasis of CHAI on low cost community oriented health facilitation is generally acknowledged:-

"CHAI have developed community involvement, holistic care and empowerment of people.

Their real focus is PHC and they have minimal tertiary and secondary services" (associate professor, JNU-I).

"CHAI are excellent. They are looking now to herbal medicines, which are cheaper and more effective for the poor" (Catholic chancellor-I).

Although there are no accessible statistics of the number of operational Protestant health facilities (as distinct from membership of CMAI), it is generally recognised by CMAI officials that there has been a significant decline in the number of such facilities and, in consequence membership of CMAI has declined, although precise quantification is confused by changes in membership categories. At the time of independence in 1947, there were 800 mission health institutions with staff who were members of CMAI. This had decreased to 610 by 1964, and by 1996 the number of institutional members was 300, and many of these institutions were under threat of closure. Ten years prior to this study three principal reasons were given by CMAI (1997) for this deterioration including a decline in the number of health professionals committed to working in CHSs; the adverse effect of church politics on the operation of CHS hospitals, which is discussed in 6.4.2.1, including their attraction as a potential source of income to the church; and ineffective management of CHS facilities.

On the centenary of its foundation, CMAI published a commemorative issue of the Christian Medical Journal of India (CMAI 2006). As well as recording the successes of CMAI, several notable contributors expressed concerns over the decline of (Protestant) Christian hospitals. In addition to the points above, Tharien (2006), a respected statesman of CHSs in India, expressed concern that the four Cs of Concern, Compassion, Competence and Commitment, for which Christian institutions were known, had become diluted because of a loss of vision during their struggle to survive. Chacko (2006.45) added that 'dilapidated buildings, rusted machinery and financial unaccountability' have led to the disenchantment of Christian health

workers, resulting in their departure from the Christian healing ministry to 'greener pastures'. This view of ineffective management is endorsed by the VHAI:-

"Failing Protestant hospitals are due to wrong leadership…too dependent on doctors… not professionally managed. The charismatic leaders of the past didn't train their second line managers".

The major difficulty for Protestant health services in India identified from the interviews and reports referred to above seems to be lack of leadership, strategic planning and responsibility for decision making regarding CHSs as a whole. CMAI carried out a review of the way in which it operates in 1996 and produced Master Plans for action, the last one in 2004. However, the view of many respondents including operational CHS managers was that these plans have not resulted in a serious change in the way in which Protestant health services are delivered compared with the change in approach implemented by CHAI. These respondents expressed a need for decisions to be made about which facilities are viable, with additional support, and which are redundant and should either close or be replaced with an alternative type of service. One external donor noted that:-

"Some [CHS facilities] are doing a wonderful job, but others are struggling and are no longer viable. There is a need to review where they can be effective" (EU-I).

The general secretary of CMAI affirms that it could have a role in institutional strengthening, as could some of the flourishing CHSs, for example, the principal of CMC-Vellore summarised the support given by her organisation:-

"…incorporating 20 failing hospitals into our fold by distance education… inculcating enquiry, evidence based education and a sense of dedication and optimism".

In practice, comments by CMAI officers suggest that the dioceses rather than CMAI have the responsibility and power to facilitate cooperation between facilities or negotiate change of use. Officials consider CMAI's role to be facilitation rather than coordination because the

organisation does not own any health facilities and the dioceses are reluctant to cede managerial authority over those they operate. Because professional analysis and decision making is needed, it is questionable whether denominational operational management of CHSs is appropriate. This issue is further discussed in 6.4.2.1.

6.4 Religious Issues affecting Mission Organisations, National Churches and CHSs

This section is divided into three parts: the first part explores the changes in policy and operational procedures made by UK based mission organisations (6.4.1), the second part examines the impact of these changes from the perspective of national churches and CHSs (6.4.2) and the third part investigates the current religious orientation of CHS facilities (6.4.3).

6.4.1   UK Based Mission Organisations

The conceptual framework (5.2) highlighted the tensions first, between the evangelising and service provision wings of mission organisations and national churches; second, between mission organisations and national churches, resulting from the achievement of autonomy for national churches whilst many of them continue to rely on their Western partner churches for support; and third, between autonomous churches valuing the prestige health institutions they inherited but experiencing difficulty in finding the human and financial resources to support them. These issues will be investigated in this section by examining the objectives and values of UK based mission organisations (6.4.1.1); their practice (6.4.1.2); financial and expatriate support provided (6.4.1.3-4); their relationships with their overseas partners (6.4.1.5) and their support of CHSs (6.4.1.6).

Twelve mission organisations (appendix 2), representing denominations which were involved in foreign mission and provided health services during the colonial era, were included in the study. Five were identified from the literature review, where the historical context in which they emerged and operated has been discussed (2.2 and 2.4.2): BMS World Mission (previously the Baptist Missionary Society), CMS (Church Mission Society, previously Church Missionary Society), EMMS International (previously known as Edinburgh Medical Missionary Society), USPG – Anglicans in World Mission (previously known as United Society for Propagation of the Gospel) and the Methodist World Church Office (carrying out the functions previously carried out by the Methodist Missionary Society). The remaining seven were identified from information given by other organisations: PMS (Pontifical Mission Societies), MMS (Medical Mission Sisters), Columban Mission Sisters, MMM (Medical Missionaries of Mary), CWM (Council for World Mission), the Birmingham Diocese Malawi Link and PWM (Partnership for World Mission). In the interests of conciseness, the abbreviated forms of these titles are used.

Church denominations carry out their mission functions in different ways. CMS and USPG are both Anglican mission organisations, but operate autonomously according to their own constitutions and management structures. Most of the 44 dioceses and many parishes within the C of E (Church of England) have a partnership with an overseas diocese or parish within the Anglican Communion. Birmingham Diocese, for example, has a partnership with the four Malawian dioceses. PWM was established by the Anglican Communion to facilitate partnerships between churches, dioceses and other Christian mission agencies in the 162 different countries in which the Anglican Church operates. However, PWM has no control

over the partnerships because of the loose relationship between Anglican mission organisations and the C of E. which is described as:-

 "…*not one body, but 44 corner shops, unlike Anglican Churches overseas which are more centrally controlled*" (PWM).

BMS is also a separate organisation with its own trustees and operating outside of, but relating to, the three Baptist Unions of England, Scotland and Wales. The mission activities of the Methodist Church are conducted by the church's World Church Office and CWM is a network of Reformed and United Churches in 31 countries worldwide and includes the work of the former London Missionary Society. EMMS International is a health specific, non-denominational, charitable company, rooted in the Evangelical and Protestant traditions, and formed from the merger of EMMS and EHA (Emmanuel Hospital Association) in 2004.

Three of the four Catholic organisations are religious orders, in which religious sisters have taken vows to dedicate their lives to God and which operate according to the structures and charisms of their individual orders. MMM and MMS, as their names imply, are health specific, whilst the mission of the Columban Sisters includes pastoral, spiritual, educational and social work as well as health. PMS comprises four Catholic mission societies, which operate collectively under the statute and decisions of the PMS National Council. Although the Malawi Link of the Birmingham Anglican Diocese and the Methodist World Church Office are part of their respective churches' structures, for the purpose of this research, they are included in the term mission organisation.

6.4.1.1 Objectives and Values of UK Based Mission Organisations

Eight of the twelve mission organisations have formal mission statements, and for the other four it was possible to extract statements about their values and intentions from their websites, documents and interviews. The mission statements vary from single sentences to five or six separate points. There are several common themes (appendix 15), but also a number of points made by particular mission organisations that either suggest a difference in emphasis or are simply omitted by others in the interests of brevity. The statements highlight four broad themes: first, the spiritual aspect of their work, particularly evangelism and prayer; second, engagement with communities of different cultures who are in need, forming partnerships, providing support and facilitating their practical and spiritual development; third, advocacy issues, particularly seeking justice and care of the environment; and finally, health issues, which emanate principally from the three health specific organisations, plus the Columban Sisters. The four themes are an indication of the tension many mission organisations experience between their spiritual mandate and what they perceive as their social agenda. The practical manifestation of this tension is discussed in the next section (6.4.1.2).

6.4.1.2 Practice of UK Based Mission Organisations

Section 2.2 suggested that there were a variety of motives for initiating mission, including 'conversion of the heathen'. By the time the first medical missionaries started to emerge at the beginning of the C19th (2.4.2), missionary societies generally saw church expansion as their principal focus and other functions, including treating the sick and education, as secondary to it, or instrumental in achieving this main objective. On the other hand, the medical missionaries themselves often interpreted their priorities differently and perceived that treating the sick was their means of carrying out God's mission.

The themes from the mission statements (6.4.1.1) indicate that this tension between the spiritual and the service, or social, roles of mission organisations still exists. The two taxonomies of FBOs advanced by Clark (4.5.1) drew distinctions first, between those organisations involved in development and those involved in mission, and second, between those whose development work was motivated by humanitarianism or was a means to seek converts. In practice, as Clark recognised, these distinctions are not clear. Several denominations have development organisations as distinct entities, for example MRDF (Methodist Relief and Development Fund), CAFOD (Catholic), Progressio (Catholic), Anglicans in Development (Anglican) and Christian Aid (ecumenical), although they also have mission organisations that carry out development activities. Even within mission organisations, there is a distinction between those that regard evangelisation as their prime role and those that view their service provision as the manifestation of their faith. For example:-

"Our primary objective is mission, evangelism and church planting. Evangelism is in everything we do" (BMS).

"Our main objective is evangelisation and our role is mission not development, which for the Catholic Church is carried out by CAFOD" (PMS).

"We look at the needs of people but not as means of evangelism. We serve all people irrespective of religious affiliation" (CWM).

"We are not a development agency, neither are we solely an instrument for evangelism" (USPG).

Several mission organisations, including BMS, USPG and MMS, proclaim a holistic mission, with initiatives such as installing water or electrification systems, constructing dams, stocking fish ponds, cooperatives, credit unions for economic sustainability, theological training, literacy, and various health projects including those which are HIV/AIDS-related. The mission organisations interviewed work principally through designated overseas missionaries,

who are either expatriate or indigenous, or through partner church organisations, whereas Christian development organisations, such as Christian Aid (www.christianaid.org.uk) and CAFOD (www.cafod.org.uk), work with a wider range of overseas partners which might include churches, FBOs, or non faith-based NGOs. The main distinction between mission and faith-related development organisations seems to be not so much what the organisations support or their motivation for doing so, as the type of people or overseas agency with which the UK organisations work. Even this distinction is not absolute, as mission statements and the information given in interviews suggest that a paradigm shift in mission organisations has seen many of them moving further away from their traditional evangelistic role and closer towards the development role.

Several mission organisation respondents expressed their appreciation of the benefits of discussing issues of common concern and sharing experiences and examples of good practice with each other. Representatives of Catholic missionary organisations stated that they do this through the Catholic Missionary Union, and both Catholic and Protestant mission organisation respondents affirmed that they meet through the Churches' Network for Mission (previously the Global Mission Network), which operates as part of Churches' Together in Britain and Ireland. The PWM (Partnership for World Mission) officer recounted that it was intended that PWM would 'pull together' all Christian missions, but there has been an increasing trend since the 1960s for partners in the UK and overseas to deal directly with each other. He added that several Anglican mission agencies were co-located in London, with the intention of moving closer together, but these closer relationships failed to develop and eventually in 2008 the building was sold and the agencies each found new separately located

premises. PWM now reported that it liaises mainly with Anglican organisations involved in mission.

Sections 2.3 and 4.5.4 discussed the tension which appears to have existed between the aims of mission organisations to prioritise the needs of the poor and the social, political and economic pressures which have often militated against this occurring. Mission organisations continue to highlight serving the poor and marginalised as their priority:-

"...seek to provide ....services to the most underprivileged communities" (EMMS).

"We feel a particular call to mission amongst the marginalised" (CMS).

"We work with the poor and marginalised..." (MMS).

"We help the poor... from each according to resources, to each according to needs" (PMS).

"We expect to work with poor and oppressed" (Methodist).

"Priorities are the poor, oppressed and excluded" (USPG).

Whereas in the past the mission organisation could exert some control over the use of its funds, the change to devolution or partnership in the allocation of funds means that although the intentions of the mission organisation are overtly stated, increasingly it is the in-country church which decides whether or how these intentions are interpreted, which might result in a dissonance between the intentions of mission organisations as donors and the actions of national churches. The effects of this on CHSs are discussed in section 7.4.1.

When mission organisations were first established, their overseas activity was carried out by expatriate missionaries (2.2). As the overseas churches became more established, expatriates were gradually replaced by indigenous workers, particularly as the churches gained greater autonomy during the C20th (2.5). The available evidence showed that the work of expatriates

was funded by a mixture of grants, donations and special appeals by their home churches, mission organisations, friends and family (2.6), but as the number of expatriates reduced so did the funds from these traditional sources (4.5.2). However, mission organisations continue to support the work of the church in developing countries by the provision of funds and a limited number of expatriates, as will be explored in sections 6.4.1.3 and 6.4.1.4.

6.4.1.3 Funding Support

Despite substantial reductions in the levels of finance available (2.6, 4.5.2) and the trend towards global partnerships, a major component of the relationship between mission organisations and developing country churches continues to be the flow of funds from the former to the latter. It emerged from this research that most mission organisations continue to rely on donations from churches and individual church members, including legacies, as their regular source of income. It was reported during interviews with their respective officers that these sources account for nearly 80% of CMS's and nearly 90% of BMS's income; PMS continues to collect through 'red boxes' placed in the homes of church members, churches and schools throughout the world; and the 21 orders of religious sisters operating in the UK, coordinated by the Franciscan Sisters, visit Catholic churches to promote donations, which they send to their international headquarters. One sister, who was interviewed, has a list of 44 churches she visits. Because the level of donations is now much less than previously, except for legacies, which are increasing, MMS reported that in the USA and the Netherlands the order employs professional fund raisers.

Some mission organisations reported that they have moved towards identifying specific projects in their partner countries as a means of allowing their increasingly discerning donors

to identify the particular topics they wish to support. This policy of balancing the wishes of donors with the priorities of recipient churches increases the complexity of system administration, as the projects receiving the most financial support are not always those regarded as the highest priority by the overseas churches. However, as USPG put it: -

"We try to be the honest broker in the middle".

Some mission organisations are benefiting from investment income realised from the sale of property. In 1994 CWM sold a hospital in Hong Kong, which realised £135 million. Income from the invested funds was reported to have contributed the major part of the £5 million available to the organisation in 2006. In addition to their investment income, all CWM member churches worldwide are expected to contribute and receive resources according to their needs and their size. Both CMS and USPG, prompted by the need to make economies, were at the time of the study, in the process of selling UK property.

There seem to be four broad approaches to the allocation of funds by mission organisations to their developing country partner churches. First, part of the budget is allocated by the UK office of the mission organisation to regional offices of the denomination for them to spend according to their own identification of their needs:-

'*Previously we targeted directly the use of funds, but now the better educated and better governed overseas churches are able to determine what is needed for themselves"* (PMS).

Thus, the local church decides whether any of the project funds are spent on health. The Methodist Church, which previously paid bulk grants to overseas churches, now responds to requests from the national Methodist Conference of overseas partner churches, to which the transfer is made, and which decides how funds are allocated within the country.

Second, national churches decide their priority projects, which they submit to the UK office

for a funding decision. BMS operates this approach by receiving funding requests for specific

purposes from overseas Baptist Unions, which are approved, or not, subject to the amount of

money available:-

*"50 yrs ago we would be in control and make the decisions of how we would help. Now
overseas partners make these decisions and articulate their own needs…the annual budget is
allocated to five regional secretaries".*

Reports are later submitted advising that the funds have been expended in the way intended.

The Catholic religious orders operate a similar system under which requests are submitted to

their international headquarters, which in the case of the orders researched are in Ireland.

Third, national churches submit their proposals to a meeting of global members at which

decisions are made. This is the approach of CWM, under which member churches receive

grants for mission support programmes and develop their own projects. For USPG the

international trustees' meeting decides the projects to be supported. Fourth, funds are

provided to directly support a limited number of institutions or programmes; an example is

the EMMS provision of funds, supplies and materials to support a number of Christian

hospitals and dispensaries in India and Malawi. USPG also has a consolidated medical fund

which can only be used to support medical services and some trusts for designated hospitals.

Of the USPG 2008 total budget of £874,000 for its core grants programme, £318,000 (37%)

was spent on health.

Although there is now greater devolution or partnership in the approach to decision making

over the uses of funds, several mission organisations highlighted the difficulty of leaving

behind the dependency relationship associated with the donor-recipient culture. The literature

reviewed highlighted the tension between mission organisations and national churches resulting from the achievement of autonomy for national churches whilst many of them continue to rely on their Western partner churches for financial support. That such tensions affect the work of CHSs was borne out by this study. The mission organisations studied reported that they face the difficulty that, with diminishing financial receipts, they need to present their funding requests to their supporters in an appealing way, whilst transferring decision making over the use of funds to the national churches. It was reported that mission organisations try to reconcile these conflicting demands, acting as 'honest broker', resulting in various combinations such as a transition from one approach to another, applying different approaches in different circumstances, or even having aspirations towards one approach, but in practice applying a different approach.

6.4.1.4 Expatriate Support

In the C19th and C20th large numbers of Western missionaries ventured overseas in faith (2.2), but all of the mission organisations researched report a steady decline since the peak around the middle of the C20th for the following reasons:-

► Decreasing need as suitable indigenous people became available.

► Reduction in funds to support missionaries resulting from reductions in donations from churches and individuals.

► Increasing cost of training expatriates – USPG estimates that it costs £37,000 to train one mission companion at a mission college in the UK.

► Increase in employment legislation, necessitating more complex arrangements for recruiting and posting expatriates overseas.

► Increase in immigration restrictions in receiving countries.

►   Decline in people coming forward to serve overseas, particularly for long term service.

►   Negative perceptions of the role of missionaries as a heritage from the colonial era.

Mission organisations reported that they have introduced a variety of measures in response to this decline, including:-

►   Shorter term postings, particularly for experienced people and often to carry out a particular project.

►   'Contracting out' recruitment, selection and induction procedures to specialist organisations.

►   'South to South' programmes under which expatriates from one developing country work in another developing country.

►   Facilitation of self-sufficiency and sustainability, including capacity building and skills sharing programmes, to reduce the need for long term expatriate support.

►   Expatriates finding alternative sources of financial support, including self-funding or sponsorship.

►   Funding indigenous people for mission.

►   Replacing the title 'missionary' with alternatives such as 'mission partner' (BMS and CMS) or 'mission companion' (USPG), which are perceived as being less pejorative despite the term 'mission' being retained in the title.

The term missionary will continue to be used in this and the next chapter in the interests of conciseness.

The interconnection between the decline in expatriate missionaries and the development of alternative approaches to mission has not been one of simple cause and effect: In some

situations the decline in the supply of mission candidates, or in the number who could be funded, prompted the search for alternative approaches. In other situations it was the development of alternative approaches which reduced the need for 'traditional' long term missionaries. Although financial support is mainly unidirectional, increasingly mission is seen as being multidirectional, i.e. people and ideas moving between different countries and different parts of their own country. Nazir-Ali (1990) coined the phrase 'from everywhere to everywhere' to describe this trend, which was endorsed by the declaration 'all the churches for all the world' by Pope Benedict XVI on World Mission Sunday in 2007 (PMS).

During the C19th and early C20th, the majority of expatriate missionaries worked overseas as a lifelong commitment. This level of commitment now tends to be limited to Catholic religious sisters. The Columban Sisters, for example, commit themselves for life and are sent wherever there is a need in any of 12 countries, mainly in Asia and South America, where the order works. Although MMS sisters, of whom there are 645 worldwide, can be posted overseas, the majority work in their own countries, principally in Asia, South America and Africa. CMS currently have 173 missionaries working in Asia, Africa and Eurasia; the Methodists have 70 working in 8 countries; and USPG have 50 missionaries in 20 countries. PMS does not send people but supports religious orders overseas to recruit their own human resource.

It was reported that the current trend is away from long term mission to medium term (between two and four years) and short term (up to two years) postings. Several organisations have schemes ranging from a few weeks up to a year, which are often geared towards young adults seeking a vacation or gap year experience. The Malawi Link encourages short term

skills' sharing between professionals in Birmingham and organisations in Malawi. Particular examples are the link between the Birmingham Children's Hospital and the Queen Elizabeth Hospital in Blantyre and the annual visits of groups of clergy, teachers, and medical and other professionals from Birmingham to Malawi to facilitate the professional development of Malawians.

The BMS officer reported that a distinction is made between 'pull mission', in which overseas churches identify their needs and send requests to a mission organisation, which is the model by which most mission organisations operate, and 'push mission', in which the mission organisation has available workers for whom a need is sought. On the 'push basis', BMS sends medical teams of health specialists to carry out short term medical mission at Chandrogona hospital in Bangladesh. Some mission organisations also seek placements for UK medical and nursing students wishing to carry out an overseas elective as part of their training.

Substantial numbers of expatriate medical missionaries were still being recruited and posted overseas by mission organisations beyond the middle of the C20th. USPG's Health Policy (2002) records 87 SPG (forerunner of USPG) medical missionaries in 1938 and 77 in 1951. Unpublished figures produced by Albert Moseley for the Methodist Church show that 35 doctors and 350 nurses were posted to 19 different countries between 1875 and 2000, principally to India, China and Africa. The peak years were between 1925 and 1974, during which 254 were sent, but by the final quarter of the C20th the number had dropped to 38. USPG commented that the nature of requests for expatriate medical missionaries had changed during this latter period to doctors and specialist posts only, including nurse tutors and

primary health care nurses. Information given during interviews revealed that USPG currently have eight medical missionaries working overseas; Methodists now only place doctors in two hospitals in Kenya and Sierra Leone; approximately 20-30% of CMS missionaries are currently involved in health (precise figures were not available); and BMS currently has 15-20 expatriate health workers including 'South to South' workers and health specialists working in Eastern Europe, particularly in Albania.

6.4.1.5 Relationships between UK-Based Mission Organisations and their Overseas Partner Churches

It emerged from this study that the common arrangement is for mission organisations to work mainly, although not exclusively, with overseas church partners of the same denomination in countries with which they have an established historic link. During their respective interviews, officers reported that PMS, USPG and the Malawi Link work through their overseas denominational dioceses; BMS works with partners in 40 countries, 90% of which are Baptist Unions and 10% are other mission organisations; the Methodists work with Methodist Churches overseas and have established partnerships with other Christian organisations; and following a reassessment of needs, USPG has discontinued help to some dioceses because they are now regarded as more self-sufficient and have transferred assistance to new partners in greater need, for example in Latin America and Sudan.

The literature review discussed the tensions between 'Western' church organisations and developing country churches at the time the latter were seeking autonomy from the former (2.5). It emerged from this study that there has been a move during the last two decades for some mission organisations, but not all, to move from systems of UK leadership and

patronage towards network arrangements and more collaborative processes of decision making, involving members from the mainly receiving countries of the developing world as well as UK-based donor members. Some organisations, particularly USPG (2003), CMS (2007) and CWM (2007), conducted extensive research and consultation with their stakeholders to produce strategies outlining their future approaches to mission. These consultations highlighted several critical issues faced by mission organisations during the process of devolving or widening the responsibility for decision making, not all of which have been resolved:-

►   Ensuring that the evangelistic focus of mission organisations is maintained when their network is fully open and participative.

►   Ensuring an equal contribution to decision making when the majority of funding is provided by more affluent countries and enabling partners from poorer countries to raise the support they need.

►   Determining the level of support for mission personnel recruited from another developing country, where they have been accustomed to a lower standard of living than colleagues from more affluent countries.

►   Ensuring that mission organisations are able to implement their objectives when funding is provided from alternative sources.

►   Determining the level of devolution of responsibility permitted by the legal responsibilities of trustees under UK Charities' Law.

►   Establishing systems for assuring donors that their funds are utilised for the purposes intended.

There seem to be two alternative models of change emerging, one based on devolution of decision making to regional or national bodies and the other based on shared decision making. CMS, CWM and USPG reported that they are endeavouring to implement partnership approaches. As a result of its three-year consultation with its stakeholders CMS (2007) opted for a decentralised structure, but with a network based on principles that can be summarised as follows:-

► Christian mission ethos and lifestyle.

► Partnership with local and national churches of many different backgrounds.

► Interchange paradigm involving a free exchange of people, theologies, training, funds and other resources for evangelistic mission.

► International governance with greater coordination of international fundraising and use of communication technology.

► Possible shift to Christians working in professional cross-cultural settings rather than the traditional mission placements.

Because USPG found its work squeezed between Christian Aid on one side and the Anglican companion links on the other, it conducted an international consultation (USPG 2003) with the purpose of determining appropriate structures and approaches for future relations between USPG stakeholders. In an e-mail from the USPG General Secretary (April 2009), he summarised the results of the consultation as:-

► 'We are a church-based mission agency, not a Northern-based development charity.

► Our partners are the constituent parts of the Anglican communion, and any resource-sharing arises from relationships and is building capacity rather than dependency.

►   We increasingly make decisions about priorities and budgets together with all our partners.

►   Mission priorities are decided by the local church, which is why partners make nominations rather than applications'.

During interview the general secretary affirmed that some of the USPG trustees are now from developing country churches and are, therefore, participating in decisions on how the global budget should be allocated. Each partner church nominates that part of their work for which they are seeking support. A consultation every three years involving all members has been introduced to discuss priorities. He explained:-

"We changed our approach because of the change in mission culture and philosophy over the past 10-20 years. There is a need to come to terms with the new contexts without compromising principles, resisting the trend of aid agencies, which patronise their own chosen projects. We want to empower global partners to decide where help should be given. It is important to re-establish Christian principles rather than allow the market (donors) to determine our priorities and undermine our raison d'etre".

CWM (www.cwmission.org.uk) held its first Assembly in 2003, at which 150 delegates from 31 member countries in six global regions met together to consider approaches to mission and participate in decisions on the allocation of resources. There is intended to be no discrimination in decision making between funding and receiving partners. The Assembly, which includes all member churches, will be held three yearly and will appoint the trustees, who will meet annually in different parts of the world. It is intended that there will be a review of this process at six yearly intervals. The Management Board is currently based in the London office, but there is an intention to decentralise it.

6.4.1.6 Mission Organisations' Support of CHSs

The extensive networks of hospitals, health centres, training institutions and other health

facilities established by medical missionaries and inherited by autonomous national churches has been described in section 6.3.1. The change in the approach of mission organisations to funding their developing country church partners was explained in section 6.4.1.3 and their provision of expatriate personnel in section 6.4.1.4. This section examines the specific assistance given to CHSs. The effects of these funding changes on CHSs are discussed in section 7.4.

In addition to those mission organisations whose sole purpose is the provision and support of CHSs some general mission organisations continue to allocate a substantial part of their budgets to supporting CHSs, which for USPG amounts to 37% of its budget, and continue to provide expatriate health workers, which for CMS is 20-30% of its total mission personnel. Partly because of the increasing cost of operating hospitals and other health institutions, and partly because of a resurgence in support for PHC, many mission organisations, including BMS, CMS, MMS and USPG, reported that they now give priority to supporting prevention and community health, and some complementary therapies, which they now regard as more important than hospitals. Although USPG continues to support ten hospitals, partly because it has trusts designated specifically for that purpose, between 1987 and 2001 the number of PHC projects it supported increased from eight to 39 and the proportion of the health budget allocated to PHC increased from 24% to 44% (USPG 2002). Two other new initiatives were reported: first, an engagement with the Community Health Global Network to evaluate with its world partners how to develop the health agenda, particularly in relation to PHC (USPG interview); and second, the Anglican Consultative Council formed an international Anglican Health Network in June 2009 to consider the future role of the Anglican Church in health with particular emphasis on PHC (correspondence from Network Coordinator).

EHA, operating under the umbrella of EMMS, on the other hand, recognises the need to support hospital provision as well as community health. The organisation operated six hospitals when it was founded in 1970 but now operates 20 hospitals, 27 Community Health and Development Projects, an AIDS programme, and six schools of nursing. In 2004, EMMS International adopted three EHA hospitals in India as 'Prime Focus' projects, with the express intention of supporting them in depth, so that significant changes could be made using available resources. MMS also continues to financially support three hospitals in India.

It was explained during interviews that CMS handed over all 500 health facilities to local churches in 1950s-60s, and because BMS was unable to provide sufficient funds, many of the hospitals handed over to local churches have either closed or are now regarded as financially unsustainable because the churches are unable to operate them satisfactorily. The withdrawal of funding from hospitals previously supported by mission organisations can often be a difficult exercise. Usually the withdrawal is phased, with tapering support over a number of years. Although mission organisations generally regard health as a priority activity for the church, it has emerged from this research that the combination of declining finances with changes in the methods of operating has caused several to review their approach to supporting CHSs. For most mission organisations it is now the receiving churches which lead the decisions on their priorities, which do not always include support of CHSs. Many mission organisations no longer have a designated health programme or specific health budget.

6.4.2 Denominational Churches in Malawi and India

This section explores, from the perspective of national churches and CHSs, the changes in policy and operational procedures made by UK-based mission organisations and the post-

autonomy tensions highlighted in the conceptual framework, between mission organisations, national churches and CHSs. The section comprises two parts: first, the different ways in which denominational churches manage their health services in Malawi and India (6.4.2.1), and second, the relationships between CHSs and their overseas partners (6.4.2.2).

6.4.2.1 Management of Denominational CHSs in Malawi and India

The literature review discussed the tensions arising from churches managing increasingly complex and professionalised health services (4.4, 4.5.1), several of which emerged during the current research. In Malawi, proprietorship of CHSs is locked into their respective church organisations through Health Boards, which for the Presbyterian and Anglican Churches are chaired by the Moderators and Bishops respectively or their nominees. The Health Boards have responsibility for policy formation, planning and overall management of the health services in the synods (Presbyterian) or dioceses (Anglican) and comprise representatives of the major health institutions in the diocese/synod, representatives of the provincial government health department and CHAM, and the DHS (diocesan health secretary) or equivalent, where this post exists.

Health Boards operate under the authority of their respective General Assembly (Presbyterian) or Diocesan Synod (Anglican), which has overall responsibility for the operation of their church organisation and institutions. There are usually one or more representatives from denominational CHSs at their respective Assembly or Synod meetings to present reports on issues and activities in their sector. There are different perceptions regarding the extent to which health representatives are encouraged to contribute on issues of general church policy, even when these affect the health service. Church officers generally

claim that such health representatives are encouraged to make such a contribution, but CHS officers themselves express less certainty on the subject. The operational management of individual hospitals with their associated health centres is managed by a management committee, usually comprising the MD, administrator, senior nurse, other senior hospital health professionals and representatives of the church.

The church organisation in India is on a much larger scale than in Malawi: whereas in Malawi there are four Anglican dioceses and three Presbyterian synods, in India there are 26 dioceses in the CNI and 22 dioceses in the CSI, both of which are combined Protestant denominations (2.5). Both CNI and CSI have Synodical Health Boards. CNI employs a synodical health secretary, who is a full member of the synod, but CSI does not. Some individual dioceses also have a Medical (or Health) Board. In Madras diocese this is chaired by one of the hospital directors and deals with policy issues. The diocese also has a Medical Executive Committee, which is chaired by the bishop. The large multispeciality hospitals usually have a Management Board responsible for the operational management of the hospital, with departmental and speciality committees accountable to the Board. The Management Boards are usually chaired by the bishop or by his nominee. The chairman of the CNI Synod, the synodical health secretary and the bishop are members of St Stephen's Board.

 In Malawi, the Catholic institutions have a similar management structure to that of the Presbyterian and Anglican churches, except that all three of those researched are operated by religious sisters who are accountable to the Diocesan Health Commission, which is in turn accountable to the bishop. Within the Catholic Health Service in India, there are two structures of management and accountability. Approximately 75% of Catholic health

facilities are operated by religious sisters, who work autonomously outside the diocesan structures and have lines of accountability within their respective religious orders. The sisters reported that they must obtain the permission of the bishop to open a new facility, and usually invite him to management meetings to facilitate cooperation and communication between the diocese, Episcopal Conference (committee of bishops in each state) and the health service, but they are not accountable to him. At local level, the mother superior of the convent is responsible for the overall conduct of health services operated by religious sisters and is accountable to the mother provincial. Both of these positions are elected through the chapter, of which all sisters are members. The other 25% of facilities are operated by the 159 dioceses, which are accountable to the bishops, but are managed through CHAI.

At St Theresa's Hospital the management board, comprising the mother superior, administrator, nursing superintendent, doctors and a lawyer, meets monthly, whilst operational matters are dealt with by the nine religious sisters, who operate as a team. There is also an Institutional Health Team with members from each health facility, which meets to consider major policy issues.

In Malawi, nursing schools and colleges have Boards of Governors, with similar membership to Health Boards plus a representative of the Nursing and Midwifery Council, to which the Board is accountable. In India accountability is split between the nursing council for educational standards and the MD of the hospitals to which they are attached for their general operation. In both countries, the dioceses have nominees on the Boards of Governors.

With a few exceptions, there is general acknowledgement within CHSs, CHAs, dioceses, and government organisations that CHSs are accountable to their denominational church organisations, supported by the Board structures described above, and the churches' proprietorship of the CHS buildings and the land on which they are built. One of the hospitals operated by religious sisters in Malawi is actually subcontracted to them by the bishop, who can terminate the contract after five years if the hospital is not working to his satisfaction.

However, in both countries there are tensions over the relationship between some CHS officers and their church organisation, which are more apparent in the Protestant than the Catholic organisations. Both CHS and church officers frequently expressed the view that major decisions need 'church approval'. One hospital administrator in Malawi expressed some frustration when he stated:-

'...clergy think they know about everything, but they don't have the knowledge to make policy decisions about medical issues'

On the other hand, both the Presbyterian moderator and general secretary recognise that they need professional guidance, which is usually provided by a health secretary who has responsibility for implementing health policy, monitoring standards and coordinating or managing their health services.

There are strong views in India that over-involvement of the church can be detrimental to the efficient operation of the health services, as expressed by several CHS managers:-

"Does the bishop have sufficient time to understand the issues? ... [He] doesn't really understand hospital management. He has made mistakes including the building of hospitals in areas where the [health] need didn't warrant such a large institution"

"The church interferes too much and doesn't trust its directors to run the place. The Catholics are autonomous, run by the sisters. There is too much politics from the Protestants. The church hierarchy interferes in medical issues they don't understand".

There is a view that over-involvement of the church can constrain the development of health services:-

"Where the church controls health services, they become retarded" (counselling coordinator, CHAI).

The Catholic health services operated by religious sisters are subject only to the control of their own religious order, which is effected on a mainly consensus basis, and both CMC-Vellore and CFH operate independently of denominational structures, which gives them a high level of autonomy to make their own decisions. CMC-Vellore is managed by a Council comprising 53 churches, which collectively own CMC-Vellore, and is in theory under church control, but because of the large number of churches involved, in reality it operates outside church control. CFH is managed by the Christian Fellowship, members of which are mainly doctors, including seven married couples. The Fellowship, which is permeated by a strong Christian ethic, deals with policy and financial matters whilst a management committee deals with operational issues.

There is general consensus in both countries that CHSs enjoy a greater degree of autonomy than their respective GHS, but there are varying views on the extent of autonomy and the reasons for it. Whilst CHSs must operate within government policy, they are not subject to the same degree of government bureaucracy, which is regarded as slow and multilayered, as their GHS counterparts. Even in Malawi, where salaries of CHS staff are paid by the government, CHS managers are able to exercise their own employment policies.

However, this autonomy can be constrained for those CHSs working in diocesan structures, by what some regard as:-

"the churches' own feudal bureaucratic structures" (EU-I).

Hospital directors in CSI, for example, can make purely medical decisions, but all other issues must be decided by the diocese.

Those hospitals outside of diocesan structures appear to enjoy the highest degree of autonomy. St Stephen's, CMC-Vellore and the CFH believe that it is also their financial self reliance which provides them with the autonomy that allows them the freedom to innovate and that their innovation attracts patients, which in turn improves their financial position. For CMC-Vellore, in particular, each department is encouraged to seek funds to conduct its own research. In the case of the religious sisters, respondents believed that their consensus-based self governance enables them to adapt to communities' needs.

The general perception outside of church organisations is that CHSs receive funds from their own churches both in-country and from overseas. However none of the CHSs in either country are aware of any financial support received from their in-country denominational churches. The CNI health secretary confirmed that:-

"Overseas funds account for only 1-2%.of our budget and CNI doesn't provide any funds to operate health services. They must find their own funds".

In some areas in India CHS hospitals are expected not only to be self sufficient, but also to be a source of funding for the diocese. Two successful hospitals in Madras diocese, for example, are expected to support two less successful hospitals by transferring funds to them and one interviewee reported that a previous bishop had sequestrated a substantial sum from the health account to build a technical institute.

6.4.2.2 CHSs' Relationship with Overseas Partners

Most of the churches researched have a continuing link with their founding church partners overseas: for the Anglican church in Malawi and for CNI and CSI the link with USPG is particularly important, and for the Presbyterian churches in Malawi the historic links are with the Dutch Reformed Church in South Africa and the Church of Scotland. The Catholic religious orders have links with their congregations in Rome and in other countries. For some churches these links are just with a diocese, while for other churches the links also involve the churches' institutions, including their health facilities. There are mixed views amongst CHS interviewees, particularly in India, about the value of overseas links: some feel that the move from dependency, which they associate with links, to self-sufficiency is welcome and a sign of maturity in the Indian church, but others express regret at the weakening of overseas relationships. Some CHS institutions that do not have a direct link, particularly schools of nursing, believe that it would be beneficial to have one based on partnership, sharing, cross-fertilisation and professional exchange, rather than patronage, as in the past. CNI has a link with the Anglican Derby diocese and seven of the CSI dioceses have individual links with UK dioceses. Although some of these have eroded over time, Sunder Nagri has an active relationship with a Derbyshire church. Madras diocese is linked with both the Carlisle and New York dioceses. The Birmingham diocesan link with the Anglican church in Malawi provides financial support and skill sharing through visiting work teams (6.4.1.4), and programmes of professional exchanges have been established by other CHSs, such as that between St Stephen's and Guy's Hospital in London.

Overseas relationships are also fostered by the employment of expatriate staff. The Protestant health facilities researched in Malawi collectively employ eight expatriates, recruited from

both mission and secular organisations. The expatriates working in the Catholic hospitals researched are all religious sisters. Some hospitals have groups of expatriate volunteers who visit, usually annually, to carry out a specific project, or work with individual Malawians to share skills. These are mainly from UK and the Netherlands. As well as support for the particular project the link often provides ongoing financial support. In India, the expatriate contribution is mainly from medical student electives and short term professional staff transferring skills. These are most extensive at CMC-Vellore which has elective students and academic links with universities in Sweden, Denmark, Norway, USA and UK, and a bilateral exchange programme with Sweden for both students and the faculty. Several hospitals in the other 11 countries researched also have small numbers of expatriate professional staff, most commonly doctors, midwives and specialist nurses, recruited from a range of mission and secular organisations.

Financial Support of CHSs by Overseas Partners is discussed in section 7.4.1.

6.4.3   Religious Orientation of CHSs

It has been suggested that church policies and values are important influences on the operation of health services and that changes in these are amongst the factors that influence the services provided by CHSs today. The conceptual framework (5.2) referred to the need to examine the extent to which national churches have continued some of the values, customs, and organisational structures inherited from their colonial partners and whether they have inherited the tension between evangelising and health provision discussed in the literature review (2.4.5, 4.5.1). The religious orientation and practice of the CHSs and its claimed influence on their services and operations are explored in this section.

Observation reveals that all of the CHS facilities researched, in both Malawi and India, show their religious identity in some explicit way. In many, this begins with the name, such as St Luke's, St Anne's, St Stephen's, St Theresa's, St Ignatius, CFH (Christian Fellowship Hospital) and CMC-Vellore (Christian Medical College). Many also have on their walls religious symbols such as crosses, pictures, religious texts, and statues, particularly of the Virgin Mary. The researcher observed, and it was confirmed by patients and staff, that in all but one health facility researched, the day begins with religious devotions, which include singing hymns, saying prayers and reading the Bible. Frequently this is conducted in the outpatients' department before work starts in the morning. In some hospitals, devotions are conducted in the chapel and sometimes relayed around the wards by a 'Tannoy' system. In others devotions are conducted in individual wards, and in one hospital they are conducted at the bottom of the central stairwell so the hymns radiate around the whole hospital. None of the patients interviewed, including Muslim and Hindu patients, had any objection to devotions taking place, and many Muslims and Hindus spoke enthusiastically about taking part. The views of the Muslim and Hindu religious leaders ranged from being comfortable with their devotees participating in a religious observance to acceptance that devotions were part of 'the package' of attending a Christian hospital and that everyone benefited from the general Christian ethos which often permeated the institution.

Only a minority of the health facilities visited were able to produce mission statements describing their faith motivation and staff were not usually aware of such statements, although they were able to broadly describe the core values of the facility, which most commonly included love, compassionate care, and serving everyone irrespective of their class, gender, ethnicity, etc. Most of the managers of the health facilities without mission statements

suggested that it would be desirable for them to develop such statements. Several health

facilities had mottos, which were displayed on walls, in leaflets and/or on letterheads, with

which staff were generally familiar. Examples of these are:-

'We Treat and Jesus Heals' (Pirimiti-M).

'Serving with love and care' (Nkhoma-M).

'In love serve one another' (St Stephen's-I).

'Sincerity, Service and Sacrifice' (Ikadu-I).

'Not to be ministered unto, but to minister' (CMC-I).

The mission statements usually refer to 'Christian love' or the 'love of Jesus', but the mottos,

which are more prominently displayed, often do not, and concentrate more on 'serving'.

All patients and community members interviewed believed that people of all religious faiths

were treated equally and no one reported any form of religious discrimination at a Christian

health facility. Typically, a Hindu patient at St Stephen's said:-

"Hindus, by-and-large, think very highly of Christian hospitals because they love and care
for all people regardless of their religion".

Most CHS hospitals in both countries either employ their own chaplain or, where they are

located adjacent to a church, use the services of the parish priest. The chaplains visit wards to

provide pastoral and spiritual support to patients and staff on an individual basis, conduct

services and, in the case of Catholic priests, take mass to patients. The health centres tended

not to have a chaplaincy arrangement. There was a general view amongst interviewees in both

countries that the ethos of Christian institutions and the religious observance of individual

Christian staff create a greater compassionate and caring ethos:-

"I come here because Christians are service motivated. Others think the same so they prefer
to come here" (St Theresa's, MCH patient, not poor -I).

This view is more prevalent in India than in Malawi. Possible reasons are that Malawi is a mainly Christian country and most of the staff working in government hospitals would also be Christian, therefore, any contrast between the type of care given in CHS and GHS facilities is likely to be for reasons other than those associated with religious belief, as expressed by this government hospital administrator:-

"...Christians are also employed in the government service, but they suffer overwork and stress, which causes problems".

On the other hand, it might be that those health workers with a stronger commitment to their faith are more likely to choose to work in a CHS rather than a GHS facility. In India there are far fewer CHS facilities as a proportion of the total than in Malawi, and a much higher proportion of these are operated by religious sisters, whose service commitment is well recognised, as expressed by a Religious sister-doctor:-

"Even non-Catholic patients have faith is us, that we will love them and try to cure them. They often pray to Jesus in the chapel. Our order means we love all people, and our way of doing this is to provide health care, schools & welfare. We are not here to convert people, but to heal them in the love of Jesus".

In addition, because of the discrimination experienced by Christians in many parts of India, it is probable that only a small proportion of Christian health workers have left the CHSs to work in the GHS or the private sector, and that the more service oriented staff have continued working with the CHS, as explained by this BSc Nurse at a Protestant hospital:-

"I am Christian and I want to serve and care for patients with love and compassion, which I can only do in a Christian mission hospital".

Most Malawian CHSs managers interviewed affirmed that they preferentially recruit staff of their own denomination to senior posts, and Christians, preferably with similar doctrines and practices to their own denomination, to other posts. Non-Christian staff are usually only

recruited to the most junior posts, usually for ancillary work. The main reasons given for this policy are to maintain loyalty to the parent church and to maintain a common religious ethos. Respondents admitted that this policy sometimes creates difficulty because the general shortage of well qualified health workers results in the most appropriately qualified person for a post not meeting these criteria.

Senior managers of Indian CHSs reported similar preferences, but acknowledged that they operate them less successfully, because they cannot recruit sufficient Christian professional staff. At most facilities, approximately 80% of staff are Christian, with a higher number of non-Christians amongst the lower grades of staff. As in Malawi, some CHSs give preference to recruiting from their own denomination. This is most apparent when recruiting for senior posts and allocating places for students at medical and nursing schools. At St Theresa's, for example, 65% of students are Catholic, 30% other Christian and 5% other faith. One school principal advised that under national legislation government educational institutions must allocate a percentage of places to OBCs (other backward classes) and SCs (special classes). Some state governments are trying to apply this to CHS schools, but so far have been unsuccessful because of CHSs' status as part of a minority religion:-

"The government is applying pressure for us to take 50% government nominees. CMC has not given way, but give priority to Christians who we take on merit. Only four out of 60 seats are allocated to non-Christians. (deputy director, CMC-I).

In contrast, fewer than 5% of patients are Christian in most facilities in India. In some cases, such as St Stephen's and St Theresa's, the health facility was built specifically to serve Hindu and Muslim women although these hospitals have since expanded their roles.

The research revealed a few potential difficulties for patients resulting from religious doctrine. The Catholic CHSs in both countries confirmed that they do not provide artificial methods of family planning themselves, although in Malawi, they allow government employed HSAs (health surveillance assistants) to do so. However, some HSAs suggested that this does result in some patients being denied a service and taught that only natural methods are acceptable. The project manager at CHAI advised that, in India, although it is against official policy, some Catholic facilities do provide condoms as a preventive measure against HIV/AIDS, some with the support of the bishop and others more covertly.

The potential for religious conversion is a politically sensitive issue in India. Managers and staff of CHS facilities and church leaders state that there is no active proselytisation on their premises and that providing health services, particularly to poor and marginalised people, is their way of manifesting their 'love for God'. However, although there is no direct attempt to convert, conversions occur in two ways. First, grateful patients, who have been impressed by the compassionate care they received sometimes convert, e.g.:-

"My family are all Hindu, When I was a patient here previously I liked the prayers in the chapel and I converted to Christianity" (Kalyani, outpatient, female, very poor -I).

Second, and more commonly, dalits and lower caste people who have entered a CHS training institution can gradually inculcate the values and liturgy of Christianity, e.g.:-

"I converted from Hinduism when I was a medical student. I am very committed and consider it noble to do God's work in a Christian hospital" (obstetrician, St Stephen's-I).

On the other hand, many Hindu and Muslim patients see no difficulty in praying or showing gratitude in the Christian tradition without experiencing any threat to their own religion:-

"Hindus show their gratitude by draping saris around the Virgin Mary, put candles and coconuts at her feet, and worship in the chapel. Even Muslims join in prayers" (nursing superintendent, St Theresa's-I).

However, the fear of conversions causes hostility towards Christian institutions by some politicians, particularly members of the Hindu nationalist BJP (Bharatiya Janata Party), as in this example reported by the Catholic health commissioner and the director of St Theresa's respectively:-

"Our (religious) sisters had to leave Gujarat where they were looking after 120 lepers and 60 HIV/AIDS patients because the state government didn't want the Christian influence".

"The nursing school receives government grants but the Andhra Pradesh government are trying to phase out Christian schools. The new state government have already stopped paying allowances to boarders".

Six states have introduced 'Freedom of Religion' laws to discourage conversion to Christianity, but according to Christian Today (http://in.christiantoday.com/), Tamil Nadu has withdrawn its law and the newly elected national government is planning to repeal laws which restrict freedom of worship. Some respondents believe that the actions of evangelical churches, which actively seek conversions, are causing the adverse political reaction:-

"Some Evangelical churches do seek conversions. Other churches should separate from them and make their disassociation known to the government" (associate professor, JNU-I)
.
"Evangelicals are a very small proportion but they spoil the reputation of others" (VHAI-I).

This investigation suggests that CHS facilities are clearly identifiable as Christian institutions where patients appreciate the faith ethos and the receipt of compassionate care. Most facilities seek to recruit Christian staff, preferably of their own denomination. There was no evidence of either discrimination against non-Christians, who comprised the majority of patients in most Indian facilities, or seeking conversions to Christianity, although there are instances of both patients and staff converting as a result of their experience in a Christian institution.

6.5 Summary

As background to an exploration of CHSs in the 13 countries included in this study, this chapter commenced by describing their geographic, economic and human development status. Because both the health status and the GDP per capita of the 13 countries, with one exception, are at the lower end of the global scale, the countries concerned have some of the most difficult health challenges but are economically amongst the least able to deal with them (6.2.1-2). There are substantial differences between India and Malawi, with India having a LEB of 63.7, an IMR of 56, GDP per capita of US$3,452 and health expenditure per capita of US$91, compared with 46.3, 79, US$667 and US$58 respectively for Malawi (6.2.1). Additionally, Malawi's maternal mortality rate is estimated to be the highest in Africa. Both Malawi and India have high rates of malaria, tuberculosis, HIV/AIDS and nutritional deficiencies, all of which are preventable conditions with appropriate education and accessible preventive services (6.2.2).

Examination of the different forms of health expenditure between the two countries indicates That government contributes a much higher proportion of health expenditure in Malawi than in India: 55% and 19% respectively. It will be shown in chapter 7, that there is greater determination on the part of the Malawian than the Indian government to collaborate with CHSs. Two of the factors contributing to this are possibly recognition by the Malawian government of the greater seriousness of its health problems and its inability to improve the situation without the assistance of major partners.

Another factor likely to affect the willingness of governments to cooperate with CHS is the extent of CHSs' contribution to the total health sector, which will be further explored in

section 7.3. Comparison of health services between countries and even between different parts of the sector is constrained by problems of definition: percentages of health services refer to the number of facilities, beds or patient consultations, statistics based on which may produce different results (6.3.1). However, acknowledging these imperfections, the contribution of CHSs to the total health services of their respective countries is estimated to vary from 1% in Bangladesh to 30-50% in most of S-SA and PNG. It is estimated to be 38% in Malawi and 10% in India. There are varying patterns of increases and decreases, in these proportions over time in many countries due to transfers between CHSs and GHSs, opening and closing of facilities due to population migration and/or financial unsustainability, and competition from the private and government sectors (6.3.1). The effects of the financial issues are discussed in section 7.4.

With the advice of senior managers in their respective CHAs, six health facilities were selected in each country for detailed study. In Malawi these were from the Catholic, Presbyterian and Anglican denominations, and in India from the Catholic Church and from the Churches of North and South India, which were the denominations with the most CHS facilities in each country. Two additional facilities were included for partial investigation in each country. The issues which emerged from both St Anne's and Likuni in Malawi, particularly in relation to service agreements, are discussed in the next chapter (7.3.4). The issues emerging from CMC-Vellore and CFH provided a critical perspective on the operation of Protestant CHSs in India, mainly because of their autonomy from denominational control, but also because of their Christian ethos (6.4.2.1).

Because GHS and CHS facilities are usually located in different areas, serving different populations, and because of the government's resource constraints, it is generally acknowledged by government officials in Malawi that the services provided by CHSs, particularly in rural areas, are an essential part of the health infrastructure. Although in India, many of the CHS facilities, particularly the Catholic facilities, are located in rural areas not served by the government, official acknowledgement of their contribution is less forthcoming (6.3.1). In both countries, there is increasing difficulty in recruiting staff to work in remote rural areas, except for Catholic religious sisters (6.2.3, 6.4.2.2).

All 13 countries studied have some form of CHA, which can be categorised in two respects. Some countries operate separate Protestant and Catholic CHAs and in others one CHA represents all CHSs. CHAs can also be categorised into 'Support CHAs', which mainly provide educational and professional support functions, and 'Coordinating CHAs' which coordinate the work of CHSs and act as a broker between CHSs and the government. In India CMAI is totally, and CHAI mainly, a Support CHA; they separately represent Catholic and Protestant CHSs, whilst in Malawi CHAM is a Coordinating CHA and represents all CHSs (6.3.3).

CMAI (mainly Protestant) and CHAI (Catholic) in India have had different trajectories in many respects. Whilst the number of Protestant facilities declined from approximately 800 to 300 between 1947 and 1996, the number of Catholic facilities increased from 776 to 2661 between 1968 and 2007. Three contributory factors to these trends were identified: first, CHAI has responded to the changed circumstances of increased costs of health service provision and declining income from overseas partners by operating a greater proportion of

small low cost facilities, whilst CHSs under the CMAI umbrella continue to operate a greater proportion of larger, more expensive, hospitals; secondly, 75% of Catholic facilities are operated by religious sisters who are constantly available and who receive only a modest living allowance, whereas Protestant facilities are usually operated by doctors and other professional staff who are paid a salary; and thirdly, the Catholic CHS is a single denomination, which facilitates a greater unity of vision and enables CHAI to speak with one voice, whilst CMAI comprises a collection of denominations with different views and aims, which causes greater difficulty in achieving consensus amongst its members. CHAM has also developed to a state where it is able to speak on behalf of all of its members. The number of CHS facilities registered with CHAM has increased from 106 in 1980 to 167 in 2007, as a result of an increase in both the number of CHS facilities operating and those registering with CHAM (6.3.3).

Of the twelve UK based mission organisations researched, the great majority prioritised in their mission statements the spiritual and community engagement aspects of their work. A lesser number prioritised advocacy and healthcare (6.4.1.1). As proposed in the conceptual framework, the mission organisations are experiencing a number of tensions: between their evangelistic and service roles, which is sometimes characterised as a tension between mission and development (6.4.1.2); between their intention to share with and/or devolve decision making over the allocation of funds to their developing country partners (6.4.1.5), when the flow of funds, which is decreasing, is still mainly unidirectional (6.4.1.3); between adjusting to the declining funds available to mission organisations and the continued need to support overseas churches and their CHSs (6.4.1.3); how to reconcile self determination by overseas churches with the objectives of UK mission organisations and their donors (6.4.1.5),

particularly serving the poor (6.4.1.2); and between supporting valued health institutions, sometimes supported by specific financial trusts, while recognising the need to change emphasis towards PHC (6.4.1.6). Several of the mission organisations studied have completed or are in the process of reviewing their operations to try and resolve some of these tensions. The conceptual framework suggested that national churches may continue some of the values, customs, and organisational structures inherited from their colonial partners, potentially including the transfer of the tension between evangelising and health provision. The study has found that church proprietorship of CHSs continues to be endorsed in two ways: first, through ownership of the land and buildings from which CHSs operate; and second, by membership, and often chairmanship, of Health Boards and Medical and Nursing School Boards. Whilst CHSs are recognised as being more autonomous than GHSs, there are strong feelings amongst CHS staff in some areas that church officials, particularly the bishop, over-involve themselves in the detailed operation of health institutions, beyond the level at which they have either the time or the expertise. Health service managers, in particular, generally believe that those facilities which operate outside diocesan control, such as CFH, CMC-Vellore and the Catholic facilities operated by religious sisters, are generally more efficient and are able to exercise a greater degree of flexibility (6.4.2.1).

Generally the religious orientation of CHS facilities is well known, sometimes denoted by the name and frequently obvious from religious artefacts and texts around their buildings. Because it is a mainly Christian country, the Christian influence is less of an issue in Malawi. In India, some politicians are concerned about the potential for religious conversion, but for the most part, Muslim and Hindu patients, and their religious leaders, are comfortable with the religious ethos in CHS facilities: many patients specifically select Christian facilities because

of the compassion associated with their Christian ethos and some participate in the daily devotions. All CHSs attempt to recruit Christian staff, preferably of their own denomination, and particularly to senior posts. Although only 5% of patients in most CHSs in India are Christian, none of the interviewees reported that they had experienced any form of religious discrimination in a CHS facility (6.4.3). The interviewees in both countries expressed a high regard for the religious ethos and appreciation of the compassion associated with CHS facilities.

Some of these issues will be further explored in chapter seven, particularly in relation to the ways in which governments and CHSs cooperate, or not, with each other (7.3); the approaches made by CHSs to replace the declining funds from their traditional partners (7.4); the effects of these changes on the socioeconomic orientation of CHSs and their users (7.5); and the reasons for the continued existence of CHSs (7.6).

CHAPTER 7

CHRISTIAN HEALTH SERVICES IN MALAWI, INDIA AND OTHER STUDY COUNTRIES: THEIR FINANCIAL SUPPORT, RELATIONSHIPS WITH THEIR GOVERNMENTS, THEIR SOCIOECONOMIC ORIENTATION, AND REASONS FOR THEIR CONTINUED EXISTENCE

7.1 Introduction

Chapter 6 discussed the results of the first two research questions which relate to first, the contribution of CHSs to their respective national health sectors and to second, aspects of their religious orientation and their relationships with their church organisations in-country and overseas. This chapter discusses the results of the research that addressed the second two research questions, which focus on the relationships between: CHSs and governments, financial issues, the socioeconomic orientation of CHSs and the reasons for their continued existence.

7.2 Government Programmes to Improve Health in Malawi and India

The underperformance of the health programmes of many newly independent governments was identified in the literature review (3.3) and some of the influences on their attempts to improve health care delivery briefly discussed in section 3.4. It was suggested (5.2) that NSPs (non-state providers) operate in contexts in which state-determined overall policy framework and regulatory arrangements influence their operations, although there may also be scope for NSPs to influence governments. Possible mechanisms for such influence have been identified in sections 6.3.3 and 7.3.1, including working through CHAs and involvement in government policy and planning processes. The studies in Malawi and India attempted to

ascertain the ways in which CHSs and governments relate to each other in order to assess the existence, nature and impact of state-CHS relationships. These are discussed in the next section (7.3).

As background to that discussion, government approaches to improving health service delivery are outlined in the remainder of this section. The governments in both Malawi and India are conscious of the deficiencies in their health sector delivery and have recently initiated major improvement programmes intended to build on previous initiatives. The Indian National Rural Health Mission 2005-12 (GOI 2005) recognises the limitations of current programmes, particularly regional inequalities and their emphasis on urban curative services which favour the non-poor. This latest initiative seeks to improve services by increasing government health expenditure by 30% each year, decentralising health programmes, improving service access by poor and marginalised people, developing PHC (primary health care), promoting the non-profit sector, promoting PPPs (public-private partnerships) and improving regulation. There is also a planned reproductive and child health programme to be funded through the Indian SWAp (Sector Wide Approach) (WHO 2005 (a)).

The Malawian SWAp programme (GOM 2004), which was agreed in 2004, focuses on delivery, free of charge to users, of the Malawi EHP (Essential Health Package) through DIPs (District Implementation Plans). Implementation of the programme is led at local level by DHOs (District Health Officers), and involves local partners such as CHAM and NGOs. The EHP concentrates on those conditions and service gaps that disproportionately affect the health of the poor and disadvantaged populations, including reproductive health, HIV/AIDS, malaria and TB. The health-related initiatives of the MGDS (Malawi Growth and

Development Strategy 2006-11) (GOM 2006), operate together with those of the SWAp programme first, to enhance the capacity of the MoH to formulate policy and regulate the sector; and second, to bring about improvements in the capacity of decentralised health systems, the health sector workforce, infrastructure, drugs and medical equipment, financial management and supervision. The MGDS also includes specific initiatives to improve achievement of the MDGs (millennium development goals).

There are general similarities in the programmes of the two countries, which also resonate with the international initiatives to improve health status and health sector performance discussed in section 3.4, which include managerial decentralisation; developing PHC; improving service access by poorer members of the community; cooperating with NSPs; and improving regulation. An important difference is that the Malawian programmes specifically refer to engagement with CHSs, whereas the Indian programmes make scant reference to the involvement of NGOs and none to CHSs or other FBOs (faith based organisations). This difference in government approach to the contribution of CHSs will become clearer in the next section.

7.3 The Relationship between CHSs and Governments

The situations of the CHSs in Malawi and India are quite different. CHSs in Malawi operate in a mainly Christian country in partnership with a supportive government. The CHS provides approximately 37% of the health service in Malawi through its 167 health facilities, 90% of which are located in rural areas, where most of the poor population live. Only 2% of services are provided by private practitioners, commercial companies, the army and the police. CHSs play a crucial role in the health sector because the government is not able, on its

own, to reach the most vulnerable people living in rural areas, in large part because its infrastructure is concentrated in urban and peri-urban areas (CHAM 2004).

By contrast, Indian CHSs operate in a minority Christian environment (2.3% of the population (24.1 million people) were Christian in 2001), in which political attitudes vary between states from moderate support to indifference and even hostility. The World Bank's review of India's health system (Peters et al. 2002) makes many references to the private sector, but only once mentions Christian or mission health services, and then in an historic context. Furthermore, the succession of reports produced by the Indian Government (7.2) on initiatives to improve the country's health services seldom mentions the contribution of CHSs. It is difficult to establish the precise proportion of total health services provided by CHSs due to the lack of reliable information regarding the multiplicity of small private informal providers and the expanding corporate health sector (3.4.2.2), compounded by problems of definition (6.3.1). However, it is estimated by both CMAI and CHAI to be around 10% of the total provision.

The conceptual framework (5.2) highlighted several aspects of the relationships between CHSs and governments emerging from the literature review: first, it is anticipated that there will be ambivalent attitudes towards cooperating with each other on the part of both CHSs and governments because they are interdependent but have mutual concerns about their own sovereignty and trust in each other (4.5.3); second, the international financial institutions are encouraging governments to work with NSPs (3.4.2.2) but, because of their secular ethos and their concerns about the presumed evangelistic activities of CHSs, many governments are apprehensive about extending partnerships to FBOs (4.5.1); and third, CHS denominations may or may not be willing and have a mechanism to cooperate with each other and/or with the

government (4.4, 4.5.3). The hypothesis proposed the possibility that the relationships CHSs have with governments have changed as a result of CHSs' need to seek alternative funding sources. The results from the investigation of these issues are reported in the following sections: first, the involvement of CHSs in government health sector policy making and planning is reviewed (7.3.1); second, whether and how governments support CHSs is discussed (7.3.2); third, two forms of cooperation are identified and analysed: memoranda of understanding and service agreements (7.3.3); and fourth, cooperation between GHSs and CHSs is considered (7.3.4). The section concludes with a consideration of regulatory relationships by analysing government regulation of CHSs (7.3.5).

7.3.1 CHSs Involvement in Health Sector Policy and Planning

In section 4.5.3, a number of factors likely to affect the willingness of CHSs and governments to cooperate with each other were identified. Of particular importance is the historical relationship between CHSs and governments, especially in the immediate post-independence period. In some countries, the actions of the government and/or CHSs created levels of mistrust which have persisted through the decades. In other countries, the cooperation sought by the government and the willingness of CHSs to respond may determine whether the foundations for future collaboration in response to the HSR (health sector reform) initiatives and other government programmes were established.

One of the factors likely to affect cooperation between governments and CHSs, referred to in the conceptual framework (5.2), is the willingness of CHSs to implement government policy. It was also suggested that this is likely to be influenced by whether or not they have opportunities to influence the formulation of such policy, whether policies are appreciative of

the contribution and limitations of CHSs, and whether CHSs are involved in the health sector planning system.

As shown in section 6.3.3, because the role of Support CHAs is limited to fellowship and professional interests, CHSs do not expect these CHAs to formulate policy for their members to implement. One of the questions addressed was whether these CHAs expect (or are expected by their members) to influence government policy and if so, whether they have been able to do so. Indian CHS managers interviewed did express an expectation that their CHAs would influence government policy but affirmed that both CMAI and CHAI lack political influence. They attributed this first, to national and state governments, particularly where the BJP is dominant, often being unsympathetic to the Christian view; second, to the relatively small and uncoordinated contribution of CHSs to the total health sector provision (6.3, 7.3, 7.3.1); and third, to the major difficulty CHAI and CMAI have in achieving a unified voice (6.3.3). This situation is compounded for CMAI by not always being able to obtain a common view amongst its own members.

In contrast to India, there is a much closer relationship between the government and CHSs in Malawi, first, because Malawi is a mainly Christian country (7.3); second, because of the major contribution CHSs make towards the total national health provision (6.3); and third, because the CHSs through CHAM are able to provide a united view (6.3.3). Because of this, there is a general understanding by all the main actors (church leaders, government and donor agencies) that CHAM will present the views of CHSs to government and that such views will be acknowledged. There is a general view amongst interviewees from CHSs, church organisations and government organisations in Malawi that CHAM has gradually been

assuming a more directive role, working more closely with the government, and acting as a vehicle for implementing government policies in CHSs. There is, however, disquiet amongst some church officials and CHS managers that this level of cooperation between CHAM and the government is causing a degree of co-optation. For example the general secretary of the Malawi Council of Churches noted that:-

"*Sometimes CHSs feel that CHAM is managing them and are too intrusive. Many people believe CHAM is an arm of the government*".

This is also recognised by some government officials. For example the Nkhotankhota DHO suggested that:-

"*CHAM has been transformed: government are seeing it as an arm of government*".

The MoH, in contrast, perceives the relationship as reciprocal:-

"*CHAM is a partner of the government with reciprocal obligations and responsibilities. There is mutual respect for each other*".

The literature review identified government failure in health sector planning, including the failure to involve NSPs, as a contributory factor to underperformance of the sector (3.3.2). It was also noted that, despite their significant contribution and long history, CHSs are often ignored in government health planning (4.3). The current research found variance in the extent to which governments have involved CHSs in health sector planning. One factor explaining this difference was the type of CHA and, in consequence, its relationship with the government. 'Coordinating CHAs' generally participate in the formulation of strategic plans and consideration of other major initiatives, such as the SWAp process or Global Fund allocations, but 'Support CHAs' are only consulted occasionally. CHSs have also sometimes been involved when particular health programmes that require a high degree of cooperation, such as HIV/AIDS care and treatment, are under discussion (questionnaires).

The Malawi government and CHAM signed an MOU in 2002 specifying the terms of their

partnership and this was reinforced by the SWAp MOU, which was signed by all collaborating partners, including CHAM, in 2004. Interviews with donors such as UNICEF, government officials including the MoH and CHS informants, suggested that in the Malawian experience, national level, programmes, such as SWAps, facilitate closer working relationships between the government, CHSs and other NSPs. This is first, because they provide a forum in which different stakeholders can engage in discussion with each other:-

"SWAp includes all stakeholders and is sustainable for 6 yrs. Funds from both the debt cancellation and the global fund are directed at health…There is a true partnership between the government and CHAM at meetings" (UNICEF- M).

"Ministry of Health planning includes CHSs 100%. CHAM are always present at meetings" (MoH-M).

Second, it is because the access they provide to badly needed resources is a powerful incentive for NSPs to participate:-

70% of Malawi's health budget is from donor funds…districts' income has increased massively through SWAp." (UNICEF- M).

With the acceleration of decentralisation policies in many countries, including India and Malawi (7.2), an increasing amount of health sector planning, as well as operational management, is being devolved from national to regional and district governments. The initial lead in involving CHSs in these developments in Malawi has usually been taken by a central government ministry, which understands more clearly the conditions of a SWAp or similar sector programme and has experience of working closely with the CHA, which attends planning meetings on behalf of its CHS members. In consequence there is an intention on the part of both the government and CHAM that CHSs also should also be involved in district planning meetings:-

"Under decentralisation the districts should determine their way forward…The DIP should include every stakeholder in the District" (MoH-M).

"…CHAM (CHSs) should attend all district health meetings" (Director of Health Programmes, CHAM-M).

However, what is actually happening varies both between districts and, in some districts, from what was intended. Some experiences are positive: CHS managers in some districts reported that, while in the past they were not regularly invited to district planning meetings, now they are. A number of interviewees attributed this change of approach to implementation of the SWAp programme. However, CHS managers from other districts reported that they are still not included. This reluctance to include them was attributed by CHS informants, such as the administrator from Nkhoma Hospital and the medical director of St Anne's, both of whom were eager to be involved, to local health officials' resistance to increased CHS influence.

Government officials, as expected, gave other reasons. For example, the Lilongwe DHO explained that:-

We only invite CHAM (CHSs) when it is relevant…donors also want to be included, so service delivery is not always a priority at meetings".

Part of the variation in approach seems to be due to the differing attitudes of government officers to the legitimacy of involving CHS representatives in what they may perceive as government planning meetings and part to inexperience resulting in a failure to recognise the need to involve CHS representatives. Responsibility in Malawi for managing the district planning process rests with the DHOs, some of whom, as acknowledged by senior officials such as the administrator of a government hospital, are very junior doctors, who have only recently graduated, and have been assigned to the position of DHO by the government, rather than making a conscious choice. In addition they experience low esteem and job satisfaction as a result of their lack of appropriate office accommodation and pressure of work, which make DHO postings unattractive, a problem that was affirmed both by the DHOs interviewed

and other government officials. The non-involvement of CHSs at district level is sometimes due to government lack of organisation and limited understanding of the planning system. The CHAM director of health programmes suggested that the new decentralised planning systems would require a more structured approach to consultation than the rushed afterthought associated with current practice.

The situation in India is more complex than in Malawi. Despite the numerous national health policy reports since independence, the Indian government acknowledged in the National Rural Health Mission Report in 2005 (7.2) that there continued to be serious deficiencies in its current programmes. The majority of officials interviewed from all organisations expressed scepticism about the prospects for implementation of the new programme because of previous experience of failure to act on recommendations. National policies, such as the National Rural Health Mission, refer to involvement of the non-profit sector (7.2), particularly in underserved areas, which is where many of the CHSs operate. However, respondents from development organisations, churches and CHSs affirmed the apparent reluctance of state officials to implement the system: the CMAI general secretary emphasised that, although the central government has formulated a National Plan it cannot control its implementation because the states have autonomy; and a PHC consultant at CFH recounted that the churches have been excluded from implementation of the Rural Health Plan in Tamil Nadu, but have been included in Orissa because, he surmised, the Orissa State government realised that they were unable to meet all of the rural health needs themselves.

Even when opportunities for participation in policy and planning occur, CHSs may avoid engagement with State governments because of previous experiences of hostility, often

associated with Hindu nationalist political control, as acknowledged both by the general secretary of CMAI and an associate professor at JNU. According to external observers, such as UNICEF and the EU, this diffidence often results in CHSs excluding themselves from opportunities to work with either the government or other non-state organisations. However, in some states, the government seems to be more conciliatory, particularly towards the Catholic Church. There are a number of possible reasons for this, including the larger proportion of Christians in the population of some states, for example Kerela: the early influence of Christianity in the lives of politicians who had attended a Christian school; or good personal relationships between individuals. The latter was clearly expressed by the director of St Theresa's hospital:-

"We have a good relationship with government officers individually, but collectively they are bureaucratic unhelpful and apathetic" (director, St Theresa's-I).

In addition, government willingness to cooperate may occur if the CHS has a particular skill or experience which the government needs or CHS staff have taken advantage of opportunities to work with government officials when they have arisen. For example, the director of the State government public health department in Andhra Pradesh affirmed:-

"*We work well together with CHAI on specified projects and programmes.[For example] we see CHAI as a centre for our District Project Management training, because CHAI has the experience*".

Thus, CHSs may be invited to a meeting when a particular campaign is being planned which needs the involvement of all health service providers:-

"The government involves us when they draw up strategic plans for dealing with HIV/AIDS, otherwise they don't" (obstetrician and gynaecologist, Kalyani-I).

"The new Integrated Child Survival Plan in Uttar Pradesh involves all NGOs, including the churches. Everyone must implement the package" (UNICEF-I).

In addition, individual clinicians may be invited to planning meetings because of their specific expertise:-

"The government invites clinicians from CMC on an individual basis to various committees for their specialist input. The government also invests in our research programmes because of the value placed on the quality…" (principal, CMC-Vellore-I).

"Individuals with specific expertise, rather than institutions, may be called to give advice to the government" (evangelist, CFH-I).

The results of the interviews in both countries suggest a dissonance between the intentions of national governments in relation to the involvement of NSPs in the implementation of health policies and practice at sub-national levels. A difference between the two countries, however, appears to be that exclusion of CHSs from the planning process in Malawi is mainly by default, through inefficient management, failure to recognise the need to involve them, inexperience on the part of the DHOs, or failure to adapt to a changed process, whereas exclusion in India is perceived, at least by CHS managers, to be more deliberate, resulting in CHSs avoiding engagement with State governments because of previously experienced hostility. CHAs in some countries have regional and sub-regional structures which enable them to respond more readily to governments' devolved planning processes.

7.3.2 Government Support of CHSs

Whether or not governments involve CHSs in the formation of health policy or in the strategic or operational planning of the health sector, some support CHSs in a variety of other ways. As suggested in the conceptual framework (5.2), 'support' can be conceptualised as a continuum: at one end governments may simply permit registered CHSs to operate and allow tax exemptions on imports of medical supplies. Moving along the continuum, government support to CHSs can include support to high priority programmes, such as those dealing with

TB (Tuberculosis), STIs (Sexually Transmitted Infections), Malaria or HIV/AIDS; supply of drugs, vaccines or other medical supplies; funding of staff salaries; providing operational running costs; and contributing towards buildings or equipment maintenance. In this section the different levels and types of government support for CHSs in all 13 study countries are assessed from data collected in the general survey, and from interviews in India and Malawi, with a view to assessing and explaining the nature and outcomes of government support to CHSs.

There seems to remain in many countries ambivalence on the part of the government, which acknowledges the value of the service provided by CHSs, but resists accepting responsibility for the requisite level of funding. According to the Catholic CHS respondent in Uganda, for example, the government only contributes 25% of the cost of services provided by CHSs (This figure is at variance with the 35% cited by Marshall and Van Saanen (2007) in 4.5.2, but is possibly accounted for by either a change since the earlier figure was obtained or by different elements being included in the calculation). In Ghana, the government contributes only the staff salaries. In fewer than half of the 13 countries for which information was collected (PNG, Malawi, Lesotho, Zimbabwe and Tanzania) do governments pay the full salary costs of all approved posts, which are commonly the agreed establishments of professional and technical staff. In Ghana, the government funds 80% of the salaries, in Kenya the salaries of only a few government health workers who are seconded to CHS institutions, in South Africa specified posts in particular facilities, while in Uganda funding is restricted to a limited number of doctors. Even where the government funds the salaries of CHS staff, the salaries paid are sometimes lower than the salaries paid to government employees, resulting in a drift of staff from CHSs to government health services, where there

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are also, according to an Anglican diocesan education secretary interviewed:-

"better salaries, better career prospects, more training and greater opportunities for promotion".

Operational running costs or grants are paid in a minority of countries. Each government decides on the criteria on which to base payments to CHSs: the Zimbabwean government uses total recurrent expenditure; in PNG standard payments are made according to the level of facilities; Tanzania uses the number of beds; Uganda calculates payments according to service outputs; and in Ghana the service delivery cost is covered by health insurance. No operational running costs are paid in the other study countries.

Support for priority programmes varies between countries, and is often affected by the level of funding support governments receive from international donors and whether there is a SWAp or similar programme which extends the available funding to non-state health providers. At the lowest level, support may be restricted to providing drugs for a single programme, such as for TB or HIV/AIDS, as in Cameroon and Bangladesh, or additional programmes such as Leprosy and STIs. In some countries vaccines are routinely provided for CHSs to immunise children against specified infectious diseases. In those countries in which the government and CHSs work most closely with each other, such as PNG, Lesotho and Tanzania, support is more likely to include all of the services mentioned above and also RCH (reproductive and child health, including antenatal care, family planning and child vaccination). Exceptionally in some countries, such as PNG, it extends to providing routine drugs to treat patients presenting with a general range of conditions in outpatients' departments.

None of the Support CHAs are involved in allocating government funds to CHSs. Of the countries with Coordinating CHAs, the Kenyan government ceased providing funds to CHSs more than ten years prior to this study; the Ministries of Health, in partnership with CHAs, allocate funds to CHSs in Lesotho, Tanzania and Zimbabwe; in Uganda allocation of health funds is a decentralised function and the CHAs advise the government on eligibility and monitor the flow of funds; and in PNG, Malawi and Ghana the CHAs take an active part in setting the budgets as well as allocating the funds.

Government support for CHSs sometimes depends on the proximity of CHS facilities to government facilities, with more support provided to facilities in areas with no government provision. Thus in South Africa, for example, some CHS facilities receive no government support and operate totally privately, whilst others receive different levels of support, with some receiving almost total funding (questionnaire). Many of the CHAs and CHSs believe that the difficulties they experience through lack of government support are compounded by the isolation of the areas in which they are located, the poverty of the communities in those areas, and the difficulty in recruiting and retaining staff, who move to better paid jobs. In many instances these difficulties pose a real threat to the survival of the institutions concerned. The following statement from the Catholic CHS in Kenya, expresses views similar to views expressed by CHSs in other countries:-

"Our facilities are generally found in remote or marginalised areas, with insufficient or no support from the government and diminishing or no support from donors. Health facilities have started closing down: about 10 in 2 years including 2 large hospitals due to debt & loss of personnel who migrate to better paid jobs with government".

Both in India and Sub-Saharan Africa, CHAs believe that governments must increase their support of CHSs if they wish to improve the health of their poorest communities. Sub-Saharan

CHAs are seeking to gain increased support by collectively raising the profile of their concerns as explained by the Protestant CHA of Kenya:-

"Advocacy is needed globally if we are to sustain these very important institutions [CHSs]. The Sub-Saharan Africa CHAs have formed a platform with the secretariat hosted by CHAK to help coordinate sharing of lessons and putting forward a common voice for the Church health work in Africa".

In some countries, the degree of support depends more on the political inclination of the government than need. In India, for example, where states operate with a high degree of autonomy, there is variation in the amount of support different State governments give to CHSs, but this is still only related to the funding of particular projects and programmes such as HIV/AIDS, DOTS for tuberculosis, child immunisation, leprosy or family planning. In accordance with the Rural Health Mission Report (7.2), officials, both within and outside of CHSs argue, the need for the Indian government to increase its recognition of, and support for, NGOs and CHSs if it is to achieve its aim of improving the healthcare available to the poor. For example:-

"The state needs to decide where it puts its subsidies – it is currently putting funds into the private end and ignoring the non-profit sectors which are better motivated to help the poor" (associate professor, JNU-I).

The data presented above indicates a wide variation in the level and type of support given by governments to CHSs, influenced by a variety of factors generally unrelated to governments' own economic position: the GDP per capita in Malawi and Tanzania, for example is only US$667 and US$774 respectively, and health expenditure per capita US$58 and US$29 (6.2.1), yet their governments provide more support to CHSs than many others. In some countries this is likely to relate, at least in part, to the higher contribution CHSs make to the national health sector, but this does not apply in all cases.

7.3.3 Memoranda of Understanding and Service Agreements

Reference was made in the conceptual framework (5.2) to the encouragement from international financial institutions, as part of the HSR movement, for governments to implement initiatives to improve the performance of their health sectors, including greater involvement of NSPs in health sector provision (3.4.2.2). Theoretical assumptions underpinning HSR led to recommendations that such cooperation should be formalised by contracts, service agreements or PPPs (public-private partnerships) which would, it was suggested, create relationships able to deliver efficiency and accountability (3.4.2.2, 4.5.3). The research set out to ascertain whether and why such approaches to cooperation had been adopted in the countries under study, and to identify and explain their form and perceived outcomes.

Agreements with CHSs are usually underpinned by a MOU or Service Agreement, which specifies what the government is paying for and what the CHSs are expected to provide in return. Such agreements may be national or local. In those countries in which there is a formal agreement with the government, CHSs usually have a defined geographical area in the proximity of their health facilities for which they provide an agreed package of services and the government pays the salaries of staff and operational running costs. CHSs in PNG, Lesotho, Zimbabwe and Malawi have MOUs with their respective governments. In Uganda, CHS facilities sign an MOU with the local government, to which they are required to submit quarterly workplans and budgets for approval before they receive their conditional grant. However, the grant covers only 25% of the cost of services the CHSs provide. A PPP in health policy has been negotiated and is awaiting ratification by the government. In Kenya, negotiations are in progress on an MOU. In some countries, such as Bangladesh and

Cameroon, service agreements are limited to cooperation on particular priority programmes, typically TB, HIV/AIDS and Malaria.

In Malawi, under the MOU signed in 2002 as part of the SWAp programme (7.2), the government pays the salaries of all approved staff in CHAM institutions and DHOs are authorised to negotiate service agreements between their District and the appropriate CHSs. In recognition of the excessively high maternal mortality rate in Malawi, which is reported to be the highest in Africa (6.2.2), the government is encouraging all pregnant women to seek antenatal care. This is provided free in government health facilities, but for many women there is no accessible government health facility where they live. Also many government health facilities are operating at full capacity. Many CHS facilities provide antenatal care and have spare capacity, but charge user fees, which the poorest women, who are usually in greatest need, are unable to pay.

Service agreements allow women from the district which has signed the agreement to receive free antenatal care at the specified CHS health facility, for which the health facility receives reimbursal from the district. The administrator of the government hospital in Lilongwe affirmed the government's intention for CHS facilities to treat the poor free for which the facility would be reimbursed by the government. At the time of the study, the CHAM executive director recounted that 53 service agreements had been signed between CHS managers and DHOs. These first agreements, which need to be renewed annually, address the poorest indicator (maternal mortality), but it is intended to extend them to children's and other priority services. Under the agreements, DHOs reimburse CHS facilities for the cost of providing antenatal examinations for women from the districts in which they are located.

Information is not available on the number of service agreements anticipated, but potentially there could be 166 for any service, which is the number of CHS hospitals and health centres in Malawi, or more if districts negotiate service agreements with more than one health facility. The end of the initial SWAp period is 2010, but, according to the Programme of Work (GOM 2004), progress will depend on the availability of funding and achievement of the planned human resource increase. CHSs generally welcome service agreements because they are desperately in need of the funds which they bring, and do not like charging women for an essential service for which they can ill afford to pay:-

"...I feel bad when mothers and children come with no money to pay. It is not right that they should pay" (OIC, Mposa-M)

There are reported to have been positive results in the districts in which service agreements have been implemented. For example, with respect to service provision:-

 "Since our service agreement poor women from Dowa district come for free antenatal examinations and deliveries. The numbers have greatly increased from thirty per month to 250. The death rate has decreased for mothers and children" (matron, FPCH-M).

Second, CHS managers reported that service agreements can encourage a closer working relationship between the government and CHSs. Some CHS managers are enthusiastic to extend service agreements but are concerned that the district administrations are not moving quickly enough. According to the Lilongwe Catholic health coordinator, only two agreements had been signed in Lilongwe district in two years. The DHO explained the reason for the delay:-

"...the church didn't accept the standard financial package agreed between the government and CHAM, but wanted individual costings. They asked for three million kwacha per month, but this was reduced to 1.2 million. The district budget only allowed kwacha700,000, so other services will suffer" (DHO, Nkhotakhota-M).

This explanation was borne out by the CHAM director of health programmes who acknowledged that St Anne's had a financial problem because of their low level of donations from overseas, but suggested that it had asked for too high a level of reimbursal which in his view risked discrediting the CHS. DFID recognised both the funding constraint and the potential for CHS facilities to be overwhelmed and urged caution:-

"… ideally we want service agreements extended, but it is too expensive to do all at once. We are moving cautiously due to the huge increase of clients overwhelming CHAM [CHS] capacities" (DFID-M).

Some CHS managers and staff were experiencing a number of difficulties in implementing service agreements:-

► CHS facilities are not likely to be able to recruit the additional staff needed to cope with the additional workload:-

   "Maternity cases have tripled since our service agreement, but with no additional staff" (matron, St Anne's-M).

► Difficulty in dealing with patients coming from a neighbouring district to claim a free service to which they are not eligible, which may also result in hospitals with a service agreement being overwhelmed and others experiencing a decrease in demand.

They also expressed anxiety for the future which, they asserted, was based on their previous experience of dealing with government officials:-

► The government will fail to reimburse CHSs for the free services they have provided:-

   "...some units struggle to get repayments from the government because districts don't have the funds and some DHOs aren't efficient" (Catholic NHS-M).

► The current SWAp will raise expectations of a free service that will come to an end if no other agreement is put in its place.

► Districts may not allocate funds to CHS facilities on a fair basis.

►   Future governments may not honour agreements unless they have some legal standing.

The CHAM executive director acknowledged these concerns and advised that discussions were taking place at the time of the study for the period beyond 2010, when the current SWAp agreement ends.

The study, therefore, indicated that in Malawi and some other countries there is a great deal of enthusiasm for service agreements on the part of both CHSs and governments. The former regard service agreements as an opportunity to access desperately needed resources at the same time as being able to offer free services to some of the most needy patients, who are often the least able to pay. Governments see such agreements as a means of providing essential services to difficult to reach groups and by so doing to move closer towards achieving the MDGs (3.4.3).

The interviews in India did not reveal any systematic approach to service agreements, although some CHSs did relate some specific examples, such as this one cited by the medical superintendent of St Theresa's:-

"We have started a service agreement. We can claim a refund from the state government for mothers who deliver their babies here".

However, similar problems of the government failing to honour an agreement and reimburse the CHS for the service it has provided occur:-

"The HIV/AIDS programme is an area where the government and church can work well together, but the government doesn't always honour agreements and although the church does the work the money is not always forthcoming" (chaplain, St Theresa's -I).

7.3.4   Cooperation between Government Health Services and CHSs

The conceptual framework (5.2) referred to the greater involvement, or increased recognition

by governments, of NSPs, including CHSs, in health service provision. In some situations, as

discussed in section 7.3.3, the arrangement is formalised by a PPP or service agreement, and

in other situations it is not. In this section, additional types of cooperation between the

government and CHSs in their respective provision of services, whether formalised or not, are

explored. It was identified from the international literature that both CHSs and GHSs have

developed a range of health facilities, community outreach (2.4.6) and health worker training

(2.4.7), which has become increasingly formalised during the post-colonial era. The nature

and extent of cooperation for each of these three services is discussed in subsections 7.3.4.1-3.

7.3.4.1 Institutional Cooperation

The discussions on PHC in the chapters 3 and 4 of the literature review emphasised the need

for accessible health care from lower level health facilities such as aid posts and dispensaries,

with patient referral systems to higher level facilities such as health centres and hospitals. As

both GHSs and CHSs operate a range of facilities, the research explored whether CHSs and

GHSs operate separate referral systems or whether there are occasions when they refer

patients to each other's facilities. It also emerged during the course of the interviews that staff

from higher level facilities visit lower level facilities to conduct clinics, at which patients are

referred for professional consultations. It also became apparent that visiting staff take the

opportunity during these visits to provide staff training and supervision. The research,

therefore, also assessed whether CHSs and GHSs operate separate or joint 'visiting' systems.

CHS managers in Malawi reported that CHS and GHS institutions cooperate with each other,

first, by their hospitals receiving referrals from each other's lower level health facilities and

second, by supervising the work in each other's lower level health facilities, as affirmed by the matron of St Luke's:-

"Referral and supervision were strengthened under CHAM. CHSs supervise government health facilities and vice versa".
There was no evidence in India of GHSs and CHSs cooperating with each other in this way.

The views expressed seem to suggest a degree of obduracy on the part of the government in failing to recognise services provided by CHSs:-

"There is not much evidence of communication or working together (between CHSs and the government)" (Christian Aid-I).

The patients' experiences in Malawi of transfer from a CHS or GHS health centre to a CHS hospital suggest that two common reasons are for complicated deliveries, particularly when a Caesarean section is required, and for treating sick children, often those with malaria:-

"My daughter was referred to St Luke's because she needed a Caesarean [delivery]" (community, female, very poor-M).

"We were referred here before because my child was very sick with malaria" (outpatient, female, Nkhoma, very poor-M).

Sometimes referrals are made from a CHS health centre to a GHS hospital because the service is provided free:-

"We give patients a choice of where they want to be referred. They usually choose St Luke's if they can afford to pay, but we send very poor patients to the government hospital" (OIC, Mposa-M).

This was confirmed by patients:-

"I was sent [previously] to the government hospital because I didn't have money to pay" (outpatient, male, Chimwalla ,very poor-M).

Many patients also self-refer to the GHS hospital because of the free service:-

"I went to the government hospital for free treatment" (community, male, moderately poor-M).

This pattern of referral from health centres to hospitals in Malawi is consistent with the practice at both St Ignatius and Sunder Nagri in India. However, patients sometimes resist referral to government hospitals, because they anticipate a long wait for attention and perceive the quality of the service provided to be lower:-

"Fractures and severe conditions are referred to Lilongwe [government hospital], but patients aren't always happy to go because of the long wait before they are treated, and the hospital has no drugs, so they just give Aspirin" (medical assistant, FPCH-M).

Another mode of cooperation is the readiness to transfer and receive patients needing the specialist expertise which may be available in one hospital, but not in another. The four central hospitals in Malawi have more specialities and treat more patients than most of the CHS hospitals (6.3.1). However, because of the expertise of particular clinicians, some of the CHS hospitals also have specialities not available in the nearest GHS hospital such as vesico-vaginal fistula surgery at Nkhoma and herpes zoster treatment at FPCH:-

"...[there is] now better cooperation [between CHSs and GHSs] over patient referrals" (administrator, government hospital-M).

"...the government hospital also refers patients to us for specialist treatment" (MD, Nkhoma-M).

There was consensus between managers in both CHS and GHS hospitals that referrals from CHS to GHS facilities greatly exceed those in the opposite direction. Both CHS and GHS managers reported improved willingness for the two services to work together in referring patients between each others' services and carrying out clinical and supervisory visits to each others lower level facilities. However, two issues sometimes militate against this cooperation. First, because the services are basically free in government hospitals, except that patients often have to purchase their drugs and pay informal charges to poorly paid junior staff, large numbers attend which causes overcrowding and long waits. In contrast, patients pay user fees

in CHS hospitals, except where these are waived (7.4.4.3), resulting in a lower number of patients. Second, some CHS and GHS hospitals in Malawi have half, or more, of their nursing posts vacant and the shortage of health professionals results in competition between services for staff (6.2.3, 7.3.3, 7.4.1).

In India there are few transfers from the large multispeciality hospitals because they have the expertise to manage most cases themselves. Less well resourced hospitals, such as St Theresa's, Kalyani and Ikadu, transfer patients needing more complex treatment, particularly intensive care or cardiac monitoring, to government hospitals, as well as patients who are unable to pay:-

"Those with no money are referred to the government hospital. Also patients needing specialist procedures" (outpatients' sister, Kalyani-I).

"I was referred with a head injury from Ikadu Hospital to the government hospital" (community, male, not poor-I).

Referrals from Indian GHS to CHS facilities seem to be less common and are restricted to situations where treatments have failed in the GHS facility, where the CHS has a specialist service not available in the GHS facility, or conversely in some cases where expensive or longer term care is needed:-

"We receive referrals from other hospitals particularly for thalassaemia, paediatric cardiac surgery, orthopaedics and transplants" (nursing superintendent, St Stephen's-I).

"I went to the government hospital, but I was not made well so I was advised to come here" (outpatient, female, St Theresa's, severely poor-I).

"Whenever government hospitals can't treat patients because they are old or poor they refer them to Catholic mission hospitals" (surgeon, government hospital-I).

However, it was reported that GHS facilities are more reluctant to refer to CHS facilities than vice-versa:-

"Government hospitals don't usually refer to CHSs. (associate professor, government hospital-I).

"We rarely receive referrals from government hospitals" (outpatients' sister, St Theresa's-I).

One of the reasons is that many patients are thought not to be able to pay. In India, it is also reported that government health workers sometimes refer patients to their own private clinics:-

"Often government employees who open their own private clinic refer patients from the government hospital there" (community nurse, Ikadu-I).

Some patients are referred to CHS facilities from outreach visits and medical camps conducted by CHS staff, or from small private clinics:-

"I was referred to Kalyani Hospital with a letter from the eye camp" (outpatient, male, very poor -I).

"Complicated deliveries are referred to us from private clinics and at night when the government hospital is not operating" (auxiliary nurse/midwife, Ikadu-I).

"I went to the private clinic because it is closer to home, but the doctor referred me here because I needed a Caesarean" (outpatient, female, Ikadu, not poor-I).

In India, there little evidence of CHS and GHS institutional cooperation, as expressed by a retired chief medical officer in Andhra Pradesh:-

"There is little cooperation. India is full of different health organisations, often duplicating and triplicating services".

Examples are also rare of CHSs working together on service delivery, except on specific campaigns, or in the very limited ways of transferring funds or a doctor from one to another,

when it is questionable whether this is an example of cooperation rather than merely decisions imposed by a more senior level in the organisation:-

"*95% of CHSs work on their own. They only work together on HIV/AIDS*" (health secretary, CNI-I).

7.3.4.2 Community Outreach

The increasing interest of both CHSs and GHSs in developing community outreach to reach people who are less likely to access services from health facilities on the grounds of cost or location was discussed in the literature review (2.4.6, 3.4.1, 4.4). Community outreach typically includes visiting people in their own homes to monitor child growth and development and to treat the sick; the provision of mobile clinics to carry out a range of health activities including child immunisation, antenatal examinations and family planning; and carrying out health surveillance in schools. It is, thus, an activity in which it would be particularly advantageous to have cooperation between the government and CHSs to avoid health workers from different agencies duplicating services to the same communities and ensure equitable coverage. This section explores the extent to which cooperation in this activity takes place in Malawi and India.

Usually CHS health centres and smaller hospitals employ a community nurse, and larger hospitals employ a PHC Coordinator, who may be a nurse or doctor, to lead a team including paid health workers and, sometimes, volunteers. All of the hospitals researched in both Malawi and India operate schools of nursing and have students who must experience periods of community outreach to fulfil the requirements of their curricula. Students may also be allocated to health centres to gain their community experience.

There is a reasonable degree of cooperation in Malawi, in that there is at least tacit agreement that CHSs and GHSs will provide outreach services to communities within their respective catchment areas, which in the case of CHS facilities range from 54 villages for Mposa to 156 villages for Nkhoma (6.3.2). However health workers in both CHS and GHS facilities had not been fulfilling this responsibility as diligently as expected. The explanation given by CHS managers, that priority is given to curative work, particularly when there is a shortage of staff and other resources, is endorsed by many officials from other organisations, such as the Nurses and Midwives Council. To remedy this deficit, the government introduced HSAs (health surveillance assistants), whose role developed from 'Cholera Assistants' in the 1980s. They are employed and paid by the government and accountable to the DHO, work from both GHS and CHS health facilities, and at CHS facilities report to the OIC (officer in charge) or PHC Coordinator on a day-to-day basis:-

"HSAs were introduced because the nurses were not going to the rural villages, which they didn't see as their role. HSAs do PHC and work hand-in-hand with CHAM [CHSs] staff. The system works well" (DHO, Nkhotakhota-M).

Because DHOs and CHS managers sometimes differ from each other in their expectations of HSAs, there are tensions in some CHS locations. These differences focus on three main issues: first, the type of responsibilities HSAs are given because of staff shortages, which the Medical Council believes exceed their level of training; second, some church officials expressed concern over disagreements regarding clinical policies such as condom use and family planning in the Catholic CHS; and third, tensions related to their joint accountability to the government as their employer and to their CHS manager as their operational supervisor.

Some CHS managers argued that these tensions are exacerbated by two further factors: first, as government employees, HSAs are subject to government conditions of service, whilst

although the salaries of other staff at CHS health facilities are funded by the government, they are CHS employees subject to CHS conditions of service; and second, whilst in some areas nurses and/or doctors conduct outreach with HSAs, each performing their own particular roles, in other areas the advent of HSAs has resulted in other disciplines withdrawing. Another example of CHS and government cooperation is TBAs (traditional birth attendants), who are trained by the government to conduct deliveries in their own community and are supported by midwives from the health facility in their catchment area, which may be either a CHS or a GHS facility. This arrangement is generally regarded as successful by CHS staff.

In India the government system includes Primary Health Centres and Sub Centres, each of which are expected to provide outreach services, as part of their PHC programme, through mobile clinics, home visits and school visits within defined catchment areas to carry out the range of services described in the opening paragraph to this section. The importance of PHC was emphasised in the Rural Health Mission report (7.2). All of the CHS facilities in the field study operate outreach, which for some is very substantial, extending to 83 villages in the case of CMC-Vellore (6.3.2).

There was a view expressed by many of the community members interviewed that government health workers do not visit them, or that the service provided during visits is inadequate:-

 "Government health workers go to the school but they don't visit houses which they are supposed to do" (community, female, very poor-I).

"They [government health workers] only come to collect statistics" (community, male, moderately poor-I).

Indeed, one of the reasons given by CHS staff for conducting outreach is the inadequacy of the government system. Some CHSs take out mobile clinics or run health camps at the invitation of particular communities:-

"We visit 38 villages in our own van. We give medicines, collect specimens for laboratory tests and do eye tests and issue glasses. We normally respond to requests from the village leaders or parish priest. Our doctors go because the government doctors won't visit these rural communities" (administrator, St Theresa's-I).

"The government only runs a polio team, so we provide camps for eyes, plastic surgery, paediatrics and orthpaedics" (director, St Stephen's-I).

However, there is generally no specific agreement between the CHS and GHS over who will serve which communities and what services will be provided, resulting in unmet need in some areas and duplication in others:-

"There is no specific agreement about who covers what…" (community nurse, Ikadu-I).

*"CHSs go to the villages and supplement government services because the government is unable to meet the need" (*WHO-I).

"There is duplication of services in some areas…" (UNICEF-I).

In some areas the government recognises the contribution of CHSs and provides support in the form of supplies and transport:-

"The government supports their [CHS] outreach services in some states provided they comply with government regulations" (government surgeon-I).

"We have a mobile dispensary which visits people at home. The government provides the vehicle and we provide the doctors" (director, Sunder Nagri-I).

However, more often the CHS provides its own resources, usually from funds generated from more affluent patients:-

The most successful [CHS] hospitals have outreach funded from money made from the rich [patients] " (VHAI-I).

In addition to Indian CHSs providing community outreach to meet needs they perceive as unmet by GHSs, the CMAI general secretary expressed the view, shared by others, that the provision of outreach by CHSs is also dependent on factors such as what they are able to fund, the requirements of training curricula, and their commitment to PHC. CHS facilities select the communities they serve in different ways, which is possibly influenced by their reasons for conducting outreach and the level of resources they are able to allocate to support it. Some comprehensively serve all of the communities within their vicinity, whilst some only serve communities they have assessed as particularly deprived or those that are the most accessible. In some cases the selection seems to be arbitrary. The CFH gives priority to tribal communities and St Stephen's provides outreach to eight communities, including Sunder Nagri. Although in both cases these communities are very deprived and have a great need for the service provided, there are other adjacent communities which only receive the minimal service provided by the government:-

"If the poor can't afford to come to us we must go to them… tribal people are not easily able to access health care from elsewhere…the Fellowship would like to extend to more villages but we don't have enough staff" (medical superintendent, CFH-I).

"We have 11 ANMs and 17 CHVs [Community Health Volunteers]. They register every house and visit every two months, entering changes on the database [at the health centre]. New births are registered and visited within the first 48 hours" (director, Sunder Nagri-I).

The approach of CMC-Vellore is seen by other CHSs as comprehensive and a model of good practice, which many seek to emulate. CMC-Vellore operates three outreach programmes, the main aims of which are to provide high quality education and research opportunities for health professionals in community health and socio-economic development. CHAD (Community Health and Development) provides comprehensive PHC to over 100,000 people in villages, tribal people living in 93 Jawadhi Hills' hamlets and 30,000 people living in the urban slums of Vellore through the CHAD base hospital, health centres and outreach visits.

As well as providing PHC to a population of 120,000 in the 39 panchayats it serves, RUHSA (Rural Unit for Health and Social Affairs) works to improve people's health through its social, educational and occupational programmes. As well as meeting the nursing needs of CHAD and RUHSA, CONCH (College of Nursing Community Health Programme) provides home visits, MCH clinics, morbidity clinics and school health to a population of 68,000 in 20 villages and semi-urban areas (CMC 2007). However, not all CHS health workers in other facilities are enthusiastic about outreach:-

"The students are involved in outreach clinics and visit patients in their own homes. There is a lack of impetus in the hospital to do outreach. The senior staff blame it on not having another doctor, but ANMs [auxiliary nurse midwives] can do outreach" (tutor, Ikadu -I).

In summary, there is a high level of cooperation between Malawian GHSs and CHSs in the provision of community outreach, with agreement over catchment areas and the provision to CHS by the government of HCAs and some medical supplies. However in India cooperation is much less structured and is subject to agreement being reached between local CHS facilities and government officers.

7.3.4.3 CHS Contribution to Statutory Training

In many countries, CHSs and GHSs, and in some countries private for-profit organisations, operate schools and colleges to train health professionals. The contribution of CHSs to the statutory training of nurses and other health professionals is often substantial. In PNG, for example, CHSs provide all of the community health worker graduates and 60% of nurse graduates to the national workforce (CMC-PNG 2006). Often the training was initiated by the missionaries to meet the needs of their own institutions during the colonial era before the government was involved (2.4.7).

School and college staff in Malawi and India expressed two incentives for cooperation between training providers. First, some schools do not have within their own organisations access to all of the clinical experiences necessary to meet the statutory needs of the curriculum. Second, training institutions contribute to the human resource pool from which service providers recruit their staff. This section reports on the findings with respect to the extent to which GHSs and CHSs in Malawi and India cooperate with each other in relation to their statutory training provision.

The government and CHSs in Malawi recognise their reciprocal relationship. The government pays training grants to CHS schools and trains, funds and seconds tutors to CHS schools to ameliorate shortages. However, government tutors are disadvantaged if they work in CHS schools because government conditions of service prevent CHSs from promoting such tutors, resulting in few of them renewing their contracts. CHS schools, for their part, train the majority of nurses to meet the needs of both CHSs and GHSs:-

"Now the government funds [training] for the nation. The nine CHAM [CHS] schools train 70% of all lower level Enrolled Nurse Technicians, of which there are currently 450 in training. The government schools train the higher level Registered Nurses, but they only train 60 per annum, which is inadequate. The government plans to increase training places and has introduced a bond to improve retention, but it is not strong enough to be effective" (nursing services and training manager, CHAM-M).

"At the end of their training newly qualified nurses are directed to vacant posts, 60% in GHSs and 40% in CHSs" (tutor, Nkhoma-M).

CHAM officers reported that, as well as increasing the number of training places and introducing a post-training bond, the government had planned to optimise the use of its resources by rationalising the schools. However this move was resisted by the individual CHSs, which recognised the advantage of local identity and loyalty in assisting recruitment to their own hospitals. As a result the plan was abandoned. CHAs usually have a monitoring,

and in some countries a coordinating, role with respect to training in CHS schools. The statutory training bodies, however, are responsible for supervision and ensuring that the requirements of the curriculum are met, which requires them to carry out periodic inspections of the schools. In Malawi this does not always occur as regularly as the schools expect, as one tutor expressed:-

"We are accountable to the Nurses and Midwives Council, but we never see them…they only come when there's trouble".

Although colleges and schools of nursing in India operate more autonomously than those in Malawi, there are a number of ways in which CHS training institutions interface with the government and to some extent they rely on each other. First, all schools must register with both their State and national statutory bodies and implement training curricula approved by them:-

"We are accountable both to the Tamil Nadu Nurses and Midwifery Council and to the India Nursing and Midwifery Council…both visit to ensure that standards are maintained…they send new training policies and changes to us" (principal, Kalyani -I).

"125 Schools of Nursing are affiliated to CMAI, who inspect schools two yearly. Both the national and state statutory bodies inspect three yearly" (nursing secretary, CMAI-I).

Second, there are some reciprocal arrangements between CHSs and GHSs to provide the necessary clinical experiences for students, and in some cases, positions for students on graduation:-

"We take students from the government nurse training college" (nursing superintendent, CMC-Vellore-I).

"We send students to government hospitals as part of their training" (principal, Kalyani-I).

"We depend on the government hospital for vacancies [for our graduates]" (tutor, Ikadu -I).

However, some take the view that cooperation is limited:-

"There is not much sharing with government schools. They ignore us and are not interested in what we do" (principal, CFH-I).

This research suggests that the services provided by the governments and CHSs in both India and Malawi are complementary to each other. A major difference is that in Malawi there is an increasing intent on the part of the government and CHSs to cooperate with each other by defining hospital catchment areas; referring patients between each others' facilities; carrying out clinical and supervisory visits to each other's lower level facilities; agreeing areas for outreach and recognising their interdependence in the provision of statutory training. In recognition of CHS cooperation and that CHSs are providing services in areas where GHSs are absent, the government is providing financial and other support to CHSs. However, in India, although individual CHSs provide a similar range of services to their Malawian counterparts and there is a degree of complementarity, if not interdependence, between CHSs and GHSs, their respective service managers appear to operate, for the most part, independently of each other, with limited communication between them.

7.3.5   Government Regulation of CHSs

As noted above, the theoretical underpinnings of HSR include mechanisms for ensuring that the relationships between governments and providers ensure efficiency and accountability. It is anticipated that service delivery by NSPs will deliver improved coverage and cost effectiveness because the operations of private for-profit providers are based on market principles and the operations of not-for-profit provider NSPs are believed to be based on altruism. However, it is also suggested that additional or alternative mechanisms are needed to ensure efficiency and accountability of all NSPs. Thus it is acknowledged that one of the key

indirect provider roles government must undertake is regulation, tailored to the requirements of the relevant sector. An effective health sector regulatory system must contain the key components needed to fulfil the objectives discussed in section 3.4.2.2, including ensuring that various types of work are carried out in accordance with the government's strategy; monitoring quality of service and professional standards; systems of accreditation; ensuring compliance with government regulations; and determining the location and pricing of services with a view to achieving equity of service provision.

Responses to the general survey indicated that CHSs are subject to government regulation. Usually they are required to: operate in accordance with governments' strategic plans and policies; submit statistical reports of the services they provide and special reports, for example about patients with notifiable infectious conditions; and, for those CHSs with Coordinating CHAs, accept the authority of their CHA.

The extent of government regulation of CHSs in Malawi and India is assessed in greater detail in this section. Regulation is exercised in five main ways. First, in Malawi, there is an assumption, expressed by most stakeholders, that CHAM exercises much of the regulation of CHSs on behalf of the government. CHAM is viewed as the means of implementing government policies and procedures as well as its own, and performing a regulatory role with respect to service provision and professional standards (7.3.1). However, some CHS managers and the medical council were concerned that the frequency of facility visits by CHAM officials was not sufficient to carry out this role adequately. Although there was an understanding by CHS managers in India that CHAI and CMAI have a responsibility for improving professional standards, it was not understood that this role was being exercised on

behalf of the government. CHS managers in India also expressed concern at the infrequency of visits from CMAI officials.

Second, as in the other study countries, CHSs in both Malawi and India are required to operate within the governments' health strategies. As discussed in section 7.3.1, CHAM is involved in the formulation of national health plans and is expected by the government to be instrumental in their implementation. CHSs within districts are involved in agreeing and implementing the DIPs (District Implementation Plans). Although Indian CHSs recognise the need to comply with national health plans, CHS managers expressed less commitment to them than their Malawian counterparts, and some added that this was partly because CMAI and CHAI were not involved in their formulation and partly because in practice few government strategies had been implemented.

Third, service provision in both countries is monitored by the government, mainly through regular statistical returns as part of the standard information system, which CHS managers confirmed that they submit, providing information on items such as births, immunisations, deaths, family planning, patients treated, and other patient-related activities. These are supplemented with special reports on high priority programmes; patients with notifiable infectious conditions, who have been treated; and in India, reports confirming that facilities comply with statutory labour and technical regulations, e.g. on biomedical equipment and procedures, anaesthetics, and sexual discernment of foetuses. When funds have been received from the government, whether from the government's own budget or from donor funds, reports need also to be submitted verifying the expenditure.

Fourth, regulation is also exercised within Malawian districts by supervisory visits by the DHO and sometimes by the District Nursing Officer. In some districts these are carried out regularly, as reported by the matron of St Luke's Hospital:-

"The *DHO visits monthly and monitors everything including the incinerator. The District Nursing Officer also visits to supervise maternity services*" (matron, St Luke's-M)

Although CHS managers reported that there has been an increase in DHO visits since the implementation of service agreements, they also noted that in many places they often do not take place, at least with any frequency. A number of possible explanations were advanced for this. It was noted above that DHOs are often inexperienced and overworked. As a result, some feel diffidence, even deference, towards experienced and respected CHS managers. Others take the view that visiting GHS facilities is a higher priority because they feel greater empathy with GHS managers and believe that CHSs already have supervisory procedures through CHAM. The Lilongwe DHO expressed these views as follows:-

 "*DHOs don't feel they can inspect CHAM facilities, which already have strong managerial structures. I have 39 government health facilities to supervise plus meetings and only five staff; therefore my priority is to inspect government facilities*"

The arrangement for CHS and GHS staff to carry out combined clinical and supervisory visits to each other's lower level facilities was discussed in section 7.3.4.1.

In India state government officials have the authority to inspect CHS facilities to check that they conform to national standards, although it is not always exercised. This applies particularly to those facilities approved to treat patients for whom treatment costs are reimbursed under the state insurance schemes. Government accountants sometimes visit CHS institutions to audit accounts.

Fifth, officials of the medical and nursing councils affirmed that they specify professional standards and can apply sanctions, including the closure of health facilities, for poor performance. However, both the assistant registrar of the medical council and the principal officer of UNICEF in Malawi asserted that sanctions are rarely applied, mainly because of the large number of health facilities which fail to meet the standards and the lack of alternative providers. Under such circumstances closure would result in a withdrawal of service for affected communities. CHS managers confirmed that professional standards in India are regulated by medical, nursing and other statutory bodies established by the government.

Overall the research suggested that in Malawi, there is ready acceptance that CHSs are accountable to the government and subject to government regulation, which stakeholders confirmed becomes more tangible when CHSs receive government funds which they must acquit. There is a definite view, which is shared by officials in the church organisations, CHSs and development organisations, such as DFID, that the combined effects of the government payment of CHS staff salaries, the SWAp programme, service agreements and government decentralisation have strengthened the accountability of CHSs to the government nationally and within districts. The Malawian interviewees affirmed that there is a general intent for the government and CHSs to work more closely together, and in so doing for the government to improve the regulation of CHS facilities by using both control and incentive mechanisms.

Despite the similarity in the regulation mechanisms in the two countries, acceptance, in India, of CHSs' regulation by the government is much lower amongst all groups of interviewees, than in Malawi: the majority of interviewees from churches, CHSs and development organisations do not perceive CHSs to be accountable to their CHAs (CMAI and CHAI),

which in turn are not perceived to be accountable to the government. Nor do respondents perceive CHSs to be directly accountable to the government. The response would possibly have been different for the 25% of Catholic institutions under diocesan control, but interviews were not carried out in those. Some CHS officials, and others, adamantly expressed the view that CHSs are not accountable to the government and value their independence because of the poor reputation of the government service. This view is reinforced for some CHS managers by the perception that the government rarely takes an interest in their service contribution, as expressed by the medical superintendent of St Theresa's and an EU Official:-

"...they (the government) are not interested in us or what we do".

"The churches have a very low profile in India…They are overlooked by the government and their accountability is very weak".

The Professor of Sociology at Jawaharlal Nehru University affirmed that:-

"There is a lack of regulation and accreditation of health systems in India"

This situation, which applies to India's non-state health sector as a whole, and is not limited to CHSs, is well documented (Palmer 2006, WHO 2005a, Peters et al. 2002). It is one of the deficiencies which the government intends to address as part of the National Rural Health Mission (7.2).

7.4 Sources of CHS Funding

The decline of financial support from mission organisations associated with the increased autonomy of churches in developing countries was discussed in the literature review (2.6, 4.5.2). It was also noted that for a variety of reasons service provision costs increased at the same time as this decline in CHSs' traditional source of funding occurred, posing a dilemma for CHSs. It was suggested (5.2) that this decline in funding and CHSs' response to it is the

single most important factor explaining their current pattern of activities. The results of this research confirmed the general decrease in the level of funds available to UK mission organisations and identified the changes they have made in the means of allocating funds (6.4.1.3). In this section, the effects of these changes on CHSs are first discussed (7.4.1), followed by the steps taken by CHSs to procure alternative sources of financial support, including project funds (7.4.2), income generation (7.4.3) and user fees (7.4.4), to contribute to an assessment of the differences these trends have made to their patterns of activities and the socio-economic profile of their beneficiaries. The latter will be discussed in section 7.5.

7.4.1 Changes in Funding from UK Mission Organisations

Most of the CHSs in India and Malawi that have maintained a relationship with their historic partners continue to receive financial donations from them, although the amounts continue to decline, the frequency is less regular and the purposes are more specific than in the past. St Luke's, CNI and St Stephens all confirmed that at the time of the study, they were in receipt of donations from USPG, and Nkhoma from the Dutch Reformed Church of South Africa. Some institutions operated by religious sisters receive financial help from their European 'mother order'. As explained in section 7.4.1, the financial accounts were not accessible for the wider group of organisations from which information was obtained, but it was possible to examine the accounts of seven. In addition, respondents were asked about the receipts of and trends in funding received from partner churches overseas. The commonly held view expressed throughout CHSs in both India and Malawi was that flows are declining, partly because much of the funding was to pay for expatriate staff and the numbers of these have declined.

Some mission organisations have given notice that even this lower level of financial support will decrease and cease over the next few years. This is causing real concern, particularly in Malawi, where both CHSs and other Malawian organisations suggest that, because of the limited resources available to the government, CHSs' sustainability is dependent on external help. However, there is a greater degree of ambivalence in India, where senior managers of CHSs and bishops are torn between their desire to be self-reliant and the continued shortage of resources faced by many facilities.

Despite the reduction in overseas income, it is still regarded, in Malawi more than India, as an important supplement to CHSs' main sources of funding, often allowing them to provide subsidised services for the poor. However, interviewees in Malawian government institutions, particularly hospitals, expressed conflicting attitudes towards this source of funding. On the one hand, there is recognition that it is an additional source of income for an important part of the health sector, and that if it ceased completely other sources of income would need to be sought, including user fees and government grants, which would put increased pressure on the share of the health budget available to GHSs. Some GHS managers perceive that failure to maintain the service provided by CHSs, through lack of funds, would increase pressure on the already overstretched GHS facilities as patients seek alternative service providers. Other GHS managers and development organisation officials expressed concern that reliance on overseas donations is creating dependency, but many of these also believed that the level of overseas church support is greater than it actually is. According to an interviewee from a donor organisation, this misconception may be fuelled by a lack of transparency on the part of CHSs and concerns about the ways in which the funds are sometimes utilised, for example to top up staff salaries. It can result in the government

underestimating the level of support it needs to provide CHSs. The suggestion that overseas funds are used to supplement CHS salaries is a particularly sensitive point for GHS managers, because CHS staff salaries are funded by the government and any addition given by CHSs is interpreted by GHS managers as an unfair advantage in the competition for scarce staff, which is compounded by their perception that CHSs are able to offer higher quality services because they benefit from expatriate expertise, as well as overseas donations of money, medical equipment and drugs.

Some governments, as in India, erect barriers, such as the need for a foreign currency account, to monitor, or even discourage, the receipt of funds from overseas, because of their association with foreign influence, evangelisation activities and possible conversions to Christianity.

There is general acknowledgement both in the church and CHSs, particularly in Malawi, that overseas financial support is attracted by the presence of expatriates as expressed by a government doctor:-
"...this is why the Anglican Church wants an expatriate to fill its bishop vacancy".
A typical experience is that overseas donations are received while an expatriate is in post, usually from the expatriate's own church or another organisation, and sometimes these continue when he/she returns home.

There are differences in the way in which overseas funds reach CHS institutions. In some cases funds are sent direct to the institutions and in others they are sent via the diocese or synod. The general principle seems to be that CHSs only receive funds specifically designated

for health, but none of the general funds, as reported in the CSI. In this situation, some senior CHS staff believe that funds intended for the health service are used by the diocese for other purposes. This may occur because the diocese perceives the facility as successfully raising its own funds. One hospital director stated that:-

"We don't receive much because we are perceived as being successful and not needing help. This is very short-sighted because if we don't invest in modern equipment we will lose our wealthier patients who want the best investigatory procedures".

In Malawi the dependence on overseas funding, where it exists, is much greater than in India and the consequence of its cessation more serious because, like many other poorer developing countries, Malawi's general economic situation is much more disadvantaged. The executive director of CHAM clearly described the effect on CHSs of Malawi's economic decline, which has coincided with the decline in funding from overseas partner churches:-

"During [President] Banda's time we had disposable income and self-sufficiency, people had money to pay for health and things were cheap. People went to CHAM [CHSs] because of the high standards and quality of care. Then came the economic decline. The World Bank and IMF were involved and the kwacha was devalued. It was then two to three kwacha to the pound sterling, but now it is kwacha268 to the pound. Privatisation of public services and the removal of subsidies caused a decline in CHSs. Aid by donors and missionaries decreased. Now CHAM hospitals can only survive on user fees, but the population has no disposable income. There are too many poor people. We are in economic crisis. Over 65% of people live below the poverty line. Fee paying is not for Malawians".

Some health facilities, such as Chimwalla, receive donations from newer churches in South Korea and other countries where the churches tend to be more affluent than in Europe. Other health facilities have developed their own church links for financial support, such as that between Nkhoma and church organisations and individuals in the Netherlands, USA, Norway, Canada, Ireland, UK and Germany; and Sunder Nagri with churches in USA, Japan, Sweden and the UK. Some CHS facilities have established Friends' organisations in other countries, to provide professional as well as financial support, such as the CMC-Vellore Friends in UK,

USA, Canada, Australia, New Zealand, Belgium, Germany, Sweden and India. Sometimes a supporters' organisation is established by an ex-missionary returning home, such as the 'St Luke's Malawi Foundation' in the UK.

The decline in overseas funds has necessitated CHSs seeking alternative sources of funding, which include funds from government, as discussed in sections 7.3.2 and 7.3.3; local congregations; international and overseas agencies; income generation; and user fees. Because CHS facilities are frequently located in economically deprived areas, the potential for raising sufficient funds from a local congregations to have any impact is limited, except for the smaller facilities with small budgets, such as the health centres and dispensaries operated by religious sisters in India, where it was reported by a counselling tutor that local churches have been asked to increase their support to enable facilities to be self-sufficient.

The financial accounts of all CHS facilities were not accessible, but examination of those of the three largest Malawian CHS hospitals researched showed a wide variation between the three main income components: government grant for salaries and service agreements 27-48%, overseas grants 18-35%, and user fees 15-49%. Hospitals receiving the highest levels of government grants and/or overseas donations were able to decrease their reliance on user fees. Information supplied by the Ugandan CHAs indicates a similar pattern to that in Malawi: government grant 23% of overall CHS income, overseas aid 38%, and 38% from user fees (again, these figures are at variance with those cited by Marshall and Van Saanen (2007) in 4.5.2, but see explanation in 7.3.3). Thus in Uganda overall the proportion of funds received from the government is slightly lower than the bottom of the Malawian range, but overseas grant assistance is slightly higher.

The situation in India is very different: overseas grants are generally less than 1-2% of total income, with user fees, including those from students at associated medical and nursing colleges, accounting for most of the other 98-99%. The high budget hospitals in India, such as CMC-Vellore and St Stephen's, regard their respective Friends' organisations as contributors towards particular pieces of equipment or capital projects, whereas the health facilities operating on more restricted budgets, both in India and Malawi, see overseas contributions, where they are available, as more of an operational necessity. The CFH treasurer affirmed that the Fellowship has a policy of being self-sufficient and does not seek external funding from either in-country or overseas, although they were reconsidering this decision at the time of the interview in April 2007 because of the availability of the Global Fund.

7.4.2 Project Funds

Not only are funds from international and overseas agencies mainly in the form of project funds, as confirmed by both CHS managers and officials of development organisations, but CHSs in most of the countries researched report that they now receive less finance from their overseas church partners as general grants that they can decide how to spend. More is now received in response to project submissions and must be spent on the specified purpose. The observation of the director of St Theresa's was frequently repeated by others:-

"We have received no bulk grants from our mission HQ since 1999. We now rely on writing our own project proposals to be self-sufficient".

CHS managers report that there are broadly four categories of organisations from which they apply for project funds:-

► Overseas churches, particularly in UK, USA, Denmark, Norway, Germany, Australia and New Zealand.

► Mission and faith-based development organisations including EED (Germany); Bread of the Earth; Christian Aid; CAFOD, Tear Fund; USPG; Methodist Church; Beith Trust; CordAid, Memisa, Miserio, Progressio, White Sisters (Netherlands), Muslim Aid (for Bangladesh).

► Secular development organisations such as the World Food Programme, UNICEF and the Global Fund.

► Government agencies, mainly in the same countries as the overseas churches. In some cases it is the overseas church which applies for funds from its national government.

Academic institutions are also able to apply for research funds. CMC-Vellore, for example, receives 50% of its research income from overseas.

While the greater availability of project funding has opened up a new source of finance for CHSs, this pattern of funding also causes some problems. First, applicants complain about funds being linked to changing donor fashion. For example, the obstetrician at LAMB hospital in Bangladesh noted that:-

"It has always been difficult to get funding for the hospital, as community health and development work has been favoured by donor agencies. In recent years large donor funding has been more targeted depending on the current 'vogue', e.g. several years ago it was reproductive health; then targeting the 'poorest of the poor', and more recently 'rights based approaches'"(questionnaire).
Second, the systems for application and acquittal of funds can be time consuming and

restrictive:-

"We have a relationship with Progressio and CAFOD, but it is difficult to access their funds. We didn't get help with the accounting so it is easy to make mistakes and then they won't give again. We don't have the time or expertise to fill in complicated project forms" (Catholic diocesan health commissioner-M).

"...some donors have unreasonable strings attached..." (Malawi Council of Churches).

"Often we spend weeks completing project proposals only to have them rejected, which is very disheartening" (project officer, CHAI-I)

However, it is possible that earlier rejections are deterring some CHSs from repeated applications, despite the increased availability of funding and greater openness of donor agencies to CHSs, as suggested by an informant from one donor agency in India:-

"UNICEF has $120million budget and can facilitate partnerships or directly fund where there is the greatest need. We are open to use CHSs. They need to put forward good proposals. UNICEF usually has bilateral agreements with NGOs in areas where the government doesn't work. [However] NGOs are not working where they are most needed. We desperately need new organisations to work in areas of greatest need. This is where FBOs could be the salvation of India. If one church is able to provide evidence of excellent impact on a population this would provide a good negotiating position for further development" (UNICEF-I).

7.4.3 Income Generation

To address their funding shortfall, some CHSs attempt to generate income from their own investments. Few CHSs in India have ventured into such projects except for the development of high fee generating clinical services (7.4.4) and in a few cases, such as Madurai diocese, accessing a government grant to build a medical college with associated urban hospital, which serves both as an income generating project, and as a means of attracting more Christian students. Malawian CHSs have been more varied in their approach to income generation: in addition to the private patients' services and CHAM's proposal to build a private hospital for income generation, other enterprises reported include maize mills, chicken rearing, petrol and paraffin pumps, furniture making, selling crops and operating canteens. Student fees at some of the Catholic schools are used to subsidise the adjacent health facility. The enterprises operated by religious sisters generate small amounts of funds, which are reported to make a useful contribution to their modest budgets. However, CHS managers reported that many of

the other projects intended to generate income have not been profitable. In addition, even when the project does generate an income, it is sometimes difficult to ensure that it benefits the health service. As a result, by the time of this study, CHS managers demonstrated little enthusiasm for developing further initiatives, other than private patients' services.

7.4.4 User Fees

The review of international experience pointed to increased reliance on user fees as one of the means utilised by CHSs to raise funds to contribute to the costs of providing services, explained by their inability to raise sufficient funds from other sources and the increased international policy emphasis on this strategy. The extent to which the CHSs under study depend on user fees and the validity of these explanations was investigated. Several supplementary benefits of levying user fees, including the regulation of use, were identified in the literature review (3.4.2.3), together with some of the disadvantages, particularly those affecting people unable to pay, and the associated difficulties of operating effective fee subsidies and exemptions. In this section the experiences firstly, of all study countries (7.4.4.1) and then Malawi and India (7.4.4.2) are examined. The implications for the socio-economic profile of CHS beneficiaries will be explored in the following section.

7.4.4.1 All Study Countries

In order to establish the context within which CHSs charge user fees, the various approaches of GHSs were also investigated. In India and Malawi the basic services are free and in South Africa patients pay nominal fees. In several countries, the government is using the fee structure to encourage patients to seek treatment at lower level facilities: in Lesotho and Zimbabwe services at health centres and dispensaries are free, and in Kenya only a token

registration fee is paid. In Zimbabwe referral to hospital is also free, but charges apply if patients attend hospital without referral from a lower level facility. However the reality does not always match the official position, as in Bangladesh:-

"On paper all citizens receive free medical care but the reality is that only those who can pay receive treatment" (questionnaire).

In Lesotho, under the partnership between the Government and the CHA, standard charges are applicable in both GHS and CHS hospitals. In Kenya hospitals charge subsidised fees. In Ghana and Uganda patients pay for hospital treatment. In some countries an insurance scheme operates as an alternative to paying at the time of treatment. Some facilities also operate private patients' services.

At most CHS facilities patients pay user fees for services. Exceptions are in Lesotho, where, under the government partnership, attendance at all lower level facilities is free. However, within the limit of their resources, hospitals in most of the study countries provide subsidised services for patients who are unable to pay due to their economic circumstances. Some hospitals operate a 'poor fund', to which patients can apply, and in others fees are adjusted according to a means test. In Kenya, CHAK estimates that the accumulation of unpaid debts, resulting from patients' inability to pay, is approximately 30% of expected CHS revenue. Almost all CHSs treat serious conditions without payment by patients who are severely poor. Because of concern over the effect of fees on poor patients, governments in several countries subsidise high priority services such as antenatal care, family planning, child immunisation and treatment for infectious diseases, particularly TB and HIV/AIDS.

7.4.4.2 User Fees in Malawi and India

In both India and Malawi, as noted above, GHSs officially provide free basic services, but

there is some inconsistency: some patients reported that they had paid for services such as antenatal examinations and child immunisation, whereas other patients said that they had received them free of charge. Medication usually needs to be purchased by patients from the hospital pharmacy, and expensive diagnostic procedures such as scanning often need to be paid for. Patients included in this study also reported that there is a problem of staff supplementing their personal income by charging for services that they should be providing free.

All of the CHS facilities researched charge fees to patients. User fees contribute around 98-99% of all Indian CHSs' income, whilst in Malawi the proportion is much lower and varies more between facilities, ranging from 49% to as little as 15% (7.4). The variation between the two countries is mainly accounted for by the financial support given by the Malawian government in the form of salaries and more recently service agreement payments and the much higher level of overseas funds received by Malawian CHSs from both churches and other donors. Variations in the funds received from these sources help explain the differences between facilities in Malawi, but a further factor is the level of fees charged to patients. Some facilities have a larger proportion of more affluent patients, including "private patients", particularly where a specialist clinical service is provided. Other facilities have much higher proportions of poorer patients, many of whom struggle to pay anything at all.

Private patients pay significantly higher fees for a variety of benefits. Private outpatients usually have their consultations in a different room or department with a better qualified health worker, who in Malawi may be a doctor rather than a medical assistant or clinical officer, and in India a consultant rather than a junior doctor. Private inpatients normally have

a sole-occupancy room and may be able to choose the surgeon if they are to be operated upon. The Malawian MoH suggested that:-

"CHAM should provide tertiary level treatment for rich people who currently go to South Africa. The market is there and it would bring in much needed profit".

Very few patients or community members interviewed in Malawi had any experience of seeking treatment in a private clinic, nursing home or hospital, in contrast with India, where this was very common, although mostly amongst people in the 'not poor' or 'mildly poor' categories. The CHS hospitals, particularly in urban areas, feel a serious threat from the expanding private sector (6.2.3), which is 'peeling off' the more lucrative work, i.e. quick and simple diagnostic tests and treatments for the middle class, which is the category of work on which the successful CHSs rely, not just to remain financially viable, but also to subsidise services for the poor. This is occurring despite general acknowledgement that CHSs are usually less expensive than the private sector. According to the CHAI director and many of his colleagues, their ability to attract those seeking such services is related to their better accommodation and 'state of the art' equipment, leading some CHS managers (for example, the director at St Stephen's) to the conclusion that CHS facilities will need to invest in superior equipment if they are to compete.

Treatment in CHS facilities was in the past generally free for everyone, because the bulk of the funds came from overseas' churches. Many older patients recalled a previous era when they received free services at CHS facilities, for which they now have to pay. Most CHS managers and staff have a deep sense of regret that they are not always able to treat those people in the greatest need because they depend on fees from more affluent patients to remain financially viable; they acknowledge that user fees do deter poorer people from seeking

treatment at CHS facilities:-

"User fees affect the service a lot. Poor village people do not have money to pay, so don't come" (midwife, St Luke's-M).

However, many people believe that CHSs, particularly those run by religious sisters, continue to be funded from overseas and can provide free services. Many patients, therefore, continue to attend Catholic facilities, without expecting to pay.

The attitudes of hospital managers to patients who are unable to pay vary. Some facilities in India, such as Sunder Nagri, St Stephen's, CFH, CMC-Vellore and the Catholic facilities, are proud of their claim that they treat all patients, whether or not they are able to pay. However, Malawian facilities do not have the major resources of the profitable Indian hospitals to draw on and operate a number of approaches to avoid unpaid bills:-

► Treat the patient first and ask for the money later, although it was felt by many nurses that this does not relieve the patients' anxiety because they know that they will eventually be presented with a bill and they reported that patients often terminate treatment early because of their inability to pay.

► Patients pay a deposit and pay the outstanding balance later.

► Full treatment is withheld until the full cost is paid.

► Reducing the medication, except antibiotics, of patients who cannot pay.

► Postponing discharge of the patient until the bill has been paid.

► Retaining the patient's bicycle or other valuable as surety until the bill has been paid.

► Maintaining a register of patients who leave without paying and denying further treatment to such patients until their outstanding debt is paid. The administrator at St Anne's, for example, reported that 380 patients had been entered into their register in the previous year.

► Referring very poor patients to the government hospital.

In practice, knowing that they cannot afford the CHS fees, many poorer patients choose to attend the government hospital, even though they may have to walk much further to reach it. Some Malawian villagers, however, expressed their reluctance to go to the government hospital in the town because of their shabby clothes and their feelings of inferiority. The cost of transport is an additional burden for many poor patients who are too sick to walk to a health facility:-

"I often feel sick, but can't go to St Luke's or the government hospital because I have no money for the fees or the fare. I'm very poor and need money. I am worried about having to pay hospital fees" (community, female, severely poor-M).

In addition, in Malawi, patients' incomes may fluctuate seasonally:-

"At this time of the year I have to buy food, grain and fertiliser so I have no money to pay hospital fees" (community, female, very poor-M).

Many of the community members interviewed in both countries, some of whom lived next door to a CHS facility, reported that they do not seek treatment when they are sick because of their lack of funds, even when they are given a concession (see below). If they attend the government hospital because it is officially free, they find that they often need to find funds for medication, diagnostic tests and informal payments, in addition to transport costs and losing a day's work, all of which affect the poorest patients the most severely. As a result, they reported that they seek other alternatives, such as self-diagnosing their condition and purchasing medication from a pharmacy; in rural areas, collecting local herbs to treat themselves; and visiting TBAs (referred to in India as 'Dhais') for deliveries or traditional healers (often referred to in India as 'Bengali Doctors'). Both TBAs and traditional healers may accept payments in kind, although these providers are not always as inexpensive as

anticipated: some community members in Delhi reported that TBAs had presented them with excessive demands, accompanied by threats of a 'curse' on their newly born child for non-payment.

7.4.4.3 Fee Concessions and Exemptions

CHSs in all 13 countries attempt to provide fee concessions to patients who cannot afford to pay the true cost, but there is variation in both their motivation and their ability to do so. Malawian and some Indian hospitals, such as Kalyani and Ikadu, can afford to give concessions only to a few patients. A minority of health workers expressed the view that all patients, however poor, should be encouraged to pay something, because otherwise, in their view, the service is not appreciated. In addition, the provision of free or subsidised services has the potential for attracting numbers that exceed the capacity of a facility. For example, because it is on the edge of Lilongwe, Chimwalla is reluctant to provide 'heavy subsidies' because of their potential for attracting an overwhelming number of patients. Some facilities have systems to positively identify poor patients, such as St Luke's, where the pharmacist must inform the administrator of any patients unable to pay for their medicines. Some hospitals have experimented with applying preferential rates for patients referred from lower level facilities over self-referrals, but have experienced difficulty because there are no lower level facilities in many areas. Some Malawian facilities make a distinction on the basis of where the patients live, charging less for village patients, using HSAs and village chiefs to issue identity passes to avoid abuse of the system. In addition, in some areas, village chiefs provide lists of orphans, usually resulting from AIDS deaths, for whom free treatment is provided, the cost of which is reimbursed by an NGO.

In some of the larger Indian hospitals, the system of fee concessions is well organised, with a specific amount identified in their budget for the provision of free or subsidised services. This may be as much as 30% of the budget, as at CMC-Vellore, CFH and St Stephens. At St Stephen's all patients requesting a subsidy are referred to the hospital social worker for assessment and recommendation of the level of concession. At CFH all doctors are able to authorise concessions. At the Catholic facilities the religious sisters usually authorise concessions.

Both the Malawian government and CHAM are concerned that poorer patients should not be denied access to treatment on the basis of cost, which is the main reason that the government has agreed to pay salaries for approved CHS posts and has initiated the negotiation of service agreements (7.3.4). CHAM introduced a fees and exemptions policy, which was intended to be mandatory for all registered members of CHAM from November 2007, and should be displayed on notice boards for all to see. The policy includes:-

► Standard charges for treatment procedures.

► Services that must be provided to everyone free of charge, including immunisations, epidemic control, family planning, STIs, ARVs (as long as they are supplied free by the government), and mental health.

► List of social and economic qualifiers for exempting patients from user charges.

Despite its mandatory intention, the policy has not been universally accepted and implemented. Negative responses to the policy from some CHS managers include:-

► A belief that it is for guidance only, and CHSs can decide whether or not to implement it.

►   Acceptance, but not yet implemented because of the projected loss of income. One

administrator estimated that 50% of their facility's patients would be exempt from

charges. He suggested that the loss of user fee income combined with the low level of

overseas funds would result in many facilities becoming financially unviable. Another

administrator expressed concern that because the government drug supply is unreliable

the facility has to purchase its own drugs but would be unable to cover the cost. The

cashier in one facility was unaware of the policy.

►   Implemented, and experiencing a reduction of income. One facility had increased its

private patient fees to compensate for the loss.

The results of the research confirm that the decline in funds from overseas mission partners

has resulted in CHSs seeking funds from alternative sources, mainly the government,

international donors and user fees. The relative importance of these sources varies between

countries and CHSs. The effect of these trends on the socio-economic profile of users is

discussed in the next section.

7.5 Socio-economic Orientation of CHSs

The hypothesis proposed the possibility that the type of services provided by CHSs and the

socio-economic profile of their users have changed as a result of alterations in the means by

which they are funded. The conceptual framework (5.2) referred to the assumption that,

because of the churches' declared priority for the poor (4.5.1, 4.5.4), CHSs give priority to the

poor, but that changes in funding and other policies have increasingly militated against this

intention being achieved (4.5.2). In this section the socioeconomic orientation of CHSs is

explored drawing first on interviews with professionals and then on information obtained from users.

It was identified in the literature review that medical missionaries had mixed motives for establishing their health posts principally in rural areas, serving the most vulnerable populations (4.3): first, was the practical consideration of locating their health facilities in close proximity to the church and its infrastructure; second, they intended to use newly acquired diagnostic and treatment techniques to serve the most needy communities (2.4.2); and third, they desired to win converts, which resulted in working in areas where people were considered most susceptible to conversion, e.g. dalits in India and followers of traditional religions in Africa (2.4.5).

This study has shown in sections 7.4.4.2-3 that many poor patients today are unable to seek treatment from CHS facilities because of the cost. The following interviewees endorsed this point:-

"Originally we served the poor and marginalised. We feel badly that we can no longer prioritise the poor. In today's world where overseas funding has more-or-less ceased we have to change or we can't operate" (bishop, CSI-I).

"The absence of government subsidies and overseas funding make CHSs dependent on user fees, which undermine their mission to the poor" (associate professor, JNU-I).

"*We speak a different language from CMAI, they don't really engage with the poorest of the poor"* (Christian Aid-I).

Nevertheless, it emerged that this was rarely the result of the original commitment to serving the poor being abandoned. In most of the CHS facilities visited in India, there is still a distinct service for the poor, for example, reference has already been made to several hospitals that set aside up to 30% of their budgets to provide free and concessionary services for the poor.

Other hospitals claim to maintain their 'preference for the poor' but are frustrated in their attempts to do so by their lack of resources. Several hospitals have a policy of not turning any patient away, for example, CFH prefers the possibility of being 'cheated' by patients who can afford to pay to the risk of turning away someone in genuine need. St Ignatius gives priority to providing services for migrant workers from Orissa. Most hospitals conduct outreach programmes as a means of reaching poor patients many of whom do not attend health facilities because of the cost, distance or because they see it as too intimidating. The VHAI respondent expressed this as:-

"CHSs provide indoor facilities for the rich and outdoor facilities for the poor".

A commonly held view in India, as expressed by one external observer, is that Catholic CHSs have a stronger commitment to the poor than Protestant CHSs:-

"Catholics are much more dedicated to focusing on the poor and very poor. Protestants have an eye to prestigious hospitals and medical education" (associate professor, JNU-I).

Nevertheless, some Protestant facilities are regarded as exceptions. These include CMC-Vellore and CFH which are outside diocesan structures and in which senior staff have a high level of commitment and are paid much less than the commercial rate. In 1980 the Institute of Management predicted that CMC would 'wind up' within five years because of its pro-poor financial policy, but the principal of CMC proclaimed:-

"...they didn't account for our Christian commitment".

Despite the provision of government funds, CHSs in Malawi also face a tension between their desire to serve the poor and the economic reality of needing fee income to achieve financial viability. This was expressed well by the DFID respondent:-

CHAM [CHSs] have a preferential option for the poor, but charge fees. The government is not religious but cares more for the poor. CHAM [CHSs] need funds to survive – a dilemma – sure"

The Nkhotakhota DHO was unequivocal:-

"I strongly disagree that CHSs give priority to the poor. The situation is now distorted: the government are looking after the poor, not CHS. Village people can't afford fees. CHSs should be looking after the poor more".

The administrator at Zomba government hospital took a more balanced view:-

"Because CHS health facilities are located in the most remote locations they automatically serve the poorest people".

As the EU respondent explained:-

"The main problem is poverty in the country. People are too poor to pay fees. What the country really needs is an economic revival".

It was acknowledged by CHS managers in India that while they had traditionally charged low fees to enable them to serve the poor in areas which were more difficult for the government, financial pressures are causing them to adopt measures to attract the more affluent middle class who are more able to pay fees, which has led to a perception amongst patients in some areas that CHS facilities are middle class institutions:-

"That place isn't for poor people. It's only any good for people who can pay. They need money to run the hospital." (community, male, not poor-I)

Some officials of government and development organisations blame CHAM for failure to develop a more pro-poor culture in Malawian CHSs, but the director of health programmes at CHAM expressed her frustration:-

"Originally, CHSs served the poor, but no longer in many areas. Many CHSs are not trying hard enough by raising funds to subsidise their treatment. Too many staff working in mission hospitals are motivated by profit rather than by Christian ethics".

Many CHS staff express regret that they have become more business oriented because of their need for financial viability and that this is in danger of undermining their compassionate care and service to the poor. As one CHS treasurer said *"There is no mission without margin"*.

Although it is not claimed that the samples of patients interviewed (appendices 5 and 7) are fully representative or statistically significant, the results do suggest that substantial numbers of poorer patients attend the CHS facilities researched, although the proportion of the severely poor is relatively small: of the 108 patients interviewed in Malawi, 67 were from the three lowest socioeconomic categories, of which 14 were severely poor; and of the 108 patients interviewed in India, 37, a much lower proportion than in Malawi, were from the three lowest socioeconomic categories, of which 11 were severely poor. The Indian results include St Stephen's, but exclude CMC-Vellore and CFH, because patients in these hospitals were not interviewed. The inclusion of these two hospitals, which operate positive 'pro-poor' procedures, would probably raise the proportion of poor patients in the total for India.

There are mixed views on whether there is any difference in the service given to poor and more affluent patients in CHS facilities. There is general acceptance that private patients pay more, sometimes significantly more, for which they receive benefits such as being seen more quickly in the OPD by a higher grade health worker, and inpatients having a bed in a private room. Health workers claim that there is no difference in the clinical treatment received by private and general patients. However, whilst the majority of patients and community members interviewed in both countries agreed that there is no difference between the way poor and more affluent patients are treated, many more Malawian than Indian patients and

community members perceived that affluent patients receive better treatment and expressed views such as:-

"It's not equal. The poor are kept waiting longer, but we all pay the same" (outpatient, female, severely poor-M).

"We're left 'til last, we feel bad, there's no respect to the poor, but they're polite to the rich" (community, female, very poor-M).

Women and the poorest patients were most likely to express feelings of being discriminated against. Some facilities in Malawi are endeavouring to overcome these perceptions by issuing tickets on a strictly first come first served basis.

In Malawi the greatest proportion of patients live within eight kilometres of the health facility. Of those who live over eight kilometres away, poorer patients reported that they walk to the health facility, whilst some of the moderately and mildly poor patients travel by bicycle, female patients sitting on the back of their husbands' bicycles, or if they can afford it, by minibus. Poor patients at one CHS facility under study reported that they commonly walk up to twelve kilometres, because the facility was their nearest health facility. It is government policy for there to be no more than eight kilometres between health facilities, but this is not always achieved. Some of the more affluent patients travel from further away, either by minibus or car. In India, in contrast, most patients reported that they live within twenty minutes walk of the health facility, or 30-45 minutes if they travel by any of the several alternative forms of transport, including rickshaw, auto or bus. Those who travel the greater distances are almost always either not poor or in the moderately and mildly poor categories.

For most patients in Malawi, the CHS they attend is the nearest health facility to where they live. Some more affluent patients travel past nearer facilities for specialist treatment or

because of the high reputation of a facility. Conversely, many of the poorer patients travel past the CHS facility for free, or less expensive, treatment at the government hospital. In India, in urban or semi-urban areas, where travel is easier and there is more choice, patients are motivated by a variety of considerations. The general perception is that the most affluent patients attend a corporate hospital, whereas the middle class choose either a corporate hospital or a CHS hospital depending on their respective reputations, charges and accessibility. Poor patients choose a CHS hospital if they believe that they will qualify for free treatment, or alternatively attend the free government facility. However, poor patients living in rural areas face similar limited choices to their counterparts in Malawi.

The main reason given by poor patients in both countries for not attending a CHS facility is lack of money to pay fees or transport costs and the difficulty of losing a day's work. In Malawi travel is more difficult in some rural areas because of the lack of all-weather access roads and bridges.

7.6   Reasons for the Continued Existence of CHSs

The international material reviewed suggested that CHSs today are commonly experiencing financial pressures exacerbated by increasing public expectations, medical and technological advances (3.2.1), and political and economic changes (3.2.3, 3.4.2). In addition CHSs often face a lack of acknowledgement of their contribution by governments and international donors (4.5.2, 4.5.3). These were confirmed by this research. However, despite these difficulties, the current research confirmed that CHSs continue to make a significant contribution to national health services in many, mainly lower human development, countries (6.2.1, 6.3.1). The purpose of this section is to explore some of the reasons given by

respondents for the continued existence of CHSs despite the difficulties they face. These focus on five main factors:-

a) Governments do not serve all communities, particularly in rural areas, so CHSs fill an important gap in service coverage. In Malawi, both CHS and GHS staff recognise that the government lacks both the infrastructure and the resources to serve all communities, and that CHSs are in a better position to serve rural communities, mainly because of the existing church infrastructure in those areas. The comment from the MD of the government hospital in Lilongwe is typical:-

"Health services were part of the original churches' mission. The government started hospitals where there was no church provision. The government has few resources so CHAM [CHSs] highly complements it. Without CHAM services people would suffer".

In addition, there is increasing difficulty in both countries, but particularly in India, in attracting staff to work in rural areas, because of concern about their children's schooling, for unmarried women the need to find a suitable husband, and the attraction of other services only available in urban areas. Church institutions, particularly those run by religious orders, are less affected by these issues:-

"...professionals don't want to work in villages, but dedicated sisters will go…" (medical superintendent St Theresa's-I).

b) Perception of a greater degree of compassionate care in CHSs in both countries, which results in continued demand for their services, as expressed by these two patients:-

"...we are shown more love and respect in mission hospitals" (St Theresa's, outpatient, female, severely poor-I).

"At government hospitals the patients are ignored. St Stephen's is like a family. I can unburden here" (St Stephen's, outpatient, female, severely poor –I).

In India, more than in Malawi, this compassionate care is often associated with serving the poor. Reference is also made to CHS staff having more time to spend with patients because

CHS facilities are generally less crowded and staff are working under less pressure than in GHSs, mainly because the services provided by GHSs are free, as expressed by the administrator of Lilongwe government hospital:-

"... mission hospitals provide a better service, but that may be because they are less busy than we are. Our staff work under great pressure and in poor conditions. CHAM [CHSs] seem better organised and spend longer with patients".

c) The higher level of trust patients feel in the honesty and integrity of staff working in CHSs compared with GHSs or the private sector is associated with the perceived Christian ethic of staff working in CHSs. This appears to be a more important factor in India than in Malawi. Many patients related anecdotes of their experience, particularly in private for-profit hospitals and clinics, of how they had been pressured into expensive, but what they believed was unnecessary treatment, or had been given conflicting advice. They reported that they had later turned to a CHS facility because they believed that CHS staff would tell them the truth because profit is not their primary motive:-

"...private hospitals charge more and persuade you that you need a 'caesarean' to get more money. I trust this place not to exploit me" (Kalyani, outpatient, female, not poor-I).

d) The general perception of a higher quality of service in CHS than in GHS facilities, resulting in more affluent patients being prepared to travel 20 kilometres, or more, for treatment. The indicators of perceived quality of service by these patients particularly focused on first, the increased likelihood that CHS facilities would have medication in stock, which health workers explained was because they purchase independently of the government system; and second, the waiting time in OPD departments, which is generally shorter than in GHS facilities, although some patients in CHS facilities complain that they have to wait several hours to be seen, usually due to staff shortages.

e) The attitude of staff, with few exceptions, is described as polite and helpful, which is likely to be engendered by the generally supportive attitude of senior staff. A number of staff who had worked in both GHSs and CHSs commented not just on how much more polite CHS staff are to their patients, but that patients are more polite to the staff, even when faced with a similar problem of a long waiting time. A senior nurse now working at CHS hospital confessed:-

"I previously worked at a government hospital where I was very overworked. I shouted at the patients and they shouted back… I felt very bad that I couldn't cope with so many people… I was so tired…"

This generally more congenial atmosphere seems to produce loyalty amongst many staff and patients, resulting in families supporting CHS facilities through successive generations.

The reasons for the continued existence of CHSs can be summarised as the need to provide services in areas in which governments are not able to meet the need and demand for their service that remains high because of particular characteristics of the service they provide.

7.7 Summary

The governments in both Malawi and India have produced strategic plans to deal with the deficiencies in their respective health sector delivery through managerial decentralisation, developing PHC, improving service access by poorer members of the community, cooperating with NSPs and improving regulation. The Malawian plan specifically refers to engagement with CHSs, but the Indian plan makes no reference to the involvement of CHSs or other FBOs. The intention of the SWAp programmes in both countries is to involve key stakeholders in decisions about the allocation of resources (7.2).

Major factors influencing whether governments engage with CHSs in the implementation of their health objectives appear to be first, the extent of CHSs' service contribution; second, whether CHSs are providing services not otherwise provided or in areas underserved by other providers; and third, the extent to which CHSs of different denominations cooperate with each other and present a unified voice (7.3). The main way in which CHS cooperation is achieved is through a CHA (6.3.3). There is a tension, particularly for Coordinating CHAs, between adequately representing the interests of their CHS members and discharging their responsibilities for policy implementation, as expected by their governments, and avoiding the slide into co-optation, particularly when a proportion of the CHAs' administrative costs are paid by the government or by international donors (6.3.3, 7.3.1).

In order to determine the extent of CHSs' contribution to national health services and the degree of cooperation between CHSs and their respective governments, a series of issues arising from the review of international experience presented in chapters three and four and summarised in the conceptual framework were explored. Governments have an interest in involving CHAs in policy making, first, because they are dependent on them to implement decisions which may affect up to half of a nation's health services; and second, because it is a requirement of their respective health development plans agreed with donors. However, Coordinating CHAs generally have a closer relationship with their governments and are more likely to be involved in national planning and policy debates.

The Support CHAs researched are at a disadvantage in this arena, first, because the proportion of the nations' services they deliver is much less; and second, because they generally have no mandate from their members to implement common policies although CHAI claims to be the

second largest provider in India and, perhaps because of its unidenominational status, has less difficulty in implementing policy throughout Catholic facilities (6.3.3).

An increasing amount of health sector planning is devolved from national to regional and district governments and both the Malawian and the Indian health sector strategies (7.2.) identified the need for increased decentralisation. However, whilst national governments officially endorse the necessity of involving other stakeholders, this has not always been fully embraced by the lower levels of government, due to a combination of adherence to custom and practice, lack of awareness, inexperience, acrimonious relationships, reluctance to acknowledge the contribution of CHSs in areas underserved by the government, and inefficiency. In some areas, however, previous harmonious relationships may facilitate a closer involvement of CHSs with decentralised health management. Thus some CHS managers may be keen to be involved because of the opportunity for more collaborative working and/or in order to access much needed funding, whilst others may be more resistant because of previous hostility or fears of increasing dependence (7.3.3).

Despite CHSs providing up 50% of national health services in some countries, there is a major difference in the amount of material support governments give to CHSs, ranging from virtually nothing except support for high priority programmes at one end of the continuum to full support including the payment of salaries and operational running costs at the other. It emerges from this research that the degree of support from governments depends on a number of factors, including the extent and nature of CHSs' contribution to health service provision (6.3.1) and their willingness to collaborate with their respective governments (7.3.1), the governments' own economic position (6.2.1), and whether collaboration occurs as part of a

donor programme under which resources are shared between state and NSPs (7.2). CHAs in a number of the 13 study countries are in the process of negotiating with governments for a share of the national health budget more proportional to their contribution to service provision. Failure to achieve agreement on this may threaten the future sustainability of many CHS facilities which are already experiencing financial difficulties (7.3.2). Both the Malawian and the Indian national health strategies (7.2) identified the need for increased support to and coordination of NSPs as key ways of meeting health sector deficiencies. There is little evidence of this occurring in relation to CHSs in India, whereas in Malawi there is a definite move in this direction (7.3.4).

In an attempt to encourage cooperation and regulate CHSs' health provision, there is an increasing trend for governments to formalise their support of CHSs by an MOU or a Service Agreement specifying what the government is paying for and what the CHSs are expected to provide in return. To reduce the high maternal and infant mortality rates in Malawi, under the SWAp agreement, DHOs in areas where there are no accessible GHS facilities are negotiating service agreements with CHS facilities to provide free antenatal care, for which CHSs will be reimbursed. This programme not only illustrates an approach by which a CHS and a government can work together to provide accessible services to a high priority group, but also reveals some of the issues which need to be addressed in negotiating such agreements (7.3.3).

Service agreements increase governments' ability to regulate CHSs because of the need to acquit funds and provide reports of services provided, but some accountability of NSPs to governments previously existed and continues to be required through a number of other mechanisms, including the routine submission of statistical reports and financial accounts,

acquitting government funds, accounting for foreign currency, compliance with statutory regulations, and the right of government officers to inspect CHS facilities. In reality these forms of accountability are not always exercised because of weak regulatory systems, the belief that CHS services are of a higher standard than GHS services and/or that they are already regulated by the CHA, and/or the diffidence of government officers towards CHS managers. In some areas where there is a hostile government the opposite applies, and the enforcement of regulations is used as a means to harass CHS managers (7.3.5).

The degree of cooperation between CHSs and GHSs as service providers was also explored. In Malawi CHS and GHS hospitals supervise lower level GHS and CHS facilities and receive referred patients from them. Both in Malawi and India, patients are commonly referred from CHS hospitals to GHS hospitals to access either a specialist clinical service or a free service, and although referrals in the opposite direction are far less frequent, there are CHS hospitals in both countries that provide specialist services which are not available in the local GHS hospital (7.3.4.1).

All of the health facilities researched in India and Malawi carry out some form of community outreach, but during periods of high workload or staff shortage, the institutional curative work takes priority. In an effort to overcome this problem, the Malawian government introduced HSAs (Health Surveillance Assistants), who carry out only preventive work with local communities. They are based at CHS and GHS facilities and are accountable to the DHO. In an attempt to avoid either neglect or duplication, all Malawian health facilities are regarded as responsible for the communities within their catchment area, but in India there is no such structured approach: the GHS is responsible for providing outreach services to all

communities, but many communities receive inadequate services. On the other hand CHS institutions, particularly those with training institutions, provide outreach to particular communities which they have selected according to their own criteria, sometimes very effectively. The overall result is that some communities receive no service and others receive duplicated services (7.3.4.2).

Statutory training was the final area of possible CHS/government cooperation considered. CHSs in many countries make a substantial contribution, sometimes training more than half of the nation's health professionals, for which the government usually pays a training grant to the CHS. Frequently CHSs and GHSs rely on each other for clinical placements during training and for recruitment of graduates (7.3.4.3).

As proposed in the conceptual framework, the research confirmed the existence of a tension between the desire of national churches and their CHSs to be autonomous and their continued need for the funds, albeit much reduced, which flow from mission organisations. There is concern, particularly in Malawi, that the decline in financial support from their partner mission organisations, exacerbated by the reduction in expatriate missionaries, could have a serious affect on the future viability of CHSs and in turn increased pressure on GHSs, unless other sources of funding are found (7.4.1). Mission organisations attempting to slow the reduction in the funds they can allocate to national churches also face a tension between presenting requests to their donors for funds in an appealing way and demonstrating influence over and accountability by recipient organisations, whilst devolving decisions for how funds will be used by national churches. An additional tension is that while national churches and their congregations appreciate the symbolic and practical value of the health facilities they

run, they seem to feel only a limited obligation to either channel funds from overseas to their health services or to raise funds locally to support them. Thus unless funds from overseas are specifically designated for health, national churches do not seem to allocate them to CHSs.

The available sources of finance for CHSs to replace the declining income from their mission partners are limited. Some CHSs, particularly those with access to a project officer, apply for project funds not just from their traditional mission partners, but also from other agencies, including secular development organisations and government agencies, even though this is often described as a time-consuming exercise, for which they lack the expertise to prepare submissions and acquittal reports. Although some applications are successful, when rejection occurs, it frequently discourages further submissions (7.4.2). Some churches in India hope to generate their own income on a large scale through seeking government grants to build medical schools with associated hospitals. However, apart from CHAM's private hospital proposal, the Malawian approaches to income generation have been modest and have not made a significant contribution to CHSs' finances (7.4.3).

Both in India and Malawi, as in a number of other countries, GHS services are technically free, although some facilities charge for particular components of treatment and some countries operate differential payment systems to encourage use of lower level facilities. On the other hand, CHSs in most countries must charge user fees to remain viable. The extent of charging varies according to the level of government and donor support. In India, fees account for 98-99% of CHSs income, whilst in Malawi their contribution ranges from less than 20% to almost 50% because of the higher levels of government and donor support and greater poverty of users (7.4.4.2).

In India CHS hospitals with well developed tertiary facilities are able to attract more affluent patients, who are able to subsidise the treatment of poorer patients by generating a profit equivalent to up to 30% of the total budget. Other facilities, particularly those operated by religious sisters, are able to provide basic low cost services to people in rural areas. Some urban hospitals are facing increasing competition from the expanding for profit sector. Malawian CHS hospitals generally have a small number of private patients who pay higher fees, but because of widespread poverty, the general level of fee income is not sufficient to permit widespread concessions to poor patients. As a consequence, health facilities face a constant tension between ensuring that those patients who can afford to pay do so and giving concessions to the poorest patients.

Many people either do not seek treatment, use self-medication or attend traditional healers because they cannot afford CHS fees or the fare to travel to a GHS facility. The Malawian government has agreed to pay CHS staff salaries and more recently, has introduced service agreements to encourage extension of free treatment to poor patients. CHAM has also introduced a fees exemption policy, which defines the criteria for qualifying for free treatment. Although the policy is intended to be mandatory, many CHS facilities had not implemented it at the time of the field study (7.4.4.2-3).

In both India and Malawi the general view is that when CHSs were established they targeted the poor and marginalised, as demonstrated by their choice of location. There are strong views, even resentment, amongst community members and some government officials that Malawian GHSs are perceived now to serve the poor and CHSs the middle class. There is some substance to this perception, but the evidence collected during this study demonstrates

that it is exaggerated: in samples selected to be as representative as possible, 67 of the 108 patients interviewed in Malawi and 37 of the same number in India were from the three lowest socioeconomic categories, although the numbers of severely poor were only 14 and 11 respectively (7.5). The Indian figures exclude CMC-Vellore and CFH because patients in these facilities were not interviewed, but include St Stephen's. As all three of these hospitals allocate approximately 30% of their budget to subsidise services for the poor, it is likely that the proportion of poor patients would have been higher had data from all of them been available.

In both countries, poorer patients tend to live in close proximity to the CHS facility they attend, whilst a higher proportion of the more affluent patients travel greater distances, particularly if a facility is known for its high quality or specialist service. Poorer patients commonly pass a CHS facility, if they believe that they will be charged, to attend a GHS facility and in some cases CHS facilities refer poor patients to the GHS. Only a minority of poor patients feel that they are discriminated against by CHS staff. This is more common in Malawi than in India, and usually refers to what is perceived as more affluent patients 'jumping the queue'. In both countries, the outreach services provided by CHSs usually focus on poor communities living in remoter areas (7.5).

There is general recognition that CHSs provide compassionate care and have a high level of integrity, neither of which are perceived to apply in either the government or the private for-profit sector. In both countries, the quality of the services provided by CHSs, including the attitudes of their staff, is generally regarded as superior to that of GHSs. A contributing factor is the difference in workload pressure experienced by the two groups of staff. In India the

quality of treatment provided by the for-profit institutions is, with notable exceptions, regarded as better than that provided by CHSs, but usually at a substantially higher cost (7.6).

In conclusion this chapter has shown considerable variation in the interface between CHSs and their respective governments, the approaches of CHSs to balancing the tension between providing a service and maintaining financial viability, and the effects on the socioeconomic profile of their users.

CHAPTER 8

CONCLUSIONS

8.1 Introduction

The starting point for this research was the evident changes in the types of services provided by CHS (Christian health service) providers since previous colonies attained their independence and the allegation that their responses to contemporary pressures has diverted them from their original mission of providing services to meet the needs of the poor. The research aimed to identify and explain changes in the types of health services provided by Christian organisations in contemporary developing countries, their users and their relationships with governments. To achieve this aim, it has been necessary to weave together three main areas of study: Christian mission history (especially the history of medical mission), health service management and how it has sought to respond to changes and pressures in the last half-century, and the role of NSPs (non-state providers) in a comprehensive health care system.

A review of the relevant literature and early indications from contacts with CHSs indicated a number of possible explanations of the changes observed, including changes in their funding base and relationships with church organisations on the one hand and governments on the other. It appeared that changes in their funding base were the driving factor, leading to the hypothesis that 'the necessity of seeking alternative funding sources has resulted in changes in the types of provision of CHSs in contemporary developing countries, their users, and their relationships with governments' (5.3).

The key factors that were thought to influence the current provision by CHSs, the socio-

economic characteristics of their users and their relationships with other organisations were brought together in a conceptual framework that was presented in section 5.2. From this four research questions were formulated that together enabled the hypothesis to be tested and the overall aim to be achieved:-

5) What is the current contribution of CHSs to the total health service of their respective countries and to what extent do they cooperate with each other?

6) How and why have the policies of mission organisations in the UK changed; how have these affected their relationships with, and support given to, their developing country partner churches and their health services; and what is the impact of CHSs' religious heritage on their service provision?

7) What is the nature of relationships with, and support given by, governments to CHSs and how and why have these changed?

4) How have CHSs responded to these changes; what impact have these changes had on the search for alternative sources of funding, the nature and extent of services provided, and their users; and what are the reasons for the continued existence of CHSs?

The investigation followed three strands, which are explained in section 5.5.5: first, interviews with officials of twelve UK based mission organisations; second, a general survey of CHSs in thirteen countries; and third, interviews in Malawi and India with selected stakeholders of CHSs.

This chapter discusses what the research has revealed about the policy changes of UK mission organisations, particularly in relation to the funding situation and policies of their overseas

partners and the epidemiological and economic challenges confronting all health services; the contribution of CHSs to their respective health sectors and the role that CHAs (Christian Health Associations) play in supporting and representing CHSs; the changing and different relationships of CHSs with their church organisations and governments and how the nature of these relationships affect the ability of CHSs to respond to challenges; and the different ways in which CHSs have responded to these changes, including the development of different models of service provision and their impact on service users. The main body of chapter (8.2-5) is organised according to the four research questions, which is followed by a general conclusion (8.6) and suggestions for further research (8.7)

8.2 The Contribution of CHSs to National Health Sectors and How They Cooperate with Each Other

It is widely asserted that CHSs make a substantial contribution to national health sector provision in many developing countries in terms of number of facilities, patients and range and type of services, but it emerged at an early stage that little systematic information was available to substantiate this assertion. The research aimed to test this assertion by validating and updating the data available. It did so first, by tracking down as many estimates as possible (table 4.1) and second, through the general survey, the results of which, as reported in section 6.3.1, show that CHS share of provision amounts to 30-50% in most of S-SA (Sub-Saharan Africa) and PNG (Papua New Guinea), including 37-38% in Malawi, but a much lower proportion in South Asia, estimated to be 1% in Bangladesh and around 10% in India. With some exceptions, CHSs operate a higher proportion of dispensaries and aid posts than of hospitals, which is consistent with a policy of encouraging patients to attend the lowest level of facility with referral to a higher level facility if necessary.

Many CHSs in all of the study countries have outreach programmes, which most commonly comprise MCH (maternal and child health) clinics, and some operate community based health care programmes using local volunteers, who are trained and supervised by CHS health workers. CHSs have the major resource of their church infrastructure and networks which they are able to utilise in their outreach work. The advent of HIV/AIDS has seen the development of community based VTCs (Voluntary Testing and Counselling Centres). In Malawi, each health facility has a broadly defined catchment area, recognised by the government, for which they provide both health facility and outreach services ranging from 54 villages for Mposa to 156 for Nkhoma. In India, because of the less cooperative relationship between CHSs and the government, complementarity with GHSs (government health services) is either very limited or non-existent and the situation is less structured. However, CHS health facilities generally provide some form of outreach to selected communities within their vicinity ranging from one village for St Ignatius to 83 for CMC (Christian Medical College)-Vellore (6.3.2).

The historic problems associated with the isolation and lack of contact between CHSs and acceleration of CHA formation from the 1960s was discussed in section 4.4. The results of the general survey and interviews in Malawi and India confirm that the main means by which CHSs now communicate with each other, and with the government, are through their CHAs. The research identified two major respects in which CHAs differ. First, some, such as CHAM (Christian Health Association of Malawi) serve both Catholic and Protestant CHSs, while others, such as CMAI (Christian Medical Association of India) and CHAI (Catholic Health Association of India) serve Protestant and Catholic CHSs separately. It is recognised by officials of CHSs and of government institutions and development organisations in Malawi

that CHAM is able to communicate on behalf of all CHSs. CHAI is also able to speak on behalf of Catholic CHSs in India, but this does not apply to CMAI, which has greater difficulty in achieving consensus between the divergent views of the Protestant denominations it represents.

The second distinction identified in this research relates to the function of CHAs, which can be divided into two categories. The first, such as the CHAs in Pakistan, Bangladesh and CMAI in India, are referred to in this thesis as 'Support CHAs' because their functions are mainly limited to fellowship, educational and professional support roles for their members. The second category, which includes CHAM and most of the other CHAs in S-SA and PNG, are referred to as 'Coordinating CHAs' in recognition that there is an expectation that they have been given a role by their members to coordinate their activities. Some CHAs, such as CHAI, fall between two categories by only partially meeting the criteria of a Coordinating CHA. It was also found that members of Coordinating CHAs are more willing to subsume part of their identity within that of the CHA and cooperate both with other denominational CHSs and the CHA itself, and that there are likely to be various forms of compulsion and incentives for CHSs to affiliate to the CHA. The effect of these differences in structure and roles of CHAs on their relationships with governments is discussed in section 8.4.

8.3 Changed Policies of Mission Organisations and their Impact

The question of how mission organisations' policies have changed, and with what outcomes, is discussed in three parts: first, the ways in which mission organisations' policy and practice has changed are identified; second, their effect on CHSs is assessed; and third, the impact of CHSs' religious heritage on their service provision is discussed. Previous surveys of CHSs

carried out under the auspices of the WCC (World Council of Churches) highlighted the financial difficulties experienced by CHSs, resulting from the widening gap between the rising costs of health service provision associated with increasingly expensive diagnostic and treatment procedures and decreasing income from mission organisations. It was found that the difficulty was exacerbated by the declining income of Western (mainly post-colonial European) churches and the increased autonomy of developing country churches (4.4). The current research confirms these findings and shows that the flow of funds from the former to the latter continues to be the major transaction between them. Four other major changes were identified from the investigation, either as a consequence, cause or complement of these changes and are illustrated in figure 8.1.

First, it was reported in sections 6.4.1.2-3 that as a result of a changed perception of the needs in developing countries, and to increase their appeal to declining church congregations in the face of competition for funds from both faith based and secular development organisations, mission organisations have, to varying degrees, shifted away from their traditional evangelistic role towards a complementary development role, which tends to blur the distinctions between the categories of FBOs defined in Clark's two taxonomies (4.5.1). In order to gain popular support, this change is accompanied by a trend for mission organisations to request from overseas partners, and to present to their donors, appeals for funds, in the form of projects.

Second, as a result of continued pressure from developing country churches since the 1910 Edinburgh Conference (2.5), to be recognised as equal partners, and more recently in response to stakeholder consultations, that were explained in section 6.4.1.5, many mission

organisations are either devolving decision making, particularly over the allocation of funds, or sharing decisions through forums comprised of both UK mission organisations and developing country partner churches. This creates a difficulty for mission organisations of needing to 'broker' the decisions of their partner churches with the expectations of their donors and their own mission statements, particularly in ensuring that their priority for the poor is realised.

□

Causes of change for mission partners	Changing activities of mission organisations	Effects of changes on developing country churches and CHSs
Reduced funds from church congregations	Decreased funding and expatriates	Traditional funding decreased
Competition from development organisations	Increasing Development focus	Search for alternative funding sources
Mission Organisations	Project funding	Preparation of project submissions and acquitting funds
Reduced supply of expatriate 'missionaries'	Devolved or shared decision making	Increased autonomy and weakened links with traditional partners
Pressure for change from developing country churches	Change in health focus	Reduced support for CHS institutions

Figure 8.1   Causes and Effects of Mission Organisation Changes

Third, there is general consensus amongst interviewees in Malawi and India that the decline in the number of UK missionaries, in some instances resulting from decreased demand and in others from decreased supply, results in weaker links with their partner churches, which in turn exacerbates the decline in overseas funds. Some churches, particularly in India, welcome this as a reduction in dependency, whilst others attempt to maintain overseas support by

developing new links, recruiting expatriates on short term projects or deliberately appointing expatriates to posts that could have been filled by national staff.

Fourth, mission organisations are taking a variety of approaches to the health institutions they bequeathed to their developing country church partners at the time they became autonomous. Along with transferring ownership, some mission organisations completely extricated themselves from responsibility; some continue to provide, albeit much reduced, financial support, sometimes from designated trusts; and others, to reduce costs and accord with the policies of both the WHO (World Health Organisation) and the WCC, as discussed in sections 3.4.1 and 4.4, are increasingly supporting PHC programmes (6.4.1.6).

Most of the developing country churches researched in Malawi and India confirm that they have a continuing link with their founding (mainly European) church partners, although this is often much weaker than in the past and many CHS facilities have sought links of their own, seeing them as a means of professional exchange, skills-sharing or financial support. Overseas relationships, including financial support, are often fostered by the employment of expatriate staff (6.4.2.2).

One aspect of the religious heritage of CHSs which was identified by the current research is a continuation of the tensions between church organisations and their health services. These were the subject of the Tübingen consultations in the 1960s (4.4), and in the current study, were evident in those CHSs that are under diocesan authority. Proprietorship of Protestant CHSs in Malawi and CNI and CSI (Churches of North and South India) CHSs in India is locked into their respective church organisations through management boards, which are

usually chaired by Bishops, their equivalents, or their nominees. Catholic health facilities under diocesan control are managed in a similar way in Malawi and managed by CHAI in India. CHS officers working within diocesan structures assert that whilst they are not subject to the same degree of government bureaucracy as their GHS counterparts, they are constrained by needing to gain 'church approval' for major decisions and the over-involvement of some bishops in operational decisions for which, it is asserted, they have neither the time nor the expertise (6.4.2.1). This was felt to be a constraint by officers of some CHS facilities, development organisations and CMAI. The latter believed that the involvement of bishops also adversely affected the ability of CMAI to negotiate with the Indian government, although this was not the case for CHAM in Malawi, where bishops also have a high profile in the management of CHS facilities, of which they are seen as the 'proprietors', but are not seen as a liability in the CHAM-government relations. The difference can partly be explained by the faith orientation of the respective governments, but also by other factors that influence the relationship between CHSs and governments and are discussed later in this chapter.

The research identified three exceptions to these diocesan management arrangements: Catholic CHSs managed by religious sisters, who are accountable to their own order (6.4.2.1); CMC(Christian Medical College)-Vellore, which in theory is managed by 52 churches, but in practice is managed autonomously; and CFH (Christian Fellowship Hospital) in Tamil Nadu, which is managed by the Christian Fellowship, which is a group of Christians, mainly doctors, who are committed to living a simple life, comparable to that of community they serve. The autonomy experienced by these three exceptions, which differ from each other,

provides them with the flexibility to adapt to particular needs, which will be further discussed in section 8.2.4.

Another aspect of CHSs' religious heritage is whether their faith base leads to distinctive practices and characteristics and if so, what effect these have on service provision. There was no evidence from the current research of CHSs using their service provision as a means of giving preference to their own faith communities or for evangelisation, as asserted by governments and donor organisations and referred to in section 4.5.1. On the contrary patients reported an absence of religious preference and discrimination.

CHS facilities are usually recognisable by their name and the presence of religious artefacts around the building. CHS managers in the current study reported that in an attempt to maintain their religious ethos, they preferentially recruit Christians, preferably of their own denomination, particularly to senior posts. This presents the possibility that the best professionally qualified candidates for posts may be overlooked in favour of candidates with appropriate religious affiliation. However, this must be weighed against the appreciation expressed by patients and community members of all religious faiths of the distinctive caring and compassionate ethos which they associate with CHS facilities. Interviewees attributed to the staff qualities of politeness, helpfulness, trust and integrity and many enthusiastically declared that they welcomed the opportunity to participate in religious devotions held at the facilities.

Although CHS staff and community members in India recounted examples of patients converting to Christianity as a result of the compassionate care they received in CHS

facilities, and some trainees, particularly from marginalised communities, reported that they gradually imbibed Christian values at CHS training institutions, none of the respondents reported attempts to proselytise. However, some Indian state governments, particularly where the right wing Hindu nationalist BJP (Bharatiya Janata Party) is dominant, are hostile to Christian organisations and operate 'freedom of religion' laws to discourage activities intended to lead to conversions, as well as bypassing CHSs in service planning and support of operational services, as was discussed in sections 6.4.3 and 7.3.1.

Only two service restrictions resulting from religious doctrine were apparent during the research: first, the limitation on the availability of termination of pregnancy in India (this is an illegal procedure in Malawi), and second, restrictions at Catholic facilities on methods of family planning, including condom use (6.4.3), which can be an obstacle to the full implementation of government strategy both in relation to reproductive health and control of HIV infection. It became obvious during the research that condom use is an issue that is not fully resolved and often presents a tension between church officials, who generally, but not always, take a more restrictive view towards condom use, and CHS health workers, who seemed more willing to waive religious doctrine in favour of meeting the health needs of their patients. The dilemma is eased in Malawi by the availability of government employed HSAs (health surveillance assistants) at both CHS and GHS facilities who are able to provide a range of family planning aids including condoms.

8.4 Relationships between Governments and CHSs

In this section the underperformance of government health sectors is first discussed, followed by discussion on the roles of CHAs; involvement of CHSs in government planning processes;

government support of CHSs; service agreements; regulation; and cooperation between GHSs and CHSs.

The underperformance of health sectors in low human development countries, the contributory factors to this underperformance, and the continued low health status of people, particularly of the poorest communities, in those countries were discussed in section 3.3. The research confirmed the low health status of the 13 countries included in the general survey, with the exception of South Africa, and their lack of economic resources to deal with it (6.2). Both Malawi and India experience high rates of preventable morbidity and mortality, particularly related to childbirth and infancy (Malawi is reported to have the highest maternal mortality rate in Africa) and especially from malnutrition, malaria, diarrhoeal diseases and tuberculosis exacerbated by HIV/AIDS (6.2.2). Among the policy initiatives suggested by international agencies for dealing with health sector underperformance were first, PHC (primary health care); second, those associated with the HSR (health sector reform) movement, principally, government decentralisation, non-state health provision, and alternative sources of funding; and third, the MDGs (millennium development goals), all of which were discussed in section 3.4.

The national health strategies in Malawi and India recognise the inability of their health systems to cope with their high levels of morbidity and mortality and aim to improve their health sector performance by increasing access for the most vulnerable people by incorporating the international policy initiatives, referred to in the previous paragraph into their respective strategies. Those initiatives relating to cooperation between governments and

CHSs will be discussed in this section, and those relating to funding approaches will be discussed in section 8.5.

A major part of the HSR strategy discussed in section 3.4.2.2. focuses on the recognition that, in most developing countries, it is neither possible nor desirable for governments to be direct providers of the total health service provision. The literature suggests that the benefits for governments in gaining the assistance of NSPs in health provision include their assumed greater managerial efficiency, flexibility, cheaper cost and ability to reach the more marginalised communities, but that these benefits are accompanied by difficulties associated with communication between governments and NSPs and coordination and regulation of their activities. One of the ways suggested for improving coordination of, and communication between, NSPs and governments, is through umbrella bodies. Much of the interface at national level between CHSs and their respective governments is conducted by CHAs and together with facilitating cooperation between denominational CHSs, is the main reason why CHAs were created and why they continue to exist. As discussed in the previous section, two differences were identified between the role and functions of CHAs. The research identified that these differences affect their relationships with governments, e.g. member CHSs of Coordinating rather than Support CHAs, are more likely to:-

► Implement both CHA and government policy;

► Operate a larger proportion of the national health sector, and usually operate in different geographic locations from GHSs;

► Be invited by governments to participate in their policy and planning processes.
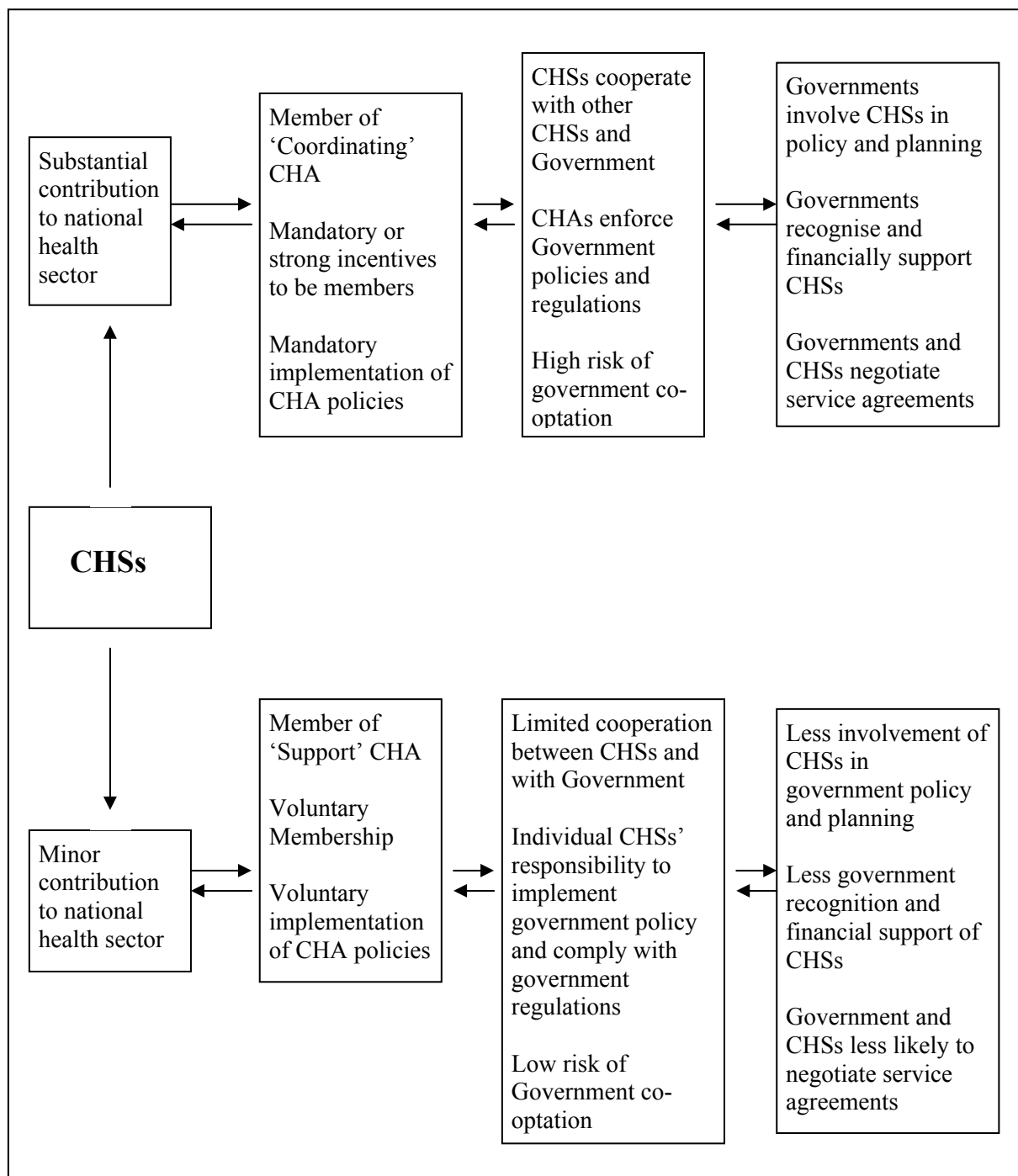
Figure 8.2   Tendencies in CHS and Government Relationships

Thus, as illustrated in figure 8.2, countries in which CHSs operate a substantial proportion of

the national health sector, tend to have the following characteristics: CHSs cooperate more

readily with each other and with the government; CHSs are affiliated to a Coordinating CHA;

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governments are more likely to financially support CHSs, although to varying extents; and governments involve CHSs in their policy formation and planning processes. Under these arrangements, both partners benefit from this closer collaboration: governments from the legitimacy and the substantial service provision of CHSs, particularly to marginalised communities, and CHSs from the recognition and financial and other resources from governments. However, there is an increased risk of co-optation, as described by Brinkerhoff (2002), by which one organisation is seen as an extension of a more dominant one. In this case CHSs being seen as an extension of governments with a consequent loss of CHSs' separate identity and independence of action. Several Malawian CHS managers expressed concern that CHAM was increasingly seen as an 'arm of the government'. This perception is likely to be exacerbated when CHAs rely on governments or international donors to fund their own operations, as is the case with CHAM.

Respondents identified three other factors which encourage governments to elicit the participation of CHSs in the planning process and were discussed in section 7.3.1:-

► Closer working relationships between GHS and CHS staff, often between individual officials, which can be heightened by decentralisation of government administration.

► High profile health programmes being planned which require participation from all providers, such as mass vaccination and HIV/AIDS prevention and treatment programmes.

► International financial and development organisations require the involvement of NSPs, including CHSs, in programmes such as SWAp (sector wide approach); Global Fund allocations for the prevention and treatment of AIDS, Malaria and TB; or

achievement of MDGs related to health, such as those aimed at reducing maternal or under-5s mortality.

CHSs report different experiences of involvement in the government planning process: whilst Malawian CHSs report that they have become more involved and usually attribute failure for their involvement to default, Indian CHS managers feel excluded and regard exclusion as deliberate action to ignore their contribution. Some officials of development organisations based in India are critical of CHSs, in particular CMAI, alleging that they have not been proactive when opportunities for potential engagement occur, but CHSs argue that their attempts at engagement have been met with hostility from government officials. On the other hand, clinicians at prestige institutions such as St Stephen's and CMC-Vellore affirm that their individual involvement is sometimes sought by both national and state governments, when their particular expertise is required.

Results from the general survey present a varied picture of government support of CHSs (7.3.2), ranging from no support other than tax concessions at one end of a continuum to provision of medical supplies and payment of salary and operational costs at the other. In addition to the factors mentioned above, the level of government support of CHSs seems also to be influenced by the political inclination of governments, that varies from grudging acknowledgement of the existence of CHSs, as in some Indian states to substantial support as in Malawi, Tanzania and PNG, although governments are not usually willing, or able, to fund CHSs to the full cost of their service provision. However, of the countries researched, Malawi and Tanzania are at the bottom end of the range of GDP and health expenditure per capita (6.2.1), yet their governments are at the higher end of those providing support to CHSs. This

suggests that, in these two countries at least, factors other than financial capacity, including some of those referred to in figure 8.2, are influencing the governments' decisions to support CHSs.

Another means by which governments can guide NSPs into complying with strategic priorities and meet the required performance standards is through agreeing contracts. The form of contracting high priority clinical services from the EHP (essential health package) favoured by the Malawian government is facility level service agreements (7.3.3). The Malawian experience provides a number of important lessons for NSPs, including CHSs in other countries. The outcomes are generally reported to be positive for patients, governments and CHSs. First, patients are able to access a service for which they previously had to pay a fee resulting in increases in attendance at antenatal clinics; second, governments are able to move closer towards achieving the MDGs on maternal and under-5s mortality by enabling CHS facilities to provide essential services to difficult to reach groups; and third, CHSs are able to access desperately needed funds for the services they provide. However, there are some anxieties:-

► DHOs (District Health Officers), who are responsible for negotiating service agreements, expressed two concerns: first, in their view, CHSs have tended to exaggerate the level of funding needed to provide the service; and second, the national government has not allocated sufficient funds to finance the agreements, which will jeopardise other services.

► CHS managers expressed four concerns: first, that a service agreement raises expectations that a free service will be provided that cannot be continued free if the agreement is not renewed and the government or economic circumstances change;

second, that DHOs might not allocate available funds to CHSs and GHSs on a proportionate basis; third, that CHSs will experience difficulty in recruiting additional staff to enable them to deliver extended services; and fourth, that patients will be attracted across district boundaries to access a free service for which they are ineligible thus, distorting workloads between facilities with and without service agreements.

As Palmer (2006) suggested, governments have sought to regulate the activities of NSPs through either control systems or by facilitation through coordination, contracting or partnerships. In this section, three means by which governments encourage the compliance of CHSs with national strategies through facilitation have been discussed: first, through enlisting the assistance of CHAs, particularly Coordinating CHAs; second, through the involvement of CHSs in government planning processes; and third, through financial incentives including the payment of salaries and the negotiation of service agreements.

Further investigation in Malawi identified that there are also provisions for the government to regulate CHSs through DHO supervision and professional registration bodies (7.3.5), although this is rarely done effectively: DHOs are unlikely to exercise their authority to conduct supervisory visits of CHSs, reportedly mainly because of their work overload and belief that CHAs are performing this role. It was also reported that the Medical and Nursing Councils rarely apply sanctions to substandard facilities because they fear that the lack of alternative providers would result in a withdrawal of service for affected communities. Although Indian CHSs are subject to the same range of government regulations as their Malawian counterparts, they are much less willing to acknowledge government regulation:

CHSs do not perceive themselves as accountable to their CHAs (CMAI and CHAI), nor that the CHAs are accountable to the government. Officials of development organisations as well as CHS staff express scepticism that the intention stated in the Indian Rural Health Mission and previous government reports to establish effective regulatory mechanisms of the non-state health sector will be achieved.

The general survey revealed that CHSs in the countries researched operate a range of facilities from which health services are provided, and in India and Malawi the hierarchy of facilities generally parallel those provided by GHSs. The health strategies of both countries recognise the inability of their state-operated services to meet the total health needs of their populations and express an intention to enlist greater assistance from NSPs, although the Indian government does not specifically mention CHSs. The research investigated the degree of cooperation between GHSs and CHSs (7.3.4) as a means of assessing the efficiency and cost-effectiveness of the sector.

First, both GHS and CHS hospitals in Malawi receive referrals from each other's lower level health facilities and transfer patients between facilities for clinical reasons, or because patients are unable to pay for treatment in CHS facilities that they can receive free in GHS facilities. In India the large multispeciality hospitals have the expertise to manage most cases themselves, but the less well resourced hospitals transfer to free government hospitals patients needing more complex treatment as well as patients who are unable to pay. Thus in Malawi transfers can be in either direction, whereas in India transfers are mainly from CHS to GHS facilities. Additionally, it was reported in Malawi, but not in India, that there are reciprocal

arrangements for health professionals from GHS and CHS hospitals to visit each other's lower level facilities to conduct specialist clinics and provide professional support to health workers.

Second, there is tacit agreement in Malawi that health workers at CHSs and GHSs facilities will provide outreach services to communities within their respective catchment areas. Two further examples of GHS and CHS cooperation is the provision of government employed HSAs (health surveillance assistants) at both GHS and CHS health facilities to supplement the outreach work of health facility staff, and training TBAs (traditional birth attendants) to conduct deliveries in their own communities, which may be either in a CHS or a GHS catchment area. Although in India both GHS and all of the CHS facilities researched conduct community outreach, it is generally conducted without any agreement over their respective responsibilities, resulting in unmet need and duplication. For Indian CHSs, outreach appears to be subject to factors such as the level of activity they are able to fund, the requirements of training curricula, and their commitment to PHC, particularly where they perceive marginalised communities are not receiving a service. Whilst the Malawian government usually provides vaccines, when they are available, and other medical supplies to support outreach, provision is more variable in India, and, as in other forms of government support of CHSs, varies according to the factors described above including the political climate in each area.

Third, both CHSs and GHSs in Malawi and India operate schools and colleges to train health professionals, for which governments provide training grants. In some countries, such as Malawi and PNG, CHS institutions train over half of the national health workforce. There is a degree of interdependence between GHSs and CHSs because of the need for clinical

experiences in and recruitment beyond the training provided by their own organisations, although it was not possible to quantify this. In addition to the supervisory role of the statutory training bodies, CHAs usually have a monitoring, and in some countries a coordinating, role for training in CHS schools.

These three examples suggest that CHSs and GHSs in Malawi are increasingly agreeing their respective responsibilities and seeking to optimise the use of each other's resources, in ways that do not appear to be occurring in India.

8.5 Impact of the Funding Changes on CHSs and their Users

In this section, the search for alternative sources of funds to replace the decrease from traditional sources is first discussed. This is followed by consideration of the impact of the changes on users, leading to the question of the continued existence of CHSs.

The church organisations and CHSs investigated in Malawi and India confirm first, that financial receipts from their traditional mission partners are declining; second, that only funds specifically designated by mission organisations for health services are allocated to CHSs; and third, that national churches do not generally provide any financial support to CHSs (7.4.1). Some CHSs confirm the findings of the CCIH (Christian Connections for International Health) study (Crespo 2000), that their funds are sometimes taken to support other parts of the church.

Church officials believe that support from overseas churches is more likely to continue when there is an association with an expatriate or a direct link with an overseas church, resulting in

expatriates sometimes being appointed to posts in preference to able national candidates. Whilst some of the thriving Indian CHSs view the decline in overseas' donations as a further step along the road to autonomy and self-reliance, Malawian CHSs and the struggling Indian CHSs rely to a much greater extent on overseas funds for their financial survival, which has necessitated a search for alternative funding sources.

Many CHSs have attempted to replace the decrease in their traditional sources of funding from mission organisations with alternatives as illustrated in the boxes along the top of the figure 8.3. First, as discussed above, CHSs, such as those in PNG, Malawi and many other counties in S-SA seek to replace their declining overseas' funds by closer collaboration with their respective governments, although governments often believe that CHSs receive larger overseas donations than they actually do, resulting in governments underestimating the financial problem faced by many CHSs. However, in the case of Malawi, where the government is unable to provide complete healthcare coverage and relies heavily on CHSs, both it and CHAM are concerned that poorer patients should not be denied access to treatment on the basis of cost. This is the main reason that the government funds the CHSs' staff salaries and has introduced the service agreement initiative (7.3.3). In addition, CHAM introduced a mandatory fees and exemptions policy, although during the research a number of CHS managers expressed anxiety over the financial difficulties they would experience if they introduced the level of exemptions stipulated in the policy.
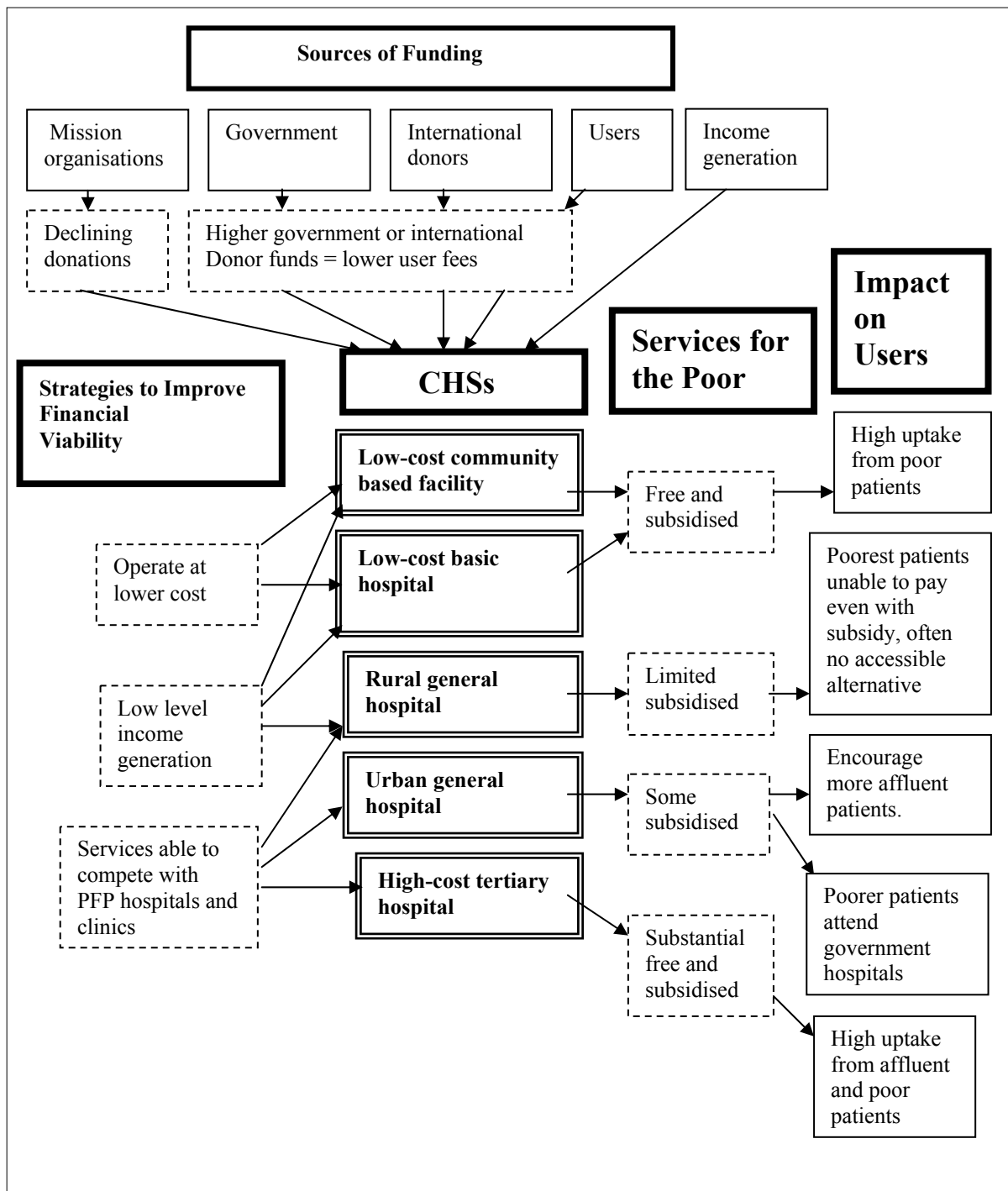
Figure 8.3 Effects of Financial Changes on CHS Services and their Users

Second, some CHSs benefit from funds from international donors, some of which are applied

for as project funds and some channelled through collaborative mechanisms with

governments, such as SWAp programmes. Constraints to greater utilisation of project funds, particularly in India include:-

► The perceived hostility of international donors to supporting faith organisations. UNICEF refuted this by affirming that they would be willing to support appropriate projects from Christian organisations (7.4.2).

► The time and expertise may not be available to prepare project submissions. This is paradoxically most acute for resource poor organisations.

► The project criteria of many donor organisations exclude funding of core activities, which is the area of greatest need for CHSs.

Many CHS managers also fear that funds channelled through the SWAp mechanism are allocated disproportionately to the disadvantage of CHSs (7.3.1 and 7.3.3).

Third, with the exception of a few capital projects in urban areas for which CHSs have successfully raised the start-up costs, income generation tends to be limited to small scale support of low cost facilities, as shown to the left of the figure, because a high proportion of facilities are located in economically deprived areas and past experience has not generally been successful.

Fourth, the general survey identified that in most countries users pay fees for services at CHS facilities and that most CHSs attempt to provide, within the limit of their resources, subsidised services for poorer patients. GHSs in both India and Malawi officially provide free basic services, although facilities have different practices, and patients reported that they are often charged for services which are officially free. All of the CHS facilities researched in India and

Malawi charge fees to patients. In India user fees contribute around 98-99% of all income as there are few other sources. The situation in Malawi varies greatly between 49% in some facilities to as little as 15% in others. This is partly because of government financial support and greater access to international donor funds through collaborative programmes with the government and partly because funds from mission organisations, whilst declining, still contribute a higher proportion of CHSs' total budget in Malawi than in India. It is difficult to be precise about cause and effect: on the one hand it is possible that Malawian CHSs are able to charge lower fees because of the financial support they receive from elsewhere, on the other hand it may also be the case that the financial support is forthcoming because a high proportion of patients are too poor to pay the level of fees that would be required to maintain the financial viability of many CHS facilities. The approaches of different types of CHS facilities to fee subsidies and the effects on their users is illustrated in the two columns of boxes on the right of figure 8.3, and is discussed later in this section.

Two further financial strategies have been employed by CHSs to improve their financial viability, that are illustrated on the left side of figure 8.3: The first is to operate low cost facilities through (a) concentrating on small community based dispensaries or basic hospital services, which exclude expensive diagnostic investigations and treatments, and (b) relying on committed Christian staff such as religious sisters, to work for a basic allowance, or, in the case of staff at the Christian Fellowship Hospital, for a much reduced salary. The second strategy adopted, which is almost the opposite of the first, is to provide hi-tech and high quality tertiary services, that are able to compete with Private For-Profit services, from which a profit is generated which is used to fund subsidised services for the poor. For example, in

two Protestant hospitals researched in India, there was a high level of Christian commitment which motivated them to allocate 30% of their budgets to provide services for the poor.

One of the accusations levelled at some CHSs in recent years has been that they are losing sight of their mission to serve the poor, either because financial difficulties drive them into providing hi-tech, secondary and tertiary services to those who can afford to pay in order to make a profit or because they find these sort of services more congenial to provide and have lost their idealism. The research attempted to provide an objective assessment of whether or not this is the case. In addition to examining the type of services provided, sources of funding and charging policies, it paid a lot of attention to assessing the impact of these financial changes on the users and assembling a socio-economic profile of patients served.

The research undertaken confirms that many poor patients are denied treatment in CHS facilities because of their inability to pay (7.5). Health workers, patients, community members and officials of development organisations in Malawi and India recall a time when 'mission' hospitals and clinics gave priority to services for poor patients, either free of charge or for a token payment. There is currently a common perception that the 'rich', particularly in India, attend corporate hospitals, the 'middle class' attend CHS hospitals and the poor attend free GHS hospitals. However, this is an oversimplification, first, because more affluent patients often travel out of an area to attend a CHS facility either for specialist treatment, or because of the facility's reputation for high standards. Poor patients do not have such a choice: there is frequently only one provider in economically deprived areas, and poor people cannot travel to another area because they cannot afford either the cost of travel or to take the time away from home or work. Poor patients are most likely to choose the local hospital subject to its

provision of free treatment. In India this is almost invariably a government facility (although many poor patients also use low-cost private providers), whilst in Malawi it may either be a government or a CHS facility, and there is evidence that poor people will choose a CHS facility providing free treatment over a government facility because of the perceived better quality of the services provided by CHS facilities.

The Catholic CHSs are generally recognised as having a stronger commitment to the poor than Protestant CHS, particularly in India, although there are some exceptions, such as CMC-Vellore and CFH. Two factors distinguish these facilities from the majority of Protestant facilities: first, they operate outside of diocesan structures and so can exercise a high level of autonomy, and second, the high level of Christian commitment of their staff is evidenced by their acceptance of salaries much lower than the market rate, and their benevolent support of poor and marginalised people both within the hospital and through their outreach programmes.

The reasons for the continued existence of CHSs were explored in the research. Interviewees in Malawi and India identified seven principal reasons for the continued existence of CHSs (7.6):-

► Governments are not able serve all communities, particularly in rural areas, where CHSs have the support of their church infrastructure and networks. This is recognised especially by the Malawian government, which supports CHSs to provide services in areas underserved by GHSs.

► CHSs are believed to provide a higher level of compassionate care and treating everyone with dignity, associated with their Christian commitment.

►   Many patients appreciate the spiritual ethos of Christian facilities.

►   Patients feel a greater confidence in the integrity of CHS staff to provide appropriate advice and treatment, than in either GHS or PFP facilities. Patients cite examples of not receiving necessary treatment in GHS facilities and receiving unnecessary, and often expensive, treatment in PFP facilities because of their profit motivation.

►   CHSs provide a higher quality of service and the attitude of staff is generally more polite and helpful than in GHSs. A contributory factor is that GHS facilities are usually much busier than CHS facilities.

►   Patients report that they are not discriminated against either on the grounds of their poverty, which they often experience in government facilities, or their religion.

►   CHS facilities, particularly those operated by religious sisters, are generally recognised for their commitment to serving the poor and not turning patients away.

The effect of the changes in sources of funding on the volume of services operated varies. As illustrated in section 8.2, the services provided by CHSs in many developing countries continue to be substantial, although quantitative assessment of their contribution are frequently dependent on figures supplied by CHAs themselves, which suffer from, not just the usual difficulty of defining what is being counted, but also distinguishing between actual CHS facilities and CHS membership of CHAs. CHAs in different countries report both increases and decreases in the number of facilities since national independence, due mainly to transfers between CHSs and GHSs (sometimes forced) and vice versa, but also to closures resulting from financial difficulties, competition from the private sector, the impact of user fees and redundancy because of GHS provision.

Comparison of figures provided by CHAM, CHAI and CMAI highlight some significant

trends. Both the number of CHS facilities operating and the number registered with CHAM

and CHAI have significantly increased, while the number of Protestant institutions and staff

members who are registered with CMAI have dramatically reduced and many of the

remaining institutions are under threat of closure (6.3.3). The principal reasons for these

different trends include support of CHSs by the Malawian government in recognition that

there is generally no alternative health service provision in areas served by CHSs, and in the

case of the Indian Catholic CHSs a combination of their concentration on low cost community

health facilities and the continued operation of the majority of the facilities by religious

sisters, who are outside church control, have a high service commitment, and are only paid a

modest living allowance. On the other hand, the decrease in Indian Protestant CHSs is

attributed to a decline in the number of health professionals committed to working in CHSs;

the adverse impact of church politics on the operation of CHS hospitals, as discussed in

6.4.2.1, because of their attraction as a potential source of income to the church; and

ineffective management of CHS facilities. However, CFH and CMC-Vellore, both Protestant

hospitals, are exceptions.

The research, therefore, revealed that CHSs have in many countries at various times been

undermined by government policy (especially nationalisation), competition from other

providers, a decline in their traditional funding sources and difficulty in recruiting and

retaining suitable staff. These have resulted in the closure of facilities and the failure of

coordinating organisations to develop effective ways of working. However, not only have

governments in some places and over time become more supportive, but also some CHSs

have managed to continue and flourish, establishing excellent reputations for the services they

provide and developing a sustainable financial base for their work, often by adapting their operations and finding alternative sources of funding. While many CHSs and individual facilities admitted that they face considerable difficulties and are pessimistic about their future survival, they clearly continue to play an important role, especially in the poorest countries, and many believe that they can and will continue to operate.

8.6 General Conclusions

As noted at the beginning of this chapter, the starting point of this research was a desire to identify and investigate in depth the changes that commentators and earlier studies had asserted are affecting CHSs in developing countries, leading more often than not to a decline in the scale, scope and importance of CHSs in many countries; concentration on types of provision more concerned with secondary and tertiary level services than primary health care; abandonment of poor users (especially in rural areas) in favour of people able to pay for good quality hi-tech services (mainly in urban areas); and poor relationships with their respective governments because of continued tensions over healthcare priorities, foreign mission control and nationalisation. The evidence available at the outset, although patchy, indicated that the main explanatory factor for the changes that CHSs have experienced and instigated was changes in the funding base. The research set out to investigate the nature of CHSs, the prevalence of the anticipated changes in ways of operating and user characteristics, and whether or not these can be explained primarily by changes in their funding.

This research confirmed that not only have funds received by CHSs from mission organisations declined, but they are increasingly provided in the form of project grants with a development focus rather than core operational funding. As there was no evidence during the

investigation of these development funds being used for proselytisation, this change would tend to put these mission organisations between the persuasive and the active categories in Clarke's (2008) taxonomy discussed in section 4.5.1. The reduction in funding has occurred for two main reasons: first, because of declining congregations attending the churches in the UK and elsewhere that had been major funders of overseas missions, and second, competition from NGOs, including faith-based NGOs, for funds. The result has been to prompt mission organisations to present their requests for funds in a form most likely to attract popular support, often for particular projects. The change to project funding would seem to run counter to the trend to devolve decision making, including over funding priorities, to autonomous national churches and also places mission organisations in the position of brokering the potentially competing preferences of donors and recipients.

A parallel trend has been the reduction, and in some cases complete extrication, of mission organisations from responsibility for the CHS facilities they have bequeathed. However, church autonomy has not been accompanied by national churches adopting financial responsibility for the CHSs they inherited because, they argue, they too are short of funds. Furthermore, the CHSs investigated reported that not only had they not received any financial support from their respective national churches, but also of the funds received by their parent churches from overseas, only those designated specifically for health services are allocated to them. The anxieties of some donors about funds intended for development being used by faith based organisations for evangelistic purposes was discussed in section 4.5.1. Although there was no evidence from the current research that this was occurring, at least not directly, some CHS respondents reported that they had been directed by their church organisation to use

funds intended by the donor for provision of health services to support other parts of the church.

As illustrated in figure 8.3, CHSs have responded to the challenge of declining funds from overseas church partners in three major ways: First, by operating inexpensive services through PHC or at low-cost facilities, which typically is an option proving successful in facilities operated by religious sisters, because of their high service commitment and low remuneration; Second, by operating hi-tech services in urban areas, the fees from which provide a profit to subsidise services for poor patients; Third, by working in partnership with, and receiving funds from, the government to provide agreed services in defined catchment areas. Some CHSs supplement these sources with limited funds from income generation activities and project funding from international donors.

This research has shown that the health sector reform movement encouraged by international development and financial organisation presents opportunities for governments and NSPs to work together. Experience in Malawi and India indicate that prerequisites for success are that national governments involve stakeholders in developing, implementing and monitoring a clear plan, and that all parties are willing to cooperate with each other. These prerequisites are more often present in Malawi than in India.

The arguments for releasing governments from total health provision in favour of the greater involvement of NSPs have been the topics of previous research and were discussed in section 3.4.2.2. Previous findings include assertions about their greater managerial efficiency, flexibility, cheaper cost (Rosenbaum 2006), ability to reach the poor (Lewis 2001) and

complementarity with government services (Salaman and Anheier 1999, Bennett 1992, Mallya 2007). The current research found differences between CHSs on the issues of managerial efficiency and flexibility: those CHS facilities under close diocesan control were seen to be little different from GHS facilities except that they operated under a different bureaucracy. On the other hand, those facilities that were able to operate relatively autonomously have been free to develop appropriate approaches to meet the specific challenges which confronted them. No figures were available from GHSs to make any comparison of costs.

On the issue of complementarity, it is clear that in Malawi both the government and CHSs have recognised the benefits of operating in different areas from each other, recognising each other's catchment areas, having joint referral systems, and providing clinical support to each other's lower level facilities. There is also recognition that CHSs have the infrastructure to provide services to people in poorer, remote and marginalised communities. The opposite is the case in India, where GHS and CHSs for the most part seem to operate services independently with little intercommunication between them, resulting in duplication of services in some areas and gaps in others.

Two difficulties identified in previous studies of NSPs are those of coordination and regulation. Gilson (1994) suggested that improved coordination of NGOs could be established through the formation of national umbrella groups. Generally CHSs have resisted participation in these wider groups in favour of their own more specific CHAs. This research has demonstrated that stronger relationships develop between CHSs and governments when the CHA represents all denominations and is able to carry out particular responsibilities of

benefit to both the government and CHSs. These include: speaking with one voice, coordination of the work of CHSs, negotiation between the members of a CHA and the government, and implementation of its own and government policies. Positive relationships between CHAs and governments are enhanced when CHSs provide a substantial proportion of health services. In addition, under these circumstances, governments are more likely to support CHSs financially and in other ways. The absence of a unified CHA at national level and positive CHA-government relationships does not preclude the development of local relationships and local cooperation independent of the situation at national level.

Previous studies have illustrated the difficulties for governments in regulating NSPs (Moran and Batley 2004, Palmer 2006), as discussed in section 3.4.2.2. The current investigation in both countries confirms the assertion by Moran and Batley (2004) that the enforcement of government regulations by medical councils (and by implication other professional councils) is ineffective. Experience in Malawi adds weight to the assertions by Gilson et al. (1994) and Palmer (2006) that regulation is more likely to be effective when it is accompanied by incentives. The provision of salary payments and service agreement funding provide powerful incentives for CHSs to cooperate with government policies and adhere to government regulatory requirements. The experience of service agreements in Malawi also provides some useful lessons to be borne in mind by CHSs in other countries. The closer relationship with government implied by a sub-contracting arrangement is not without its hazards: for example, Brinkerhoff (2002) pointed out the risk of co-optation by which an organisation can be subsumed by a more dominant organisation, with a loss of the former's separate identity and the specific attributes it brings to the partnership. CHAM officials expressed their recognition of this risk and their intention of maintaining their autonomy.

As discussed in section 3.4.2.1, previous research has suggested that opportunities to improve efficiency and intersectorial collaboration are among the benefits brought by decentralised government (Green 2007, Collins 1994). However other research has pointed to problems of local managerial incapacity, which can exacerbate inequity between districts (World Bank 2004). This is seen as a problem in Malawi because of the inexperience of DHOs (district health officers) and systems that are not fully developed. The Malawian experience also indicates that local intra-sectorial cooperation can be encouraged by the formulation of joint programmes, such as the SWAp (sector wide approach), although local implementation needs to be externally monitored.

Another major element of HSR is the search for alternative sources of funding for health services, particularly those that rely on individual contributions such as user fees and health insurance, as discussed in section 3.4.2.3. Previous studies identified two main rationales for such an approach. The first is the reduction of public expenditure (Collins et al. 1999). However, in both India and Malawi, although not in all of the other countries studied, GHSs provide services free of charge, requiring government funds to remain financially sustainable. Thus the use of CHSs as a means of reducing public expenditure will only be realised if CHSs are more cost effective than GHSs or if they can attract overseas funds which may not be available to GHSs. The second rationale for permitting health facilities to raise part of their own revenue is to provide funds for health facilities to improve services, as recommended by the Bamako Initiative (World Bank 1993). However, previous studies by Green (2007) and Bennett and Gilson (2001) identified the difficulty of raising funds locally due to high poverty levels and low levels of participation in the formal labour market.

The current research identified major differences between CHS facilities located in economically poor areas, particularly in Malawi, at which local people are only able to pay very modest fees, if anything at all, and hi-tech tertiary hospitals in major urban centres, particularly in India, at which more affluent patients are able to pay substantial fees, which can be used to contribute to the improvement of services for both fee-paying and poorer patients.

There is a belief amongst most respondents in this research that when CHSs were first established, they gave priority to the poor and marginalised by providing them with free or highly subsidised services. Currently, poorer patients are attracted to some CHS facilities because they continue to receive free or subsidised services, but are deterred from using others because they are unable to afford the higher charges that are now made. This finding concurs with that of other studies (Green 2007, Turshen 1999, Mills et al. 2001, Bennett and Gilson 2001) referred to in section 3.4.2.3 that user fees disadvantage the poor. Although some CHSs seem to have abandoned serving the poor as their prime mission, the majority retain this commitment, although the extent to which they have been able to achieve it in difficult financial circumstances varies.

It is clear that, as proposed in the hypothesis, the main driver for CHSs changing their relationship with governments, the nature of their service and in consequence their users has been the need to seek alternative sources of finance, as their traditional sources have declined. However, other factors have had, and continue to have, an important influence. These include the continued concern of CHSs with values such as compassion, justice, and quality; CHSs' willingness to work constructively with other CHSs and governments; the epidemiological,

demographic and technological developments that are urging all health services to embrace change; and the political and economic pressures on governments to enlist the assistance of non-state providers in national healthcare provision. The relative importance of CHSs varies in different countries. In those countries in which CHSs make a substantial contribution to the sector, particularly in areas not served by the government, failure of CHSs would result in loss of an essential service to communities, which governments in many situations would have difficulty in replacing. However, there is also a difficult tension in maintaining the Christian ethos that users value, the commitment of church organisations to support their CHSs, and allowing CHSs the autonomy to manage their facilities in a way that enables them to adapt to changed circumstances.

8.7 Reflection

It is probable that the initiatives promoted by international organisations to improve on the poor performance of health sectors in low income countries and improve the health status of their poorest populations will present challenges to CHSs as well as governments in those countries. Combined with the continued decline in CHSs' traditional sources of finance, these challenges also present CHSs and other FBOs with opportunities.

The search for alternative sources of funding is shared by governments and CHSs. For governments this is regarded as necessary in order to reduce public expenditure and is seen as a component of HSR, while CHSs need to replace reduced funding from their traditional mission partners (6.4.1.3, 7.4.1). Some urban CHS facilities are able to charge user fees similar to those charged by for-profit providers, yielding profits that can be used to subsidise services for poorer patients. However, user fees, insurance schemes and income generation

have limitations in economically deprived communities, which are the communities that CHSs are often better able than GHSs to serve because of their church infrastructure and networks. There is increased interest from international donors in financing the work of FBOs, including CHSs, sometimes in preference to funding governments and secular NGOs (4.5.1-2). CHSs sometimes submit their bids independently and in other circumstances funds are accessed through a government mechanism such as a SWAp. The research suggests that neither of these sources has been fully exploited by CHSs. Sometimes this is due to the lack of support from governments and sometimes due to the reluctance of CHS, because their previous submissions have received a negative response or because of unacceptable conditionality imposed by the donors (7.4.2). However, circumstances change, and previous negative responses are not necessarily an indicator of future response, so this remains an opportunity to be more fully pursued by many CHSs.

The general trend towards government decentralisation of service planning and operational management as part of the HSR movement offers opportunities for CHS managers to develop relationships with local government officials, with the potential for closer cooperation. However, there are two particular threats. First, national policy might not be interpreted and implemented as enthusiastically by regional and district governments. Thus, although national governments may embrace a policy of working with CHSs, this might not be welcomed by local government officials, who can sometimes hinder implementation of national policy (7.3.1). Second, the successful operation of national CHAs may be disturbed by government decentralisation. Some of the functions carried out by CHAs nationally on behalf of their member CHSs might be more appropriately carried out at a lower level (State/province or local, depending on the arrangements in a particular country). These functions include the

regulation and coordination of CHSs' activities, participation in formulating and implementing government policies and plans, and participation in decisions on the allocation of government and donor funds. CHAs in some countries have taken a lead by establishing regional and sub-regional offices and/or designating particular CHS officers to liaise between CHSs and government officers in local areas (7.3.1), although this is not always easy to achieve because of its resource implications. Whether it is appropriate for CHAs in other countries to follow this or similar routes will depend on the nature of decentralisation in each country. In some countries, particularly large countries in which states/provinces have a high level of autonomy on policy, resource allocation and planning, then a State-level CHS organisation may be needed. However, in many countries government decentralisation is tokenistic, and in practice sub-national levels of government have little autonomy and so few resources that would render decentralised CHAs ineffective.

Another component of HSR which is included in the national health strategies of India, Malawi and other study countries is the intention of working with non-state providers. CHSs in many countries have a long history of service provision, but government recognition of and material support for them is variable. Some governments refuse to acknowledge the contribution of all FBOs on ideological grounds or because of concerns about evangelisation. Some value CHSs' contribution and support them in various ways, but others are unable or unwilling to provide a level of support commensurate with their contribution (7.3.2).

There are several benefits for governments to work more closely with CHSs. First, CHS are perceived as being stable and enduring: whilst many NGOs are of relatively recent origin and may operate only as long as their project funding exists, CHSs generally originated from the

mission hospitals and other facilities founded by medical missionaries in the C19th and C20th and are thus well established and committed to long-term service provision (2.4). Second, CHSs not only provide services to people in rural areas where there are generally no alternative providers, but also to poor and marginalised people in urban areas. Third, CHSs are able to draw on the support of churches' infrastructures and networks where those of government agencies are often limited (6.3.1).

In addition to the frequently extolled ability of NGOs to provide better services to hard to reach communities, at lower cost, with greater flexibility and altruistic behaviour (3.4.2.2), this research suggests that the public attribute an additional distinctive ethos to CHS facilities, which includes a spiritual dimension; polite and helpful staff; compassionate care, particularly to patients who may be marginalised in some way; trust and integrity evidenced by patients being given accurate information and offered appropriate treatment; absence of discrimination on religious, racial or socioeconomic grounds and a commitment to treat all patients irrespective of their ability to pay (6.4.3, 7.6). It is these qualities that prompt many patients to choose CHSs, where they exist, in preference to other providers.

Many CHSs also perceive benefits in cooperating more fully with governments including access to much needed resources and an opportunity to influence government policy and planning (7.3). However, the advantage of greater flexibility attributed to CHSs and other NGOs as compared with government organisations can be compromised for those CHSs under direct diocesan control. The research indicated that CHSs not under diocesan control were able to adapt and respond to changed environments in a way that was constrained for their diocesan counterparts (6.4.2.1). In order for CHSs to capitalise on their advantage,

churches need to find ways of maintaining the spiritual and moral ethos of their health facilities, which enables them to provide the distinctive service that is valued by their patients, while avoiding the temptation for church officials to be over-involved in the operational management of CHSs and resisting governments' attempts to co-opt CHSs as an extension of themselves.

A further motivation for governments to enlist the assistance of CHSs and thus an opportunity for CHSs to work more closely with governments is the lack of sufficient progress in achieving the MDGs. Many governments recognise that the major improvements necessary will only come about by improving the standards of health, education, nutrition, housing, water, sanitation and economic status of their poorest and 'hardest to reach' communities. This is accompanied by increased recognition by governments and international development organisations that the means of reaching these communities is often through churches and other FBOs, which play a central role in the lives of these communities. Churches and other FBOs have also played an important advocacy role in achieving increased acceptance by Western governments that sustainable poverty reduction is only achievable by a more equitable approach to international trade and debt resulting in a number of low income countries having their international debt cancelled. However, there is also a need for strengthened political commitment to pro-poor economic growth, redistribution of resources and social protection policies within many of the countries concerned.

The last five years have seen renewed enthusiasm for PHC from both the WCC and WHO (3.4.1), with increased emphasis on PHC as part of an integrated approach to healthcare. This is because perceived threats and misunderstandings amongst health professionals, politicians

and some WCC members resulted in PHC previously not reaching its full potential. The example of some CHSs in utilising their church networks and infrastructures for developing their PHC programmes have lessons for other CHSs. Examples of such initiatives include the recruitment and support of community health volunteers, and extending their programmes beyond the usual health promotion initiatives conducted by most CHSs to address the root causes of ill health by including social, educational and occupational activities in their programmes.

The current research revealed that UK based mission organisations are also increasing their support for PHC initiatives. USPG, for example, has increased its support for PHC from eight to 39 projects and from 24% to 44% of their health budget in just over ten years (6.4.1.6). Because facilities operated by CHSs are generally located in different areas from those operated by GHSs, and frequently in isolated areas where government infrastructure is limited, CHSs are well situated to develop PHC programmes. These initiatives are likely to be attractive not just to their traditional mission partners but also to other international donors, as indicated by UNICEF (7.3.2). The substantial increase in the number of health facilities operated by the Catholic Church in India during the last half-century is largely attributable to its emphasis on small scale rural facilities: over 80% of the facilities are health centres and dispensaries and almost half are dispensaries operated mainly by religious sisters (table 6.2). The CHSs in several of the S-SA countries also have high proportions of small scale facilities and in PNG 589 of 605 facilities are health centres or aid posts. Staff recruitment is one of the difficulties in operating this type of facility and on the assumption that Christian staff are motivated by their religious conviction and that they have the support of their local churches, CHSs perhaps have an advantage over secular providers in operating this type of service.

Some CHSs reported closure of rural facilities because of financial unsustainability or redundancy. In such situations a viable alternative might be to operate from a smaller facility incurring lower costs and from which PHC programmes can be facilitated.

The moral teaching and values of churches, in common with other FBOs can have an important effect on the delivery of healthcare and the receipt of health promotion messages. Churches can have a positive role in encouraging a positive approach among their congregations towards issues such as child immunisation, nutrition, and prevention of malaria, tuberculosis and diarrhoeal diseases. Reference has been made above to qualities such as the altruism, compassion, and preference for the poor, attributed to CHSs. These qualities can be valuable in recruiting community health volunteers and developing PHC.

The impact of churches' doctrines can be critical in some of the more contentious aspects of healthcare, particularly in relation to reproductive health and HIV/AIDS (4.5.1). The intention of governments to reduce family size can be constrained by churches and other FBOs which teach that mechanical methods of birth control are morally wrong. The approach can be arguably even more crucial in attitudes towards families affected by AIDS and the control of HIV infection. Whilst churches often help to overcome the community stigmatisation of people with AIDS, the efforts of governments and health agencies to control infection can be constrained by some churches which prohibit the use of condoms. However, the current research suggested that church doctrine is not always rigorously applied by health workers when they are faced with serious human needs. This situation can create a tension between governments and church authorities and between church authorities and health workers. To avoid this, it is necessary for the appropriate bodies to negotiate a solution which

acknowledges church doctrine and enables the provision of essential services to people requiring them.

CHSs can be perceived as occupying a dual position within a development context. As service providers they possess some characteristics which are also associated with government institutions and as development agencies some characteristics in common with development NGOs. First, CHSs' core activity of diagnosing and treating sick patients at their aid posts, dispensaries, health centres and hospitals has great similarity with the core activity of government health facilities albeit in different locations and with a different ethos (4.5.1). Both GHSs and CHSs conduct community outreach, although for CHSs the level of activity is often dependent on available resources and has a lower level of priority than treating sick patients (6.3.2, 7.3.4.2). In common with GHSs, many CHSs operate nurse training schools and sometimes medical schools (7.3.4.3). Second, in common with GHSs, CHSs are generally part of an established bureaucracy which despite their disadvantages (6.4.2) provide supportive networks and infrastructure as well as increasing their level of stability and permanence. Many CHSs can trace their origins to over a century ago and the majority pre-date the formation of independent government in the countries concerned (4.3, 6.4.2).

On the other hand, although many development NGOs are of relatively recent origin and might only be present in a particular area until a specific project is complete, they have a number of characteristics in common with CHSs:-

► CHSs and many NGOs, particularly those that are faith-based are attributed with an ethos of altruism and compassion (3.4.2.2).

► CHSs and NGOs, particularly grassroots organisations, are often believed to be close to poor and marginalised communities to whom they deliver services (3.4.2.2).

► CHSs and NGOs have a focus on development projects, although the extent of this activity may vary between the two types of organisation. As stated above, CHSs' core activity is providing basic health services, which provides a foundation upon which their development programmes are built, for example, the distribution of anti-malarial bed nets or the training of village birth attendants is usually in the communities in which CHSs are providing basic health services. On the other hand development projects are usually the core activity of development NGOs (3.4.2.2).

► CHSs and NGOs frequently seek funds from external sources including governments and international development agencies. Whilst the latter often favour NGOs over government providers because of the characteristics identified above, CHSs experience two disadvantages. First, international donor agencies are sometimes reluctant to fund FBOs, because of their concern that funds intended for development may be used to finance evangelism activities. Second, the focus of international donors on projects disadvantages CHSs because project activities are usually peripheral to their core activity of treating sick patients for which they are seeking financial support and can result in CHSs distorting their core activities to fit project criteria (4.5.1, 4.5.2).

This dual position of CHSs give them an advantage over development NGOs in dealing with the important issues of accountability, coordination, capacity building and sustainability. Two particular concerns regarding NGO activity is that they are sometimes perceived to lack accountability to the governments of the countries in which they work and the lack of

coordination of their activities either with other NGOs or with governments. The research identified that the work of CHSs is increasingly coordinated by their CHAs and that accountability to governments is improving with the involvement of CHAs in government planning systems and the development of measures such as service agreements. However, this is accompanied by concerns shared by NGOs of ensuring that CHSs retain their independence and do not become arms of governments (4.5.3, 8.4).

Because CHSs are firmly rooted into the communities in which they are located and have the support of church networks and infrastructure they are able to utilise these in developing the capacity of local people (4.5.1). The two examples referred to above illustrate this. First, churches are able to utilise their congregations in distributing anti-malarial bednets, maintain a programme of regular chemical treatment of the nets and encourage their proper use. Second, churches are able to identify suitable members of the community to train as village birth attendants and village health aides and to encourage them in their work. In terms of sustainability, the permanence of CHSs as part of church structures enables them to give continued support to their development programmes by training and supporting community volunteers and the provision of supplies. In addition development programmes generally operate in the communities in which CHS health workers visit as part of their outreach programmes, which enables them to monitor and support development programmes on a regular and long-term basis. The resurgent interest of the WCC, WHO and other international agencies in the further development of PHC suggest that this is an area in which CHSs supported by their CHAs are well placed to play a major role (3.4.1, 4.4).

This reflection has discussed some of the challenges currently faced by CHSs. First, it has

examined how to balance their commitment to serving poor and marginalised communities with a widening gap between the cost of service provision and their traditional sources of income. Second, it has discussed how they might respond to the opportunities presented by government initiatives such as PHC, HSR and achievement of the MDGs whilst maintaining their distinctive Christian ethos, which is appreciated by their patients. Third, it considered whether CHSs should concentrate their energies and resources in those areas where they have the infrastructure and networks to be most effective and withdraw from those where the need is lower or where CHSs are not able to be effective.

8.8 Suggestions for Further Research

This research focused on interviews with a range of respondents in Malawi and India to add a more in-depth investigation to the e-mail responses from CHSs in the 13 countries included in the general survey. Interviews were also conducted with senior officials of 12 UK mission organisations. This enabled a general picture to be constructed of the changes in resource provision from mission organisations, the impact of CHSs' responses to these changes, and the relationships between CHSs and governments, as well as more detailed insights into these in two contrasting country contexts. The conceptual framework proved adequate for the investigation and all of the issues posed were explored, subject to the limitations explained in section 5.4. Areas worthy of further research include:-

► The research conducted in India and Malawi provided useful insights into the contrasting operation of CHSs in two countries. It would be useful to conduct the research in other countries, particularly in S-SA because of the concentration of CHSs in that region, first, to explore the effects of different CHA roles and structures such as the Muslim as well as the Catholic and Protestant Medical Bureaux in Uganda;

second, to further evaluate the impact of different CHA models on health service delivery and relationships with governments; and third, to investigate the forms and outcomes of alternative service agreements.

► Differences between CHSs which operate under diocesan authority and those which do not were explored in the research. However, the interviews were limited at the two Protestant hospitals which were outside of diocesan authority, and no interviews were conducted at Catholic hospitals which were under diocesan authority. Further exploration of these alternative structures may produce additional insights into the implications of different structures of authority and accountability for service provision

APPENDIX 1

REVIEWS OF THE ROLE AND OPERATIONS OF
CHRISTIAN HEALTH SERVICES

1.1 World Council of Churches' Tübingen Consultations

The Tübingen Consultations, commenced in 1963 at the German Institute for Medical

Mission at Tübingen in Germany, sponsored by the WCC (World Council of Churches) and

the Lutheran World Federation because of increasing concern on two issues:-

   a) The serious financial difficulties experienced by CHSs (Christian Health Services).

   b) The widening gap between their healing ministry and the increasingly autonomous

       mission hospitals staffed by health professionals.

The first consultation, which came to be known as Tübingen 1, recommended:-

   a) An extension of the national surveys already initiated by the WCC.

   b) Endorsement of the importance of the church congregation as the primary agent of

       healing and the need to integrate existing health institutions into the life and witness of

       the church.

The second consultation in 1967, Tübingen 2, set out to establish the relationship between

health and salvation, but because it was unable to identify a satisfactory role for church

congregations in the healing process due to the increasing complexity and cost of health

provision, it failed to produce any formal findings or bridge the gap between churches and

medicine (McGilvray 1981).

1.2 World Council of Churches' National Surveys

National surveys of church-related medical programmes were initiated in Nigeria, Uganda

and Kenya at the end of 1963 as the WCC's response to the concerns of national churches

regarding the programmes and institutions they had inherited from the Western missions during their transition to autonomy. The purpose of the surveys was to identify the relevance of CHSs to the work of the churches and the health programmes of the government and other agencies.

During the next four years surveys were conducted in 18 developing countries in Asia and Africa. The results were variable: whilst some produced only a set of statistics, others identified common concerns, such as the inherited concentration of CHSs on hospital and clinic curative services. Concerns raised from the surveys included:-

► Collectively health services reached only 20% of the population, and failed to give the development of public health measures sufficient priority, whilst the other 80% of people, usually the poorest and most needy, were largely deprived of services other than from traditional healers.

► Increasing costs of providing health services, which were leading many institutions to levy user fees, which it was believed further excluded the very poor.

► Lack of planning and coordination of CHSs and their exclusion from government health plans.

► Tendency to serve particular church denominations rather than the general population's health needs.

1.3 WCC Satellite Consultations and the Christian Medical Commission

The WCC satellite consultations were launched in 1967, the first of which was in South India, followed by consultations in Tanzania, Ghana and South Africa. These mainly dealt with theological issues related to of the churches' understanding of healing and bypassed the

practical issues of operating CHSs, except for some consideration in the Ghana consultation

of indigenous healing practices and the formation of a CHA (McGilvray 1981). The WCC

established the CMC-WCC in 1968 because of concerns emerging from the National Surveys

regarding the effectiveness of CHSs. These concerns included:-

►   Increasing technology and costs of providing services.

►   Lack of coordination of CHSs.

►   Recognition that CHSs were not always reaching people with the greatest needs.

►   Inadequate communication with overseas churches and agencies that were potentially

           able to support CHSs by providing resources.

►   Increasing availability of alternative services from governments and secular agencies.

The CMC-WCC was charged with investigating the most appropriate ways for the churches to

fulfil their healing role, and promoting national coordination of church-related medical

programmes (McGilvray 1981, WCC 1990). In 1974 a Joint Standing Committee was

established for the CMC-WCC and WHO to work cooperatively, the major result of which

was the acceptance by the World Health Assembly in 1975 of the principles of PHC.

The view of the CMC-WCC that Christian organisations should aim to benefit the majority of

people by reducing the inequity resulting from Western style medical care and focusing solely

on integrated community health programmes caused a serious rift with the churches, which

were looking for practical solutions to the immediate problems associated with the

management of the health facilities they had inherited. The response of institutions like CMC-

Vellore (Christian Medical College in Vellore), India, was that such a policy would severely

undermine their work because their community programmes were funded from their provision

of high technology care to more affluent patients (Paterson 1993). The CMC-WCC view also ignored the principle that the provision of care at the local level required supervisory and referral support from an integrated health system which includes hospital services (McGilvray 1981). Many churches were less than enthusiastic about introducing innovative PHC programmes because of their commitment to the hospitals and clinics they had inherited from Western missions, which were often viewed as prestige symbols (McGilvray 1981).

The dispute over the promotion of PHC or hospital treatment, which had been constructed as alternatives rather than complementary, was no closer to reconciliation after the regional consultations of pastors, theologians and professionals that were held between 1979 and 1987. After ten consultations held in different parts of the world, the CMC-WCC concluded in 1989 that, despite the increasingly sophisticated and expensive technology involved in diagnosis and treatment, most of the world's health problems would be more effectively dealt with by recognising the social, economic and spiritual causes of disease as well as the biomedical causes, and addressing issues of poverty, violence, lifestyle, community life and disharmony in relationships (WCC 1990). These conclusions were endorsed at the WCC Conference on World Mission and Evangelism in 2005 (WCC 2005).

1.4 Investigation into the Sustainability of Church Hospitals

By 1992 the general economic, political, demographic and medical technological pressures on the health sector had combined with the reductions in government subsidies and overseas aid to seriously threaten the sustainability of many CHSs. By this time many had already closed. The response of the WCC, in 1995, was to commission a further investigation of CHSs

(Asante 1998). 43 church hospitals in nine African and two Asian countries were identified for study, two thirds of which were located in rural areas.

Asante (1998) reported that all of the hospitals studied had religious symbols such as chapels, crosses or Bible verses displayed, indicating their Christian distinctiveness. There were marked differences between those identified as thriving and those 'at risk'. The thriving hospitals were:-

► More effectively managed.

► Less likely to be located in economically deprived areas.

► Provided a better service, resulting in patients travelling a greater distance to seek treatment.

► Attracted and retained better qualified staff, possibly because they were less remote, had a good reputation, good staff accommodation, good schools for staff children to attend, and were able to pay higher salaries, because of their multiple sources of income and more efficient financial systems.

Another important distinction was that, although 3-6% of patients in the thriving hospitals were given fee exemptions (the figure was not available for the at-risk hospitals), many of the poorer patients were given minimum care and then transferred to a government hospital, which prompted a criticism that these Christian institutions had become hospitals for the rich (Asante 1998). Two major omissions of the study are that it failed to carry out further investigation of services for the poor and it excluded services other than hospitals.

1.5 Study of Christian Hospitals by Christian Connections for International Health

In 2000, a further study of Christian Hospitals was funded by the WCC and carried out by

CCIH (Christian Connections for International Health). CCIH was formed in 1987 and

describes itself as a 'forum for Christian agencies and individuals concerned about

international health' (CCIH Website). 80 questionnaires were sent to Christian hospitals

worldwide, of which 42 were returned, and identified the following concerns:-

- ► Lack of clear and shared vision
- ► Inadequately trained administrators and leaders
- ► Church interferes in hospital leadership and administration
- ► Lack of understanding of health determinants
- ► Lack of community ownership
- ► Poor communication between Church and government hospitals
- ► Church does not financially support hospitals but sees them as a source of income
- ► Hospitals operating at a financial loss
- ► Foreign church agencies want to maintain control through funding
- ► Foreign church agencies decrease funding
- ► Expatriates don't share knowledge of international funding connections
- ► Decreasing affordability of health services due to poverty
- ► Competition with, and loss to, other institutions for patients
- ► Lowered government commitment to health care
- ► Cultural conflicts between Western and traditional medicine
- ► Dependence on Western technology which they can't maintain or afford

The study intended to build on previous studies, focusing on the challenges facing Christian

hospitals, and analysing the issues which precipitated the closing of hundreds of these

hospitals in the previous decade (Crespo 2000). Only cursory reference was made to the

previous studies of hospital closures by the Tübingen and CMC-WCC consultations, which

focused principally on the role of CHSs and their relationship with their respective churches

(McGilvray 1981), and the subsequent Asante (1998) investigation, which focused on

sustainability. The CCIH study had a number of limitations, which include its restriction to

hospitals, no indication of whether the hospitals that responded are rural or urban, and failure

to assess the Christian ethos of the respondent hospitals or whether they received any

government support.

1.6 ARHAP (African Religious Health Assets Programme)

Instead of focusing on the problems experienced by CHSs, ARHAP is taking a different approach. Because of the growing health crisis in many parts of the world, particularly as a result of HIV/AIDS, and the paucity of studies on FBOs working in health, ARHAP was established in 2002 at the University of Capetown, as the first stage of a global initiative to establish what religious health assets exist and what faith based initiatives do best. Its approach is to explore those dimensions of FBOs which are harder to identify and generalise about, and consequently are omitted from many studies of religious organisations. These dimensions include their world-views, motivations, commitments, attitudes and strengths, which influence their actions (ARHAP 2006). Despite the ubiquitous nature of religion in many African countries and its significant role in the struggle for health and wellbeing, much of it is hidden from Western view. The mapping exercise in Lesotho and Zambia showed that a great deal of public health activity is carried out by religious entities, although the services provided are not necessarily aligned with the public health systems of their respective governments (ARHAP 2006). ARHAP emphasised that the intention of the programme is to understand and strengthen FBO health assets without undermining the essence of what they have to offer.

APPENDIX 2

SCHEDULE OF UNITED KINGDOM BASED
MISSION ORGANISATIONS INTERVIEWED

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APPENDIX 3

CHRISTIAN HEALTH ASSOCIATIONS & CHRISTIAN HEALTH INSTITUTIONS CONTACTED

AND RESPONSES FROM QUESTIONAIRES

Initial questionnaires were sent by e-mail to CHAs (Christian Health Associations) as they were identified from April 2006 onwards. Several reminders were sent to those that did not respond. For those countries in which the CHAs had still not responded by July 2007, e-mail questionnaires were sent to denominational CHSs from July 2007 and postal questionnaires to CHAs, for whom their addresses were known, from October 2007. Dates of responses are given below.

Not available in the digital version of this thesis

APPENDIX 4

SCHEDULE OF INTERVIEWS IN CHRISTIAN HEALTH ASSOCIATIONS, CHRISTIAN HEALTH SERVICES AND OTHER INSTITUTIONS IN MALAWI

Not available in the digital version of this thesis

APPENDIX 5

SCHEDULE OF PATIENT AND COMMUNITY INTERVIEWS - MALAWI

<u>Southern Region</u>

Southern Region Interviews 17th November – 7th December 2006

	Poverty Categories(*1)				
	Not	**Mild**	**Moderate**	**Very**	**Severe**
St Lukes Hospital (Anglican)					
Outpatients x 6 (M)			4	2	1
x 6 (F)	2		2		2
MCH(*2) Mothers x 6 (F)	1	1	1	1	1
Total Patients	*3*	*1*	*7*	*3*	*4*
Community members x 6 (M)	1		1	2	2
x 6 (F)	1			1	4
Total Community	*2*		*1*	*3*	*6*
Pirimiti Community Hospital (Catholic)					
Outpatients x 6 (M)	1		4	1	
x 6 (F)	3	1	1		1
MCH Mothers x 6 (F)	2		3	1	
Total Patients	*6*	*1*	*8*	*2*	*1*
Community members x 6 (M)	1	2	2		1
x 6 (F)	2	2	1	1	
Total Community	*3*	*4*	*3*	*1*	*1*
Mposa Health Centre (Anglican)					
Outpatients x 6 (M)	1		3		2
x 6 (F)		1	2	1	2
MCH Mothers x 6 (F)	2		4		
Total Patients	*3*	*1*	*9*	*1*	*4*
Community members x 6 (M)	1		5		
x 6 (F)			4	1	1
Total Community	*1*		*9*	*1*	*1*
Southern Region Total Patients	*12*	*3*	*24*	*6*	*9*
Southern Region Total Community	*6*	*4*	*13*	*5*	*8*

Central Region Interviews 8th-22nd December 2006, 27th-29th December 2006 and 2nd – 9th January 2007.

Nkhoma Hospital (Presbyterian)

Outpatients x 6 (M)	1	2	3		
x 6 (F)	1		4	1	
MCH Mothers x 6 (F)			3	2	1
Total Patients	*2*	*2*	*10*	*3*	*1*
Community members x 6 (M)	1		4		1
x 6 (F)				4	2
Total Community	*1*		*4*	*4*	*3*

Francis Palau Community Hospital (Catholic)

Outpatients x 6 (M)	5	1			
x 6 (F)	3	1	1	1	
MCH Mothers x 6 (F)			4	1	1
Total Patients	*8*	*2*	*5*	*2*	*1*
Community members x 6 (M)			4	2	
x 6 (F)			1	2	3
Total Community			*5*	*4*	*3*

Chimwala Health Centre (Presbyterian)

Outpatients x 6 (M)	4	1			1
x 6 (F)	2	1	1	2	
MCH Mothers x 6 (F)	2	2			2
Total Patients	*8*	*4*	*1*	*2*	*3*
Community members x 6 (M)			5	1	
x 6 (F)			6		
Total Community			*11*	*1*	

Total Patients Central Region	*18*	*8*	*16*	*7*	*5*
Total Community Central Region	*1*		*20*	*9*	*6*
Total Patients Both Regions	*30*	*11*	*40*	*13*	*14*
Total Community Both Regions	*7*	*4*	*33*	*14*	*14*

Total Patient and Community Interviews Both Regions 108+72=180

(*1) See appendices 12 and 13 for clarification of poverty categories

(*2)   MCH – maternal and child health, which includes attendance at antenatal, family planning, postnatal or under 5s clinics.

APPENDIX 6

SCHEDULE OF INTERVIEWS IN CHRISTIAN HEALTH ASSOCIATIONS, CHRISTIAN HEALTH SERVICES AND OTHER INSTITUTIONS IN INDIA

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Interview Summary

Community members	*72*	*(See separate schedule)*
Patients	*108*	*(See separate schedule)*
Hospital managers (Christian)	*26*	
College/School of Nursing/Medicine	*8*	
Other health/social workers	*32*	
Volunteer Workers	*2*	
Religious Leaders – Christian	*6*	
Religious Leaders – Hindu/Muslim	*9*	
Key Officers (church)	*7*	
Key Officers (Coordinating Organisations)	*13*	
Key Officers (government)	*4*	
Key Officers (university)	*2*	
Key Officers (development agency)	*6*	
Total Interviews	*295*	

APPENDIX 7

SCHEDULE OF PATIENT AND COMMUNITY INTERVIEWS - INDIA

Church of North India

Interviews 28th February -13th March

	Poverty Categories(*1)				
	Not	Mild	Moderate	Very	Severe
St Stephen's Hospital, Delhi (Urban)					
Outpatients x 6 (M)	5				1
x 6 (F)	4	1			1
MCH(*2) Mothers x 6 (F)	6				
Total Patients	*15*	*1*			*2*
Community members x 6 (M)	3		3		
x 6 (F)	5		1		
Total Community	*8*		*4*		
Sunder Nagri Health Centre, Delhi (Urban)					
Outpatients x 6 (M)	2	1			2
x 6 (F)	1	2	2		2
MCH Mothers x 6 (F)		1	4	1	
Total Patients	*3*	*4*	*6*	*1*	*4*
Community members x 6 (M)	2		2		2
x 6 (F)	1	1		2	2
Total Community	*3*	*1*	*2*	*2*	*4*

Church of South India

Interviews 10th – 18th April 2007

	Not	Mild	Moderate	Very	Severe
Kalyani Hospital, Chenai (Urban)					
Outpatients x 6 (M)	4	2			
x 6 (F)	5				1
MCH Mothers x 6 (F)	6				
Total Patients	*15*	*2*			*1*
Community members x 6 (M)			3		3
x 6 (F)	3				3
Total Community	*3*		*3*		*6*

Ikadu Hospital, Tamil Nadu, (Rural)

Outpatients x 6 (M)	3		3		
x 6 (F)	2		1	3	
MCH Mothers x 6 (F)	4		1	1	
Total Patients	*9*		*5*	*4*	
Community members x 6 (M)	3		3		
x 6 (F)	2	1	2	1	
Total Community	*5*	*1*	*5*	*1*	
Total Patients CNI/CSI	*42*	*7*	*11*	*6*	*6*
Total Community CNI/CSI	*19*	*2*	*14*	*9*	*4*

Catholic Church

Interviews 14th- 24th March 2007

St Theresa's Hospital, Kunoor, (Rural)

Outpatients x 6 (M)	3		3		
x 6 (F)	4				2
MCH Mothers x 6 (F)	5		1		
Total Patients	*12*		*4*		*2*
Community members x 6 (M)			1	3	2
x 6 (F)	1			2	3
Total Community	*1*		*1*	*5*	*5*

St Ignatius Health Centre, Gagillapuram, (Rural)

Outpatients x 6 (M)	3		1	1	1
x 6 (F)	1	2	1	1	1
MCH Mothers x 6 (F)	3	1		1	1
Total Patients	*7*	*3*	*2*	*3*	*3*
Community members x 6 (M)	2		4		
x 6 (F)	1	1	2		2
Total Community	*3*	*1*	*6*		*2*
Total Patients Catholic	*19*	*3*	*6*	*3*	*5*
Total Community Catholic	*4*	*1*	*7*	*5*	*7*
Total Patients All	*61*	*10*	*17*	*9*	*11*
Total Community All	*23*	*3*	*21*	*14*	*11*

Total Patient and Community Interviews All CHSs 108+72=180

 (*1) See appendices 12 and 13 for clarification of poverty categories
(*2) MCH – maternal and child health, which includes attendance at antenatal, family planning, postnatal or under 5s clinics.

APPENDIX 8

TOPIC GUIDE FOR UK BASED MISSION ORGANISATIONS

1. Name of organisation

2. Contact details
Address

Phone

Fax

e-mail

Website

3. Names and positions of persons interviewed

4. Religious orientation of organisation

5. Policies, priorities, mission, values of organisation (documents)
Now

Previously

Reasons for change

6. Social orientation of organisation - is there a priority for any particular social group
(eg poor, able to pay, remote areas, urban settlements, sufferers of particular conditions)
Now

Previously

Reason for change

How is this orientation put into practice

7. Support currently given to overseas church health services
   (countries, type of services, nature of support given – people, finance)

8. Change in support over time
   (countries, type of services, nature of support given – people, finance)
   Recent

   Post-colonial

9. Reasons for changes

10. Reason for supporting overseas church health services
Originally

Now

11. Contact of health service partners overseas and coordinating organisations
(name, position, organisation, address, phone, fax, e-mail)

12. Recorded or published history, annual report.

13. Accountability of overseas church health service to UK body

14. Any religious or ethical issues related to supporting overseas church health service

APPENDIX 9

QUESTIONNAIRE FOR CHRISTIAN HEALTH ASSOCIATIONS

The following questions are designed to provide information about church health services in developing countries. It would be appreciated, if you could give as full an answer as you are able. If you are not able to answer any of the questions, please indicate, if possible giving the reason, and move on to the next question. Completed questionnaires will be treated in confidence and comments will not be attributed to you personally unless you have given permission to do so. The completed questionnaire can be returned by one of the following:

e-mail to

Fax to

Post to

.

………………………………………………………………………………………………

Please enter (x) after any answer you do not wish to be attributed to you

1. Name of your organisation
2. Country in which you operate
3. Name of person completing questionnaire
4. Your position in the organisation

5. How many church health facilities (hospitals, health centres, aid posts and dispensaries) are there in your country and what religious denominations (Catholic, Anglican, etc) are they?

Denomination	Number of Hospitals	Number of Health Centres	Number of Aid Posts	Number of Dispensaries

6. Approximately, what percentage (%) of total health facilities in the country is provided by the churches?

   How has this changed during the last 40 years?

7. Approximately what percentage (%) of church health facilities are provincial or district hospitals?

   How has this changed during the last 40 years?

8. What type of support (financial or other) does the church health services receive from the government for:-

Salaries   yes/no
     comment

Operational running costs   yes/no
     comment

Specific programmes and projects   yes/no
     comment

Drugs   yes/no
     comment

Medical supplies yes/no
     comment

Buildings and equipment maintenance   yes/no
     comment

9. What type of service agreement exists between the church health services and the government?

a) Government pays church health service to provide a full range of services (including outpatients, inpatients, MCH, Primary Health Care) for a designated geographical area.
yes/no
comment

b) Government pays church health service to provide specific services (for example outpatients services, care for leprosy patients).
yes/no
comment

c) Church health services are able to provide whatever services they wish
yes/no
comment

d) Other - Please specify
comment

10. Is it mandatory for church health services to register with the Church Health Association?

11. What is the role of your Church Health Association in terms of:-

Liaison between government and church health services
yes/no
comment

Policy formation and implementation
yes/no
comment

Allocating and accounting of funds
yes/no
comment

12. How are the operating costs of the Church Health Association funded?

13. Please add any other comments about the church health services in your country.

14. If possible, please provide the names and e-mail and/or postal addresses of the national or provincial manager/coordinator of any denominational church health services in your country.

Name	Position	Denomination	Postal and/or e-mail address

Thank you for your assistance
Peter Rookes

APPENDIX 10

QUESTIONNAIRE FOR DENOMINATIONAL
CHRISTIAN HEALTH SERVICES

The following questions are designed to provide information about church health services in developing countries. It would be appreciated, if you could give as full an answer as you are able. If you are not able to answer any of the questions, please indicate, if possible giving the reason, and move on to the next question. Completed questionnaires will be treated in confidence and comments will not be attributed to you personally unless you have given permission to do so. The completed questionnaire can be returned by one of the following:
e-mail to
Fax to
Post to

……………………………………………………………………………………………

Please enter (x) after any answer you
do not wish to be attributed to you

1. Name of your organisation
2. Country in which you operate
3. Name of person completing questionnaire
4. Your position in the organisation

6. How many health facilities does your organisation operate?
       Hospitals
       Health Centres
       Aid Posts or Dispensaries

7. What type of support (financial or other) does your Church health service receive from the government for:-
     Salaries?

     Operational running costs?

     Specific programmes and projects?

     Drugs, medical supplies and maintenance?

8. What type of service agreement, if any, exists between your Church health service and the government?

9. For which services, if any, do patients pay fees?

10. Are fees charged at the full rate or are they subsidised?

If subsidised, what are the criteria for applying the subsidy?

11. How do you deal with patients who cannot afford to pay?

12. If you receive assistance from any UK based organisation, could you state which organisations for:-

Recruitment of expatriate health workers?

Finance?

Is this finance in the form of regular grants, or for specific projects?

Other support?

13. How has this situation changed over the last 40 years?

14. Is your organisation registered with the Christian Health Association?

15. Is it mandatory for church health services to register with the Christian Health Association?

16. What is the role of the Christian Health Association in terms of:-
Liaison between government and church health services?

Policy formation and implementation?

Allocating and accounting of funds?

17. What is the name and e-mail address of the Director or Executive Secretary of the Christian Health Association in your country?

18. Could you briefly state the mission and priorities of your organisation?

19. Does your organisation have a website?

If yes could you give the website address

20. Please add any other comments about the church health services in your country?

Thank you for your assistance
Peter Rookes

APPENDIX 11

TOPIC GUIDE FOR KEY OFFICER INTERVIEWS IN MALAWI AND INDIA

1. Country

2. Name of organisation

3. Names and positions of person(s) interviewed

4. Religious orientation of organisation, if any

5. Support currently given to church health services

Church Health Service

6. Extent of CHS (approx % of total health facilities)

7. Reasons for CHS

8. Policies, priorities, mission, values

9. Social orientation

10. Urban/rural, Hospital/PHC orientation

11. How accessible are services (geographical, social)

12. What type of outreach services are provided

13. Coordination of services (role of church health association)

14. Cooperation between services (church/church)

15. Management and accountability to church

16. Relationship with church
    funding, service agreement, planning

17. Management and accountability to government

18. Relationship with government
    funding, service agreement, planning

19. Other financial support

20. Income generating activities, including user fees

21. Relationship with UK church/mission organisation

22. Standards and quality of service

23. Attitudes of staff and managers

24. Autonomy and innovation

25. Religious and ethical issues

26. Any other comments

APPENDIX 12

TOPIC GUIDE FOR HEALTH FACILITY AND COMMUNITY INTERVIEWS – MALAWI AND INDIA
(Q1-16 everyone, Q17-27 Managers, and others as appropriate)

Factual Details
1. Country
2. Name of Health Facility
3. Religious denomination
4. Location
5. Type of facility
6. Services available
OIC/Administrator/Director - average number of patients
Others – experiences and perceptions of these services

OPD

IP

Antenatal

Deliveries

Family Planning

Child Development

Immunisation

Surgery

Specialist services

Occasional services (eg eye camp)

7. Social orientation of health facility

8. Accessibility of health facility

9. Outreach services

10. Cooperation between this facility and other facilities (referrals, etc)

11. User fees (including which services, exemptions and effects on use of service)

12. Standards and quality of service

13. Attitudes of staff and managers

14. Religious and ethical issues

15. Any other comments

Policy and Management Issues of the CHS
16. Reasons for CHS

17. Policies, priorities, mission, values

18. Urban/rural, Hospital/PHC orientation

19. Management and accountability to church

20. Relationship with church
    funding, service agreement, planning

21. Management and accountability to government

22. Relationship with government, including local government
     funding, service agreement, planning

23. Other financial support

24. Relationship with UK church/mission organisation

25. Autonomy and innovation

26. Other Comments

APPENDIX 13

POVERTY MATRIX - RURAL

Indicator	Not Poor	Moderately Poor	Severely Poor
Dependency Ratio	Two dependents:One non dependent	Three dependents:One non dependent	Four dependents:One non dependent, or all dependent
Children in Primary School	All children in school	Some, but not all children in school	no children in school
Adult Literacy	All adults literate	1 adult literate	no adults literate
Food	3 meals a day and 1 protein per day	2 meals a day and 2 protein per week	1 meal per day and no protein
Home	Owns well maintained permanent house made of concrete or commercial brick	Rented permanent house, or owns house needing repair, or homemade brick house	Bush house or mud house
Occupation	Regular Government, Business, Church or sells cashcrop to dealer	Irregular or seasonal worker or sells produce in local market	Subsistence gardener/farmer or below subsistence
Assets	Mattresses,table,chairs,garden tools, gas stove	Few garden tools, cooking utensils, kerosene stove	Kitchen utensils only, cook on open fire

Notes
1.The matrix was initially agreed for use in Malawi. It was modified for use in India by agreeing alternative criteria for some of the categories.
2. Primary School attendance was eliminated from the assessment because so few children were reported as not attending school which is free in both countries
3. It was necessary for respondents to meet 4 of the remaining 6 indicators to be placed in the appropriate poverty level.
4. Respondents assessed with an equal number of indicators from two poverty levels are placed in an intermediate category of mildly poor or very poor (section 5.5.5.3)

APPENDIX 14

POVERTY MATRIX - URBAN

Indicator	Not Poor	Moderately Poor	Severely Poor
Dependency Ratio	Two dependents:One non dependent	Three dependents:One non dependent	Four dependents:One non dependent, or all dependent
Children in Primary School	All children in school	Some, but not all children in school	no children in school
Adult Literacy	All adults literate	One adult literate	no adults literate
Food	3 meals a day and 1 protein per day	2 meals a day and 2 protein per week	1 meal per day and no protein
Home	Owns or rents permanent cement or brick house with 3 or more rooms	Rents part of a permanent house,with 2 rooms	Lives in shanty or other non-permanent home
Occupation	Regular Government, Business, Church, etc	Irregular or seasonal worker	No paid employment
Assets	Raio, TV, own water tap, phone, electricity, bed, furniture, electric or gas stove	Mattress, radio, gas or kerosene stove, metal cooking utensils, standpipe water	Clay cooking pots or need to borrow, cook on wood fire

Notes
1.The matrix was initially agreed for use in Malawi. It was modified for use in India by agreeing alternative criteria for some of the categories.
2. Primary School attendance was eliminated from the assessment because so few children were reported as not attending school which is free in both ountries
3. It was necessary for respondents to meet 4 of the remaining 6 indicators to be placed in the appropriate poverty level.
4. Respondents assessed with an equal number of indicators from two poverty levels are placed in an intermediate category of mildly poor or very poor (section 5.5.5.3)

APPENDIX 15

THEMES FROM VALUES' STATEMENTS OF UK MISSION ORGANISATIONS

The names in brackets indicate the mission organisations which mentioned each particular point, or a similar point. A key to the acronyms is at the end of this list.

a) Spiritual

Spreading the Good News of the Gospel (or Jesus Christ) (BMS, CMS, EMMS, Methodist, MMS, PMS, USPG).

Worshipping the Triune God (CWM, USPG).

Learning from each other the true meaning of life in Christ (CMS, CWM, PMS).

Prayer (CMS, CWM, EMMS, PWM).

Proclaiming God's love (CMS, Columban, PMS).

Transformative work of the Holy Spirit (CMS, CWM).

Spiritual development (Methodist, USPG).

b) Engagement and Partnerships

Encouraging development of partnerships with, and between, like-minded organisations (EMMS, Methodist).

Encouraging best possible practice with partner organisations, using resources and facilities appropriate to their location and situation (EMMS).

Deepening our fellowship, partnership and engagement with the world church and ecumenical community (CWM).

Engaging Christians from grassroots in offerings of prayer, insight and expertise (PWM).

Spiritual, practical and material support for faith communities, enabling them to become self-sufficient (PMS).

Go to peoples of different cultures where human needs are greatest (Columban, MMS).

Becoming friends with people of different cultures and faiths (Methodist).

Strengthening our unity amidst diversity, upholding the values of mutuality, equality, respect, power-sharing in just ways (CWM).

Responding with openness and consideration to the requests of the Christian faithful worldwide (PMS).

Giving time, expertise and money amongst like-minded individuals and organisations (EMMS).

Caring for individual people and communities (Methodist).

Improving the quality of life (BMS).

Social Development (Columban, Methodist).

Being alongside the poor and marginalised (Columban, Methodist)

c) Advocacy

Working for reconciliation, justice and peace (BMS, CWM, Methodist, MMM, USPG).

Supporting those who struggle for their basic human rights (Columban).

Taking responsibility for the earth and all creation. (CWM, Methodist).

d) Healthcare

Promoting the worldwide development of sustainable, holistic healthcare (EMMS, MMM, MMS).

Identifying and supporting indigenous leaders of developing healthcare systems who share our vision (EMMS).

Enabling processes to be adapted and applied through carefully chosen partners, as a result of learning from the experiences gained from past and current healthcare projects (EMMS).

Serving the basic health needs of the poor (Columban).

Key

BMS - BMS World Mission (previously the Baptist Missionary Society)

CMS - Church Mission Society

Columban - Columban Mission Sisters

CWM - Council for World Mission

EMMS - EMMS International (previously known as Edinburgh Medical Missionary Society)

Malawi Link - Birmingham Diocese Malawi Link

Methodist - Methodist World Church Office (previously Methodist Missionary Society)

MMM - Medical Missionaries of Mary

MMS - Medical Mission Sisters

PMS - Pontifical Mission Societies

PWM - Partnership for World Mission

USPG – USPG:Anglicans in World Mission (previously known as United Society for Propagation of the Gospel)

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