EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

Title *African Religious Health Assets Program*

Participants Harald Askeland, Mary Baich, Christoph Benn, Jim Cochrane, Frank Dimmock, Niels French, Gary Gunderson, Tor Haugstad, Manoj Kurian, Deborah McFarland, Barbara Schmid, Rich Watson, Susan Purcell Gilpin, Mwandira Ruth Hope, Vuyelwa Tenjiwe Chitimbire, Simon Mphuka, Eva Ombakka, Samuel Mwenda, Marlon Banda, Eli Nangawe, Frits v.d. Hoeven

Date December 1-3, 2002

Location World Council of Churches, Geneva Switzerland

Background This meeting expanded the key issues raised in the April 2002 meeting on global religious health assets (a document summarizing that meeting is available in the IHP archive). This document demonstrates the development and clarification of methodologies for mapping religious health assets and brought core partners from Christian Health Associations in Sub-Saharan Africa and from European mission organizations to the table. In this meeting, one can see the later work on mapping religious health assets in Zambia and Lesotho carried out by the African Religious Health Assets Program (ARHAP) and IHP begin to take shape.

AFRICAN RELIGIOUS HEALTH ASSETS PROGRAM
Meeting II: European & African Partners

John Knox Centre
Geneva, Switzerland

December 1-3, 2002

We are grateful to Vesper Society and World Council of Churches for sponsoring this meeting.

"Relational and mental health, linked to environmental conditions and personal capabilities, are as crucial as biomedical issues in considering how one might deal with health crises in any local context."

- Jim Cochrane, *Religion and Health of Migrant Communities: Asset or Deficit?*, 2003

"The congregation functions a little like a permeable membrane around the resources and capacities of society for those who are on its outside or underside."

- Gary Gunderson, Deeply Woven Roots, 1997

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"Why … is the richness of the African traditional discourse with its holistic view of being and its emphasis on relations scarcely seen as opportunity, and so often merely as something needing correction…"

- Barbara Schmid, University of Cape Town Masters Thesis, 2002

I. MEETING SUMMARY

A small intense work group gathered in Geneva December 1-3, 2002, to clarify the basis and locale of the African Religious Health Assets Project and to clarify what we do not yet know. (See bios, Appendix I.)

Background

This meeting was the second step in a process begun in April, 2002, in Atlanta. Then, representatives of key North American religious agencies and researchers in schools of public health, relevant academic settings and religious structures met to begin the process of creating a working relationship and to talk about religious health assets globally, with a primary focus on Africa.

By the end of the Atlanta meeting, certain conclusions had been reached:

- The initiative needs to be about religious health *assets*, rather than *needs* or *resources*. *Needs* come from voids and *resources* are static and consumable, but *assets* are working capital which can be leveraged into additional assets.

- Currently, no reliable guide or documentation exists to map religious health assets in Africa. A critical task is to develop a conceptual framework and documentary evidence necessary to guide African decision-makers in aligning their health assets with a strong public health strategy. This knowledge base can serve as a helpful complement to the urgent challenges now facing the church and public health regarding HIV/AIDS, TB and malaria.

- This work must primarily rely on the creative work of African scholars and experts, especially students in religion and health science who can place their scholarly skills in the service of this profound challenge.

This vehicle for this work was named the African Religious Health Assets Program, ARHAP.

Because participants in the Atlanta meeting clearly recognized the lack of African voices, insights and participation in their deliberations, and also those of European partners with a long history of working with religious health assets in Africa, they suggested a follow-up meeting to bring European and African partners on board. In order to maximize time and assets, representatives from Europe, South Africa and North America met in Geneva the first weekend in December in order to interface with a New Partnerships Meeting co-sponsored by the World Council of Churches, Caritas Internationalis, and UNAIDS, which included representatives from five African nations.

We were very grateful to Manoj Kurian, Executive Secretary of the World Council of Churches (who had attended the Atlanta meeting), who arranged for our smaller group to join the larger group for conversation, to explain our thinking and ask for feedback on our process and direction. While the Cape Town involvement already places ARHAP clearly on the African continent, the knowledge and experience of these additional African religious leaders was crucial to the process. Because of the extraordinary networks they represent, they shed light on what the

strengths of African religious health systems are, how to assist them without over-burdening them, and what their long-term strategic role could be in the next couple of decades.

The Geneva meeting was also attended and supported by the Vesper Society Foundation of Hayward, California, a faith-based non-profit foundation, which supports research efforts and forums for in-depth thinking and dialogue that help move society toward a more compassionate world. We are enormously grateful for their generous grant which made this meeting possible, and for their participation in it.

Tasks for this Meeting

Because the first meeting was largely with North American partners, this second meeting was designed to test assumptions and conclusions from that meeting with European and African partners. In addition, we made concrete plans for a First Research Meeting to be held in 2003, and suggested revisions for a funding proposal to be submitted to the Templeton Foundation in mid-2003.

Before the meeting, Interfaith Health Program Director Gary Gunderson posed five key questions as the basis for discussion:

- **Who** are key academic and expert partners we need in order to create a conceptual framework and the evidence base African leaders will need to act faithfully?
- **What** will be the product(s) of our work together?
- **How**–through what process–will we create our product(s)?
- **When** will we work on each stage of this process?
- **Why** is ARHAP significantly urgent and important enough to cause busy people to leave other work undone to work on this project?

The Problem Defined . . .

In Africa, as elsewhere, the role of religious health networks and religious health institutions is, at best only dimly recognized–often by the religious community itself. "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

Outcomes of this Meeting

This working group brought together three corners of the program: Emory University, the University of Cape Town, and the University of Oslo–or, more broadly, Africa, Europe, and the USA. It was agreed that to firmly anchor ARHAP in Africa, the project will be centered in the Religious Studies Department of the University of Cape Town, where James Cochrane already has done work in this area (see paper, appendix II).

Research Component of the Project More Clearly Defined:

Scope: While some members urged that the project begin in Cape Town initially and gradually extend into the rest of Africa, the group decided to focus on three nodes that encompass more of the continent: Pietermaritzburg in South Africa; probably Nairobi, in East Africa; and a third center in French-speaking West Africa.

In addition, Norway has extensive archives concerning religious health assets developed not only by Norwegian missionary societies, but also those of Denmark, Finland, Sweden and Germany. However, most documents are currently printed texts in unfamiliar languages. For them to be accessible to Africans, they will need to be translated. This could be projects for graduate students in Norwegian universities and seminaries–or for African students brought to study in Norway. The thrust of this work would be to "bring knowledge about Africa back to Africa" by translating it into languages usable by Africans

Methodologies: It was determined that research needs to be conducted in each of these sites by graduate students who can use their research for theses or dissertations. Their work will either contribute to the map of religious health assets or broaden knowledge about connections between religion and health. One or two core faculty in African universities will also work on some component of this project. In addition, there needs to be a scientific advisory committee to assess research proposals.

Funding: Funding will need to be found for graduate work centering on this project and to staff ARHAP.[1]

Preliminary Questions: Most of those assets are embedded in some parent organization. What kind of organizations are we discussing? How are they led? How do they function? It was also recognized that churches are sometimes perceived to be useless and their work mediocre. This is the context in which we will be working and the myth we will need to dispel.

Aim: The aim of this research is that it be useful in the short term, in the fight against pandemic diseases such as HIV/AIDS, TB and malaria, but also be sound enough to serve as a base for future planning.

Potential outputs: Products of this research will be theses, conference papers, courses to be taught at African universities, analysis and evaluation of religious health assets, a map of those assets, and leadership development. The research is to be seriously grounded in community, but will not be driven exclusively by the needs of communities, including

[1]As a result of this meeting, the St. Luke's Foundation in Norway, under the leadership of Tor Haugstad and Harald Askeland from Diakonhjemnet College in Oslo, has become an active partner in this project

academic communities.

African respondents from the larger group suggested that case studies can be more useful than just a map of existing religious health assets in Africa.

ARHAP could also conduct executive seminars with policy makers and decision makers in each of the three regions to interact and assess the research process. This would include all stakeholders in all regions.

Dissemination: This was seen as crucial. This data must not sit on shelves. ARHAP already needs to be linking to policy makers who can use and distribute this information. A website was also proposed, with print media pointing to the site.

Additional Partners Deemed Important:

It was determined that to get a complete picture of religious health assets in Africa, links need to be made to Islam, traditional African religions, and minority faith groups such as Hindus and Buddhists, who also have religious health assets on the continent.

Funding Proposal Strengthened:

One accomplishment of this meeting was to suggest revisions for the Templeton funding proposal to strengthen it and make it a useful basis for other funding proposals. As a result of this discussion:

- concept sections of the proposal have been strengthened;.
- the foundational history of ARHAP–the fact that the Faith Health Consortium out of which ARHAP has grown was originally funded by a Templeton grant–has been stressed, to show continuity of concern, focus, and academic qualifications for the task ahead;
- other funding partners have been included, to demonstrate breadth of support;
- objectives have been re-ordered, condensed to four, more clearly defined and framed in active, compelling language;
- levels of network involvement have been more thoroughly defined;
- methods of leadership development have been clearly described;
- the "Creating Leverage" section has been fleshed out;
- the ARHAP time-line has been revised to reflect realistic expectations.

ARHAP's Critical Path Defined:

While research into religious health assets in Africa is the goal of ARHAP, it was decided that initially ARHAP needs to focus on a one-year preliminary phase which will produce a report on this meeting, find core groups in Southern, Eastern and Western Africa, make contact with government and communities, summarize what is already known, and raise funds for the larger project.

An immediate priority is revising and submitting the Templeton funding proposal.

A second immediate priority is preparing for a research meeting in August 2003 in Cape Town, to which 40 researchers and academics from agencies, denominations, seminaries, religious health organizations and graduate students will be invited. The purpose of this meeting will be

- to announce and launch the project,

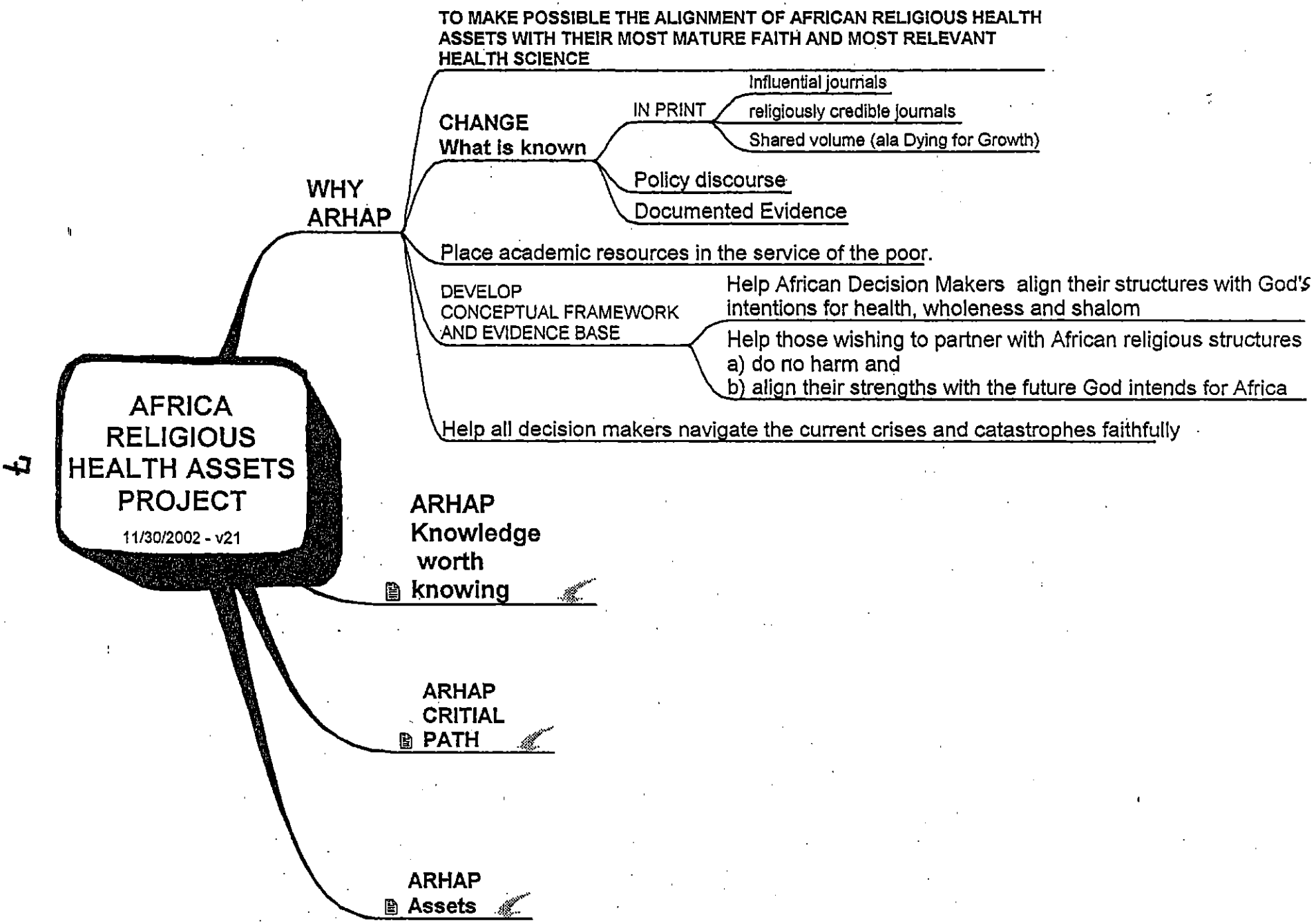
- to compare writings in process,
- to research frameworks,
- to consider challenges and issues for this project,
- to discuss practical applications of research,
- to frame student thesis writing related to this project,
- to serve as a model for later regional research meetings.

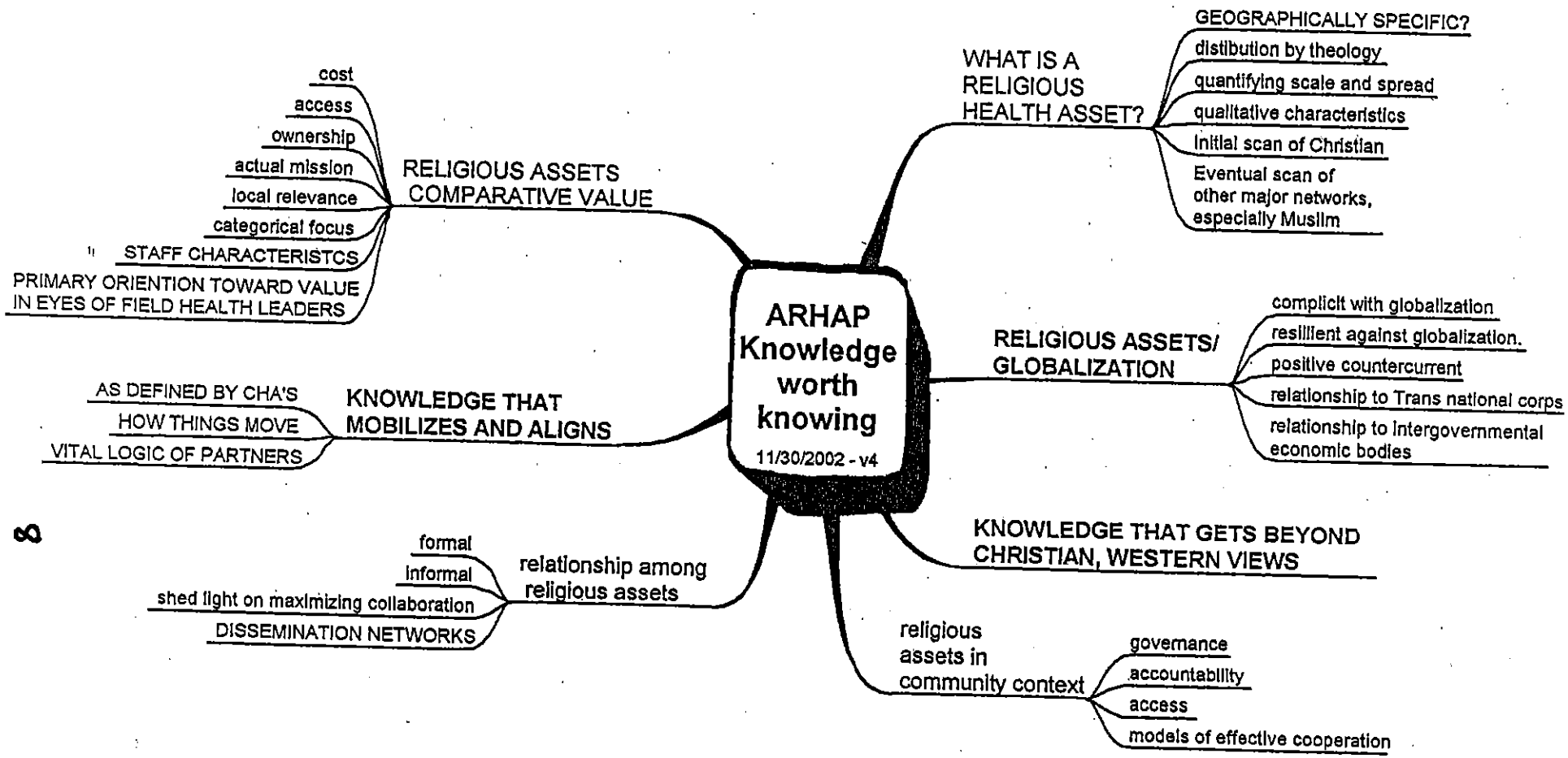
Response From The Larger Meeting

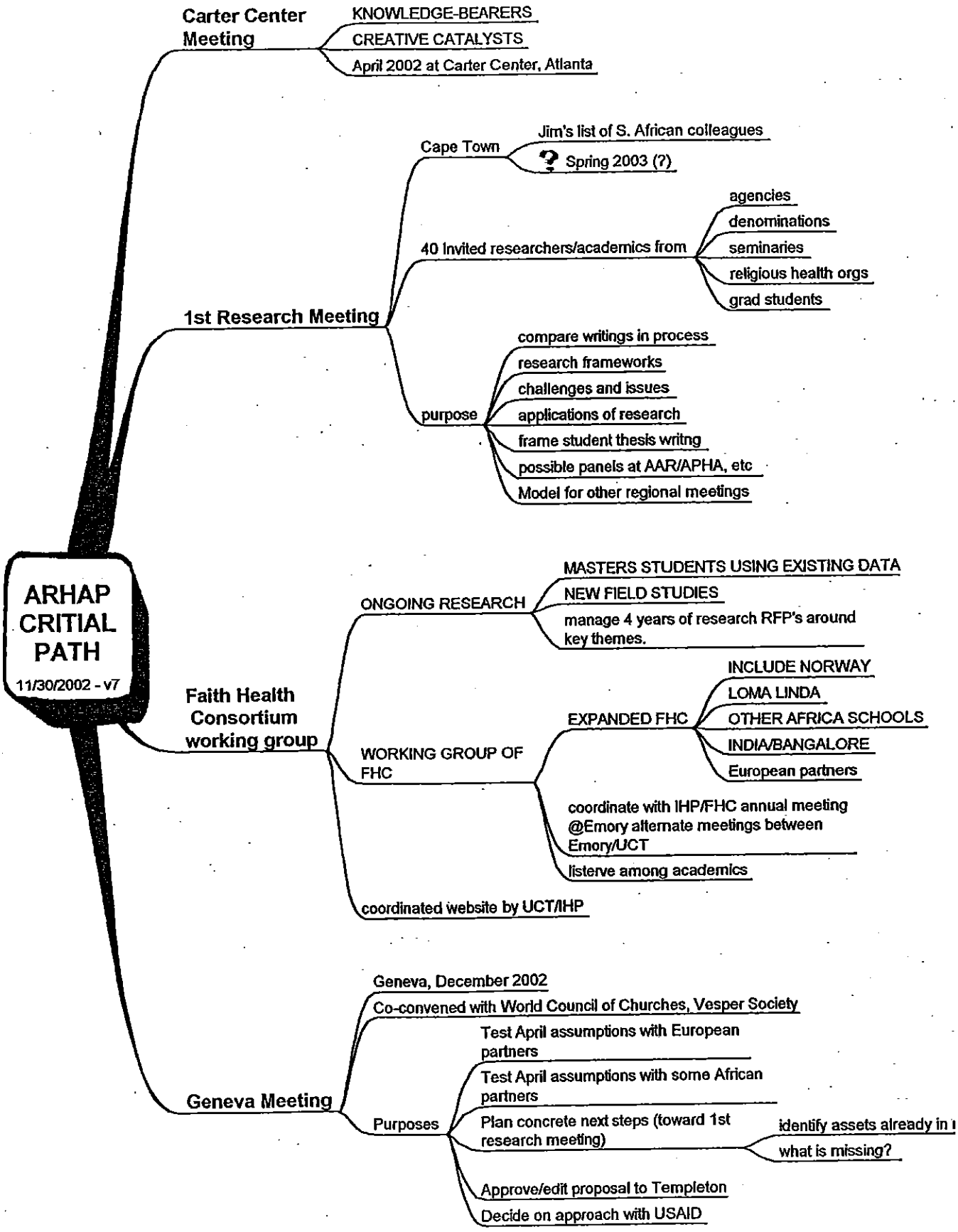
A report on the working group's discussion was warmly received by the larger group. Representatives of African religious organizations expressed that this project is something urgently needed. They emphasized that religious institutions are treated as "second fiddles" in governmental health planning in their countries. Therefore, they critically need documentation to provide higher credibility which can allow their voices to be heard.

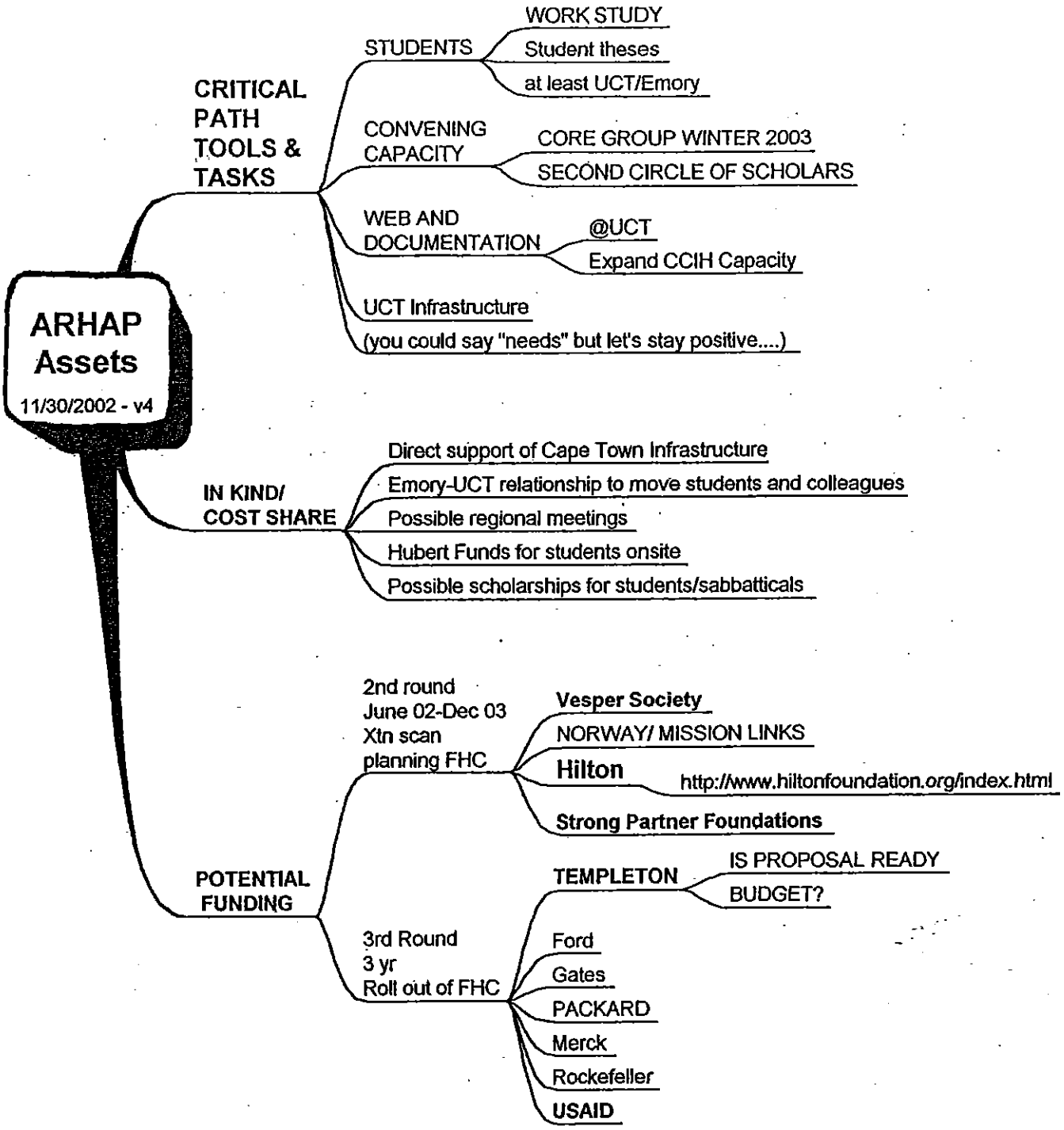
" ... the biggest weapon wielded and actually daily unleashed ... is the cultural bomb. The effect of a cultural bomb is to annihilate a people's belief in their names, in their languages, in their environment, in their heritage of struggle, in their unity, in their capacities and ultimately in themselves. It makes them see their past as one wasteland of non-achievement and it make them want to distance themselves from that wasteland. It makes them want to identify with that which is furthest removed from themselves. ... [In response we envision] ordinary men and women...in South Africa, Namibia, Kenya, Zaire, Ivory Coast ... who have declared loud and clear that they do not sleep to dream, 'but dream to change the world'."

- Kenyan writer Ngugi wa Thiong'o, Decolonizing the Mind, 1986


AFRICA RELIGIOUS HEALTH ASSETS PROJECT
11/30/2002 - v21
WHY ARHAP
TO MAKE POSSIBLE THE ALIGNMENT OF AFRICAN RELIGIOUS HEALTH ASSETS WITH THEIR MOST MATURE FAITH AND MOST RELEVANT HEALTH SCIENCE
CHANGE What is known
IN PRINT
Influential journals
religiously credible journals
Shared volume (ala Dying for Growth)
Policy discourse
Documented Evidence
Place academic resources in the service of the poor.
DEVELOP CONCEPTUAL FRAMEWORK AND EVIDENCE BASE
Help African Decision Makers align their structures with God's intentions for health, wholeness and shalom
Help those wishing to partner with African religious structures
a) do no harm and
b) align their strengths with the future God intends for Africa
Help all decision makers navigate the current crises and catastrophes faithfully
ARHAP Knowledge worth knowing
ARHAP CRITIAL PATH
ARHAP Assets


ARHAP Knowledge worth knowing
11/30/2002 - v4
WHAT IS A RELIGIOUS HEALTH ASSET?
GEOGRAPHICALLY SPECIFIC?
distibution by theology
quantifying scale and spread
qualitative characteristics
initial scan of Christian
Eventual scan of other major networks, especially Muslim
RELIGIOUS ASSETS/ GLOBALIZATION
complicit with globalization
resilient against globalization.
positive countercurrent
relationship to Trans national corps
relationship to intergovernmental economic bodies
KNOWLEDGE THAT GETS BEYOND CHRISTIAN, WESTERN VIEWS
religious assets in community context
governance
accountability
access
models of effective cooperation
relationship among religious assets
formal
informal
shed light on maximizing collaboration
DISSEMINATION NETWORKS
KNOWLEDGE THAT MOBILIZES AND ALIGNS
AS DEFINED BY CHA'S
HOW THINGS MOVE
VITAL LOGIC OF PARTNERS
RELIGIOUS ASSETS COMPARATIVE VALUE
cost
access
ownership
actual mission
local relevance
categorical focus
STAFF CHARACTERISTCS
PRIMARY ORIENTION TOWARD VALUE IN EYES OF FIELD HEALTH LEADERS


ARHAP CRITIAL PATH
11/30/2002 - v7
Carter Center Meeting
KNOWLEDGE-BEARERS
CREATIVE CATALYSTS
April 2002 at Carter Center, Atlanta
1st Research Meeting
Cape Town
Jim's list of S. African colleagues
Spring 2003 (?)
40 Invited researchers/academics from
agencies
denominations
seminaries
religious health orgs
grad students
purpose
compare writings in process
research frameworks
challenges and issues
applications of research
frame student thesis writng
possible panels at AAR/APHA, etc
Model for other regional meetings
Faith Health Consortium working group
ONGOING RESEARCH
MASTERS STUDENTS USING EXISTING DATA
NEW FIELD STUDIES
manage 4 years of research RFP's around key themes.
WORKING GROUP OF FHC
EXPANDED FHC
INCLUDE NORWAY
LOMA LINDA
OTHER AFRICA SCHOOLS
INDIA/BANGALORE
European partners
coordinate with IHP/FHC annual meeting @Emory alternate meetings between Emory/UCT
listerve among academics
coordinated website by UCT/IHP
Geneva Meeting
Geneva, December 2002
Co-convened with World Council of Churches, Vesper Society
Purposes
Test April assumptions with European partners
Test April assumptions with some African partners
Plan concrete next steps (toward 1st research meeting)
identify assets already in
what is missing?
Approve/edit proposal to Templeton
Decide on approach with USAID


ARHAP Assets
11/30/2002 - v4
CRITICAL PATH TOOLS & TASKS
STUDENTS
WORK STUDY
Student theses
at least UCT/Emory
CONVENING CAPACITY
CORE GROUP WINTER 2003
SECOND CIRCLE OF SCHOLARS
WEB AND DOCUMENTATION
@UCT
Expand CCIH Capacity
UCT Infrastructure
(you could say "needs" but let's stay positive....)
IN KIND/ COST SHARE
Direct support of Cape Town Infrastructure
Emory-UCT relationship to move students and colleagues
Possible regional meetings
Hubert Funds for students onsite
Possible scholarships for students/sabbatticals
POTENTIAL FUNDING
2nd round
June 02-Dec 03
Xtn scan
planning FHC
Vesper Society
NORWAY/ MISSION LINKS
Hilton
http://www.hiltonfoundation.org/index.html
Strong Partner Foundations
TEMPLETON
IS PROPOSAL READY
BUDGET?
3rd Round
3 yr
Roll out of FHC
Ford
Gates
PACKARD
Merck
Rockefeller
USAID

African Religious Health Assets Programme ARHAP

African Religious Health Assets Programme Cape Town Office
University of Cape Town Religious Studies Private Bag 7700 Rondebosch South Africa

Preparatory Research Project

What:

The programme seeks to develop a systematic knowledge base of religious health assets in sub-Saharan Africa; thus to assist in aligning and enhancing the work of both religious health leaders and public policy makers in their collaborative effort to meet the challenge of disease, e.g. HIV/AIDS; and hence to promote sustainable health, especially for those who live in poverty or under marginal conditions.

Why:

Our understanding of how religious health assets function in communities and in public health systems to advance or retard health outcomes is still undeveloped. Recent literature focusing on the social determinants of health notes the key role of religious values and organizations in shaping the capacity of communities to respond to ~~negative~~ challenges or to seize opportunities to advance health. Our emphasis on "assets" points to what people already do that can be built upon and better leveraged.

Who:

The co-principal investigators are Prof James Cochrane, Religious Studies, UCT; Prof Deborah McFarland, Public Health Economist, and Prof Gary Gunderson, Interfaith Health Programme, both from the Rollins School of Public Health, Emory University, Atlanta. A core research group of academics from African universities will be supplemented by the expertise of other academics and religious networks in Africa, Europe and the USA.

Planned outcomes:

1. Create an interdisciplinary, interfaith network of scholars, religious leaders, health and development professionals.
2. Develop conceptual frameworks, analytical tools and measures to define and capture religious health assets as seen from African perspectives.
3. Provide a reliable survey of existing baseline data sources on religious health institutions and networks in Africa.
4. Commission original research to create an increasingly comprehensive mapping of religious health assets in sub-Saharan Africa.
5. Build leadership capacity regarding religious health assets.
6. Disseminate and communicate results and learnigs widely and regularly.

The current state of ARHAP:

January – August 2003, the preparatory phase, will set up local infrastructure, begin establishing the network, finalise larger grant proposals and plan a Masters level course at UCT for the latter half of 2003.

Please contact us:
bschmid@humanities.uct.ac.za
021-650 3457

University of CAPE TOWN
EMORY UNIVERSITY
BROADSHEET

THE INTERFAITH HEALTH PROGRAM OF

THE ROLLINS SCHOOL OF PUBLIC HEALTH.

EMORY UNIVERSITY

Participants to the Geneva Consultation
World Council of Churches Meeting
John Knox Center
December 1-4, 2002

November 25, 2002

Dear colleague:

Thank you for your continued commitment to ensure quality health services for our brothers and sisters throughout sub-Saharan Africa. Your work embodies the shared mission of people of faith to provide compassion, justice and hope to those in need.

Dr. Kurian indicated in his invitation to you that your planning meeting will overlap with a small working group focused on the Africa Religious Health Assets Project (ARHAP). The Health and Healing Programme of World Council of Churches and Vesper Society (http://www.vesper.org) are co-sponsoring this meeting as an early step in creating a learning consortium among the key religious organizations that have a moral commitment and in some cases, legal responsibility, to reinforce the networks of hospitals and health systems in Africa. We are looking forward to briefing you on this project on Monday morning and receiving your guidance as to how best to proceed. In advance of that discussion, let me give you a little background on our thinking so far.

Last spring we began to describe the networks of global faith-based health services and to identify their assets for providing health services worldwide. We met at The Carter Center and found that there is little public information pertaining to these networks, but a committed interest on the part of a number of key religious health organizations to share this process of learning.

There are three knowledge challenges before us:
- First, we need a conceptual framework to help all the relevant decision makers in their responsibilities as they guide the hundreds of religious organizations relevant to responding to disease and advancing health.
- Second, we need an evidence base regarding religious health networks that will then be available to those who are the leaders and funders of the global health agenda. *This is urgent.*
- Third, (and this will take more time) we need some of the best academics and wise field experts to reflect deeply on that evidence base so that religious structures align their future efforts with their most mature faith and most relevant health science.

As you are aware, there are rapid changes occurring throughout global healthcare systems. The roles of religious hospitals are quickly expanding and these systems are expected to carry a vast strategic load in the face of many health crises. Economic instability and HIV/AIDS has swept away large parts of the governmental health structures and placed incredible demands on the religious systems. Many international and multinational donors are turning to these partners for their expertise. In some cases, there is the possibility of new resources coming

into the religious health networks.

The problem with this recent turn of interest and appreciation for religious health networks is that for almost a generation there has been little analysis and reflection on the assets/potential roles of these religious systems. Consequently, this is a moment of profound danger as well as an opportunity to serve. The lack of knowledge may be a greater threat than the lack of financial resources.

Although dynamic faith-based health networks exist, these networks function primarily to strengthen their particular health systems within their own religious frameworks. The ARHAP however, seeks to facilitate a learning consortium among individuals and networks of all religious health organizations as well as the academic community. At the center of our concerns are the "health assets," which is a way of avoiding restricting the opportunity to just hospitals. Both health science and theology demand that we take a broad view of the "health assets" the religious community must be accountable for.

It is important to say that while the initiative has a tentative name, we have not moved to secure long term funding, developed a full plan of action, or even formed a formal advisory structure. Our small working group will be moving on all those things while we are in Geneva. However, we want your guidance before we go very far. Thus, we hope that you are willing to engage in this work with us on Monday 1 December.

Your knowledge and experience is crucial to shed light on what the strengths of the religious health systems are, how to assist them without over-burdening them and what their long-term strategic role could be in the next couple of decades. You are crucial, not only because of your personal expertise, but also because of the extraordinary network of people you represent. We think that this initiative will contribute directly to the mission of your organization, just as it is in the heart of our own.

Finally, we must underline that we view this entire shared work as a profound opportunity. You may have already read the "call to colleagues" that has emerged from a series of retreats with public health and faith people in the last year that we helped author. The last paragraph is especially appropriate as we move toward this particular shared work. "We are grateful that we live in a time of such possibility. We have an extraordinary menu of technical and policy tools that could be aligned with enduring social strengths to advance the health of our communities. Thus our science and our faith traditions make it impossible for us to be patient or timid. We will help each other fulfill our commitments to these goals." (http://www.ihpnet.org/joincolleagues.htm) We look forward to hearing from you.

Thank you for all that you are doing.

Sincerely,

Rev. Gary Gunderson, D. Min., M. Div.
Director, Interfaith Health Program
Department of International Health
Rollins School of Public Health
Emory University, Atlanta, Georgia U.S.A.
http://www.ihpnet.org

GENEVA MEETING PARTICIPANTS [A-W]

Harald Askeland
Diakonhjemmet College
Oslo,
Norway

harald.askeland@diakonhjemmet.no

Norway

Mary Baich
Director
Vesper Society
22351 City Center Dr. Ste 100
Hayward, CA 94541

Phone: 510-885-1774
Fax: 510-885-1887

mobaich@vesper.org

United States

Christoph Benn
Deputy
DIFAEM
German Institute for Medical Mission
P O Box 1307
Tubingen, 72003
Germany

Phone: [49] 7071/206512
Fax: [49] 7071/206510

benn@difaem.de

Germany

James R. Cochrane
University of Cape Town
Dept of Religious Studies
Private Bag
Rondebosch 7700,
South Africa

Phone: [27] 021-650-3461
Fax: 021-689-7575

cochrane@humanities.uct.ac.za

South Africa

Frank E. Dimmock
Presbyterian Church (USA)
3/129 Lister Ave
P O Box 1266
Lilongwe,
Malawi

fdimmock@malawi.net;fdimmock@yahoo.com

Malawi

Niels French
Program Administrator
Interfaith Health Program
Emory University
1256 Briarcliff Rd, A-107
Atlanta, GA 30306

Phone: 404-727-5257
Fax: 404-727-5261
Mobile Phone: 404-396-6441
Home Phone: 770-664-7432

nfrench@emory.edu

United States

Rev. Gary Gunderson
Director
Interfaith Health Program
Emory University
1256 Briarcliff Rd, A-107
Atlanta, GA 30306

Phone: 404-727-5221
Fax: 404-727-5261
Mobile Phone: 404-966-0530

ggunder@emory.edu

United States

Tor Haugstad
Kirkeradet/Kirkens Arbeidsgiverorganisasjon
Karl Johans gt. 35
0162 Oslo,
Norway

Phone:
[47] 23 31 04 40/65
Fax: [47] 23 31 04 50

tor.haugstad@ka.no

Norway

Manoj Kurian
Executive Secretary
World Council of Churches
150 route de Ferney,
Box 2100
Geneva 2, CH-1211
Switzerland

Phone: [41] 22 791 6323
Fax: [41] 22 791 6122

mku@wcc-coe.org

Switzerland

Deborah A. McFarland
Assoc. Professor
Dept of International Health
Emory University
1518 Clifton Rd
Atlanta, GA 30322

Phone: 404-727-7849
Fax: 404-727-4590

dmcfarl@sph.emory.edu

United States

Barbara Schmid
University of Cape Town
Dept of Religious Studies
Rondebosch 7701,
South Africa

Phone: [27] 021 650 3457
Fax: [27] 021 689 7575

bschmid@humanities.uct.ac.za

South Africa

Rich Watson
Vesper Society
22351 City Center Dr. Ste 100
Hayward, CA 94541

Phone: 510-885-1774
Phone Ext.: 120
Fax: 510-885-1887

rwatson@vesper.org

United States

NEW PARTNERSHIPS MEETING

CO-SPONSORED BY:
THE WORLD COUNCIL OF CHURCHES, CARITAS INTERNATIONALIS AND UNAIDS

Susan Purcell Gilpin
Regional Coordinator for Southern Africa
Ecumenical HIV/AIDS Initiative in Africa
No 5 Barrington Close
Glen Lorne
Harare Zimbabwe
Tel: +263-4-499766
Cell: 091-723-961
sueparry@mweb.co.zw

Mwandira Ruth Hope,
Christian Health association of Malawi
P.O Box 30378
Lilongwe, Malawi
+265-1-775404
+265-1-775180, +265-1-776492

Vuyelwa Tenjiwe Chitimbire
General Secretary
Zimbabwe Association of Church related
Ballymena, Co. Antium
United Kingdom

Email marlonbanda@ukonline.co.uk
Tel ++44 28 256 43227

Simon Mphuka
Churches' Medical Association of Zambia
P.O. Box 34511
Ben Bella Rd., Plot no.9306
Lusaka / **Zambia**
Tel: +260 1 237 328
Fax: 260 1 223297 or 260 1 2312266
E-mail: cmaz@zamnet.zm
or mphuka@zamnet.zm

Eva Ombakka
Ecumenical Pharmaceutical Network,
P.O. Box 73860, Nairobi – KENYA
Tel: 254-02-4444832 /4445020
Fax: 254-02-4440306 / 4445095
email: epn@wananchi.com

Hospitals.

Office address
P.O. Box 1556
Harare
Tel. 790597 or 724371
Fax 790597
e-mail: zach@africaonline.co.zw

Samuel Mwenda Rukunga
General Secretary,
Christian Health Association of Kenya
P.O. Box 30690
Nairobi, Kenya
e-mail -mwenda@insightkenya.com

Marlon Banda
Proposed Researcher for stock taking exercise
(from Zambia, currently residing in U.K)
43 Summerfield Street,

BT43 7DP, N. Ireland
Website: www.epnetwork.org

Eli Nangawe (not confirmed)
Christian Social Services Commission
P.O. Box 9433
Dar Es Salaam
Tanzania
elinanga@hotmail.com

Frank Dimmock
PC USA Representative for East and
Southern Africa
+265 1 750007
fdimmock@malawi.net
fdimmock@yahoo.com

Frits v.d. Hoeven
Medical Coordination Secretariat
P.O. Box 8506
3503 RM, Utrecht / Netherlands

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