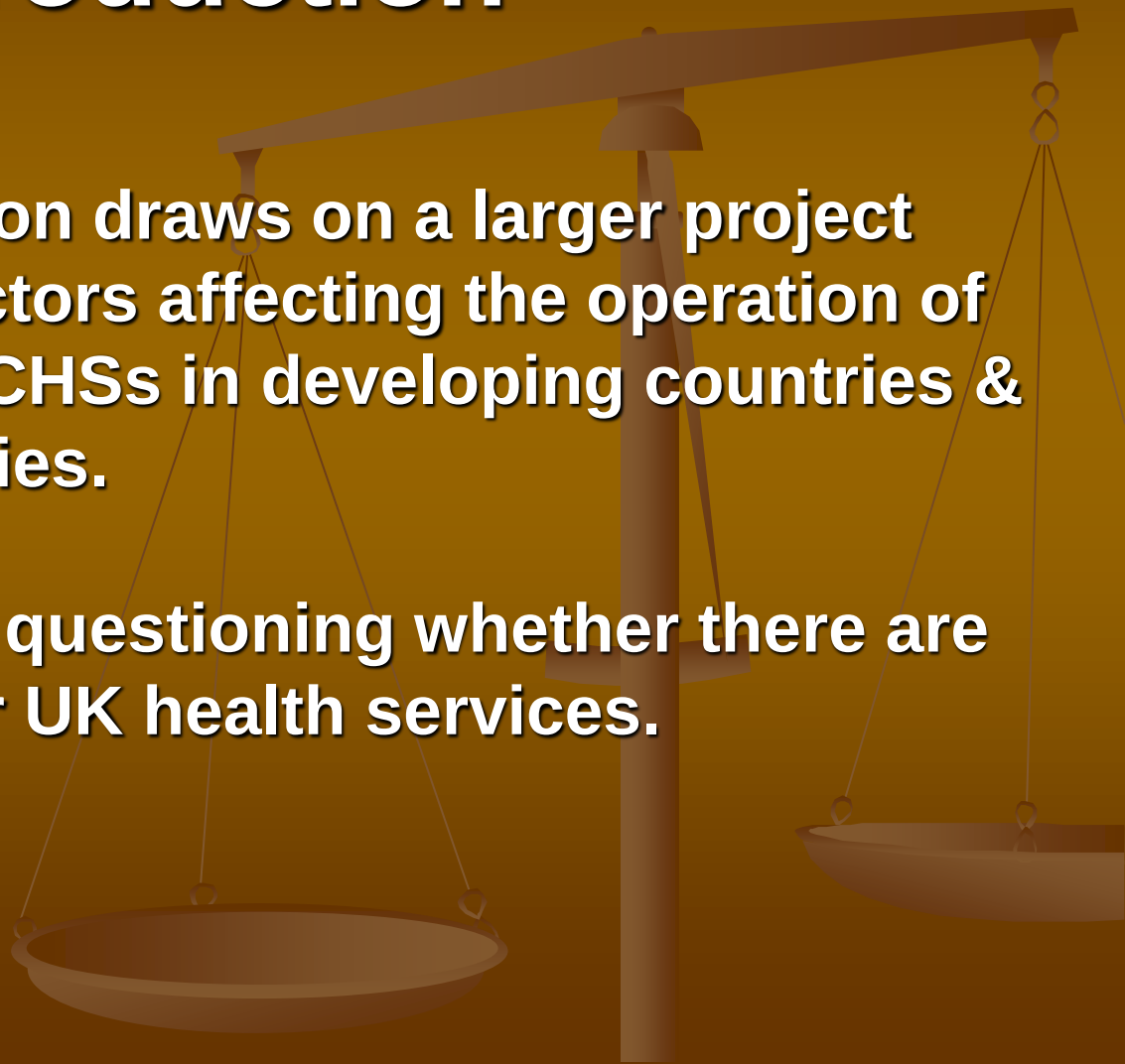
Christian Health Services in Developing Countries – Are there any lessons for us?

Dr. Peter Rookes PhD. MPH. DHSA. FETC. RCNT. RGN. RNMH

Mrs Jean Rookes MA. BEd. BSc.

Contents

3. Introduction



This presentation draws on a larger project researching factors affecting the operation of contemporary CHSs in developing countries & their beneficiaries.

It continues by questioning whether there are any lessons for UK health services.

4. Health Sector underperformance in developing countries

LEB – 75.7 HHD, 47.9 LHD
IMR – 13:1000 HHD, 108:1000 LHD

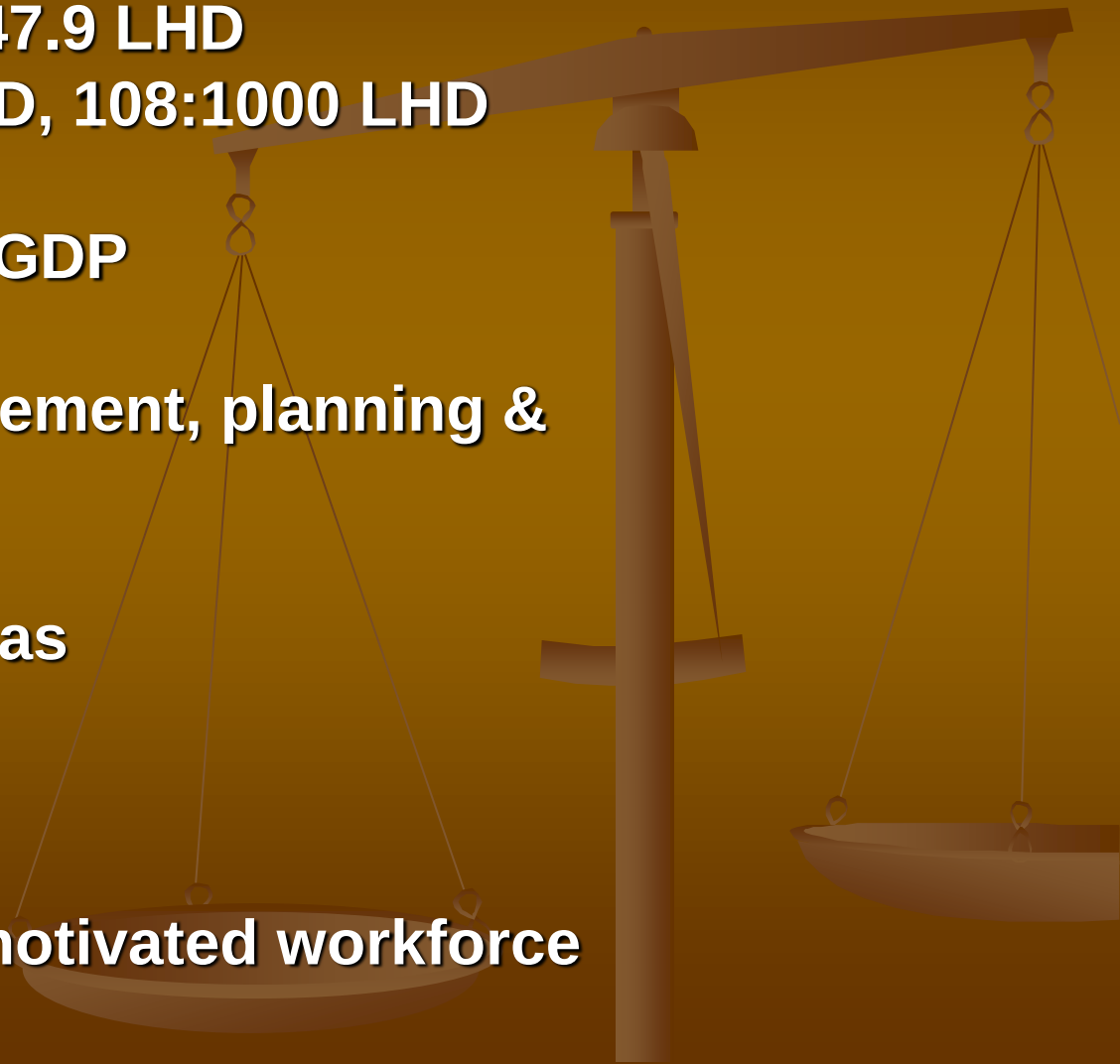
Health - Lower % GDP

Ineffective management, planning & accountability

Urban, curative bias

Inverse care law

Inadequate & Demotivated workforce



5. History of CHSs

CHSs established by Christian missionaries in colonised countries particularly in poor rural areas

Often pre-dated government and other non-state health services

At independence some nationalised or integrated into government service by post-colonial governments.

Others still provide significant proportion of services in many countries, particularly in rural areas.

6. Current extent of CHSs

Uganda and Papua New Guinea – 50%
Tanzania – 48%

Zimbabwe – 45%
Lesotho, Ghana & Kenya – 40%
Malawi - 35%

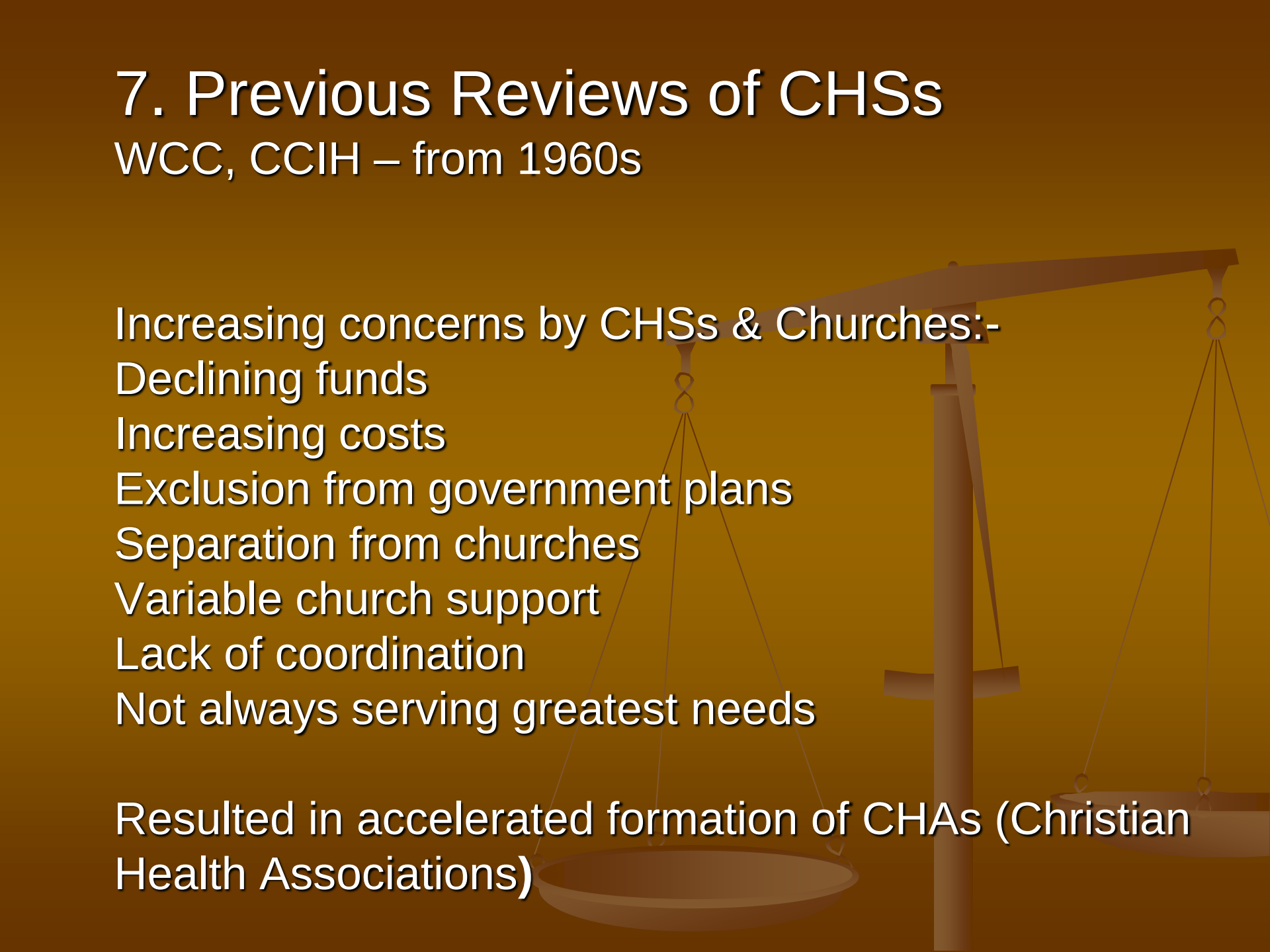
Zambia – 30%

% varies depending on beds or facilities -

Disregards community services

7. Previous Reviews of CHSs

WCC, CCIH – from 1960s



Increasing concerns by CHSs & Churches:-
Declining funds
Increasing costs
Exclusion from government plans
Separation from churches
Variable church support
Lack of coordination
Not always serving greatest needs

Resulted in accelerated formation of CHAs (Christian Health Associations)

8. Our Research

- Data by e-mail from 13 countries – S.Asia, Sub-Saharan Africa & Pacific
- Interviews with 12 UK Mission Orgnstns
- 570 Interviews Malawi & India:-

  CHS managers, staff, patients – 16 HFs

  community members – 12 communities

  church, govrnmt, devlpmnt org officials

  - 20 Interviews Kenya & Uganda

9. Denominations Researched

- Malawi

Catholic, Presbyterian, Anglican

- India

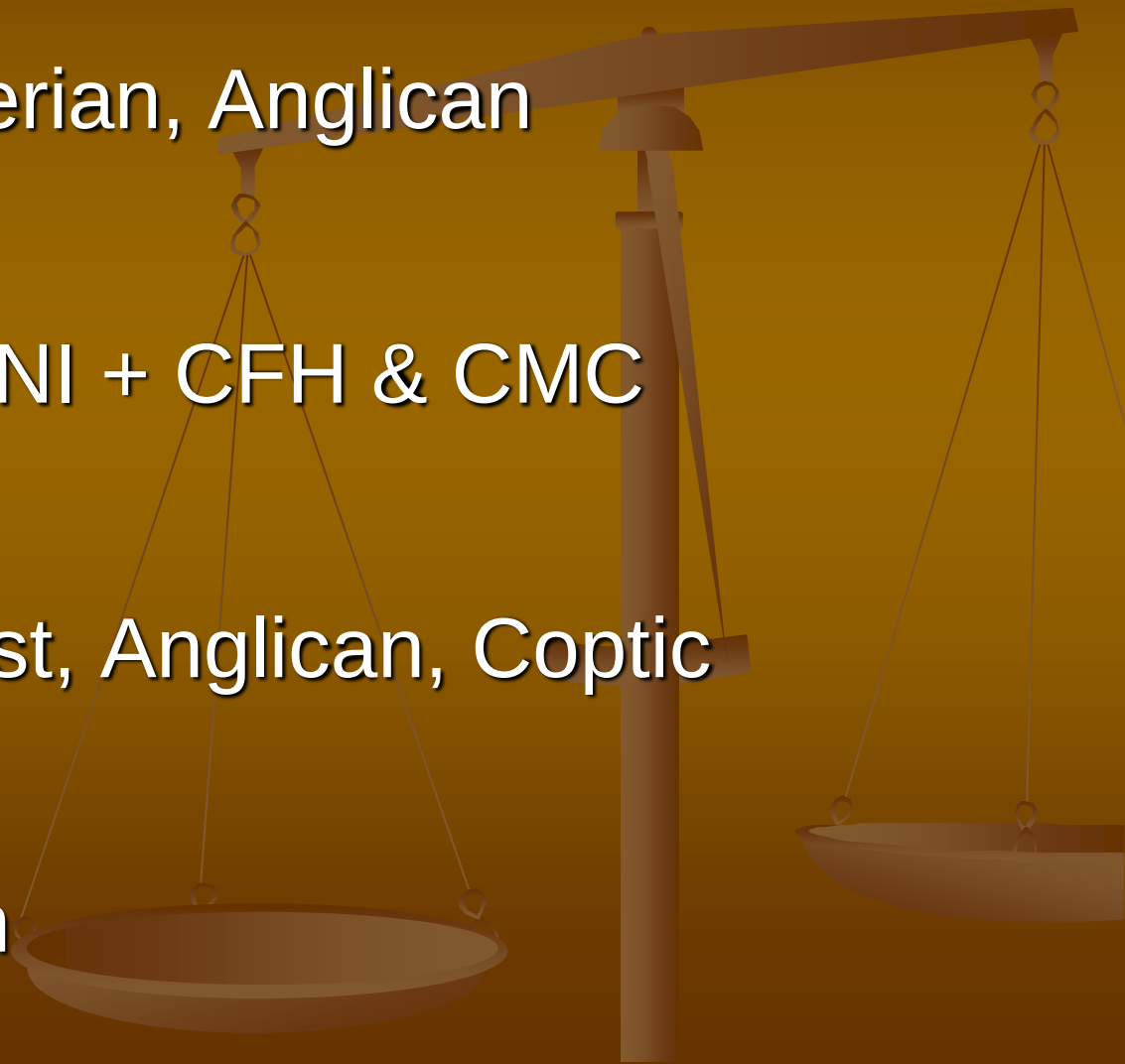
Catholic, CSI & CNI + CFH & CMC

- Kenya

Catholic, Methodist, Anglican, Coptic

- Uganda

Catholic, Anglican



10. Types of CHS Services

Specialist & General Hospitals

Health Centres

Aid Posts/Dispensaries

Community Outreach

Congregational services

Natural Medicine in some areas

Catholics – higher proportion smaller facilities operated by Religious Sisters

11. Nature of Service Provision

- Range of Services similar in CHSs & GHSs
- Patients' relatives contribute to basic care
- Meals provided in larger hospitals, but often provided by relatives in smaller facilities
- CHSs benefit from congregational involvement
- CHS often distinctive because of name, religious artefacts & devotions.

12. Christian Health Associations

Coordinate denominational CHSs
Conduit between government and CHSs

Vary between different countries:-

Ghana - CHAG, Malawi - CHAM, Nigeria - CHAN
Able to represent all CHSs and speak with one voice

Kenya – Protestant CHAK, Catholic KEC,
Uganda – Protestant, Catholic & Muslim Medical Brx
India – Protestant CMAI & Catholic CHAI
Greater difficulty in achieving common view

13. Funding Difficulties of CHSs

Declining funds from partner churches – more project oriented

Loss of contact with donors.

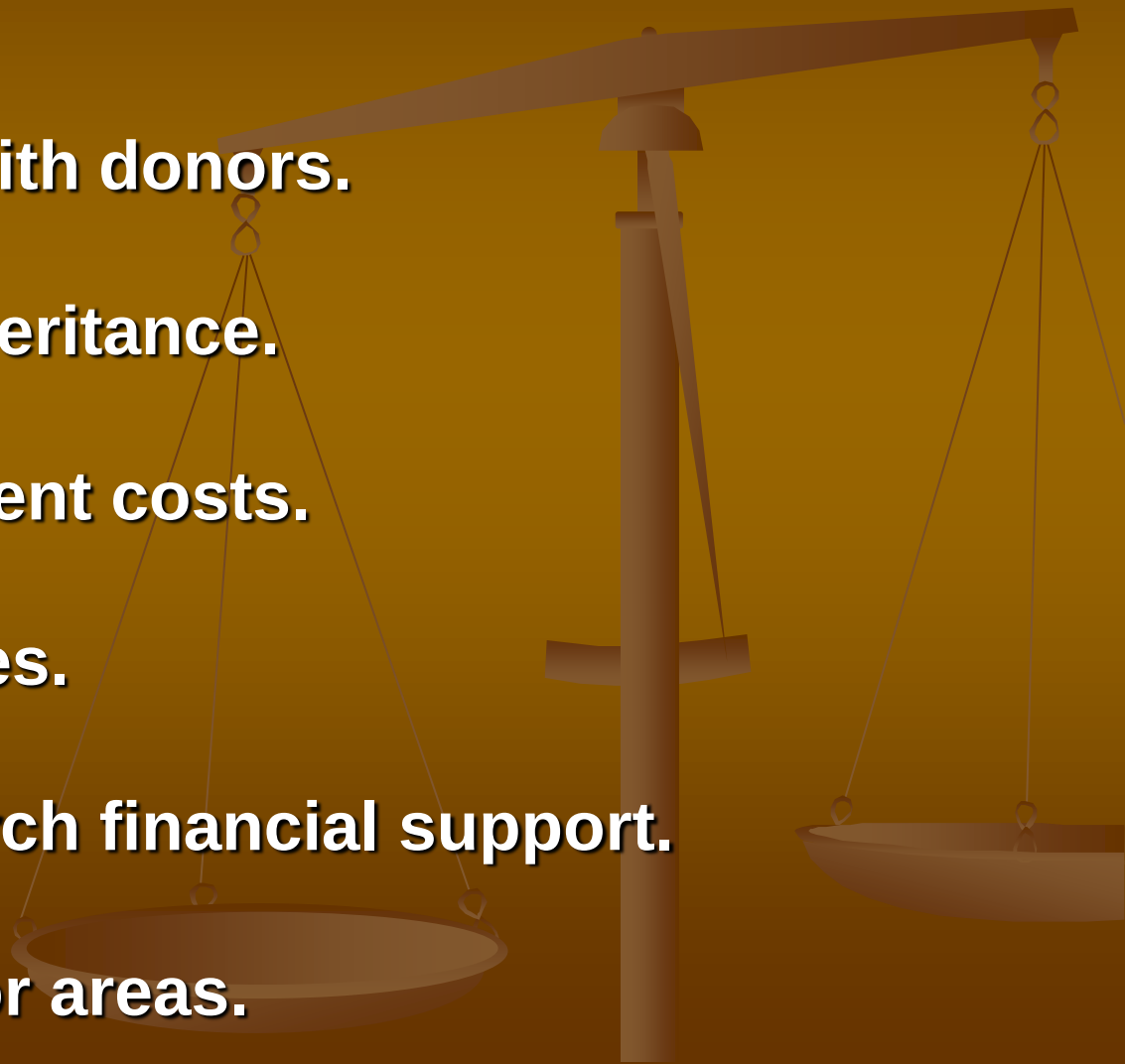
Devolutionary inheritance.

Increasing treatment costs.

Increase in salaries.

Lack of local church financial support.

Economically poor areas.



14. Funding Sources

India

Overseas grants – 1%-2%

Gov grants – Minimal

User fees – 98%-99%

Malawi

Overseas grants – 18%-35%

Gov grant for salaries & service agreements – 27%-48%

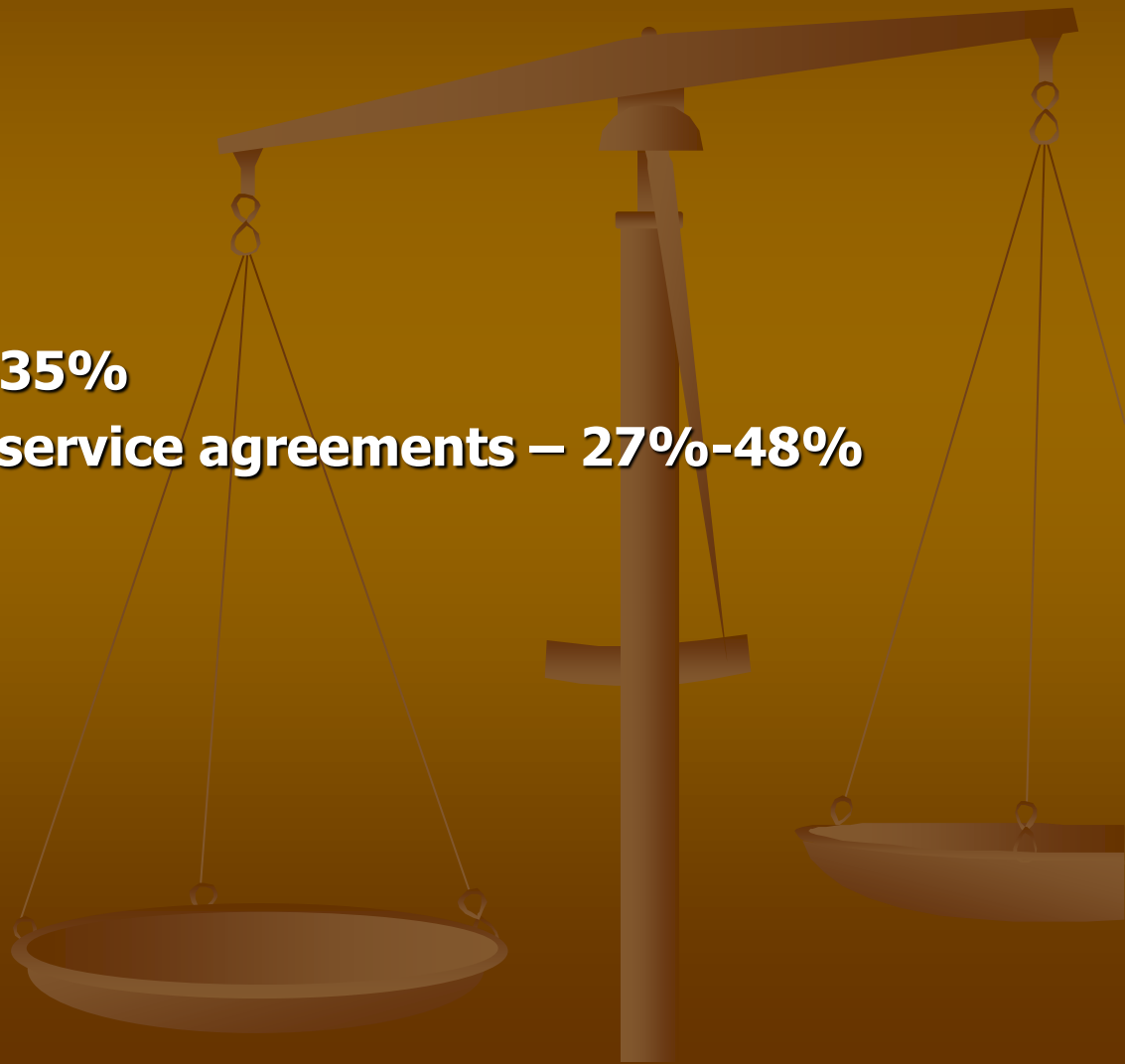
User fees – 15%-49%

Uganda

Overseas grants - 38%,

Gov grant - 23%

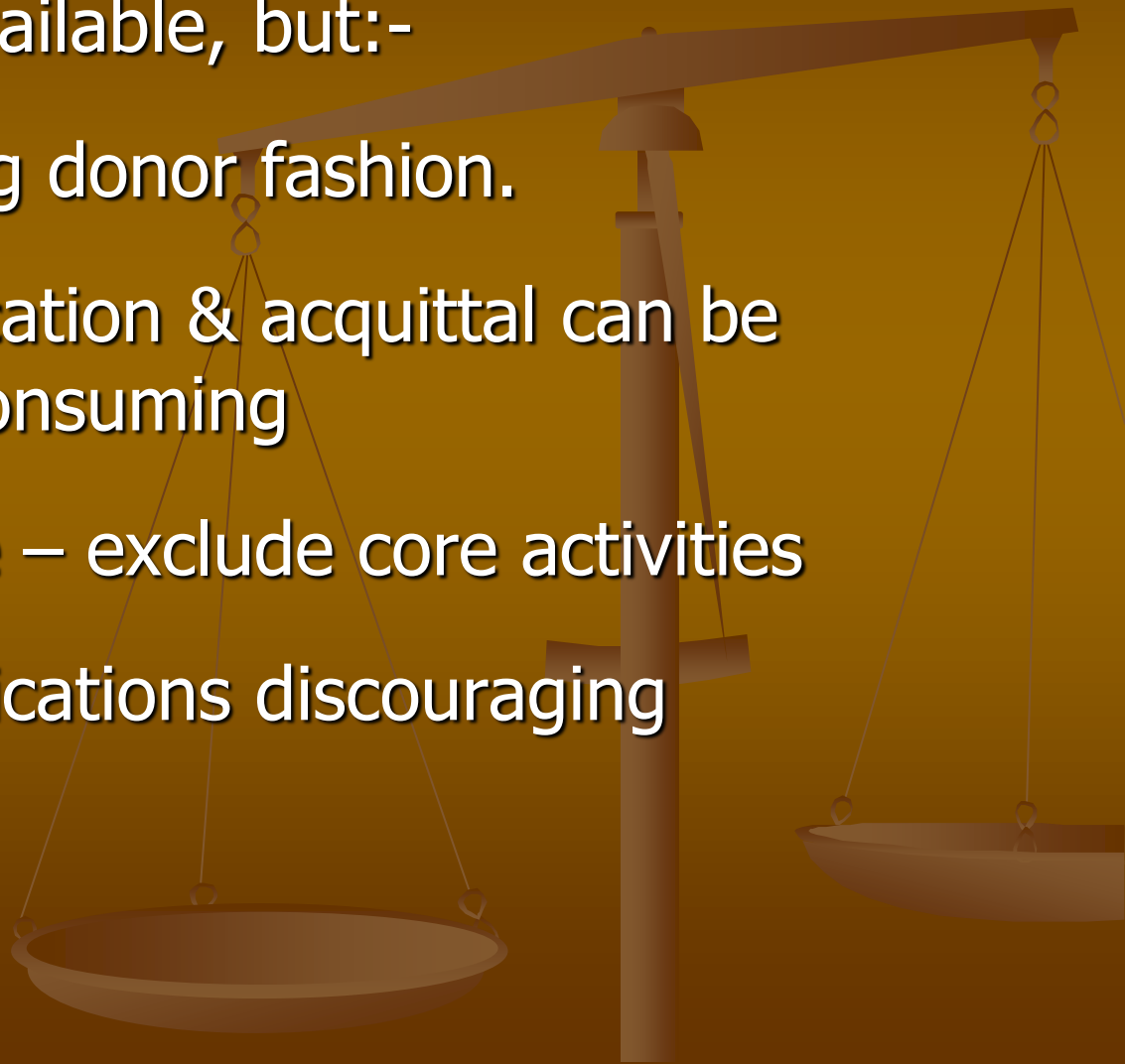
User fees - 38%



15. Project Funding

Now more widely available, but:-

- Linked to changing donor fashion.
- Systems for application & acquittal can be complex & time consuming
- Limitations on use – exclude core activities
- Unsuccessful applications discouraging



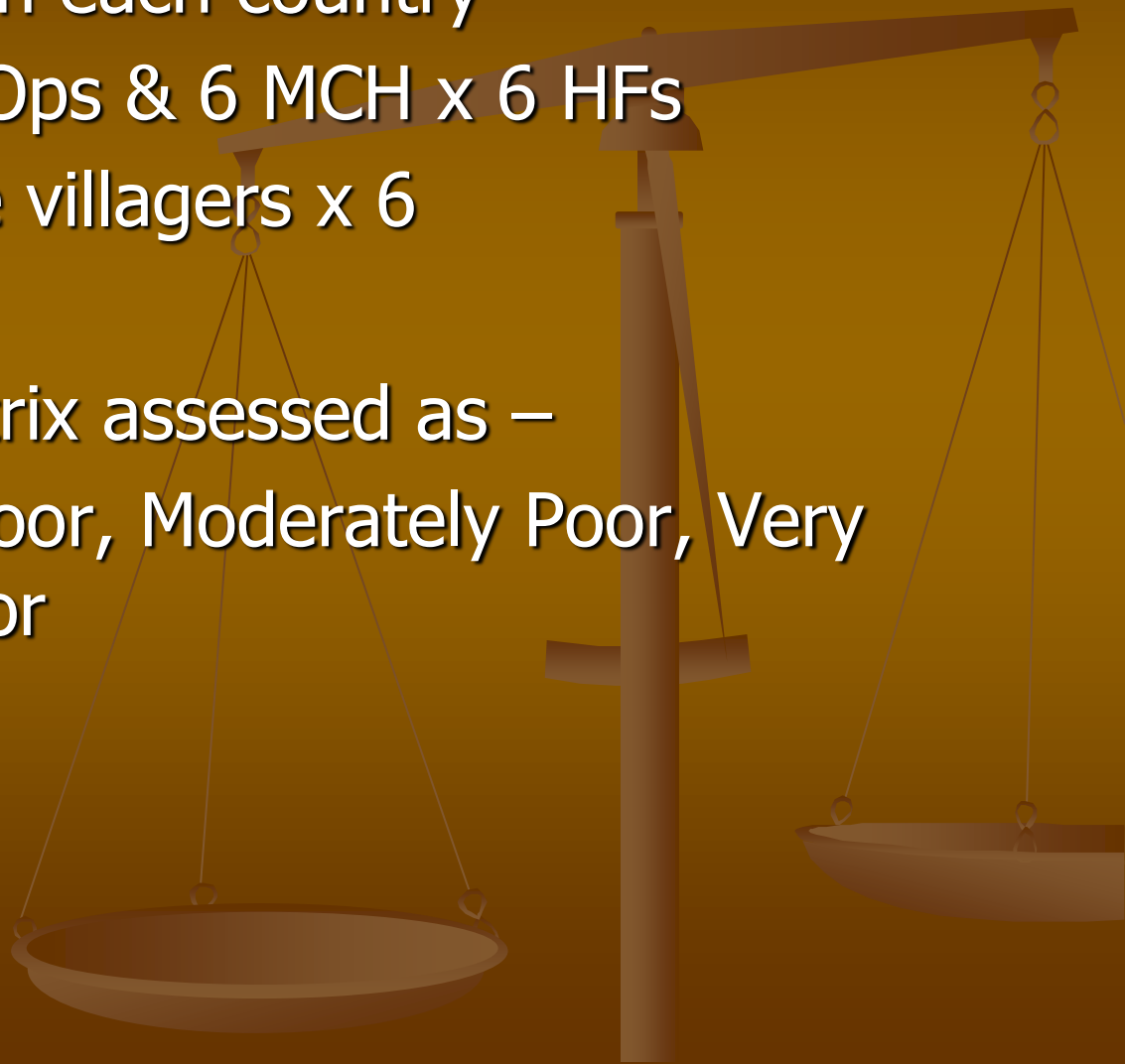
16. Fee Subsidies

- All CHSs investigated charge user fees
- ‘private patients’ pay significantly more
- Most CHSs provide subsidies, within limit of their resources, to poor patients.
- Kenya CHSs estimate 30% income lost through unpaid fees.
- Gov in several countries subsidise high priority services – TB, Malaria, HIV/AIDS, FP, Child Immunisation
- CHAM (Malawi) mandatory exemptions – not fully implemented

17. Poverty Assessment

- Malawi & India – in each country
  6 female, 6 male Ops & 6 MCH x 6 HFs
  6 female & 6 male villagers x 6

- Using Poverty Matrix assessed as –
- Not Poor, Mildly Poor, Moderately Poor, Very Poor, Severely Poor



18. Number of Poor Patients attending CHS facilities

Malawi & India – 108 patients interviewed in each country (excludes CFH & CMC):-

3 poorest categories

Malawi 67, India 37

Severely poor

Malawi 14, India 11

Substantial numbers of poorer patients attend the CHS facilities researched, although the proportion of the severely poor is relatively small

19. Effect of Fees on Poor Patients

Poor patients have neither the money to pay fees at CHS facilities or fares to travel to government facilities:-

- *"I often feel sick, but can't go to the mission hospital or the government hospital because I have no money for the fees or the fare. I'm very poor and need money."* (severely poor female villager, Malawi).
- *"User fees affect the service a lot. Poor village people don't have money to pay, so don't come"* (midwife, CHS hospital, Malawi)

20. Why do patients choose CHSs?

1. CHS is the nearest or only accessible health facility, particularly in rural areas & poor urban settlements. Government staff less willing to work in these areas.

2. Perception of greater compassion in CHSs:-

"*…we are shown more love & respect in mission hospitals…"* (severely poor, female outpatient)

"*…at government hospitals we are ignored. St S is like a family. I can unburden here…"* (severely poor, female outpatient)

21. Why do patients choose CHSs?

3. Patients feel a higher level of trust in the honesty & integrity of CHS staff than in GHSs or the private sector:-

"…private hospitals charge more and persuade you that you need a caesarean to get more money. I trust this place not to exploit me…" (not poor, female, outpatient).

"…*the staff in government hospitals do not give poor patients the tests they need. They charge well off patients for tests that are supposed to be free…"* (moderately poor, female, outpatient).

22. Why do patients choose CHSs?

4. The perception of a higher quality of service in CHS than in GHS facilities – more affluent patients may travel 20km.

- More likely to have necessary medication
- Shorter waiting times
- Sometimes have expatriate specialists

23. Why do patients choose CHSs?

5. Attitude of Staff – more polite & helpful, engendered by supportive attitude of senior staff.

"…I previously worked at a government hospital where I was overworked. I shouted at the patients & they shouted back. Here it is much calmer & respectful…" (Nurse at CHS hospital)

Congenial atmosphere engenders loyalty. Successive generations work at same CHS.

24.Why do patients choose CHSs?

6. Faith/Spiritual dimension to care

In some cases this is the religious ethos of the institution –

- chaplains
- devotions
- religious texts and artefacts
- chapel to attend for services, to pray or be quiet

None of the patients from other faiths interviewed objected to Christian devotions

25.Why do patients choose CHSs?

Many Hindus & Muslims spoke enthusiastically about taking part in the spiritual life of the hospital.

The views of Muslim & Hindu Leaders:-

"…everyone benefits from the Christian ethos permeating this hospital…"

26. Issues for us to consider?

1. Should relatives, if they wish, take a greater role in caring for patients in hospital?

2. Should facilities founded on a Christian ethos be more confident about their Christian presence?

3. Should Faith-based organisations seek to fill the gap left by statutory services, particularly for vulnerable & marginalised people?

4. How can health workers of faith best be confident compassionate role models in secular health settings following the Francis Report?

27. Issues for us to consider?

5. How can health workers of faith be recognised as advocates for honesty & integrity in health service provision, & have the courage to speak up when things are not right?

6. Can health workers of faith give a lead in ensuring that the faith & spiritual needs of all patients in hospital are met?

7. Should health workers of faith be good role models & facilitators in treating all patients with dignity & courtesy?

28. Issues for us to consider?

8. Do faith-based organisations have a role in promoting the greater use of complementary therapies when appropriate?

9. Would faith-based health providers enhance their ability to work in partnership with statutory services if they formed a consortium?

10. Do faith organisations have a role in facilitating more health care being provided closer to, or in, patients' own homes?

Publications by Peter & Jean Rookes

- 'Have Financial Difficulties Compromised Christian Health Services' Commitment to the Poor' a chapter in 'Religion, Religious Organisations and Development (ed C Rakodi) Published by Routledge.

- 'Commitment, Conscience or Compromise: The Changing Financial Basis and Evolving Role of Christian health services in Developing Countries' published by Lambert Academic Publishing

Publications by Peter & Jean Rookes

- 'Have Financial Difficulties Compromised Christian Health Services' Commitment to the Poor' chapter in 'Religion, Religious Organisations and Development' (Ed C.Rakodi) published by Routledge

- Commitment, Conscience or Compromise: The Changing Financial Basis and Evolving Role of Christian health services in Developing Countries' published by Lambert Academic Publishing