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Hubert Department of Global Health

Appreciating Assets: The Contribution of Religion to Universal Access in Africa

Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

In support of Universal Access to HIV/AIDS Treatment, Care and Prevention

Report of

The African Religious Health Assets Program (ARHAP)

Under Contract to

The World Health Organization (WHO)

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Table of Contents

Chapter 3: Understanding Religious Health Assets - Zambia Research

Chapter 4: Translating Religious Health Assets - Lesotho Research

Chapter 5: Engaging Religious Health Assets - Conclusions and Recommendations

Appendices

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

1

I. Executive Summary

Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives.

The study, "Appreciating Assets," documents the contribution made by religion and religious entities to the struggle for health and wellbeing in Zambia and Lesotho, in a context dominated by poverty, stressed public health systems and the HIV/AIDS pandemic. By mapping and understanding these Religious Health Assets (RHAs), the study calls for a greater *appreciation* of the potential they have for the struggle against HIV/AIDS and for universal access and offers recommendations for action by both public health and religious leaders at all levels. Through respectful engagement, these assets, rooted in the community and already *appreciating*, have the potential to increase in strength and value and become more effective in the long-term sustainability, recovery and resilience of individuals, families and communities.

The research was undertaken in a participatory, respectful and *appreciative* manner, with a view to making a difference to the lives of ordinary people in Africa. The findings and recommendations are offered to that same end.

Background

The year 2006 marks the 25th anniversary of the first published description of HIV/AIDS and a pivotal year for the pandemic. Over the past quarter century, an estimated 60 million people worldwide have become infected with the virus, 20-25 million have died and millions more have been affected by the loss, pain and suffering that accompany the disease. Zambia and Lesotho, in southern Africa, the two study sites for this research, are among the countries hardest hit, with estimated adult HIV/AIDS prevalence rates of 17.0% and 23.2% at the end of 2005, respectively.

The World Health Organization (WHO) has called for an unprecedented humanitarian effort to stem the tide of this pandemic and to alleviate the suffering of millions through universal access to HIV/AIDS treatment, care and prevention services by 2010. Potential key partners in this effort are religious entities, including organizations, initiatives, congregations and individuals that are hold a considerable portion of the medical infrastructure in sub-Saharan Africa and an even greater degree of *health-promoting religious assets*.

In this context, the African Religious Health Assets Program (ARHAP) undertook research to identify, map and assess religious health assets (RHAs) that can be marshaled in the fight against HIV/AIDS in these two high priority countries and to make this new body of information accessible to a diverse audience. This knowledge is urgently needed to mobilize current capacities, align resources, fill critical gaps, and target interventions. It is also critical to the long-term sustainability, recovery and resilience of individuals, families and communities.

Research Overview and Findings

This study, which presents research findings comprehensively, is the first attempt to assess and map both the tangible and intangible assets of religious entities through a blending of Participatory Engagement Workshops and GIS Mapping. A suite of research tools, PIRHANA, (Participatory Inquiry into Religious Health Assets, Networks and Agency) was developed for this purpose. Over the course of nine months,

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

2

November 2005 - July 2006, ARHAP research teams engaged more than 350 citizens and religious and health leaders, identified through purposive sampling, from the remote mountains of Mohlanapeng in Lesotho to the urban center of Lusaka in Zambia, in a participatory and appreciative inquiry into the nature and potential contributions of religious entities to the struggle against HIV/AIDS, to universal access to treatment, care and prevention, and to health and wellbeing more broadly. Our findings reflect the collective knowledge and deep wisdom of the participants who work in a daily struggle for survival and at the heart of the pandemic.

The report on the study lays out the theoretical basis of the research and, at its heart describes the results of mapping, understanding and translating Religious Health Assets in four regions of Zambia and three of Lesotho. Our findings make visible - and in many cases map for the first time - approximately 500 religious and partner organizations working in the area of HIV/AIDS, some 350 at the local level. These groups, in particular the community congregations, support groups and intermediary bodies, are seldom seen by policy-makers and often remain unknown even to their formal religious structures. Our findings suggest these assets could and should be more effectively mobilized and linked for scale up to universal access. Many have been identified as "Exemplars" by their peers and have "promising practices" to share and build upon. These findings underlie our call for an appreciation of those assets held by the religious community in Africa that are engaged in health.

Focusing on the research undertaken with the PIRHANA suite of tools and through the lens of fourteen key findings from each country, the study analyzes RHAs in a deeper manner and examines what happens when concepts like religion and health are translated into an African language and what we have termed a "healthworld". This concept acknowledges the complex and canny ways in which people mix their health-seeking strategies based on social and cultural norms and values of importance to them. It rests on holistic African perceptions of health that often differ hugely from that applied by policymakers and is somewhat alien to the public health community. The failure to understand the influence of religion in African *healthworlds*, or the failure to reflect on certain assumptions of western *healthworlds*, threaten the important work of organizations like WHO.

In conclusion the report on the study presents and elucidates a composite set of key findings that confirm, contradict and challenge previous studies and conventional wisdom at the interface of religion and public health, especially in the struggle against HIV/AIDS and for future struggles against rising infectious disease, a deteriorating environment, abject poverty and increasing conflict. The findings, summarized below, form an important base for a way forward, marked by respectful dialogue and meaningful collaboration:

Summary of Key Findings

1. Religion is ubiquitous in Zambia and Lesotho, yet often hidden from Western view. Given this, an engagement with religiously informed *healthworlds* is vital for the shaping of public health policy in southern Africa.

2. Religion, health and wellbeing are locally and contextually driven. For those seeking to engage RHAs, religion cannot be viewed as a single, simple cultural "variable" - no "one size fits all."

3. Religious involvement in health and HIV/AIDS is increasing - particularly since 2000 - and religious entities have expressed a strong local commitment and desire to be more effective in the area of HIV/AIDS. Interfaith engagement and dialogue require further exploration.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

3

4. Religious entities are perceived as contributing to health, wellbeing and the struggle against HIV/AIDS through tangible and intangible means. It is this combination that distinguishes them and gives them strength. Leading tangible factors comprise compassionate care, material support and health provision; leading intangibles are spiritual encouragement, knowledge giving and moral formation.

5. Certain religious entities are acknowledged as "Exemplars" in the community and these demonstrate exceptional programmatic, operational and associative characteristics.

6. An Assets-Based Approach to research and implementation of religion and health initiatives and HIV/AIDS scale up offers the potential for more rapid, sustainable and effective capacity-building and action.

Respectful Dialogue and Recommendations - A Way Forward

We have conducted our study and written our report with four key audiences and constituencies in mind: first, public health researchers, leaders, policy- and decision-makers who are working at all levels to understand and develop effective partnerships to address HIV/AIDS; second, religious researchers, leaders, theologians and clergy who are similarly engaged, or seeking to engage, with the pandemic and the public health sector; third, the ARHAP network of colleagues who share a set of guiding principles and commitments to an appreciative, assets-based and community-centered approach; and finally, our participants and their communities who live and work daily in the struggle against HIV/AIDS and in face of the underlying social, economic, environmental and political determinants of the pandemic.

These audiences and constituencies have a range of views, perspectives and relationships, sometimes convergent, but often divergent. In the conclusion to the report, Appreciating Assets, we offer the following set of recommendations in a spirit of respectful dialogue:

Appreciating Assets: Recommendations

1. Develop Religious and Public Health Literacy

Given the need for dialogue, it is crucial that as a first step religious leaders in Africa gain a basic level of public health "literacy", and that public health practitioners gain a basic level of religious "literacy". To this end we recommend that key agencies such as the World Health Organization:

    i. Invest in the development of formal courses and experiences to build religious/interreligious and public health literacy for the full range of leaders, policy makers, scholars and practitioners working in the fields of religion, public health and HIV/AIDS, and especially for those working at the intersection of all three.

    ii. Develop and make available a "shared lexicon" and "knowledge base" of terms, tools, methods and results drawn from interreligious and public health disciplines, beginning with the definitions and schemas presented in this report.

    iii. Provide joint training and orientation for religious and public health workers already in the field and for those to be newly deployed.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

4

2. Engender Respectful Engagement

Our findings make clear that "religion" is perceived by ordinary people to be extremely significant in the struggle for health and wellbeing in African communities. At the same time this "religion" only exists as specific religious commitments and practices in specific contexts. To take forward respectful dialogue means to engender respectful engagement. To do this we recommend that key actors in public health and religion:

    i. Build on local wisdom, context and commitment, and develop more formal ties to the individuals and organizations, such as those participating in this study and similar groups found in other nations and social contexts. The expansion of the PIRHANA tool to include local community engagement in community health issues from a religious perspective has great promise, given the positive impact experienced by those who participated in this field investigation.

    ii. Develop a new approach to engage with religious and health leaders, academics, policy- and decision-makers, potentially based on an "Executive Sessions" model (see Hauser Center http://www.ksghauser.harvard.edu/) that allows for long-term engagement and collaborative policy development.

3. Align Religious and Health Systems, Beginning with Tangible Assets

Our research has found a great deal of public health activity being undertaken by Religious Entities that is not always effectively aligned with public health systems. To strengthen this alignment we recommend that key religion and public health actors:

    i. Use Health Mapping in strategic ways to recognize the assets on the ground and their potential connections.

    ii. Strengthen local community "Support Groups" working in the field of health and wellbeing and link them to public health structures, including neighboring hospitals, clinics, dispensaries and laboratories.

    iii. Support the replication of "Network hubs" "to leverage existing RHAs and develop and nurture additional ones.

    iv. Further link to the Exemplar REs such as those identified in this study to understand "promising practices" and implications for adaptation to other settings.

4. Conduct Further Collaborative Research

The interdisciplinary nature of this research project and the nature of the findings suggest that the alignment of religious health assets and public health systems in Africa requires ongoing research and reflection. In particular, this calls for further research to:

    i. Extend Participatory Religious Health Assets Mapping to other African countries and other regions of the world and in particular in settings where Christianity is not the dominant religious tradition.

    ii. Explore the link between "Compassionate Care", "Respectful Relationships" and "Decent Care" and their extension to the Community level

    iii. Further study the Exemplar Religious Entities and Existing Case Studies to determine "Promising Practices" and Effective Strategies for Alignment

    iv. Explore specific areas in which exemplar REs are vulnerable in the context of health systems that are fragile, and develop specific strategies to obviate the vulnerabilities so that the REs maximize

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

5

their potential and are not undermined by demands and expectations that far exceed their capacity to act and to do.

v. Engage in further study of what have been identified as "intangible" religious health assets and how public structures can relate to them in a respectful way.

vi. Explore further the "healthworlds" found in Africa and the impact that religio-cultural frameworks have upon the way in which people conceive of health and wellbeing and undertake health-seeking agency.

In conclusion, our aim has not been to force a single perspective or overly simplistic view on the deeply textured study results but rather to present the full complexity of issues and findings, with a desire to build greater understanding, communication and engagement.

The research theory guiding this project emphasizes the importance of appreciating local wisdom, practice and perceptions. The methods have drawn from participatory research that seeks always to integrate research with action. The proof of the effectiveness of the research process and findings will be in transformed practice. In Lesotho and Zambia and throughout southern Africa, the HIV/ AIDS pandemic is a major human tragedy. It is incumbent upon religious and public health leaders to undertake respectful dialogue and mutual engagement to make a difference.

Chapter One

Considering Religious Health Assets
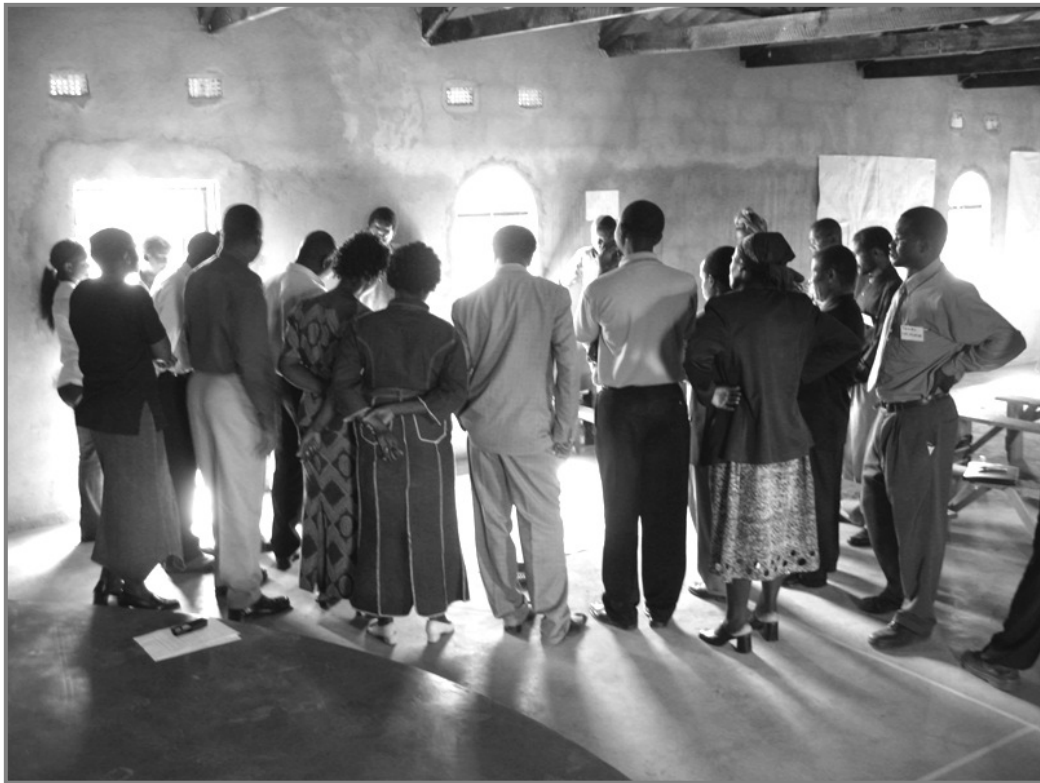
Bauleni Community Workshop, Lusaka, 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

6

Chapter One: Considering Religious Health Assets

II. Introduction

A. Purpose

The World Health Organization (WHO) has called for an unprecedented humanitarian effort to stem the tide of the HIV/AIDS pandemic and alleviate the suffering of millions through universal access to HIV/AIDS treatment, care, and prevention services by 2010. Potential key partners in this effort are religious organizations and entities that are considered to hold a considerable portion of the medical infrastructure in sub-Saharan Africa and an even greater degree of *health-promoting religious assets*.

The year 2006 marks the 25th anniversary of the first published description of HIV/AIDS. Over the past quarter century, an estimated 60 million people worldwide have become infected with the virus, 20-25 million have died, and millions more have been affected by the loss, pain, and suffering that accompany the disease.

Sub-Saharan Africa remains the region of the world most affected by the pandemic. At the end of 2005, according to UNAIDS, almost two-thirds of all people living with HIV/AIDS worldwide - an estimated 24.5 million - were living in this region, including 13.2 million infected women, or three-quarters of all women living with HIV/AIDS around the globe. Prevalence rates are exceptionally high in many countries, with a full one-third of the population projected to be infected in some areas.

The purpose of this report is to summarize the recent study of the African Religious Health Assets Program (ARHAP) to identify, map and assess religious health assets (RHAs) that can be marshaled in the fight against HIV/AIDS in two high priority countries, Lesotho and Zambia, and to make this new body of information accessible to a diverse audience. This knowledge is urgently needed to mobilize current capacities, align resources, fill critical gaps, and target interventions. It is also critical to the long-term sustainability, recovery, and resilience of individuals, families, and communities.

We have conducted our study and written our report with four key audiences and constituencies in mind: first, public health researchers, leaders, policy- and decision-makers who are working at all levels to understand and develop effective partnerships to address HIV/AIDS; second, religious researchers, leaders, theologians, and clergy who are similarly engaged, or seeking to engage, with the pandemic and the public health sector; third, the ARHAP network of colleagues who share a set of guiding principles and commitments to an appreciative, assets-based, and community-centered approach; and finally, our participants and their communities who live and work daily in the struggle against HIV/AIDS and in face of the underlying social, economic, environmental, and political determinants of the pandemic. These audiences and constituencies have a range of views, perspectives, and relationships, sometimes convergent, but often divergent. Our aim is not to force a single perspective or overly simplistic view but rather to present the full complexity of issues and findings, with a hope of creating greater understanding, communication, and engagement.

B. Contract Summary

Despite the long history and tradition of religious health care and care-giving in Africa, there has been no comprehensive, independent assessment of religious health assets, especially in the sub-Saharan region. However, the few formal surveys and qualitative assessments available demonstrate substantial tangible

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

7

capacities spanning a broad range of faith traditions and denominations. In Lesotho, approximately 40% of national health service is estimated to be provided by 9 Christian hospitals and 75 health centers whose managing churches are members of the Christian Health Association of Lesotho (CHAL); in Zambia, the numbers are similar, with 30% of services provided by 30 hospitals and 66 rural health centers whose managing churches are members of the Churches Health Association of Zambia (CHAZ).[1]

Religious entities have also been shown to have other critical, but less tangible assets, including extensive volunteer networks, expert lay professionals, congregations/churches/ mosques/temples in even the most remote locations, and deep systems of community support, "voice," advocacy, trust, consolation, and hope. Religious entities have also demonstrated strong governance and financial accountability. UNICEF and the World Council of Religions for Peace recently found that in six countries in Africa the overall organizational capacity of local faith-based organizations was on a par with that of many larger NGOs.[2]

Recognizing the importance of religion in Africa, in May 2005, WHO's Partnerships, External Relations, and Communications team, Department of HIV/AIDS, issued a Request for Proposal for a comprehensive assessment of religious health assets at the province or district level in two of six African countries: South Africa, Swaziland, Lesotho, Zambia, Kenya and Tanzania. In July 2005, WHO entered into a Project Agreement with the Interfaith Health Program, Rollins School of Public Health, Emory University, and collaborating partners of ARHAP - the Universities of Cape Town, KwaZulu-Natal, and Witwatersrand - to conduct the study described in this report. The agreement called for a series of Participatory Engagement Workshops to be conducted over an approximately 12-month period at both community and regional levels in seven provinces/districts in Zambia and Lesotho. These countries were chosen due to their particular circumstances, described in more detail below, and prior case study research conducted by ARHAP in these locations. The workshops were intended to map in a comprehensive way the contributions and potential for partnership among religious and health structures and leaders in support of HIV/AIDS treatment, care, and prevention in these areas and to accompany this with GIS mapping of related sites, facilities, and other tangible assets.

C. Research Theory/Approach

The research that lies behind this report is shaped by five important theoretical approaches, namely, grounded theory, appreciative inquiry, an intentional combination of quantitative and qualitative methodologies, participatory disclosure and interdisciplinary analysis.

- The fundamental theoretical approach that characterizes ARHAP research as a whole is "grounded theory." Given that we are exploring areas with, as yet, very little established theory, we are intentionally involved in a research spiral moving among certain broad research questions and hypotheses, an emerging body of data "from the ground," and a process of analytical reflection, which in turn shapes emerging theoretical insights and helps to sharpen the next round of research questions. This gives a fundamental inductive orientation to our work.
- Our research attitude is one of respect for the insights and perspectives of ordinary people, community and religious leaders, and health workers, and in doing this we draw from the approach of Appreciative Inquiry.

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[1] A. Green, J. Shaw, F. Dimmock and C. Conn, "A Shared Mission? Changing Relationships between Government and Church Health Services in Africa", *International Journal of Health Planning and Management* 17 (2002)**,** 333-353.
[2] G. Foster, "Study of the Response by Faith-Based Organizations to Orphans and Vulnerable Children: Preliminary Summary Report", (World Conference of Religions for Peace and United Nations Children Fund, 2003).

- Because the contribution of religion to public health in Africa is hidden from view, we have adopted a quantitative methodology - mapping of assets - to point to the real presence of these assets in the community. Yet to understand what this presence means we have adopted qualitative research methodologies to provide a depth of insight into the meaning of beliefs, perceptions, attitudes and practices within the contexts in which they appear. This combination of quantitative and qualitative approaches helps to generate the evidence and insights that are necessary in this emerging field of research.

- A creative contribution of this research project to the study of the relationship between religion and public health has been the development of the PIRHANA tool - Participatory Inquiry into Religious Health Assets, Networks, and Agency - which encourages the participatory disclosure of community perceptions rather than individual information.

- Finally, the analysis of the data and the identification of the key findings and implications for public health and for religious practice have been undertaken by an interdisciplinary team that draws upon insights from the fields of public health, religion, sociology, ethnography, development, and geographic and environmental sciences.

D. Research Question, Hypotheses and Tools

The fundamental research question at the heart of this report is:

> *What is the contribution of religion and religious entities to health and wellbeing in the context of HIV/AIDS in Zambia and Lesotho?*

This study is based on the following key hypotheses:

- Religious entities are widely present on the ground in many contexts where health crises are most urgent.
- No matter how impoverished, under-resourced or isolated they may be, such religious entities nevertheless represent or contribute major assets to health in their contexts.
- These assets are both tangible and intangible.
- They have an impact on health at a public or community level (in addition to providing particular health services to individuals).
- They need to be understood in relation to each other and as part of a complex and significant social reality.
- Properly assessing, appreciating and enhancing their potential will produce better alignment between public health systems and the religious structures with which they might partner.

The research theory, question and hypotheses have led us to the development of the specific set of ARHAP Tools and Methods for this study:

- Participatory Engagement Workshops - employing Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA)
- GIS Mapping - Database and Definitions

These tools and methods are examined in more detail in Chapter 2.

E. Limitations of the study

This study has focused on two southern African countries, Zambia and Lesotho, with workshops conducted in four provinces in Zambia and three health service areas in Lesotho. In those sites it has engaged a wide

range of religious and health leaders and has drawn together a limited number of people in workshops through purposive sampling. The PIRHANA research tool has examined the perceptions of participants through highly participatory exercises alongside the more objective data from the GIS mapping component. The inductive approach meant that it was desirable that local context have a significant impact upon the research process itself, and this has led to a certain degree of unevenness in the data. Nevertheless, as noted in the discussion on the research tools (below): 1) great care was taken in the choice of the sites *and* the participants to reflect a range of religious and health experience, 2) the tools were designed to examine perceptions in an open, transparent and accountable way, and 3) the sustained engagement of the participants in the process and local commitment to the outcomes suggests that the data that emerged are valid and have significance beyond the immediate context.

F. Ethics Clearance

The study design and tools were presented to the WHO Country Offices in Zambia and Lesotho following the contract award. In addition, ethics clearance was sought and received from the University of Zambia ethics committee for the research undertaken in Zambia, and the Ministry of Health in Zambia was duly informed. Similarly, ethics clearance was sought from the Ministry of Health in Lesotho.[3] Participants to all workshops were informed of the purpose of the research at the time of invitation and again at the start of the workshops. A full consent form was read and translated where necessary, and participants were required to sign this, giving permission for their collective insights and images to be used in research reports.

G. Time Frame of Study

The study was conducted in three phases from October 31, 2005 through August 15, 2006, as follows:

Phase I, Participatory Workshops: Following extensive contract start-up activities extending from mid-July through mid-October 2005, the project was officially launched October 31, 2005, with the first Participatory Workshops conducted in the Copperbelt, Zambia. The Workshops continued in both Lesotho and Zambia through April 8, 2006, engaging approximately 350 organizations and individuals.

Phase II, GIS Mapping: Concomitant with the Participatory Workshops and continuing beyond, members of the ARHAP research teams and network of collaborators conducted GIS Mapping of approximately 500 sites and facilities in the two countries. The GIS Mapping Phase continued through the end of the study, with the majority of field work completed in early July and analysis and interpretation of the GIS maps proceeding through final report preparation.

Phase III, Data Synthesis and Writing: Formal team debriefings followed each Participatory Workshop, and data review and analysis were undertaken at key milestones throughout the study. The Data Synthesis and Writing Phase officially began with a review of Lesotho data in early April 2006 and continued through final submission of the report to WHO on August 15, 2006.

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[3] See Appendix B for sample letters to Lesotho Ministry of Health and from Zambian ethics committees.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

10

H. Research Teams

The study has been conducted by four ARHAP Research Teams, reflecting the diversity and contributions of each University/organizational partner, faculty, and research staff. Key personnel and key WHO and country contacts, at inception of the study, are as follows:[4]

ARHAP - Zambia Research Program

University of KwaZulu-Natal, Pietermaritzburg, South Africa
Professor Steve de Gruchy, School of Religion and Theology and Director, Theology and Development Program
Mr. Sinatra Matimelo, Researcher
Ms. Mary Mwiche, Researcher

ARHAP - Lesotho Research Program

Department of Sociology, University of Witwatersrand, Johannesburg, South Africa
Rev. Paul Germond, Senior Lecturer in the Sociology of Religion in Southern Africa
Mr. Sepetla Molapo, Researcher
Ms. Tandi Reilly, Researcher

ARHAP - University of Cape Town Office

University of Cape Town, Cape Town, South Africa
Professor James Cochrane, Department of Religious Studies and Director, Research Institute on Christianity and Society in Africa
Ms. Shirley Butcher, GIS Consultant
Mr. Frank Dimmock, GIS Consultant
Ms. Jill Olivier, Researcher
Ms. Barbara Schmid, Researcher

ARHAP - Emory University Office

Rollins School of Public Health, Emory University, Atlanta, GA
Ms. Deborah L. Jones, Project Director, ARHAP
Dr. Gary Gunderson, Principal Investigator, Interfaith Health Program, Hubert Department of Global Health
Dr. Deborah McFarland, Associate Professor, Hubert Department of Global Health

WHO - Zambia

Dr. Stella Anyangwe, WHO Resident Representative, Lusaka
Dr. Sansan Myint, HIV Prevention, Treatment and Care Officer, Lusaka

WHO - Lesotho

Dr. Angela Benson, WHO Resident Representative, Maseru
Dr. Esther Aceng, HIV Prevention, Treatment and Care Officer, Maseru

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[4] See Appendix C for further research team information

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

11

WHO - Regional Office for Africa

>   Dr. Evelyn Issacs, Division of Communicable Disease Prevention & Control, Harare

WHO - Headquarters

>   **Partnerships, External Relations & Communication/ Department of HIV/AIDS**
>   Rev. Canon Ted Karpf, Partnerships Officer, Geneva
>   Mr. Mark Forshaw, Liaison Officer, Civil Society, Geneva
>   **Strategy, Partners and Coordination/Public Health Mapping and GIS**
>   Ms. Kathy O'Neill
>   Mr. Johan Lemarchand

I. Layout of the Report

This report is designed to present a coherent framework about religious health assets in Zambia and Lesotho in five logical steps: 1) Considering, 2) Mapping, 3) Understanding, 4) Translating, and 5) Engaging these assets.

Chapter 1, "Considering Religious Health Assets" covers preliminary information, an analysis of the literature, and current context of HIV/AIDS which suggests why it is crucial to consider religious health assets at this time in Africa. The work of ARHAP and its theoretical contribution to this research are noted.

Chapter 2, "Mapping Religious Health Assets" begins with an introduction to the two basic research tools used to identify, map and understand RHAs, and then sets out the framework for mapping these assets, presents the maps themselves and considers the most significant findings.

Chapter 3, "Understanding Religious Health Assets" draws from the research process in Zambia to articulate what was learned about the contribution of religion to public health in that country, with the primary findings helping us to understand how RHAs are perceived to work and contribute to health and wellbeing.

Chapter 4, "Translating Religious Health Assets" draws from the research process in Lesotho to articulate what was learned about the relationship between religion and public health in a setting in which Sesotho language and culture are dominant features, with the primary findings helping us to understand the role of RHAs within an African healthworld.

Chapter 5, "Engaging Religious Health Assets" concludes this report with a series of integrated findings into RHAs across the two countries and a set of recommendations for "a way forward" in responding to and working with RHAs in the struggle for universal access.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

12

III. Background

This study was undertaken during a pivotal year - a time of increased awareness and renewed commitment to HIV/AIDS treatment, care and prevention worldwide, a special concern for sub-Saharan Africa in general, and for Lesotho and Zambia in particular. To provide essential context and grounding for our study, we summarize here three important contexts, each working singly and in tandem to form a dynamic "backdrop" for viewing and understanding religious health assets:

A quarter century into the epidemic, the global AIDS response stands at a crossroads. For the first time ever the world possesses the means to begin to reverse the epidemic…But success will require unprecedented willingness on the part of all actors in the global response to fulfill their potential…to embrace new ways of working with each other, and to…sustain the response over the long term - Report of the UN Secretary-General, *Declaration of Commitment on HIV/AIDS: Five years later*, 24 March 2006

A. HIV/AIDS "Situation Reports"

Significant features and trends of the changing HIV/AIDS pandemic in Lesotho and Zambia have been well-documented by WHO, UNAIDS, and a series of national and international agencies and organizations. We have reviewed reports currently available and compiled a composite "subset" of key demographic, health, and socioeconomic indicators to provide a profile for each country (Table: Appendix D and E). Given our focus at the community and provincial levels, we will briefly summarize here developments in each country deemed new or significant and those with special implications for the religious community. Additional background data are available in the documents referenced.

i. Zambia[5]

a. State of the Epidemic[6]

Zambia is considered to have an HIV/AIDS epidemic that has become "mature and generalized," with a national prevalence rate among adults of 17.0% and significant impact across the socioeconomic spectrum. Zambia reported the first official case of HIV/AIDS in 1984 and witnessed a dramatic acceleration in infection rates thereafter. Today, Zambia stands as one of the hardest hit nations worldwide, with an estimated 1,100,000 people living with HIV/AIDS, 52% of them women. Urban residents overall are more than twice as likely to be infected as their rural counterparts (23% vs 11%), and the HIV prevalence rates vary significantly according to geography, with ranges of 8%-22% nationwide. Rates in our four study sites were: 14%-Eastern Province, 18%-Southern, 20%-Copperbelt, and 22%-Lusaka. Life expectancy for Zambians has dropped precipitously since the first HIV/AIDS report - from 51 to 40 years - with negative results for the economy and for sustainable livelihoods; 56.1% of Zambians now live on less than 2$ US per day, and the country is attempting to support an estimated 750,000 orphans.

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[5] This section is informed by the following documents: Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro, *Zambia Demographics and Health Survey 2001-2002*, (Calverton, Maryland, USA: Central Statistical Office, Central Board of Health and ORC Macro, 2003); Central Statistical Office [Zambia], *Zambian Sexual Behaviour Survey*, *2005* (Lusaka: Central Statistical Office, MOH, Measure Evaluation, 2005); R. Hakkert and R. Wieringa, "The Republic of Zambia", *International Demographics* 5, no.5 (May 1986), 1-9; UNAIDS, *Report on the Global Epidemic* (Geneva: UNAIDA, 2006); WHO, *The World Health Organization Statistical Information System* (WHOSIS), 2006, <http://www.who.int/whosis/en> (20 June 2006); See also WHO, *World Health Statistics,* 2006, WHO, *Global Tuberculosis Control: Surveillance, Planning, Financing: WHO Report 2006,* and *The World Health Report,* 2006 <http://www.who.int> (20 June 2006).

[6] See Appendix D for further country-specific data in tabularized form.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

13

b. Special "Drivers"

A variety of agencies and task forces have analyzed Zambia's wide-scale epidemic and the special "drivers" at work. Civil society in whole and the religious community in particular are seen as important partners in addressing these issues.

- Gender Differences:
    - o Women and girls are 1.4 times more likely than men to become infected, potentially reflecting higher levels of vulnerability, inadequate access to information on prevention, low levels of negotiation skills, and unequal protection under statutory and customary laws and traditions.
    - o Young women 15-24 years old are 4 times more likely to be HIV positive than men of the same age group (12.5% vs. 4%); AIDS cases peak among women 20-29 years old and among men 30-39 years old, suggesting significant transmission from older men to younger women.
    - o The deteriorating economy has forced many women to engage in transactional sex as a "last resort" for survival - for themselves and their children.
    - o Mother-to-child transmission is a serious mode of pediatric transmissions in Zambia, with 39% of all infants born to HIV-infected mothers becoming infected.
- Constellation of HIV/AIDS, TB, and Malaria:
    - o Malaria is endemic throughout Zambia and continues to be a major public health concern. It is the leading cause of morbidity and second highest cause of mortality, especially among pregnant women and children under the age of five, with an estimated 3.5 million cases and 50,000 deaths per year. Malaria accounts for 37 percent of all out-patient attendance in Zambia.
    - o African countries with a high prevalence of HIV/AIDS infection have witnessed an increase in TB cases, despite stable or falling numbers in the other regions of the world. Zambia ranks sixth among the 15 countries worldwide with the highest estimated TB incidence rates per capita; the estimated prevalence rate of HIV in adult TB patients is 54%.
    - o The constellation of HIV/AIDS, TB, and malaria has had severe health consequences and strained the overburdened public health delivery system. Religiously owned hospitals and clinics are seen as "preferred" providers in many areas.
- Environmental Issues:
    - o Safe water and overall environmental issues are significant concerns, especially in regions where the deteriorating economy has left few resources for maintenance and cleanup.
    - o Extremely poor roads and general lack of transport in many areas severely limit health care access and services; religiously sponsored home-based care groups have become a critical resource in providing health services and material support to those in rural areas.

c. Significant National/International Events and Plans - Zambia

The following significant national/international events occurring during our study year are highlighted here:
- *National HIV/AIDS/STI/TB Policy* finalized, 2005
- *Antiretroviral Therapy(ART) and Ancillary Services Policy Decision* to provide ARV drugs and laboratory services free of charge to all in need, July-September 2005
- *National Strategic Plan for HIV/AIDS 2006-2010* developed, 2005
- *HIV/AIDS Workplace Survey of 21 Largest Zambian Companies*, conducted by National AIDS Council covering treatment, care, and prevention options, 2005
- *HIV/AIDS Income Generation Strategy for Women's Groups,* developed in 4 Districts to mitigate socioeconomic impact for women most affected by HIV/AIDS, 2005
- *Multisectoral Partnerships, Policies, and Structures* strengthened and expanded through National Strategic Plan and Policy Assessment, 2005; specific agreements developed with key partners

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

14

- *Capacity-Building for HIV/AIDS School Programs* undertaken by Ministry of Education, with 4,000 educators trained on HIV/AIDS Interactive Participatory Learning Methods through 2005
- *Scaling-up and Rolling out of Prevention, Care and Support Activities (including roll out of ARV services)*, particularly through US Government funding of FBOs, and related partners, such as Development Aid from People to People (DAPP), the Copperbelt Health Education Project (CHEP)
- *Expansion and Strengthening of Church Health Association of Zambia (CHAZ) and the Zambian Inter-Faith Networking Group (ZINGO)*, with special support for grant-making to FBOs, 2005-6
- *Initiation/Expansion of Community Mobilization Projects,* including the International HIV/AIDS Alliance's Stigma and Discrimination Project, Treatment Advocacy and Literacy Campaign (TALC), and the community-based ARV treatment literacy and compliance project, ARV Community Education and Referral (ACER), 2005-6
- *Traditional Health Practitioners Association of Zambia (THPAZ)*, expanded role and research activities with biomedical and public health systems, 2005-6;
- *World Health Day- 2006* launched with strengthened coalition of faith-based partners and Lusaka "kickoff" - April 2006

d. Funding and Support

Although there is no single source of tracking for all public and private funding and support for HIV/AIDS worldwide, international estimates demonstrate that resources for the AIDS response have grown more than 5-fold over the past four years, from US $1.6 billion in 2001 to US $8.3 billion in 2005, with additional funds allocated in 2006. In addition to donor funding, domestic public expenditure in heavily impacted countries grew to US $2.5 billion in 2005. At the same time, however, the funding gap continues to increase. The estimated need in low and middle income countries is US $15 billion for 2006, growing to US $22 billion annually in 2008.[7,8]

According to UNAIDS, the Zambian national government spends $32,000,000 on domestic health.[9] In 2003 the Zambian government spent 11.8% of its total budget on health - equaling about USD 11 per capita. However, 44.7% of total heath expenditures are funded through outside resources and then channeled through the Ministry of Health. In addition, more than 48% of total health expenditures were provided through non-governmental channels.[10]

In 2004, Official Development Assistance (ODA) to Zambia totaled more than US$ 1 billion - with top donors including the UK, Germany, and the European Commission. Of the total aid, about 50% was used for education (~20%), health (~15%) and other social services (~15%).[11] Top donor governments for HIV/AIDS include the US, the UK, Canada, Norway, Ireland, Japan, and the European Union.[12]

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[7] UNAIDS, *Report on the Global AIDS Epidemic*, 2006, <www.unaids.org> (16 October 2006).
[8] A. Nordstrom, "Presentation", XVI International AIDS Conference, Toronto, (18 August 2006).
[9] UNAIDS, 2006, <www.unaids.org/en/Regions_Countries/Countries/zambia.asp> (16 October 2006).
[10] WHO, 2003, <www3.who.int/whosis/core/core_select_process.cfm?country=zmb&indicators=nha&language=en> (11 October 2006).
[11] OECD, World Bank, <www.oecd.org/dataoecd/12/59/1883515.gif> (12 October 2006).
[12] Kaiser Family Foundation, 2005, "The HIV/AIDS Epidemic in Zambia", HIV/AIDS Policy Fact Sheet, October 2005, <www.kff.org/hivaids/upload/7369.pdf> (16 October 2006).

Top Ten Donors of Gross ODA to Zambia (2003-04 average) *Measured in million USD*[13]		
1	United Kingdom	174
2	IDA	148
3	Germany	135
4	SAF& ESAF (IMF)	122
5	EC	107
6	United States	76
7	France	53
8	Netherlands	44
9	Denmark	38
10	Norway	36

The assistance from the UK is provided through the Department for International Development (DFID). In the 2005-2006 fiscal year, DFID provided 40 million pounds (74 million USD) of aid with an additional £4 million (7.4 million USD) in emergency humanitarian assistance. DFID has pledged another £40 million for the 2006-2007 fiscal year. DFID funds in Zambia are used for poverty reduction, health, HIV/AIDS, education and hunger alleviation. [14]

In the United States, the President's Emergency Plan for AIDS Relief (PEPFAR) selected Zambia as an initial focus country. In 2004, PEPFAR, working through the Centers for Disease Control and Prevention and USAID, provided US $130,088,605. At the time of this writing, PEPFAR has allocated US $149 million dollars to its program in Zambia for the year 2006. PEPFAR funds projects in HIV education, prevention, PMTCT, treatment, and other aspects included in a comprehensive response to HIV/AIDS. PEPFAR provides funding to many faith-based organizations involved in HIV/AIDS treatment, care and prevention.[15]

The Global Fund to fight AIDS, TB, and Malaria has approved US $219,129,674 in current round 1 and 4 grants to organizations throughout Zambia and has already dispersed US $113,794,624. The Churches Health Association of Zambia has been approved for US $50,905,608 in grants with US $34,366,202 disbursed to date. Other grantees include the Ministry of Health, the Ministry of Finance, and the Zambia National HIV/AIDS Network.[16] The World Bank has approved $42 million in funding to support the Zambia National Response to HIV/AIDS (ZANARA) project.[17]

In addition to funding from public donors and agencies, private corporations and foundations have also been active in Zambia, including international faith-based organizations; these include the Gates Foundation, the Elizabeth Glaser Pediatric AIDS Foundation, PhRMA affiliates, the Open Society Institute, the Panos Global AIDS Program, AIDS Fonds, World Vision, and major denominational bodies.[18, 19, 20]

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[13] Kaiser Family Foundation, "The HIV/AIDS Epidemic in Zambia", 2005.

[14] DFID, 2006. <www.dfid.gov.uk/countries/africa/zambia.asp> (12 October 2006).

[15] PEPFAR, 2006, <www.state.gov/documents/organization/61633.pdf> (12 October 2006).

[16] Global Fund, 2006, <www.theglobalfund.org/programs/countrysite.aspx?lang=en&countryid=ZAM> (12 October 2006).

[17] World Bank, "Portfolio for Zambia", (Washington: World Bank, August 2005).

[18] Funders Concerned About AIDS, "US Philanthropic Commitments for HIV/AIDS", March 2005, <www.fcaaids.org/documents/FCAA_2006_ResourceTracking_comp.pdf> (16 October 2006).

[19] European HIV/AIDS Funders, "European Philanthropy and AIDS: A Report by the European HIV/AIDS Funders Group", July 2006, <www.kbs-frb.be/files/db/EN/European-Philanthropy-HIV-AIDS_08-06.pdf> (16 October 2006).

[20] PhRMA, "Global Partnerships: Humanitarian Programs of the Pharmaceutical Industry in Developing Nations", 2005, <//world.phrma.org/global.partnership.2003.pdf> (16 October 2006).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

16

ii. Lesotho[21]

a. State of the Epidemic[22]

The first case of HIV/AIDS in Lesotho was officially reported two decades ago, in 1986, and over the ensuing 20 years, the epidemic has escalated to become one of the world's most severe. Lesotho currently ranks in the top five countries globally in several key HIV/AIDS indicators, including overall HIV prevalence rate, adult mortality rate, declining life expectancy, and percentage of HIV/AIDS-related deaths in children under age 5. The epidemic has been characterized as "mature but unstable," with a high case-fatality ratio, increasing numbers of new infections, escalating mother-to-child transmission, and high rates of seroconversion among people with tuberculosis (50%) and sexually transmitted diseases (60%). Approximately one-quarter (23.2%) of adult Basotho are infected, with skewing toward women (25.7% vs 20.3% for all adults; 14.0% vs 6.0% for 15-24 year-olds) and people living in urban areas (28.8% vs 21.8%). An estimated 270,000 Basotho are currently living with HIV/AIDS, and 66 die of the disease each day; since 1986, life expectancy has dropped from 55 to just under 40, with unprecedented level of productive years of life lost. The number of orphans continues to grow rapidly - with 96,900 children under the age of 18 reported to have lost one or both parents.

b. Special "Drivers"

Partners and stakeholders in Lesotho's National HIV/AIDS Strategic Plan have identified special "drivers" that continue to fuel the epidemic; many have implications for religious engagement.

- Cultural Factors:
    - Multiple concurrent sexual relationships, with low condom use
    - Gender inequality, gender-based violence, and legal status of women
    - Intergenerational sex - by both men and women
    - Early ages of sexual debut
    - Lack of communication and guidance, parent-to-child
- Socioeconomic Factors:
    - Poverty, unemployment, and food insecurity, leading to transactional sex and substance abuse
    - Binge drinking and dagga smoking
    - High population mobility, especially migrant labor patterns leading to separation of spouses and families
- Beliefs and Behaviors:
    - Ineffective and poorly coordinated communication messages, in languages other than Sesotho and inaccessible via radio and television over broad, mountainous terrain
    - Lack of vocal leadership at the community level from civil society, including Faith-based organizations, traditional leaders and healers, NGOs, and governmental bodies
    - Growing myths that condoms spread HIV/AIDS and have other harmful effects
    - Perception of HIV/AIDS as a "foreign" disease and initial prolonged state of denial at the national level

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[21] This section is informed by the following documents: Ministry of Health and Social Welfare [Lesotho] and ORC Macro, *Lesotho Demographics and Health Survey 2004-2005*, (Calverton, Maryland, USA: Lesotho Bureau of Statistics and ORC Macro, 2005); Ministry of Health and Social Welfare [Lesotho], *Lesotho National HIV/AIDS Strategic Plan 2006-2011*, (Maseru, Lesotho: Ministry of Health and Social Welfare, 2006); Ministry of Health and Social Welfare [Lesotho], *Know Your Status Campaign National Operation Plan 2006-2007*, (Maseru, Lesotho: Ministry of Health and Social Welfare, 2006); UNAIDS, *Report on the Global Epidemic* (Geneva: UNAIDA, 2006); WHO, The World Health Organization Statistical Information System (WHOSIS), 2006, <http://www.who.int/whosis/en> (20 June 2006); See also WHO, *World Health Statistics,* 2006 and *The World Health Report,* 2006 <http://www.who.int> (20 June 2006).

[22] See Appendix E for further country-specific data in tabularized form.

The placement of our Community, Regional, and National Workshops in three highly different Health Service Areas in urban and rural Lesotho afforded an opportunity to learn first-hand of these special drivers.

c. Significant National/International Events and Plans - Lesotho

During the course of our study year, several significant events and plans were launched in Lesotho, potentially accelerating Universal Access and engagement with the religious community:

- *National AIDS Prevention and Control Program (NAPCP)* restructured, 2005
- *National AIDS Commission (NAC)* established by Act of Parliament, with coordinating structures - District AIDS Task Force (DATF) and District AIDS Coordinator (DAC), August 2005
- *First Local Government Elections* held, with expanding role for HIV/AIDS at the district and community levels, 2005
- *Public/Private Partnerships* for management of Pediatric AIDS and other HIV/AIDS issues established with UNICEF, WHO, the Clinton Foundation, and Baylor University, 2005
- *National "Know Your Status" Campaign* - Launched on World AIDS Day, December 1, 2005, with goal to have all people in Lesotho 12 years of age and older know their HIV status by the end of 2007
- *Lesotho Network of Persons Living with HIV (LENEPWA)* developed strategic initiative to guide response of PLWHA to the epidemic, 2005-6
- *National Monitoring and Evaluation Unit* established, with new district data officers trained and deployed and plan created for Central National Database, 2005
- Accelerated progress by Lesotho on the *United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS*, 2005
- *National Action Plan on Women and Girls and HIV/AIDS* developed, 2005
- *ARV Programs* expanded through Memorandum of Agreement with Christian Health Association of Lesotho and private health sector, 2005; ART coverage increased to 25.9% coverage by March 2006
- *Lesotho National HIV/AIDS Strategic Plan, 2006-2011,* Researched and drafted by May 2006
- *Vulnerable populations* for special focus identified by national HIV/AIDS partners and stakeholders:
  - Orphans and street children, especially in hard-to-reach and rural areas
  - Women and girls
  - Prisoners
  - People with disabilities
  - Sex workers
  - Migrant populations
  - Herd boys
  - People in the workplace

d. Funding and Support

According to UNAIDS, the Lesotho national government spends US $1,357,875 on domestic health.[23] In 2003 the Kingdom of Lesotho spent 9.5% of its total budget on health - equaling about USD 25 per capita. Unlike in Zambia, where external donors contribute a significant amount to health, only 8.2% of expenditures were provided through external donors in 2003 and only 20.3% of total health expenditures were funded through non-governmental sources.[24]

Over the last few years, Lesotho has received an increased amount of attention from the international community as the world became more aware of the peculiarities present in the Lesotho - especially in the

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[23] UNAIDS, 2006, <www.unaids.org/en/Regions_Countries/Countries/lesotho.asp> (12 October 2006).

[24] WHO, 2003, <www3.who.int/whosis/core/core_select_process.cfm?country=lso&indicators=nha&language=en> (12 October 2006).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

18

areas of HIV/AIDS.[25] In 2004, Official Development Assistance (ODA) to Lesotho totaled US$102 million-with top donors including the European Commission, Ireland, and the UK. Of the total aid, more than 55% was used for education (~20%), health (~10%) and other social services (~25%).[26] Top donors for HIV/AIDS in Lesotho include the US, the UK, Ireland, Germany, Sweden, and Japan.[27]

Top Ten Donors of Gross ODA to Lesotho (2003-04 average) *Measured in million USD[28]*		
1	EC	19
2	IDA	15
3	Ireland	14
4	AfDF	8
5	SAF& ESAF (IMF)	8
6	United Kingdom	6
7	Germany	6
8	Arab Agencies	5
9	WFP	4
10	United States	3

The Ireland Department of Foreign Aid gave a total USD 10.1 million in the year 2005. This money was used for interventions in health, education, HIV/AIDS, and general governance.[29] Although Lesotho is not a focus country of the United States President's Emergency Plan for AIDS Relief (PEPFAR), the US provides bilateral support to Lesotho for HIV/AIDS and contributes through the Global Fund, described below.[30]

The Global Fund to fight AIDS, TB, and Malaria has approved US $2,020,570 in current round 1 and 4 grants to the Kingdom of Lesotho, Ministry of Finance and Development Planning for activities focused on HIV/AIDS and tuberculosis.[31] The World Bank has approved US $5 million in funding to combat HIV/AIDS in Lesotho and $6.5 million for health sector reform related to HIV/AIDS.[32] Several UN agencies, including UNAIDS and UNICEF also fund initiatives related to HIV/AIDS in Lesotho.[33]

Private donors, corporations, and faith-based organizations have also been active in Lesotho, providing major funding and HIV/AIDS health and pediatric facilities. These include the Baylor School of Medicine, Médecins Sans Frontières (MSF), the Clinton Foundation, Bristol-Myers-Squibb Foundation, Pfizer Foundation, and the new Sentebale Charity of Great Britain.[34,35,36]

B. Universal Access and Millennium Development Goals: Support and Linkages

Concomitant with WHO's award for this study in July 2005, leaders of the G8 countries proposed an expanded initiative for Universal Access to HIV/AIDS treatment, care, and prevention by 2010, building on treatment gains achieved through 2005 and the furtherance of the health-related Millennium Development Goals. In September 2005, the initiative was endorsed by Heads of State and Government attending the 2005 World Summit, and a progress report on Universal Access was submitted to the United Nations General Assembly in May-June 2006 as part of the five-year review in implementing the earlier Declaration of Commitment on HIV/AIDS. The announcement of this initiative was recognized by our study teams, collaborators, and workshop participants as significant for framing and interpreting our findings and recommendations.

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[25] UNAIDS, 2006, <www.unaids.org/en/Regions_Countries/Countries/lesotho.asp> (12 October 2006).
[26] OECD, World Bank, <www.oecd.org/dataoecd/63/38/1878276.gif> (12 October 2006).
[27] Kaiser Family Foundation, "The HIV/AIDS Epidemic in Lesotho", HIV/AIDS Policy Fact Sheet, 2005, <www.kff.org/hivaids/upload/7357.pdf> (16 October 2006).
[28] Ibid.
[29] Ireland Department of Foreign Affairs, <www.irishaid.gov.ie/lesotho.asp> (12 October 2006).
[30] Kaiser Family Foundation, 2005.
[31] Global Fund, 2006, <www.theglobalfund.org/programs/countrysite.aspx?countryid=LSO&lang=en> (12 October 2006).
[32] World Bank, "Portfolio for Lesotho", (Washington: World Bank, August 2005).
[33] UNAIDS, 2006, <www.unaids.org/en/Regions_Countries/Countries/lesotho.asp> (12 October 2006).
[34] Funders Concerned About AIDS, "US Philanthropic Commitments", 2005.
[35] European HIV/AIDS Funders, "European Philanthropy and AIDS", 2006.
[36] PhRMA, "Global Partnerships", 2005.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

19

It is recognized that Universal Access will require a comprehensive health- and community-sector response, with increased advocacy, action, and alignment of resources. Five key strategic directions, with focused top-priority interventions, will guide global health efforts; each offers continuing or expanded engagement with religious health structures and leaders:[37]

Universal Access: Five Strategic Directions

1. ***Knowing HIV/AIDS status through confidential HIV testing and counseling***, and leveraging these services as important entry points for treatment and prevention activities
2. ***Maximizing six prevention strategies:***
   - promoting safer sex, especially for young people at high risk
   - reducing mother-to-child transmission
   - reducing transmission through injecting drug use
   - reducing transmission within the health-care setting
   - improving services to people living with HIV/AIDS
   - developing new health technologies

   Prevention efforts will also address gender inequalities and will target most vulnerable populations.
3. ***Continuing scale-up of HIV/AIDS treatment and care***, expanding partnerships and multi-sectoral collaboration
4. ***Improving strategic information***, and providing cross-country access and sharing
5. ***Building health systems capacity***, in-country and across regions

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C. Rationale for Religious Engagement in Universal Access

While universality implies a sense of equality and indivisibility in access to prevention, care, treatment and support, the notion of access is intimately tied to concepts of availability, affordability and acceptability. In the context of HIV/AIDS, the loci of a core package of treatment, prevention and care interventions are understood to be a hospital, a health center, a community or a home.

It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home based care and support of orphans - Christoph Benn 2003

From an African perspective, all of these concepts can be related to the strengths and capabilities of religious entities or interventions. We know that many hospitals, clinics or health centers in Africa have been initiated by and to a greater or larger extent sustained by religious bodies or institutions. We know, and the research carried out for this report reinforces, that innumerable community initiatives around orphans and vulnerable children (OVCs), treatment education and literacy, support groups and the like have arisen since the 1990s on the back of religious or faith initiatives and commitments in response to the HIV/AIDS challenge. The same can be said for initiatives that touch the home and the family, in particular around HBC and support for households headed by children or youth. Purely pragmatically, therefore, it is critical that we see religious and faith engagement in these ways as vital for any capacity to provide for universal access.

But further than that, the goal of universal access will not be met without meeting the criteria that define availability, affordability and acceptability. Here religious entities and initiatives once again are important points of reference in giving effect to those criteria. We hypothesize that this is so given that:

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[37] WHO, "WHO's Contribution to Universal Access to HIV/AIDS Prevention, Treatment and Care: Report of the Secretariat" (WHO, Fifty-Ninth World Health Assembly, 4 May 2006)

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

20

- They rest most often on a close, if not intimate, connection to the communities within which they work, and thus are a key entry point for making preventative, treatment and care interventions available in ways that even the state is unable to achieve in many parts of Africa, especially in rural areas.

- Their local rooting is usually not just organizational but linked to well-understood norms and values that shape, to some extent, the lifeworlds, behavioral patterns and health-seeking choices of the communities in which they are based. This means that interventions that go through, or at least are understood by and "blessed" by religious or faith based bodies, can be expected to have a high level of acceptability, again often higher than those associated with the state, as our previous research shows in terms of levels of trust.[38]

- Finally, while this is not always the case, religious or faith based organizations and initiatives frequently are able to bring to bear personnel, including volunteers, to work with health interventions, and to provide material resources such as a shelter, a refuge, a means of transport, emergency food or clothing, and the like. They also play the role in many circumstances of mediating between health facilities or agencies and people on the ground, thus providing a service that would otherwise be costly to provide from the fiscus of the state or any other kind of intervening body. In short, they may well, and often do, help to address the question of affordability in prevention, treatment, care and support.

D. Religion, Health and HIV/AIDS in Africa: Other Literature

This study, and more generally the ARHAP research vision, emerges out of a large and diverse body of knowledge, much of which is dispersed or "grey" literature generated by organizations working in the field rather than from academic institutions. In the following section, we will briefly consider the literature that most directly informed this study or that is specifically focused on Lesotho and Zambia. For a more in-depth review of literature informing the ARHAP research, please refer to the *ARHAP Literature Review: Working in a Bounded Field of Unknowing*, and its companion bibliography.[39]

i. REs and Health Systems in Africa

There are a handful of studies which seek to assess the presence of FBO/Is in terms of broader national health systems - that is tangible religious health assets such as hospitals and clinics, or FBO/Is recognizable to public health frameworks. These studies estimate that 30% and 70% of medical infrastructure is owned (or health services provided) by religious organizations.[40] What these studies demonstrate is that while the religious-health infrastructure in Africa appears to be significant, there is still a critical lack of systematic research or information that can ultimately guide policy. The full scope of the religious health system is unknown, and what information there is, remains disparate and often conflicting. Furthermore, while visible structures such as hospitals can be counted, the multitude of smaller faith-based programs and initiatives are rarely visible to decision makers at a national or international level. Even the religious coordinating bodies

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[38] See L. Thomas, J.R. Cochrane, B. Schmid, *Let us Embrace: The Role and Significance of a Faith-based Initiative in HIV/AIDS Work,* ARHAP Report (Cape Town: ARHAP, University of Cape Town, 2006).

[39] J. Olivier, J. Cochrane, B. Schmid, *ARHAP Literature Review: Working in a Bounded Field of Unknowing* (Cape Town: ARHAP, University of Cape Town, 2006); J. Olivier, J. Cochrane, B. Schmid, *ARHAP Bibliography: Working in a Bounded Field of Unknowing* (Cape Town: ARHAP, University of Cape Town, 2006).

[40] R. Asante, *Sustainability of Church Hospitals in Developing Countries: A Search for Criteria for Success*, (Geneva: World Council of Churches, 1998); C. Ausherman, *Religious Health Networks Survey Report*, (Los Altos, CA: David and Lucille Packard Foundation, 1998); F. Baer, "IMA signs $25 Million Contract for SANRU III", Forum, (Christian Connections in International Health, May 2001); T. Baird, "Christian Hospitals in Nigeria Provide Post Abortion Care and STD Management", Forum, (Christian Connections in International Health, March 1999); C. Benn, "Why Religious Health Assets Matter", in ARHAP: Assets and Agency Colloquium Report, Pietermaritzburg, South Africa, August 2003 (Cape Town: African Religious Health Assets Program, 2003); Green et al. "A Shared Mission?"; M. Robinson and G. White, "The Role of Civic Organizations in the Provision of Social Services: Towards Synergy", in *New Patterns of Social Provision in Low Income Countries*, edited by G. Mwabu, C. Ugaz and G. White, (Oxford: Oxford University Press and UNI.WIDER, 1998).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

21

are often oblivious to their own congregations' initiatives - that is, religious responses are often locally-based to such an extent that their denomination or religious body are unaware of them.[41] Therefore, even the "religious health system" is not aware of its own assets.

ii. Religious Responses to HIV/AIDS in Africa

However, what is indisputable is that religion, more generally, is central to society in Zambia and Lesotho, indeed Zambia has been declared a Christian nation. This centrality emphasizes the importance of not only a clearer assessment of religious-owned facilities, but also of religious entities, organizations and other initiatives - especially in the context of HIV/AIDS which demands such multisectoral response and action.

If there is a lack of information on what tangible religious assets there are, then there is even less understood on how religious groups and communities are responding to the HIV/AIDS crisis at a local, community and personal level - that is, not only through hospitals and clinics, but also through prevention, care or health promoting initiatives.

There are, however, an increasing number of recent studies which have sought to comment on the over-arching response of religion to HIV/AIDS. These can be roughly divided into large-scale studies with a broad focus, and localized assessments. The studies with a global or continental focus[42-43] - generally suffer as a result of their broad perspective, as they attempt to cross diverse religious and cultural perspectives, yet are successful at

Half the work in education and health in sub-Saharan Africa is done by the church…but they don't talk to each other, and they don't talk to us - World Bank President James Wolfensohn, 2002

showing the prevalence of religious action in health and particularly in the HIV/AIDS crises. Country-specific or community studies (most frequently focused on Uganda[44], or South Africa[45]), are rare, but are generally more successful at showing the variety of services religious communities and groups offer in

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[41] J. Liebowitz, *The Impact of Faith-based Organizations on HIV/AIDS Prevention and Mitigation in Africa,* (Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, 2002).

[42] See G. Byamugisha, L. Steinitz, G. Williams and P. Zondi, *Journeys of Faith: Church-based Responses to HIV and AIDS in Three Southern African Countries*, (Pietermaritzburg: Cluster Publications, 2002); Foster, *Study of the Response*; Liebowitz, *The Impact of Faith-based Organizations*; J. Liebowitz, *Faith-based Organizations and HIV/AIDS in Uganda and KwaZulu-Natal*, Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal (2003); A. Munro, *Belated, but Powerful: The Response of the Catholic Church to HIV/AIDS in Five Southern African Countries*, (Pretoria, South Africa: Southern African Catholic Bishops' Conference, 2002); J. Munene *A Situational Analysis of the Church's Responses to HIV/AIDS*, (PACANet, Christian HIV/AIDS Country Coordinating Mechanisms in Zambia, Swaziland, Uganda and Namibia, 2003); S. Parry, *Responses of the Churches to HIV/AIDS: Three Southern African Countries*, (Harare and Geneva: World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office, 2002); S. Parry, *Responses of the Faith-based Organisations to HIV/AIDS in Sub-Saharan Africa*, (Harare and Geneva: World Council of Churches and Ecumenical HIV/AIDS Initiative in Africa, 2003); J. Trinitapoli and R. Regnerus, *Religious Responses to AIDS in Sub-Saharan Africa: An Examination of Religious Congregations in Rural Malawi*, (Philadelphia: American Sociological Association Annual Meeting, 2005); S. Woldehanna et al, *Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS, A multi country key informant survey*, (Washington, DC: Global Health Council, 2005).

[43] The WCC has completed a series of studies focused on specific African regions: See H. Lusey-Gekawaku, *The Churches Confronted with the Problem of HIV/AIDS: Analysis of the Situation in Five Countries of Central Africa,* (Geneva: World Council of Churches and Ecumenical HIV/AIDS Initiative in Africa, 2003); M. Molonzya, *The Churches Confronted with the Problem of HIV/AIDS: Analysis of the Situation in Six Countries of Eastern Africa,* (Geneva: World Council of Churches and Ecumenical HIV/AIDS Initiative in Africa, 2003).

[44] E.C. Green, *Faith-based Organizations: Contributions to HIV Prevention,* (Washington DC: US Agency for International Development and The Synergy Project, TvT Associates, Harvard Center for Population and Development Studies, 2003).

[45] See M. De Waal and O. Nakedi, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programs,* (South African Catholics Bishops Conference and The University of Pretoria, 2005);
D. Gennrich and A. Gill, *Churches and HIV/AIDS: Exploring how Local Churches are Integrating HIV/AIDS in the Life and Ministries of the Church and How Those Most Directly Affected Experience These*, (Pietermaritzburg, South Africa: Pietermaritzburg Agency for Christian Social Awareness, 2004); S. Parry, *Responses of the Churches to HIV and AIDS in South Africa*, (Geneva: World Council of Churches, 2005).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

22

combating the HIV/AIDS crises. Looking at all these studies, there are certain key (generalizable) statements that can be made about religious responses to HIV/AIDS in Africa:[46]

- Such religious responses are more prevalent than is currently recognized, and are making a difference in the communities in which they are based.

- Religious responses range across the continuum of prevention, care and support, treatment and rights, and are often "holistic" in nature, focusing on the emotional and spiritual aspects of care as well as the physical.

- There is also general acknowledgement that religious responses do not always fit into the norm or schema of health responses, often employing many strategies at the same time.

- There is, however, still a startling lack of information on religious organizations' activities in the HIV/AIDS sector, particularly in relation to small-scale or community initiatives which remain undocumented.

- Much remains to be understood about the nature, scale and scope of these contributions and the way in which they supplement and interface with more centralized responses to the HIV/AIDS crisis.[47]

- There, therefore, appears to be a crucial lack of alignment between health systems (and resources) and religious communities.[48]

- Orphans and vulnerable children are a primary focus of FBO/Is in the HIV/AIDS arena, and they are well suited to this work and a viable option for further support.[49]

- FBO/Is are also particularly focused on care, often at a home-based or community level.

- In some cases an element of "special care" has been attributed to religious interventions.[50]

- Religious responses to HIV/AIDS can include factors that contribute to stigma and discrimination, as well as those which mitigate against them.[51]

- Similarly, literature on religious responses to HIV/AIDS is mainly focused on issues of sexuality - where religion is seen both as a tool for prevention or behaviour change, and as cause for risky behaviour.[52]

- Finally, it is recognised that in an African setting, there is a complex blending of multiple religious and cultural practices which needs to be acknowledged - particularly in relation to sexual practices,[53] and in relation to beliefs and behaviours linked to traditional religions and practices.[54]

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[46] See Appendix I for further information on studies relating to GIS data in Lesotho and Zambia.

[47] See K. Birdsall, *Faith-based Responses to HIV/AIDS in South Africa: An Analysis of the Activities of Faith-based Organizations (FBOs) in the National HIV/AIDS Database*, (Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation, 2005).

[48] See DIFAEM, *Global Assessment of Faith-based Organisations' Access to Resources for HIV and AIDS Response*, (German Institute for Medical Mission, 2005); S.K. Josephine, A.Y. Agapit and K. Tatagan-Agbi, *Churches and the HIV/AIDS Pandemic: Analysis of the Situation in Ten West African Countries* (Geneva: World Council of Churches, World Alliance of YMCAs, 2001); N. Taylor, *Many Clouds, Little Rain? The Global Fund and Local Faith-based Responses to HIV and AIDS*, HIV/AIDS Briefing paper 4 (Teddington, UK: Tearfund, 2005); N. Taylor, *The Warriors and the Faithful: The World Bank MAP and Local Faith-based Initiatives in the Fight Against HIV and AIDS*, HIV/AIDS Briefing Paper 5 (Teddington, UK: Tearfund, 2005).

[49] See Foster, *Study of the response*; UNICEF, *The Role of Faith-based Organisations in Providing Support to Orphans and Vulnerable Children in Africa,* (New York: United Nations Children's Fund and World Conference of Religions for Peace, 2003); H. Young, *More than Words? Action for Orphans and Vulnerable Children in Africa: Monitoring Progress Towards the UN Declaration of Commitment on HIV/AIDS,* (Milton Keynes, UK; World Vision, 2005).

[50] See R. Reinikka and J. Svensson, *Working for God? Evaluating Service Delivery of Religious Not-for-profit Health Care Providers in Uganda*, (Washington DC; World Bank, 2003); Thomas et al, Let us Embrace.

[51] See W. Parker and K. Birdsall, *HIV/AIDS, Stigma and Faith-based Organisations: A Review*, (Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation and DFID Futures Group MSP, 2005)

[52] See V. Agadjanian, "Gender, Religious Involvement, and HIV/AIDS Prevention in Mozambique", *Social Science and Medicine* 61, no.7 (2005), 1529-1539; R.C. Garner, "Safe Sects? Dynamic Religion and AIDS in South Africa", *Journal of Modern African Studies* 38, no.1 (2000), 41-69; Green, *Faith-based organizations;* E. Lagarde et al, "Religion and Protective Behaviours Towards AIDS in Rural Senegal", *AIDS* 14, no.13 (2000), 2027-2033; Liebowitz, *Faith-based Organizations;* B.K. Takyi, "Religion and Women's Health in Ghana: Insights into HIV/AIDS Preventive and Protective Behaviour", *Social Science and Medicine* 56 (2003), 1221-1234.

[53] See C. Baylies and J. Bujra, *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia,* (London and New York: Routledge, 2000); Q. Gausset, "AIDS and Cultural Practices in Africa: The Case of the Tonga (Zambia)", *Social Science and Medicine* 52, no.81 (2001); A. Kapungwe, "Traditional Cultural Practices of Imparting Sex Education and the Fight against HIV/AIDS: The Case of Initiation Ceremonies for Girls in Zambia", *African Sociological Review* 7, no.1 (2003), 35-52;

This overview of the literature helps to locate the work of the African Religious Health Assets Program (ARHAP), and the research that has produced this report. To understand the wider context of this work, we turn now to a consideration of current work around African Religious Health Assets.

IV. African Religious Health Assets

A. History of ARHAP

The African Religious Health Assets Program (ARHAP) an international research collaboration, was formed in December 2002 in order to address the general paucity of studies on faith based organizations working in health, in the face of growing public health crises in many parts of the world. Africa became the focus because it offers the potential for contributing a great deal of learning globally, given major public health challenges, a complex mix of religious traditions in varying contexts, and a wide variety of actors in the field of health.

Since its launch, ARHAP has worked at refining its focus and conceptual frameworks, and extending its dialogue with religious and public health agencies, practitioners and academics, particularly in Africa. In the process, ARHAP has become visible to players in the field of public health internationally, and a series of case studies have been undertaken in southern Africa.

The major ARHAP partners are: the University of Cape Town (UCT), Emory University, the University of KwaZulu Natal (UKZN), and the University of the Witwatersrand (WITS) - but there are firm connections to others, such as the Centers for Disease Control and Prevention (CDC), various NGOs, and many specialist individual collaborators.

B. ARHAP Vision and Objectives

ARHAP's overall objectives are as follows:

- To assess existing baseline information sources and conduct an inventory ("mapping") of religious health institutions and networks in Africa.
- To articulate conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives, across geographic regions and different religions, in order to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative efforts.
- To develop a network that will include nodes of scholars and religious as well as public health leaders in sub-Saharan Africa; plus scholars from outside Africa, religious leaders and representatives of key funding, development and policy-making organizations.
- To train future leaders of both public health and religious institutions in religious health asset assessment skills (capacity building).
- To provide evidence to influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies.
- To disseminate and communicate results and learnings widely and regularly.

J.R.S. Malungo, "Sexual Cleansing (kusalazya) and Levirate Marriage (kunjilila mung'anda) in the Era of AIDS: Changes in Perceptions and Practices in Zambia", *Social Science and Medicine* 53 (2001), 371-382; C.B. Yamba, "Cosmologies in Turmoil: Witchfinding and AIDS in Chiawa, Zambia", *Africa* 67, no.2 (1997), 200-223.

[54] See V.G. Chipfakacha, "STD/HIV/AIDS Knowledge, Beliefs and Practices of Traditional Healers in Botswana", AIDS Care 9, no.4 (1997), 417-25; R. King, *Collaboration with Traditional Healers in HIV/AIDS Prevention and Care in Sub-Saharan Africa: A Literature Review*, (Geneva: Joint United Nations Program on HIV/AIDS, 2000).

C. ARHAP Research Status

ARHAP has a selection of research projects located in Southern Africa in various stages of completion - including both research teams and individual projects generated by graduate students.

- *Eastern Cape, South Africa: "Evaluating the Faith-Factor" (2004-2006)*

The Vesper Society, California, commissioned ARHAP to do research on the integrated Masangane HIV/AIDS program affiliated with the Moravian Church in Eastern Cape, South Africa. Completed in 2006, this study aimed to understand the role of the religious health assets of the Masangane ART program for public health, as a model for a replicable response to HIV/AIDS. A crucial aspect of this research involved teasing out what value is added to this program by its faith-based nature. The Masangane case study team consisted of researchers from the University of Cape Town and was linked to the Medical Research Council (MRC) through the Centre for Health Policy at the University of the Witwatersrand (WITS).[55]

- *Copperbelt, Zambia: "Testing ARHAP Theory" (2004-ongoing)*

This project is closely aligned to the ARHAP Theory Matrix, utilizing interdisciplinary research methods in order to unpack and evaluate it. Seven key research foci are being addressed by different researchers, of which the first four focus on specific assets and the other three on the agency of various players. It aims to understand the current state of health - and the wealth of religious agencies providing health-related services - in the Copperbelt against the conditions that shaped them. The Zambian research team consists of researchers from the University of KwaZulu Natal (UKZN) under the leadership of Prof Steve de Gruchy.

- *Lesotho: "Bophelo" (2004-ongoing)*

A research team consisting of graduate students under the leadership of Paul Germond (University of the Witwatersrand) has been investigating the intersection of health and religion in Lesotho. A significant advance here was the introduction of the term "Bophelo" into the ARHAP theoretical framework - conceptualized in English as "healthworld" - to capture the complex manner in which the Basotho construct their understandings of health and illness in local contexts, and how these play themselves out in terms of multiple health seeking behaviors.

- *Memphis - USA: "Transporting African Research to the USA" (2006-ongoing)*

A newly established research site, Memphis is the location for an initiative to transport what has been learnt so far in Africa to an American setting in order to develop our understanding of how ARHAP theory and tools translate into a multicultural American setting. This research is managed by the ARHAP-Emory team.

- *CDC National Center for Public Health and Faith Collaborations (2005 - present)*

The Centers for Disease Control and Prevention (CDC) has established the first national Center for Public Health and Faith Collaborations with the Interfaith Health Program/ARHAP, Emory University; one purpose is to identify and assess religious health assets in "paired" US and global sites and to determine effective strategies for alignment with public health systems.

- *Graduate research*

16 ARHAP-related student dissertations have been initiated, of which 6 have been completed. These deal with RHA in particular contexts, often relating to HIV/AIDS. They range from intangibles like agency and discourse to tangible interventions, from understanding bophelo to analyzing the role of leadership.[56] What is

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[55] Thomas et al, *Let us Embrace,* 2006.
[56] For more on graduate research Lesotho, Zambia and South Africa see <http://www.arhap.uct.ac.za>

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

25

largely missing from most studies that might inform our work is the dimension of religion that is "internal" to faith based communities or organizations, an element that explains their motivations, commitments, attitudes, actions and relational or associational strengths on the basis of their own self-understandings and world-views.

This dimension is harder to take into account in defining religious health assets, particularly in any way that makes for easy identification, replicability and generalization - the requirements of a mapping process that would be useful to policy makers and other decision makers. However, the magnitude of the HIV/AIDS pandemic has already forced decision makers to try to engage all aspects of these assets as agencies struggle to plan expanded programs. This necessarily complex approach makes demands on all aspects of religious health assets, including those traditionally countable and those that are obviously necessary (for example shared loyalties and care giving), but difficult to quantify. This is precisely the research focus of ARHAP: To develop criteria and related assessment tools that will enable a richer, more dynamic and ultimately more productive approach to religious health assets and their contribution to health in Africa and elsewhere.

A guiding research question for ARHAP is: *In the context of major health crises (linked to environmental and social conditions), given the widespread engagement of religious entities (REs) in health activities, what criteria, categories and related assessment tools will engender a richer, more dynamic and more productive view on "religious health assets" (RHAs), their contribution to health, and their alignment (or lack of it) with public health systems*?
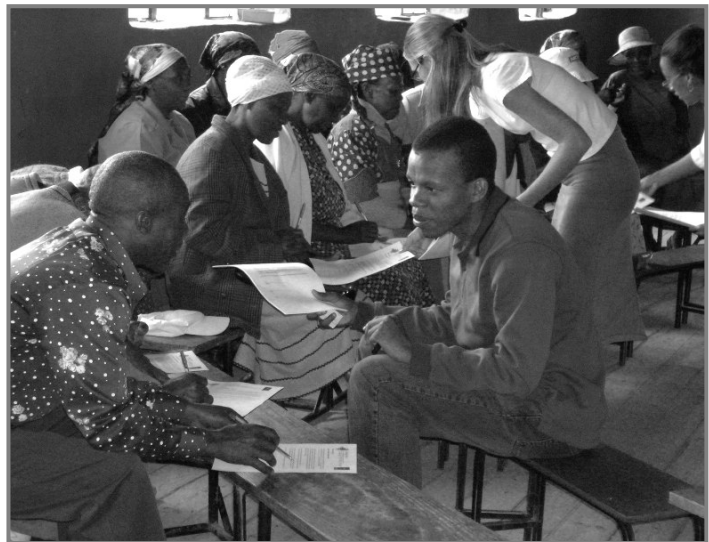
Scott Community, signing of consent forms, Masite, 2006

We are interested in focusing on what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.

We begin with a positive view of faith based initiatives in health in the first instance, hence our description of them in terms of religious health *assets*,[57] which we understand much more broadly than the more traditional focus on facilities such as hospitals and clinics. At the same time, a naïve view of the role of religion would undermine our grasp of the necessary social realities; hence we recognize the need to balance the positive with a clear grasp of the limits and possible negative impact of religious traditions or faith based practices in particular contexts.

It is within these various frameworks of theory and interest that this study moves forward towards the mapping of a variety of religious entities in seven locations in Lesotho and Zambia - followed by an exploration of how these religious entities work within their communities, as well as within the religious and public health arenas in which they are engaged.

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[57] ARHAP bases its work on the assets-based approach as advocated by Kretzmann and McKnight, see J. Kretzmann and J. McKnight, *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets* (Chicago: ACTA Publications, 1993).

Chapter Two

Mapping Religious Health Assets

Maramba Community Mapping, 2006

Chapter Two: Mapping Religious Health Assets

Our study stems from the broader ARHAP Research Framework described in Chapter 1 and maps Religious Health Assets (RHAs) through a blending of Participatory Engagement Workshops and GIS mapping. This blending of approaches adds new dimensions to our understanding of religious entities and structures missing in prior surveys, contributes to the emerging field of Participatory GIS (PGIS), and should lead to more effective engagement between public health and religious entities.

The linking of community participation with geospatial technologies remains in its infancy but is taking place in all world regions and in a diversity of social and geographic contexts… Participant communities have valuable local knowledge that augments conventional GIS applications, and these can be successfully employed in academic research and for development planning – **"Linking Community Participation to Geospatial Technologies" by Harris and Weiner.**

We will first describe each approach, with its tools and methods, then briefly examine the GIS database and resulting maps. This information will provide the grounding for deeper exploration of religious health assets in Chapters 3 and 4.

Throughout, we will use the terms "map" and "mapping" in the broad sense to mean both the process and result of making visible both tangible and intangible items and their relationships. Thus, we make use of *participatory tools* to *draw out* and *diagram* community perceptions of religious and health entities and their relationships - one type of mapping - and later employ *GIS tools* to create a physical typology - a more traditional type of map.

V. Participatory Engagement Workshops

The participatory inquiry component of the study was accomplished through a series of Participatory Engagement Workshops, conducted at the community, district/provincial, and national levels in each country.

The Participatory inquiry tool, entitled **Participatory Inquiry into Religious Health Assets, Networks, and Agency** (hereafter referred to as **PIRHANA**), was developed for ARHAP and this purpose, drawing on the legacy of participatory methods established by Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA). The full toolset and facilitator guidebook for conducting the workshops is available as a separate document, to be accompanied by facilitator training and technical assistance; a summary is provided here and in Appendix F.

The PIRHANA was broadly designed to elicit the following information:
- Increased understanding of religion and religious entities, as religious health assets, in the local area/context
- Perceived strengths of the assets
- Ties and connections between identified assets
- Changes of scale, order or character taking place among the assets
- Capacity challenges in relation to the community at large
- Actual use of the assets by people on the ground

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

27

- Deeper dynamics in the choices people make about religious health assets, as a crucial contribution to understanding what maps at a more general level mean in practice, especially in local communities where policies must be implemented

The PIRHANA tool consists of two "suites" of exercises designed to engage participants at two levels:
- Community members
- Area/Regional/National Leadership

 And makes use of the following PRA/PLA techniques:
- *Participatory mapping* in which participants map their communities, identifying the existing social and religious entities.
- *Participatory diagramming* in which participants produce diagrams of the relationships between religious and health entities.
- *Participatory indexing* in which participants create their own collective definitions of key factors to do with religion, health and wellbeing.
- *Participatory ranking* in which participants rank the relative strengths and weaknesses of the religious contribution to health and wellbeing

The PIRHANA tool is applicable in a variety of settings, both urban and rural. Special care must always be taken to ensure translation and adaptation to the local context.

A. The PIRHANA Toolset

The PIRHANA toolset was piloted in three workshops in the Copperbelt in Zambia and further analysed by eight key ARHAP researchers from the Zambia and Lesotho teams. A number of important changes were made, and the revised tool was then used in both countries.

Each PIRHANA workshop was designed as a one-day event to include 20-25 key informants each and employed a mix of exercises focused on six key questions. Attention was paid to the logical flow of the exercises so that certain exercises created the data that could be used in subsequent sets; thumbnail sketches of the exercises are displayed in Appendix F and a fuller description is provided below.

Paray Leadership Workshop, Traditional Healers Group, Thaba Tseka, 2006

The exercises were supplemented with Transect Walks/Drives, tours of local facilities, and discussions with WHO and other officials to provide orientation and context. All the facilitators of the workshops were trained by ARHAP team members, with great attention paid to the importance of participation and appreciative inquiry.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

28

B. The Logic Flow of PIRHANA

The logical flow of the exercises was designed so that there was coherence to the process and to the research findings. Both community-level and regional-level workshops incorporated seven interlocking steps:

Community-Level PIRHANA Exercises

Step 1: Contextual considerations
The exercises began with a deliberate focus on context. Prior to the workshops the research team was led by key informants on a *transect walk* through a section of the community. The workshops then began with participants drawing *community maps* and identifying the key religious and social entities and facilities in their community. In the light of insights gained through the transect walk and other preparatory work, the research team were able to dialogue with community members about the context.

Step 2: Health and wellbeing within the community context
Having engaged in conversation about context, participants were then asked to identify the key factors that both (i) contribute to and (ii) undermine health and wellbeing in the community. These two sets of factors were then integrated in a participatory discussion to create a contextual group-identified *health and wellbeing index*.

Step 3: The contribution of community facilities to community health and wellbeing
The third exercise then combined key social facilities (including religious entities) identified in Exercise 1 with key factors contributing to health and well-being from Exercise 2 to create a *facility/health ranking* matrix. This enabled participants to rank the relative contribution of community facilities to the group-identified factors contributing to health and wellbeing. Within this process, we were interested to see the relative contribution of religious entities to health and wellbeing.

Step 4: The contribution of religion to health and wellbeing
The next exercise moved the focus specifically to the perceived contribution of religion to health and wellbeing, and through a participatory process a *religion and health index* was created. These broad factors were then synthesized and prioritised in a participatory discussion into a group-identified set of key religious factors.

Step 5: The relative contribution of religious entities to health and wellbeing
This process closely followed that used to create the facility/health ranking matrix. It drew together the religious entities that were identified in the transect walk and the community maps with the synthesized key religious factors of the previous exercise, and enabled participants to rank the relative contribution of religious entities to the group-identified religious factors. In this way a *health/religious entity ranking* matrix was created.

Step 6: Identification of exemplars
The previous exercises were undertaken with a great deal of intensive discussion in small groups and in plenary, and participants were strongly immersed in thinking about the contribution of religion and religious entities to health and wellbeing and to the language of *Religious Health Assets*. In a participatory exercise they were then asked to identify the best examples of such assets in their community, in the context of HIV/AIDS. The plenary discussion sought to reflect on the reasons why these exemplars were chosen, thus providing a set of group-identified *characteristics of exemplar RHAs*.

Step 7: Local commitment
As a respectful and appreciative research tool, PIRHANA did not end with the research teams' extracting the data for their own purposes. Throughout the workshop all the information that was being accessed by the research team was at the same time being accessed by the participants. For this reason the workshop ended with an intentional time for participants to talk amongst themselves about what they would like to do with the information they had generated and to make any appropriate *local commitment* to take forward the process. This opportunity was taken very seriously.

Regional-Level PIRHANA Exercises

Step 1: Considerations of context: "space"
The regional workshops began with a transect drive around key areas in the region and drew on what had been gained at the community level. Then, in workshop, participants undertook a series of exercises that raised contextual matters to the fore. Of particular importance was the *timeline*, in which participants located events to do with religion and health into a wider socio-political context and the *mapping exercise* in which participants took maps of the region and the town and identified the presence of health-related entities (both general and religious).

Step 2: Considerations of context: "time"
Assets, networks and agency exist in time and are therefore always in flux and always responding to changing circumstances. What we map today may not have been there a year ago, and may well not be there in a year's time, and thus the *timeline* exercise gave participants and the research team an opportunity to reflect on the causes and effects of certain events and their wider relationships.

Step 3: RHAs and their relationships
In the process of the timeline and mapping exercises, a range of significant religious entities, and other health facilities were identified. These were used in a *spidergram exercise* in which participants mapped the relationships among the entities, enabling us and them to identify the nature and scope of these relationships.

Step 4: The contribution of religion to health and wellbeing
The next exercise paralleled the community workshop, with the focus moving to the perceived contribution of religion to health and wellbeing, and through a participatory process a *religion and health index* was created. These broad factors were then synthesized and prioritised through a participatory discussion into a group-identified set of key religious factors. In this process participants were introduced to the concept of *Religious Health Assets*.

Step 5: The contribution of religion to health and wellbeing in a time of HIV/AIDS
This exercise expanded the previous one, with a focus specifically on HIV/AIDS, and enabled participants and the team to gain insights into the contribution of religion to the struggle against the pandemic. In some settings this flowed organically out of the previous exercise; in others it was introduced by the facilitator.

Step 6: The identification of exemplars
With the data from and discussions around the previous exercises to do with the timeline, mapping exercise, spidergram, religion and health index, and religious health assets fresh in their minds, participants were now asked to identify the best examples of such assets in their community. The plenary discussion sought to reflect on the reasons why these exemplars were chosen, thus providing a set of group-identified *characteristics of exemplar RHAs*.

Step 7: Local commitment
As a respectful and appreciative research tool, PIRHANA did not end with the research teams' walking away with the data for their own purposes. Throughout the workshop all the information that was being accessed by the research team was at the same time being accessed by the participants. For this reason the workshop ended with an intentional time for participants to talk amongst themselves about what they would like to do with the information that they had generated and to make any appropriate *local commitment* to take forward the process. This opportunity was taken very seriously.

C. Nature of the Research Data Emerging From the PIRHANA Tool

As is evident, the entire research process was driven by a participatory, inductive and non-extractive approach. This had an important impact upon the generation of research data in three ways.

- The discussion about HIV/AIDS was, by and large, generated "from below", as participants reflected upon religion, health and wellbeing in a context dominated by the pandemic. At times specific questions were posed about HIV/AIDS, but it served as the constant backdrop to all the research.

- The generation of research data is uneven across the research sites. The use of group-identified participatory factors in all the ranking exercises and the contextual identification of social and religious facilities and entities generated data that is highly context-specific. While this has its obvious weaknesses for quantitative research purposes, considered in full, it is the extraordinary strength of this research theory and method. Given the state of knowledge about RHAs at this point in time, this is a significant boundary that has been interrogated.

- The attention given to participation both at the content and process levels meant that at times, participants took hold of the discussions and steered them in their own directions. Keeping a hand on this required both (i) sensitive respect for the participants and (ii) attention to the stated research goals on the part of the research team. We are aware that at times there were tensions between these two objectives and that this also has a bearing on the nature of the research findings.

D. PIRHANA in a Time of HIV/AIDS

A major reason for using PIRHANA to audit, analyse and align religious health assets is so that such assets can contribute to the struggle for health and wellbeing in the midst of the HIV/AIDS pandemic, and because of this, HIV/AIDS is specifically named in the consent form.

At a local community level it was important that we did not "force" the issue about HIV/AIDS in a communal setting, owing to the range of sensitive issues to do with disclosure, stigma and local custom in a setting where neighbours and local religious leadership may be present. However, our overwhelming experience is that ordinary people are attentive to the issues, and if they are able to trust the appreciative attitude of the facilitators and the creative space to reflect about health in the community they will naturally connect with issues to do with HIV/AIDS. This was borne out in the research.

At the regional level many of the participants were specifically involved in responsibilities to do with HIV/AIDS. For this reason, there was a specific "trajectory" of questions about HIV/AIDS throughout the PIRHANA exercises.

E. PIRHANA Workshop Overview

A total of 16 workshops were conducted in Lesotho and Zambia between 31 October 2005 and 8 April 2006. In this period, 9 Community and 7 Regional/National workshops were held, including the 3 Pilot Workshops in the Copperbelt, Zambia. In total, 358 people participated. The sites were selected to reflect a mix of geographic and social settings and to provide a multi-level view of religious health assets in each location (see tables and maps below).

Workshops were held in a variety of community facilities, including religious halls and conference centers.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

31

Zambia Workshop Sites, Dates and Participant Numbers

Country	Province	Community Site	Area/ Regional Site	National Site	Dates	# Participants
Zambia	Copperbelt	Mushili and Kitwe	Kitwe		31Oct-2Nov	27/17/29 = **73**
	Southern	Maramba	Livingstone		10-11 Jan	24/21 = **45**
	Eastern	Chipata	Chipata		04-05 Apr	21/26 = **47**
	Lusaka	Bauleni	Lusaka	Lusaka	07-08 Apr	20/10 = **30**
						Total 195

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

32
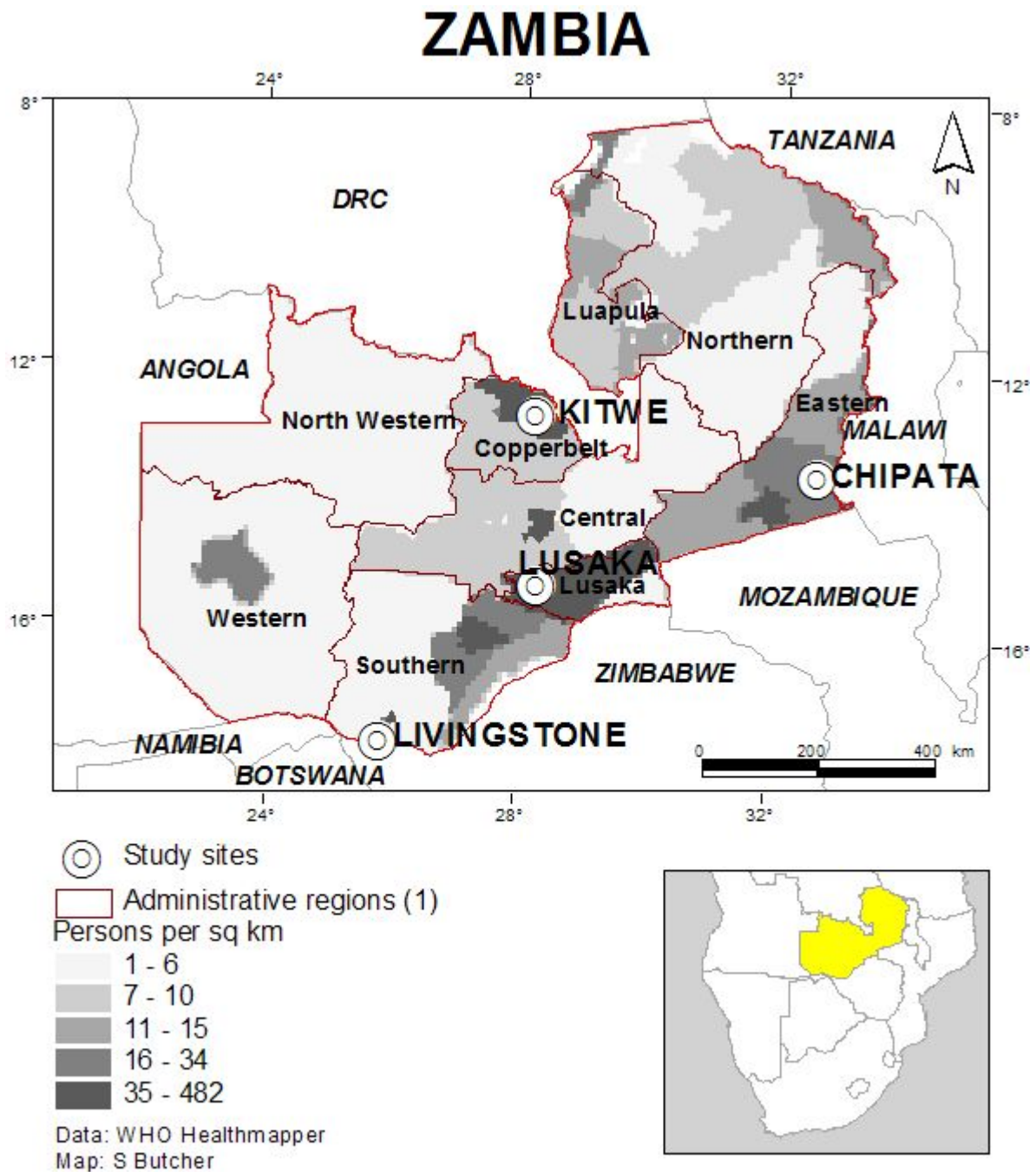
Lesotho Workshop Sites, Dates and Participants

Country	Health Service Area	Community Site	Area/ Regional Site	National Site	Dates	# Participants
Lesotho	Maseru	Ha Thamae	Maseru	Maseru	18-19Jan; 07 Apr	32/21/21 = 74
	Scott	Masite	Morija		01-02 Mar	23/19 = 42
	Paray	Mohlanapeng	Thaba Tseka		03-04 Apr	34/13 = 47
						Total = 163

LESOTHO

Study sites

Administrative regions (1)

Persons per sq km

5 - 22
24 - 41
45 - 67
68 - 102
105 - 543

Data: WHO Healthmapper
Map: S Butcher

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

33
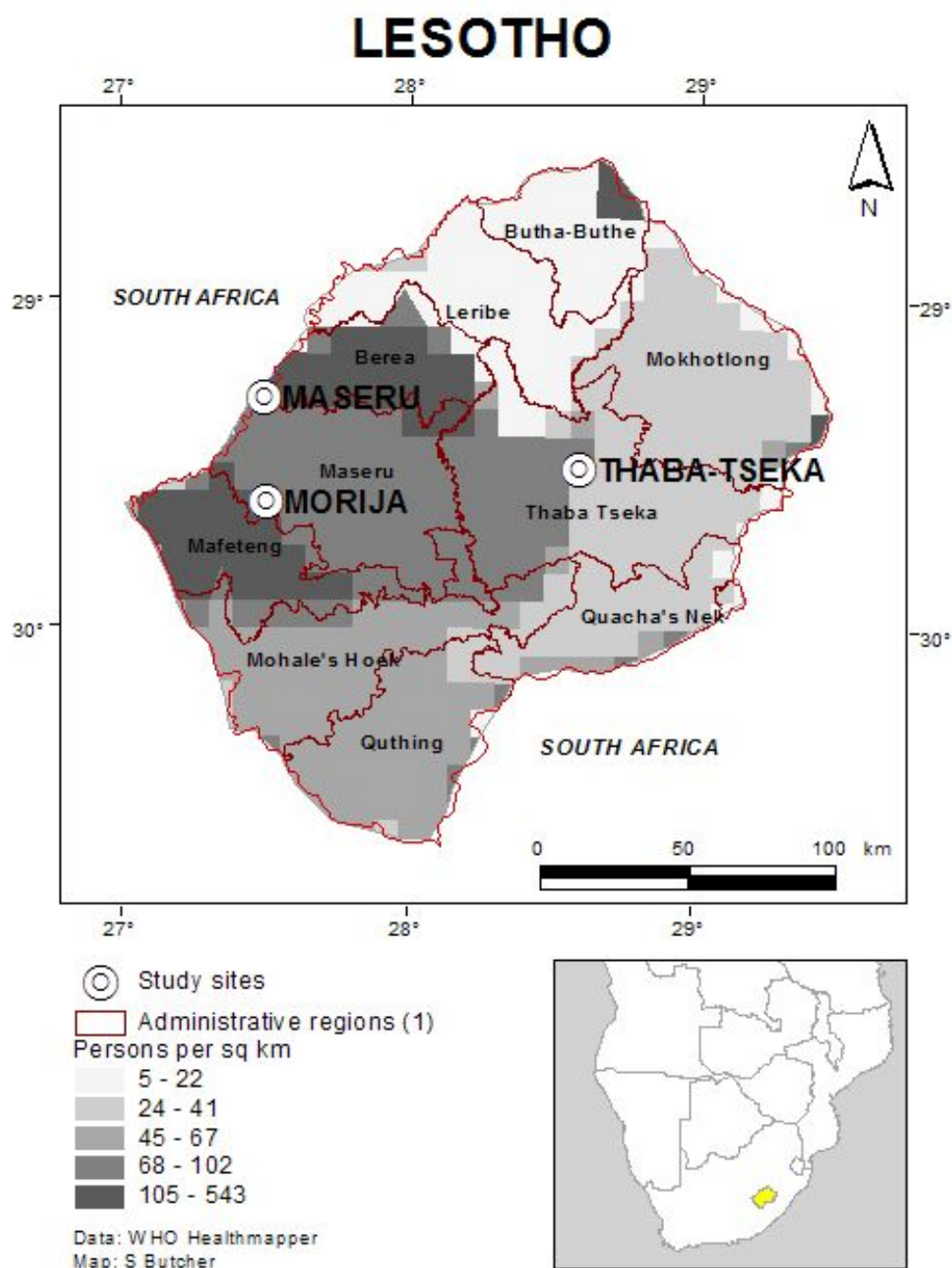
i. Participants

Participants were identified and invited to attend the workshops through an intensive "on the ground" purposive sampling process of personal contacts, meetings, and referrals, led by ARHAP facilitators from each country and trusted local community and area leaders. Invitations were hand-delivered and confirmation was managed through personal visits and telephone calls. Advance, onsite preparation required approximately 4 weeks for each location, but this process was considered key to the success of the workshops and the validity of the findings.

For each type of workshop, participants were selected to represent a range of groups and perspectives, based on the following definitions:

Community Level Participants:
Local community members/ordinary residents who are health-seekers and could provide a greater understanding of the relationship between religion and health; identify those religious people, groups and institutions in the community considered to be "strong assets"; and provide the reasons for these judgements.

Area Leadership Level Participants:
Leaders engaged in religious leadership (such as local pastors), community structures (such as a local CBO) or health provision (such as a local clinic). Owing to issues of power and access to information it was important that the engagement with this group be conducted separately from the community level meetings.

Regional/National Leadership Level Participants:
People who exercise leadership in either regional/national religious organisations, both general and health-specific, or regional/national public health and community health entities. They were understood to be "key informants" who have specific knowledge and insight into religion and health in the region or at country-level.

In addition, the initial pool of invitees for both types of workshop was created to reflect a mix of demographic and other characteristics, which included:

- gender
- age
- organization represented
- position/occupation
- education
- religious affiliation
- time in the community/area

Further special considerations were:

- language:
- power dynamics/relationships:
- representation of people living with HIV/AIDS

Care was taken during the workshops to create participant groups separated or balanced by these characteristics to ensure that all voices were heard; typical groupings were women's groups, men's groups, and mixed groups reflecting a range of ages, occupations, religious affiliations, and time in the community.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

34

The side-by-side profile of attendees in each country is provided below:

Zambia Participants by Age

Lesotho Participants by Age

Zambia Participants by Education Level

Lesotho Participants by Education Level

Zambia Participants by Occupation

Lesotho Participants by Occupation

Zambia Participants by Religious Affiliation

Lesotho Participants by Religious Affiliation

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

35

ii. Workshop Materials and Setup

Extensive descriptions of workshop logistics and required setup are provided in the PIRHANA Guidebook. Three areas are highlighted here as key to the validity of the results.

Preparation of Background/Invitation/Informed Consent Materials

A package of background materials and formal letter of invitation were prepared in advance and hand-delivered, as described above. A Participant Information Sheet and Consent Form, consistent with these original materials, was provided to each participant upon arrival and explained verbally in English and the appropriate local language (Sesotho, Bemba, Nyanga) (see Appendix G). The workshops did not proceed until all consent forms had been signed; in only one instance did a participant refused to sign the form and therefore left the workshop.

Use of Audio and Video Recordings and Photos

In Zambia, 6 of the 9 workshops were recorded using a combination of audio and video recordings, and in both Lesotho and Zambia extensive digital photos were taken of key workshop exercises; all participants consented to these techniques and to the use of recordings and photos for illustrative purposes. The audio recordings from Zambia, in particular, proved important in capturing participant and facilitator comments for further analysis.

Language/Translation

It was considered critical that participants interact in their first language to the highest degree possible, and the study teams provided a combined approach to the workshops: 1) Community Workshops were conducted in a mix of languages - in Lesotho almost wholly in Sesotho - with ARHAP facilitators providing English translation where needed; 2) Regional/National Workshops were generally conducted in English, with ARHAP facilitators also providing local translation.

We will now turn to the GIS component of the study.

VI. GIS Mapping

Concomitant with the development of new computer tools and technologies, there has been an accelerating interest in the use of GIS mapping for public health and other purposes. WHO's Public Health Mapping and GIS Programme has now become "a global partnership," and WHO's HealthMapper and Service Availability Mapping (SAM) programs are in use by a wide range of partner organizations.

Prior to this work, the few previous studies of religious health entities have focused primarily on surveys of health facilities and clinics, to include those that are religiously owned. A smaller number have included other types of religious organizations, and fewer still have collected profile information and locational coordinates. This is the only study known to date to combine both Participatory and GIS mapping in the context of religion and health, and thus has required the development and refinement of an additional set of GIS-related tools and methods.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

36

A. Approach and Methodology

Technical direction for GIS mapping in Zambia and Lesotho was centred at the University of Cape Town, Department of Environmental and Geographical Studies, with extensive field work conducted by the Zambia and Lesotho Research Teams. The mapping approach made use of five important methodological steps:

i. Orientation to HealthMapper and Identification/Review of Existing Datasets

Three members of the ARHAP team received an initial orientation to WHO's HealthMapper and SAM systems in Geneva in August 2005 and reviewed data for Lesotho and Zambia available in these systems. Team members in each country then contacted the WHO offices, Ministries of Health and Education, and land and surveys offices, to gain access to current maps, identify existing surveys, and learn of near-term and future plans. Additionally, a call was put out through Christian Connections for International Health (CCIH) for access to any other mapping surveys or data in the two countries. These pre-existing sources of data were reviewed by team members with an eye to areas for linking, to avoid duplication, and for critical gaps in information previously captured.

ii. Preparation of Existing Maps for Verification

Where possible, UCT specialists developed provincial or area maps for use in the PIRHANA workshops and for general review. However, due to the paucity of information available for each country, these maps were used primarily as topographical maps for orientation rather than as survey maps for verification.

iii. Collection of Additional Information via PIRHANA Workshops

The PIRHANA workshops were a vital source of new and previously unmapped data. These emerged from three activities:

- *Invitation Process*: The purposive sampling approach in the invitation process led the fieldworkers to an ever expanding set of RHAs.
- *Community Workshops*: The community workshops produced new names and entities via the registration forms and the community mapping and assessment exercises
- *Regional Workshops*: The regional workshops produced a significant new data set through the registration forms, timeline, spidergram and assessment exercises.

iv. Collection of GPS Coordinates by Community Field Workers

The PIRHANA process established a wide-ranging database, and fieldworkers were then engaged to follow up after the workshops to secure GPS coordinates and complete data profile sheets; in some instances, they supplemented this information with digital photos of sites and facilities. In this way the gains made via the participatory process were formalised into, and onto, the GIS maps.

v. Development of GIS Database

Owing to the participatory and inductive approach of the process, there was no pre-existing data dictionary or database including all parameters. Therefore, a team of ARHAP researchers created a coherent coding scheme and set of definitions, building on expert opinion, on previous ARHAP theory matrices and studies, and on the basis of what emerged from the ground. This information was then verified back with the community field workers in-country, who re-examined the data and prepared them for final data entry and analysis. (See Definitions below for detailed description.)

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

37

B. Design Factors and Limitations of Approach

UCT's GIS specialists led the technical development of the database, with consideration of the following general factors:

- That database records contain identifiers and attribute data and must be able to be ported to HealthMapper/SAM formats
- That attribute *categories* must also be consistent with HealthMapper/SAM, where applicable
- That the new Coding Scheme and Verification Process must be developed and iteratively reviewed by ARHAP researchers
- That the symbology must be developed based on usability and potential expandability
- That the database and GIS maps should have the potential for supplemental photos and additional "pop-up" information/displays from the data profile sheets

The following scale issues were also considered:

- That *each RHA*, regardless of its type, was GPS "point-located"
- That spatial *coverage* of RHAs was to be determined by each community - rather than by a pre-existing coverage scheme or algorithm
- That secondary checks for concordance were not possible under the current study design

i. Other Issues and Limitations of Approach

Given our methods and available data, the following limitations should be noted; some apply to other mapping approaches as well:

- Review of HealthMapper, SAM and other databases and surveys revealed little extant GIS data on Zambia or Lesotho.
- Data that were available were primarily in hardcopy form, electronic versions often undergoing update and therefore not available for release or prohibitively expensive.
- In preparing background maps for the workshops, ARHAP researchers were aware of the limited coverage of organisations and the possible bias that could be introduced by having certain "fixed" starting points, displaying entities that may or may not have been seen as "RHAs" by participants, or displaying entities may have had negative connotations in a particular workshop setting.
- We considered introducing a spatial view of each locality using aerial photography or satellite imagery but were limited by available technology in many workshop settings.
- As with other databases, ours is subject to the common issues of currency and accessibility.

The working database contains 494 entities, additional sites will continue to be added; the coding scheme and key definitions are described below; additional terms and acronyms are contained in the Glossary, Appendix A.

VII. Definitions

A. Defining the ARHAP Lexicon

As with all emerging fields, nomenclature and definition of terms are critical to understanding, replicability, and interpretation of results. The following are offered as the beginning of a new "lexicon" of Religious Health Assets, Networks, and Agency. We begin with overall terms, organized in subject groups, then present a new categorization schema developed for the Participatory and GIS Mapping components of the study.

Religion A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations.

> **Healthworld** Neologism for *bophelo* (Sesotho), *impilo* (isiXhosa), *ubumi* (Bemba) and other African linguistic equivalents, but expressed as a concept argued to be of general significance. Refers to peoples' conceptions of health, as framed by the background store of inherited or socialized knowledge that defines their being in the world. A person's healthworld expresses and guides health-seeking behaviour, choices and actions, in respect of illness or dysfunction in health, towards a *telos* of comprehensive well-being. Culturally and linguistically constituted, spiritual and corporeal, it addresses the condition of the whole body - understood as the ecology of the individual body in relation to the social body under particular material conditions - and thus includes the social and environmental determinants of health.

> **Bophelo** A Sesotho word, bophelo has a rich lexical range. Its meanings range from biological life (of humans, animals and plants) to the social life of individuals, families, villages and countries. Religion and health are an integral and integrated dimension of the social dimension of bophelo. In this report, the term, "religio-cultural" is also used as an attempt to capture the fundamental integration of religion and culture in the Sesotho (bophelo) worldview (see Chapter 4, XII C).

Religious Entity (RE) The term "religious entity" seeks to capture the broad range of religious institutions, facilities, organisations and initiatives, as well as self-standing individual practitioners, both bio-medical and traditional, found in Africa. This encompassing term is necessary in order to be able to speak of more regular religious entities such as faith-based organizations, as well as those more amorphous entities such as individual traditional healers, each of which might offer identifiable health services or support. Where these REs are involved in health work, they may be understood as (tangible) Religious Health Assets (see below). The following are some of the key REs that are identified in this report.

> **Faith-based Organization or Initiative (FBO/I)** Faith-based organizations are those religious entities that have a more structured nature as well as religious support. This includes organizations tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks. We add the term "Initiative" to refer to identifiable, significant work in health that is not yet formally organized but may exist for some time through loose arrangements, often the early phase of a formal organization and not uncommon for religious leaders.

> **Community Support Group (CSG)** This term applies in particular to Lesotho where community support groups of a particular nature were identified. In communities where access to healthcare services and facilities is beyond the financial reach of ordinary Basotho there has been a dramatic upsurge of local community support groups. Self-initiated, deeply religious, though not formally linked to any religious structure, they are identified as an important health provider in these communities.

> **Church** Aware of the problematic issues surrounding the use of the word "church", especially in inter-religious writing, we have used this term as sparingly as possible. However, in the context of this report, the term has occasionally been used to indicate Christian denominational structures at a

regional/national/international level. For example, a regional collective of congregations of the same nature would be a church - or in terms of such denominational structure as "The Catholic church" or "The Anglican church".

Congregation A locally organized religious or faith-based entity, meeting regularly for specifically religious purposes, whose primary function is the formation of faith. This term is not intended to indicate only Christian groups but is used to signify all such gatherings of any faith.

Traditional Healer This is a complex typology, and is differently constituted in different contexts in Africa. However, for the purposes of this report, we indicate here three types of indigenous health providers, or traditional healers, in Lesotho and Zambia which are constituted by (i) Diviners, (ii) Herbalists and (iii) Zionist/Apostolic healers. Some herbalists distinguish themselves as working solely with herbal remedies. Diviners practice on the basis of engagement with ancestral and spirit forces, and other diviners are also Zionist/Apostolic priests. The three "types" must be understood as operating on a complex continuum.

Agency The capacity to "do", to move into action, to utilize the assets one has, to seek and achieve desired goals, as affected by social and environmental conditions. In the context of dramatic health challenges such as HIV/AIDS (and conditions of poverty), human communities have assets and the capacity to exert agency. Agency rests within individuals, but even more so in communities, organizations. The common assumption that poor people are "not able to do" is untenable. Poor people are always engaged in strategies and struggles for survival, adaptation and freedom.

Asset This term refers to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation. Assets carry value and may be leveraged to create greater value. Beginning with assets is to set aside the dominant approaches that begin with needs or deficits, so as to make local agency more clearly visible. *Needs*, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, *resources,* as distinct from assets, is more passive; they are there to be *used* rather than leveraged and grown. An asset-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than viewing them in terms of deficits, which hamper their development.

Religious Health Asset (RHA) A religious health asset is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the fundamental idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith; particularly we include here those assets typical of African traditional religions.

Tangible and Intangible Assets The more obvious, and most studied RHAs are those which are tangible, i.e. facilities and personnel, acts of caring and compassion, and material support or curative interventions, most of which appear identical to secular entities. Underlying this tangible level, however, are the volitional, motivational and mobilising capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behaviour and ties. Local knowledge,

access, reach, participation, trust, hope, resilience and accompaniment are just some of these "invisible" or what we prefer to call intangible religious health assets.

Relationship between REs and RHAs. Not all Religious Entities (REs) are tangible Religious Health Assets (RHAs), and not all tangible RHAs are REs. Insofar as REs are engaged in health work, they are considered to be tangible RHAs. On the other hand, tangible RHAs include REs, but also include a range of other tangible religious health assets such as caring and material support. Furthermore, what this research shows is that REs themselves embody a number of intangible health assets.

HIV/AIDS For this report, the term HIV/AIDS will be used to indicate the complete range of stages of infection, sero-conversion and resulting opportunistic infections associated with the disease, in the context of the cultural, behavioural, political and spiritual factors impacting on the course of the pandemic. While it is acknowledged that HIV and AIDS are different conditions, for the sake of consistency and in keeping with current convention, the term "HIV/AIDS" will be used instead of "HIV *and* AIDS". Furthermore, it is also understood that there is not just one epidemic but multiple local and national epidemics with different characteristics and patterns, and at the same time, a "pandemic" that spans localised and national borders.

Antiretroviral therapy (ART), Rollout, Scaleup For the purposes of this report, antiretroviral therapy is used to mean the provision of antiretroviral drugs (ARVs) for HIV/AIDS; however, the terms "rollout" and "scaleup" also encompass the range of accompanying clinical and support services linked to the provision of medicine, such as treatment literacy, nutrition support, laboratory monitoring, and adherence support. In this sense, ART rollout or scaleup is seen as a comprehensive program spanning issues of diagnosis, treatment, care, support, and prevention of transmission

PIRHANA Participatory Inquiry into Religious Health Assets, Networks and Agency, is the primary research toolset developed by ARHAP to assess the contribution of religion and religious entities to health and wellbeing in Africa. It is based on a commitment to appreciative inquiry, as well as to the framework of assets and agency described above.

Participatory The nature of both the process and content of the research. The *process* is inclusive and engaging of ordinary people, so that while the broad direction of the discussion is introduced, the *content* is driven by the participants themselves.

Inquiry The desire to know more, to map, to appraise, to identify, and analyse. Drawing on the approach of Appreciative Inquiry, the research seeks to be empowering and not extractive.

Assets, network and agency The three focus areas of the research is on what religious entities and capacities exist (assets), how these entities relate to one another (networks), and how people make use of the assets (agency).

Map/Mapping For purposes of this report, we use the terms "map" and "mapping" in the broad sense to mean both the process and result of making visible both tangible and intangible items and their relationships. Thus, we make use of *participatory tools* to *draw out* and *diagram* community perceptions - one type of map - and later employ **GIS** *tools* to create a physical typology - a more traditional type of map.

GIS Geographic Information Systems provide a means to collect, manage, analyse and display spatial data. By collecting locational coordinates (longitude and latitude) for religious entities we are

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

41

able to place their presence and activities at a specific location on a map. This affords both an absolute location and the possibility of considering location relative to other organisations, or relationships between these entities and other data that have been mapped. Such other data may include infrastructure such as transportation networks, social data such as census-derived data, or biophysical data such as terrain, landuse, agricultural production, climate. Although there is a strong relationship between GIS and maps, fundamentally GIS relies on:

- a database which contains both spatial and attribute (descriptive) information;
- software with which to view and/or analyse the data.

Data may be exchanged between GIS users, but the user interface, analytical possibilities, and basic matters such as available symbology are dependent on the specific software.

GPS Global Positioning Systems are used to determine locational coordinates. In this study GPS receivers were used to collect a latitude and longitude reading for each religious entity. These were recorded in degrees and decimal minutes and stored to 5 decimal places. Since the readings were taken as discrete points, not differentially corrected or processed in any way, the accuracy is sufficient for our purposes, with an error margin of the order of tens of metres.

P/GIS Participatory Geographical and Information Systems (P/GIS) PGIS is a rapidly emerging field that integrates geographic information technologies and systems with community-centred developmental initiatives. The common goal of such work is the empowerment of underprivileged communities, and the integration of multiple realities and diverse forms of information to foster social learning, support two-way communication and broaden public participation across socio-economic contexts, locations and sectors. The practice is multidisciplinary in nature, relies on the integration of "expert" with socially and gender differentiated local knowledge, and builds on high levels of stakeholders' participation in the processes of spatial learning, analysis, decision-making and action. P/GIS aims at placing the emerging culturally sensitive spatial data in the hands of those who generated these thereby protecting traditional knowledge and wisdom from external exploitation. In the context of RHAs, P/GIS is a flexible tool that is able to recognize non-traditional health facilities and entities, and to value local wisdom.

In sum, participatory GIS seeks to involve local communities in creating spatial databases reflecting their own areas, and there are examples from many different contexts with different levels of technological sophistication. In this case we were dealing with communities that were not highly computer literate. Maps were hand drawn, not to scale, nor referenced to degrees   latitude   and longitude. Hence, the followup GPS field work was critical to the preparation of maps - to confirm sites and to collect the locational coordinates.

B. Terms and Categorization Schema for Further Mapping REs

Our mapping tools were designed to identify and map both tangible and intangible Religious Health Assets, especially those that are often not "visible" to the authorities. Building upon the methods and definitions described above, we now turn to a subset of these assets for further categorization.

We will focus here on tangible assets, in particular the Religious Entities that can be located on geographic maps. We will also address their Partner Entities - primarily secular organizations and people - that participants have identified as important to religious health efforts and to HIV/AIDS in particular. While our terms (with codes) and categorization schema were developed based on the characteristics of REs, we found

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

42

that they also fit well the Partner Entities included here and have thus applied them to both, with resulting maps that then have a common, coherent framework.

In order to capture their diversity and differences, four "dimensions" of an RE are considered: (i) Its type - a noun descriptor; (ii) its scope and scale - an adjective descriptor; (iii) its relevant activities - a verb descriptor; and (iv) a time dimension. The last, the time dimension, cannot be mapped at this point, as a longitudinal survey would be required to gather adequate data for that purpose.

Leaving aside time, then, the mapping allows us to present REs according to the following schema:

Religious Health Assets - Religious Entities: Categorization Schema

Type of RE	Noun	x axis
Scale and Scope of RE	Adjective	y axis
Activities of RE	Verb	z axis

We now define each of these in more detail.

i. Types of RE (A Noun descriptor)

First we disaggregate the REs according to the type of facility or organization they represent (the noun descriptor). As outlined above, these type codes were drawn from other WHO and health surveys, where possible, with an attempt for consistency with codes already in use in HealthMapper and SAM.

The first step in defining the type of entity is to determine whether it is religiously-affiliated. Entities may be divided into three types, Religious Entities, Partner Entities and Sites of Bophelo (Figure 1). Religious Entities are those determined to have a clear religious nature. Partner Entities are generally secular entities identified by participants in the participatory workshops as key partners with religious entities in the struggle against HIV/AIDS.[58] Sites of Bophelo are identified as key *community* locations of religious-health importance, such as local gathering places.

REs and PEs are next defined according to their primary identity - e.g., Health Provider, Development Agency, Education Provider, and so on - based on 9 types/32 codes, shown in Figure 2; sites of Bophelo do not have a primary identify as either a religious or health entity and, therefore, are not further mapped.

For REs and PEs, then, one code is selected for each (Figure 2).

ii. Scale and Scope, or Authority and Reach of REs (An Adjectival Descriptor)

The second dimension considered is scale and scope, or authority and "reach" of REs. This dimension does not merely represent the scale of operations of an entity, but more importantly it locates the seat of authority that is to be approached in order to leverage the assets it holds.

For each RE and PE, we assign a single classification code, distinguishing among the following; as with type, we determine the primary scope:

Local | District-Regional | National | International

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[58] Included here are also entities which were identified by participants as religious, but which subsequent research found that these entities do not identify themselves as primarily religious - for example, some could have developed from religious roots into secular identification.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

43

iii. Activities of REs (A Verb Descriptor)

Third, REs only are differentiated according to the activities offered (the verb descriptor) (Figure 3). The selection of activities, as mandated in the contract, is concentrated on HIV/AIDS-related, Prevention, Treatment, Care and Support as well as Linking/Networking activities in support of these. In this dimension, any one or combination of 22 identifiers listed may be attached to a particular RE; these were drawn from a composite of HIV/AIDS activities, especially those highlighted in Zambia and Lesotho country plans. It is in undertaking these various and diverse activities that an RE can be considered to be a Religious Health Asset. Comparable information was not collected on PEs, and they are thus excluded from this analysis.

iv. Time

The fourth dimension would locate the RE in time: when it was established, how long it has been operational, its current stage of organisational development, and major changes over time. It is clear, for instance, that emerging faith-based initiatives and well-established organisations have different assets and differing potential for leverage. While we regard this kind of information as important in assessing REs with respect to depth, durability, sustainability and credibility, further work would be required beyond the scope of this contract to gather such data. We, therefore, do not include this dimension in this Report as such. However, we do recommend that such data be sought for any concrete, specific interventions aimed at drawing particular REs into public health systems or strategies for HIV/AIDS scale-up.

v. Definition Tables

Entities divided into religion, partner and "bophelo" entities (Noun descriptor)

TYPE	CODE	DEFINITION
Religious Entity	RE	Entities with a clear religious nature, to include structured organizations, self-formed groups, and, occasionally, individuals
Partner Entity	PE	Entities identified as key partners by and with religious entities, initiatives and programmes.
Site of "Bophelo"	SB	Community sites identified in participatory workshops as key locations of religious-health significance.

Types of REs (Noun descriptor)

TYPE	CODE	DEFINITION	INCLUSION CRITERIA or EXAMPLES
Health Provider	**HP**	Facility or other infrastructure offering health treatment, care or prevention	
	HP1	Tertiary or third level hospital. These generally provide training as well as specialized care.	
	HP2	Second level referral hospital. This is generally the provincial level hospital.	
	HP3	First level hospital. The district level hospital.	
	HP4	Health centre	Clinic
	HP5	Hospital affiliated health centre	
	HP6	Private hospital	
	HP7	Private practice, surgery	Individual practice, e.g. physician, traditional healer
	HP8	Health post	Dispensary
	HP9	Unknown	
Development Agency	**DA**	Organization involved in development or relief work	
	DA1	Agency with general development orientation, with some health activity	Catholic Relief, ICCO, World Vision
	DA2	Agency with specific orientation toward health intervention	
Education provider	**EP**	Facility or infrastructure that is primarily educational, with some health activity	
	EP1	Tertiary institution for general education, often with formally defined health programmes	University, college, seminary

	EP2	Tertiary institution for training of health workers	Nursing college
	EP3	Secondary institution for general education, often with formally defined health programmes	Secondary school
	EP4	Primary institution, with formally defined health programmes	Primary school
	EP5	Pre-primary institution, often with formally defined health programmes	Pre-primary school, nursery school, day care centre, early learning centre
	EP6	Non-formal skills and vocational training programme often with formally defined health programmes	Vocational training, technikon
	EP7	Non-formal health training organization	Primary health care training centre, training centre for traditional healers, Community HIV education, literacy programme, educational NGO, resource centres
Congregation	**CG**	Organized religious community whose primary function is faith-forming, but which carries out identifiable health supporting activities	Any religious or faith-based community that is organized congregationally, meeting regularly for specifically religious purposes
Support Group	**SG**	Free-standing group offering identifiable activities, programmes or initiatives whose primary purpose is health intervention (community care).	
	SG1	Targeted-need programme offering a specific intervention	HBC, PMTCT, HIV/AIDS advocacy, support group, hospice
	SG2	Targeted-population programme	Women's group, youth group, sex workers' ministry
Linking Body	**LB**	Structure that links different agencies, congregations or programmes as their primary identity	
Connectional system	**LB1**	Linking body with clear lines of authority and control over its sub-units which generally share a common identity	Umbrella organizations offering funding, organizing. Denominational structures, e.g. church province or diocese
Networking Association	**LB2**	Linking body established through voluntary association, collaboration or cooperation for mutual support in health interventions and common representation of interests	CCIH, ZINGO, CHAZ
Intermediary	**LB3**	Organization, body or key individual, serving more than one FBO/I, and acting as mediating link between them, and between them and other local or translocal agents, usually facilitating access, funding, organizational support and training, communication, and advocacy.	
Pressure group	**PG**	Organization or group that works to effect policy changes which impact health through advocacy, research, activism	Think-tank organization, activist group
Media	**MD**	Organization whose primary function is mass communication to a specific population or the general public	Newspaper, radio station, TV station
Other	**OR**	Religious Health Assets/Entities whose primary identity does not fit into any of the other categories	

Activities offered by REs: (Verb descriptor)[59]

TYPE	CODE	DEFINITION	INCLUSION CRITERIA or EXAMPLES
Prevention	*p*	Activities which aim to stop or slow spread of HIV in a population	
HIV/AIDS education/ life skills development	p1		Awareness, Empowerment, Reduction of stigma/self stigma

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[59] Where available, definitions and codes from the WHO SAMS have been used, and where possible, we have adapted appropriately with modifications for new kinds of entities that are required to describe RHAs.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

45

VCT	p2	Voluntary counselling before and after HIV testing as well as diagnostic HIV/AIDS testing	Counseling and testing for diagnostic purposes should be included, but only if **both** counseling and testing are carried out at that facility.
PMTCT	p3	HIV/AIDS counseling and testing to pregnant women along with *any* ARV drugs to prevent transmission form mother to child.	
Behaviour change	p4		Abstinence, fidelity, condom use; partner reduction; needle exchange; use; limiting workplace exposure
Advocacy	p5		Policy development; legislative action; resource allocation
Treatment	*T*	Bio-medical interventions for PLWHAs	
ARV therapy /ramp up	t1	HIV/AIDS treatment can be initiated, drugs prescribed and patients monitored.	
Treatment of STIs and opportunistic infections	t2		
Laboratory monitoring	t3		Facility to determine CD4 count, viral load
Compliance monitoring	t4		
Phyto-therapy	t5		Herbal remedies from traditional practitioner
Care and support	*C*	Non-medical interventions in support of PLWHAs	
HBC	c1	Groups providing home based care	
Palliative care	c2		Hospice
OVC / widows	c3	Care and support for orphans and vulnerable children as well as widows	
PWLA specific	c4	PLWH/As meeting for mutual support	Story-telling, sharing health strategies
Treatment support	c5		Compliance support, collecting ARV drugs, noting side-effects, etc.
Material support	c6		Food, Transport
Spiritual support	c7		Pastoral care, theological response; traditional healing
Linking	*l*	Non-medical interventions in support of bodies engaged in prevention, treatment and care	
Coordination role	l1	Helping an RE convene, vision, plan	
Financial/ Funding	l2	Helping raise funds, control finances	
Incubation and consolidation	l3	Helping build or stabilize an RE	
Mobilization	l4	Assisting in connections to others	
Technical Assistance	l5	Acting as a resource and advice centre	

Having established the definitions and categorization schema, we can now examine the GIS results.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

46

VIII. GIS Results

A. Overview of Mapping Results

Our GIS Mapping efforts yielded a total of 494 locations identified and captured in the Master Database. Members of the ARHAP Research Teams and Community Field Workers were able to secure GPS coordinates for 449 of these and 434 were mapped. The 15 sites excluded from mapping represented "Sites of Bophelo" as described above and did not meet the criteria for GIS mapping for this report.

Results of GIS Mapping Efforts - Zambia and Lesotho
November 2005 - August 2006

Country	Area	# Sites in Master Database	# Sites with GPS Coordinates	#Sites Mapped	# REs	#PEs
Zambia	Copperbelt	117	117	114	86	28
	Eastern	67	65	65	31	34
	Lusaka	48	48	48	19	29
	Southern	38	38	38	28	10
Subtotal		**270**	**268**	**265**	**164 (62%)**	**101 (38%)**
Lesotho	Maseru	38	33	33	6	27
	Paray	44	37	36	30	6
	Scott	142	111	100	63	38
Subtotal		**224**	**181**	**169**	**99 (58%)**	**71 (42%)**
Total		**494**	**449**	**434**	**263 (60%)**	**172 (40%)**

We attempted to match these ARHAP entities to existing points in HealthMapper based on the administrative areas in which our study sites were located (HealthMapper Administrative Area level 2) and the name and type of facility (see Table below). Only 2 perceived matches were found: Queen Elizabeth II Hospital (QE II) in Lesotho and Kabushi Clinic in Ndola, Zambia. In the case of QE II, however, the hospital does *not* appear in the expected QE II Administrative Area in HealthMapper, but rather in the Berea area (as shown below) and, therefore, was not visible to workshop participants; in the case of the Kabushi Clinic, our GPS coordinates differ by 7 km from those in HealthMapper and may represent a different facility or change in location.

Points Existing in HealthMapper, Administrative Level 2 - Zambia
As of August 2005

Level ID	Admin Level	HealthMapper Code_Type					
LvlId	Admin2	H1	H2	H4	H5	S1	Grand Total
ZMP003001000000000000	CHIPATA	2		32	2	1	37
ZMP002004000000000000	KITWE	3		24	1		28
ZMP008003000000000000	LIVINGSTONE		1	13		1	15
ZMP001001000000000000	LUSAKA			3		7	10
ZMP002006000000000000	NDOLA	2		21	1	6	30
	Grand Total	7	1	93	4	15	120

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

47

*Points Existing in HealthMapper, Administrative Level 2 - Lesotho*
As of August 2005

Level ID	Admin Level	HealthMapper Code_Type	
LvlId	Admin2	S1	Grand Total
LSP005001000000000000	ROMA		0
LSP005003000000000000	QEII		0
LSP006002000000000000	BEREA	2	2
LSP010002000000000000	PARAY		0
	Grand Total	2	2

Despite additional attempts[60], we did not find other matches or "duplicates" and believe that the ARHAP sites represent new entities for HealthMapper. By way of example, in Chipata ARHAP identified the following 6 health facilities, none of which was in HealthMapper: Chipata Adventist Clinic, Chipata Community Medical Centre, Chipata General Hospital, Chipata Health Care (Health Centre), Ebenezer Health Care, Kapata Referral Clinic. In contrast, HealthMapper showed only a sentinel site at Chipata, sourced from Global Insight Placenames, and one health facility (H4) at Lunkwakwa. Our ARHAP mapping revealed a new site at Lunkwakwa - a local health support group, approximately 1 km from the Healthmapper facility.
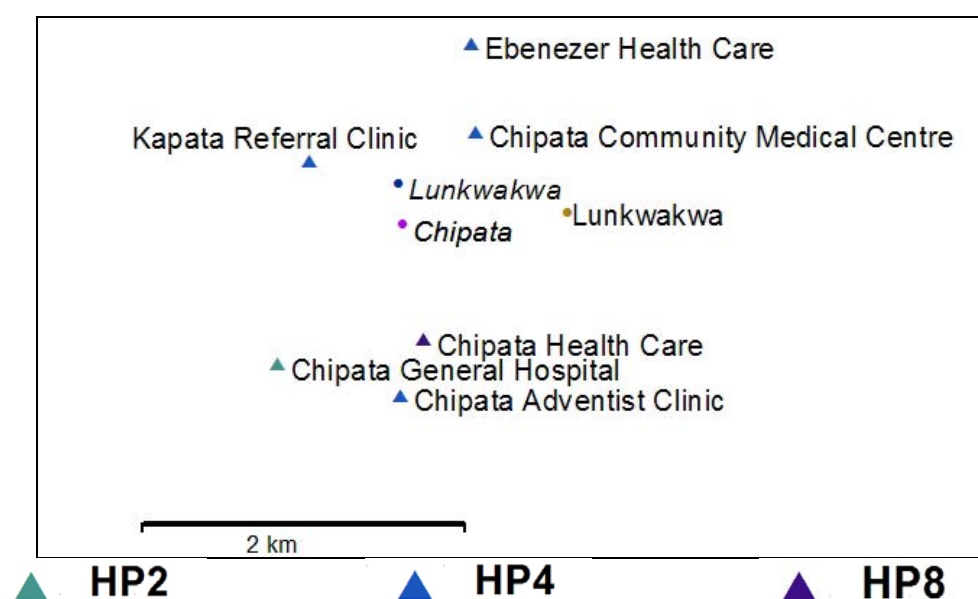
Italicised names are from Healthmapper; normal typeface ARHAP

In summary, then, of the 434 mapped points in the ARHAP database, 432 appear to be new to HealthMapper and represent important new entities for engagement. These are further characterized below.

Our Participatory approach yielded an overall "60-40 split" of Religious to Partner Entities (263 and 172, respectively), the high number of Partner Entites attributed primarily to the inclusion of a substantial number

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[60] Spatial matching was considered, but was not possible since (a) even for the 2 perceived matched facilities, our GPS coordinates differ considerably from those in HealthMapper; and (b) the ARHAP data has a densely clustered set of points in the surveyed communities – i.e. many facilities within a given radius of existing HealthMapper points. Several H4 points in the Zambia database are commented in HealthMapper as "Catchment area centroids" and thus do not reflect an accurate location of facilities. Our data for facilities in four of these are possibly better located, but again it is not possible to say for certain that they reflect the same entities.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

48

of partner school systems in Lesotho, many providing HIV/AIDS education and training. Twenty-six of the 27 types of entities were represented in the database (26 in Zambia, 19 in Lesotho), the only exception being "Health Provider, Other" a catch-all type borrowed from prior studies of health facilities.
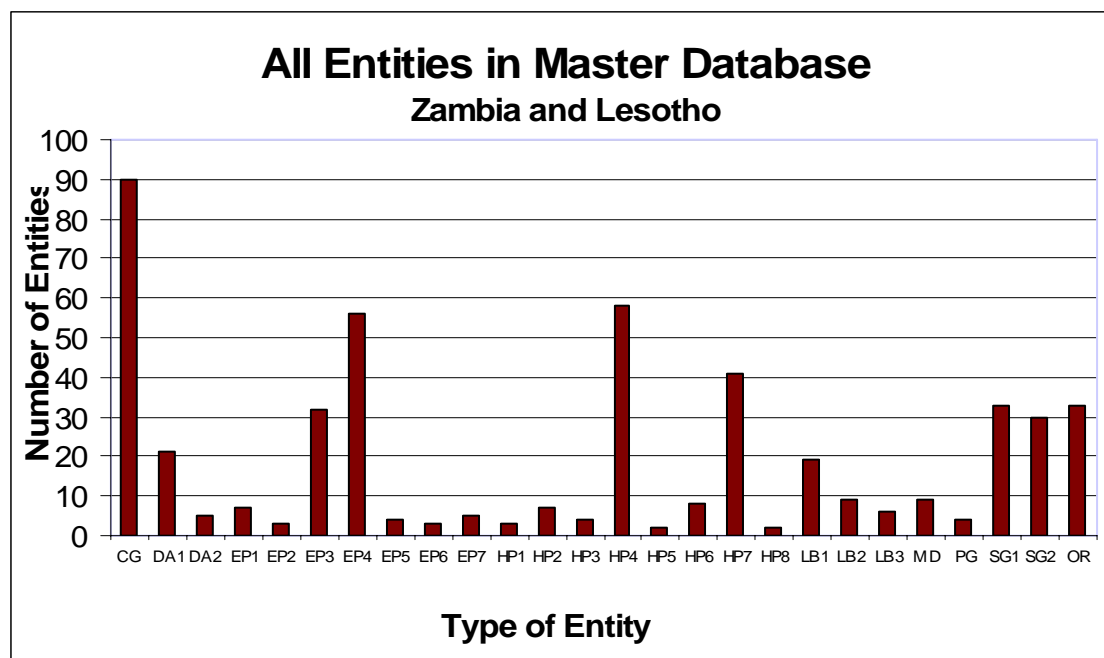
Focusing now on mapped entities, the top three identified overall were Health Providers, Education Providers, and Congregations; however, in Zambia, Support Groups ranked number 2, with Linking Bodies and Development Agencies also receiving significant mention. The overall breakouts are displayed below; listings by name, province/health service area, and category appear in Appendix K and L.

Zambia and Lesotho - Mapped Entites
Totals and Rankings

	TYPE	Zambia Total	Zambia Rank	Grand Totals	Lesotho Total	Lesotho Rank
	Health Provider	44	3	110	66	1
	Education Provider	40	4	99	59	2
	Congregation	61	1	83	22	3
Totals: By Frequency	**Support Group**	53	2	58	5	4
	Linking Body	31	5	34	3	5
	Development Agency	20	6	25	5	4
	Media	5	8	9	4	6
	Pressure Group	4	9	4	0	7
	Other	7	7	12	5	4
Total		265		434	169	

Among Health and Education Providers, the preponderance of entities were Health Centers or Clinics (HP4) and Primary Schools (EP4); in Lesotho, Health Providers (HP7) also includes a significant number of Traditional Healers, working primarily in remote, rural areas.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

49

All Mapped Entities
Zambia and Lesotho
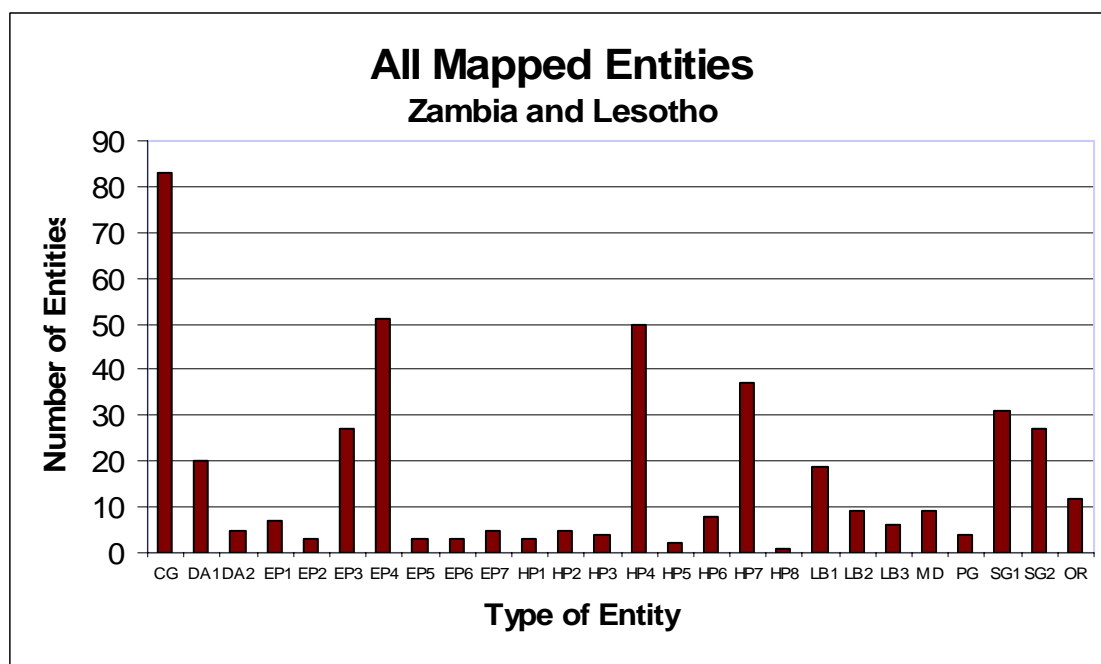
We shall now take a look at each country in turn, with a focus on Religious Entities.

B. Zambia Mapped Entities

Though not intended to represent a statistical sampling of Religious and Partner organizations, the database of mapped entities in Zambia roughly parallels that expected by Province. Of significance for this study, are the large numbers of **Local Religious and Partner Entities** identified by participants - 196, or 74% of the total - many believed to be mapped for the first time here in a global study. Also of significance are the **Regional Developmental Agencies and Linking Bodies,** that serve as "hubs" and "intermediary groups" and may figure significantly as "leverage points" for future HIV/AIDS scaleup activities.

All Mapped Entities - Zambia

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

50

All Mapped Entities - Zambia
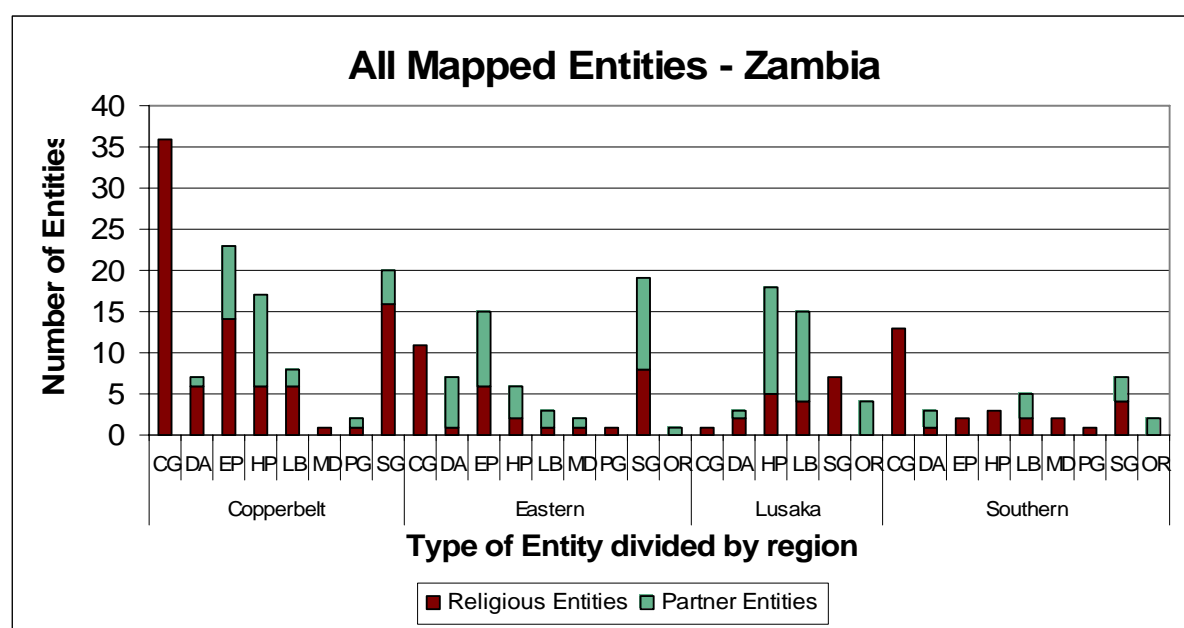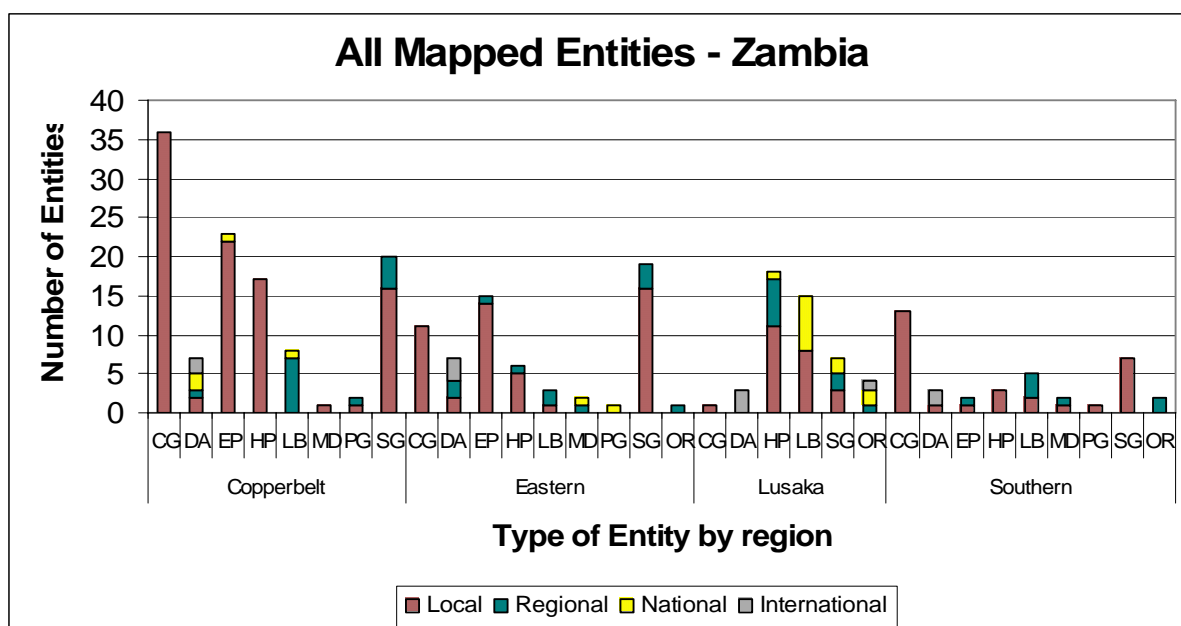
Chipata Regional Workshop, Mapping, 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

51

All Mapped Entities - Zambia

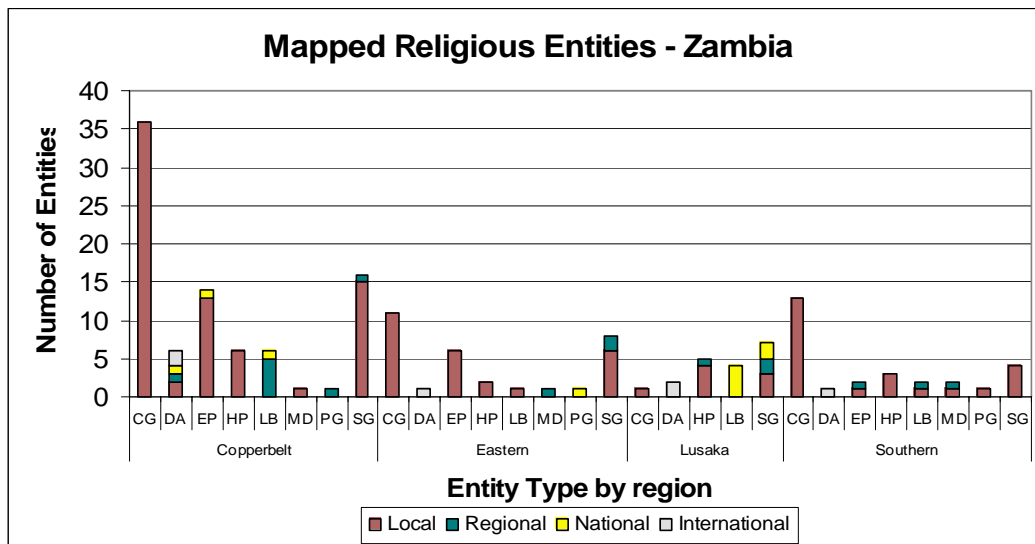|		Religious	Partner	Total	Local	Regional	National	Intl
Copperbelt	CG	36		36	36			
	DA	6	1	7	2	1	2	2
	EP	14	9	23	22		1	
	HP	6	11	17	17			
	LB	6	2	8		7	1	
	MD	1		1	1			
	PG	1	1	2	1	1		
	SG	16	4	20	16	4		
		86	28	114	95	13	4	2
Eastern	CG	11		11	11			
	DA	1	6	7	2	2		3
	EP	6	9	15	14	1		
	HP	2	4	6	5	1		
	LB	1	2	3	1	2		
	MD	1	1	2		1	1	
	PG	1		1			1	
	SG	8	11	19	16	3		
	OR		1	1		1		
		31	34	65	49	11	2	3
Lusaka	CG	1		1	1			
	DA	2	1	3				3
	HP	5	13	18	11	6	1	
	LB	4	11	15	8		7	
	SG	7		7	3	2	2	
	OR		4	4		1	2	1
		19	29	48	23	9	12	4
Southern	CG	13		13	13			
	DA	1	2	3	1			2
	EP	2		2	1	1		
	HP	3		3	3			
	LB	2	3	5	2	3		
	MD	2		2	1	1		
	PG	1		1	1			
	SG	4	3	7	7			
	OR		2	2		2		
		28	10	38	29	7	0	2
Total		**164**	**101**	**265**	**196**	**40**	**18**	**11**

When we focus in on Religious Entities in Zambia, we begin to see the types of organizations seldom visible to outside agencies, in particular the ***Congregations and Support Groups*** providing care and support for HIV/AIDS as well as for a range of other health issues at the Local Level. These entities and their roles are described more fully in Chapter 3.

Livingstone Regional Workshop, 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

52

Mapped Religious Entities by Province and Scope - Zambia

		Local	Regional	National	Intl	Total
Copperbelt	CG	36				36
	DA	2	1	1	2	6
	EP	13		1		14
	HP	6				6
	LB		5	1		6
	MD	1				1
	PG		1			1
	SG	15	1			16
Eastern	CG	11				11
	DA				1	1
	EP	6				6
	HP	2				2
	LB	1				1
	MD		1			1
	PG			1		1
	SG	6	2			8
Lusaka	CG	1				1
	DA				2	2
	HP	4	1			5
	LB			4		4
	SG	3	2	2		7
Southern	CG	13				13
	DA				1	1
	EP	1	1			2
	HP	3				3
	LB	1	1			2
	MD	1	1			2
	PG	1				1
	SG	4				4
Grand Total		131	17	10	6	164

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

53

C. Lesotho Mapped Entities

We see a somewhat different picture when we consider the Lesotho mapped entities, with a preponderance of sites identified in the Scott Health Service Area, where Scott Hospital has traditionally played a prominent role as an area "hub" and key partner organization. Still, the large number of ***Local Religious and Partner Entities*** identified (145 of the 169 total, or 86%) is significant for our study, as are the 16 National Organizations, who play vital policy- and decision-making roles for HIV/AIDS.
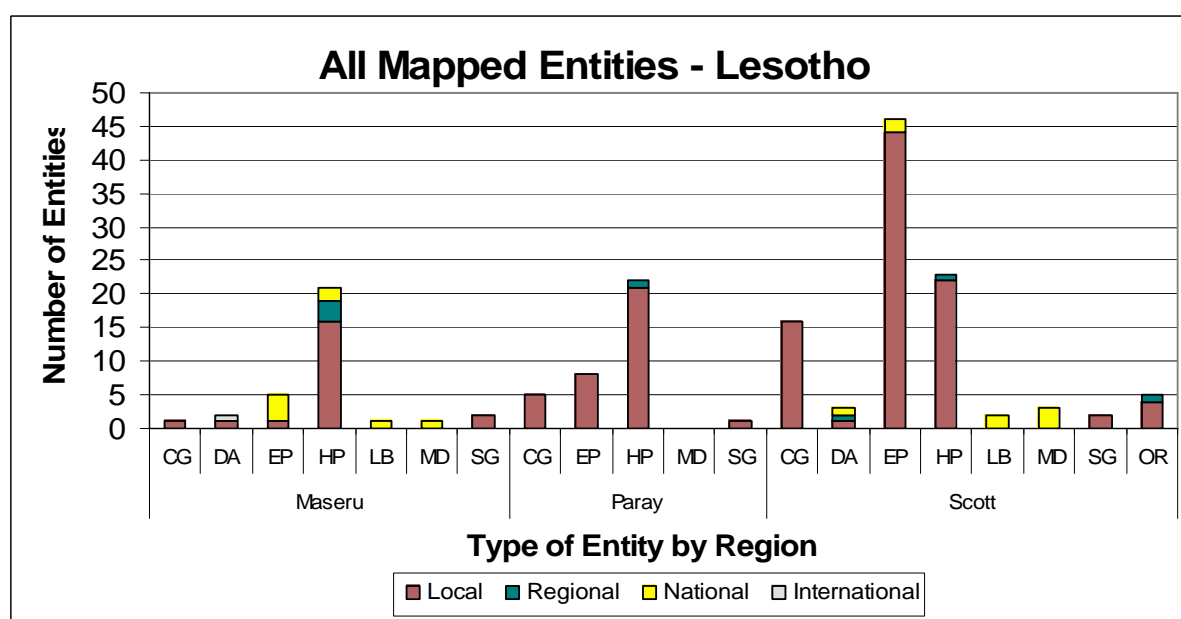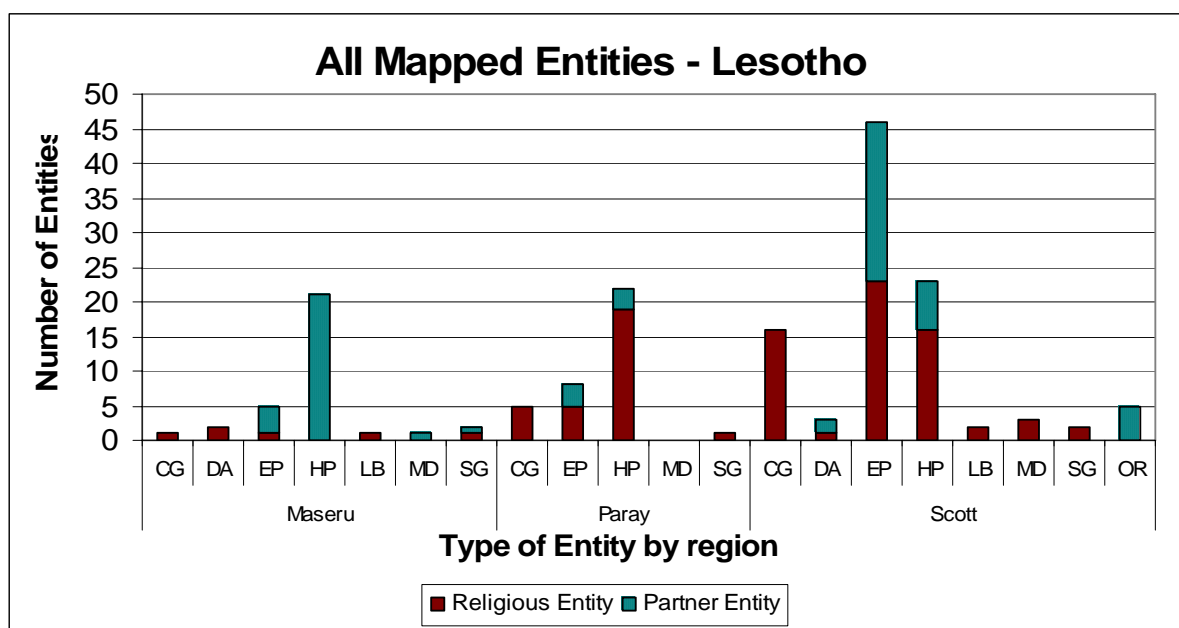
All Mapped Entities - Lesotho

		Partner	Religious	Total	Local	Regional	National	Intl
Maseru	CG	1		1	1			
	DA	2		2	1			1
	EP	1	4	5	1		4	
	HP		21	21	16	3	2	
	LB	1		1			1	
	MD		1	1			1	
	SG	1	1	2	2			
				33				
Paray	CG	5		5	5			
	EP	5	3	8	8			
	HP	19	3	22	21	1		
	MD			0				
	SG	1		1	1			
				36				
Scott	CG	16		16	16			
	DA	1	2	3	1	1	1	
	EP	23	23	46	44		2	
	HP	16	7	23	22	1		
	LB	2		2			2	
	MD	3		3			3	
	SG	2		2	2			
	OR		5	5	4	1		
				100				
Grand Total		**99**	**70**	**169**	**145**	**7**	**16**	**1**

Turning now to Religious Entities in Lesotho, we see a significant number of Educational and Health Providers, reflecting the participants' identification of schools as key assets in providing HIV/AIDS-specific education and training programs, sometimes linked to other community efforts. Health providers, again, include individual Traditional Healers, who serve as key religious and health entities in remote mountainous areas.

Mohlanapeng clinic, Paray HSA, Lesotho, 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

55
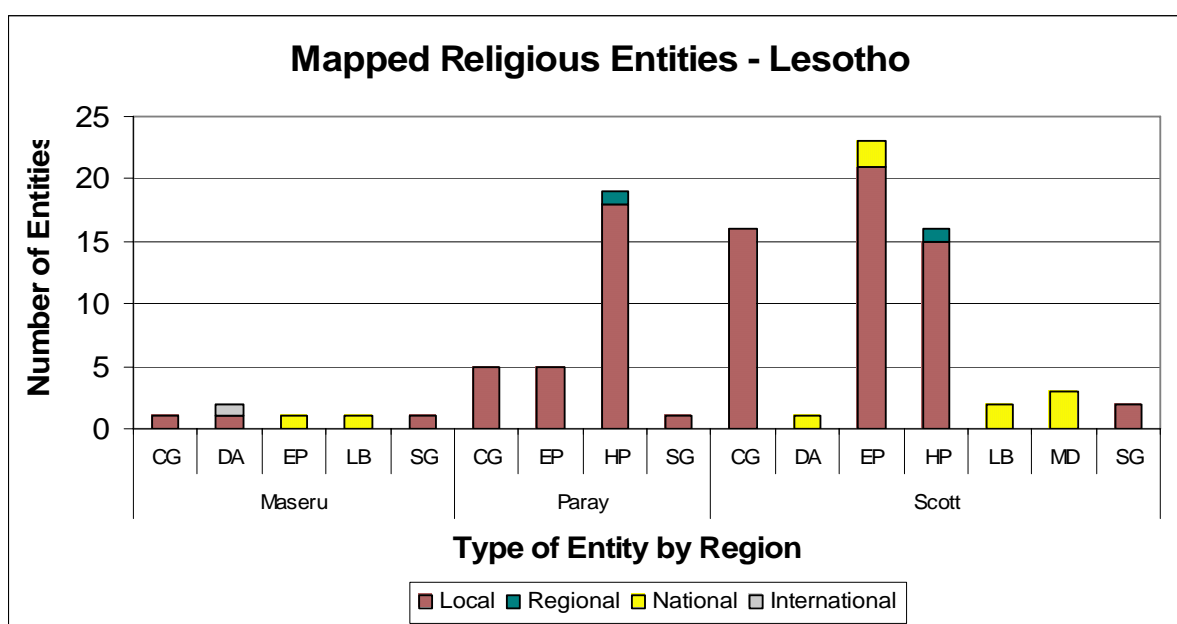
Mapped Religious Entities - Lesotho

		Local	Regional	National	International	Total
Maseru	**CG**	1				1
	DA	1			1	2
	EP			1		1
	LB			1		1
	SG	1				1
Paray	**CG**	5				5
	EP	5				5
	HP	18	1			19
	SG	1				1
Scott	**CG**	16				16
	DA			1		1
	EP	21		2		23
	HP	15	1			16
	LB			2		2
	MD			3		3
	SG	2				2
Grand Total		**86**	**2**	**10**	**1**	**99**

D. Activities of REs and PEs: Z-Axis

i. Methods

In addition to the identification of entities by type, scope, and scale, in some instances, we were able to collect further information on current HIV/AIDS activities, either during the Workshop mapping exercises themselves or through follow-up onsite interviews with key contacts. While these data are incomplete, we offer them as further elucidation of the various role(s) and patterns of activity being undertaken by Religious and Partner Entities.

Activities were identified and clustered in 4 areas (the z-axis), as described in the Definitions Tables, Figure 3. These clusters of Prevention, Treatment, Care and Support, and Linking Activities have been variously defined in other studies; in this instance, they also derive from the draft 2006 Lesotho National Plan for HIV/AIDS, and thus have currency and relevance for this region. Given the important contextual differences in Zambia and Lesotho, we will examine each separately.

ii. Results

a. Zambia

In Zambia, we collected information on 270 entities for the master database, of which 198 (73%) are known to offer at least one activity in the 4 HIV/AIDS areas surveyed. The 198 entities are comprised of 140 religious entities (REs) and 58 Partner organisations (POs), 85% and 57% of the total numbers, respectively. We sought additional information from the remaining 72 entities but did not receive responses in time for this analysis.

For the 198 entities examined in more detail, there was a wide spectrum of activities across the 4 areas:

- 155 (78%) offer **Prevention** activities, with HIV education/life skills development (p1) the most common
- 145 (73%) offer **Care and Support**, most frequently Spiritual Support (c7; 72), Home-Based Care (c1; 47) and Care for OVC and Widows (c3; 38). The entities providing the greatest range of care also offer the greatest range of other activities (e.g., 7 offer 4 to 6 activities in this cluster)
- 38 (19%) offer **Linking** activities, with Coordination (l1) and Financial/Funding (l2) the most common
- Only 20 entities (10%) offer **Treatment** services, with Laboratory monitoring (t3, 14) most common; 7 entities (4%) offer ARV Treatment.

In summary the data show that most religious and partner entities are either specialised in one activity (p1, c7) or they are involved in a range of activities across the continuum of HIV services.
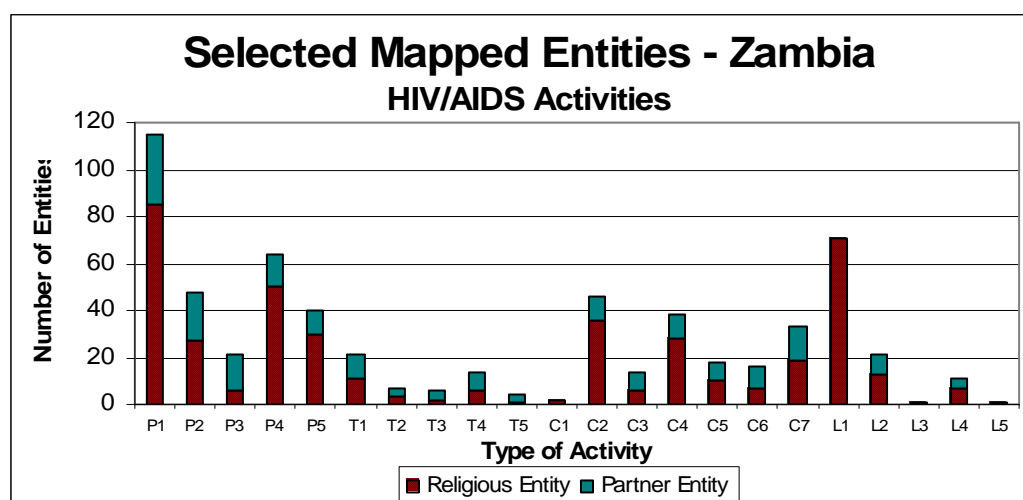
Now focusing on the primary Religious Entities:

Of 60 **Congregations** surveyed, 56 were engaged in one of the four areas as follows:
- 53 (88%) offer Care and Support, most commonly only 1 such activity (40) but almost always in combination with Prevention (39). The most frequent care activities are Spiritual support (c7; 40), HBC (c1; 11) and care for OVC and widows (c3; 13), often in combination with each other (17).
- 43 (72%) are involved in Prevention, with 32 offering HIV education/ life skills development (p1), 20 of these in combination with Behaviour change (p4).
- No congregations offered direct Treatment services.
- 3 (5%) congregations have a Linking role, all of them in combination with Prevention and /or Care.

Of 36 Religious **Support groups** surveyed, 32 offered services:
- 28 Support Groups (78%) offer Care activities, some up to 6 of these. Most of them also offer Prevention (23) and Treatment (6). As with other REs the most frequent care activities are HBC (c1; 15), Spiritual support (c7; 12), care for OVC and widows (c3; 11); but Material support (c6) also ranks high (11).
- An almost equal number, 27 Support groups (75%), offer Prevention activities, 23 in combination with care. The most common are HIV education/ life skills development (p1; 19) and Behaviour change (p4; 11)
- 6 Support Groups (16%) offer Treatment activities across the whole range of activities surveyed.
- 4 Support Groups (11%) also have a Linking function.

Of 9 **Traditional healers** surveyed, 5 offer no activities.
- 2 offer Prevention (p1)
- 2 offer Treatment, one of them in combination with 3 Care activities.

ARV therapy/ramp up (t1) was reported by 7 of the surveyed entities: 4 POs, 2 Religious Support groups and 1 Religious Development agency. In 4 entities ARV therapy was offered with other treatment activities; all 7 also offer Prevention and Care activities.

b. Lesotho

In Lesotho, we collected Information on 224 entities exactly half of which, 112 (50%), are known to offer activities in the 4 areas surveyed. The 112 entities comprise 75 religious entities and 37 Partner organisations, 75% and 52% of the totals mapped, respectively. Again, we attempted to gather information from the remaining 112 entities but were unable to do so for this analysis.

The most common **Prevention** activity offered is HIV education/life skills development (p1; 96), and for 49 entities this is the only activity reported; 59 of the entities offering this service are Religious entities, including 18 congregations, 12 traditional healers and 3 support groups.

In 44 cases HIV education/life skills development is offered jointly with VCT (p2). Here 26 REs are involved, including 7 congregations, 4 traditional healers and 2 support groups.

A total of 22 of these entities offer p1, p2 with HBC (c1). These are mostly health providers (19) including 4 of the traditional healers; 8 of them also offer ARV therapy /ramp up (t1).

The most common **Care** activity offered is HBC (c1), offered by 26 entities, of which 22 also offer some Prevention activities. These entities include no congregations, 7 traditional healers, and 1 support group.

8 REs offer **Treatment** as well as do 5 of the POs; these are mostly health providers, 1 Education Provider and 1 Media entity; 6 of these REs offer ARV therapy /ramp up (t1), and 2 Phyto-therapy (t5).
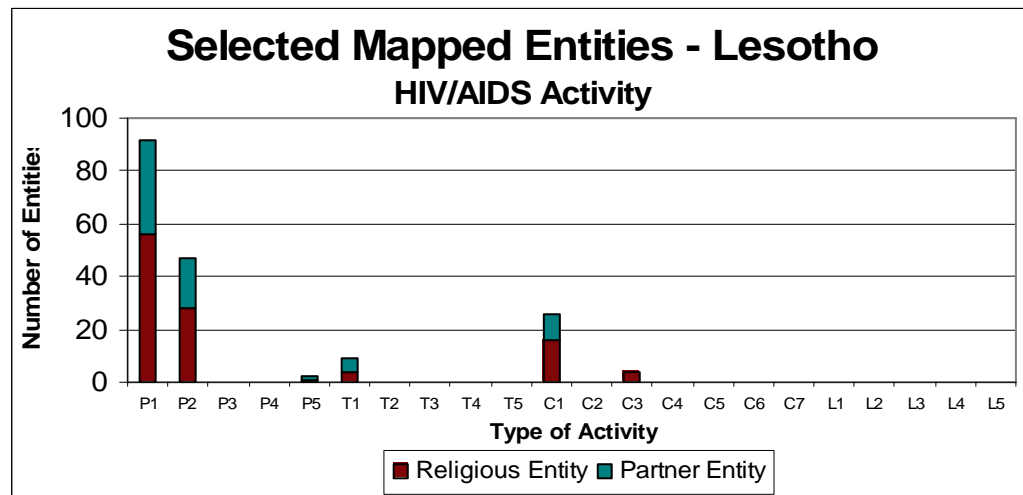
Of the 29 **Congregations** surveyed, 18 are involved in Prevention activities, mostly HIV education/ life skills development (p1; 16), VCT (p2; 8) and Advocacy (p5; 2).

Only 2 congregations offer any Care activities. Both give support to OVC /widows (c3), one in combination with PWLA specific care (c4) and Material support (c6). Ten congregations offer no surveyed activities.

8 religious **Support groups** were surveyed. Of these 3 offer Prevention activities (p1), 2 also p2, while 2 offer Caring activities, i.e. HBC and PLWA specific care.

Of the 25 **Traditional healers** of various types included in the survey, the most common activities are HIV education/ life skills (p1; 12 - 4 of these in combination with VCT) and HBC (c1; 7). 9 offer no surveyed activities.

ARV therapy/ramp up (t1) is provided by 11 entities: 6 REs (see above) as well as 5 POs in the Education Provider, Health Provider, and Media sectors.

iii. Key Findings

In sum, our master database of 494 Religious and Partner entities in Zambia and Lesotho constitutes the first known Participatory/GIS database on Religious Health Assets and makes visible *341 Local Congregations, Support Groups, Health and Education Providers* working in HIV/AIDS and related health areas *identified as significant* by trusted community, provincial/area, and national leaders. It is believed that many if not most of these have gone unrecognized in previous studies. The accompanying listings of organizations in Appendix K further highlight the breadth of religious affiliations and the programs being conducted.

Although an indepth analysis of these entities is beyond the scope of this report, our examination to date indicates the following:

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

59

- These entities span a wide spectrum of activities across the 4 categories of Prevention, Treatment, Care & Support, and Linking Functions
- Dominant activities are: 1) Care and Support Services, incorporating Spiritual Support, Home-Based Care, and Care for OVC and Widows, and 2) Prevention Services, centered on HIV/AIDS education/life skills development and behaviour change.
- A small number of entities - mostly health care providers - offered direct Treatment Services, including provision of ARV therapy or rampup to other programs
- Religious and Partner entities tended to either specialize in type of activity, such as HIV Education/Life Skills Development, or to involve themselves across the continuum of HIV services

The contributions of these entities to health, well-being, and HIV/AIDS *in their local context and as seen through the eyes of the participants themselves*, will be explored in Chapters 3 and 4.

E. Zambia and Lesotho Maps

We may now examine the entities described above in a series of Map Views, consistent with existing information in HealthMapper. Printed views are provided in Appendix M. Although detailed multi-layering and analysis of the sites has not yet been undertaken, this will be pursued through online queries; of special interest will be correlation with HIV/AIDS data, other infrastructure layers, and key socioeconomic indicators.

Based on our experience to date, we offer the following summary of our P/GIS findings:

1. First, in an African context, and especially in these two countries, **geography matters**.

The realities of distance, terrain, climate and local conditions are of special importance in Zambia and Lesotho and have particular implications for treatment, care, and prevention programs, especially Home-Based Care and Support Groups, and for communications and messaging. Universal access, by its very nature, must take into account the needs of Zambians and Basotho, who live in remote villages and highland passes, difficult to identify and reach. The new Lesotho HIV/AIDS Strategic Plan cites difficult mountainous terrain as a critical barrier to electronic health communication/ messages, which may fail to reach much of the country. Our maps demonstrate, perhaps for the first time, local religious assets that may be brought to bear on these issues.

2. GPS coordinates serve as the **only locator system in many areas.**

In many areas, there are few roads and virtually no postal addresses. Even where the few post offices exist, they are often many kilometres from dwellings and other facilities. Without accurate GPS locator systems, the difficulties of delivering of HIV/AIDS and health services, supplies, drugs, food, and water are compounded not to mention the plotting of practical routes for HIV/AIDS laboratory testing, clinic followup, and monitoring.

In many areas, territories, health service areas, political boundaries, and other jurisdictions also change periodically, with concomitant changes in responsibility and authority. These may result in gaps in health provision to be recognized and perhaps addressed within the more enduring religious "boundaries."

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

60

Of note in many of our study areas was the lack of even hard-copy maps that were available and up-to-date; in one district the single map in existence was an office copy 3 decades old. It is hoped that the maps generated here and others becoming available will be of assistance in these areas.

3. Maps *make the invisible visible;* P/GIS Maps *make the locally important visible* and *honor community wisdom and agency.*

Beyond the immediate uses, maps also make the invisible visible and may provide the impetus for communities to see themselves and others for the first time and in a new light. It is striking in this study that diverse religious entities and partner organizations now appear on the same maps and, based on the workshop experiences, have already begun to form linkages and ties to address HIV/AIDS needs. P/GIS maps may further help demonstrate current "facilitators/barriers" to alignment of resources.

4. Maps offer links to *surprising layers and discoveries* via query.

The potential for the maps and data generated here is just beginning to be tapped. Future applications and discoveries may 1) demonstrate wider linkages and "leverage" points and 2) help track trends over time - in HIV/AIDS, health and other indicators and in the "appreciation" and change of religious health assets. P/GIS Maps may also empower local communities to see their own assets and potentialities and to create "ideal" maps of the future. P/GIS Maps *can be* powerful communication tools for planning and decision-making, *if* used appropriately.

Caveats

Despite their advantages, both traditional GIS mapping systems and P/GIS maps must be viewed with following issues in mind:

1. **Access:** These systems are often difficult to access, especially in southern Africa, where there is a general lack of technology and high-speed communication and spotty "mapped information."

2. **Usability:** GIS systems are complex, and the user interface tools sometimes difficult to master. There are few truly online interactive systems for queries/discoveries, and, as we found, hard-copy static maps are expensive to secure and produce.

3. **Standards:** There are still few standard definitions, symbols, icons, and other conventions. It is sometimes difficult to truly see what's on the map and to know why it's important.

4. **Accuracy**: With the increased use of GPS mapping for a variety of public health applications, there are now many mappers, but little quality control. We often tried to use existing map layers only to find that key sites/facilities appeared in the middle of streams or highways, or in some cases, in the wrong country.

5. **Currency**: Especially in the context of community organizations, religious and partner entities, names/focus areas/locations change quickly, often due to the coming and going of grant funding. Few mapping systems store archival maps for tracking these and important trend data over time.

6. **Cost:** Electronic maps are expensive to develop and keep, and to keep up-to-date over time. Costs and benefits must be weighed and every effort made to maximize linkages and avoid duplication of effort.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

61

Specific Recommendations for Interface with WHO Health Mapper/SAM

1. **Purpose and Data Structure**: HealthMapper and SAM were developed for a broad range of needs at certain levels of analysis and using proprietary software. In some cases the resulting data views and analyses are at a level higher than that for meaningful use locally; in others, the proprietary nature of the system precludes the use of the full range of GIS tools. To employ an open-systems approach and use full GIS capability for access and analysis, we recommend storing information in standard, full GIS packages and then porting data to HealthMapper for common use.

2. **Key Data Elements:** As our extensive Definitions tables demonstrate, there is need for expanded key data elements for many entities not currently found in HealthMapper. In addition, in the African context, the use of multiple local languages requires that facilities and other entities be stored with multiple names and descriptions - at minimum with an English or Western language name and the most prevalent African language name for that area. In Lesotho, for example, we recommend an accommodation to store names in both English and Sesotho.

3. **Uneveness of Data:** As cited above, at the inception of our study there was little extant data on Zambia and Lesotho and information that was available was uneven across various boundaries and jurisdictions. We hope that our datasets may form the foundation for a consistent religious health assets layer and offer additional technical considerations and response.

4. **Supplements to the Maps:** We recommend at least three supplements to the current maps and are experimenting with various technical approaches: 1) the inclusion of "pop-up" profiles of mapped entities, with key descriptive information, 2) the inclusion of digital photos to accompany the "pop-ups", 3) an innovative approach to displaying scope, scale, reach of entities, beyond the current tools for coverage areas.

5. **Training, Equipment, and Technical Assistance**: In addition to the systems orientation provided at headquarters, extensive training and technical assistance, concomitant with training for Zambia health officials, was planned and committed by WHO for all ARHAP field research teams in our study. Unfortunately, this training was not able to be arranged due to the complexities of scheduling with many diverse groups. We strongly endorse the need for indepth training for those interfacing to these systems, complete with provision of standard GPS units for field use.

We shall now take a closer look at Religious Assets, Networks, and Agency in each country, as seen from, and through, the Participatory Workshops.

Chapter Three

Understanding Religious Health Assets - Zambia Research

Copperbelt Community Workshop, 2005

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

62

Chapter Three: Understanding Religious Health Assets - Zambia Research

IX. Background

Zambia is a landlocked country in Southern Africa, bordering Zimbabwe, Namibia, Angola, the Democratic Republic of the Congo, Tanzania, Malawi, and Mozambique. It has a population of 10.5 million consisting of 73 ethnic groups and the key indigenous languages are Bemba, Tonga, Losi, Luvale, Lunda and Nyanja. English is the main language of civic life. Zambia gained its political independence from Britain in October 1964 and was ruled by President Kenneth Kaunda of the UNIP (United National Independence Party) from 1964 to 1991. Following the introduction of multiparty democracy in 1991, the MMD (Movement for Multiparty Democracy) came to power and has remained there since. President Chiluba served from 1991-2001 and President Mwanawasa since 2001.

Zambia underwent major economic changes due to the Structural Adjustment Program implemented in the 1990s which had an impact upon the public provision of health, education and community services. The policy of privatization also saw major changes to the mining industry which has historically been the economic backbone of Zambia. Furthermore, political instability amongst its neighbors, Angola, Namibia, Zimbabwe, DRC, and Mozambique, many of whom provide the only access routes to the sea, has had a strongly negative impact upon the economy. The economic difficulties experienced by ordinary Zambians are evidenced by the huge inflation and devaluation of the Zambian Kwacha, until it stabilized in late 2005.

The agricultural sector which is dominated by small scale subsistence farmers has also been affected by the economic difficulties and the impact of climate change. Zambia experienced several droughts in the years 1979, 1981 and 1983, and although it is a water-rich country, holding 60% of all the fresh water of Southern Africa, this also had a negative impact upon the livelihoods of ordinary Zambians. Current statistics show that 73% of Zambians live below the poverty line, 71% of Zambian's today live in abject poverty, and the rate of unemployment has continued to grow.[61]

Zambia is divided into nine provinces, with the capital being Lusaka in the central south of the country, north of the Zimbabwe border. Each province has a capital town, and they are linked by a network of tarred roads - many in poor condition. Zambia has modern communications networks in the urban areas, with land line telephones, cellphones and television common in the population centers.

A. The Religious Landscape of Zambia

Zambia is a predominantly religious nation, with the majority of the population identifying themselves as Christian, and the country being officially declared a Christian nation by President Chiluba in December 1991. The Central Statistics Office of Zambia indicates that approximately 85% of the population is Christian; 5% are Muslim; 5% adhere to other faiths, including Hinduism and the Baha'i Faith; and 5% are atheist.

The Christian faith was introduced by foreign missionary groups in the 1890's and among Christians, there are four major groupings:

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[61] B.P. Mpepo, *The Path Away from Poverty: An Easy Look at Zambia's Poverty Reduction Strategy Paper 2002-2004*, (Lusaka, Zambia: Civil Society for Poverty Reduction, 2004), 9.

- Roman Catholics represented by the Zambia Episcopal Conference (32%).
- Mainline Protestants (United Church of Zambia, Anglican, Lutheran, etc) affiliated to the Christian Council of Zambia (~27%).
- Evangelical Protestants belonging to the Evangelical Fellowship of Zambia (12.5%).
- Charismatic Pentecostals gathered together in the Independent Churches Association of Zambia (approx 20.2%). It must also be noted that Pentecostal Charismatic Churches are clearly the fastest growing religious body in Zambia.

Other congregations which are not affiliated to any mother body but play a key role in shaping religious life in Zambia are Christian Missions in Many Lands, Seventh Day Adventists, and Jehovah's Witnesses

African Traditional Religions are not dominant in the public eye, but are evident as a minority tradition in many communities.

Islam is growing in Zambia, and is strong in the eastern province, owing to the influence of the Muslim communities in Tanzania and the east coast of Africa. While most of the Muslims are Zambians of Asian descent, a number of indigenous people in Zambia have been converted to Islam, especially in Chipata, the capital of the Eastern Province.

B. The Contribution of Zambia to This Research

Zambia contributed significantly to this research in three key ways. First, it was the place in which the PIRHANA tools were piloted and tested. Drawing on earlier research work with Zambian Masters' students, contact was made with key leaders in Zambia, who facilitated early access to key informants in the Copperbelt. A team comprising of representatives from both the Zambia research team and the Lesotho research team spent a week in Ndola and Chipata familiarizing themselves with the process, and sharpening the tools. Second, the wide geographic spread of the country enabled the research to examine the contribution of religion and religious entities in a number of different contexts including urban, peri-urban and remote areas. Finally, Zambia has a developed NGO and FBO sector, and owing to the Christian status of the country, there are a wide range of Christian and other religious organizations present. The Zambian research has made a specific contribution by mapping this reality, and examining the nature and contribution of the REs to health and wellbeing.

X. Running PIRHANA Workshops in Zambia

A. Selection of Sites

Considerable attention was given to the selection of the research sites for Zambia. Zambia is a vast country, and so the first decision was to identify four regions that would offer diverse contexts. In discussion with local role players in Zambia it was decided that the Copperbelt in the north, would serve as the best place for the pilot workshops, and then Livingstone in the south west, Chipata in the far east, and Lusaka as the capital would provide good variation. The second important factor was the presence of local leadership that could be of assistance. This was particularly important in terms of identifying the location for the local community workshop. The research officer spent several weeks in each site making contact, identifying participants, and ensuring that the invitation process served the purpose. Contacts were made with local and national leadership including role players in the Zambia Interfaith Networking Group (ZINGO), Christian Health

Association of Zambia (CHAZ), Christian Council of Zambia (CCZ) the Tropical Diseases Research Center, various hospitals, and some government official such as the Town Mayor, the Town Clerk, and District Aids Task Force Chairpersons in the various research sites.

Profiles – Provincial Workshops, Zambia

Copperbelt Province

Sq Km: 31,328
Est. Pop: 1.5 mil
Est. HIV Prevalence Rate: 20%
Capital: Ndola
Est. Pop: 375,000

Community Level: Pilot
31 October 2005
Mushili Township
Mushili Baptist Church
Peri-Urban

Area Leadership Level: Pilot
1 November 2005
Kitwe (Est. Pop: 365,000)
Copperbelt Health Education
Project
Urban

Copperbelt Province, Community Market, 2005

Regional Leadership: Pilot
2 November 2005
Kitwe
Edinburgh Hotel
Urban

Southern Province

Capital: Livingstone
Sq Km: 85,283
Est. Pop: 1.2 mil
Est. HIV Prevalence Rate: 18%

Community Level: Pilot
10 January
Maramba Compound
Maramba United Church of Zambia
Peri-Urban

Area Leadership Level: Pilot
11 January 2006
Livingstone
Wasawange Lodge
Urban

Maramba Community, Livingstone, Southern Province 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

65

Eastern Province
Sq Km: 69,106
Est Pop: 1.3 mil
Est HIV Prevalence Rate: 14%
Capital: Chipata
Est. Pop: 75,000

Community Level:
5 April 2006
Chipata
Loungwa Lodge
Peri-Urban

Area Leadership Level:
4 April 2006
Chipata
Loungwa Lodge
Peri-Urban

Chipata, Eastern Province, 2006

Lusaka Province
Sq Km: 21.896
Est Pop: 1.4 Mil
Est HIV Prevalence Rate: 22%
Capital: Lusaka
Est. Pop: 1.1 mil

Community Level:
8 April 2006
Bauleni Community
Bauleni Pentcostal Church
Peri-Urban

Regional Leadership Level:
7 April 2006
Lusaka
Amaka Lodge
Urban
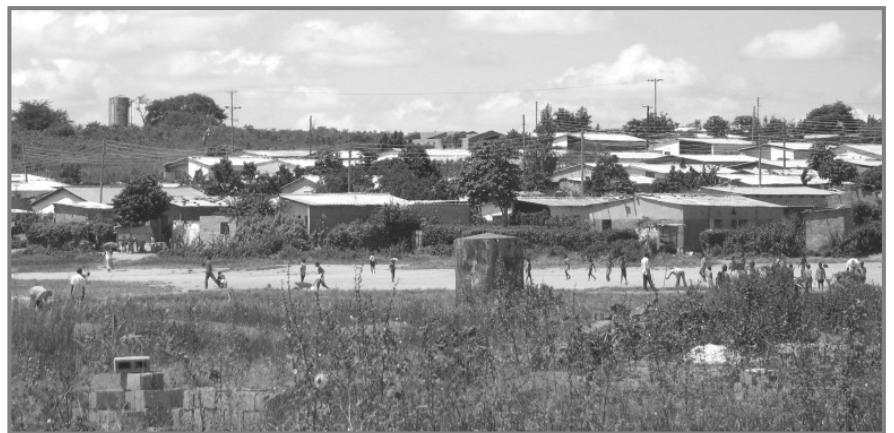
Bauleni Community, Lusaka Province, 2006

B. Participant Description

While a great deal of attention was given to ensuring the representative nature of the participant groups, the nature of African communal life is such that in some cases people who confirmed their attendance were not able to attend, while on the other hand others assumed that because a friend or colleague had been invited they were also welcome. In the end the five community workshops were attended by 109 participants, and the 4 regional workshops by 86 participants, as described below. (For information on the participant demographics please refer to the data in Chapter 2.V.E)

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

66

i. Community Workshop Participants
a. Representivity

In the pilot workshops, it was realized how crucial it was to be clear about the representivity of the workshop participants. It was agreed that the ideal workshop would comprise 3 people who are from the Roman Catholic church, 4 people from different Pentecostal faith healing ministries, 3 Muslims, 3 people from the Baha'i faith, 3 people from the Hindu community, 3 general house wives, 3 unemployed men, 3 people running businesses and 2 general invitations. As noted above, in the social and cultural context of Africa it is almost impossible to ensure that such representivity is maintained. Nevertheless, while attendees of the pilot workshop at Mushili were predominately of one church tradition, the other community workshops at Kitwe, Maramba, Chipata and Bauleni were much more representative; we were especially cognizant of the efforts to have members of the Islamic faith present.

b. Power Dynamics

The facilitators were aware of and expected certain power dynamics in the community level workshops. First, there was an awareness that women would defer to men in public discussions, even though women outnumbered men in 4 of the 5 workshops, making up 59 of the 109 participants. Second, there was the awareness that lay people would defer to ordained pastors. Because of this, the exercises were designed so that the plenary discussion would not be dominated and influenced by a few strong voices. Furthermore, the small groups were usually divided on the basis of gender, so that men did not control the perspectives of women (only 4 out of 17 groups were "mixed"), or pastors were placed in their own group so that their views did not dominate those of the lay members of their churches. A further power dynamic to do with the use of the English language was dealt with through translation and the fact that local languages were used in all the small group work.

ii. Regional level workshops
a. Representivity

For the regional workshops, following lessons learned in the pilot, it was decided to invite key people who were Directors for NGOs, FBOs, Project Managers, Church Pastors/ Bishops, Muslim leaders, as follows: 2 people from the Muslim community leadership or priests, 2 people from the Baha'i faith leadership, 2 Hindu leaders or priests, 3 Pentecostal faith healing Pastors/ Bishops, 3 people from the Protestant Evangelicals, 3 Catholic Church leaders, 6 Project Managers from regional Faith Based Organizations, 2 medical doctors, 3 people from NGO and 3 people from government health providing institutions. With a few exceptions, this was achieved in Livingstone and Chipata. In Lusaka, although workshop attendance was lower than expected, this was believed to have been influenced by the events of World Health Day, organized just prior to the workshop, and the group was still diverse in its perspectives. In retrospect, the team agreed that the smaller group in fact was more productive in many some ways, allowing for maximum participation, and that the data were not compromised in terms of their depth and integrity.

b. Power Dynamics

Those who attended the leadership level workshops were generally people who had the ability to participate comfortably amongst their peers. However, there was a gender dynamic owing to the fact that fewer women hold leadership roles. Thus while women were in the majority in 4 of the 5 community level workshops (with 54% overall), they were in the minority in all the leadership level workshops with only 30%. Facilitators were attentive to this and ensured that all participants had the chance to contribute to the discussions.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

67

XI. Research Findings

In exploring the major research question: *What is the contribution of religion and religious entities to health and wellbeing in a time of HIV/AIDS*, our participatory research in Zambia covered four key regional areas and involved a range of participants from both community level and leadership level, invited through a purposively sampled process. There was a high degree of participation in the workshops and the exercises, and these generated a combination of quantitative data in the form of maps, spidergrams, timelines, indices and ranked factors, and qualitative data in the form of recorded discussions around the outcomes of the exercises.

Summary of Key Research Findings in Zambia

Findings about religion within the Zambian social, economic, political and cultural context

1. Ordinary Zambians perceive their struggle for health and wellbeing to be located in a context of poverty, weak public-health capacity, and the HIV/AIDS pandemic.
2. Regional variations in Zambia impact on people's experiences and perceptions of health and wellbeing.
3. Since the mid 1990s there has been a dramatic proliferation of the number of religious entities (REs) involved in promoting health and wellbeing in a variety of ways, many of which are directly responding to HIV/AIDS. This is altering the nature of the religious contribution to health in Zambia.
4. Religion and religious entities (REs) are perceived to play an important role in the struggle for health and wellbeing in Zambia, with REs ranking higher than other "general" health facilities.

Findings about the nature of the religious contribution to health and wellbeing in Zambia

5. Religion is perceived to contribute in six key ways - tangible and intangible - to health and wellbeing in Zambia. The intangible factors are spiritual encouragement, knowledge giving, and moral formation, and the tangible factors are compassionate care, material support, and curative interventions.
6. Ordinary Zambians perceive a strong relationship between religion, moral agency and health in the context of poverty, unemployment, alcohol, drugs and commercial sex. This has implications for understanding the religious framework for tackling stigma.
7. There is little recognition and appreciation of the role of religion in advocacy and policy formulation around health and wellbeing.

Findings about the nature of the contribution of religious entities to health and wellbeing in Zambia

8. REs operate within a network of relationships with three important characteristics: (i) They are integrated with secular entities and public health facilities in the local situation; (ii) they are linked to a range of entities that are located outside the local context; and (iii) there are significant "intermediary" groups or relationship hubs. Furthermore, in Zambia, it would seem that Christian REs are integrated into these networks much more than REs of other faiths
9. The perceived contribution of traditional healers to health and wellbeing in Zambia is contested, with awareness that there is a difference between herbalists and diviners. Strong Christian opposition was noted towards the latter.
10. A wide range of REs contribute to health and wellbeing in both tangible and intangible ways and the combination of these two is what is perceived to give them "strength". "Compassionate care" (expressed in HBC groups) is perceived as the most important response of REs to HIV/AIDS
11. Certain REs are acknowledged as exemplars in the community, and these perform well in three important areas, namely, programmatic, operational and associative
12. There is an overwhelming desire to be more effective against HIV/AIDS.

On the basis of these data we have been able to identify twelve key research findings, which we have grouped into three broad clusters, all within the context of HIV/AIDS:

A. Religion within the Zambian Social, Economic, Political and Cultural Context

The first four findings from the research in Zambia relate to the context in which religion engages with the struggle for health and wellbeing.

Finding 1:   Ordinary Zambians perceive their struggle for health and wellbeing to be located in a context of poverty, weak public-health capacity, and the HIV/AIDS pandemic

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A consistent finding from a range of experiences and exercises was that the context in which people struggle for health and wellbeing in Zambia is characterized by wider social and economic dislocation. The first significant factor that points to this finding was the way in which participants in all four of the regional-level workshops noted the significance of 1991 as crucial in the time line exercises. This was perceived as the "key moment" which saw the re-introduction of multi-party democracy, the election of Fredrick Chiluba of the MMD as President, the introduction of the Structural Adjustment Policy and the adoption of privatization as the major economic approach of the state. Participants at all four workshops spoke about the impact that this has had on increased unemployment, the devaluation of the Kwacha, and increasing levels of poverty together with the weakening of the public health system, the introduction of "user fees" and "cost

Because of lack of food, HIV/AIDS speeds up, even if you are taking ARVs, if you don't have food it won't help – Bauleni, Lusaka, 2006

sharing" and the medical scheme (1992), the loss of institutional ability as doctors and nurses have left the country, and the re-emergence of TB and Malaria as previous social controls were liberalized.

The time lines also provided an opportunity for the participants to identify the way in which HIV/AIDS has emerged as the crucial issue in health and wellbeing in Zambia. The first case of HIV/AIDS was diagnosed at UNZA by Dr Anie Belly in 1981 (although the time line also suggests the first case in Zambia was in 1985), and AZT, which had been withdrawn as an anti-cancer agent in 1975, was re-introduced as an ARV in 1985. In 1985 President Kaunda made a public announcement that his son had died of AIDS. In 1989 Winston Zulu made a public declaration of his HIV positive status and became an AIDS activist. By the 1990's - in parallel with the health issues noted in the previous paragraph - there was a major increase in HIV/AIDS agencies and organizations in Zambia, alongside an increasing number of deaths.

As a pastor, we had a patient who was sick, a church member, and we prayed for her for two weeks, and each time there was no improvement. Until one time the spirit of God says, "can you just ask, if she has eaten anything?" So I asked, "Madam, have you eaten anything". And she said, "how can I get anything?" So the church decided to do something. In the afternoon they all went and bought her this and that, such as a bag of maize-meal. And the very next morning…she was healed! - Bauleni Community, 2006

This broad context of poverty that was noted in the timeline exercises was also evident as the major factor shaping the lives of Zambians in the five transect walks, as key informants led the research team for approximately an hour on each occasion through Mushili (Ndola), Kitwe, Maramba (Livingstone), Chipata and Bauleni (Lusaka).

Four key factors that were identified in this exercise across the five sites were (i) evidence of a wide-spread informal economy, with many people selling food and charcoal and offering hair dressing, from small makeshift shacks on the side of the road. This generally involved women, and there were many signs of child labor as children contributed to family livelihoods. (ii) it was noted that a large number of industrial

buildings stood unused, a sign that local manufacturing companies (in, for example, the textile, radio and motor assembly sectors) could not compete with imported and cheaper goods from countries like China and South Africa after the liberalization of the Zambian economy. (iii) Third, it is clear that there is an extremely degraded road network, with disintegrating tarred surfaces, large potholes, and no rainwater drainage systems leading to huge mud pools. Public transport in the form of blue mini-busses and taxi

Maramba Community Mapping, Livingstone

cabs is found all over Zambia, and there are few privately owned vehicles, with bicycles evident in many communities as the main mode of transport. (iv) The final factor that was noted was that there are huge environmental health hazards. In evidence were blocked sewerage systems and bad drainage leading to many pools of stagnant unhygienic water, broken taps, and pollution in the streams as well as in the air (from the mining in Kitwe). These four "common denominators" point to the context of poverty in Zambia.

The community map drawing exercise confirmed this context, when participants were asked to draw maps of their communities. The local markets - characterized by a lack of facilities and sanitation, staffed mainly by women, and showing little sign of profit - were noted on all maps as places where people both engage in their livelihoods and seek the food, traditional herbs and social interaction (even religious worship) necessary for survival. The number of taverns and pubs indicated on the maps also drew comment. They were spoken of as places that are connected to the "unemployment-alcohol-sex-infection-AIDS" complex that emerged time and time again in discussions about health in Zambia (see Finding 6 below). Cemeteries or graveyards were noted on all the maps. This led to discussions about the reality of death in the community, and the impact of AIDS. Clinics, hospitals, traditional healers and home based care groups were constantly noted on maps, suggesting a high degree of awareness about the importance of health facilities in daily life.

Every day is a burying day…every hour and every day - **Maramba, Livingstone, 2006**

This is the context in which ordinary Zambians seek to secure their health, wellbeing and livelihoods. This was confirmed in the exercise in which participants were asked what factors *undermined* health and wellbeing in the community. The aggregated response from the five community workshops suggested the following key factors:

Factors undermining health and wellbeing

Participant terms	Number	Synthesized Category	Total
Bars, taverns, nightclubs	32	"Immoral" activities	58
Prostitution	6		
Laziness	5		
Sin and immorality	5		
Drugs	5		
Beer drinking	4		
Unfaithfulness and adultery	2		

Poverty	46	Economic factors	55
Unemployment	9		
Hospitals/clinics	28	Medical factors	32
Health Centers	10		
Facilities/access	4		
Enough drugs	1		
Blood	1		
Ignorance	24	Educational Factors	24
Lack of food	8	Food Security	8
Pollution and poor sanitation	5	Environmental factors	8
Unclean water	3		
Worries	5	Emotional factors	8
Stigma	3		
Ungodliness	5	Religious factors	7
Religion	2		
Gender inequality	1	Wider social factors	5
Crime	2		
High population	1		
Lack of peace	1		
Traditional beliefs/witchcraft	3	Traditional factors	4
Lack of traditional healers	1		
Lack of sports facilities	3	Local Factors	3

Given what we have noted thus far, the ranking of economic factors should not surprise us. The cluster of factors to do with "immoral activities" such as alcohol/prostitution/drugs/adultery, and which tops the list (58) points to the deteriorating social conditions in which people find themselves, and the perceived way in which immoral activities undermine health and wellbeing. (See Finding 6 below). It is important to note here that this understanding of morality and immorality is the perspective of the participants that was noted across the community workshops, and is the way they choose to express this issue. The cluster around medical factors further illustrates the struggle for health in the midst of a struggling public health environment. In discussion around the terms "infection" and "death" participants referred directly to HIV/AIDS.

When asked what factors *contributed* to health and wellbeing in the community, the aggregated response from the five communities (see below) indicated the following five key elements, with the top two suggesting the need for the mental and spiritual resources necessary to navigate the difficult context, and the next three pointing to the need for an enabling environment in the form of medical access, food and water/sanitation/housing.

Factors contributing to health and wellbeing

Participant terms	Number	Synthesize Category	
Schools and Education	50	Educational factors	51
Community sensitization	1		
Churches	36	Religious factors	47
God, spirituality	11		
Hospitals/clinics	28	Medical Factors	44
Health Centers	10		
Facilities/access	4		
Enough drugs	1		
Blood	1		
Food/nutrition	26	Food Security	36
Water	9	Environmental Factors	14
Good sanitation	2		
Housing	2		
Environmental control	1		
Economic empowerment	5	Economic Factors	7
Money	2		

Love	1	Attitude and Emotions	3
Emotional freedom	1		
People's attitude	1		
Healthy activities	2	Local factors	5
Community groups	2		
Organization	1		
Donor Funding	2	Wider social factors	2
Traditional healers	1	Traditional factors	1
Total	210		210

One of the factors about context that emerged in the discussions around HIV/AIDS was the struggles of people in rural areas to access decent health care. Participants spoke about the fact that health facilities and VCT centers were far from the rural areas, and there was little access to transport. Even in some towns, which were far from the central regions of the country, like Chipata, there were health disparities in terms of access. For example there is only one CD4 count machine in Chipata, and people have to wait a long time to make use of it. Thus participants commented: "In Zambia, the delay is not getting tested, it is getting your CD4 count so that you can go onto treatment" and "In Zambia, you usually are given a notice of three months before they do a CD4 count test."

In conclusion then, the struggle for health and wellbeing in Zambia takes place within a context marked by poverty, weak public health capacity, and the HIV/AIDS pandemic, and it is in this context that the relationship between religion and health needs to be understood and appreciated.

> **Finding 2:   Regional variations in Zambia impact on people's experiences and perceptions of health and wellbeing**

Notwithstanding the overall context of health and wellbeing noted above, the research did note regional variations in the perceptions of health and wellbeing in Zambia, and which are related to the different regional contexts.

In *Mushili* and *Kitwe*, two communities on the Copperbelt where the copper mining economy has been severely affected by globalization and privatization, communities were very aware of the lack of economic opportunities available to citizens. The lack of an agricultural base for the regional economy (unlike many other parts of Zambia, and owing to the mines) possibly led to the high awareness of the role of food in good health - as these were the only two communities where "food" figured, and in both cases it was ranked first. Kitwe, a town right up against the mine tailings and smelters was the only community in which "pollution and poor sanitation" appeared in the top three.

Alcohol is a big issue in Livingstone because there is a high rate of unemployment - because people are drinking and engaged in illicit activities we are aware that this is one of the main problems we have, drinking goes to HIV/AIDS and these other sicknesses as well.

Prostitution is tied up with cross-border trade, truckers and tourists…women are engaged in this business who have lost their husbands to the epidemic and have children with no income…many factories have been shut down, and the women were mostly employed at these factories, such as material factories, so now they have no other choice – **Maramba, Livingstone. 2006**

In *Maramba*, a township of Livingstone, on the border with Zimbabwe, and on the main trade routes from Zimbabwe, Namibia and Angola; as well as being the town nearest to the Victoria Falls participants were very aware of the impact of border traffic and tourism on their lives and wellbeing. In this community bars, taverns, nightclubs, prostitution and drugs featured extremely strongly amongst the factors undermining health and wellbeing. Participants spoke strongly of the link between truck traffic, prostitution, and HIV/AIDS, as well as between tourism, taverns, prostitution and HIV/AIDS.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

72

Chipata is on the far eastern border of Zambia, and is closer to the capital of Malawi, Lilongwe, than to Lusaka. It was the most remote rural town that the research team visited, and was characterized by challenges of transport and accessibility, and a lack of infrastructure. Participants spoke of poverty and unemployment as key factors undermining health and wellbeing, and pointed to the contribution of "political neglect" to their struggles.

Bauleni is a suburb of Lusaka, the capital of Zambia. Community members have a greater access to the infrastructure of the city, and particularly its health facilities, yet even here "poverty" surfaced as a key factor undermining health and wellbeing. As with Maramba, bars/taverns/nightclubs were seen as the most important factor undermining health and wellbeing, pointing to the struggles of an urban environment.

It is clear that these communities share the common experience of poverty, with "poverty" identified as one of the top three factors undermining health and wellbeing in all five communities, nevertheless as we have noted there are a range of concerns that are peculiar to the local contextual reality of each community that need to be taken seriously in thinking about strategies for future interventions.

Finding 3: Since the mid 1990's there has been a dramatic proliferation of the number of religious entities (REs) involved in promoting health and wellbeing in a variety of ways, many of which are directly responding to HIV/AIDS. This is altering the nature of the religious contribution to health in Zambia

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We have noted above how the timeline exercise identified 1991 as a crucial "moment" in Zambian history in terms of multi-party democracy, Structural Adjustment and privatization. Participants also noted that at the same time, when Chiluba and the MMD came to power, Chiluba declared Zambia to be a Christian nation, and this was followed by the establishment of a religious desk in state house and government funding of religious groups. The combination of a rapidly privatizing economy and state privileging of evangelical Christianity saw the arrival of the American Evangelical Christian television network, TBN (Trinity Broadcasting Network), as well as a number of large-scale evangelism and healing crusades, which participants noted as having a powerful impact upon the religious landscape of Zambia, and which led to a large-scale proliferation of Christian "ministries", many of a Pentecostal or charismatic nature. The relaxing of property laws and zoning regulations in the cities also enabled many emerging "ministries" to acquire land and build churches.

The church was silent about HIV/AIDS for some time - but when we started burying our own, when it was our own righteous who were dying, we had to come out and speak about it and do something - Livingstone Regional, 2006

The churches have always been involved in health and education…the issue of HIV/AIDS seems to have increased the involvement of the churches in health. But right from the start, you see in the most remote rural areas, there are medical facilities provided by the churches, the Anglicans and Catholics, those early missionaries…But this challenge is now too big and provokes this type of response from us all - Lusaka Regional, 2006

There are much more readily available funds coming into the country, more resources such as the development fund and World Bank. The increased number of orphans has made many NGOS emerge – Lusaka Regional, 2006

In short, this meant that by the mid 1990's in Zambia, (i) poverty and unemployment were on the increase due to the Structural Adjustment Program and privatization, (ii) the public health sector was struggling for the same reasons; and (iii) there was a rise in the public profile of Evangelical and Pentecostal Christianity.

Participants helped us to understand that it is crucial to bear these three factors in mind as providing the context in which HIV/AIDS appeared in Zambia. There was thus (i) an emerging health and humanitarian crisis which required care and funerals, two tasks for which religious bodies in Africa are well prepared; (ii)

the availability of financial grants through the Gates foundation, PEPFAR and the Global Fund, which, in a context of unemployment and poverty, provided an opportunity for some churches, ministries and projects to establish themselves on a secure footing; and (iii) the emergence of public structures such as the District AIDS Task Forces (DATF) which drew on the clergy as an important leadership constituency. All of this helps to explain the dramatic proliferation of religious entities and initiatives in Zambia in the past decade which was indicated in visual form on the timelines (see Appendix G). These organizations have all been mapped as part of the GIS process, as shown in the sample maps in Chapter 2 and Appendix K.

The actual contribution of these religious entities to health and wellbeing in Zambia will be discussed in more detail in the next sections of this chapter. The two points that are important to note here are (i) that the research makes clear the significant presence of religious entities contributing to health and wellbeing in Zambia, and suggests that it is impossible to understand health and wellbeing in Zambia without serious consideration of these entities; and (ii) that the nature of the new religious entities that have emerged on the wider social landscape in the last decade has altered the nature of the relationship between religion and public health. The religious entities contributing to health and wellbeing are no longer just the well established historic and traditional churches (represented in a body like CHAZ), but now include many Pentecostal and charismatic churches of varying size and scope.

Maramba UCZ, Livingstone, 2006

Finding 4: Religion and religious entities (REs) are perceived to play an important role in the struggle for health and wellbeing in Zambia, with REs ranking higher than other "general" health facilities

An important finding of the research was the relative importance of religion and religious entities in the struggle for health and wellbeing in Zambia. This emerged in the answers to two important exercises in the PIRHANA workshops.

In the first exercise participants were asked to rank the factors that contribute to health and wellbeing and which undermine health and wellbeing (see Finding 1 above). When the two tables noted in Finding 1 are combined we get the following table.

Table 3: Aggregate factors contributing to and undermining health and wellbeing

	Health	Sickness	Total	%
Medical Factors	44	32	76	18
Educational Factors	51	24	75	17.8
Economic Factors	7	55	62	14.7
Immoral Activities*	0	58	58	13.7
Religious factors	47	7	54	12.8
Food Security	36	8	44	10.4
Environmental factors	14	8	22	5.2
Emotional factors	3	8	11	2.6
Local factors	5	3	8	1.9
Wider social factors	2	5	7	1.7
Traditional factors	1	4	5	1.2
	212	212	422	100

The factor "religion" is the second most important in terms of *contributing* to health and wellbeing. When combined with the factors which undermine health and wellbeing, "religious" factors rank only 5th, behind medical, educational, and economic factors and what we have termed "immoral activities". We also need to bear in mind that the category of "traditional factors" has some relationship to religion as well. However, when the data for the aggregate factors is examined and the interpretation from the participants is taken into consideration then an interesting relationship between the categories of "religious factors" and "immoral activities" emerges.

▪ No moral factor is given for contributing to "good health and wellbeing", whereas "immoral activities" tops the list of factors undermining good health and wellbeing.

▪ On the other hand while we have noted that religious factors score well in terms of promoting good health (ranked a close second to education/ignorance), they are insignificant in working against good health (only 7).

Following the logic of the participants themselves, it is possible to recognize that in their understanding of religion and religious practice, there is a strong link between religion and moral behavior. The clue here is the term "ungodliness", which is an obvious religious term, but is usually explained in moral terms. Participants moved from religion to morality through a logical sequence: "ungodliness = sin = immorality". When religious and moral factors are combined, a total of 112 "hits" is recorded making this by far the greatest perceived factor in community health and wellbeing (26.5%). This relationship will be examined in greater detail in Finding 6 below.

In the second exercise participants were asked to rank a range of social institutions that existed in their community (as indicated on the community map) in terms of their own definition of what contributes to and militates against health and welfare in their community. A matrix was created that had health factors along the vertical axis and social institutions along the horizontal axis. In smaller groups, participants were to score each

The Ministry of Health is not able to give adequate facilities, so the church has to complement the limited capacity of the government health services – **Lusaka Regional, 2006**

institution against each health factor on a scale of 0-5, where 0 represented "no contribution" and 5 represented "great contribution". There was a great deal of discussion and negotiation amongst the participants (with no involvement of facilitators) prior to the scoring of each. In this transparent, negotiated and participatory manner the relative contribution of each social institution to health was noted. As a few religious entities were normally included in this list, it is possible to identify the perceived relative contribution of religious entities to health in the community. The findings from this exercise strengthen the perception of the significance of religion in the struggle for health and wellbeing,

Mushili	Kitwe	Maramba	Chipata	Bauleni
Church clinic (3.9)	Schools (3.2)	Churches and mosques (4)	Religious hospitals and clinics (3.9)	Churches (4)
Churches (3.7)	Church clinic (3)	Schools (3.7)	Churches and Mosques (3.5)	Schools (3)
Government Clinic (2.5)	Churches (2.9)	Hospitals and Clinics (3.2)	Schools (2.9)	Shops (2.8)
Market (2.1)	Market (2.9)	Markets (3)	CBO (2.4)	Clinic(2.8)
Schools (1.9)	Govt Clinic (2.2)	Old-age homes (2.2)	Gov clinics and hospitals (2.2)	Boreholes (2.7)
Chemist (1.7)	Private Clinic (1.5)	Traditional Healers (1)	Markets (2.1)	Markets (2.6)
Faith healer (1.1)	Chemist (1.1)		Traditional Healers (0.6)	Football field (2.1)
Ing'anga (0.6)	Ing'anga (0.9)		Graveyards (0.5)	Taverns (0.5)

In terms of analyzing this data it is crucial to remember that - owing to the participatory and inductive approach of the workshops - there are a number of important elements that make it difficult to aggregate the

results across the five communities and reach simple conclusions. Nevertheless, it is possible to calculate the average score out of a possible 5 that was cast in each workshop for each institution (rounded to one decimal point). This provides some measure of relative comparison - where the same factors are present - across the differing research sites. Then the most reliable form of data analysis is a ranking exercise in which the ranking of each community is noted, and then comparisons across the communities are undertaken. Making use of these two approaches, the following conclusions can be drawn.

i. Four factors appear in all five communities: Churches and mosques, schools, health facilities, markets. Traditional healers (Ing'anga) appear in four communities (not Bauleni).
    o In four out of five communities churches and mosques scored higher than schools.
    o In four out of five communities schools scored higher than health facilities
    o In four out of five communities health facilities ranked higher than markets
    o In the four places where traditional healers appear they rank lower than markets.
ii. The average number of beans cast across the sites for these five factors in order of ranked importance make this ranking clear:

Churches	3.7
Schools	3
Health facilities	2.6
Markets	2.5
Traditional healers	0.8 (average adjusted for only 4 appearances)

iii. In the three communities where church clinics were differentiated from government clinics they always ranked much higher. These were Mushili (3.9-2.5), Kitwe (3-2.2), and Chipata (3.9-2.2). The average difference in these three sites is 3.6-2.3. For example in Chipata community, despite the general hospital being more central, all participants preferred Mwami SDA and St Francis hospitals to Chipata General Hospital. This was attributed to a combination of better facilities and better care, relating to staff having a greater purpose in their work.
iv. Where church clinics were identified they always scored higher than churches/mosques themselves. These were Mushili (3.9-3.7), Kitwe (3-2.7) and Chipata (3.9-3.5). The average difference in these three sites is 3.6-3.3.
v. Schools ranked first in one community (Kitwe) second in two communities (Maramba and Bauleni), third in one community (Chipata) and fifth in Mushili. It must be remembered that in many cases the schools are themselves run by churches.

People prefer to go to the SDA hospital, rather than the general hospital because the facilities are better. There is excellent care there as well. The personnel give encouragement and pray for you, and that will give you more confidence and encouragement that you will get well there…that doesn't happen at the general hospital, nobody will pray for you there.

The general hospital takes more time to attend to a patient. Some of the people die because of lack of attention.

There is also negligence at the general hospital, the nurses are just there for a career, they have no heart for the patient. Service doesn't happen at the general hospital - **Chipata Regional, 2006**

This analysis makes clear that (i) religious entities outrank all other social institutions in terms of the perceived relative contribution to health; and (ii) where they are represented, religious health facilities always outrank government health facilities, and also outrank the category of "church and mosque". They therefore represent the most significant social institution perceived to be contributing to health and wellbeing in these communities in Zambia, and confirm our finding that religion and religious entities are perceived to play an important role in the struggle for health and wellbeing in Zambia.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

76

B. The Nature of the Religious Contribution to Health and Wellbeing in Zambia

Having seen the importance of religion and religious entities in the struggle for health and wellbeing in Zambia we turn now to three important findings to do with the nature of this contribution.

> **Finding 5: Religion is perceived to contribute in six key ways - tangible and intangible - to health and wellbeing in Zambia. The intangible factors are spiritual encouragement, knowledge giving, and moral formation, and the tangible factors are compassionate care, material support, and curative interventions**

While the contribution of religion to health has been explored by a range of scholars much of this research has taken place at the level of individual health seeking behavior. The PIRHANA exercises were designed to explore this question from the perspective of public or community health. The findings suggest a typology of six ways in which religion is perceived to contribute to health and wellbeing in Zambia. In the three post-pilot community level workshops, participants were asked the question, "What does religion contribute to health?" In this way an index of key factors was created.

Religious-health index, Livingstone, 2006

When we synthesize the answers into a set of clusters, we see the following:

Maramba	Chipata	Bauleni	ARHAP Cluster	Total
Hope (13)	Spiritual care (8)	Faith (6)		
	Hope (4)	Trust (5)	Spiritual Encouragement	41
	Prayer (1)	Hope (3)		
		Encouragement (1)		
Care (6)	Care and support (16)	HBC (6)	Compassionate care	28
Education (16)	Education (5)	Education (2)	Knowledge giving	24
	Training (1)			
Material support (7)	Commodities (4)	Support (6)	Material Support	17
Morals (2)	Behavior change (1)	Self control (7)	Moral Formation	10
Facilities (3)	Reduce illness (2)	Healing (4)	Curative Interventions	9
47	42	40	Total	129

From the perceptions of participants from community level, three points can be identified:

- A category of "intangible" factors to do with hope, spiritual care, prayer and encouragement tops the list. This set of factors is first in one community, and second in two others.
- The category of care, compassion and home based care is second overall, and first in one community. It ranks medium in the other two communities.
- Likewise, education and training, which is third overall, is first in one community.

When the same question was asked at the four regional level workshops the following data emerged:

Participant Term	Copperbelt	Livingstone	Chipata	Lusaka	Total	ARHAP Cluster	Total
Hope	9	12	9		30	Spiritual encouragement	68
Faith	8	2	9		19		
Spiritual counseling/ support		8	4	3	15		
Prayer			3	1	4		
Care and support/compassion		9	8		17	Compassionate care	57
Love	14	16	6	4	40		
Behavior change	8		3		11	Moral formation	22
Life/positive living	6		1	1	8		
Patience			2		2		
Temperance			1		1		
Healing/health services	5	6	1	4	16	Curative interventions	19
Infrastructure			2		2		
Human resources		1			1		
Sensitization/teaching	8	3		2	13	Knowledge giving	13
Material support/OVC support		1	1	5	7	Material support	7
Advocacy		2			2	Public engagement	2
TOTAL							**188**

What is striking in this presentation of the data from the regional level workshops, is the clear dominance of two factors which we have termed "Spiritual encouragement" and "compassionate care".

Having noted the data that has emerged we are in a position to describe in more detail each of the six clusters defined by the ARHAP researchers to synthesize the findings.

i.   *Spiritual encouragement* denotes a range of terms that was used to describe the way in which religion gives people an inner strength to proceed with resilience, courage and determination in the midst of ill health, poverty, and misfortune. This includes the terms "hope, spiritual care, prayer, faith, trust, encouragement" and "hope, faith, spiritual counseling, prayer".

ii. *Compassionate care* clusters together the words, "care, care and support, Home Based Care", and "care and support, compassion, love". It describes the way in which religion is seen to respond to situations of difficulty with a desire to help and be of assistance.

iii. *Knowledge giving* describes the contribution of religion in the areas of "education, "training", and "sensitization, teaching". We must remember that in

Physical and spiritual healing are inseparable – they must go together to create wellbeing – **Chipata Community, 2006**

Sometimes in the government hospitals you are a nurse because it is the last thing you are able to do, because of circumstance, but with home based care it is people who are voluntarily getting involved because they have the heart to do so. So the kind of care is very different than in government hospitals, because it is more of a calling, more of a ministry to individuals. That is something money can't by that the church brings – **Lusaka Regional, 2006**

Patience and gentleness are important part of religious care – the fruits of the spirit comes out in positive impressions – you have the patience to care and not rush. You can have the love, but if you do not have the patience, the patient will not appreciate it. If you have patience and love, assurance, providing all the support they need - **Chipata Regional, 2006**

Donors don't understand – Zambia, people are more religious, very few clinics who do psychological support…here the churches are the only ones providing psychological support – **Lusaka Regional, 2006**

Zambia, following the disastrous impact of the SAP on public education, religious bodies have stepped into the gap and are key providers of formal education. Also, for many people the churches do provide what they consider to be reliable information about health and wellbeing.

iv. *Material support* clusters together the terms "material support, commodities, support" and "material support, OVC support". It refers to activities such as providing food parcels for the sick and clothing for orphans.

v. *Moral formation* denotes a range of terms that are used to describe the way in which religion is perceived to shape the behavior and lifestyle of people, "morals, behavior change, self control", "behavior change, life/positive living, patience, temperance".

vi. *Curative interventions* covers the range of ways in which religion consciously intervenes to cure ill health in either a biomedical or alternate way, and includes the terms "facilities, reduce illness, healing", and "healing/health services, infrastructure, human resources".

An important theoretical hypothesis in ARHAP's work has been that religion contributes to health in both tangible and intangible ways. This set of findings confirms this hypothesis. When the two sets of workshop data are put together we get this picture.

Community	Leadership	Intangible	Tangible	Community	Leadership
41	68	Spiritual encouragement (109)	Compassionate care (85)	28	57
24	13	Knowledge giving (37)	Material support (24)	17	7
10	22	Moral formation (32)	Curative interventions (28)	9	19
75	93	TOTAL (178)	TOTAL (137)	44	83

Apart from the insignificant 2 "votes" for "Public engagement" at the regional level (see Finding 7 below), the same six elements appear in both sets of workshops, and in both sets the first element that religion contributes to health care is perceived to be Spiritual Encouragement and the second element that religion contributes to health care is perceived to be "compassionate care". The pattern of tangible and intangible factors is similar at both levels.

What is important to remember here is that these six ways in which religion contributes to health are not discrete, as if they existed in themselves. It is the interweaving of the intangible within the tangible which gives the tangible its specific "religious" character, and it is the expression of the intangible in tangible ways which gives the intangible its legitimacy. This interconnection is noted again in the discussion about Religious entities and their contribution to health (see Finding 10 below).

Finding 6: Ordinary Zambians perceive a strong relationship between religion, moral agency and health in the context of poverty, unemployment, alcohol, drugs and commercial sex. This has implications for understanding the religious framework for tackling stigma

In our discussion around the first finding about social context we noted how the struggle for health and wellbeing takes place within the context of poverty. We have noted how in this context workshop participants pointed to factors such as alcohol, prostitution and unfaithfulness as undermining health and wellbeing. Alongside this we have noted in the discussion around the contribution of religion to health and wellbeing, the relationship between religion and morality. The data indicated that whilst religious factors contribute towards health and wellbeing (ranked second) they are insignificant as a factor undermining health and wellbeing. On the other hand, while not a single moral factor was advanced for contributing to health and wellbeing, immoral activities ranked first as undermining health and wellbeing.

In analyzing the discussions around the indexing and ranking exercises, it is clear that participants understand religious practice and immoral activities as being strongly related in an oppositional manner. The language in the discussions is a helpful clue to this.

- Religion, faith, prayer, church-going are seen to provide the positive energy that generates a life of health and wellbeing.
- Against this are a range of moral failings, alcohol, drugs, prostitution, characterized by terms such as sin, immorality, and unfaithfulness.

We have identified the term "ungodliness" as a religious term because it has reference to God in it, but in fact it is almost always used by Zambian participants in the sense of immoral activities. Thus to be "godly" or "religious" means to live a healthy life, and to be "ungodly" means to lead an unhealthy life. In a context dominated by HIV/AIDS, participants move between religion and morality through a logical sequence: "ungodliness = sin = adultery, alcohol, drugs, prostitution = infection = sickness".

It needs to be noted that references to taverns, bars and prostitution were not only perceived in individual moralistic terms. Participants saw the connection to wider social issues such as tourism, poverty and unemployment. They were aware that sex work and the selling of alcohol were livelihood strategies for poor women and men. Yet the overriding perception of participants was that the "religious" or "spiritual" capacity of people to withstand the temptation to be involved in such activities was weak, and so people were vulnerable to infection with HIV.

In this way we see the emergence of a triad of factors which point to religious *agency* in the search for health and wellbeing. This triad involves (i) social conditions; (ii) religion; and (iii) morality. Here the language shift between "godly" (a religious term) and "ungodly" (a moral term) indicates the connection.

i. There are objective social conditions to do with poverty, unemployment, loss of meaning, which we have noted in Finding 1. These do have a direct impact upon health and wellbeing in themselves.

ii. Then, the way in which people engage with this social reality is understood in moral terms, and it is these "immoral" activities thriving in the social context, namely, taverns, bars, nightclubs, alcohol, prostitution and drugs, which is itself a further cause of ill-health. Here the direct connection with HIV emerges time and again in the participatory discussions. These moral factors only emerge in the "negative". Being "moral" does not cause good health or wellbeing, but being "immoral" undermines health and wellbeing.

iii. Finally there are religious factors which contribute to health. This is the way in which people express being "moral", namely being godly, spiritual, going to church, having faith. In this way religion and moral action are held together in a coherent healthworld for people in the community.

Copperbelt Community Workshop, 2005

Thus it is clear that the role of religiously informed moral action - or agency - is very significant in the perception of community members in Zambia. In their perception, this combination of religion and morality contributes just over a quarter of the "energy" towards good health and wellbeing.

The shadow side of this positive religious agency is that this logical connection between godliness and morality may be part of the powerful religious perception that drives a sense of guilt and stigma for those diagnosed with HIV. For if there is perceived to be a strong connection between religion, morality, and health, then those who are sick through engaging in "immoral activities" are understood to be at fault religiously. This has implications for the way that stigma is dealt with. We shall examine this in Finding 10 below.

> **Finding 7: There is little recognition and appreciation of the role of religion in advocacy and policy formulation around health and wellbeing**

Our earlier discussion of findings from the PIRHANA exercises has already pointed to the fact that there is little recognition and appreciation of the role of religion in advocacy, prevention and policy formulation around health and wellbeing. As we have seen in answer to the question "what does religion contribute to health and wellbeing?", the responses from the community level workshops did not mention this broader public role of religion and REs. Likewise, at the regional level, only two "votes" were recorded for advocacy.

This finding parallels that of Finding 7 which suggests that the perception of ordinary Zambians is that the role of religion and REs is to help people at an individual level, rather than to seek social change at the public and collective level. Religion connects to morality in terms of personal lifestyle, rather than in terms of political policies. This is not to suggest that the focus is on care rather than prevention, for the categories of "knowledge giving" and "moral guidance" do involve the shaping of individual lifestyles to prevent ill health and infection. However, the point being made here is that the preventative strategies are focused on individual behavior rather than social policies.

Religion does have a public role in Zambia, as seen from the engagement of religious leaders in the Oasis Forum around various political issues such as the "third term" for the president, and the debates around constitutional reform. If would seem that this has not translated into advocacy around health issues.

C. The Nature of the Contribution of Religious Entities to Health and Wellbeing in Zambia

Having noted the perceptions about the contribution of religion in general to health and wellbeing in Zambia, the research identified five specific findings with regards to Religious entities (REs). It is important to see the connections between these two clusters of findings because religion never exists in itself, it is always embodied in people, organizations, networks and initiatives - which are rooted in a specific time and culture.

> **Finding 8: REs operate within a network of relationships with three important characteristics: (i) They are integrated with secular entities and public health facilities in the local situation; (ii) they are linked to a range of entities that are located outside the local context; and (iii) there are significant "intermediary" groups or relationship hubs. Furthermore, in Zambia, it would seem that Christian REs are integrated into these networks much more than REs of other faiths**

Having identified the emergence of REs in the timeline exercise, participants at the regional level workshops engaged in a spidergram exercise which "mapped" the relationships between the organizations that had been named, as well as others that were subsequently added (see spidergram photograph in Appendix G).

Alongside the sheer number of RHAs connected to other groups in a wide network of relationships, a thorough analysis of this exercise in the three post-pilot regional workshops indicates three important characteristics of these networks.

First there is a great deal of integration between REs and public health facilities. This is represented in the spidergram by the many lines that run between "secular" or "state" entities and REs.

- In *Livingstone* between public entities such as the District Health Management Team, the District AIDS Task Force, Livingstone General Hospital and NZP+ (National Association of Zambian People living with AIDS), and religious organizations such as ZINGO, St Francis HBC, Anglican Children's Project and CCAP HBC.
- In *Chipata* between the District AIDS Task Force, Zambia Youth Development, NZP+ (National Association of Zambian People living with AIDS), DAPP Hope and Government DDCC, and religious organizations such as Bread of Life, Anglican Diocese, Chipata Adventist Clinic, the Catholic Diocese and St Francis Hospital.

Now, because of the more multi-sectoral approach, there is more networking and linking, between the church and the secular. Before the church was working on its own, now, we are working inside the community.

There is a lot of interaction between us that we wouldn't have known if we hadn't come today – Lusaka Regional, 2006

- In *Lusaka* between public entities such as the MOH, WHO, USAID and Care international, and religious entities such as the SDA, THPAZ, CCZ, Salvation Army, World Vision.

A key reason for this is that many of the people who work in "secular" or "state" entities are themselves members of the churches, and in some cases Christian ministers are identified as trustworthy community leaders and asked to sit on governing boards, or chair organizations that are non-religious. In Zambia, we noted that key leadership-individuals who belong to one geographic community but wear many different hats in terms of institutional responsibility are a great strength. It builds and nurtures institutional networks.

A second finding is that these networks include a number of important entities that are not "indigenous" to the area, and which suggest that RHAs in a local context draw strength from a wide network of local, national and international relationships.

- In *Livingstone* this includes the "Mother bodies" of the churches CCZ and EFZ, as well as health and development agencies such as CHAZ, JICA and International AIDS Alliance
- In *Chipata* this includes Care International, the World Food Program, Lutheran World Federation
- In *Lusaka* this includes CHAZ, World Vision, Care International, International AIDS Alliance, WHO, and USAID

Having described the scope and reach of the networks in the first two insights, the second two highlight some of the key internal dynamics of those networks.

Thus third, the spidergram clearly showed up the presence of "hubs", organizations, entities or initiatives, which are connected to many others, and through which funding, ideas and strategies flow.

ZINGO Offices, Livingstone, 2006

- In *Livingstone* the hubs were ZINGO, NZP+, DATF, Anglican Children's Project, CCAP HBC, and St Francis HC

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

82

- In *Chipata* these were DAPP-Hope, Bread of Life, DATF and Chiyembekezo with many lines connecting them
- In *Lusaka* the identified "hubs" were AIDS Alliance, UCZ, THPAZ, PMAZ

The fourth insight is that there are a number of entities that are not well connected in the networks. On the whole (with some exceptions) in Zambia, our finding is that Christian groups are well integrated into the networks, whilst those of other faiths are not.

- In *Livingstone* we see this demonstrated by the relative isolation of such organizations as THPAZ, Zion Church, ZESCO and YWCA.

The formation of ZINGO was very significant to Zambian health, as well as the formation of THPAZ – **Lusaka Regional, 2006**

- In *Chipata*, Chipata General Hospital seems strangely disconnected, whereas Mwami Adventist Hospital, Nyanje Mission Hospital and St Francis Hospital are well connected.
- In *Lusaka* the disconnected entities include OMI, NZP+, ZEC, ZINGO and YWCA.

In reflecting on this, we need to recognize that the spidergrams are a reflection of the perceptions of the participants who happened to be there. Here we should bear in mind the following comment from a participant in Lusaka. "There are lots of organizations working with the HIV/AIDS Alliance that are not represented, like the Young Christians Association, or the teachers association that are working with faith-based communities, but are not on the spidergram."

Of particular importance for our research was the insight that religious groupings other than Christian seemed isolated. The *Hindu community* appears almost as an afterthought. Yet participants commented: "HIV/AIDS Alliance works with other faiths such as Baha'i and Hindus"; "The Hindus help Cheshire Homes a lot more than the Zambians, and they are not Catholic, they bring food on birthdays and such."

Given the large *Muslim community* in Chipata, a specific issue of interest in that workshop was the relationship with the Islamic Council. The following comments made by participants provide a good insight into the perception of people around such networks.

> There appears to be little connection to the Islamic council - because they are not networking, "we do not invite them, we discriminate", "they do not come to meetings", "a lot of people leave them out", "I am on the district coordinating committee - they shun us and do not come to developmental meetings", "they can only come at certain times", "they think they are invited to be teased, so they do not come", "they have their own protocol and can't just come at an invitation". "We should honor their protocols and invite them."

In conclusion then, the research highlighted the significance and scope of the networked relationships amongst RHAs and with public bodies at local, regional, national and international levels. The unevenness of those networks was also noted with attention paid to certain "hubs" as well as to isolated organizations, entities and initiatives.

Finding 9: The perceived contribution of traditional healers to health and wellbeing in Zambia is contested, with awareness that there is a difference between herbalists and diviners. Strong Christian opposition was noted towards the latter

Our research indicates that the place and role of traditional healers is contested in the religious sphere. The presence of traditional healers was noted on all the community maps, and the discussion around this

suggested that they were pervasive in the communities, and that their services were sought after by members of the community. However, when it came to evaluating and ranking ing'anga against (i) contributing to health and wellbeing, or (ii) participating in the religious contribution to health and wellbeing they were ranked very poorly.

In terms of contributing to health and wellbeing, traditional healers appeared as a social entity in four of the five ranking exercises. In all four cases, their contribution to health and wellbeing was ranked lowest, lower even than markets. Their specific scores were:

	Mushili (3 groups)	Kitwe (3 groups)	Maramba (3 groups)	Chipata (4 groups)
Food/Nutrition	0	0.66	0.66	0
Healing	1.66	N/A	N/A	2.25
Spiritual growth	0	0.66	1	0.75
Knowledge	1.33	1	1.66	0
Poverty	0	1	0.66	0
Environment/ sanitation	N/A	1	1	N/A
Moral behavior	N/A	N/A	1.66	N/A
Average	0.6	0.9	1.0	0.6

In terms of participating in the religious contribution to health and wellbeing, traditional healers were also consistently ranked lowest. Their specific scores were:

	Maramba	Chipata	Bauleni	Average
Spiritual encouragement (Hope / faith)	1.33	2	2	1.78
Compassion and Care (Caring)	0.66	1	2.5	1.39
Knowledge giving (education)	0.33	1		0.67
Material Support (food)	0	0	2.25	0.75
Moral Guidance (Behavior change/ Self control)		1.5	0.25	0.88
Healing			3.25	3.25
Average	0.6	1.1	1.9	1.45

In the discussions in the workshops, which were very intense in the small groups that were involved in the ranking exercises, it was clear that traditional healers represent a contested terrain. Participants highlighted the following issues.

i.   There is a recognized difference between traditional healers ("Ing'anga" who can also be "diviners" or "witchdoctors") and herbalists. One of these differences is that herbalists have learnt the application of African medicines from community elders, becoming specialists through teaching, while traditional healers are primarily guided by spirits. In Zambia these two groups belong to Traditional Healers Practitioners Association of Zambia (THPAZ), although there currently appears to be some movement of herbalists towards the development of an association of their own.

ii.   There is a difference in terms of the way other religious groups relate to the various kinds of traditional healers and herbalists. The Islamic community and the Roman Catholic Church allow members to make use of herbalists, but not traditional healers. The African initiated churches have a close connection, with one THPAZ

With traditional healing, the medicine comes from the roots, and we all use the same medicine, so when someone goes to a traditional healer it doesn't mean that they don't trust in God, it is the God who created these things and gave wisdom to a traditional healers to use those roots and to that person who was given the wisdom to make the drugs from those roots…all the medicines comes from the roots - **Bauleni Community, 2006**

Although we are traditional healers, we are also Christians…when a person is sick or has died, we pray for that person. When a person is in hospital we go to visit them, take them food parcels and such – **Lusaka Regional, 2006**

representative at a regional workshop also being a Bishop in the Zionist Church. It was very clear that the Evangelical and Pentecostal churches were strongly against any form of traditional healing or consultation with herbalists, with the Evangelicals seeing a strong link between Christianity and "Western Medicine", and the Pentecostals preferring "spiritual healing" that located in the church itself.

iii.   Some of the criticisms that were advanced by participants included the common perception that they were only interested in money from their patients, as well as their lack of contribution to moral values and self control. There were many participants who argued that the traditional healers are not reliable and that their medicines do not cure people, whilst others felt that the medicines do work, "It might take a long time, but it works."

iv.   Yet even with these strong feelings, it was also clear from participants that ordinary Zambians do seek out the traditional healers, particularly for sexual matters. Women visit the healer when they are barren, both men and women when they need STI medicines. Yet, because of the contested terrain, a common insight was that people "visit at night", as these three comments from three different workshops point out"
    a.   "A lot of people in Livingstone visit traditional healers at night for their medical problems."
    b.   "In public they get less recommendations, but at night Chipata goes there"
    c.   "There is different usage of these healers in the day and the night - when people can see - of the Ing'anga or witchdoctor" (Bauleni)
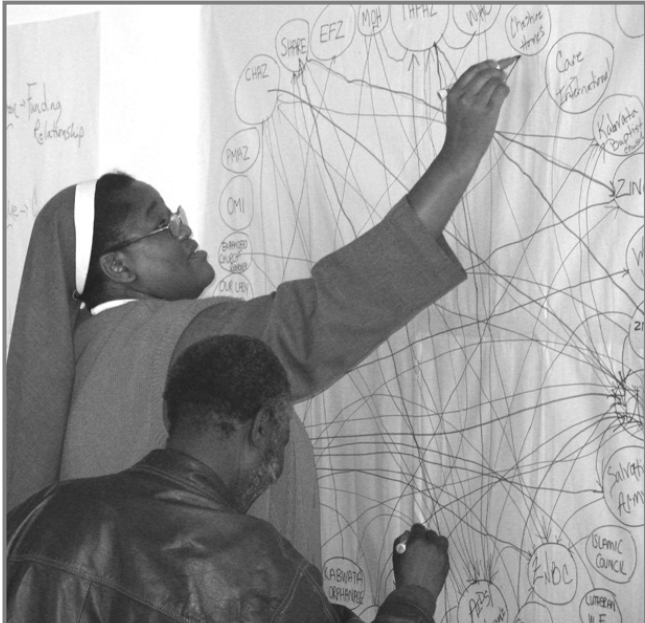
v.   At a few workshops there were traditional healers present, and they affirmed that people did make use of their services. A range of comments made by these representatives include pointing out the educational role of traditional healers, the links they have with the Ministry of Health (MOH) and with hospitals, and a willingness to deal with problems that others are not able to. One strongly contested the role of the church in healing: "When people are sick they go to the hospital and the ing'anga, the last place they go to is the church.", whereas another saw no conflict between the Christian faith and Traditional healing:

Catholic and THPAZ representatives, Lusaka, 2006

    a.   "With traditional healing, the medicine comes from the roots, and we all use the same medicine, so when someone goes to a traditional healer it doesn't mean that they don't trust in God, It is the God who created these things and gave wisdom to traditional healers to use those roots and to that person who was given the wisdom to make the drugs from those roots…all medicines come from those roots."

vi.   At the regional level, THPAZ (the Traditional Health Practitioners Association of Zambia) was represented, and appeared in all timelines and spidergram. They are recognized by the government.

However, the spidergram suggested how disconnected they were, and their representative spoke of a desire to be more linked to other initiatives.

vii. In speaking about THPAZ, representatives mentioned the following activities that they undertook which contributed to health and wellbeing:

    a. They were involved in Home Based Care, nutrition, and sensitization about prevention, care and support around HIV/AIDS.

    b. They have community wisdom, and offer alternative medicine.

    c. They go to where they are invited, including going to hospitals.

    d. They have a cushioning effect

    e. They are involved in sub-granting for HIV programs

    f. They undertake research

In summary then our research suggests that the perceived contribution of traditional healers to health and wellbeing in Zambia is contested, with awareness that there is a difference between herbalists and diviners. Strong Christian opposition was noted towards the latter.

> **Finding 10: A wide range of REs contribute to health and wellbeing in both tangible and intangible ways, and the combination of these two is perceived to give them "strength". Compassionate care (expressed in HBC groups) is perceived as the most important response of REs to HIV/AIDS**

Finding 5, above, notes that religion is perceived to contribute to health and wellbeing in both tangible and intangible ways. This finding is strengthened by further data which indicated that RHAs - as formal entities - contribute to health and wellbeing in both tangible and intangible ways, and it is the combination of these that gives them strength. This finding emerges in the exercises which explored the contribution of REs to health and wellbeing. Participants at the community workshops (not the two pilot ones) were asked to rank (on a scale of 0-5) a range of religious institutions that existed in their community (as indicated on the community map) in terms of their own definition of what religion contributes to health and wellbeing in their community.

In the following table we list the ranking of these facilities in the three communities. The shaded institutions appear in all three communities.

Rank	Maramba	Chipata	Bauleni
1	Women's Fellowships (4.4)	HBC groups (4.6)	Pentecostal Ministries (4.3) Churches (4.3)
2	HBC groups (4.3) Religious Schools (4.3)	Religious Hospitals and Clinics (4.4)	
3		FBOs (4.3)	HBC groups (4.1)
4	Orphanages (4.0)	Religious Schools (4.3)	Orphanage/s (4.0)
5	Mainline churches (3.8)	Orphanage/s (4.3)	Hospice (3.9)
6	FBOs (3.7)	Churches (4.2)	Mosques (2.6) Radio Station (2.6)
7	Mosques (3.2)	Mosques (3.5)	
8	Pentecostal Ministries (2.7)	Traditional healers (1.1)	Traditional healers (1.9)
9	Men's fellowships (1.7)		
10	Religious Traditional Healers (0.6)		

In terms of analyzing this data it is crucial to remember that - owing to the participatory and inductive approach of the workshops - there are a number of important elements that make it difficult to aggregate the results across the five communities and reach simple conclusions. Nevertheless, it is possible to calculate the

average score out of a possible 5 that was cast in each workshop for each institution (rounded to one decimal point). This provides some measure of relative comparison - where the same factors are present - across the differing research sites. Then the most reliable form of data analysis is a ranking exercise in which the ranking of each community is noted and then comparisons across the communities are undertaken. Making use of these two approaches, the following conclusions can be drawn.

i. Perhaps the most striking thing from this list is the great variety of Religious Institutions that were considered important enough to rank. 12 were identified and ranked.
    The following appeared in all three communities:
    > Home Based Care Groups
    > Churches
    > Mosques
    > Orphanages
    > Traditional Healers

    The following appeared in two communities (excluded one in brackets)
    > Pentecostal Ministries (Chipata)
    > Religious Schools (Bauleni)
    > Faith Based Organizations (Bauleni)

    The following appeared in only one community (included one in brackets)
    > Women's Fellowships (Maramba)
    > Men's Fellowships (Maramba)
    > Religious Hospitals and Clinics (Chipata)
    > Hospice (Bauleni)
    > Radio Station (Bauleni)

    This is of course borne out by the discussion in Finding 3 about the variety of REs in Zambia.

ii. When we analyze the five religious institutions that do appear in all three communities a fairly standard ranking emerges with one exception in Bauleni (with average scores across the 3 sites)
    a. Home based care groups
    b. Orphanages
    c. Churches
    d. Mosques
    e. Traditional healers

    The one exception to this is in Bauleni where churches out rank both Home Based Care groups and orphanages. A reason for this may be the factors which were used for the ranking in Bauleni included both "faith" and "healing" which did not appear in the exercise in the other two communities. The churches scored well in these categories. This may also account for the high score that Pentecostal ministries scored in Bauleni (ranked joint 1st) as opposed to Maramba (ranked 8th)

iii. Religious schools were ranked on two sites, and in those two places ranked above orphanages on both occasions with an average of 4.2.

iv. In looking at the low ranking of Mosques and traditional healers we are reminded that we are here dealing with the *perceptions* of the participants, who were primarily from Christian churches. Nevertheless as an indication of the perception of these community members it indicates that while Mosques have some recognition for contribution to health and wellbeing, the contribution of traditional healers is not generally acknowledged (as noted in Finding 9 above).

In order to understand why these facilities were ranked the way they are, we can turn to the more detailed data which provides the average score for each facility ranked against the six health and wellbeing factors. In the following table we provide the average score for each of the five religious entities that appeared in all three workshops, for each of the six factors.

	HBC	Orphanages	Churches	Mosques	Trad. Healers
Spiritual encouragement	4.47	4.11	4.64	2.78	1.78
Compassionate care	4.58	4.42	4.03	2.80	1.39
Knowledge giving	4.42	4.42	4.46	3.29	0.67
Material support	4.25	4.14	3.58	3.19	0.75
Moral formation	4.38	3.88	4.25	2.88	0.88
Curative interventions	3.00	3.75	3.25	3.25	3.25
Average	4.33	4.12	4.03	3.03	1.45

We can note the following from the data in this table

- We should not be surprised that the first four REs rank lowest in health provision as none of them are intentionally involved in health provision; whereas the traditional healers rank their highest here given that this is their primary role.
- Churches rank highest in the intangible areas of spiritual encouragement, and knowledge giving, but do not rank high for the tangible areas of compassionate care and material support.
- Home Based Care groups, on the other hand, do well in both the tangible areas of compassionate care and material support, and in the intangible areas of spiritual encouragement, knowledge giving and moral guidance.
- As would be expected, orphanages score higher than churches in the tangible areas, but they also do relatively well in the intangible areas - and this enables them to outrank churches as RHAs.
- The comments about mosques and traditional healers above suggest that we do not need to analyze this data too deeply.

Thus we can summarize our finding by noting that when religious groups do more than simply gather as a congregation they are perceived to be making a greater difference. REs clearly contribute to health and wellbeing in both tangible and intangible ways and it is the combination of these two that is perceived to identify those that are strong RHAs.

In terms of the response of REs *specifically to HIV/AIDS* the general perception is that the six-fold contribution of religion to health and wellbeing in general (see Finding 6) is particularly true of engagement with HIV/AIDS. In Bauleni (Lusaka), for example, in answer to the question: "How does religion contribute to HIV/AIDS?" participants responded:

Spiritual encouragement   "the church gives hope in the area of HIV/AIDS"; "by going to church, that is how you can get all the support"

Compassionate care: "support to people who are mourning"; "home based care"

Moral formation   "moral support"; "abstinence"

Material support: "in food supply and funerals"

Knowledge giving: "the church is very involved in sensitization"

    "we go out into the community and explain about HIV/AIDS"; "involved in prevention"

Curative interventions   "healing, faith-healing"

Compassionate care emerged as the most significant factor in all the workshops. In the Kitwe regional workshops participants were asked: "What are religious organizations and people contributing to HIV/AIDS?" and 10 out of 24 responses were with the terms "care, compassion, support". In Livingstone,

participants made a strong claim for the church around the theme of care. They argued that there was a difference between religious and government hospitals.

> "The difference is that the care done by church organizations is done with care, compassion and love, with encouragement - but in government hospitals, people just do it for money - no compassion, love or care."
>
> "In government hospitals, people are treated professional, without emotional attachment, but religious organizations treat the person as an individual, they provide more quality care."
>
> "In the medical circles we talk about care, but in spiritual circles we do not differentiate between care and support."

A similar pattern emerged in the regional workshops in Chipata. In response to the question, "What do you think religion contributes to the struggle against HIV/AIDS?" participants ranked Care and support, and Love highest of all factors. When asked about this, they responded:

> "With the advent of HIV/AIDS, and now as a chronic illness where people are discharged back into the community, and most of the community did not have expertise to care for the chronically ill, because they thought there were benefits to taking care of patients at home. There are family support and the support of other church members there in the community."
>
> "Even the food is better at home, and the cost of transport has made HBC a better option."
>
> "Religion contributes in spirituality and infrastructure - both homes and hospitals are infrastructure that religion supports."

These findings were echoed in Lusaka, where it was also clear that although compassionate care is a factor in itself, it does permeate all the other things that the church does in terms of both its tangible and intangible contribution to HIV/AIDS.

Following on from the reflection on compassionate care, we can note the following eight issues with regards to the RE response to HIV/AIDS.

a. *Spiritual encouragement* is recognized as the second major area of contribution in the struggle against HIV/AIDS. This is our synthesized cluster for such factors as hope, faith, prayer, spiritual counseling or encouragement. In Livingstone, there was a discussion about hope:

> "To give people encouragement, even if they HIV they can live on. If you are giving care as a church, there is still hope with ARVs."
>
> "The pastor can come in even when there is no more medical hope - and pastors can come in and promise false hope - or life after death. We are talking about giving hope to the hopeless."

b. Given our finding around religion and morality (see Finding 7 above), it should not surprise us that the churches have taken a strong role in contributing to *behavior change and moral guidance* around HIV/AIDS. Abstinence is a major area in which the churches are seeking to change behavior. When asked about the factor of Abstinence:

> "As Zambians, we have lots of controversy aver abstinence - but with HIV/AIDS, the churches have singled out abstinence as the number one way of trying to prevent HIV/AIDS."
>
> "Some HBC organizations are not into the ideas of condoms, so abstinence is the prime way of preventing HIV."
>
> "In a church set-up you cannot say all young people must abstain…so what can you do?"

c. Participants perceived that the role of the church in *prevention* was basically in the area of moral guidance and knowledge giving. Thus for example when prompted about the absence of the factor of prevention, participants replied:

> "The meaning of the word sensitization means prevention - and counseling is prevention too - this is education."

> "There are a lot of prevention programs going on in Livingstone."

d. As noted in Finding 6 above, moral formation can, of course, have a shadow side in terms of *stigmatization*, as people who are HIV positive are assumed to be immoral. Participants spoke about this on a number of occasions, recognizing that in some instances people did find better care in non-religious hospitals than churches. A Matron at one workshop commented:

> "When the hospital was given a chance to talk at the church, I was condemned, why are you bringing this in, we wanted to talk to the people in the church, about three years ago, and we were

Maramba Community Workshop, Livingstone, 2006

condemned, told to stop bringing the devil in. We were invited to talk about fibroids, nutrition and family planning, but not about HIV."

However she noted that there has been a big change, and it was clear throughout our research that stigma is now being challenged by many in the churches.

- There are people in both religious and medical circles who stigmatized, but in face of the overwhelming problem we face, stigma is dying down
- The church was the worst culprit in stigmatization, labeling people as immoral, but having realized that the best men and women in our own ranks have begun to die, the church has begun to overcome their stigma - in the past people rushed to the hospital, but now people rush to their pastor - we are all involved in care and counseling and support.
- The clergy are now very interested in teaching the Christians to care so that stigma can die down - the churches have realized that this is a time for care, and that it can overcome stigma.

e. Whilst it is clear that REs are very involved in caring for people living with HIV/AIDS, and offering spiritual encouragement, there was little obvious discussion about the role of the church in *shaping public policy or advocacy* around HIV/AIDS. When prompted about the absence of the factor of advocacy, participants in Livingstone replied:

> The church advocated for free ARVS

> The church advocated for people staying at work even once they are on ARVS

> The churches have been speaking to the authorities on behalf of PLWHA.

f. There is a perceived recognition of a growing *relationship between the REs and the state* in terms of responding to the HIV/AIDS crisis (as also noted in Finding 8). On the one level, the government has

worked with individual clergy in training them as HIV/AIDS counselors, through the initiative of the Roman Catholic Church. On the other level, there has been some structural networking:

> "Now, because of the more multi-sectoral approach, there is more networking and linking, between the church and the secular. Before the church was working on its own, now, we are working inside the community."

g. In terms of the local congregations *being used as ARV sites*, there was divided opinion. On the one hand, some participants felt that churches could be key delivery points, as they have a presence in many far-flung places, and can reach a large number of people. They could make use of the doctors and nurses in their churches. On the other hand, there were those who were skeptical. Some argued that "The churches do not have trained personnel at churches - without that they could do more harm", and "ARVs are toxic and need expert people - churches don't have the facilities and are the wrong place." These participants also felt that introducing ARVs through the churches could lead to some kind of segregation in churches, and that clinics or hospitals would be better because they are more neutral. A more moderate position was to recognize that churches can play a significant role in referring people to the right place even if they do not have the capacity to do it themselves.

h. An overwhelming perception of the participants was that the struggle against HIV/AIDS would not succeed if religion and religious entities were not drawn in as *significant partners*. In the first instance, people trust REs, and there was a regular finding that mission hospitals were "better" than state hospitals in terms of care, but also in terms of delivery of essential health provision such as HIV testing and CD4 counts. Also, there is very little psychological support offered by the state medical facilities, and this is where the churches play an important role. But there was a deeper concern too. As one participant put it: "Donors don't understand, in Zambia, people are very religious." Therefore, even though pastors are not talking specifically about medicine, this does not mean they are not involved in responding to the HIV/AIDS crisis.

In conclusion, our finding is that REs are involved in a range of tangible and intangible activities to contribute to health and wellbeing, with the integration of the two being perceived as important. In the context of HIV/AIDS, there is particular recognition of the role of REs in compassionate care.

Finding 11: Certain REs are acknowledged as exemplars in the community, and these perform well in three important areas, namely, programmatic, operational and associative

Once participants had mapped and reflected on the role of RHAs, they were then asked to identify those RHAs that they considered to be "best practice" models or exemplars - RHAs that they respected, were most proud of, and would like others to know about. These RHAs were then identified and the participant discussion recorded, analyzed and coded, to provide us with an insight into the kinds of characteristics that constitute "best practice". From this exercise it is clear that participants consider that exemplar RHAs are those that perform well in three important areas: programmatic, operational and associative.

Programmatic characteristics refer to the respect an RHA has because of the program(s) it undertakes. RHAs were respected because they are seen to perform well in these kinds of activities:
▪ *Caring* for the sick, vulnerable, orphans and the poor
▪ *Education* around health, and particularly HIV/AIDS
▪ *Treatment* of sickness, such as eye clinics and mission hospitals
▪ General *development* issues to do with poverty such as digging wells or income generation projects
▪ Undertaking important *research* that others are not doing

Operational characteristics refer to the respect an RHA has because of the way it functions as an entity. RHAs were respected because they are seen to perform well in these kinds of activities:

- *Networking* with other organizations and the state
- The ability to *manage* the organization in a competent manner.
- The provision of respected *leadership*
- Ability to access and manage *finance*
- Ability to have a *public profile* over certain issues.
- The ability to recruit and keep competent *personnel*

Associative characteristics refer to the respect an RHA has because of the way it associates with or relates to people inside and outside the entity. RHAs are respected because they perform well in the way that they:

- are *present* amongst the poor, especially in rural areas
- maintain a good reputation with the community which builds *trust*
- *nurture* their staff through intentionally training and "caring for the carers"
- seek to be as *inclusive* as possible
- Recruiting, using, training and caring for *volunteers*

> *At (St Francis HBC) we have a strict policy of taking care of our carers. They have to want to do this for themselves, it is not a job, it has to be something you want to do as a vocation…we care for them, and have a good relationship with them and they respond to their needs… caring for the carers is very important…these carers are ecumenical, and many have been with them for eleven years…*
>
> *We do not have a lot of money, but our books are fully audited and open to anyone, and write frequent reports, we keep all our receipts. We have had the same funders since we started –* **Livingstone Regional, 2006**

The absence of particularly "religious" or "spiritual" factors may seem surprising. In reflecting on this, two points need to be borne in mind. First, it is crucial to remember that this finding follows on from Finding 10. In assessing those entities which were considered to be exemplar RHAs, participants had already focused in on those that were religious, and were seen to be engaged in spiritual activities. This was taken as a given, rather than re-introduced as a new factor.

Secondly, however, this is itself an important insight into the perceptions of participants. A RHA is not an exemplar simply because it is religious or spiritual, for all religious entities can claim this. What sets an exemplar RHA apart is its performance in the programmatic, operational and associational areas of its work. These characteristics are not unlike those necessary for any good business or NGO, a reminder that good RHAs are well organized, purposeful, and responsible - and that they have the capacity to engage with other role players in constructive ways.

Finding 12: There is an overwhelming desire to be more effective against HIV/AIDS

Alongside the formal findings about the contribution of religion and REs to health and wellbeing in Zambia, the participatory, appreciative and non-extractive approach of the research was itself an exercise in asset-based development, for it enabled the participants themselves to understand the assets that they hold, the networks they participate in, and the energy that their religious commitment gives to them. Thus the workshops had a strong and immediate outcome for the participants. The spidergram exercise, in particular, led to discussions about the state of networking and the desire to build stronger relationships in the context of HIV/AIDS.

> *The churches are able to reach all the rural areas, so the problem of transport is not so bad, the church can reach everywhere -* **Chipata Regional, 2006**
>
> *There are a lot of resources within us that is not know by everyone, if we worked together, there is a lot we could achieve, together as religious institutions we could help each other, and then help more people in that way –* **Lusaka Regional, 2006**

Following the pilot workshops it was decided to add, at the end of the workshop, an opportunity for participants to engage in a "local commitment" in the light of the insights and data that had emerged. This came at the end of a long and tiring day, but the facilitators were always struck by the intense level of engagement with this. The question that was asked was: "What can you do to help the other religious organizations and entities in your community to make a better contribution to health?" The discussion also spilled over into general reflections on the day long workshop. The following responses suggest the seriousness with which the participants understood their engagement in the workshop process, and their overwhelming desire to be more effective against HIV/AIDS.

In terms of community level workshops, at *Maramba* (Livingstone), participants committed themselves to live by example; to work together on smaller programs, coordinate activities, and be inclusive of smaller FBOs; to seek capacity building in needy areas; and to create a database and be involved in an exchange of information. At *Chipata* there was a strong sense of organizing for effectiveness and including others. This would involve education "about issues pertaining to health", and "about HIV/AIDS for prevention measures." This also involved starting "some income generating activities (IGA)". There was a specific commitment to include Muslims, encouraging them to work on issues of stigma and cooperation, and then to organize traditional healers "to teach them about information giving (work hand in hand with them)." At *Bauleni* (Lusaka) there was a commitment to both make sure that churches were involved in health work, and to interact with other organizations. Participants also spoke about the benefits of the workshop itself, where participants felt they had gained knowledge, interacted with diverse people, and addressed real problems. There was also a request for the workshop to take two or three days.

At regional level, at *Livingstone* this exercise was led by a local leader. The workshop mandated the local DATF to coordinate follow up to the meeting with a view to using the information that had emerged. At *Chipata*, participants were asked: "What can you do to help the other religious organizations and entities in your community to make a better contribution to health?" The answers included learning from each other, supporting each other, having a common goal, avoiding duplication, coordination, networking and working together against HIV/AIDS, and embracing diversity. In answer to the same question in *Lusaka*, participants spoke of greater coordination, "working together properly", and unlocking the resources that were within: "If we worked together, there is a lot we could achieve, together as religious institutions we could help each other, and then help more people in that way".

A significant contribution of the workshops was the provision of language for participants with which to conceive of their contribution to health. There was a broad consensus that the use of the term Religious Health Assets, and of understanding the contribution of religion to health in a wide range of ways, was extremely helpful for participants as it enabled them to strengthen their dialogue with those involved in the public health sector.

XII. Conclusion

The overall conclusion is that in the current social context of Zambia religion is perceived to be a significant contributory factor to health and wellbeing, and that this contribution can be understood to be in both tangible and intangible ways. Furthermore, this contribution is embodied in a wide range of REs that are involved in an important set of networks with each other and other public health facilities, and that certain exemplar REs can be recognized for their ability to perform in programmatic, organizational and associative ways. "Compassionate care", infused with "spiritual encouragement" is perceived to be the most significant contribution of religion to health and wellbeing in Zambia, and those REs that embody this - primarily home based care groups - are widely recognized as significant RHAs.

Chapter Four

Translating Religious Health Assets - Lesotho Research

Thaba Tseka HSA, Lesotho, 2006

Chapter Four: Translating Religious Health Assets - Lesotho Research

XIII. Background

Lesotho is a land-locked country entirely surrounded by South Africa. It has a relatively small population of 2,022,331 million (July 2006 est), and is one of the few countries in Africa with one dominant indigenous language and one dominant culture. It is a small mountainous country of 30,355 km^2, unique in the world by virtue that all its land is above 1,400m. Roughly two-thirds of the country is mountainous - the highest point is 3,482 m - with the remaining third, part of the vast highland plateau that constitutes much of the central region of South Africa.

The Kingdom of Lesotho gained its independence from Britain in 1966, with Moshoeshoe II as King, and Chief Leabua Jonathan of the Basotho National Party as Prime Minister. The next decades were characterised by both political and economic instability, with the constitution being suspended in 1970, the King being exiled, a military coup in 1986 and again in 1991, and fighting amongst rival army factions. The victory of the Lesotho Congress of Democrats (LCD) in the 1998 elections precipitated riots and military intervention by the South African Development Community (SADC). Since that time, there has been general political stability in the country, with the LCD winning the parliamentary elections in 2002, although the opposition parties did boycott the first local elections since independence in 2005.

Economically, Lesotho has been deeply affected by its reliance on the South African economy, and the remittances by migrant workers on the mines have been a crucial form of income for the country. Thus the pressures of the apartheid period, the sanctions and divestment period of the 1980s, and the effects of globalisation on the South African mining industry, in particular, have had very real implications for the socio-economic life of Basotho. Furthermore, the Structural Adjustment Programme (SAP) of the 1980's and Enhanced SAP of the early 1990s, has had a negative effect upon health, education and social services in the country.

A. The Religious landscape of Lesotho

Two religious traditions dominate the religious topography of Lesotho: the historical religio-cultural formations of the Basotho and the Christian traditions of the West. The arrival of Paris Evangelical Missionaries in 1833, followed by the Roman Catholic Church in 1863 and the Anglican Church in 1876, began an enduring and shifting process of interaction between these two religious traditions.

A central feature of the religious topography of Lesotho is the continued vitality of Traditional Sesotho religio-cultural forms which operate alongside, beneath, intertwined with, and at times, in competition with the Christian formations which are much more obvious to the Western eye.

The dominant religious forms in Lesotho thus comprise of a complex interaction of religious impulses and traditions, central elements of which are:

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

94

Christian	1,648,622	91%
Roman Catholic Church (RCC)	38%	
Lesotho Evangelical Church (LEC)	23%	
Anglican Church of Lesotho (ACOL)	5%	
Other Christian	25%	
(incl Methodist Church, Seventh Day Adventist, Pentecostal Churches, Zionist Churches)		
Traditional Sesotho religio-cultural forms	161,787 8%	
Baha'i	15,915	0.89%
Hindu	1,078	0.06%
Islam	828	0.05% [62]

An important feature of the religious scene in Lesotho is the historical relationship of the two major denominations in Lesotho, the Roman Catholic Church (RCC) and the Lesotho Evangelical Church (LEC). The RCC was closely aligned to the Basotho National Party which came to power in 1966, under Chief Leabua Jonathan, while the LEC was aligned with the opposition Basotholand Congress Party, under Ntsu Mokhehle. In 1970 elections were declared null and void by Jonathan with the BCP claiming victory. Decades of civil strife between the two parties followed. In 1993 democratic elections were held with the Basutoland Congress Party coming to power and Ntsu Mokhehle becoming Prime Minister. These party-political dynamics have long been recognised as impacting on the articulation of ecumenical relations in the country.

In Lesotho the religious communities play a decisive role in healthcare provision in several respects: from the most obvious health provision of the Christian Health Association (CHAL) hospitals and health centres, to the widely recognised but still not well understood role of traditional healers, to the intangible contributions to wellbeing made by the variety or religious communities and entities across Lesotho.

B. The Contribution of Lesotho to this research

Lesotho contributed significantly to this research in two important ways. First, it provided a context in which we could explore the relationship between religion and health in an African context. Though characterised by rural-urban differences, viz. the modern African urban environment of Maseru, the lowland village of Masite (Scott HSA), and the highland village of Mohlanapeng (Paray HSA), the three areas in which this research was conducted, Lesotho provided a mono-cultural setting suited to probing specific religio-cultural conceptions of health in their impact upon behaviour and action.

Owing to the dominance of Sesotho, it made sense to conduct surveys and facilitate the PIRHANA workshops in this indigenous language. This required translation of basic ideas informing the research and its questions. Second, therefore, this immediately raised important issues to do with the manner in which religion and health are perceived within a Sesotho linguistic framework. Basotho[63] perceptions do not match reigning Cartesian notions of religion or health - separating the subject from the object and asserting mind or 'consciousness', as methodical critical reflection upon the object of reflection, as the only reliable guarantor of knowledge or 'science' about illness and health. Thus, an instrumental or technical view of health, governed, say, by germ theory or gene manipulation, powerful as it is, appears to a Mosotho as one that sidelines the role of human interaction in the world as itself a key determinant of health and health-seeking or health-providing actions. Indeed, it is more likely to be seen as a truncated and therefore deficient view of the causes of illness and, hence, of what makes for appropriate interventions. In short, views of health, its character and the related methods for achieving it that most public health policies and biomedical interventions tend to assume or propagate, are frequently dissonant with Basotho views.

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[62] Accurate, reliable figures on the religious demographics of Lesotho are simply not available. The Lesotho Bureau of Statistics has produced nothing in the past twenty years on religion. The recently completed 2006 Census will hopefully address this lacuna.
[63] Basotho refers to the people, Sesotho to the language.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

95

Because of this, *mis-communication* and hence, misunderstanding, with the consequent likelihood of failed interventions, occurs. In other words, at worst something like a clash of healthworld conceptions occurs; or at least, a variable and usually pragmatically strategic mixing of healthworld conceptions that often confounds policies and their implementation. Much of the research data below illustrates this point, as does parallel work done in the Xhosa framework in the Eastern seaboard area of South Africa.[64]

This is the explicit context that leads to the generative concept of a *healthworld*. It is a neologism intended to direct attention to a way of conceiving of the relation between health, on the one hand, and the background knowledge into which persons are born and socialized and which they in turn reproduce and further shape through individual and social learning, repetition and invention, on the other. Because it is new and potentially confusing, the concept of a healthworld needs some prior elaboration and grounding, before its relevance to - indeed, genesis in - the research done in Lesotho is articulated.[65]

i. "Healthworld" and "Lifeworld"

The concept of a healthworld depends directly upon the long-standing social scientific notion of lifeworld.[66] Our use of it, however, rests upon the influential exposition of lifeworld provided by Jürgen Habermas.[67] In brief, he rejects an idealist understanding of lifeworld (in the framework of the 'philosophy of consciousness' from Descartes onwards), in favour of an understanding that roots lifeworld in language, more precisely, in *communicative action*. By communicative action, he refers to linguistically mediated (including gestures, symbolic acts, etc.) and normatively regulated interaction that not only serves to enable understanding, but also works to coordinate goal directed activities of human subjects, socializing them at the same time.[68]

The pragmatic meaning of this concept may be expressed as follows: In coming to understand themselves and each other, human beings thereby relate, simultaneously, to three domains of life: an objective world about which propositional truth statements are possible; a social world of legitimately regulated interpersonal relations; and a subjective world of experience to which only the subject has privileged access but which can be expressed in public.[69] Even when, for strategic or situational reasons, a person emphasizes one or other of these domains explicitly, all three domains (objective, social and subjective world) are implicitly at play, and *all three domains must be taken into account together* if an adequate grasp of the relevant social dynamics and human behaviour is one's intention in seeking a cooperative process.

What shapes and underlies any human being's action in relation to the objective, social and subjective worlds is a rich reservoir of language and culture into which one is inserted at birth, and into which one is socialized over time, which has the character of 'background knowledge'. This is the lifeworld. Particular aspects of this background knowledge come to the fore only in specific action situations that require some response, so that the lifeworld is never fully consciousness. It acts as the *horizon within which one thinks and acts*; it is 'always already' there, and one cannot step out of it. This is true even if it is the case that any lifeworld in not set in stone but is continually renegotiated or reinvented according to circumstances and history. Seen thus, the lifeworld is foundational for human interaction.

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[64] Much of the research data below illustrates this point, as does parallel work done in the Xhosa framework in the Eastern seaboard area of South Africa – Thomas, J.R. Cochrane, B. Schmid, *Let us Embrace: The Role and Significance of a Faith-based Initiative in HIV/AIDS Work,* ARHAP Report (Cape Town: ARHAP, University of Cape Town, 2006)..

[65] A more comprehensive defence of the concept of healthworld is contained in a joint paper by P. Germond and J.R. Cochrane, "Healthworlds: Ontological, Anthropological and Epistemological Challenges on the Interface of Religion and Health", Paper for *Reasons of Faith: Religion in Modern Public Life*, Conference of the Wits Institute for Social and Economic Research (University of Witwatersrand, 2005).

[66] Most notably evident in the work of Husserl, Heidegger, Schutz, and Luckman.

[67] J. Habermas, *Lifeworld and System: A Critique of Functionalist Reason*. Vol. 2, *The Theory of Communicative Action,* (Boston: Beacon, 1987).

[68] Ibid., ch. 1: "The Foundations of Social Science in the Theory of Communication".

[69] Ibid., p.120ff.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

96

Habermas's notion of the lifeworld, essentially an articulation of action theory in social science, is not left hanging in the web of philosophical idealism both because he roots it in communicative action, hence language, and because he does not ignore what goes on behind and within communicative action, in the political and economic life of a society. In his view, the concept of lifeworld must be linked to system theory in social science. The lifeworld is subject to, and shaped by 'system imperatives'. These, under modern conditions, have primarily to do with the way in which societies are steered by the media of money (markets) and power (bureaucracies). The concept of lifeworld that results, linked as it is to system, imperatives, thus brings into relation the basic theories, largely separated hitherto, of Marx, Weber, Durkheim, Husserl and Schutz.

ii. Communicative Action

The key point for our purposes here lies in Habermas's determination to introduce *communicative action as central to any adequate understanding of society*. The instrumental rationalities of money and power, expressed primarily through markets and state bureaucracies and managed primarily by technical-instrumental means (the domain of 'science'), emerge as too limited in understanding how people actually function. They are certain to fail in the long run as the basis of policy if not corrected by an understanding of communicative rationality. Communicative action has to have other foundations than instrumental or technical ones, if the intention is that human beings should thrive, and societies survive as something other dysfunctional systems at best, or tyrannies at worst. The decoupling of lifeworld and system is the problem, a recoupling of them a necessity.

Applied to health interventions generally, or to public health more specifically, this means that the lifeworlds of persons must be taken seriously as impacting upon their actions and behaviour. In our research in Lesotho, we have considered what this means for conceptions of health and health-seeking behaviour. The question of translation noted already demonstrated that the general notion of lifeworld needed to be specified more closely in relation to health. Given that health in a Basotho context is a comprehensive vision of well-being that goes well beyond any individual person, to incorporate family, community, nation, ancestors and the earth itself - as we explain more fully below - we have elected to introduce the idea of a healthworld.

It is, in effect, the same as lifeworld with this one simple, but decisive, difference: lifeworld per se incorporates any and all learning (objective, social, subjective) by which any particular situation is interpreted and acted upon; within that background horizon of knowledge lies a fundamental ontological imperative, however, one that does not simply comprehend life, but seeks to enhance and fulfill life, that has a *telos* or particular goal, in other words. This goal we may describe as comprehensive well-being. Health is a synonym for such comprehensive well-being, and it applies whether one lives in a culture with a cyclical, repetitive or linear paradigm of time. A healthworld is therefore that orientation of lifeworld that expresses this *telos*.

Can we sustain this claim empirically? Yes. First, as noted, the concept of healthworld is not arrived at a priori, but by way of expressing in English (in our case) an insight derived from the research context. It provides a technical term by which to integrate this insight into standard social scientific language. Second, the research itself, as the data below suggests, serves to reinforce this insight, in the way in which people on the ground express their responses to a variety of questions about their health, their beliefs, and their actions.

To understand this further, we give some attention to the religio-cultural context in which we conducted our research on health in Lesotho, via the Basotho idea of *bophelo*. This is the word that originally drew attention to our paradoxical attempt to understand the relation between religion and health - terms well-established linguistically in European languages but deeply differentiated in the philosophy of consciousness that has split subject and object since Descartes - in another linguistic and philosophical context where the split between religion and health makes no sense and cannot be translated for research purposes. *Bophelo*

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

97

encapsulates the relation between them, but it is a single term. That there is no differentiation of any significance means that addressing questions of health as if they may be separated from larger religious worldviews is flawed conceptually, and will likely lead to flawed interventions.

C. Bophelo: A View into the Sesotho Religio-Cultural World

The complexity and importance of questions of translation has been noted. Driven by a commitment to run the Lesotho workshops in such a way as to maximize participant engagement, a concerted effort was made to conduct the workshops, as much as possible, in the dominant language, Sesotho, and to facilitate the expression of traditional religio-cultural dimensions of the participants' lives. Research in Lesotho which preceded this WHO project (cited in Chapter 1) alerted the Lesotho team to the importance of moving beyond the terms and conceptual framework imposed by the two English words "religion" and "health", as also noted: they do not, in Sesotho, exist as separate and distinguishable words. In order, then, to allow Sesotho conceptions to drive the participant engagement, we used the Sesotho term "bophelo" to frame the central questions we posed, even in sessions conducted partly in English. Bophelo is a complex term which defies neat translation into English. Thus far our research has permitted us to develop the following picture of bophelo, which encompasses Basotho conceptions and practices of health and religion.

motho (person)
lelapa (family)
motse (village)
naha (land)
borapeli (spirituality)
lefatse (the earth)
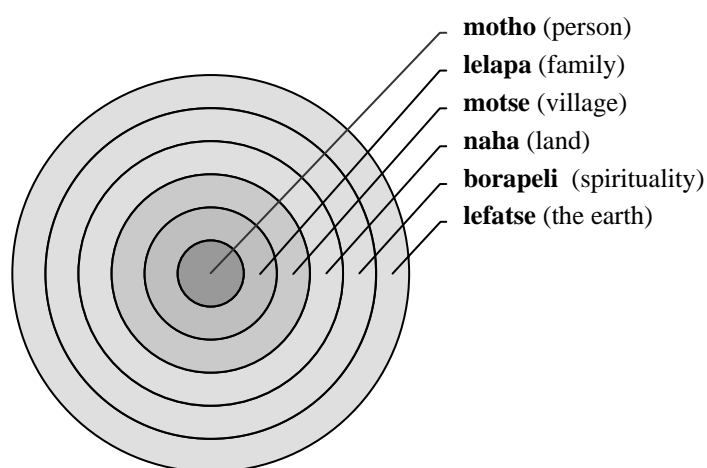
The socio-spatial configurations of bophelo

At its most elementary, bophelo is biological life. As one respondent has put it, "If I did not have bophelo I would be there", pointing to a graveyard. Thus, plants have bophelo, animals have bophelo, and human beings have bophelo. At a more complex level bophelo is full human life in its complex of expressions and social relationships. Here bophelo is social. Thus a family can have bophelo, as can a village or a nation. This social characteristic of bophelo can be understood in terms of a series of social relations depicted in the following diagram.

At the heart of the world of bophelo lies *motho*, the person, as shown in the inner circle above. Each *motho* has bophelo, in the most basic biological sense of being a living organism, but also in the rich, more complex sense of being a social being. The bophelo, the well-being of a person is fundamentally social, for *motho* cannot exist in isolation, only in relation. The bophelo of *motho* is radically dependent on the bophelo of *lelapa*, just as the health of *lelapa* is dependent on the health of its individual members.

The third circle signifies *motse* (the village). *Motse* is constituted by an agglomeration of *malapa* (homesteads). Here the relationship of reciprocity we observed between *motho* and *lelapa* is sustained. The bophelo of a village is dependent on the health and wellbeing of the individual homesteads. The bophelo of the villages is enhanced by belonging to *Naha ya Basotho* (the Basotho nation).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

98

In this world it is the ancestors, from the realm of *borapeli*, who above all provide for bophelo. It is their interventions that protect a village, a family, a person from the multitude of threats and menaces that populate the world. Not only do *badimo* sustain bophelo, but they themselves also have bophelo, which is sustained by *batho* (people). The final element of bophelo in this schema is *lefatse*, the physical earth and its natural phenomena.

Three fundamental elements of this bophelo worldview are important for understanding the data presented in this chapter. First, *in the bophelo world separation of health and religion does not make sense*. They are intrinsically part of a whole.

Maseru, Lesotho, 2006

Second, *bophelo is conceived of in fundamentally relational terms*. Bophelo has at its heart a relational ambition. Healthy relationships constitute the basis of life and wellbeing -healthy relationships among family members, between *malapa* (families/homesteads) and *motse* (the village) and so on. The relationship of *batho* (the people) to *badimo* (the ancestors) is probably the most important of these relationships in the traditional Sesotho religio-cultural world.

Third, *trust (tsepho) is central to wellbeing*. Good relationships are built on trust. Trust is central to wellbeing, for without trust the relational ambition of bophelo is compromised. These two notions of relational ambition and trust will be discussed further below in several of the findings.

During the pilot phase of this study, in November 2005, we made an unexpected discovery in Zambia. In presenting our understanding of bophelo and this schema to a group of religious leaders in Ndola, a predominantly Bemba-speaking area, we learned that the Sesotho concept of bophelo correlates almost precisely to the Bemba concept of *ubumi*. This discovery is important, because it suggests that similar conceptions of life, health, and well-being has cultural purchase across much of Southern Africa, and probably much more widely in Africa and beyond.[70] While we have yet to complete a broad-ranging investigation in other settings, initial inquiry indicates that this particular understanding of the wellbeing is shared in the following cultural and linguistic families represented in the table below.

Conceptual and linguistic parallels of bophelo

English	Sesotho	Bemba	isiZulu
The economy of life	*Bophelo*	*Ubumi*	*Impilo*
person/individual	Motho	umuntu	unmuntu
family/homestead	Lelapa	ulupwa	ikhaya
village	motes	umushi	umzi
land/country	Naha	ichalo	ilizwe
spiritual/ancestral realm	borapeli	ifikolwe	amadlozi

Lesotho contributed significantly to this research in two important ways. First, it provided a context in which we could explore the relationship between religion and health in an African context in a mono-cultural setting, but one characterised by rural-urban differences, such as the modern

African urban environment of Maseru, the lowland village of Masite (Scott HSA), and the highland village of Mohlanapeng (Paray HSA). Second, owing to the dominance of the language of Sesotho, it was decided to

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[70] See for example, Lazarus, S. (2004). An exploration of how Native American worldviews, including healing approaches, can contribute to and transform support services in education. Cape Town: SA National Research Foundation - Indigenous Knowledge Systems & the University of Western Cape.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

99

facilitate the PIRHANA workshops in that language. This required the translation of the exercises into Sesotho, which raised a range of issues to do with the manner in which religion and health are perceived within a Sesotho healthworld.

To understand this further, we need to give some attention to this religio-cultural context.

XIV. Running PIRHANA Workshops in Lesotho

A. Selection of Sites

In order to organise the community and leadership workshops the researchers had to identify relevant organisations and informed individuals. This process was influenced by a number of interdependent factors that primarily relied on the ability of the researchers to tap into local networks and knowledge systems existent within the HSAs and selected communities. One of the principal influences affecting the research process was the "presence" of the researchers in the HSAs. As such the researchers had to be sensitive to the cultural norms and practices of Basotho. This involved careful attention to political and social protocol, which if not adhered to would threaten the support and assistance of key informants and institutions.

The PIRHANA workshops in Lesotho were well attended by a range of participants. Participants for the leadership workshops were selected from leaders from a wide range of social groups within the three HSAs, while community workshops were comprised of community members.

Profiles - Health Service Area Workshops - Lesotho

Maseru Health Service Area

Community Level:
19 January 2006
Ha Thamae Community
Thamae Community Hall
Peri-Urban

Area Leadership Level:
18 January 2006
Maseru Proper
Lancers' Inn
Main Urban

National Leadership:
7 April 2006
Maseru Proper
Lancers' Inn
Main Urban

Maseru HSA, view towards Ha Thamae, Maseru, 2006

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

100

Scott Health Service Area

Community Level:
1 March 2006
Masite Community
Masite Primary School
Lowland Village

Area Leadership Level:
2 March 2006
Morija
Maphato Ecumenical Youth Centre
Lowland Regional Urban

Matsieng Royal Village, Morija, 2006

Paray Health Service Area

Community Level:
3 April 2006
Mohlanapeng Community
Bethel LEC Church
Highland Village

Area Leadership Level:
4 April 2006
Thaba Tseka
Thaba Tseka Skills Training Centre
Highland Regional Urban

HaTsiu Village, Mohlanapeng, 2006

B. Participant Description

The seven PIRHANA workshops in Lesotho were attended by 163 participants, as described below. *(For information on the participant demographics please refer to the data in Chapter 2.V.E)*

i. Community Workshop Participants

a. Health Seekers

The community workshops were comprised of participants that have been categorised as "health-seekers". When inviting community members the researchers sought to attract an assortment of community members. A majority of the participants were unemployed, housewives or farmers who had not completed secondary school. This varied with urban, peri-urban and highland communities. The majority of the community members that attended the Ha Thamae community workshops were housewives, while those that attended the Masite and Mohlanapeng community workshop were unemployed or farmers. As a result, no restrictions

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

101

were placed on category of community members who could attend the community workshops. It was only suggested that the workshops be proportionality represented by men and women.

b. Gender Dynamics

Female participants who represented a wide age group overwhelmingly attended the community workshops. This could have been a result of a number of factors. Possibly men were unavailable to attend the workshops due to work related commitments that could have included employment or farming activities or possibly. As such each community workshop was characterised by a contextual idiosyncrasy, this was also evident in the leadership workshops.

ii. Leadership Workshops

a. Health Providers

When selecting the participants to attend the leadership workshops specific criteria were used to ensure that the correct people attended these workshops. The leadership participants have been characterised as "health providers" selected on the basis of their active involvement in healthcare provision. A number of participants represented organisations that were involved in either health related or religiously affiliated organisations that were situated at the interface between health and religion. Some of these organisations include groups like the Lesotho Catholic Bishops Conference, World Vision, Beautiful Gate and Dorcas Aid International. When approaching hospitals, clinics, religious groups, government or FBOs the researchers enquired about their HIV/AIDS programmes. In most instances organisations that were actively involved in HIV/AIDS or related programmes were given participation preference over those organisations that were not. As a result, most of the participants who attended the leadership workshop were actively involved in HIV/AIDS related programmes. These included HIV/AIDS programmes at various churches, Salvation Insured Church, Assemblies of God, Green Crescent Islamic Information Centre, African independent Churches Council and Scripture Union. In addition traditional healers and birth attendants who represented "traditional" healthcare provision were invited through two organisations, the Traditional Health Practitioners Council and the Lesotho Traditional Medical Practitioners Council.

b. Traditional Healers

The traditional healers were unlike most of the participants who attended the leadership workshops. They were not proficient in English and as a result, the workshops had to be conducted in both English and Sesotho. In addition most of the traditional healers had not completed school whereas a great majority of the participants had completed some form of tertiary education. This did create a complex dynamic between participants and stimulated intense debates. At times it was thought that the traditional healers would be better represented at the community level workshops, but this would have confused the leadership criteria of health providers. In addition there where far more traditional healers represented at both the Morija and Thaba Tseka leadership workshops than there were at the workshop held in Maseru.

c. Gender Dynamics

Women mostly attended the leadership workshops, which is possibly representative of provincial healthcare leadership in Lesotho. The national workshop was overwhelmingly attended by a majority of male participants. This is possibly representative of the national leadership composition in Lesotho.

d. Religious affiliation

All participants in both the leadership and the community workshops were affiliated to religious groups. This even included participants from Queen II Hospital, the Environmental Health Department in the GOL, and state clinics. The participants' religious affiliation roughly represented the national demographics in Lesotho, and, as a result, the majority of the participants were Roman Catholic. In addition the majority of participants in all the workshops were Christians, while Muslims and other minority groups were only represented in the national and leadership workshops. This is not unusual considering that the majority of Muslims live in Maseru. Traditional indigenous religions were mostly represented at community workshops. These included African Independent Churches, Apostolic Faith Mission and Zionists.

Maseru Community Workshop, Ha Thamae, 2006

iii. National Workshop

The participants who attended the national workshop, held in Maseru, were selected on the basis of the positions they held within National organisations in Lesotho in both religious and health sector. The workshop was attended by a diverse range of participants who represented various organisations and communities. These included representatives from Christian Health Association of Lesotho, Lesotho Planned Parenthood Association, World Vision, Dorcas Aid International, CARE Lesotho, Lesotho Traditional Medical Practitioners Council, Traditional Health Practioners Council, Lesotho Evangelical Church, Hope of Africa Foundation, Ministry of Health and Social Welfare, and the Society of Women and AIDS in Africa. The fact that this Workshop was held on World Health Day meant that some of the participants from WHO and MoHSW were unable to attend.

XV. Research Findings

Our participatory research in Lesotho, then, covered three key regional areas and involved the broad range of participants described above from both community level and leadership level, invited through a purposively sampled process. There was a high degree of participation in the workshops and the exercises, and these generated a combination of quantitative data in the form of maps, spidergrams, timelines, indices and ranked factors, and qualitative data in the form of recorded discussions around the outcomes of the exercises.

In exploring the major research question, *What is the contribution of religion and religious entities to health and wellbeing in a time of HIV/AIDS*, the Lesotho research has produced twelve key findings which we have grouped into three clusters.

Summary of Research Findings from Lesotho

Findings about religion in the Lesotho context
1. Ordinary Basotho perceive their struggle for health and wellbeing (bophelo) to be located in a context of enduring political instability, the daily struggle for subsistence in a harsh economic climate and costly health services.
2. Regional variations in Lesotho impact on peoples' experiences and perceptions of health and wellbeing.
3. The recent proliferation of religious entities involved in promoting health and wellbeing, many of which are directly responding to HIV/AIDS, is altering the nature of the religious contribution to health in Lesotho
4. Religion is an integral dimension of perceptions and experiences of health and wellbeing (bophelo) in Lesotho.

Findings about the nature of the religious contribution of religion to health and wellbeing
5. Religion (borapeli) is perceived to contribute to holistic wellbeing (bophelo) in tangible and intangible ways and which are most effective when driven by a relational ambition
6. A prominent explanation for HIV/AIDS among Basotho is that it is a result of witchcraft (boloi)
7. There is growing recognition and appreciation of the role of religion in advocacy and policy formulation around health and wellbeing.

Findings about religious entities and organizations
8. In Lesotho, REs operate within a network of relationships with other local and translocal entities, with some REs functioning as key hubs. However, other than the CHAL-MOH link, REs are not integrated with public health facilities.
9. The role of traditional healers is ambiguous. On the one hand they are isolated from Public Health and Christian Health networks. On the other hand they are an important feature of both the religious and healthworlds of many communities in Lesotho.
10. Local networks of community support groups are significant religious health assets.
11. Good healthcare is perceived to be healthcare that is trustworthy, culturally and linguistically familiar, and is concerned with the wellbeing of the whole person.
12. A very strong desire for more collaborative work was expressed among participants of both Leadership and Community Workshops.

A. Religion within the Lesotho Social, Economic, Political and Cultural Context

The first four findings from the research in Lesotho relate to the context in which religion engages with the struggle for health and wellbeing.

Finding 1: Ordinary Basotho perceive their struggle for health and wellbeing (bophelo) to be located in a context of enduring political instability, the daily struggle for subsistence in a harsh economic climate and costly health services

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A consistent finding across a range of exercises was that ordinary Basotho perceive their struggle for health and wellbeing, what we have identified as bophelo, to be located in a context of enduring political instability, the daily struggle for subsistence in a harsh economic climate and costly health services.

The first major obstacle to health and wellbeing noted through the timeline exercises was the political instability that has characterised Lesotho's recent history. Events that were regularly named on the time line included the coups of 1986 and 1991, the exile of King Moshoeshoe II in 1990, his restoration in 1995 and subsequent death in a car accident, the disruptive changes of government in 1993, 1997, 1998, and 2002, internal fighting amongst rival army factions in 1994 and the SADC military intervention in 1998 which resulted in civic unrest and widespread destruction of property in Maseru and elsewhere. Participants at the leadership level workshops perceived that this instability has had a major effect upon the ability of

government and civil society, including the churches, to provide comprehensive and coherent healthcare and to develop an adequate and timely strategy to deal with the HIV/AIDS pandemic. The democratic elections of 2005 were widely perceived to have provided an adequately stable platform upon which Lesotho could respond to HIV/AIDS.

The second major obstacle to health and wellbeing was identified as the disabling economic climate in which Lesotho finds itself. In the timeline exercises participants consistently made the connection between health and wellbeing and economic challenges. Factors that were identified were firstly, the first stage of Structural Adjustment Programmes in the mid 1980's which specifically targeted government provision of health and education, and the Enhanced Structural Adjustment Programme of the early 1990's which focused on water, electricity and other public services. Secondly, Lesotho's heavy dependency upon migrant labour in South African mines coupled with the crisis of mining in South Africa which led to huge retrenchments, has resulted not only the loss of income, but also in the return of large numbers of unemployed men, with both factors impacting heavily upon household economies. Thirdly, the three-year drought starting in 2001, which led to a declaration of a State of Emergency in 2004, had a massively negative impact upon commercial agriculture and subsistence farming and was perceived by participants to have undermined health and wellbeing in Lesotho.

The perceptions of the leadership level workshop participants were echoed in the community level workshops. Here the transect walks, community maps and discussions helped us recognize that Basotho at the community level survive through a patchwork of subsistence farming, migrant remittance, low-paying, temporary, seasonal work with low and uncertain returns. As a result community members are vulnerable to drought, hunger and external environmental circumstances beyond their control. All of this is seen to undermine the *Bophelo* of communities.

This recognition of the daily struggle for subsistence in a harsh economic climate was further illustrated by the perceptions of the key factors that contribute to and undermine health and wellbeing in Lesotho. Participants at the community level workshops were asked, in Sesotho, to identify the factors that contribute to and undermine bophelo. Their answers appear in the table below.

Rank	Factor	Total	%	For wellbeing	Against wellbeing
1	Food and Hunger	76	23.4	33	43
2	Sickness	55	16.9		55
3	Water and Drought	47	14.5	44	3
4	Alcohol and Drugs	39	12.0		39
5	Church/Religion (incl Traditional Healers)	26	8.0	23	3
6	Farming	20	6.2	20	0
7	Clinic	19	5.8	19	0
8	Education / Lack of Knowledge	14	4.3	8	6
9	Employment / Unemployment	11	3.4	3	8
10	Shelter	5	1.5	5	0
11	Immorality	4	1.2	0	4
12	HIV/AIDS	3	0.9	0	3
13	Other	9	2.8	5	4
	Total	325	100.0	**160**	**165**

The data from this table suggests that the single greatest factor working against health and wellbeing is "sickness". To the western medical mind this may seem a tautology, however, this reminds us that Basotho understand bophelo as far more than an absence of illness. (We shall dwell upon this in Finding 4 below).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

105

Secondly, the data confirms the findings from the timelines, transect walks and mapping exercises that basic subsistence, here represented by the three factors, food and hunger, water and drought, and farming, taken together are the major factors that are perceived to impact upon bophelo.

Surprisingly, gaining access to employment was not a priority amongst many of the participants in the peri-urban and rural community workshops. Rather, they express the financial dimensions of life in terms of having enough for subsistence. Employment and the lack of money was mentioned less frequently than we expected, and when it was mentioned, it was in light of access to healthcare and traditional healers.

The dependence upon subsistence agriculture which we have noted above provides us with a helpful clue about an important feature of these communities that they sit in a marginal relationship to the dominant cash-based economy of the health system. The high cost of health services, particularly at the local clinics, was frequently identified as a factor that undermined bophelo. Participants further pointed out that traditional healers were also increasingly requiring cash payment, rather than in-kind payment, for their services, thus adding to the in-affordability of formal health-care provision from either the "western" or traditional sectors. Participants indicated that they relied increasingly on self-medication and folk medicine, and on local initiated support groups, which are identified as the principal form of health-care provision within the communities (see Finding 10).

That both clinics and traditional healers rank much lower than these support groups is possibly a further indication of the alienation that participants feel from access to formal health provision and may also be one way of understanding the factor "sickness" which can be read as a code word for the loss of previously familiar and accessible pathways to health. In the past if one was sick one had open access to the clinic or traditional healer; now that this is perceived to be closed by the cash economy, "illness" emerges as a factor.

All of this confirms our first finding that ordinary Basotho perceive their struggle for health and wellbeing to be located in a context of enduring political instability, the daily struggle for subsistence in a harsh economic climate and costly health services.

Finding 2: Regional variations in Lesotho impact on peoples' experiences and perceptions of health and wellbeing

Notwithstanding the broad context of political instability and economic vulnerability, the transect walks, timelines and community maps suggests that there are regional variations that impact on people's experiences and perceptions of heath and wellbeing in Lesotho.

- main urban (Capital City - Maseru)
- peri-urban (Ha Thamae - Maseru)
- lowland regional urban (Morija)
- lowland village (Masite)
- highland regional urban (Thaba Tseka)
- highland village (Mohlanapeng)
- national representative workshop

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho
106

Maseru and Ha-Tamae - Urban Lesotho

Maseru Central is characterised by a formal economy that relies primarily on tertiary services, textile factories, shopping centres and large markets. This structured economy exists alongside a thriving informal economy characterised by large taxi ranks, small shops, taverns, markets and street side stalls selling food, vegetables, fruit and other commodities. People living in Maseru rely predominantly on cash-based incomes for subsistence and healthcare provision. This would explain the presence of private clinics and hospitals in Maseru not present in the other Scott and Paray HSAs.

Ha Tamae is a small community located 10 minutes drive south-east of Maseru Central. In Ha Thamae people have access to a number of facilities and services which include a public clinic, a number of schools, churches and shops. Like Maseru Central Central, Ha Thamae consists of both a formal and an informal economy, but unlike Maseru Central people in Ha Thamea are involved in both cash-based and subsistence livelihoods strategies.

Maseru Community Workshop, Ha Thamae, 2006

The reliance on cash-based services such as the high cost of water, refuge removal and road works, allied to the dominant cash economy of the city, might well be the principal reason why unemployment is perceived to be a factor contributing to "illbeing" in this urban community.

In both the urban located workshops of Maseru and Ha Thamae alcohol and drugs were identified as the largest factors undermining health and wellbeing. This is not surprising when considering the availability of numerous taverns and liquor stores in both these urban areas.

Morija and Masite - Lowland Lesotho

Morija is a small town, a 45-minute drive south of Maseru, and was the site of Lesotho's first European Evangelical mission. As a result there is a strong presence of Evangelical churches and schools in the HSA. In Morija there is a formal and an informal economy coexisting alongside a subsistence economy based on livestock and agriculture farming. In Morija people can access a number of facilities and services that include Scott Hospital, a number of schools, churches and shops. The majority of the households in Morija have vegetable gardens, fruit trees, cattle kraals and access to farming and grazing lands.

The community workshop took place in the local community of Masite, a small community North of Morija. Households in Masite are located within walking distance of the local clinic, church and schools. A number of communal taps serviced roughly 10 households each. In addition community members had access to a clean stream that passed through the village.

In Masite water was given a higher ranking than food and was substantially prioritised over electricity and telecommunications. In Masite none of the households had access to electricity or household telephones.
In addition hunger was seen as one of the greatest factors contributing to illbeing. This can possibly be attributed to a majority of households residing in the lowlands subsisting off the fields, vegetable gardens, fruit trees and cattle, goats, pigs and horses.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

107

Thaba Tseka and Mohlanapeng - Highland Lesotho

Thaba Tseka HSA is located in the remote highlands of Lesotho. It is a highland urban town located in a remote rural setting. In Thaba Tseka there is one hospital, Paray Hospital and a number of other subsidiary health services that includes a pharmacy. It is the largest town in the Paray HSA. The town is electrified and a majority of the buildings have access to piped water systems. The town consists of both a formal and informal economy comprised of shops and markets stalls. During the leadership workshop participants identified the following key events to be of significance: in 1965 the road to Thaba Tseka was constructed, in 2004 elderly people were provided with a pension scheme and in 2005 the post bank opened in Thaba Tseka. These key events highlight the remoteness of Thaba Tseka and the importance of transport, pension schemes and banking services for the health and wellbeing of the remote highland communities.

The community workshop took place in Mohlanapeng, an area located South-East of Thaba Tseka. The area comprises of nine villages, a shop, a primary and secondary school, as well as a clinic. The village located closest to the clinic and the school had access to public telephones, a post office, and a shop.

In Mohlanapeng the community members relied predominantly on a subsistence economy based on (i) fields and vegetable gardens, (ii) livestock and (iii) homebrewed beer taverns. The dependency on subsistence agriculture makes the high ranking of water and rivers understandable. In a country often beset by drought these factors gain increased importance.

The following table, identifying the facilities and services identified in the community mapping exercise in the three community workshops provides a good overview of the different contexts in which people are seeking health and wellbeing in Lesotho.

Facilities and Services Identified in Community Workshops

Ha Thamae	Masite	Mohlanapeng Community Maps
Churches	Schools	Water
Prayer Meetings	Creches	Rivers
Support Groups	Clinics	Taps
Church Schools	Church Schools	Agriculture, farming
Traditional Healers	Village Health Worker	Trees
Small Christian Churches	Traditional Healer	Fields
Muslim Schools	Chief's Place	Wild Vegetables
Clinic	Local Court	Animals
Garage & Filling Station	Roads	Churches
Shops	Mountains	MOH Clinics
Informal Markets	Shops	Traditional Medicine, mainly folk remedies
Cemetery	Post Office	Businesses
Police Station	Telephones	Shops
Vetinary Clinic		Wool Shearing Shed
Chief's Place		Mill
Community Hall		Communications
Public Phones		Roads
Roads/Streets		Telephones
Spring/well/public taps		Post Office
Taxi Rank		Support Groups
		Schools (primary, secondary, shepherd)
		Traditional Healers
		Initiation Lodge
		Chief's Place

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

108

> **Finding 3: The recent proliferation of religious entities involved in promoting health and wellbeing, many of which are directly responding to HIV/AIDS, is altering the nature of the religious contribution to health in Lesotho**

As we noted in the discussion around the timelines in Finding 1 above, Lesotho was in a state of political and economic flux through the 1990s, and this had an impact upon health and wellbeing. This is also the time that the HIV/AIDS pandemic was becoming manifest in Lesotho. However, the timeline exercise in the leadership workshops presented evidence of the proliferation of religious entities involved in promoting health and wellbeing in Lesotho, which began in 2000 and showed a notable upsurge in 2005.
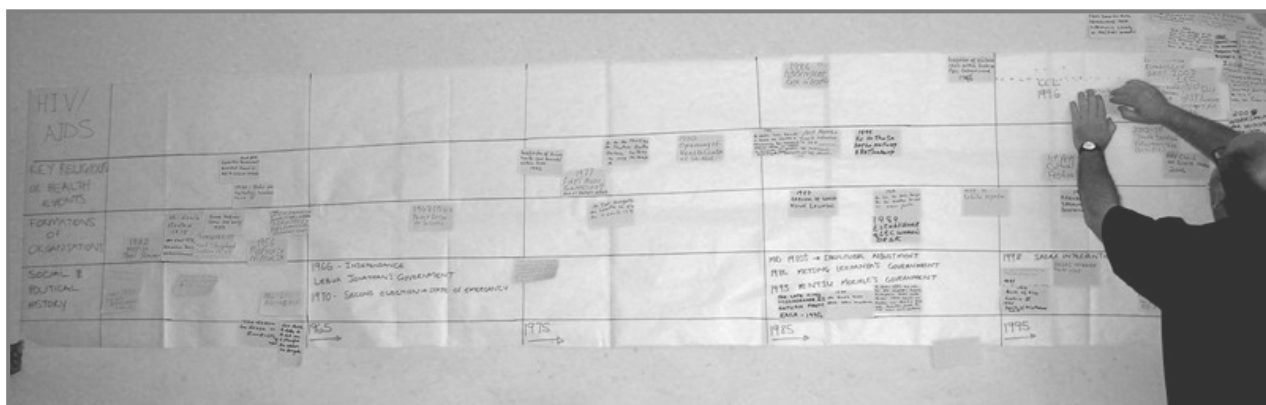
Scott Leadership Workshop, Timeline Exercise, Morija, 2006

This is further illustrated when the timelines from the four leadership workshops are amalgamated into a graph as follows:
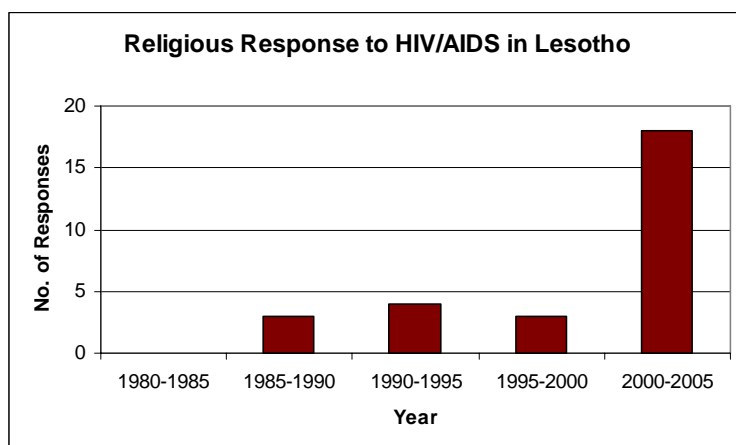
Although the first case of HIV/AIDS in Lesotho was reported in 1986 it was only in 2000 that a substantial religious response to HIV/AIDS began. The participants at the leadership workshops attribute this delayed religious response to HIV/AIDS to a number of key factors. (i) Basotho thought that HIV/AIDS was not a Basotho problem as the first person infected with HIV was a foreigner. One participant at the National workshop stated "we as Basotho had a wall of denial. We thought it was a disease of the foreigners." (ii) The unstable political and economic context prevented a coherent response by religious or government agencies to the pandemic in the 1990s. (iii) REs did not feel that it was their problem but rather that of the government. (iv) Many Christians thought that HIV/AIDS was a product of sin leading to discrimination and stigmatisation of Basotho infected and affected by the disease. A participant at the Morija leadership workshop stated "even though religious groups are envisaged to help with HIV/AIDS things like stigma are obstacles to their progress." (v) Prevention strategies that promoted condomization deterred churches from responding practically to the disease. This was clearly articulated by a participant at the Morija leadership workshop "You teach your children that they should use condoms, but then the church tells them that is a sin. This leads to a higher prevalence of HIV/AIDS and causes great confusion amongst the youth."

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

109

The religious response to HIV/AIDS in Lesotho can be characterised by internal and external factors that challenged REs to question their role in a society deeply affected by HIV/AIDS.

The actual contribution of these REs to health and wellbeing in Lesotho will be discussed in more detail in the next sections of this chapter. The two points that are important to note here are (i) that the research makes clear the growing presence of religious entities dealing with health and wellbeing in Lesotho, and suggests that it is impossible to understand health and

At first people thought HIV/AIDS was the sole responsibility of the health-care institutions, but when people started dying in our families, communities and congregations we could no longer ignore the responsibility of the church to fight this disease. It took us a long time to acknowledge our role; hence, it took a long time to get other social partners like the Government of Lesotho to come on board and assist us to fight this disease - **Thaba Tseka Regional Workshop, 2006**

wellbeing in Lesotho without serious consideration of these entities; and (ii) that the nature of the new religious entities that have emerged on the wider social landscape in the last decade has altered the nature of the relationship between religion and public health.

Finding 4: Religion is an integral dimension of perceptions and experiences of health and wellbeing in Lesotho

A fundamental finding of the research was that religion is absolutely integral to perceptions and experiences of health and wellbeing in Lesotho. In the first exercise in the community workshops, participants were asked to identify the factors that contribute to health and wellbeing (see Finding 1). These were:

Rank	Factor	Score
1	Water and Drought	44
2	Food and Hunger	33
	Church/Religion	20
3	Farming	20
5	Health provision	19
6	Education	8
7	Shelter	5
	Traditional Healers	3
8	Employment	3
10	Other	5
	Total	**160**

In Finding 1 we noted the significance of the subsistence factors of water, food and farming to wellbeing. In this Finding what is significant is that church/religion and traditional healers rank directly after subsistence factors and above health and education services in the provision of wellbeing. While religion is clearly not the most important factor, its relative significance to wellbeing is clear.

In the second exercise, as described in Chapter 2, participants were asked to rank a range of social institutions that existed in their community (as indicated on the community map) in terms of their own definition of what contributes to and militates against health and welfare in their community. A matrix was created that had health factors along the vertical axis and social institutions along the horizontal axis. In smaller groups participants were asked to score each institution against each health factor on a scale of 0-5, where 0 represented "no contribution" and 5 represented "great contribution". There was a great deal of discussion and negotiation amongst the participants (with no involvement of facilitators) prior to the scoring

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

110

of each. In this transparent, negotiated and participatory manner the relative contribution of each social institution to health was noted. As a few religious entities were normally included in this list, it is possible to identify the perceived relative contribution of religious entities to health in the community. The findings from this exercise strengthen the perception of the significance of religion in the struggle for health and wellbeing,

Ha Thamae		Masite		Mohlanapeng	
Support Groups	2.9	Clinic	4	Clinic	3.6
Schools	2.8	Communication	4	Support Groups	3.3
Water	2.8	Schools	3.7	Churches	3.2
Clinic	2.5	Churches	3.7	Schools	3.0
Churches	2.3	Support Groups	3.6	Traditional Healers	2.9
Subsistence	1.9	Traditional Healers	3.1	Communication	2.6
Governance	1.8	Governance	2.5	Subsistence	2.4
Communication	1.3	Schools	2.3	Initiation Schools	0.2
Shops	1.0				
Cemeteries	0.5				

Support groups, schools, clinics and churches score in the top five of the community workshops.

- While the clinics rank very well in two of the communities, they receive a mid-table ranking in the other.
- Schools outrank churches in two communities.
- Support groups rank first in one, second in another, and mid-table in the third.

This ranking suggests that churches are seen to play a relatively important role in health, but not the most important, in the overall context of a suffusion of religion in all life in Lesotho.

We gain deeper perspective on this when we consider the participants' responses to a further exercise in which they were asked to identify religious entities and to rank their ability to embody the religious contribution to health. The entities that were chosen were wide ranging, and did not conform to the assumption of "religion" embedded in the research tool. The list of entities chosen was:

- Churches
- Support groups (not formally connected to churches)
- Schools
- Prayer meetings
- Communications (post-office, roads, telephone)
- Traditional healers
- Small Christian communities
- Clinics
- Mountains/fields
- Governance structures (chief, court, local government)

This unexpected response from the community participants confirms the finding that religion is an integral dimension of perceptions and experiences

Maseru HSA, Outlying Village, 2006

of health and wellbeing in Lesotho and is a further indication of the manner in which healthworld of the Basotho is shaped by the idea and experience of bophelo. It is clear that this dynamic emerges in the research and the data because the tool is written and conceived in English, which assumes a clear distinction between religious entities such as churches and prayer meetings, and secular entities such as post offices, mountains and governance structures.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

111

In order to make more sense of this emerging data, the research team tested the understanding of bophelo with the participants at the leadership level workshops, many of whom had a great deal of wisdom about religion and health in a Sesotho cultural context and are key informants on the matter. Given (i) that the workshops were conducted primarily in Sesotho, and the word "bophelo" was used for health, and (ii) that discussion centred around religion and health in this context, a great deal of discussion took place around the Bophelo healthworld. Rich qualitative data was collected in the form of discussion comments, all of which confirmed the hypothesis that once the English words, "religion" and "health", are translated into Sesotho, Western categories also tend to be less significant, and a more holistic vision of health and wellbeing emerges, one in which the role of religion is highly significant.

Here is a selection of comments from participants at the National Leadership workshop which illustrate the point (note that some have been translated from Sesotho):

- Customs of Sesotho include health. Health was included in the way we live. Health is embedded in the way we live your life. There was no separate way of health. If you don't have bophelo in one, you can't have it in another.
- In English we have a distinction between life and health, but even though you have to have health in order to have life, this is physical health. We want to bring borapeli (religion) back into health.
- In the Western approach we only treat illness and not people. These are old ideas…"Basotho do not have a religion, there are no temples, churches, books". The western world looks at the categorisation of life and religion.
- There is a realisation that all bophelo factors contribute to health. Some doctors just look at the physical disease.
- Scientific approach has only looked at the physical being. Traditional healers look at both. We need to acknowledge all entities of being.
- Western health is limited. WHO uses a broad definition. There needs to be recognition that we are trying to be broad. We have to look at practice that is narrow. Authorities in the healthcare sector focus on the physical. Leadership is stuck on that.

The data as a whole, as well as the significant information about the holistic bophelo worldview in which health and wellbeing are understood by Basotho, confirms our finding that religion is an integral dimension of perceptions and experiences of health and wellbeing in Lesotho.

B. The Nature of the Religious Contribution to Health and Wellbeing in Lesotho

Having laid out our findings about the context in which religion and health are found in Lesotho, the second set of findings from the research helps us to understand the *nature* of the religious contribution to health and wellbeing in Lesotho.

Finding 5:   Religion (borapeli) is perceived to contribute to holistic wellbeing (bophelo) in tangible and intangible ways which are most effective when driven by relational ambition

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The previous finding made clear that religion is integral to the bophelo healthworld, which underlies the Basotho conceptions of religion and health and that religion is part of the whole way in which health and wellbeing is conceived. In a further exercise, participants were asked to identify the specific contribution of religion to health. When the exercises were translated into Sesotho and made use of the words *borapeli* (religion) and *bophelo* (health), participants regularly struggled to understand the way in which the research team was posing the question, because it all seemed tautological to them.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho
112

Nevertheless, as the matter was clarified with participants, the following factors were raised as the key ways in which borapeli contributes to bophelo. Owing to local participatory factors to do with time, this question was not asked at either of the Thaba Tseka workshops - and so we have data for five workshops to consider: two community level, and three leadership level (including the national workshop):

Participant		Community level		Leadership level			ARHAP cluster	Total
English	Sesotho	Ha Tamae	Scott	Scott	Maseru	National		
Faith	Tumelo	5	5			5	Spiritual Encouragement	60
Hope/Trust	Tshepo		3	10	6			
Prayer	Thapelo		3	2		5		
Baptism	Kolobetso		3					
Salvation	Tsokoloho	4		2	5			
Peace	Khotso			5				
Care	Ho Thusang	4				4	Compassionate Care	31
Love, Holistic Health Wellbeing	Lerato	6	2	7	7	1		
Unity	Kopang	4		5			Respectful Relationships	22
Respect	Tlhompho	8						
Belonging	Ubuntu				5			
Morality					10	6	Moral Formation	16
Instruction	Taeo	10					Knowledge Giving	11
Awareness				1				
Healing					6		Curative Interventions	6
Food	Lijo		5				Material Support	5
TOTAL		41	21	31	40	21		154

To make sense of these participant-identified factors, we have suggested a typology in which we have clustered them together around ARHAP defined terms.

1. The most significant contribution of religion (borapeli) to health (bophelo) is what we have termed *Spiritual Encouragement*. This encompasses such terms as faith, hope/trust (which is one word in Sesotho - tsepo), prayer and peace (which was expressed as an inner feeling), as well as salvation and baptism. Spiritual encouragement emerged in all the workshops, with hope/trust and faith being its most important elements. It embodies the religious contribution to resilience, courage and a willingness to continue in times of difficulty, ill health, and misfortune.

2. *Compassionate Care*, which includes the factors love and care and refers to the religious willingness to be of assistance to those who are needy, sick or in difficulty; it also concerns itself with holistic health and wellbeing.

3. *Respectful Relationships* includes the factors of unity, respect and belonging that point to the fact that religion creates relationships among people, which are important for health and wellbeing. The connection between this and bophelo, where health is understood as essentially relational should be noted once more. This observation is reinforced by two observations about elements of 1 and 2. Two factors hope/trust (tsepo - from 1) and love (lerato -from 2) were often understood by participants as having fundamentally relational dimensions. That love is in Compassionate Care and not in Respectful Relationships is something of an arbitrary decision.

The final four terms ranked relatively lowly. These we have termed:

4. *Moral formation*, meaning the role religion plays in guiding life choices;

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

113

5. *Knowledge giving*, pointing to the role of religion in providing information about health;

6. *Curative interventions* being our term for specific interventions by religious entities to cure people from ill health, sickness or illness - however this is understood; and

7. *Material support* being the contribution of religion and religious entities to assist the needy with particular material help such as food or clothes.

An important theoretical hypothesis in ARHAP's work has been that religion contributes to health in both tangible and intangible ways. When this set of findings is analysed in terms of the tangible/intangible distinction, as in the chart below, the hypothesis we worked with is confirmed. It also becomes clear that in Lesotho, the intangible contribution of religion to health is recognised as more important than the tangible contribution.

87	Intangible	Tangible	47
60	Spiritual Encouragement	Compassionate Care	31
16	Moral Formation	Curative Interventions	11
11	Knowledge Giving	Material Support	5

The data we work with however also raise a challenge to the neat division of RHAs into tangible and intangible. The relational force of bophelo, which we have represented by the term Respectful Relationships, does not fall neatly into the tangible/intangible categories. Respect is an intangible factor, and yet relationships are tangible. The difficulties posed by the category respectful relationships are driven not simply by the categorisation that was made above but rather by the insistence of the relational ambition of bophelo. This leads us to conclude that the strength of both the tangible and intangible aspects is relative to the quality of the relationships that are established between the two. We might well depict this relational dimension in the following table.

87	Intangible	Tangible	47
60	Spiritual Encouragement	Compassionate Care	31
16	Moral Formation	Curative Interventions	11
11	Knowledge Giving	Material Support	5
22	Relational Ambition		22
22	Respectful Relationships		22

Upon analysis and reflection it is clear that in Lesotho, religion contributes to wellbeing in intangible and tangible ways and, when driven by a relational ambition, these are seen to be at their most effective.

Finding 6:   A prominent explanation for HIV/AIDS among Basotho is that it is a result of witchcraft (boloi)

It is clear that several explanations for the origin and nature of HIV/AIDS exist among Basotho. These range from the accepted biomedical explanation of HIV/AIDS as a virally transmitted illness, to explanations of it as an expression of God's judgement for immoral behaviour, to understanding it as a result of *boloi* (witchcraft). This finding is to be understood in the context of the discussion in Finding 4 about the religious practice of Basotho and is consistent with Finding 9 about the importance of traditional healers in the bophelo landscape of Lesotho.

In a country in which the vitality of traditional religio-cultural forms is so prominent we should expect that HIV/AIDS would be interpreted, mediated and treated in the idiom of traditional medicine. The dominant understanding in this idiom is that HIV/AIDS is a result of witchcraft.

This relationship between witchcraft and HIV/AIDS was the subject of a long discussion at the National Workshop. The discussion is captured in the following points.
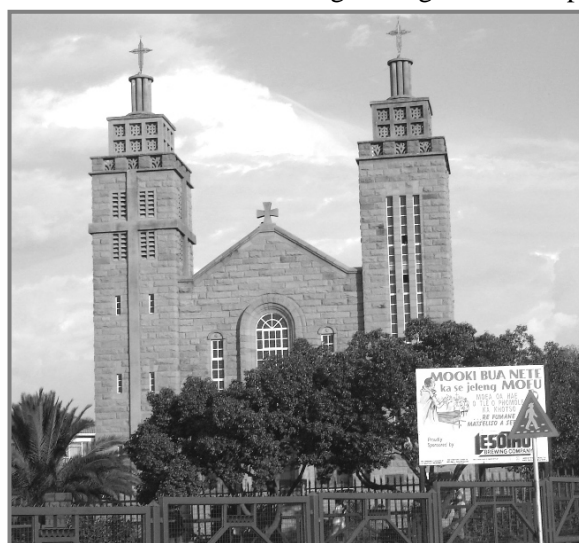
- The advent of HIV/AIDS was perceived to be linked to a recent upsurge in matters around witchcraft.
- In terms of traditional religio-cultural forms, human misfortune can be understood as either the result of the displeasure of the ancestors or as the malice of other human beings expressed in boloi.
- Witchcraft must be understood in terms of its essentially relational dynamics. It is primarily an expression of failed relationships. As one participant put it, "There is no witchcraft between people who do not know each other. Boloi only generates between people who know one another." Another said, "Boloi emanates from an evil heart, which is motivated by an evil spirit. Boloi does not exist without people knowing one another and wishing the other ill."
- The presence of boloi is an expression of the failure of bophelo, of the maintenance of respectful, healthy relationships.
- Dealing with witchcraft is the realm of the traditional healers, especially the diviners.

In conclusion, among the multiple explanations and treatment regimes for HIV/AIDS in Lesotho is the lived experience of witchcraft. Treatment and prevention strategies which fail to take this reality seriously will be weakened.

Finding 7: There is growing recognition and appreciation of the role of religion in advocacy and policy formulation around health and wellbeing

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In Lesotho the construction of health is primarily driven by western dichotomies that separate the overlapping and interfacing relationships that exist between religion and health. This has resulted in a separation between religion and health that has profoundly impacted on the way the relationship between religion and health is articulated in the minds and practices of key public health practitioners and policy makers in Lesotho. As such the integration of religion and health is contested in antagonizing relationships that ignore the potential role of religion in advocacy, prevention and policy formulation around issues of health and wellbeing. Through the articulation of RHAs in a bophelo context, participants at the leadership level rediscovered the integration between religion and health. The significance of RHAs explicitly challenged western dichotomies, which enabled the participants to reassess the role of religion in public healthcare.

Roman Catholic Church, Maseru Central, 2006

In the leadership workshops the growing recognition and appreciation of the potential role of religion in advocacy, prevention and policy formulation around health and wellbeing was also expressed in both the timeline and spidergram exercises. In the timeline exercises, with the proliferation of a religious response to HIV/AIDS taking place from around 2000, a number of issues become apparent: (i) REs can no longer ignore the impact of HIV/AIDS on adherents and fellow community

members, and (ii) REs are increasingly acknowledging their potential role in combating HIV/AIDS through initiating HIV/AIDS related policies and programs. As a result, REs are acknowledging the role of religion in health related issues even though this is not simultaneously occurring amongst public healthcare professionals. In the spidergram exercises many of the REs were isolated from public healthcare facilities, which is evidence of the lack of an integrative relationship amongst religious leaders and public healthcare professionals.

In the community workshops participants explicitly acknowledged the potential capacity of REs in dealing with public healthcare issues. Overwhelmingly, participants in the community workshops criticised the church and REs for not effectively accessing their social, physical and spiritual capital in order to combat and tackle public healthcare issues. These are some of the participants' responses directly related to the growing recognition and appreciation of the potential role of religion in addressing public healthcare problems:

- "The church is important, and I take this challenge to the church to ask them how they can respond to the needs of the people." (Participant, Ha Thamae community workshop)
- "It looks like the church is important in the community, but looking at their assets I think that there is a deficit in their responses to assisting the community, and I challenge them to do more for the community." (Participant, Ha Thamae community workshop)
- "The church has to play a crucial role in encouraging bophelo." (Participant, Masite community workshop)
- "Jesus helped the sick, hence it is the responsibility of the church to help them too." (Participant, Mohlanapeng community workshop)

From these statements it is clearly evident that community members would encourage a religious response to health related issues including HIV/AIDS that entail policy and advocacy.

C. Religious Entities and Organisations

> **Finding 8: In Lesotho, REs operate within a network of relationships with other local and translocal entities, with some REs functioning as key hubs. However, other than the CHAL-MoH link, REs are not integrated with public health facilities**

Having identified the key role that REs can play in combating HIV/AIDS, participants at the regional level workshops engaged in a spidergram exercise to represent the relationships that exist between REs and other participating organisations.

From discussions with participants at the leadership workshops four key findings were identified, (i) there is minimal integration between REs and public health facilities apart from the CHAL-MoH relationship. (ii) REs are integrated into collaborative networks that include a number of important entities not "indigenous" to the area. This makes it possible

Scott Hospital, Scott HSA, 2006

for REs in local contexts to draw on a wide network of local, national and international relationships. Hence World Vision Lesotho is an important actor as are REs affiliated to international denominational structures

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

116

(RCC, Seventh Day Adventist). (iii) The spidergram showed up the presence of "hubs" which are connected to many others entities. In Maseru the MoH and the LEC were seen to have a number of existing relationships; while in Morija, Scott Hospital, was connected to almost all organizations represented in the workshop. The Mophato Ecumenical Youth Centre and LEC Education Secretariat were also well connected. In Paray the Thaba Tseka LEC and RCC churches appear to be the hubs for this HSA. (iv) A number of REs are left out entirely or at least not well connected to existing religious networks. Examples were:

- In the Maseru workshop it was shown that the Muslims and the Traditional Healers Associations were not extensively connected to many church organisations, with Green Crescent Islamic Centre is only linked to the Roman Catholic Church.
- While most church groups were keen to work with the Muslims, they showed less enthusiasm to collaborate with the Traditional Healers. The complex relationship with traditional healers emerged at all three sites and is discussed further in Finding 9.
- The Paray workshop led to the conclusion that the competitive nature of some churches contributes to the lack of cooperation between varying religious groups.

It is also evident from a comparison of spidergrams of actual and desired relationships that more groups want to form relationships then there are relationships already existing. Hence in Maseru the LEC indicated a willingness to work with all represented groups because "all touch the hearts of the Basotho." (Participant, Maseru leadership workshop)

Participants attending the leadership workshops attributed the dislocation between various REs to a number of factors: (i) Traditional healers are not part of the mainstream since most social partners exclude them. As one respondent in Thaba Tseka stated "church people are still struggling to strike relationships with traditional healers because of spiritual reasons. Their interpretation of disease is totally different from the churches. They rely on witchcraft as the source of their patients aliments." (ii) The history of the church serves as an obstacle to institutional collaboration. (iii) Some REs are given a clear jurisdiction to work in. Hence they fail to collaborate with REs and social partners outside their jurisdiction. (iv) The lack of cooperation depends on the urban/rural divide. Cooperation amongst REs is expected to be higher in rural areas where churches are compelled to accept traditional values. In reflecting on these statements, it is important to acknowledge that the spidergrams are a representation of the perceptions of the participants and their personal desire to establish further relationships. As such, the finding highlights the unevenness of these networks with some entities being established as clear "hubs" while others function on the periphery existing as isolated organisations, entities and initiatives. There is clearly a lot of work that needs to be done if collaboration is to take place amongst REs and between these entities and public healthcare professional, services and facilities.

> **Finding 9: The role of traditional healers is ambiguous. On the one hand they are isolated from Public Health and Christian Health networks. On the other hand they are an important feature of both the religious and healthworlds of many communities in Lesotho**

In Lesotho traditional healers form a critical element of the multiple health-seeking strategies of the Basotho. Their integration into the public healthcare system is marred by the negative assumptions and misconceptions of public healthcare professionals and government officials. These misperceptions extend into the religious realm of Christian networks where traditional healers are often demonized and commonly portrayed as witches. This pushes traditional healers to the fringes of Basotho society isolated from public healthcare systems and religious networks. This dynamic was evident in a number of workshops, and was

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

117

addressed at length in the Morija and Thaba Tseka Leadership Workshops stimulated by the robust presence of Traditional healers in these workshops.

There are three dominant types of indigenous health providers, or traditional healers, in Lesotho which are constituted by (i) Diviners (Dingaka tsa Ditaola), (ii) Herbalists (Dingaka Chitja) and (iii) Zionist/ Apostolic healers (Mapostola, Mapropheta). Some herbalists distinguish themselves as working solely with herbal remedies. Diviners practice on the basis of engagement with ancestral and spirit forces. Some diviners are also Zionist/Apostolic priests. The three types must be understood as operating on a continuum.

A quick glance at the pie-chart evidences an interesting feature of the Lesotho religious landscape. Apart from a small representation of Muslim and Baha'i the participants in the Lesotho workshops appear to be overwhelmingly Christian in religious affiliation with no presence of the traditional religious world of the Basotho.

It could not be more misleading to conclude from this chart that there was a complete absence of what we call the historical Sesotho religio-cultural forms in the workshops we ran for the following reasons.

- There was a strong presence of traditional healers, who are among the principal custodians of traditional religion in Lesotho, at the workshops. 11% of the participants (18 of the 163) identified themselves as traditional healers by occupation/profession.
- These custodians of traditional religion simultaneously identified themselves as affiliated to some form of Christianity (chiefly Zionist, but also Roman Catholic).
- It became clear, especially in the community workshops that many of the participants who identified themselves as affiliated to a Christian church were simultaneously either shaped by participated in, or practiced some form of traditional religion.
- This reality points to a fundamental difference between the way Christianity works (and with it Western understandings of how religion works) and the way the traditional Sesotho religio-culture operates. Generally,
    - Christianity makes exclusivist claims of its adherents, while
    - Sesotho traditional religion is more pragmatic, inclusive and syncretic.

In Lesotho then, we are faced with a reality in which there is much pragmatic and syncretic behaviour in both health-seeking behaviour and in religious practice. Multiple health and religious practices are driven by a worldview that is intrinsically pluralistic and inclusive. This is evidenced in the following discussion.

The isolation of traditional healers was clearly evident in all the regional workshops. In the spidergram exercises a majority of traditional healers were not connected to any religious group or healthcare facility. This observation was commented on by many participants and was an obvious matter for discussion.

- "Traditional healers are not part of the mainstream since most social partners exclude them." (Participant, Morija Leadership Workshop)
- "One of the reasons why there is no connection between the church and traditional healers is because the church does not want to work with us. We want to work with them. My mother is LEC, I am LEC. I want to work with the church. Recently the church took me to the local village court in

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

118

Matsieng where they were accusing me of bringing initiation into the community. This was because the church did not want initiation taking place in its vicinity. The outcome of the court case decided that the church should remember that the church cannot erase Basotho practices. They must learn to coexist with these practices." (Participant, Morija Leadership Workshop)

On the one hand there was a clear sense of an often painful isolation of traditional healers. On the other hand, what is clear is that traditional healers are a significant feature of the health topography of many communities in Lesotho.

Many traditional healers understood themselves as integral to the healthcare provision in the communities. For example, in the Thaba Tseka spidergram exercise, the five traditional healers present in the group drew themselves as being connected to all the organizations on the chart, by drawing a circle through all of them. (See adjacent diagram.)

One of the traditional healers explained this decision:

> "The reason I say I have relations with all these other organisations on the map is because almost all of them come to me for help, even pastors. Some are ashamed to come to me during the day because they fear people not God, but at night they come to me and I heal them."

Paray Leadership Workshop, 2006

A further point was made in the workshops, where differences in rural and urban areas were identified as an important variable in the profile of traditional healers. In urban centers dominated by Western cultural, religious and medical forms one could anticipate a greater isolation of traditional healers than in rural areas, especially in the remote highlands, where the strength and vitality of the traditional religio-cultural forms is much higher.

It is clear from the above discussion that in Lesotho the role of traditional healers is ambiguous. On the one hand they are isolated from Public Health and Christian Church networks. On the other they are an important feature of both the religious and healthworlds of many communities in Lesotho.

> **Finding 10:   Local networks of community support groups are significant religious health assets**

In communities where access to healthcare services and facilities is beyond the financial reach of ordinary Basotho there has been a dramatic upsurge of local community support groups.[71] Self-initiated, deeply religious, though not formally linked to any religious structure, they are identified as among the most important health providers in these communities. As one participant at the Mohlanapeng community workshop put it, "Support groups help with people who cannot be helped by medical doctors."

In discussion with community members we discovered two kinds of support groups: (i) support groups initiated by local communities that function independently of public healthcare facilities and religious networks, and (ii) support groups that are served by Village Health Workers linked to healthcare facilities,

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[71] In 2004 it was estimated that there were approximately 5000 support groups in Lesotho (CARE, 2004).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

119

e.g., Scott Hospital. Our concern in this section is with the first type, the self-initiated and independent support groups.

These support groups are:

- deeply religious (representing various religions), yet independent of any specific church
- made up by a majority of female members
- self funded and use their own resources to feed, cloth, hospitalize, and medicate patients
- not supported by churches or the public health system

We've seen a lot of teenagers die. We asked how we can prevent this death. Before we made this group, we asked why teenagers die…every week, four to five die. When we first met we were three. Then we went to the chief and asked in 2001. By the end of 2002 we said, let's make group and go from house to house and ask them about these children...The chief made the whole country, women, men and children talk about it. Then the group was ten. We went from house to house getting patients…the whole country are teenagers…there are no elders.

We went to Queen II to get something to help when we heard about the virus…on a date we went (to the clinic)…and from then we knew about HIV/AIDS. The church did not say anything about HIV/AIDS, but there is stigma…maybe that is why then they don't help us. Churches give old clothes and food packages and give to the poor, about a 100. We feel pain for the community. This is something like what happens in the mountains. We do it because of love. Love for the community **- Interview with Support Group Leader for the Lower Thamae Support Group, 2006**

In every community workshop across all three HSAs, support groups, as opposed to the churches, were rated very highly as being proactive and addressing the health of the community in practical and effective ways. In Ha Thamae participants identified 7 support groups while in Masite 50 support groups were recognized. The dramatic increase of support groups in rural areas can be attributed to several factors; these include: (i) increased HIV/AIDS infection, (ii) economic constraints preventing community members from accessing formal healthcare services, and (iii) the stressed economic situation of small local churches, preventing an effective religious respond to HIV/AIDS.

Support groups are mobilised by individuals who are motivated by a concern for the health of the community. Their lack of formal connection to, or support from, the churches might lead one to suspect that they are not REs, but this would be to miss the important fact that while they operate outside the formal "church" structures they understand themselves to be fundamentally religious. Their perceptions of and compassion for community members derives from an innate sense of community service, love and compassion. CARE Lesotho (2004) attributes these perceptions to the cultural value systems of Basotho.

By drawing on the cultural assets of Basotho to tackle HIV/AIDS, support groups are indicative of a culturo-religious response to HIV/AIDS that is rooted in a holistic understanding of wellbeing and health, expressed by bophelo. Their greatest assets include trust and cultural and linguistic familiarity, which are essential assets when reaching out to Basotho infected and affected by HIV/AIDS. Support groups are therefore exemplar RHAs (see Finding 11), which are trusted by their communities and draw on the cultural assets of Basotho.

In the leadership workshops, support groups were not identified in the mapping verification exercises, with the exception of Scott Hospital which runs a system of village health workers. In most instances community leaders and national public healthcare professionals were ignorant of the role of the support groups.

In Lesotho the national public healthcare policy should identify and focus on strengthening the capabilities of support groups in responding to HIV/AIDS. This is necessary given the important role that support groups play in communities affected by HIV/AIDS.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho
120

CARE Lesotho has made a notable effort in providing training, funding and on-going support to village health workers. Since 2004 CARE Lesotho has been providing financial and technical support to these health workers. However the support provided by CARE cannot provide enough assistance to these support groups. The lack of funding, human capacity and assistance from the GOL further handicaps the outreach and coverage of these groups in Lesotho. This is partially worsened by the stressed economic situations of small local churches that cannot actively support and assist these groups with additional funding. From discussion with participants in community workshops, local congregations were criticized for not placing HIV/AIDS as a major priority of the churches. However, the lack of resources on the part of the religious institutions was identified as a factor contributing to the inability of these institutions to address pressing public health issues. The stressed economic situation of the local churches prevents these churches from developing a religious response to HIV/AIDS, as witnessed in other exemplar RHAs.

> **Finding 11: Good healthcare is perceived to be healthcare that is trustworthy, culturally and linguistically familiar, and is concerned with the wellbeing of the whole person**

Because of the extended discussions on bophelo in the Lesotho workshops, the PIRHANA exercise to identify the exemplar REs was run more briefly in Lesotho than in Zambia. Nonetheless, the discussions held revealed the following.

In the both the Morija Leadership Workshop and the National Leadership Workshop, Scott Hospital was identified as an exemplar response to health and HIV/AIDS.
- There is a realisation at Scott that all bophelo factors contribute to health. Some doctors just look at the physical disease. Scott Hospital was different.
- The doctors at Scott did not only focus on the physical body of their patients but also their social and emotional health.
- They realized that people were more than just bodies.
- They counselled patients which developed trust before they gave medicine out.
- "Scott Hospital is doing amazing work with regards to HIV/AIDS. We must acknowledge their efforts and commend their hard work. We are proud of what Scott is doing in this area."

In the National Leadership Workshop the following elements were regarded as important for an effective health intervention:
- It is essential for medical services to be trusted for them to perform.
- Familiarity in terms of culture, language, and practice were identified as important elements of an effective health intervention.
- This pointed to a crucial vulnerability in Western medicine. As a participant pointed out, "In Western medicine the language is different, practices strange, it is expensive. If little things go wrong it is terrible for the medical profession. When it fails, everything falls down."

Support Groups were widely recognized in the community workshops as being one of the principal health-care providers in the community, ranked first, second and fifth in three community workshops. (By contrast, despite the discussion above, the support groups that were principally engaged by Scott Hospital were ranked fifth). These support groups have the following characteristics:
- They are community-initiated and supported.
- Their practice is culturally and linguistically rooted in the local culture.
- They are clearly trusted by the community members.
- They promote strong relationships with the community.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

121

While there was not enough time across the workshops to explore this further, it is clear that for the participants the key characteristics of an exemplar RE are that it (i) is trusted by the community, (ii) is culturally and linguistically familiar, and (iii) is concerned with the wellbeing of the whole person, including the social and emotional health of the person.

Finding 12: A very strong desire for more collaborative work was expressed among participants of both Leadership and Community Workshops

One of the most powerful impressions that the research team left all the PIRHANA Workshops with was the very strong desire expressed by the participants at both Community and Leadership levels for more collaborative work.

There was a strong perception in the Leadership Workshops that in the public health sector *of* Lesotho the construction of health is primarily driven by western dichotomies that separate the overlapping *and* interfacing relationships that exist between religion and health. This is seen as resulting in a separation between religion and health that has profoundly impacted on the way the relationship between religion and health is articulated in the minds and practices of key public health practitioners and policy makers in Lesotho as well as religious leaders.

By the end of the workshops participants were expressing the desire to overcome these historical barriers to the provision of bophelo to communities. Two features dominated discussions. i) A strong desire to overcome isolations and lack of connections that were revealed in the Spidergram exercise. Four kinds of isolation were identified: of minority groups (eg Islamic Organizations), of traditional healers, of denominational divides, and of geographic isolation in rural areas. ii) A strong commitment to overcome the historical conceptual barriers to providing holistic bophelo by rediscovering the integration between religion and health.

These commitments were expressed in a number of tangible ways. Two examples illustrate. i) After the Maseru Leadership Workshop a coordinating group, comprised of two MoH professionals and two religious leaders was formed to stimulate cooperation and learning between the various religious groups and other healthcare

Maseru Leadership Workshop, Maseru Central, 2006

providers. ii) After the Morija Leadership Workshop in which historic tensions between the Lesotho Evangelical Church (LEC) and traditional healers had been discussed at some length, some traditional healers were invited to address students at the LEC Seminary as part of what was hoped to be an ongoing dialogue.

In the Community Workshops individual participants expressed a commitment to themselves engage in new and renewed action to build the bophelo of the community. A concrete example of this was seen at the Ha Thamae Workshop where the Roman Catholic participants resolved to start a Support Group in their own congregation.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

122

XVI. Conclusions

The overall conclusion, in the context of Lesotho, is that health and religion are linguistically, culturally and practically inseparable in any consideration of wellbeing. The notion of bophelo, in relation to which we have developed the more technical, generalizable concept of healthworld, reflects the multiple dimensions of well-being and their inseparability. Health interventions by external authorities, whether this means the government, civil society organizations, or international agencies, are likely to be deeply effective and sustainable only if the way in which Basotho healthworlds impact upon behaviour and action are understood well, and recipients of such interventions see that this is the case. A contestation of healthworlds at the formal level, that is, where they function as definable paradigms of health - for example, between biomedical science and traditional healing - is likely to be unproductive. At the same time, the health-seeking behaviour of any one person, family or local community is likely to evidence not so much a contestation of such health paradigms, as a mixing of them, either sequentially (trying one thing, then another) or in a complex way (simultaneous use of different paradigms). Accordingly, translation in linguistic terms (between "religion and health" and "bophelo") implies the need for translation across paradigms of illness, healing, and health.

A second conclusion is that the contribution or religion in the context of health occurs in both tangible and intangible ways. A crucial element of this contribution is the concern with respectful relationships, a vital element of the understanding of health embedded in the Sesotho concept of bophelo. Relationships based on trust and respect are crucial to the provision of health and wellbeing in Lesotho. Thus "compassionate care", infused with "spiritual encouragement" and expressed in "respectful relationships" is perceived to be the most significant contribution of religion to health and wellbeing in Lesotho. Those REs which embody this dynamic, notably the local community support groups, are widely recognized as significant RHAs by the local communities.

Furthermore, access to and utilization of the integrative force of the religio-cultural concept of bophelo, has great potential to unlock inherent Sesotho social capital which integrates religion and health in the struggle for health and wellbeing in Lesotho. Indeed, the main function of the work in Lesotho in relation to the overall research design and report has been to highlight one of the most fundamental, but often seriously neglected, aspects of health provision and policy in Africa, if not elsewhere, which has particular relevance to deeply rooted patterns of choice and behaviour in dealing with the HIV pandemic: namely, the critical role that the healthworld of a person plays in what they do and do not, why they do it or do not, and what must be considered for any successful, sustainable intervention.

Chapter Five

Engaging Religious Health Assets - Conclusions/Recommendations

Bauleni Community Workshop Participants, Lusaka Zambia, 2006

Chapter Five: Engaging Religious Health Assets-Conclusions/Recommendations

We conclude our report, with a set of integrated findings and recommendations for engaging RHAs in the struggle for health and for universal access to HIV/AIDS treatment, care, and prevention. We offer these in three sections: 1) Confirmations, Contradictions, Challenges, 2) Leveraging and Alignment of RHAs, and 3) Respectful Dialogue - A Way Forward.

XVII. Confirmations, Contradictions, Challenges

In April, May, and July 2006, members of ARHAP's interdisciplinary Research Teams met in three plenary workshops to review the study data and to synthesize findings across the multiple dimensions of the study. The teams also sought a "first round" of input and review from several members of the larger ARHAP network of colleagues. Our conclusions and recommendations represent an initial look at the study results; we anticipate opportunities for further integration and synthesis of the findings and vetting/dissemination to wider audiences.

Given the 25-year trajectory of the HIV/AIDS pandemic, our findings rest on a considerable body of research and practice. However, we hope that our focus and approach have yielded new observations and perspectives that will ultimately be of value to those living and working in the struggle against HIV/AIDS. We synthesize our findings in this section, noting those that:

- **Confirm** previous studies, current knowledge and/or conventional wisdom,
- **Contradict** the same,
- **Challenge** us with new insights, challenges, opportunities, and issues for further research.

> **1. Religion is ubiquitous in Zambia and Lesotho, yet often hidden from Western view. Given this, an engagement with religiously informed healthworlds is vital for the shaping of public health policy in Africa**

Study findings support our fundamental hypothesis that religion is ubiquitous in our study sites in Zambia and Lesotho, and we further postulate, in sub-Saharan Africa. In the declared Christian nation of Zambia, previous studies have found that 95% of Zambians identify themselves as affiliated with a major religion, 85% of them with Christian denominations. In Lesotho, Traditional Basotho and Christian traditions have been intertwined in a dynamic and complex interaction over the past 175 years. In our study ordinary Zambians perceived religious entities to be the most significant social institution contributing to community health and wellbeing, while in Lesotho the world of "bophelo" suffuses everyday life.

Yet despite this ubiquity, religion and religious expression in the African context are often hidden from Western view, and, therefore, health leaders, policies, and systems do not take religion fully into account in the global struggle for universal access for HIV/AIDS and other urgent health measures. One of our researchers has noted that "like housework in the economy…which is absolutely foundational to economic life yet almost never shows up in standard economic analyses or scholarly debate…religion is so overwhelmingly significant in the African search for wellbeing…so deeply woven in the rhythms of

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

124

everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives."[72]

We are conscious that both Lesotho and Zambia are countries in which Christianity is dominant. We have sought to be attentive to African Traditional Religions and have worked with Traditional Health Practitioners as religious entities. Where it has been possible, we have worked with participants from the Muslim, Hindu and Baha'i faiths. However, we recognize that further research in non-Christian contexts is necessary. While we would anticipate variation in the forms and structures of religion, the wider literature and our experience on the ground would lead us to expect a similar ubiquity and social significance in other contexts.

The combined study approach, employing both Participatory Engagement and GIS mapping, has helped to "make the invisible visible" - the tangible and intangible assets, relationships, networks of trust, religious factors - to a broader range of audiences. We are not suggesting that public health practitioners must themselves be religious or that to engage with these assets they need to be "believers" in one of the multitude of religious expressions found in Africa. What we are suggesting is that if they are to take seriously the on-the-ground key factors that have a significant impact upon people's perceptions of health and wellbeing, then there needs to be a greater willingness to seriously engage with this religiously informed healthworld. It is clear that the concept of health promotion is one that is inherently linked to the notion of healthworld and without a greater appreciation of the assets held by religious entities in Africa, health promotion is likely to be a contested part of the HIV/AIDS continuum.

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2. Religion, health, and well-being are locally and contextually driven

Our study confirms that religion, health, and well-being are contextually driven, and that local context is most significant. Ordinary Zambians and Basotho perceive their daily struggle for health and well-being and their response to HIV/AIDS in the overall context of a daily struggle for survival - marked by extreme poverty, weak public health capacity, and serious environmental challenges - and most significantly by factors in their local communities. Similarly, their religious belief systems and practices are locally contextually driven. There is a rich variety of religious expression, as evidenced by the diversity of participants and religious entities included here and by the underlying influence of African traditional beliefs and healing practices. For those seeking to engage, religion cannot be viewed as a single, simple cultural "variable" - no "one size fits all."

Our study demonstrates significant and important differences in context at all levels - country to country, region to region, community to community - spanning language, culture, environment, religious interplay, health indicators - all important to the accessibility, affordability, and acceptability of HIV/AIDS treatment, care, and prevention strategies. Our findings reinforce previous recommendations that health policies, interventions, and resource allocation be driven by local strategies and that local assets and agency be appreciated and strengthened. Furthermore, in the dialogue between religion and health this means that just as there is no such thing as "health" other than health for particular people in a particular context, so there is no such thing as "religion" other than a particular religious expression by particular people in a particular context.

Religious landscape and motivations are complex and must be appreciated and understood. Alignment with public policy requires one to deal with these assets in many different ways; effective engagement is not a

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[72] S. de Gruchy, "Like Housework in the Economy, the Hidden Ubiquity of Religion in African Well-Being", Presentation (Atlanta: Religion and Health Connection, Rollins School of Public Health, Emory University, February 21, 2006).

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

125

matter of "business as usual." As one of our researchers put it: "You can't talk to one bishop and think you've dealt with the whole religious community." Another added, "If you are in Zambia, you must go through the pastor; if you are in Lesotho, you must go through the chief." These contextual realities have significant implications for mass scaleup of HIV/AIDS and other health interventions and for replicability of research and programmatic approaches and strategies.

Our study sought to engage religious leaders and organizations across the religious spectrum in each country through purposive sampling and extensive engagement and networking at all levels. As we have noted, we were not successful in engaging *all* religious traditions in each instance, though we were able to bring together a range of leaders and ordinary citizens in each setting - some for the first time - who participated fully in the PIRHANA process and often joined together to form local task forces for continued work. We believe that the PIRHANA tool and our overall approach and methods are replicable in a variety of religious settings, with proper adaptation and, most importantly, facilitator training in the understanding and appreciation of religious tenets and "protocols."

A challenge and opportunity for the future is adaptation to other African contexts, including Islamic environments, and to regions beyond Africa.

3. Religious involvement in health and HIV/AIDS is increasing, and religious entities have expressed a strong local commitment and desire to be more effective in the area of HIV/AIDS

In Zambia and Lesotho, ordinary citizens and religious and health leaders recognize a significant shift in the involvement of religious entities in health and HIV/AIDS, especially over the past 5 years. This finding both confirms and contradicts current perceptions and presents opportunities and challenges for effective engagement.

Our study documents a proliferation of religious entities working in the areas of health and HIV/AIDS over the past decade, with a rapid acceleration since the year 2000; involvement has been prompted by a combination of 1) external and 2) internal driving forces. These include: 1) the worsening pandemic; changing health policies surrounding ARV therapy; advances in HIV/AIDS rapid testing and other new technologies; and a significant increase in donor funding as well as 2) gripping needs at the local level; increased impact and demand on congregations and clergy, especially in the care of families, orphans, and vulnerable children; breaking of silence by many religious leaders around issues of stigma and discrimination; disclosure of HIV/AIDS status by clergy and other religious leaders and encouragement for living positively with HIV/AIDS; increasing linkage of religious leaders worldwide and new uses of mass communication and networking.

The variety, scope and scale of religious entities involved in health and HIV/AIDS is evident from our extensive GIS mapping database and our detailed new schema of organizational categories and types. The religious community spans multiple sectors and levels - from local congregations, traditional healers, and support groups in the remote Lesotho mountains of Thaba Tseka to national health-care providers in Zambia and a broad range of primary to post-tertiary educational systems, mass media, international development agencies, new faith-based NGOs, and various linking, intermediary, and connecting bodies.

We hypothesized that RHAs have a public impact on health, well beyond health services. Our study demonstrates a wide variety of health and HIV/AIDS-specific activities, blending the independent perspectives of Workshop participants and reports from GIS mapping and field interviews; 84% of religious

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho

126

organizations with profile data were engaged in HIV/AIDS work, spanning the spectrum of 22 subcategories of Prevention, Care and Support, Treatment, and Linking activities. Of special note were the consistently high participant ratings of the perceived quality and accessibility of religious hospitals, schools, support groups, and linking organizations in these contexts. These ratings seem to reflect a complex understanding of objective quality as well as contextual qualities including dignity, respect, and linguistic and cultural competence.

Our research also identified an extremely strong desire to use these religious health assets in the area of HIV/AIDS., an example of our double meaning of asset appreciation - assets that are appreciated and those that increase in value. It is clear that there is great benefit in undertaking further research and study to appreciate and enhance the potential of these entities and their RHAs and to produce better alignment between religious and public health structures.

> **4. Religious entities are perceived as contributing to health, well-being, and the struggle against HIV/AIDS in both tangible and intangible ways, and it is this combination that distinguishes them and gives them strength**

Our study provides new evidence that the contribution of religion to health and to HIV/AIDS indeed comprises both tangible and intangible factors and that it is the unique interplay that distinguishes the contribution of religious entities and gives them strength. Previous studies that have focused primarily on the tangible contributions of religion to health, such as religious health provision or material support, as well as those that have examined intangible factors such as prayer on *individual* health outcomes have not documented this complex interplay.

In both Zambia and Lesotho we found a set of three *intangible* ways in which religion is perceived to contribute to health and wellbeing. We have identified these as Spiritual Encouragement, Moral Formation and Knowledge Giving. Furthermore, in both Zambia and Lesotho we have found a set of three *tangible* ways in which religion is perceived to contribute to health and wellbeing. We have identified these as Compassionate Care, Material Support and Curative Interventions. In both Zambia and Lesotho "Spiritual Encouragement" is perceived by far to be the strongest contribution of religion to health and wellbeing. This term includes such factors as hope, faith, prayer, and trust and builds resilience and inner strength to deal with the health crisis in which people find themselves. "Compassionate Care" is perceived in both Zambia and Lesotho to be the second most important contribution of religion to health and wellbeing.

When focusing on Religious Entities (REs) we have found that it is their ability to integrate these tangible and intangible factors that gives them "strength". It is perceived that to make a contribution to health and wellbeing, "spiritual encouragement" needs to find an expression in "Compassionate Care", but likewise, such caring outside of a "spiritual" framework loses its strength. Thus, in Zambia, church-initiated home-based care groups are seen as the most important REs contributing to health and wellbeing, while in Lesotho it is community-based support groups - with a strong religious flavor - which are significant.

In Lesotho, characterized by the Bophelo healthworld, which understands religion, health and wellbeing in a relational context, we noted a further factor that religion contributes to health and wellbeing, namely, "respectful relationships". This is both a tangible and intangible factor and a reminder that when the tangible and intangible are working together, religion is at its "strongest". Furthermore, in Lesotho we noted that once we translate the terms "religion" and "health" into Sesotho, we move out of the categories implicit in English into a more fluid spectrum in which religion is seen to permeate all of life, to build the relationships that are

essential for wellbeing, and to provide a sense of integration and coherence. Thus, for example, we noted that a wide range of "secular" entities in the community are understood by Basotho to have a "religious" nature.

Such findings uncover deep differences in language, vocabulary, concepts and frameworks that sometimes hamper discourse and obscure common ground. The fundamental terms "prevention," "treatment," "care and support" as well as "spiritual encouragement, knowledge giving, and moral formation" have very different meanings in religious and public health settings, though they contain, within, many of the same ideas and messages. A key recommendation for the future is the creation of a "shared lexicon" of terms, tools, and methods from both religious and public health disciplines and formal training in "interreligious and public health literacy" for leaders, policy-makers, and practitioners.

One specific area for potential engagement is in the emerging, global dialogue on "Decent Care" now being catalyzed by WHO leadership as a mediating concept. "Decent Care" could engage the findings of this study around "Compassionate Care", "Respectful Relationships" and the integration of tangible and intangible factors, and expand practical strategies beyond the individual and the family to communities living with HIV/AIDS. "Decent Care", if expressed in caring behavior at all levels of social structure from family to nation, would be consistent with the complex understandings of religious health assets found in our study.

> **5. Certain REs are acknowledged as "Exemplars" in the community, and these demonstrate exceptional programmatic, operational, and associative characteristics**

This finding may contradict conventional wisdom that REs lack the skills and capacities found in secular organizations and therefore are more "costly" (in time or material resources) to engage. In addition to the "intangible" religious assets they bring, many "Exemplar" REs also demonstrate a high level of expertise and competence in program management, human resources, financial management, and partnership development on a par with high-performing organizations in the public and private sectors. Their capacity to achieve both efficiencies and innovations that are valued by public health agencies may reflect their capacity to weave together specifically religious assets as well as more commonly recognized skills of resource management.

However, such expertise and competencies are not to be overstated, especially in these times of fragility brought about by HIV/AIDS. The context of the pressures on health systems, especially the exodus of health workers and financing pressures, means that the REs cannot be expected to continue to do the job that they do without substantive support that does not undermine their strengths but gives them strength to go on. Furthermore, this finding should not under any circumstances be read as implying that REs may substitute for state responsibilities and business engagement in the life of the society.

Finally, engagement with REs must not be with an eye to "convert" them to exemplary NGOs and diminish the very intangible dimension that distinguishes their contribution to health. A key opportunity for future research and engagement is deeper examination of the Exemplar REs identified here and of case studies such as the ARHAP Masangane Project, described in Appendix J. The opportunity is not to turn public structures into religious ones or to turn religious structures into public ones, but to gain the benefits of the alignment of their respective strengths for the community. Exemplar REs tend to model this alignment and thus may suggest skills and behaviors that are more generalizable.

African Religious Health Assets Program for the World Health Organization
Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho
128

> **6. An Assets-Based Approach to research and implementation of religion and health initiatives and HIV/AIDS scaleup offers the potential for more rapid, sustainable, and effective capacity-building and action**

While this finding goes well beyond the design and scope of our study, we think it is important to acknowledge that, at its core, our assets-based approach is part of the growing field of appreciative, participatory, community-centered inquiry and development that seeks the building - and revival - of communities based *not* on what they lack - their "needs" - but on what they already have - their "assets, networks, and agency." Such an approach may contradict conventional wisdom which often views religion and religious engagement as a "liability" for health and development, just as it tends to view communities as fraught with liabilities. Religion is not the only community asset that tends to be overlooked by external bodies, but it is a fundamental one. By appreciating religious assets, we may learn to appreciate the other assets held by local communities.

We are not naïve about the role of religion, especially in the struggle against HIV/AIDS and especially in Lesotho and Zambia, nor are we naïve about the danger of romanticizing local experience and knowledge. Rather, we have a keen appreciation for the social realities on the ground and hence recognize the imperative to balance the positive with a clear grasp of the limits and potential negative impact of religious traditions, practices, and influences on the lives of individuals, families, and communities and on global discourse and decision-making regarding HIV/AIDS. A further challenge and opportunity is to more accurately measure the value and impact of an assets-based strategy over time and to determine the societal and economic benefits that might accrue from strengthening and aligning RHAs with public health assets, especially in the most vulnerable communities. Our PIRHANA workshops have already spawned a number of local interfaith and interdisciplinary task forces formed as a result of this study to carry forward the local action plans generated by the participants. These offer a starting point for the next level of engagement.

Building on these findings, we now turn more specifically to the issues of Leveraging RHAs and effective strategies for such alignment with public health systems.

XVIII. Leveraging RHAs and Alignment with Public Health Systems

Describing and locating RHAs and their activities, networks and agency using the tools provided by the PIRHANA and GIS techniques in Zambia and Lesotho is important. This enables us to appreciate these assets and their contribution. We need also, however, to shift the focus to how these assets can appreciate and grow stronger. Thus, asking how these assets may be leveraged for greater alignment with public health systems and greater health outcomes relevant to scaling up a response to HIV and AIDS is the next, vital step. What will allow for such leverage, and what do we mean by leverage and alignment?

At the first level, assets for health held by religious entities remain at rest until they are acted upon, that is, until an agent does something with them. ARHAP's work shows that such agency is widely present, often where other agents, including the state, are not. This is an important finding in itself. It suggests that religious entities have a strategic advantage in many contexts for health promotion and care, hence, some power to accomplish better health outcomes for the populace. This is one understanding of leverage, leverage that may best be exercised through the agency of boundary leaders, as described below.[73]

The ARHAP work also shows, with some exceptions, that this first level of leverage by religious entities occurs in many contexts with weak, or no, alignment with public health systems. Moreover, the potential of

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[73] See G. Gunderson, *Boundary Leaders: Leadership Skills for People of Faith,* (Minneapolis: Augsburg Fortress, 2004).

health assets held by religious entities could be realized to a significantly greater degree were there better ways of aligning public resources and programs with them. Most REs and their leaders were knowledgeable about public and secular health structures, but the public structures were often not conscious of the significance of these relationships. Leaders of REs often displayed the agency needed to gain access to some of the benefits of relationship with public systems, but the public systems often failed to appreciate the potential gains to be had from a systematic alignment of their respective strengths. Thus, both leaders - public and religious fail to gain the leverage that could be found in systematic alignment. This alignment requires leadership agents with skills that allow them to appreciate and negotiate with systems beyond their traditional boundaries of control. We call this type of agency, boundary leadership. Like other aspects of RHAs, it is already present in the social systems at every level, but often unappreciated, even by those who may have the skills. A number of the "Exemplar" RHAs noted in this study exhibited this kind of leadership.

At a second level, leverage has to do with how one strategically enhances the contribution of RHAs in three directions: 1) helping religious entities realize their potential more effectively; 2) encouraging the replication of "promising practices" among religious entities; and, 3) promoting meaningful ties between such religious entities and public health services in strengthening health systems. The work of ARHAP shows, with adequate sensitivity to the nature of RHAs and religious entities in particular and to the way in which religious discourses function to motivate and mobilize people, that such leverage is possible. The Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) represents one example of a body that is both an outcome of such leverage and a mechanism for further leverage. At the same time, not all conditions are equally favourable to the leveraging of health assets. This will depend, among other things, on at least two factors: 1) the type of regime that governs the nation-state within which the work is done; and 2) the extent to which mediating agents are part of the equation.

RHAs are more likely to bypass state institutions "where government capacity is weak, particularly in some of the poorest sub-Saharan African societies, where local government has almost disintegrated under structural adjustment."[74] At the same time, they cannot replace the state, nor should they, in the sense of substituting for its responsibilities. Many NGOs often lack broader structures of accountability, and they tend to have short lives, both of which affect credibility and sustainability. In this respect, the more enduring character of RHAs, *if* they are rooted in enduring traditions to which local people are also committed and linked to translocal parent or partner organizations and institutions, is a important asset. Mediation is an empowering action to the extent that it helps create, manage and sustain important links to donors, partners and government agencies where these are necessary for the life and work of the local agent. In terms of social capital theory, mediation in this sense is the work of networking connected bodies and simultaneously bridging social holes between otherwise disconnected bodies[75] - of establishing, strengthening and extending ties that carry knowledge, resources and finance relevant to the local agent - for comparative advantage.

One finding from ARHAP's work, both in the WHO study and its recently completed Masangane Case Study (Appendix J), is that mediation together with the role of mediating agents or boundary leaders, is crucial to sustainable activities for many religious entities working in health. Further, many religious entities "naturally" enter into mediating relationships through their denominational, confessional or international religious partners, who frequently offer support of all kinds and access to resources. Where strong mediating agents are present, the entity tends to be strong and able to expand its activities sustainably; where they are

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[74] W. Campbell, *The Potential for Donor Mediation in NGO-State Relations: An Ethiopian Case Study*, (Brighton: Institute of Development Studies, 1996), 9.
[75] R.S. Burt, "Social Holes Versus Network Closure as Social Capital", in *Social Capital: Theory and Research*, edited by N. Lin, K. Cook and R.S. Burt, (New York: Aldine de Gruyter, 2001), 31-56.

absent, sustainability is much less likely. Mediation, therefore, is a crucial aspect of leverage, if one wants to scale up and sustain the work of religious entities in health.

In our research we identified a number of important network hubs that acted as mediating agencies. In Zambia participants pointed to organisations like CHAZ, ZINGO, and denominational structures such as the UCZ and Catholic Church as providing such mediation. In Lesotho, entities such as CHAL, World Vision and Scott Hospital played such a role. At the same time, we noted that in Lesotho there is little role played by non-religious entities in aligning the assets of REs apart from the formal CHAL-Ministry of Health connection. In Zambia, however, we noted how non-religious organisations play an important mediating role. In Zambia the District AIDS Task Forces included many REs and provided a clear example of how RHAs could be leveraged into alignment with public health systems.

The organization CHEP (The Copperbelt Health Education Project) is a good example of a secular mediating agency that is assisting FBOs and CBOs in exemplary fashion.[76] With respect to mediation, CHEP operates on the assumptions that CBOs do not have, and never will have, all the capacities necessary for sustainable health interventions, that it can play the role both of strengthening their own capacity on the ground through long-term accompaniment, that it can offer access to the funds and other partnering resources of national and international agents (such as donors), that it can act as brokers - in effect, in situ auditors and comptrollers - of funds, and that in this way it mediates sustainable engagements between local agents engaged in health work and translocal agencies interested in supporting such work. In our view, a replication of a model of mediation such as this is vital to scaling up the potential contribution of locally rooted and effective RHAs or religious entities in general in a sustainable manner. It is the institutionalization of the best of social capital bridging possibilities.

XIX. Respectful Dialogue - A Way Forward

Our broader work in ARHAP and the findings of this particular research project have reinforced our belief that religious leaders and public health practitioners have a responsibility to engage in respectful dialogue. The commitments of the best of religious imagination and of public health policy are to a world in which health and wellbeing are the experience of all, particularly those living on the margins of society, and today this means those infected and affected by HIV/AIDS. This dialogue is therefore essential, not for the sake of polite conversation, but for the sake of decency, universal access and the development of communities.

It is clear that there have been tensions around religion and public health, especially when it comes to HIV/AIDS and matters to do with sexuality, condoms and stigma. The findings of this research suggest that this tension is part of the past, and that the sheer human impact of the pandemic is drawing religious entities into new and significant contributions to health and wellbeing. Indeed, our confidence in respectful dialogue is strong given that in Zambia and Lesotho we have uncovered a large and diverse range of religious people and organizations who are doing significant work, and who are committed to partnering with health practitioners in the struggle for health and wellbeing.

What is clear, however, is that this dialogue needs to be undertaken in a way that is respectful of all partners, and this does mean dealing with the suspicions on both sides. Given the way in which religion and health are intertwined in Africa, public health practitioners need to ask: "How can we expect to understand and help people if we miss the very thing that *they* consider to be the most important thing in their lives even if it may not be so in our own?" At the same time, religious leaders need to ask: "How can we expect to make a real

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[76] See <www.chep.org.zm >

difference in the health and wellbeing of our communities, if we do not draw on the wisdom and experience of those dedicated to and trained in these fields?" A mutual appreciation of the assets held by both the religious and public health sectors is necessary.

Appreciating Assets: Recommendations

In concluding this report, Appreciating Assets, we offer the following set of recommendations for all audiences interested in this work in a spirit of respectful dialogue:

1. Develop religious and public health literacy

Given the need for dialogue, it is crucial that as a first step religious leaders in Africa gain a basic level of public health "literacy", and that public health practitioners gain a basic level of religious "literacy". To this end we recommend that key agencies such as the World Health Organization:

- Invest in the development of formal courses and experiences to build religious/interreligious and public health literacy for the full range of leaders, policy makers, scholars, and practitioners working in the fields of religion, public health, and HIV/AIDS, and especially for those working at the intersection of all three.
- Develop and make available a "shared lexicon" and "knowledge base" of terms, tools, methods, and results drawn from interreligious and public health disciplines, beginning with the definitions and schemas presented in this report.
- Provide joint training and orientation for religious and public health workers already in the field and for those to be newly deployed.

2. Engender respectful engagement

Our findings make clear that "religion" is perceived by ordinary people to be extremely significant in the struggle for health and wellbeing in African communities. At the same time this "religion" only exists as specific religious commitments and practices in specific contexts. To take forward respectful dialogue means to engender respectful engagement. To do this we recommend that key actors in public health and religion:

- Build on local wisdom, context, and commitment and develop more formal ties to the individuals and organizations, such as those participating in this study and similar groups found in other nations and social contexts. The expansion of the PIRHANA tool to include local community engagement in community health issues from a religious perspective has great promise, given the positive impact experienced by those who participated in this field investigation.
- Develop a new approach to engage with religious and health leaders, academics, policy- and decision-makers, potentially based on an "Executive Sessions" model (see Hauser Center http://www.ksghauser.harvard.edu/) that allows for long-term engagement and collaborative policy development.

3. Align religious and health systems, beginning with tangible assets

Our research has found a great deal of public health activity being undertaken by Religious Entities that is not always effectively aligned with public health systems. To strengthen this alignment we recommend that key religion and public health actors:

- Use Health Mapping in strategic ways to recognize the assets on the ground and their potential connections.
- Strengthen local community "Support Groups" working in the field of health and wellbeing, and link them to public health structures, including neighboring hospitals, clinics, dispensaries, and laboratories.
- Support the replication of "Network Hubs" to leverage existing RHAs and develop and nurture additional ones.
- Further link to the Exemplar REs such as those identified in this study to understand "promising practices" and implications for adaptation to other settings.

4. Conduct further collaborative research

The interdisciplinary nature of this research project and the nature of the findings suggest that the alignment of religious health assets and public health systems in Africa requires ongoing research and reflection. In particular, this calls for further research to:

- Extend Participatory Religious Health Assets Mapping to other African countries and other regions of the world and in particular in settings where Christianity is not the dominant religious tradition.
- Explore the link between "Compassionate Care", "Respectful Relationships" and "Decent Care" and their extension to the Community level
- Further study the Exemplar Religious Entities and Existing Case Studies to determine "Promising Practices" and Effective Strategies for Alignment
- Explore specific areas in which exemplar REs are vulnerable in the context of health systems that are fragile, and develop specific strategies to obviate the vulnerabilities so that the REs maximize their potential and are not undermined by demands and expectations that far exceed their capacity to act and to do.
- Engage in further study of what have been identified as "intangible" religious health assets and how public structures can relate to them in a respectful way.
- Explore further the "healthworlds" found in Africa and the impact that religio-cultural frameworks have upon the way in which people conceive of health and wellbeing and undertake health-seeking agency.

In drawing this research project and report to a close we emphasize yet again the importance of respectful dialogue. In conclusion, our aim has not been to force a single perspective or overly simplistic view on the deeply textured study results but rather to present the full complexity of issues and findings, with a desire to build greater understanding, communication, and engagement.

The research theory guiding this project emphasizes the importance of appreciating local wisdom, practice, and perceptions. We believe that the depth of the findings and the goodwill generated by this process more than justifies this approach. Furthermore, the methods have drawn from participatory research that seeks always to integrate research with action. The proof of the effectiveness of the research process and findings will be in transformed practice. In Lesotho and Zambia and throughout southern Africa, the methods have drawn from participatory research that seeks always to integrate research with action, and the impact of this project and report needs to be found at the level of transformed practice. In our context in which the HIV/ AIDS pandemic is a major human tragedy. It is incumbent upon religious and public health leaders to undertake respectful dialogue and mutual engagement to make a difference.

APPENDIX A: Acronyms and Glossary

ACRONYMS

AfDF	African Development Fund
AIDS	acquired immune deficiency syndrome
ACER	ARV Community Education and Referral
ARHAP	African Religious Health Assets Program
ART	antiretroviral therapy
ARV	antiretroviral treatment
CCIH	Christian Connections for International Health
CBO	community-based organization
CCZ	Council of Churches in Zambia
CDC	Centers for Disease Control and Prevention
CHAL	Christian Health Association of Lesotho
CHAZ	Churches Health Association of Zambia
CHEP	Copperbelt Health Education Project
CHW	community health worker
CSG	community support group
DAPP	Development Aid from People to People
DATF	District AIDS Task Force
DFID	Department for International Development
DOT	directly observed therapy
EC	European Commission
ECZ	Evangelical Church in Zambia
EFZ	Evangelical Fellowship of Zambia
ESAF	Enhanced Structural Adjustment Facility
FBO/I	faith-based organization or initiative
GIS	geographic information systems
GIT/S	geographic information technologies and systems
GPS	global positioning system
HBC	home-based care
HSA	health service area (Lesotho)
IDA	International Development Association (World Bank)
IHP	Interfaith Health Program
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
LCD	Lesotho Congress of Democrats
LEC	Lesotho Evangelical Church
LENEPWA	Lesotho Network of Persons Living with HIV
MMD	Movement for Multiparty Democracy
MOH	Ministry of Health
MRC	Medical Research Council
MTCT	mother-to-child transmission
NAC	National AIDS Commission
NAPCP	National AIDS Prevention and Control Program
NGO	non-governmental organization
NZP+	Network of Zambian People Living with HIV/AIDS
ODA	Official Development Assistance
OVC	orphans and vulnerable children

P/GIS	participatory geographic information systems
PIRHANA	Participatory Inquiry into Religious Health Assets, Networks, and Agency
PE	partner entity
PEPFAR	President's Emergency Plan for AIDS Relief
PhRMA	Pharmaceutical Research and Manufacturers of America
PLWHA	person living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RCC	Roman Catholic Church
RCZ	Reformed Church in Zambia
RE	religious entity
RHA	religious health asset
SADC	South African Development Community
SAF	Structural Adjustment Facility
SAM	Service Availability Mapping
STD	sexually transmitted disease
STI	sexually transmitted infection
SDA	Seventh-day Adventist
TALC	Treatment Advocacy and Literacy Campaign
TB	tuberculosis
TBN	Trinity Broadcast Network
THPAZ	Traditional Health Practitioners Association of Zambia
UCT	University of Cape Town
UCZ	United Church of Zambia
UKZN	University of KwaZulu Natal
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIP	United National Independence Party
VCT	voluntary counselling and testing
WCC	World Council of Churches
WFP	United Nations World Food Programme
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System
WITS	University of the Witwatersrand
ZANARA	Zambia National Response to HIV/AIDS
ZINGO	Zambian Inter-Faith Networking Group
ZNP+	Network of People Living with HIV/AIDS in Zambia

GLOSSARY[1]

acquired immune deficiency syndrome (AIDS)
A group of illnesses resulting from an immune system weakened after years of battling HIV.

adherence
Closely following (adhering to) a prescribed treatment regimen. This includes taking the correct dose of a drug at the correct time, exactly as prescribed. Failure to adhere to an anti-HIV treatment regimen can lead to virologic failure and drug resistance.

African Religious Health Assets Program (ARHAP)
An international research collaboration working at the interface between religion and public health.

agency
The capacity to "do", to move into action, to utilize the resting assets one holds, to seek and achieve desired goals, as affected by social and environmental conditions.

alignment
In this report used to signify the drawing together of religious and public health systems for better mutual articulation of their respective strengths and, hence, for more effective health interventions.

antiretroviral treatment (ARV)
A medication that interferes with the ability of a retrovirus (such as HIV) to make more copies of itself.

antiretroviral therapy (ART), rollout, scaleup
For the purposes of this report, antiretroviral therapy is used to mean the provision of antiretroviral drugs (ARVs) for HIV/AIDS; however, the terms "rollout" and "scaleup" also encompass the range of accompanying clinical and support services linked to the provision of medicines, such as treatment literacy, nutrition support, laboratory monitoring, and adherence support. In this sense, ART rollout or scaleup is seen as a comprehensive program spanning issues of diagnosis, treatment, care, support, and prevention of transmission

appreciative inquiry approach
Our research attitude is one of respect for the insights and perspectives of ordinary people, community and religious leaders, and health workers, and in doing this we draw from the approach of appreciative inquiry

assets
Assets refer to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation.

assets-based approach
An assets-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than as having deficits, which hamper their development.

bophelo
A Sesotho word, bophelo has a rich lexical range. Its meanings range from biological life (of humans, animals and plants) to the social life of individuals, families, villages and nations. Religion and health are an integral and integrated dimension of the social dimension of bophelo.

CD4 cell count
A measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS.

church
Aware of the problematic elements (especially in inter-religious writing), this term has been used as sparingly as possible. However, in the context of this report, the term has occasionally been used to indicate Christian denominational structures at a regional/ national/international level. For example, a localized gathering of congregations of the same nature would be a church – or in terms of such denominational structure as "The Catholic church" or "The Anglican church".

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[1] The definitions given here apply to terms as used in this publication; they are not necessarily applicable in other contexts

community-based organization (CBO)
Generally, a service organization that provides social services to local clients.

community health workers (CHW)
A general term referring to a peer educator, outreach worker, community health advisor, lay health worker, volunteer, community health representative, or promotora. Community health workers are often selected from the intended audience and thus serve as a bridge between a community and its available health care services. By training local people, the community is empowered to act toward its own health promotion.

community support group (CSG)
This term applies in particular to Lesotho where community support groups of a particular nature were identified. In communities where access to healthcare services and facilities is beyond the financial reach of ordinary Basotho there has been a dramatic upsurge of local community support groups. Self-initiated, deeply religious, though not formally linked to any religious structure, they are identified as an important health provider in these communities.

complementary and alternative medicine (CAM)
Therapies are termed as complementary when used in addition to conventional treatments and as alternative when used instead of conventional treatment.

condom
A latex or natural membrane sheath placed over an erect or partially erect penis for use during intercourse to reduce the risk of disease and unwanted pregnancy. The tip of the condom catches the semen. Condoms are readily available in most countries.

congregation
A locally organized religious or faith-based entity, meeting regularly for specifically religious purposes, whose primary function is the formation of faith. This term is not intended to indicate only Christian groups but is used to signify all such gatherings of any faith.

development studies
The academic discipline which addresses issues of concern to developing nations.

directly observed therapy (DOT)
A treatment strategy in which a health care provider or other observer watches a patient take each dose of a drug. This strategy is used with diseases like tuberculosis (TB) and HIV infection, where adherence is important for effective treatment and to prevent emergence of drug resistance.

effectiveness
The measure of the success of a treatment for a particular disease or condition.

efficacy
The ability of a treatment to produce the desired effect on the disease or condition being treated.

epidemic
A disease that has spread rapidly through a segment of the human population in a given geographic area.

epidemiology
The study of how disease is distributed in population groups and of the factors which influence its distribution.

faith-based organization or initiative (FBO/I)
Faith-based organizations or initiatives are those religious entities that have a more structured nature as well as religious support. This includes initiatives and organizations tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks.

Geographic Information Systems (GIS)
A system of hardware and software used for storage, retrieval, mapping, and analysis of geographic data. This includes spatial features stored in a coordinate, which references a particular place on the earth. Descriptive attributes in tabular form are associated with spatial features. Spatial data and associated attributes in the same coordinate system can then be layered together for mapping and analysis.

grounded theory
Emergent methodology, or theory developed inductively from a corpus of data.

health
The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

health care providers
Individuals who are trained to provide various health services.

HealthMapper
A surveillance, data management and mapping application, developed by WHO and customized specifically for public health users. It aims to address critical surveillance information needs across infectious disease programs at national and global levels.

health system
The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.

healthworld
Neologism for *bophelo* (Sesotho), *impilo* (isiXhosa), *ubumi* (Bemba) and other African linguistic equivalents, but expressed as a concept argued to be of general significance. Refers to peoples' conceptions of health, as framed by the background store of inherited or socialized knowledge that defines their being in the world. A person's healthworld expresses and guides health-seeking behaviour, choices and actions, in respect of illness or dysfunction in health, towards a *telos* of comprehensive well-being. Culturally and linguistically constituted, spiritual and corporeal, it addresses the condition of the whole body - understood as the ecology of the individual body in relation to the social body under particular material conditions - and thus includes the social and environmental determinants of health.

high-risk behaviour
A term used to describe certain activities, like frequent change of sex partners, which increase the risk of transmitting the human immunodeficiency virus. These include anal and vaginal intercourse without a condom, oral-anal contact, semen or urine in the mouth, sharing intravenous needles or syringes, intimate blood contact, and sharing of sex toys contaminated by body fluids. These behaviours are also referred to as "unsafe" activities.

high-risk groups
Those groups in which epidemiological evidence indicates that there is an increased risk of contracting HIV. Highrisk groups include: commercial sex workers, people with promiscuous behavioural patterns, homosexuals, bisexuals, intravenous drug users, haemophiliacs, and the sexual partners of anyone in these groups.

HIV/AIDS
For this report, the term HIV/AIDS will be used to indicate the complete range of stages of infection, sero-conversion and resulting opportunistic infections associated with the pandemic, as well as the cultural, behavioural, political and spiritual factors impacting on the course of the pandemic. While it is acknowledged that HIV and AIDS are different conditions, for the sake of convenience and to remain in line with current conventions the term "HIV/AIDS" will be used instead of "HIV and AIDS". Furthermore, it is also understood that there is not just one epidemic but multiple local and national epidemics with different characteristics and patterns, but at the same time, HIV/AIDS is also a "pandemic" that spans localised and national borders.

immune deficiency
Describes the condition where a person's immune system cannot protect the body, resulting in an increased susceptibility to various infections and cancers.

incidence
The number of new cases in a surveyed population reported over a specified period of time.

intangible religious health assets *(See also tangible religious health assets)*
The volitional, motivational and mobilizing capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behavior and ties. Local knowledge, access, reach, participation, trust and accompaniment are just some of these "intangible" religious health assets.

integrated services
Availability of multiple health services, for instance, family planning and STI treatment, through a single facility or at a single visit.

interdisciplinary
An effort or team that draws on insights, concepts, knowledge, or experience from several disciplines.

knowledge base
A collection of facts, rules, and procedures organized into schemas. The assembly of all the information and knowledge of a specific field of interest.

leverage
First level: moving 'resting' religious health assets through the human agency for health interventions;
Second level: strategically enhancing RHAs to help religious entities realize their potential more effectively, to encourage the replication of promising practices among religious entities, and to promote meaningful ties between such religious entities and public health services in strengthening health systems.

map/mapping
For purposes of this report, we use the terms "map" and "mapping" in the broad sense to mean both the process and result of making visual representations of tangible and/or intangible items and their relationships. Thus, we may use *participatory tools* to *draw out* and *diagram* community perceptions of religious and health entities and their relationships and later employ *GIS tools* to locate these same entities on geographic maps.

mediation
In this context, strategically acting in ways that intercede between local agents and translocal bodies on behalf of local agents for things they cannot do, or can do only with great difficulty themselves.

migration
The movement of people across a specified boundary for the purpose of establishing a new or semipermanent residence.

outpatient
A patient who receives treatment without being hospitalized.

opportunistic infection
Infection that takes advantage of the body's lowered resistance due to the destruction of the immune system by HIV. They may be infections such as toxoplasmosis encephalitis, or cancers such as Kaposi's sarcoma.

palliative care
Medical care that helps to alleviate symptoms of chronic illnesses without offering a cure. Palliative care offers therapies to comfort and support patients with terminal illnesses.

pandemic
Denoting a disease affecting or attacking the population of an extensive region, country or continent; extensively epidemic.

participatory geographical information systems (PGIS)
The adoption of GIS to empower indigenous and local communities through their participation in the data collection, review, and analysis process.

Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA)
The Participatory Inquiry into Religious Health Assets, Networks and Agency, is the primary research toolset developed by ARHAP to assess the contribution of religion and religious entities to health and wellbeing in Africa. It is based on a commitment to participatory inquiry, as well as to the framework of assets and agency described above.

Prevalence
A measure of how common or widespread a disease or infection is in the community or population group at a given period of time. This measure includes existing and new cases.

prevalence rate
The number of cases of a disease existing in a given population at a specific point or period of time.

preventive measures
Measures aimed at stopping the spread of HIV from person to person.

public health
The science and art of promoting health, preventing disease and prolonging life through just and organized efforts of society.

qualitative research methodologies
Approaches and tools used to provide a depth of insight into the meaning of beliefs, perceptions, attitudes and practices within the contexts in which they appear.

religio-cultural
In this report, the term, "religio-cultural" is used as an attempt to capture the fundamental integration of religion and culture in the Sesotho (bophelo) worldview.

religion
A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations.

religious entity (RE)
The term "religious entity" seeks to capture the incredibly broad range of (tangible) RHAs, incorporating religious facilities, organizations as well as practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more traditional religious entities such as faith-based organizations, as well as those more amorphous entities such as individual traditional healers.

religious health asset (RHA)
A religious health asset is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith; particularly we include here those assets typical of African religions.

safe(r) sex
Term currently used when describing sexual activities most likely to reduce the risk of transmission.

Service Availability Mapping (SAM)
Service Availability Mapping (SAM) is a tool developed by WHO to collect and present basic information on health services: health infrastructure, human resources and services offered. Its main application is at the subnational or district level, where district health management teams can use the results of the SAM in conjunction with WHO's HealthMapper application, developed by the Public Health Mapping and GIS program, to map and monitor health services. SAM is made up of a survey methodology, remote field data collection devices, and WHO's HealthMapper application

sub-Saharan Africa
The geographic region of Africa south of the Sahara Desert

tangible religious health assets *(See also intangible religious health assets)*
The more visible and most studied religious health assets, including facilities, personnel, and activities, sometimes resembling those of secular entities. Interwoven with this tangible level, however, are the "intangible" religious health assets described above.

traditional healer
This is a complex typology and is differently constituted in different contexts in Africa. However, for the purposes of this report, we indicate here three types of indigenous health providers, or traditional healers, in Lesotho and Zambia which are constituted by (i) Diviners, (ii) Herbalists and (iii) Zionist/Apostolic healers. Some herbalists distinguish themselves as working solely with herbal remedies. Diviners practice on the basis of engagement with ancestral and spirit forces, and other diviners are also Zionist/Apostolic priests. The three "types" must be understood as operating on a complex continuum.

traditional medicine
Indigenous treatment regimes which manifest themselves in three principal forms: (i) home or folk remedies, (ii) herbalist medicine, and (iii) diviner treatment regimes, or combination of the three. The term traditional medicine embraces all three.

voluntary counselling and testing (VCT)
Counselling prior to HIV test, testing itself, and post-test counselling conducted when results of the test are given to the patient.

APPENDIX B: Zambia and Lesotho Introductory Letters

Sample letters from research introductory- and ethics clearance process in Zambia and Lesotho

Hon. Dr. Motloheloa Phooko   November 9, 2005
Minister of Health & Social Welfare
P0 Box 514
Maseru

Dear Dr. Phooko:

On behalf of the African Religious Health Assets Programme (ARHAP) and our collaborators at Emory University, Atlanta, Georgia, USA, and the Universities of Cape Town (UCT), KwaZulu-Natal (UKZN), and Witwatersrand (WITS), South Africa, we are writing to introduce ourselves and to request your permission to commence work on a new Project Agreement with the World Health Organization (WHO): Assessment and Mapping of Religious Health Assets in Lesotho and Zambia.

This Project seeks to identify, assess and map the health assets of religious organizations that can be mobilized and aligned to address high priority public health issues, with special emphasis on HIV/AIDS treatment, care, and prevention. We are very pleased to have been selected by WHO to conduct this work and most excited to have an opportunity to collaborate with you, the Ministry of Health & Social Welfare, and the WHO Country and Regional Offices.

Lesotho holds a special place in our hearts and minds. Two of our Lesotho Research Team, Mr. Paul Germond, Lead Faculty, and Mr. Sepetla Molapo, Research Director, are native sons of Lesotho, and two others, Ms. Evelyn Vera, and Mr. Frank Dimmock, have lived and served in Lesotho, as faith and health leaders. Other members of the team, including Ms. Tandi Reilly, Student Researcher and Program Coordinator, WITS, Ms. Shirley Butcher, Lecturer in Geospatial Studies, UCT, and Dr. Deborah McFarland and Ms. Debbie Jones, Rollins School of Public Health, Emory University, have visited or spent time here and have a deep interest in and appreciation for Lesotho.

Our new Project grows out of a broader research and capacity-building programme, ARHAP, officially launched in December 2002. It is the aim of ARHAP to establish a multisite "collaborative," beginning in southern Africa, to serve as an international locus for advancing knowledge and understanding of religion and health and fostering sustainable health in all its dimensions, as defined by WHO (we have provided additional information about the programme in the attached documents.) It is our hope that the work in Lesotho and Zambia will catalyze these efforts and that ARHAP will become a truly global initiative.

The Lesotho Research Team is planning to conduct a series of briefings as part of the initial commencement of the project and looks forward to an opportunity to meet with you and others on your staff. We value so much your collaboration and guidance and the opportunity for a continuing and long-term relationship in the work of ARHAP.

Sincerely,

Rev. Paul Germond   Ms. Deborah Jones
Director, Lesotho Research Team   Program Director, ARHAP/Emory

<u>Appendix C: Full Research Team & Acknowledgements</u>

Zambia Research Team: University of KwaZulu Natal
- Prof Steve de Gruchy: *UKZN* (Zambia Research Leader)
- Mr. Sinatra Matimelo: *UKZN* (Researcher)
- Ms. Mary Mwiche: *UKZN* (Researcher)

Lesotho Research Team: University of Witwatersrand
- Rev. Paul Germond: *WITS* (Lesotho Research Leader)
- Mr. Sepetla Molapo: *WITS* (Researcher)
- Ms. Tandi Reilly: *WITS* (Researcher)

University of Cape Town Office
- Prof James Cochrane: *UCT* (Researcher)
- Ms. Jill Olivier: *UCT* (Researcher)
- Ms. Shirley Butcher: *UCT* (Researcher/GIS Consultant)
- Mr. Frank Dimmock: *UCT* (Researcher/GIS Consultant)
- Ms. Barbara Schmid: *UCT* (Researcher)

Emory University Office
- Ms. Deborah L. Jones: *Emory* (Project Director)
- Dr. Gary Gunderson: *Emory* (Principal Investigator)
- Prof Deborah McFarland: *Emory* (Research Advisor)

Vesper Society
- Ms Mary Baich: *Vesper Society* (Consultant/Reviewer)

Research Colleagues (Listed in Alphabetical Order)
- Dr Godfrey Biemba (Executive Director, CHAZ, national assistance*)*
- Rev Michael Bwembya (Chairman DATF, Livingstone, local assistance and GIS)
- Bishop Albert Chama (Kitwe local assistance)
- Mr. Topman Champalama (Copperbelt, local assistance)
- Mr. Nathan Dimmock (Chipata, local assistance and GIS)
- Ms. Stephanie Doan (Emory, Data analysis and technical assistance)
- Ms. Tessa Dooms (Morija, local assistance)
- Dr. Ted Germond (Thaba-Tseka, local assistance)
- Mr. Roy Hamalyang'ombe (Lusaka, local assistance and GIS)
- Mr. Tumelo Lepheane (Morija and Thaba-Tseka, local assistance)
- Mr. Timothy Miyoba (Regional Manager ZINGO, Livingstone, local assistance)
- Mr. Philip Molise (Lesotho national, GIS data capturer)
- Ms. Elizabeth Mukwavi (Bauleni, workshop assistance)
- Mr. Francois Murukezi (Copperbelt, local assistance)
- Ms. Maiya Mwandama (Bauleni, workshop assistance)
- Mr. Abraham Mwanza (Chipata, local assistance and GIS)
- Mr. Justin Mwanza (Chipata, local assistance and GIS)
- Mr Alick Nyerenda (Executive Director CHEP, Kitwe local assistance)
- Ms. Takadzani Rambuda (UCT, GIS technical assistance)

And most especially…

To the many individuals, in Zambia, Lesotho and internationally-located, who lent interest and assistance to this project and, most especially, to the local participants who generously invited us into their communities and homes, and who shared their wisdom with us.

APPENDIX D: Zambia HIV/AIDS Statistics

Data primarily from the following documents:

1. WHO, The World Health Organization Statistical Information System (WHOSIS), 2006, <http://www.who.int/whosis/en> (20 June 2006); WHO, World Health Statistics, 2006 and The World Health Report, 2006 <http://www.who.int> (20 June 2006);
2. UNAIDS, Report on the Global Epidemic (Geneva: UNAIDA, 2006);
3. Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro, Zambia Demographics and Health Survey 2001-2002, (Calverton, Maryland, USA: Central Statistical Office, Central Board of Health and ORC Macro, 2003).
4. Central Statistical Office [Zambia], Zambian Sexual Behaviour Survey, 2005 (Lusaka: Central Statistical Office, MOH, Measure Evaluation, 2005).
5. R. Hakkert and R. Wieringa, "The Republic of Zambia", International Demographics 5, no.5 (May 1986), 1-9.

ZAMBIA: Key Demographic/Socioeconomic/Health Indicators	Value (year)	Rank: WHO African Region (N = 46)	Rank: WHO World-wide (N = 192)
Population Statistics			
Population (in thousands) total	11,668[1]	20	70
Population in urban areas (%)	36.5 (2005)[1]	25	145
Population growth rate (%)	1.7 (2005)[2]		
Life Expectancy			
Life expectancy at birth (years) males	40.0 (2004)[1]	40	186
Life expectancy at birth (years) females	40.0 (2004)[1]	43	190
Healthy life expectancy (HALE) at birth (years) males	34.8 (2002)[1]	39	185
Healthy life expectancy (HALE) at birth (years) females	35.0 (2002)[1]	42	188
Life expectancy at year 1st case of HIV/AIDS reported	50.5 (1984)[5]		
Mortality Rates			
Infant mortality rate (per 1 000 live births)	104.0 (2004)[1]	16	18
Neonatal mortality rate (per 1 000 live births)	40 (2000)[1]	25	34
Maternal mortality ratio (per 100 000 live births)	750 (2000)[1]	24 of 44 Reporting	23 of 169 Reporting
Under-5 mortality rate males (Probability of dying per 1 000 population under five years of age)	190 (2004)[1]	16	18
Under-5 mortality rate females	173 (2004)[1]	15	17
Adult mortality rate males (Probability of dying per 1 000 population between 15 and 60 years)	683 (2004)[1]	5	5
Adult mortality rate females	656 (2004)[1]	5	5
Educational Indicators			
Adult literacy rate (%)	67.9 (2004)[1]	18 of 40	102 of 134
Net primary school enrollment ratio (%) males	69.0 (2003)[1]	25 of 40	142 of 161
Net primary school enrollment ratio (%) females	68.0 (2003)[1]	19 of 40	134 of 161
Economic Indicators			
Gross national income per capita (international $)	450 (2004)[1]	34 of 44	154 of 165
Per capita GDP in international dollars	1,013 (2004)[1]		
Population living on less than $2 US a day (%)	87.4 (2005)[2]		
Total expenditure on health as percentage of gross domestic product	5.2 (2003)[1]	17	115 of 191
Per capita total expenditure on health at international dollar rate	51 (2003)[1]	26	170 of 191

ZAMBIA: Key HIV/AIDS Indicators	Value (year)	Rank: WHO African Region (N = 46)	Rank: WHO World-wide (N = 192)
HIV/AIDS Prevalence Rates			
HIV prevalence among adults aged 15-49 years (%) [Range in 2005 = 15.9 – 18.1]	16.5 (2003)[1] 17.0 (2005)[2]	7	7 of 148
HIV prevalence rate among men aged 15 – 49 years (%)	12.9 (2001)[3]		
HIV prevalence rate among women aged 15 – 49 years (%)	17.8 (2001)[3]		
HIV prevalence rate among men aged 15 – 24 years (%)	3.1 (2001)[3]		
HIV prevalence rate among women aged 15 – 24 years (%)	11.2 (2001)[3]		
HIV prevalence rate – urban areas (%)	23.1 (2001)[3]		
HIV prevalence rate – rural areas (%)	10.8 (2001)[3]		
Estimated Number of People Living with HIV/AIDS [Range]			
All Age Groups [1,100,000 – 1,200,000]	1,100,000 (2005)[2]	NA	NA
Children aged 0 to 14 living with HIV [53,000 – 250,000]	130,000 (2005)[2]	NA	NA
Adults aged 15 and over living with HIV [950,000 – 1,100,000]	1,000,000 (2005)[2]	NA	NA
Women aged 15 and over living with HIV [540,000 – 610 000]	570,000 (2005)[2]	NA	NA
Orphans aged 0 to 17 due to AIDS [630,000 – 830,000]	710,000 (2005)[2]	NA	NA
HIV/AIDS Deaths Per Year			
Deaths due to HIV/AIDS (per 100 000 population per year) [Range in 2005 = 77,000 – 120,000]	89,000 (2003)[1] 98,000 (2005)[2]	8 of 38	7 of 129
Deaths among children under five years of age due to HIV/AIDS (%)	16.1 (2000)[1]	7	7 of 188
HIV/AIDS Counseling and Testing			
Men aged 15 and over who have been tested for HIV/AIDS (%)	11.4 (2005)[4]		
Women aged 15 and over who have been tested for HIV/AIDS (%)	15.3 (2005)[4]		
Antiretroviral Therapy			
People with advanced HIV infection receiving antiretroviral (ARV) combination therapy (%)	26.0 (2005)[1]	16 of 40	90 of 155
Pregnant women receiving treatment to reduce mother-to-child transmission (%)	4.0 (2005)[2]		

ZAMBIA: Key HIV/AIDS Indicators (Continued)	Value (year)	Rank: WHO Countries in Africa Region (N = 46)	Rank: WHO Countries World-wide (N = 192)
Educational Indicators			
School attendance among orphans (%)	73.0 (2005)[2]		
School attendance among non-orphans (%)	78.0 (2005)[2]		
Knowledge/Attitude Indicators			
Men aged 15 – 49 who know 3 "ABCs" of HIV prevention (%)	76.0 (2005)[4]		
Women aged 15 – 49 who know 3 "ABCs" of HIV prevention (%)	73.0 (2005)[4]		
Young men aged 15 – 24 with comprehensive knowledge of HIV/AIDS (%) (includes knowledge of transmission/rejection of misconceptions)	46.1 (2005)[4]		
Young women aged 15 – 24 with comprehensive knowledge (%)	40.5 (2005)[4]		
Men aged 15 – 49 with knowledge of mother-to-child transmission (%) (includes	31.4 (2005)[4]		

knowledge of preventive drug therapy *and* transmission via breastfeeding)			
Women aged 15 – 49 with knowledge of mother-to-child transmission (%)	37.2 (2005)[4]		
Men aged 15 – 49 who express specific accepting attitudes toward people with HIV (%; range)	33.7 – 90.7 (2005)[4]		
Women aged 15 – 49 who express specific accepting attitudes toward people with HIV (%; range)	30.8 – 91.3 (2005)[4]		
Behavioral Indicators			
Young men aged 15 to 24, median age at first sex	18.5 (2005)[4]		
Young women aged 15 to 24, median age at first sex	18.5 (2005)[4]		
Young men aged 15 to 24 who had sex with casual partner in past 12 months (%)	86.0 (2005)[2]		
Young women aged 15 to 24 who had sex with casual partner in past 12 months (%)	30.0 (2005)[2]		
Young men aged 15 to 24 who used condom last time they had sex with casual partner (%)	40.0 (2005)[2]		
Young women aged 15 to 24 who used condom last time they had sex with casual partner (%)	35.0 (2005)[2]		
Economic/Policy Indicators			
Policy on information, education, communication and prevention for most-at-risk populations?	Yes (2005)[2]		
Policy to expand access to essential preventive commodities among most-at-risk populations?	Yes (2005)[2]		

APPENDIX E: Lesotho HIV/AIDS Statistics

Data primarily from the following documents:

1. WHO, The World Health Organization Statistical Information System (WHOSIS), 2006,
    <http://www.who.int/whosis/en> (20 June 2006); See also WHO, World Health Statistics, 2006 and The World
    Health Report, 2006 <http://www.who.int> (20 June 2006)
2. UNAIDS, Report on the Global Epidemic (Geneva: UNAIDA, 2006);
3. Ministry of Health and Social Welfare [Lesotho] and ORC Macro, Lesotho Demographics and Health Survey 2004-
    2005, (Calverton, Maryland, USA: Lesotho Bureau of Statistics and ORC Macro, 2005).
4. Ministry of Health and Social Welfare [Lesotho], Lesotho National HIV/AIDS Strategic Plan 2006-2011, (Maseru,
    Lesotho: Ministry of Health and Social Welfare, 2006).
5. Ministry of Health and Social Welfare [Lesotho], Know Your Status Campaign National Operation Plan 2006-2007,
    (Maseru, Lesotho: Ministry of Health and Social Welfare, 2006).

LESOTHO: Key Demographic/Socioeconomic/Health Indicators	Value (year)	Rank: WHO Countries in Africa Region (N = 46)	Rank: WHO Countries World-wide (N = 192)
Population Statistics			
Population (in thousands) total	1,795 (2005)[1]	35	142
Population in urban areas (%)	18.2 (2005)[1]	42	183
Population growth rate (%)	0.1 (2005)[2]		
Life Expectancy			
Life expectancy at birth (years) males	39.0 (2004)[1]	41	187
Life expectancy at birth (years) females	44.0 (2004)[1]	36	181
Healthy life expectancy (HALE) at birth (years) males	29.6 (2002)[1]	45	191
Healthy life expectancy (HALE) at birth (years) females	33.2 (2002)[1]	45	191
Life expectancy at year 1st case of HIV/AIDS reported	55.0 (1986)[3]	NA	NA
Mortality Rates			
Infant mortality rate (per 1 000 live births)	55.0 (2004)[1]	38	61
Neonatal mortality rate (per 1 000 live births)	28 (2000)[1]	38	61
Maternal mortality ratio (per 100 000 live births)	550 (2000)[1]	31 of 44 Reporting	40 of 169 Reporting
Under-5 mortality rate males (Probability of dying per 1 000 population under five years of age)	87 (2004)[1]	39	55
Under-5 mortality rate females	76 (2004)[1]	38	56
Adult mortality rate males (Probability of dying per 1 000 population between 15 and 60 years)	845 (2004)[1]	2	2
Adult mortality rate females	728 (2004)[1]	4	4
Educational Indicators			
Adult literacy rate (%)	81.4 (2004)[1]	8 of 40	79 of 134
Net primary school enrollment ratio (%) males	83.0 (2003)[1]	10 of 40	117 of 161
Net primary school enrollment ratio (%) females	89.0 (2003)[1]	7 of 40	89 of 161
Economic Indicators			
Gross national income per capita (international $)	740 (2004)[1]	11 of 44	110 of 165
Per capita GDP in international dollars	3,210 (2004)[1]	13 of 44	120 of 165
Population living on less than $2 US a day (%)	56.1 (2005)[2]		
Total expenditure on health as percentage of gross domestic product	5.2 (2003)[1]	18	122 of 191
Per capita total expenditure on health at international dollar rate	106 (2003)[1]	12	140 of 191

LESOTHO: Key HIV/AIDS Indicators	Value (year)	Rank: WHO Countries in Africa Region (N = 46)	Rank: WHO Countries World-wide (N = 192)
HIV/AIDS Prevalence Rates			
HIV prevalence among adults aged 15-49 years (%) [Range in 2005 = 21.9 – 24.7%]	28.9 (2003)[1] 23.2 (2005)[2]	3	3 of 148
HIV prevalence rate among men aged 15 – 49 years (%)	20.3 (2005)[3]		
HIV prevalence rate among women aged 15 – 49 years (%)	25.7 (2005)[3]		
HIV prevalence rate among men aged 15 – 24 years (%)	6.0 (2005)[3]		
HIV prevalence rate among women aged 15 – 24 years (%)	14.0 (2005)[3]		
HIV prevalence rate – urban areas (%)	28.8 (2005)[3]		
HIV prevalence rate – rural areas (%)	21.8 (2005)[3]		
Estimated Number of People Living with HIV/AIDS [Range]			
All Age Groups [250 000 – 320 000[3]]	270,000 (2005)[2]	NA	NA
Children aged 0 to 14 living with HIV [6900 – 34 000]	18,000 (2005)[2]	NA	NA
Adults aged 15 and over living with HIV [240 000 – 270 000]	250,000 (2005)[2]	NA	NA
Women aged 15 and over living with HIV [140 000 – 160 000]	150,000 (2005)[2]	NA	NA
Orphans aged 0 to 17 due to AIDS [88 000 – 110 000]	97,000 (2005)[2]	NA	NA
HIV/AIDS Deaths Per Year			
Deaths due to HIV/AIDS (per 100 000 population per year) [Range in 2005 = 20,000 – 27,000]	29,000 (2003)[1] 23,000 (2005)[2]	4 of 38	3 of 129
Deaths among children under five years of age due to HIV/AIDS (%)	56.2 (2000)[1]	2	2 of 188
HIV/AIDS Counseling and Testing			
Men aged 15 and over who have been tested for HIV/AIDS (%)	9 (2004)[4,5]		
Women aged 15 and over who have been tested for HIV/AIDS (%)	12 (2004)[4,5]		
Antiretroviral Therapy			
People with advanced HIV infection receiving antiretroviral (ARV) combination therapy (%) (number)	14.0 (2005)[1,2] 25.9 (11,036) (2006)[3]	23 of 40	111 of 155
Pregnant women receiving treatment to reduce mother-to-child transmission (%)	5.1 (2005)[2]	NA	NA

| LESOTHO: Key HIV/AIDS Indicators (Cont'd)	Value (year)	Rank: WHO Countries in Africa Region (N = 46)	Rank: WHO Countries World-wide (N = 192)
Educational Indicators			
School attendance among orphans (%)	79.0 (2005)[2]		
School attendance among non-orphans (%)	91.0 (2005)[2]		
Knowledge/Attitude Indicators			
Men aged 15 – 49 with comprehensive knowledge of HIV/AIDS (%) (includes knowledge of transmission + rejection of misconceptions)	19.1 (2004)[5]		
Young men aged 15 – 24 with comprehensive knowledge (%)	18.4 (2004)[5]		
Women aged 15 – 49 with comprehensive knowledge (%)	24.4 (2004)[5]		
Young women aged 15 – 24 with comprehensive knowledge (%)	25.8 (2004)[5]		
Men aged 15 – 49 with knowledge of mother-to-child transmission (%) (includes knowledge of preventive drug therapy *and* transmission via breastfeeding)	31.7 (2004)[5]		

Women aged 15 – 49 with knowledge of mother-to-child transmission (%)	41.8 (2004)[5]		
Men aged 15 – 49 who express specific accepting attitudes toward people with HIV (%; range)	46.9 – 79.3 (2004)[5]		
Women aged 15 – 49 who express specific accepting attitudes toward people with HIV (%; range)	48.0 – 87.3 (2004)[5]		
Behavioral Indicators			
Young men aged 15 to 24 who had sex before age 15 (%)	27.5 (2005)[2]		
Young women aged 15 to 24 who had sex before age 15 (%)	14.4 (2005)[2]		
Young men aged 15 to 24 who had sex with casual partner in past 12 months (%)	89.5 (2005)[2]		
Young women aged 15 to 24 who had sex with casual partner in past 12 months (%)	43.3 (2005)[2]		
Young men aged 15 to 24 who used condom last time they had sex with casual partner (%)	48.0 (2005)[2]		
Young women aged 15 to 24 who used condom last time they had sex with casual partner (%)	50.0 (2005)[2]		
Economic/Policy Indicators			
Policy on information, education, communication and prevention for most-at-risk populations?	**No**		
Policy to expand access to essential preventive commodities among most-at-risk populations?	**Yes**		

APPENDIX F: PIRHANA - Community Level Workshops Questions and Products/Outcomes

Exercise 1: Community Map
Question: Please draw a map of the local community area, and locate on it all the key public entities – such as schools, police, churches, markets, clinics.
**Outcomes**: 3-4 Community Maps & 2 Synthesized Lists of Community Structures (Social Structures & Religious Entities)
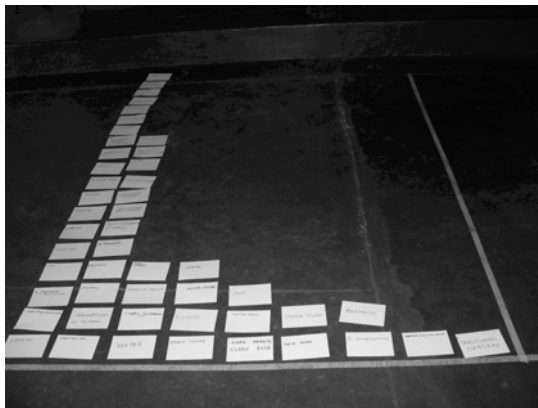
Exercise 2: Health/Sickness Index
Question: What do you consider to be the two key factors that cause well-being/sickness in this community?
Outcomes: 'Bar graph' of the key factors that the participants believe cause well-being in the community & 'Companion Bar Graph' of the key factors that the participants believe cause sickness in the community
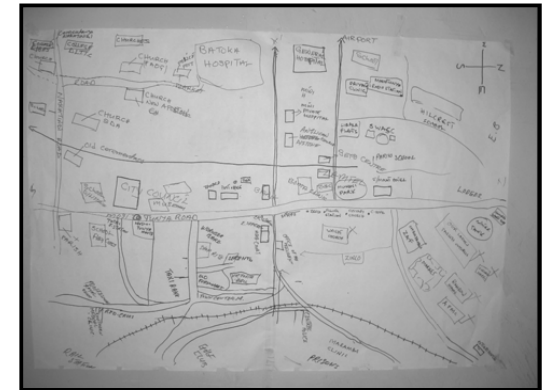
Exercise 3: Facility/Health Ranking
Question: In group discussion, the participants confirm from the lists in Exercise 1 the key social structures/facilities that work for and against well-being in the community. These are arrayed against the key factors identified in Exercise 2 to form a matrix for determining the relative contribution of specific social structures to well-being. Participants return to their small groups to discuss and agree on each facility's contribution to health in that community and place the number of beans (high = 5, low = 0) in the cell that corresponds to the contribution of that specific facility. The scores among the small groups are then collated and color-coded onto newsprint and a composite picture emerges for discussion.
Outcomes: Matrix, with beans forming relative rank of key social structures/facilities to well-being & Composite table of all matrices, collated and color-coded for group discussion.

Exercise 4:   Religion/ Health Index
Question: If the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organizations) contributes to health in your community – what would you say?
**Outcomes:** Participant -driven list of the key ways in which religion contributes to health & a reflective discussion on the significance of these factors for the participants

Exercise 5: Religion/ Health Ranking
Question: As in exercise 4, in group discussion, participants aid in creating a matrix that allows for ranking the relative contribution of listed religious entities to health. Participants return to their small groups to discuss and agree on each facility's contribution to health in that community and place the number of beans (high = 5, low = 0) in the cell that corresponds to the contribution of that specific facility. As they proceed all the squares of the matrix will be dealt with.
Outcomes: Matrix, with beans forming relative rank of key religious entities/facilities to key factors for well-being and composite table of all matrices, collated and color-coded for group discussion
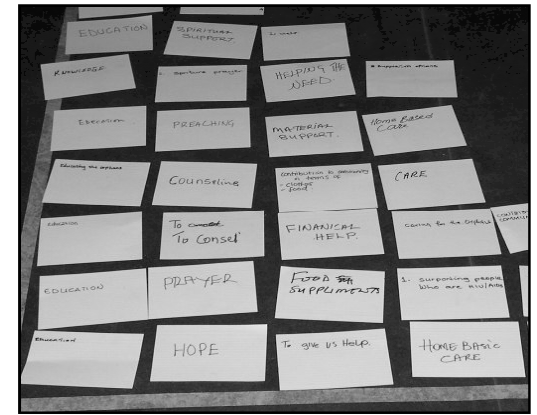
Exercise 6: Mapping Key Religious Health Assets
Question: In the light of the previous discussion make a list of the best five religious entities that contribute to health, in particular HIV/AIDS treatment, care, and prevention in your community?
Outcomes: List of exemplar Religious Health Programs with special emphasis on HIV/AIDS, including common characteristics and contact information
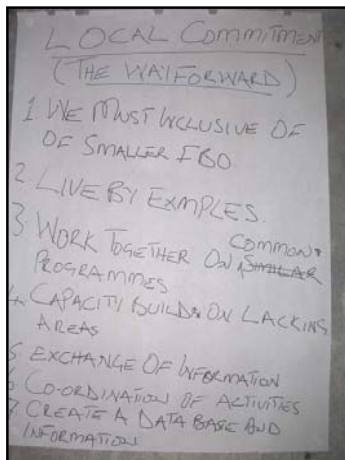
Exercise 7: Local Commitment
Question: What *can* you do to help religious organizations and entities in your area make a greater contribution to health? What *will* you do as a result of this workshop?
Outcomes: Community Action Plan, developed and led by participants

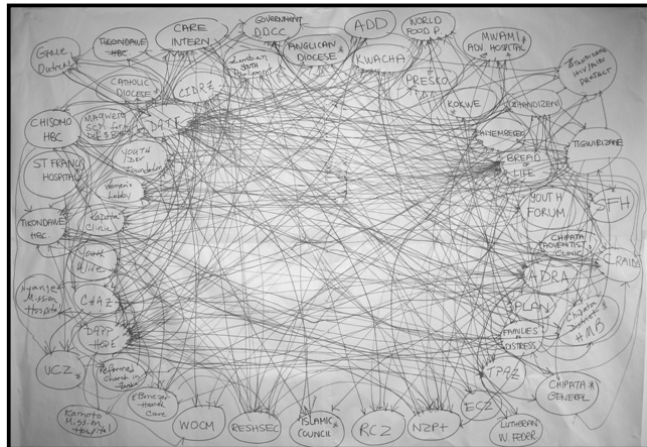# APPENDIX G: PIRHANA – Regional/National Level Workshops Questions and Products/Outcomes

EXERCISE 1: Timeline and Timetrends
Question: Each participant is asked to contribute the following to the timeline: One key significant social, political or economic event; The name of the organisation they represent or belong to; A key event to do with religion or health; A key religious or health event related to HIV/AIDS
Outcome: A deeper appreciation of the historical trends that have shaped the current health situation.

EXERCISE 2: Spiderweb
Question: Participants are now asked to consider the relationships that exist between these organisations and institutions, and draw these relationships on the spidergram chart, followed by discussion.
Outcome: A picture of the 'spaces between' the facilities, the ties, networks, and links; and a picture of the connections to wider institutions and facilities that play a role in local situation.

EXERCISE 3: Verification of Maps
Question: Using local maps, participants are asked to verify and add to the religious and health facilities that are marked on the maps. Particular attention is to be given to the marking of specific 'assets' for HIV/AIDS Treatment Programs and broader HIV/AIDS activities
Outcome: An expanded set of data about health facilities in the area in the form of a set of 'corrected' maps that can then be followed up with GIS mapping.

EXERCISE 4: Religion/Health Index
Question: Using a series of methods, participants are asked - if the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organisations) con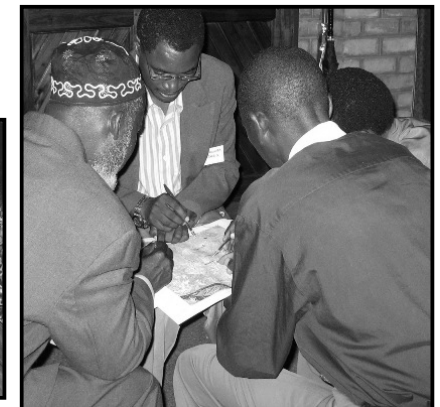tributes to health in your community – what would you say? Following this exercise and discussion, participant are then asked - if the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organizations) contribute to HIV/AIDS treatment, care, and prevention, what would you say?
Outcomes: A participant driven list of the key ways in which religion contributes to health that is both important in its own right, and important for the next exercise; a reflective discussion on the significance of these factors for the participants; and integration with issues of HIV and AIDS.

EXERCISE 5: Religious Health Facility Index
Question: In the light of the previous discussion participants are asked to identify up to three actual examples of religious entities that are making an excellent contribution to health, and particularly in the field of HIV and AIDS.
Outcome: The identification of significant Religious Health Assets in the region/district, and a discussion on reasons for its contribution.

EXERCISE 6: Local Commitment
Question: What can you do to help the other religious organisations and entities in your community to make a better contribution to health? What can you do to help the other religious organizations and entities in your community to make a better contribution to HIV/AIDS treatment, care, and prevention?
Outcome: Regional action plan, developed and led by participants

APPENDIX H: Sample Invitation Letter, Participant Information Sheet and Consent Form

ARHAP – ZAMBIA
c/o Prof S. de Gruchy
School of Religion & Theology,
University of KwaZulu-Natal
Pvt Bag X01, Scottsville, 3209
Pietermaritzburg, RSA
arhapzambia@ukzn.ac.za
+27 33 260 6273

Dates:
Invitation to a consultative workshop on Religion and Health: ARHAP and WHO………………………..

Dear Sir/Madam
I write to invite you to a workshop which will be held in…………………………..on …………………………

The workshop will be hosted by the African Religious Health Assets Programme (ARHAP). ARHAP is a research programme that involves scholars from a range of disciplines and institutions of learning such as Emory University in the U.S.A., and the University of Cape Town, University of KwaZulu-Natal, and Witwatersrand University in South Africa, and many other leading institutions and organizations that are involved in health and religion. Our goal is to identify, assess and map religious assets in Africa and make the information we get accessible to faith and health leaders, organizations such as the World Health Organization (WHO), government and private policy makers, so as to make a difference to people's lives in Africa.

ARHAP has recently received a contract from the WHO to map Religious Health Assets in Zambia. By *assets* we do not mean physical resources only, but all the tangible and intangible 'things' that religious people and groups contribute to health and well-being. As you can imagine, part of the work is to gain an in depth appreciation of these Assets; and to this end we will be engaging in a series of consultative workshops in at least four centres in Zambia.

The aim of the workshop in………………………………. will be to engage in consultative group discussions with approximately 25 informants such as yourself, so as to gain a Zambian perspective on religion and health, particularly in………………………; and to explore how these assets could be mapped and presented to the World Health Organization to contribute to their work with HIV and AIDS, TB and Malaria.

Workshop facilitators include the following:
1. Professor Steve de Gruchy – Director of Theology and Development Programme at the University of KwaZulu-Natal, South Africa.
2. Ms. Debbie Jones, ARHAP Coordinator, Rollins School of Public Health, Emory University, Atlanta U.S.A.
3. Mr. Sinatra Matimelo, ARHAP-Zambia Research Officer, Ndola, Zambia
4. Ms. Mary Mwiche, ARHAP-Zambia Researcher, Ndola, Zambia.

We would greatly appreciate and value your presence at this workshop, to represent your organization and also contribute to the discussions that will take place. Because of the format of the workshop it is crucial that you are present for the full day, from 09.00 hours to 16.00 hours. Teas and lunch will be provided. The venue will be……………………………

Please call this number, ………………………….to confirm if you are attending this workshop or send an e-mail to arhapzambia@ukzn.ac.za by…………………to help us make adequate arrangements.

We will look forward to seeing you at this research workshop.
Yours faithfully,

_____
Mr. Sinatra Matimelo
ARHAP-Zambia Research officer

ARHAP is the African Religious Health Assets Program. It is a research program that identifies the contribution that religion is making to health in Africa. By *religion* we mean all religious traditions, including African Traditional Religions, and we include the great variety of facilities, organizations, professionals, volunteers, practices, beliefs and networks that have a religious orientation.

We respect and appreciate that many people in Africa are deeply religious. We know that religious beliefs have an impact upon such important things as decision making, the use of money, social responsibility and human relationships. We know that religion can have a negative impact on these things, but that is not the focus of this research program. We are interested in what works, what is positive, what motivates, what gets things done, what makes people proud, what gives life.

We are particularly interested in how religion contributes to *health*. Health can mean things like hospitals, medical operations and pills. In an African context however, the word for *health* usually has a much wider meaning than this – it means 'comprehensive well being'. So we are taking a very broad view of health, and respecting African understandings of health and religion. This is very important at this time when Africa is suffering under the burden of HIV and AIDS, and other diseases like TB and malaria.

The positive contribution that religion makes to health is understood as an *asset* - something that religion 'has', which can make a positive impact upon people's lives and well-being. Surprisingly, while it is clear to many people that religion does make an important contribution to health in Africa, there has never been an independent assessment of such assets. This is what ARHAP is doing.

In order to understand this we need to learn from people in Africa who are involved in seeking health, and from those who are involved in providing health. This is what the participatory research process is all about.

We want to gain a good understanding of the relationship of religious assets to health so that we can make a difference to people's lives through influencing the policies of government, health organizations and religious institutions particularly in the long-term struggle against AIDS. At the same time the way we do the research is to make you excited by the assets you have in your community, and to encourage you to make a difference here and now through better use of these assets.

For more information about ARHAP and this research please contact:
Administrative Officer, ARHAP, C/o Religious Studies Department, University of Cape Town, Pvt Bag Rondebosch 7700. <arhap@humanities.uct.ac.za> Tel: +27 21 650 3457

For local information contact: (*Insert appropriate local information*)

Example of a consent form used in Zambia

ARHAP: PARTICIPATORY WORKSHOP CONSENT FORM

I agree to participate in the Participatory Inquiry into Religious Health Assets workshop held today, _____ in_____, as part of the WHO/ARHAP Project.

I understand that my comments and answers will be combined with those of others in the workshop and will be used to help ARHAP and the WHO gain a deeper understanding of the relationship between health and religion in Africa and of the "assets" and "capacities" most important for HIV/AIDS treatment, care, and prevention."

I grant permission for my photograph or image to be captured during the workshop, and to be used in reports and documents reporting the findings.
All information will be anonymous, and will be kept in protective storage during and after the research.

I understand that a report on this research workshop will be made available to me if I request it.

I understand that I may withdraw from this process at any time.

This series of declarations has been read in English and interpreted for me in Bemba.
Aya amalembo yali belengelwe kabili noku londolelwa mu chi Bemba Kuli ine.

_____
Name

_____
Signature

_____
Date

APPENDIX I: Selected Surveys/Databases Identified/Reviewed To Date

Lesotho Specific
- Ministry of Health and Social Welfare [Lesotho] and ORC Macro, Lesotho Demographics and Health Survey 2004-2005, (Calverton, Maryland, USA: Lesotho Bureau of Statistics and ORC Macro, 2005).
- Ministry of Health and Social Welfare [Lesotho], Lesotho National HIV/AIDS Strategic Plan 2006-2011, (Maseru, Lesotho: Ministry of Health and Social Welfare, 2006).
- Ministry of Health and Social Welfare [Lesotho], Know Your Status Campaign National Operation Plan 2006-2007, (Maseru, Lesotho: Ministry of Health and Social Welfare, 2006).
- Family Health International and the Lesotho Ministry of Health: HIV/AIDS Behavioral Surveillance Survey - Lesotho 2002: Summary Technical Report
- Medical Care Development International: Lesotho Health Center Rationalisation Study, 1999
- Ziken - Sechaba Joint Venture/ Ministry of Health and Social Welfare: Lesotho Health Sector Reform Baseline Assessment - 2001

Zambia Specific
- Ministry of Health, Zambia: Zambia Health Facility Census, 2005 and Zambia Health Facility Atlas 2006
- Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro, Zambia Demographics and Health Survey 2001-2002, (Calverton, Maryland, USA: Central Statistical Office, Central Board of Health and ORC Macro, 2003).
- Central Statistical Office [Zambia], Zambian Sexual Behaviour Survey, 2005 (Lusaka: Central Statistical Office, MOH, Measure Evaluation, 2005).
- Central Board of Health: Health Institutions in Zambia, 2002
- CCIH (Christian Connections for International Health) Global Religious Health Assets Mapping Database
- ZINGO (Zambia Interfaith Networking Group on HIV/AIDS) ZINGO (2002) *Faith-based organizations (FBO) responses to HIV/AIDS in Livingstone, Lusaka and Kitwe - Zambia. Strategic visioning for a Zambia free of HIV/AIDS,* (ZINGO) Zambia Interfaith Networking Group on HIV/AIDS and (NAC) The National AIDS Council of Zambia.

General Regional Datasets
- SAHIMS, Dataset - general regional
- SECHABA, Dataset: Lesotho, Heath service areas, 2004
- LUPD, Dataset: general regional (topographical - including roads)
- Lutheran World Federation, Vatican Survey, Denominational Surveys
- NAC (both Lesotho and Zambia), ARV Centres, 2005
- WHO HealthMapper and SAM Surveys, 2006
- WHO Core Indicators Database, WHO Statistical Information System, WHO Global Health Atlas, 2006

APPENDIX J: ARHAP Masangane Case Study - Executive Summary

"Let us Embrace"** - **Role and Significance of an Integrated Faith-Based Initiative for HIV/AIDS (April 2006)

Masangane, is an AIDS programme operated by a faith based organisation in the Eastern Cape, South Africa. It provides a range of *integrated services* to a predominantly rural poor population. Though small in scale, Masangane has developed a successful programme providing anti retroviral treatment (ART) as part of its overall programme. This study is an evaluation of the project.

The data collection was undertaken when Masangane was the only source of free anti retrovirals (ARVs) for a population living in the predominantly rural districts of the Eastern Cape, South Africa, which it served. Since the research took place, the State ARV programme has begun providing drugs from hospitals and clinics in the vicinity of the three Masangane sites. Nevertheless, the State ARV programme, operating in terms of the Operational Plan adopted in 2003, has been slow to deliver ART across the country, especially in rural areas. Estimates are that as at 1 December 2005 nationally, 85 000 people have access to ARVs through the public health service, providing for less than 20% of those needing them. The demand for treatment will be increasing as the HIV prevalence continues to increase.

Given the current and likely future demand for ART, a key issue is what the *potential role of faith based organisations* could be in helping to respond to this need. The research addresses this question in a number of ways. The aim of this study is to describe the activities of the Masangane ARV programme, assess the various stakeholders views of the activities, evaluate the impacts of this faith based organisation, and to assess the 'value added' in its services due to it being faith based. The study also explores the practices of beneficiaries of the ART programme in their regular use of multiple health systems – biomedical, traditional, faith – simultaneously or consecutively. The report concludes with an overview of findings, followed by policy recommendations for public health and religious leaders in considering the potential role faith based organisations/initiatives (FBO/Is) could play in ART, and in identifying how the 'added value' of Masangane's activities could be replicated. Finally, further research questions emanating from the study are identified.

Masangane's *continuum of care* includes a very successful treatment programme serving 85 people operated in partnership with private doctors and run by a treatment co-ordinator, herself on ART. Key to their success is getting those who are very ill onto ARVs quickly, and the use of an effective treatment literacy programme, modelled on the MSF (Médicín Sans Frontières) approach. Adherence to ARV drugs is also very good. According to the beneficiaries, this is in important ways linked to several factors: Linking the routine of taking the drugs to a daily bible reading ritual; being given crucial hope and encouragement by strong support groups and treatment supporters; challenging stigma theologically through enlightened leadership in the Moravian and other faith communities in the area; being welcomed (*Masangane = "Let us embrace!"*), supported and encouraged in their ART regimen. The Masangane treatment programme is complemented by its orphan support initiative and HIV awareness educational work in local communities, and in Matatiele by home based care provided by Noncedo, a partnering community based organisation.

The range of services provided are seen in a positive light by the clients as well as a range of other key actors. The activities are managed by a small team who have been able successfully to negotiate funding with church based agencies in Europe and the USA, manage the resources astutely, and simultaneously maintain a high standard of care. Masangane can justifiably be regarded as a vital *community and health asset*. The impact of Masangane extends from the improved health and well being of the clients to their acceptance in the community where stigma has been reduced. Beneficiaries not only participate in treatment support groups that offer a sense of belonging, fellowship and dignity, but also often volunteer to work in the broader community.

To its credit, Masangane as a programme has been able to maintain a connection to the teaching, values and structures of the religious tradition within which it is embedded while maintaining a scientific approach to the actual treatment it offers. To be able to call on the resources of its religious tradition, and yet remain open to new possibilities in responding to AIDS; to offer a Christian embrace to those with HIV – wherever they come from – and draw them into a well controlled bio-medical treatment programme, is no mean feat. In this context, its *faith-based character* clearly adds considerable value, something that is difficult to measure, yet very clearly an important part of its success.

The *diversity and plurality of health-seeking approaches*, or what we here call mixing of health systems, among Masangane health seekers is common. Mixing strategies while on ART is a controversial, even dangerous matter. But it is more often than not the norm in the context in which Masangane works, perhaps even pervasive, and it has its own logic. This is a problem given the lack of mutual respect even, much less an integrated approach between the various actors offering different means of healing to those with AIDS.

Masangane itself might be seen as resting primarily on 'Western' ways of dealing with AIDS and this is certainly true in respect of its treatment practices and protocols. But it also represents something that has become increasingly part of public health thinking, namely, the need for a far more *holistic response to illness and disease*. In the case of Masangane, this includes its comprehensive range of responses to prevention, care and support beyond its bio-medical activity. The clients see considerable benefit in being associated with Masangane because of the importance its gives to the integration of their Christian belief system with healing, to the point where they regard its ARVs as more efficacious as a result.

Using the ARHAP framework, what appears to be highly valued is the integration of the drugs to address the physical condition of the body, with the person's belief system and social context, referred to as the spiritual and social body. From a Western medical perspective, what is valued could be described as the integration of the physical healing (control of the virus with ARVs) with the psycho/social aspects of the individual as well as re-integration/re-acceptance into the community. The *integration of care across the continuum of activities* offered by Masangane may well be what beneficiaries have been referring to when describing the Masangane drugs as 'different' and the reason for their reluctance to be transferred to public institutions for their ARVs.

This takes us to the *potential role of FBO/Is in health care* especially in a context of HIV/AIDS and the roll out of ARVs in South Africa.

The study was commissioned by Vesper Society, USA, which has funded most of the ARV drugs provided by Masangane to its clients. The research has been undertaken by a team of researchers interested in the interface between public health and religion and under the ambit of the international *African Religious Health Assets Programme* (ARHAP).

Policy recommendations ask for the public health system to take greater cognizance of:
- The critical role that a faith dimension has on treatment, especially the value for clients of the integration of the faith component into treatment and support group activities
- The potential shown through the Masangane case for FBO/Is, in partnership with the State ARV programme, to provide for some aspects of an ART programme that are very time-intensive such as treatment literacy, stabilization on treatment, support groups, and monitoring adherence
- The infrastructure, influence and respect FBO/Is often have in communities, and thus their potential contribution to addressing stigma and mobilising for treatment
- The need to assist in the education and training of religious leaders so as to be able to mobilise these important religious assets for health gains
- It is not suggested in any way that FBO/Is and their like should be seen or treated as a substitute for what the state and the public health system should and could do.

Further research questions emanating from the study include:
- The need to compare Masangane with other ART programs to be able to document lessons learned and good practice, so as to inform the potentially expanded role of FBO/Is and NGOs in ART
- Exploring ways in which the 'added value' of religion can be monitored
- Additional evaluation of the cost effectiveness of Masangane compared to other programmes
- The use of Benefit Incidence Analysis as a way in which to explore the extent to which ART provision is in fact meeting the needs of the poorest.

April, 2006
© ARHAP

APPENDIX K: List of Mapped Organizations – Zambia

Copperbelt

Religious Entity

Congregations
African Methodist Church
Anglican Church
Apostolic Church in Zambia - Kabushi Congregation
Bethel City Church International
Bible Way Ministries, Maranatha Grace Temple
Calvary Christian Centre
Cathedral of Christ the King
Chimwemwe United Church of Zambia
Christian Miracle Centre
Church of Christ
Elim Pentecostal Church
Grace Baptist Church
Hindu Temple
Holy Trinity Catholic Church
Immanuel Mercy Reachout Ministries
Kitwe Evangelical Church in Zambia
Kitwe Mosque
Kwacha Baptist Church
Lubuto Baptist Church
Masala Baptist Church
Mosque
Mt. Sinai Lutheran Church
Mushili Reformed Church in Zambia
Ndola Baptist Church
Ndola Bread of Life International
People's Church
Reformed Church in Zambia
Reformed Church in Zambia-Buchi Congregation
Reformed Church in Zambia-Masala Congregation
Salvation and Miracle Centre
Salvation Army
Seventh Day Adventist
St Margarets United Church of Zambia
St. James Anglican Church
St. Peters Parish
United Church of Zambia
Development Agency 1
Bridge International
Chishilano Multifuntional Centre
Kingdom Empower Trust
Prison Fellowship of Zambia
RAPIDS/World Vision
TEEN Mission
Education Provider 1
Mapepo Pre-School Teacher Training
Theological College of Central Africa
Education Provider 3
Dominican Girls Convent School
Sathya Sai Schools
St Andrews School
UCZ Bethel School
UCZ Mapepo School
Education Provider 4
Emmanuel Christian School

Little Angels Primary School for Orphans
Education Provider 5
Eagles Wings Children's Centre
Education Provider 6
Mobile Mission Maintenance Vocation Training Centre
Education Provider 7
Isubilo Community Resource Centre
New Life Health Information Centre
St. Martha's Skills Training Centre
Health Provider 7
Carewell Oasis Clinic
Carewell Oasis Medical Services Ltd
Traditional Healer
Traditional Healer
Traditional Healer
Traditional Healer
Linking Body 1
Anglican Diocese of Northern Zambia
Kitwe Muslim Association
New Life Ministries International
The Catholic Diocese of Ndola
Linking Body 2
Zambian Inter-Faith Networking Group
Linking Body 3
ECZ HIV/AIDS Program
Media
Radio Ichengelo
Pressure Group
Jubilee Centre
Health Supporting Group 1
Cheshire Home
Cicetekelo Home
Dawn Trust Community Care
Mitanda Home for the Aged
St. Anthony Village and St Therese Village
Twafwane Christian Community Care
Health Supporting Group 2
Buseko Childrens Home
Bwafwano Women's Group
Childlife Touch
Chimwemwe Orphans & Vulnerable Children
Funsani Hospice/orphanage
Jehovah Jireh Orphan Girl Child & Widow Centre
Mercy Touch Missions
New Start Centre
Positive and Living
SALEM Children's Village

Partner Entity
Development Agency 2
Copperbelt Health Education Project
Education Provider 3
Lubuto High School
Education Provider 4
Dambwa School
Kabushi Middle Basic School

Kantolomba Community School
Kawama Community School
Mackenzie Community School
Masala Primary School
Education Provider 5
SOS School
Education Provider 6
Kabushi Library
Health Provider 4
Kabushi Clinic
Kantolomba RD Clinic
Luangwa Government Clinic
Masala Clinic
Mulenga Clinic
Mushili Clinic
Health Provider 6
SINOZAM Friendship Hospitals
Health Provider 7
Ajjali Clinic
Hope Clinic
Nalwange Family clinic
Tender Care Medical Clinic - Masala
Linking Body 1
Zambia Community Schools Secretariat
Linking Body 3
Children in Distress
Pressure Group
Ubumi Bwesu
Health Supporting Group 1
Copperbelt Zambia Field
Kawama Counseling and Testing Centre
Health Supporting Group 2
Families for Children Project
Nkwanzi Drop-in Centre NZP+

Non-Mapped Entity
Site of Bophelo
Kantolomba Cementry
Masala Main Market
Zambia Police Community Post

EASTERN

Religious Entity
Congregations
Anglicans of Chipata
Central Jami Mosque
Grace Outreach Ministries
Jami Mosque
Jesus the Same Ministries
Pentecostal Assemblies of God-trinity Temple Church
Pilgrim Weshian Church Kapala
Reformed Church in Zambia
Seventh Day Adventist Church
St. Paul's Anglican Church
Unified Church of Zambia
Development Agency 1

Catholic Relief Services
Education Provider 3
St. Anne's Basic School
St. Monica's Secondary School
Education Provider 4
Chipata Christian School
Hadalisika Mission Community School
St Anne's Childcare Community School
St Antanio Orphan School
Health Provider 4
Chipata Adventist Clinic
Ebenezer Health Care
Linking Body 2
CHAZ, Catholic Diocese of Chipata
Media
Radio Maria Zambia
Pressure Group
Catholic Centre for Justice Development and Peace
Health Supporting Group 1
Chisomo Home Based Care
St. Anne's Home Based Care
Tigwilizane Home Based Care
Tikondane Home Based Foundation
Tithandizane
Health Supporting Group 2
Chipata Cheshire Homes
Widows and Single Mother's Christian Aid
Youth Skills and Moral Support Programme

Partner Entity
Development Agency 1
Care International -Zambia
Mthunzi Development Foundation
World Food Programme Chipata
Zambia Red Cross Society
Development Agency 2
District AIDS Task Force
Kwacha Kumawa
Education Provider 1
Chipata College Education Board
Education Provider 2
Chipata School of Nursing
Education Provider 3
Anoya Zulu Boys High School
Chipata Day High School
Education Provider 4
Chipata Basic School
Chipililo Orphan Community School
Chiyembekezo Community School
Ment School
Education Provider 7
Cherish Nlakubale Resource Centre
Health Provider 2
Chipata General Hospital
Health Provider 4
Chipata Community Medical Centre
Kapata Referal Clinic
Health Provider 8
Chipata Health Care
Linking Body 2

Chipata District Health Board
Linking Body 3
DAPP Hope Station
Media
Kolbe Printing Press
Other
Centre for HIV/AIDS Research in Zambia
Health Supporting Group 1
Chipata Care Preventive Support Team
Chipata Dzithandizeni Nutrition Group
Dzithandizane Nutritious Group
Lunkwakwa
Network of People Living with HIV/AIDS in Zambia
Planned Parenthood Association of Zambia
Tikondane PLHAs Support Group
Timatsuke HIV/AIDS Project
Health Supporting Group 2
Chiyembekezo Home based Support Group
Madaliso Widows OVC/ Home Based Care Group
Society for family Health

Non-Mapped Entities
Education Provider 3
Muslim School
Health Supporting Group 2
Chiyembekezo Support Group

LUSAKA

Religious Entity
Congregations
Chreso Ministries
Development Agency 1
Catholic Relief Services
World Vision International
Health Provider 3
Coptic Church Hospital
Health Provider 4
CorpMed Clinic
Laura Anna Clinic
Health Provider 6
Zambia-Italian Hospital
Health Provider 7
Country Herbs
Linking Body 1
Zambia Episcopal Conference
Linking Body 2
Campus Crusade
Evangelical Fellowship of Zambia
Linking Body 3
Churches Health Association of Zambia
Health Supporting Group 1
Hope House
New Start Centre
Health Supporting Group 2
Bauleni Street Kids Project
Cheshire Homes

Mother of Mercy Hospice-Chilanga
Mother Theresa Missionaries of Charity
Our Lady of Hope Hospice

Partner Entity
Development Agency 1
World Health Organization, Zambia
Health Provider 1
Chainama Hills College and Hospital
University Teaching Hospital
Health Provider 2
Maina Soko Military Hospital
Health Provider 3
Lusaka Trust Hospital
Victoria Hospital
Villa Hospital
Health Provider 4
Mutti Medical Clinic
Pendletone Health Care Clinic
Premier Medical Services
Health Provider 6
Care for Business
Hill Top Hospital
Pearl of Health
St. John's Medical centre
Linking Body 1
Bauleni-Lusaka Urban District Health Management
Board (UDHMB)
Chainda-Lusaka UDHMB
Chelstone-Lusaka UDHMB
Chilenje-Lusaka UDHMB
Kabwata-Lusaka UDHMB
Kalingalinga-Lusaka UDHMB
Kamwala-Lusaka UDHMB
Ngombe-Lusaka UDHMB
Ministry of Health (MOH)
Linking Body 2
National Aids Council
Linking Body 3
Aids Alliance
Other
Madison Health Solutions
Premier Medical Aid
ProMed Health Insurance
Zambia Emory HIV Research Project

SOUTHERN

Religious Entity
Congregations
Anglican Church
Apostolic Faith Mission Libuyo Assembly
Bretheren in Christ Church
Calvary Church
David Livingstone Memorial
Presbyterian Church
Livingstone Moslem Society

Maramba Parisa-Roman Catholic Church
Paog Dambwa Assembly
Reformed Church in Zambia
Salvation Army Livingstone Corps
Trinity Baptist Church
UCZ Coillard Congregation
UCZ Maramba
<u>Development Agency 1</u>
Young Women's Christian Association
<u>Education Provider 3</u>
St Mary's High School
<u>Education Provider 6</u>
Youth Community Training Centre
<u>Health Provider 5</u>
St Francis Care Centre
<u>Health Provider 7</u>
Mr Patrick Mayamba
Mr Sainani S Phiri
<u>Linking Body 2</u>
ZINGO South
<u>Linking Body 3</u>
Ray of Hope
<u>Media</u>
Gospel Promotion Ministries
Radio Mosi-o-Tunya
Pressure Group
Living Women Make a Difference
<u>Health Supporting Group 1</u>
March
OVR Lady's of Angel
<u>Health Supporting Group 2</u>
Anglican Children's Project
Kwenuha

Partner Entity
<u>Development Agency 1</u>
Care International
Changes 2
<u>Linking Body 1</u>
District Health Management Team
<u>Linking Body 2</u>
Network of Zambian People Living with HIV/AIDS
SEPO Centre
<u>Other</u>
Livingstone City Council
Zambian Electricity Supply Company
<u>Health Supporting Group 1</u>
New Start Centre
Society for Family Health
<u>Health Supporting Group 2</u>
CTYA

APPENDIX L: List of Mapped Organizations – Lesotho

MASERU

Religious Entities
Congregations
Ministry of Insured Salvation
Development Agency 2
Beautiful Gates
Hope of the World
Education Provider 1
Assembly Bible College
Linking Body 1
Scripture Union, Lesotho
Health Supporting Group 1
PSI Newstart

Partner Entities
Education Provider 1
Institute of Education
Lesotho College of Education
Education Provider 2
National Health Training Centre
Education Provider 4
SOS Children's Village School
Health Provider 1
Queen Elizabeth II
Health Provider 2
Mohlomi Hospital
Health Provider 4
Carewell
Centre for Excellence Paediatric Clinic
Lehlakeng Clinic
LPPA Youth Centre Clinic
Mafube Clinic
Mahlompho Clinic
Masechaba Clinic
Masianokeng Clinic
Molopi Clinic
MSU South Filter Clinic
Nelese Clinic
Pepangoana Clinic
Rosyn Clinic
Health Provider 5
Baylor University Children's Clinic
Health Provider 6
Baylor Paediatric Hospital
Maseru Private Hospital
Health Provider 7
Thetsane Clinic
Thetsani Industrial Area Clinic
Willies Private Clinic
Media
Blue Cross Centre
Health Supporting Group 1
Nthati Reproductive Health Counseling Services

Non-Mapped Entities
Health Provider 2
Botshabelo Hospital and Leper Settlement

Makoanyane Hospital
Health Provider 4
Senkatana Centre
TB Clinic
Developent Agency 1
Youth for Christ

PARAY

Religious Entity
Congregations
Anglican Church
LE Church
Lipaki Church
New Jerusalem Church
Seventh Day Adventist Church
Education Provider 3
Mohlanopeng High School
Education Provider 4
Bobete Primary School
Mohlanopeng Primary School
Paray Primary School
Sehonghong Primary School
Health Provider 2
Paray Hospital
Health Provider 4
Mashai / St Theresa High School
Mohlanopeng High School
Mokoto High School
Health Provider 7
Chelete Naha
Frede Chelete
Jack Moeko
Janki Masiu
Lekarapa Mohanoe
Maria Mofokeng
Mathabo Thola
Me Maleaoa Mokone
'Me Mamolaeng Mokhethi
'Me 'Mamolung oa Masimong
'Me Matlooang Poroane
Ramone Lechoalichoali
Thabo Moshoshoe
Thabo Motsoasele
Tlooelang Motsumi
SG1
Ha Phaila Support Group

Partner Entity
Education Provider 3
Sehonghong High School
Education Provider 4
Nkokana Primary School
Education Provider 7
Semenanyane Resource Centre

Health Provider 4
Bobete High School
Linakeng High School
Sehonghong H C

Non-Mapped Entities
Sites of Bophelo
Credit Union
Assembly of God Lesotho
Health Provider 4
Khohlo-Ntso Clinic
Health Provider 7
Lechoalichoali Ramone
Mamotloang Poroane
Ngaka ea Moetlo
Other
Local Government
Mokoto

SCOTT

Religious Entity
Congregations
Anglican Church Morija
Apostolic Churches Morija
Kolo LEC Church
Makeneng LEC
Makhakhe Roman Catholic Church
Masite Anglican Church
Matsieng LEC
Mofoka LEC Church
Morija Lesotho Evangelical Church
Reisi LEC
Sebelekoane Church
Seroeng LEC Church
St Louis Roman Catholic Church
St Matthews Roman Catholic Church
Tolane LEC Church
Tsoeneng LEC Church
Development Agency 1
Women's Programme LEC
Education Provider 1
Theological Seminary LEC
Education Provider 2
Scott Hospital Nursing School
Education Provider 3
Child Jesus High School
Kolo High School
Makhakhe / St. Thomas High School
Moshoeshoe II High School
Ribaneng High School
Sebelekoane High School
St Barnabas High School
St Rodrique High School
Education Provider 4
Khubetsoana Primary School
Kolo Primary School - Ntsie
Makhakhe / Emmaus Primary School
Masemouse Primary School
Mofumahali oa Fatima Primary School
Sebelekoane Primary School

St Louis Primary School
St Matthews Primary School
St Rodrique Primary School
St. Barnabas Primary School
Tsoeneng LEC Primary School
Tsoeneng Primary School
Health Provider 2
Scott Hospital
Health Provider 4
Kolo HC
Makhakhe / Emmaus HC
Masemouse HC
Ramabanta / Fatima HC
Ribaneng HC
Sebelekoane / St Andrews HC
St Barnabas / Masite HC
St Peter Claver HC
St Rodrique HC
St. Louis clinic Roman Catholic
Health Provider 7
Lefa Kobo
Lineo Rampai
Makalee Majoro
Mathabeli Mokhetlu
Poulo Khabo
Tsitso Mokhutsoane
Linking Body 1
Education Secretariat LEC
Lesotho Evangelical Offices
Media
Morija Museum and Archives
Morija Printing Works
Sesotho Book Depot
Health Supporting Group 1
PLWHA Support
Health Supporting Group 2
Mophato Oa Morija

Partner Entities
Development Agency 1
Sekameng ADP
Water and Sanitation Ass
Education Provider 3
Ha Mofoka High School
Ha Tlali High School
Matelile High School
Morija Girls School
Thabeng High School
Education Provider 4
Ha 'Maliepetsane Primary School
Ha Mdunga Primary School
Ha Mofoka Primary School
Ha Toloane Primary School
Lekota Primary School
Mafika Lisiu Primary School
Makeneng Primary School
Malealea Primary School
Mamaebana Primary School
Matelile Primary School
Mohlaefi Primary School
Monyake Primary School
Morija English Medium School
Morija Primary School

Reisi Primary School
Seroeng Primary School
Setleketseng Primary School
Education Provider 5
Mantloaneng Nursery School
Health Provider 4
Ha Mofoka HC
Ha Toki HC
Malealea HC
Matelile HC
Matsieng HC
Motsekuoa HC
Nyoko-Soba HC
Other
Kolo Local Court
Morena Matete Khotla
Morija Police Station
Rothe Local Court
Rothe Principal Chief

Non-Mapped Entities
Sites of Bophelo
Agric Stockade

Central Court
Ha Makhakhe Post Office
Lesotho Electricity Corporation
Lesotho Telecom
Matsieng Post Office
Morija Fields
Morija Pitso Ground
Morija Post Office
Morija Shops
Rothe Post Office
Education Provider 3
Malealea High School
Education Provider 4
Ha Pholo Primary School
Ha Tlali Primary School
Thabana-Li-'Mele Primary School
Education Provider 5
Kholikane Primary School
Health Provider 4
Thusang Health Center
Other
Village Council

Research Areas - Zambia

admin
Livingstone
Lusaka
Chipata
Ndola
Kitwe

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0   50   100   200 Kilometers

N
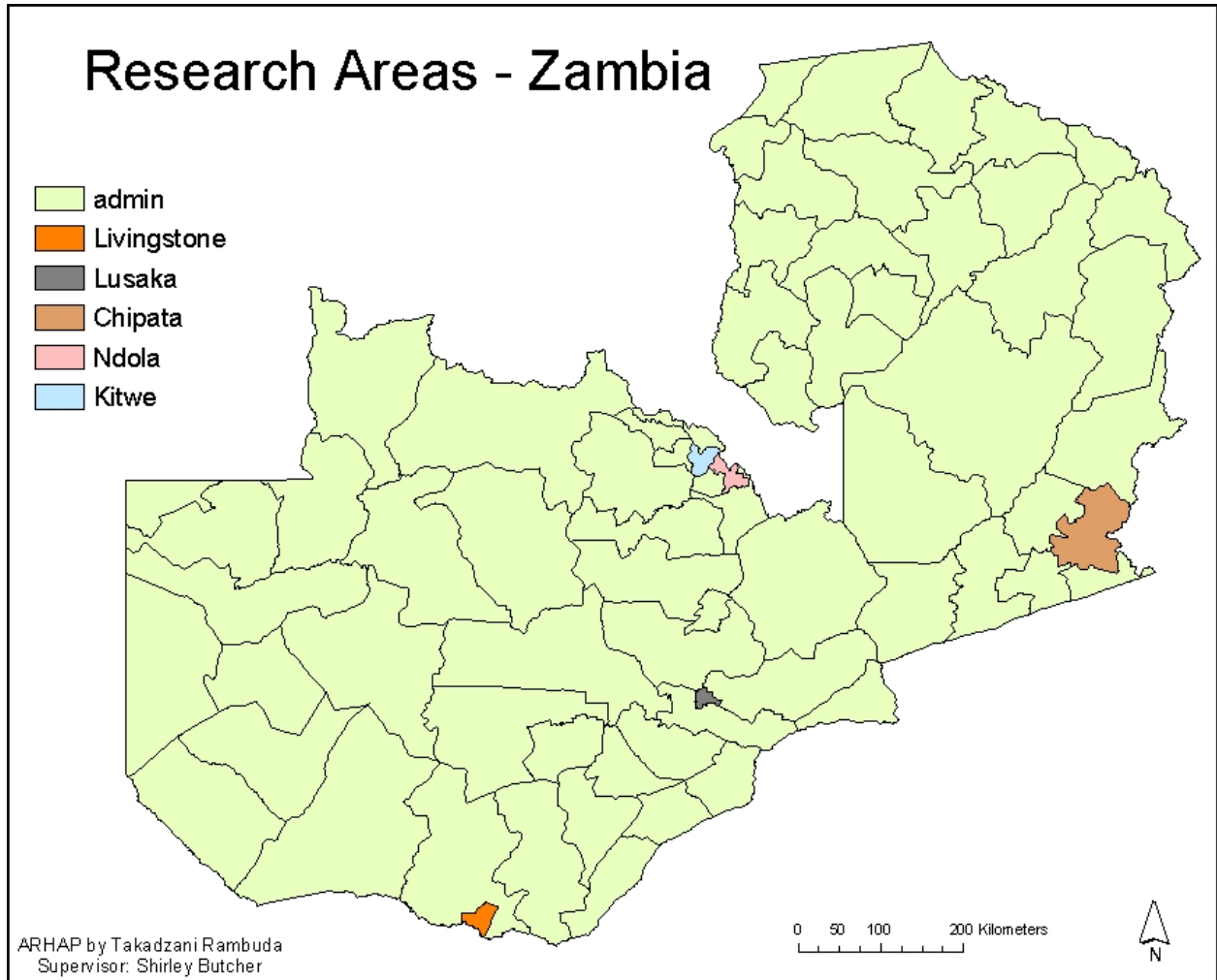
CHIPATA, Zambia - ALL ENTITIES

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

N

| | | 0 | 0.25 | 0.5 | 1 | Kilometers |

Zambia

TYPECODE, SCOPE

★	CG, LOC	✳	DA2, REG	◆	EP7, LOC	●	HP6, REG
✳	DA1, INT	■	EP1, LOC	✚	HP1, NAT	●	HP7, LOC
✳	DA1, LOC	■	EP1, NAT	✚	HP1, REG	●	HP8, LOC
✳	DA1, NAT	▪	EP2, NAT	✳	HP2, REG	●	HP9, LOC
✳	DA1, REG	▪	EP2, REG	◉	HP3, LOC	▲	LB1, LOC
✳	DA2, INT	⊠	EP3, LOC	◎	HP3, REG	▲	LB1, NAT
✳	DA2, LOC	⊠	EP3, REG	●	HP4, LOC	▲	LB1, REG
✳	DA2, NAT	▪	EP4, LOC	●	HP4, REG	▲	LB2, LOC
		▣	EP5, LOC	●	HP5, LOC	▲	LB2, NAT
		◆	EP6, LOC	●	HP6, LOC	▲	LB2, REG
		◆	EP6, NAT	✚	HP6, NAT	▲	LB3, LOC

▲	LB3, NAT	⚑	PG, NAT		
▲	LB3, REG	⚑	PG, REG		
◎	MD, LOC	◆	SG1, LOC		
◎	MD, NAT	◆	SG1, NAT		
◎	MD, REG	◆	SG1, REG		
●	OR, INT	◆	SG2, LOC		
●	OR, LOC	◆	SG2, NAT		
●	OR, NAT	◆	SG2, REG		
●	OR, REG		Urb		
⚑	PG, LOC		admin2		

KITWE, Zambia - ALL ENTITIES

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0 0.45 0.9   1.8 Kilometers

N

Zambia.new

TYPECODE, SCOPE

CG, LOC	DA2, LOC	EP3, REG
DA1, INT	DA2, NAT	EP4, LOC
DA1, LOC	DA2, REG	EP5, LOC
DA1, NAT	EP1, LOC	EP6, LOC
DA1, REG	EP1, NAT	EP6, NAT
DA2, INT	EP2, NAT	EP7, LOC
	EP2, REG	HP1, NAT
	EP3, LOC	HP1, REG

HP2, REG	HP6, REG	LB2, NAT	OR, INT
HP3, LOC	HP7, LOC	LB2, REG	OR, LOC
HP3, REG	HP8, LOC	LB3, LOC	OR, NAT
HP4, LOC	HP9, LOC	LB3, NAT	OR, REG
HP4, REG	LB1, LOC	LB3, REG	PG, LOC
HP5, LOC	LB1, NAT	MD, LOC	PG, NAT
HP6, LOC	LB1, REG	MD, NAT	PG, REG
HP6, NAT	LB2, LOC	MD, REG	SG1, LOC

SG1, NAT	
SG1, REG	
SG2, LOC	
SG2, NAT	
SG2, REG	
Urb	
admin2	

NDOLA, Zambia - ALL ENTITIES

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0 0.45 0.9   1.8 Kilometers

N

Zambia.new

TYPECODE, SCOPE

CG, LOC	DA2, LOC	EP3, REG
DA1, INT	DA2, NAT	EP4, LOC
DA1, LOC	DA2, REG	EP5, LOC
DA1, NAT	EP1, LOC	EP6, LOC
DA1, REG	EP1, NAT	EP6, NAT
DA2, INT	EP2, NAT	EP7, LOC
	EP2, REG	HP1, NAT
	EP3, LOC	HP1, REG

HP2, REG	HP6, REG	LB2, NAT	OR, INT
HP3, LOC	HP7, LOC	LB2, REG	OR, LOC
HP3, REG	HP8, LOC	LB3, LOC	OR, NAT
HP4, LOC	HP9, LOC	LB3, NAT	OR, REG
HP4, REG	LB1, LOC	LB3, REG	PG, LOC
HP5, LOC	LB1, NAT	MD, LOC	PG, NAT
HP6, LOC	LB1, REG	MD, NAT	PG, REG
HP6, NAT	LB2, LOC	MD, REG	SG1, LOC

SG1, NAT	
SG1, REG	
SG2, LOC	
SG2, NAT	
SG2, REG	
Urb	
admin2	

LIVINGSTONE, Zambia - ALL ENTITIES

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0 0.25 0.5   1 Kilometers

N

Zambia

TYPECODE, SCOPE

☆ CG , LOC	✳ DA2 , REG	◆ EP7 , LOC	● HP6 , REG	▲ LB3 , NAT	⚑ PG , NAT
✳ DA1 , INT	■ EP1 , LOC	● HP1 , NAT	● HP7 , LOC	▲ LB3 , REG	⚑ PG , REG
✳ DA1 , LOC	■ EP1 , NAT	✚ HP1 , REG	● HP8 , LOC	◉ MD , LOC	◆ SG1 , LOC
✳ DA1 , NAT	▪ EP2 , NAT	⊞ HP2 , REG	● HP9 , LOC	◎ MD , NAT	◆ SG1 , NAT
✳ DA1 , REG	▪ EP2 , REG	◉ HP3 , LOC	▲ LB1 , LOC	◎ MD , REG	◆ SG1 , REG
✳ DA2 , INT	⊠ EP3 , LOC	◎ HP3 , REG	▲ LB1 , NAT	● OR , INT	◆ SG2 , LOC
✳ DA2 , LOC	⊠ EP3 , REG	● HP4 , LOC	▲ LB1 , REG	● OR , LOC	◆ SG2 , NAT
✳ DA2 , NAT	▪ EP4 , LOC	● HP4 , REG	▲ LB2 , LOC	● OR , NAT	◆ SG2 , REG
	▣ EP5 , LOC	● HP5 , LOC	▲ LB2 , NAT	● OR , REG	⬜ Urban
	◆ EP6 , LOC	⊕ HP6 , LOC	▲ LB2 , REG		⬜ admin
	◆ EP6 , NAT	● HP6 , NAT	▲ LB3 , LOC	⚑ PG , LOC	

LUSAKA, Zambia - ALL ENTITIES

Roma

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0   0.5   1   2 Kilometers

N

Zambia

TYPECODE, SCOPE

CG , LOC	DA2 , REG	EP7 , LOC	HP6 , REG	LB3 , NAT	PG , NAT
DA1 , INT	EP1 , LOC	HP1 , NAT	HP7 , LOC	LB3 , REG	PG , REG
DA1 , LOC	EP1 , NAT	HP1 , REG	HP8 , LOC	MD , LOC	SG1 , LOC
DA1 , NAT	EP2 , NAT	HP2 , REG	HP9 , LOC	MD , NAT	SG1 , NAT
DA1 , REG	EP2 , REG	HP3 , LOC	LB1 , LOC	MD , REG	SG1 , REG
DA2 , INT	EP3 , LOC	HP3 , REG	LB1 , NAT	OR , INT	SG2 , LOC
DA2 , LOC	EP3 , REG	HP4 , LOC	LB1 , REG	OR , LOC	SG2 , NAT
DA2 , NAT	EP4 , LOC	HP4 , REG	LB2 , LOC	OR , NAT	SG2 , REG
	EP5 , LOC	HP5 , LOC	LB2 , NAT	OR , REG	Urban
	EP6 , LOC	HP6 , LOC	LB2 , REG	PG , LOC	admin
	EP6 , NAT	HP6 , NAT	LB3 , LOC		

Lesotho Overview
All Entities
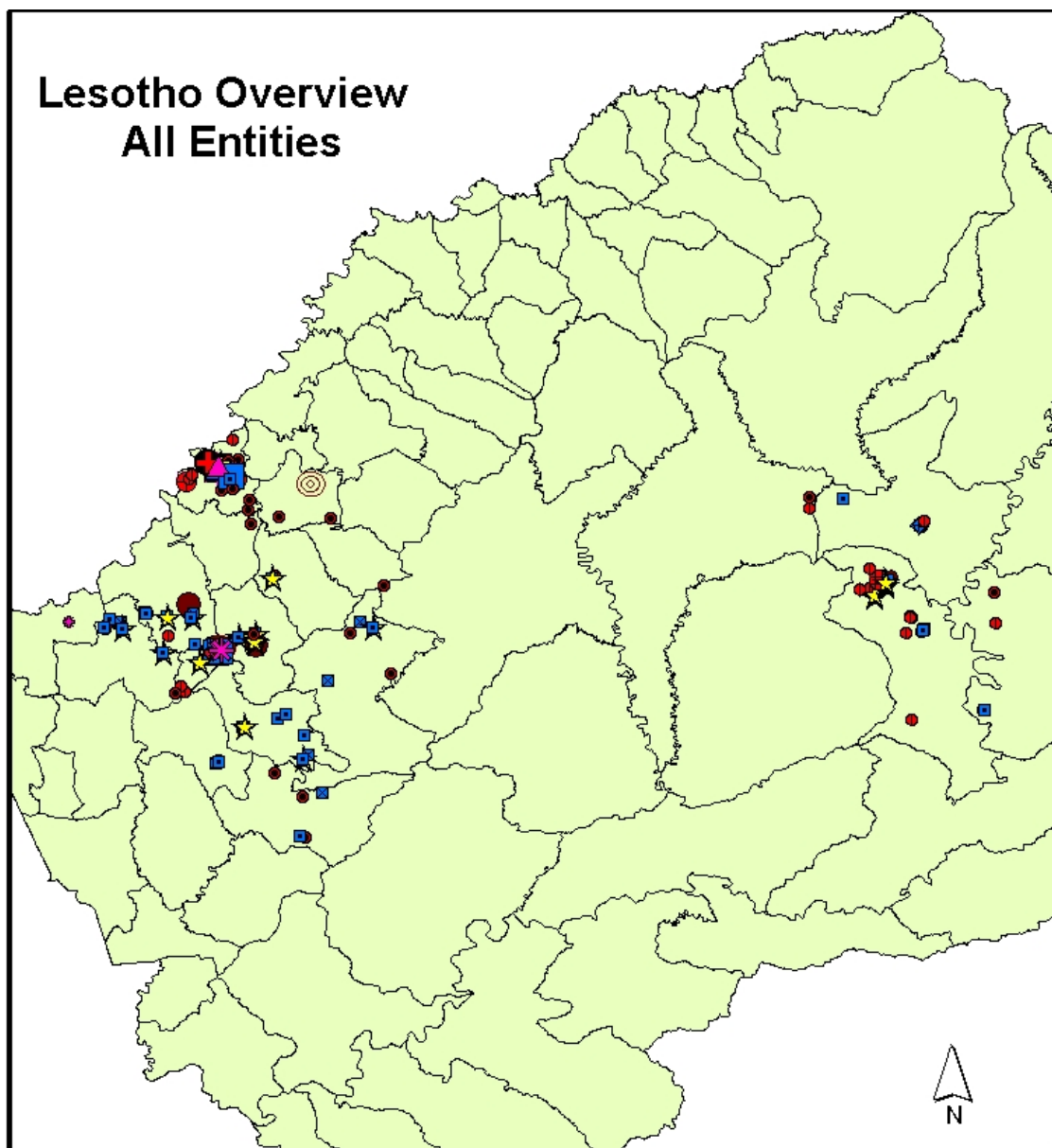
Lesotho

TYPECODE, SCOPE

☆ CG, LOC	✳ DA2, INT	▣ EP5, LOC	● HP4, LOC	● HP8, LOC	◎ MD, NAT
• DA1, LOC	✳ DA2, LOC	◆ EP6, LOC	● HP4, REG	● HP9, LOC	● OR, LOC
✳ DA1, NAT	■ EP1, NAT	◆ EP7, LOC	● HP5, LOC	▲ LB1, NAT	● OR, REG
✳ DA1, REG	▣ EP2, NAT	✚ HP1, NAT	● HP6, NAT	▲ LB2, LOC	◆ SG1, LOC
	▣ EP3, LOC	● HP2, REG	● HP6, REG	▲ LB3, LOC	◆ SG2, LOC
	▣ EP4, LOC	● HP3, LOC	● HP7, LOC	◎ MD, LOC	

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

LESOTHO Religious Entities

RE_Type
TYPECODE, SCOPE

⭐ CG, LOC	✳ DA2, INT	▣ EP2, NAT	● HP4, LOC	◆ SG1, LOC
✳ DA1, NAT	✳ DA2, LOC	▨ EP3, LOC	● HP7, LOC	◆ SG2, LOC
	■ EP1, NAT	▪ EP4, LOC	▲ LB1, NAT	constituent reg
		● HP2, REG	◉ MD, NAT	
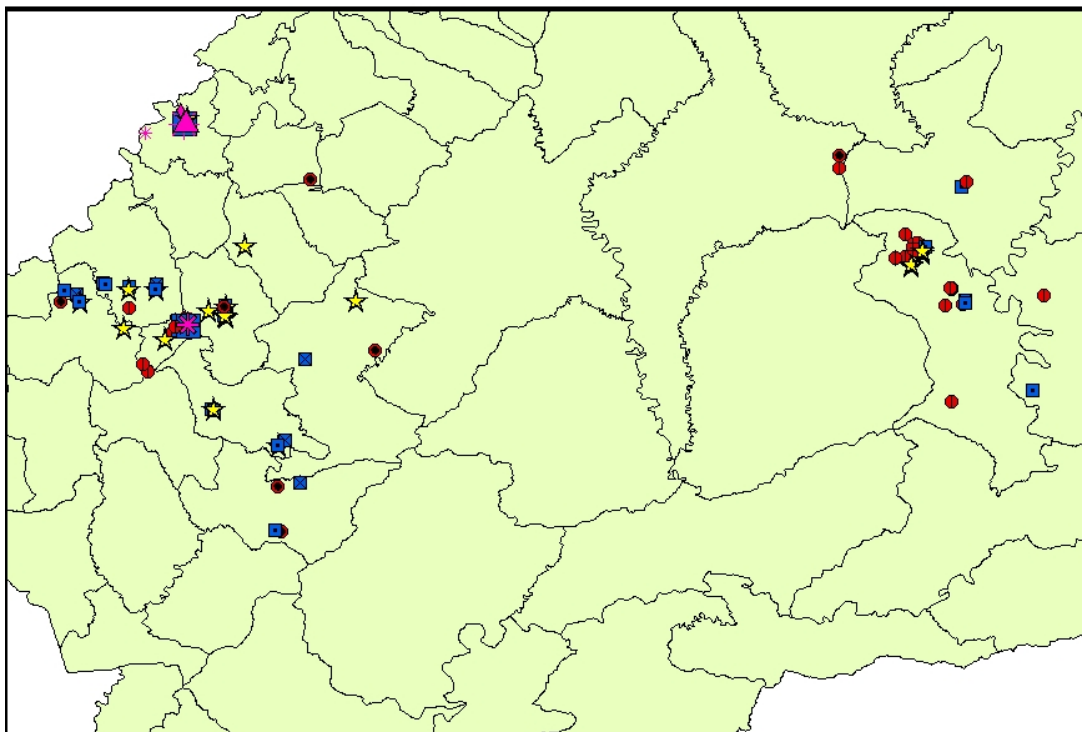
0   4.5   9   18 Kilometers

N

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LESOTHO Partner Entities

PO_Type

TYPECODE, SCOPE
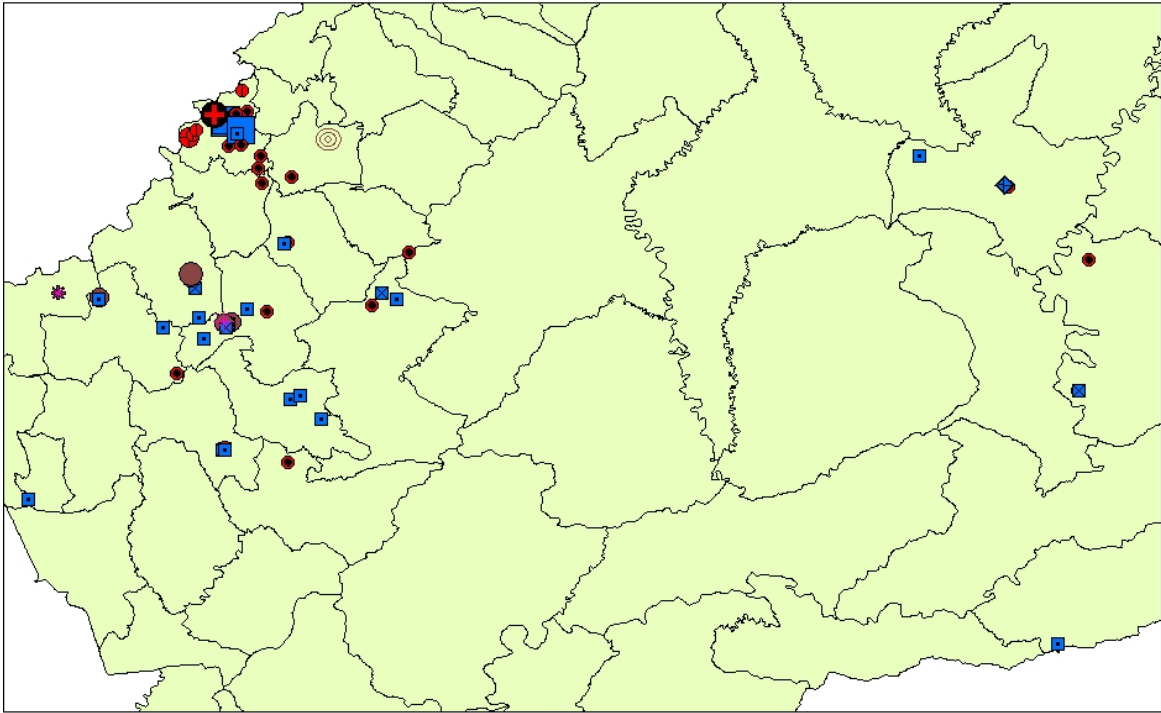
Symbol	Label	Symbol	Label	Symbol	Label
DA1, LOC		EP3, LOC		HP4, LOC		MD, NAT
DA1, REG		EP4, LOC		HP4, REG		OR, LOC
EP1, NAT		EP5, LOC		HP5, LOC		OR, REG
EP2, NAT		EP7, LOC		HP6, NAT		SG1, LOC
		HP1, NAT		HP6, REG		constituent reg
		HP2, REG		HP7, LOC		

0 7501,500Kilometers

N

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Supervisor: Shirley Butcher

MASERU, Lesotho - All Entities

Lesotho

TYPECODE, SCOPE

✳ DA2, LOC	◆ EP7, LOC	⊕ HP6, NAT	▲ LB3, LOC		constituent reg
⭐ CG, LOC	■ EP1, NAT	⊕ HP1, NAT	⊕ HP6, REG	◎ MD, LOC	
● DA1, LOC	■ EP2, NAT	⊕ HP2, REG	● HP7, LOC	◎ MD, NAT	
✳ DA1, NAT	■ EP3, LOC	● HP3, LOC	● HP8, LOC	● OR, LOC	
✳ DA1, REG	■ EP4, LOC	● HP4, LOC	● HP9, LOC	● OR, REG	
✳ DA2, INT	■ EP5, LOC	● HP4, REG	▲ LB1, NAT	◆ SG1, LOC	
	◆ EP6, LOC	● HP5, LOC	▲ LB2, LOC	◆ SG2, LOC	

0   1.25   2.5 Kilometers

N

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

NDOLA, Zambia - ALL ENTITIES
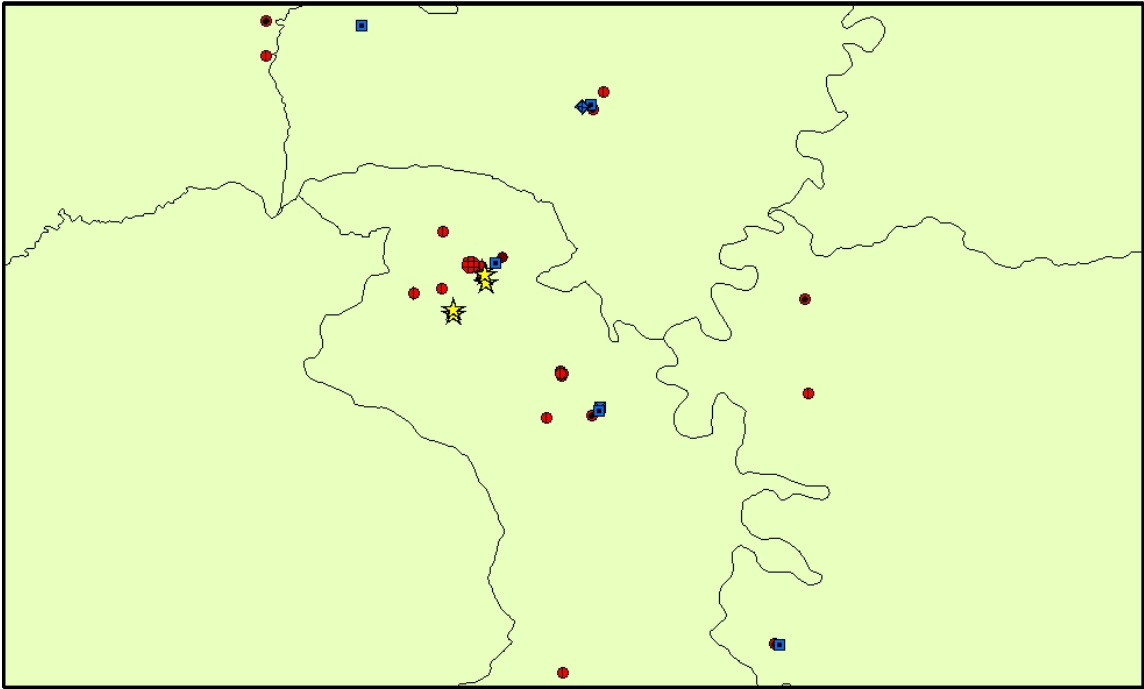
ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

0 0.45 0.9   1.8 Kilometers

N

Zambia.new

TYPECODE, SCOPE

Symbol	Label		Symbol	Label		Symbol	Label		Symbol	Label		Symbol	Label		Symbol	Label		Symbol	Label
	CG, LOC			EP3, REG			HP2, REG			HP6, REG			LB2, NAT			OR, INT			SG1, NAT
	DA1, INT			EP4, LOC			HP3, LOC			HP7, LOC			LB2, REG			OR, LOC			SG1, REG
	DA1, LOC			EP5, LOC			HP3, REG			HP8, LOC			LB3, LOC			OR, NAT			SG2, LOC
	DA1, NAT			EP1, LOC			HP4, LOC			HP9, LOC			LB3, NAT			OR, REG			SG2, NAT
	DA1, REG			EP1, NAT			HP4, REG			LB1, LOC			LB3, REG			PG, LOC			SG2, REG
	DA2, INT			EP2, NAT			HP5, LOC			LB1, NAT			MD, LOC			PG, NAT			Urb
	DA2, LOC			EP2, REG			HP6, LOC			LB1, REG			MD, NAT			PG, REG			admin2
	DA2, NAT			HP1, NAT			HP6, NAT			LB2, LOC			MD, REG			SG1, LOC			
	DA2, REG			HP1, REG																

PARAY, Lesotho - All Entities

Lesotho										
TYPECODE, SCOPE		✳ DA2, LOC	◆ EP7, LOC	⬤ HP6, NAT	▲ LB3, LOC	▭ constituent reg				
☆ CG, LOC		▣ EP1, NAT	✚ HP1, NAT	● HP6, REG	◎ MD, LOC					
✳ DA1, LOC		▣ EP2, NAT	▦ HP2, REG	• HP7, LOC	◎ MD, NAT	0 3 6 Kilometers				
✳ DA1, NAT		▣ EP3, LOC	• HP3, LOC	• HP8, LOC	• OR, LOC					
✳ DA1, REG		▣ EP4, LOC	• HP4, LOC	• HP9, LOC	⬤ OR, REG					
✳ DA2, INT		▣ EP5, LOC	● HP4, REG	▲ LB1, NAT	◆ SG1, LOC	N				
		◆ EP6, LOC	• HP5, LOC	▲ LB2, LOC	◆ SG2, LOC					

ARHAP by Takadzani Rambuda
Supervisor: Shirley Butcher

SCOTT, Lesotho - All Entities

Lesotho		* DA2, LOC	◆ EP7, LOC	⊕ HP6, NAT	▲ LB3, LOC		constituent reg
TYPECODE, SCOPE		■ EP1, NAT	✚ HP1, NAT	⊕ HP6, REG	◎ MD, LOC		
☆ CG, LOC		⊡ EP2, NAT	⬣ HP2, REG	● HP7, LOC	◎ MD, NAT		
✳ DA1, LOC		⊠ EP3, LOC	● HP3, LOC	● HP8, LOC	● OR, LOC		0 3.75 7.5 Kilometers
✳ DA1, NAT		▪ EP4, LOC	● HP4, LOC	● HP9, LOC	● OR, REG		
✳ DA1, REG		⊡ EP5, LOC	● HP4, REG	▲ LB1, NAT	◆ SG1, LOC		N
✳ DA2, INT		◆ EP6, LOC	● HP5, LOC	▲ LB2, LOC	◆ SG2, LOC		

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