

**THE ROLE OF FAITH-BASED HEALTH PROVIDERS IN THE SOUTH
AFRICAN HEALTH SYSTEM:
A HISTORICAL CASE STUDY ON THEIR NATIONALIZATION AND
PRIVATIZATION**

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Abstract

Faith-based health providers (FBHPs) have been identified as important actors and allies in health service delivery, especially in weak and fragile health systems in sub-Saharan Africa (SSA). Although FBHPs are still present in a number of SSA countries in varying degrees and capacities, in South Africa FBHPs were nationalized in the 1970s with some of these missionary facilities later being entirely closed. This historical case study draws on primary and secondary archival data collection as well as in-depth interviews, and discusses the reasoning and some of the results of nationalizing FBHPs in South Africa. We find that FBHPs were nationalized for financial and political reasons in the Apartheid era with the effects of the decision still being felt in the late 1990s. This has resulted in the shifting of efforts of some faith communities from health service delivery to more 'health-related development programming' such as orphanages, old age homes, step-down primary clinics and 'faith inspired organizations' that promote health through the provision of food, water and shelter. The story of the nationalization of FBHPs into the South African health system is important, especially for other countries still pondering the presence of these types of faith health providers in their national health systems' architecture.

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Finally, I would also like to express my appreciation for all those who participated in this study for their time and permission to share their thoughts, resources and experiences.

Declaration

I, Dineo Kwena Maitisa (MTSDIN005) hereby declare that the work in this thesis is based on my original work (except where acknowledgements indicate otherwise) and that neither the whole work or in part, is being or has been submitted towards another degree, at this University or elsewhere.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

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Part A: Protocol

The role of faith-based health providers in the South African health system: a historical case study of their nationalization and privatization

Introduction

The contribution of faith-based health providers (FBHPs) to the delivery of health services in sub-Saharan Africa has been noted as being historically important, and has been understood to be a key feature of health system strengthening over the past several decades (Olivier et al. 2015). Recently, the role of non-state actors and in particular, of non-state non-profit health providers has recently come back into the spotlight, particularly FBHPs, which is a sector inclusive of the old 'missionary' facilities (Norder et al. 2015). FBHPs have been shown to be a reliable part of the health care system in many low to middle-income countries (LMICs) (Söderlund et al. 2003), where they are believed to play a role in health system strengthening, especially in rural environments, although the evidence is by no means comprehensive (Blatley and Mcloughlin 2009). Numerous countries in sub-Saharan Africa (SSA) such as Malawi, Uganda, Zambia, Lesotho and Ghana continue to have substantial numbers of mostly Christian and some Islamic FBHPs present in their national health systems; organizations that play a recognized role in health care delivery as well as the training of health workers – most noticeably nurses and midwives (Chand and Patterson 2007; Green et al. 2002; Olivier et al. 2015).

Unlike in South Africa, where FBHPs were nationalized (the focus of this study), these countries have retained FBHPs as a distinct sector in their health system (Robinson and White 1997; Schmid et al. 2008), and their presence is said to likely 'strengthen' the health system by providing extended access to health services and alternative options beyond what can be offered by the sometimes limited and overburdened state-run facilities (Boulenger and Criel 2012). At present, it is estimated that FBHPs are strongly present in 23 of the 54 African countries (Dimmock et al. 2017).

The presence of both state and non-state run facilities in such countries gives rise to public- private partnerships (PPP) – which is important in health system strengthening (HSS) as they represent both national and global policies and thus have the power to advocate for specific policies and health issues (Buse et al. 2005).

Although FBHPs are present in most LMICs health systems (Kagawa et al. 2012), their contribution to the South African health sector (past or present) has not been well documented. This is interesting as FBHPs were said to have provided some important health services in the country prior to the 1970s (Coovadia et al. 2003) – but their current role and presence is not clearly understood. This brings to question, what happened to FBHPs in South Africa in the past several decades?

Background to FBHPs in the SA health system

The South African health sector has undergone many changes over the past century, with the most noticeable changes being in the past 20 years (1990s-2000s). During Apartheid¹, FBHPs were noticeable health care deliverers across the provinces (Cape of Good Hope, Natal, Orange Free State and Transvaal) (WHO 1983) with Christian missionary hospitals and clinics often being the only medical services in remote and rural areas of the country for a significant period in the 1900s particularly in the homelands² where the black majority and so-called 'coloured' populations lived (Coovadia et al. 2009; Horwitz 2009). At this time, the South African health system was orientated towards the white minority population living in urban areas (Coovadia et al. 2009; Horwitz 2009; Price 1986). This included the funding and availability of basic health care, health advances such as technologies and medication as well as social determinants of health such as clean water and sanitation, nutrition and housing (Benatar 2013). During this period, the international community did not condone the discriminatory racial policies, resulting in the withdrawal of South Africa from the Commonwealth of Nations in 1961 and the implementation of sanction in 1962 (Davenport 2000). This prevented the presence of international funders in the country, with FBHPs providing some of the only health services to marginalized communities (WHO 1983).

In the 1970s, over several years, FBHPs (specifically mission hospitals and clinics), were nationalized – that is, taken over by the national authorities. Since then and particularly post-Apartheid (1994), FBHPs in the form of missionary hospitals and clinics seem to have

Problem statement

As noted above, there has been renewed interest in non-state providers and in particular FBHPs in LMICs. However, apart from the general understanding that FBHPs in South Africa were gradually nationalized or subsumed in the 1970s, almost nothing is known about this history – nor, in retrospect, what this particular decision (to nationalize them) means for the current health system.

Health policy and systems research (HPSR) has shown the importance of history in understanding the present health system as decisions made in the past can, and do have long term effects on various factors and sectors of the health system (Buse et al. 2005; Gilson 2012). The current structure of the health system and the presence of FBHPs in the sector is a direct result of the country's past national policy changes. Therefore, in this study, we aim to explore the historical narrative of 'what happened to FBHPs' in

¹ In South Africa, apartheid was the political system of institutionalized racism and discrimination that existed between 1948 and 1991s. During this time health care facilities were separated based on race and those designated for the black population in rural areas were inadequate and underfunded (SAHO, 2011).

² Homelands or Bantustans were areas to which the majority of the black population were moved under Apartheid (10 across the country). This removed them from the political system and this forced them to run their own governments and health care services (SAHO, 2011) disappeared, with FBHPs changing their form and structure into orphanages, old-aged homes and health facilities such as lay-clinics (SA NPO Report 2012) following some international trends of privatizing FBHPs (Coovadia et al. 2009; James 2009) – although this will be explored in more detail in this study.

Purpose of the study

The purpose of the study is to retrospectively describe the role and presence of FBHPs in the South African health system over the last 65 years (from 1950 to 2015).

Research question

The main research question to be answered is: *How has the changing role and presence of faith-based health providers affected health care provision in South Africa from the period of 1950 to 2015?*

The sub-questions that needed to be answered in order to guide the main question are:

- How significant were FBHPs in the South African health system?
- How and when did the role and presence of FBHPs change in South Africa?
- To what extent are FBHPs still significant with regards to health provision in South Africa?

Study design

In order to understand how and why the current South African health system is designed as is, it is worthwhile to narratively track key health system developments that have, over time, had a particular impact on the role of FBHPs. HPSR draws on a number of disciplines including economic, sociology, politics, epidemiology and anthropology and seeks to understand how different actors interact in policy in order to implement process to contribute to positive health outcomes (Gilson 2012) - and it is with this in mind that a case study methodology will be used. This methodology takes into consideration how a phenomenon is influenced by the contextual situation, by allowing the researcher to answer the 'how' and 'why' type questions (Baxter and Jack 2008). A case study comprises "an empirical investigation into a contemporary phenomenon within real life, using multiple sources of data" (Yin 1984). Case studies allow for the complicated understanding of a reality that cannot easily be measured and can be better understood by gaining a broader understanding and appreciation of the health system through this approach (Thomas et al. 1998), and a better appreciation of the policy implementation in the health sector (Crowe et al. 2011). A case study is also appropriate when a unique story has to be told (Neale et al. 2006), which is the case of the role of FBHPs in the South African health system.

Over the past 65 years, South Africa has had some great political changes that affected many laws and policies. The changes that occurred over the years have shaped the manner in which FBHPs operate in the country and this has (directly or indirectly) perhaps impacted the strength and reach of the health system, making this a historical case study on the South African health system.

This retrospective case study will take a look at the history of the South African health system, with the focus being on the past 65 years (1950-2015), noting the chronological timeline of FBHPs through the nationalization and privatization of FBHPs (mission facilities). This historical case study, will integrate several types of data, and will ensure that the issue is described through multiple lenses and allows for multiple contextual factors to be revealed and better understood (Baxter and Jack 2008).

The purpose of this investigation will be 'descriptive': it serves to describe how nationalization has impacted the presence and role of FBHPs. The actors, political climate and social conditions that led up to the decisions will be essential in understanding the results of these decisions.

There are a few existing publications that track and describe the historical evolution of FBHPs in other African LMIC countries (Dimmock et al. 2012) (also see Part B). In the scoping review part of this research, the main trends will be drawn out from these – and then compared against the findings from this study.

Phase 1: Rapid scoping review and archival data collection

The first phase of this study will be a scoping literature review of the information available with regards to the South African health system and the presence and role of FBHPs from 1950 (with some consideration of materials on FBHPs in other African countries). To develop this history, primary materials will be gathered from libraries and archives – such as archived policies, newspaper articles and other materials (accessed mainly through the University of Cape Town). It is known that there are additional denominational archives (for example, the Catholic National Secretariat), and access will be sought from these as well. Such materials are not classified – but are generally not available open access online. In all cases, the privacy or confidentiality particulars for any such archive or specific document would be checked and adhered to. However, in this mini-thesis project, a full archival search will not be undertaken. Instead, during interviews (see below), key informants will be asked to share any relevant documents. If, during this process, it is shown that there are relevant documents in the local institutional archives, then proper permission will be sought for access to these. In our experience, this would not require a formal permission process (for example, the interviewee should be able to provide limited access to these archives of the Methodist Church of Southern Africa). However, if it does become necessary, full permission for archival access will be sought in writing to the appropriate authorities before any archival searches are conducted.

Institutions that will be approached include the Methodist Church of Southern Africa (MCSA), The Catholic Church in South Africa as well as the Department of Health, where access can be obtained through the key informants. It is anticipated that institutional archives might hold documents such as meeting minutes or reports which might provide historical insight into the timing and process of decision-making relating to the nationalization of the FBHPs in South Africa. Through these materials, information pertaining to the

PART A: Historical case study on nationalization & privatization of FBHPs in SA social, economic and political climate will be extracted. Individual accounts, organizations and institutions programs, recorded dates and socio-economic circumstances will also all be used to develop a timeline. At this time, we do not know how much archival material is available – so an early effort will be made to check this availability.

This literature review and analysis can be used to build theory by better understanding the social and health context and the actors that were involved and affected by these decisions (although the extent of ‘theory-building’ will be limited in this small project). This phase of research will result in a literature review, an analysis framework, and a timeline which tracks the presence of FBHPs against the national health systems developments.

Phase 2: In-depth interviews

Semi-structured key informant interviews will be conducted to support the literature review and archival work conducted in Phase 1. Key informants would consist of individuals identified in Phase 1 who have a particular historical knowledge of the role of FBHPs in the South African system. Christian organizations (Catholic and Methodist facilities) will be the main focus as they were the most prominent FBHPs in South Africa.

Table 1: Summary of Possible Interview Participants

Potential Interview Participant	Position	Reason and Access
Name removed*	History and Public Health Lecturer	Has an interest in both history and Public Health and has some knowledge on the laws and policies that have shaped the South African health sector.
Name removed	Director of the SACBC AIDS Office	Has worked in FBHPs for many years and has some first-hand experience on the changing role of FBHPs in health care.
Name removed	Bishop of the Central District of the Methodist Church	Has always had a passion for understanding and improving the role of the church has on health care delivery. His office is involved with the political government and could provide church views the faith and health partnership.
Name removed	Adviser to the Minister of Health	Has knowledge on the present health system and will provide insight on how the government views the role of FBHPs in health care.

*The names were provided in the original version approved by ethics, but have been redacted due to the blinding of Part C

Interview participants will be identified through the scoping literature review and by reviewing key speakers and attendees at conferences relating to Faith and Health. Additionally, the snowball process will be used by asking these key informants of other individuals with knowledge and information on the research topic. The same process will be used in obtaining participants’ contact details where email or telephonic requests will be made. It is anticipated that between 5 and 15 stakeholders will be interviewed – depending on how many are identified, and when informational and conceptual saturation is reached (to

PART A: Historical case study on nationalization & privatization of FBHPs in SA
be decided jointly by the researcher and supervisor).

An interview guide will be used for the semi-structured interviews - see Appendix II. The researcher will conduct interviews. See below in Informed consent and Privacy for more details.

Table 2: Research Method

Phase 1:	Data collection	Archival searches of policies, documents, articles and other written text in university, public libraries, FBHPs and church archives for evidence as to how the health architecture has changed in the past 65 years with respect to FBHPs and the social and political factors that affected this change.
Phase 2:	Supplementary interviews	Interviewees can provide clarity and commentary on the primary and secondary data collected and opinions on the role of FBHPs in health system strengthening.

Data analysis

Data analysis will be conducted across parallel streams of data. Thematic analysis will be used across all data (primary and secondary documents and resources) as well as the interview transcripts. Data from each participant will be represented individually, interpreted and patterns assessed and explored in order to understand the thoughts and beliefs of the relevant interviewee.

These parallel streams of analyzed research will feed into each other and integrated. Qualitative analysis emphasizes how data fit together to make a whole, and includes context and meaning because social phenomenon cannot be understood outside of the context in which they are located. Therefore, 'constant comparative analyses' will be used in the analysis process (Attride-Stirling 2001). In this way, the perceptions of the participants can be integrated with the other evidence types. Appendix IV displays a summary of the steps involved in thematic analysis. After the themes have been analyzed, a conceptual diagram will be created to illustrate the findings and relationships between them. The researcher will be hand-coding the themes and not using computer software due to the nature of the data collection (historical documents). The findings of this data collection will be discussed with the supervisor to ensure better reflexivity.

Reflexivity

In order to be aware of her own views and biases regarding the topic and as well as her relationships with some of interview participants, the researcher needs to exercise constant reflexivity. She will do so by ensuring by having several debriefing sessions with her supervisor in which analysis and findings will be considered.

Informed consent process and privacy

Interview participants will be identified based on their perceived knowledge and professional engagement with the research topic (faith and health). They will then be contacted after which they will receive an invitation to participate in the interview. The interviews will be conducted in person, but if that is not possible, telephonically. Prior to the interview taking place, an informed consent form will be given to the interviewee with an option to have the interview recorded. The interviewee will be required to sign the form if he/she consents or choose not to sign the form if he/she does not want to participate.

Participants will receive a copy of the consent form and detail of the research objectives (Appendices I and II). For interviews conducted telephonically or via email/skype, interviewees will receive Informed Consent forms as an attachment via email. Researcher will require a (scanned or faxed) signed copy to be returned before interview is conducted.

Upon request, interview participants' name will not be included in the study and recordings and transcripts will be deleted upon study conclusion. However, due to the nature of the research topic and question, anonymity of the participants cannot be guaranteed, as they may be identifiable. This is because participants may be specialists in the field and due to organization/institutional affiliation and/or position and views, readers may identify the participants despite their name not being mentioned (participants will be fully informed of these challenges in this type of historical case study).

Each interview will be conducted in English, will last for approximately one-and-a-half hours and will be held in a private room with only the researcher and interviewee being present and at the participants' convenience. Each interview will be audio taped (if agreed) and transcribed verbatim, and analysis will be conducted based on the transcribed audio files. Upon refusal of being audio taped, only notes will be taken. All audio recordings and written transcripts (in the possession of the researcher) will be locked in a cabinet or on a password protected computer will be deleted within 3 years' research conclusion.

Risks and benefits

This is a low risk study, given its focus on historical health systems change, and on a sector that has no major presence in the current health systems context. No children or at-risk populations will participate in this study. There are some minor risks associated with this research with regards to data collection and interview participants. Due to it being a historical case study there is a risk that all the archival documents, texts and literature may not be accessible, available or present at all. Not finding any data to document the evolution of FBHPs would note a gap in historical data on the topic. This could be overcome by increasing the number of interviews undertaken. Additionally, there is the risk that the research may find

PART A: Historical case study on nationalization & privatization of FBHPs in SA comparatively less data relating to the earlier health systems development. Efforts will be made to compensate by conducting additional archival searches for materials in these periods.

Another potential risk would be the inability to get the required information from the key informants and interview participants due to the potential of damaging their relationships or the releasing of confidential information. Due to the nature of the research topic and question, anonymity of the participants cannot be guaranteed as they may be identifiable. This is because participants may be specialists in the field and due to organization/ institutional affiliation and/or position and views, readers may identify the participants despite their name not being mentioned.

Other risks related to the interview process would be to potentially mention something that could result in damaging the relationships built by informants and actors in the field. In a situation where this were to happen, clarification and the rephrasing of questions and statement will take place. It is important that the correct channels be observed and that personal and professional relationships be maintained throughout.

Lack of information from the participant may also be due to the actor not being knowledgeable in that particular area. If this were to happen, referrals to other specialists would be requested.

Budget and costs

There will be no reimbursement or incentives to participate in interviews as it is assumed that majority of the interviews will take place at the office or workplace of the health and religious professionals. The only cost that will ensure will be related to travel of the researcher. As the researcher is primarily located in Cape Town and some interviewees and some potential archival documents and resources located in Johannesburg and Pretoria, a travel budget of R3000 will be needed. The researcher will provide this.

Table 3: Budget

	Cost	Reason
Travel	R 3000	Flight to and from Johannesburg (transport)
Accommodation	-	Researcher has personal accommodation in both Johannesburg and Pretoria
Total	R 3000	

Research schedule

The researcher hopes to have the study concluded by February 2017 with interviews taking place during the month of November and follow up interviews in January if required.³

	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017
Submit protocol to Ethics Committee					

³ Due to unforeseen personal circumstances, the publication of this research was delayed by a year.

Data collection and Full Literature Review				
Interviews				
Data Analysis				
Report Writing				
Final Report Submission				

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Part B: Literature Review

The evolution of faith-based health providers in sub-Saharan Africa: A scoping review

Introduction

The role of faith-based organizations (FBOs), specifically faith-based health providers (FBHPs) has received an increasing level of interest in recent decades as potential allies in assisting national and international health sectors achieve their Millennium Development Goals (MDGs) (James 2009; Olivier and Wodon 2012b) and likely will be for the Sustainable Development Goals (SDGs) as well. FBHPs have been identified as a significant part of many health systems in sub-Saharan Africa (SSA) for several decades (Olivier et al. 2015) – a role which can be attributed to various historic, social, political and economic factors – including colonization (Barnard 2016; Coovadia et al. 2009; Ityavyar 1987; Wamai 2009). However, FBHPs have also been noted for providing health services in difficult-to-reach rural and peri-urban areas during and post-colonization (Bielefeld and Cleveland 2013; Boulenger 2012). More recently, FBHPs have been recognized as being instrumental in providing health support – particularly with regards to maternal and childcare and in the high prevalence of communicable disease (Spillman 2016; UN News Centre 2007; Vogel et al. 2012).

Over the years, FBHPs have proven to be consistent players in health care delivery and in the training of health care workers in low to middle-income countries (LMICs) in roughly half of the 54 African countries (Dimmock et al. 2017; Kagawa et al. 2012; Söderlund et al. 2003; Vogel et al. 2012). In some of these countries, FBHPs show no sign of disappearing or decreasing their presence or relevance in health provision (Haakenstad et al. 2015).

This literature review will explore the historical relevance of FBHPs in SSA. Furthermore, the challenges FBHPs face with regards to their viability as health system partners in achieving SDGs and Universal Health Coverage (UHC) will be considered. Additionally, the social, political and financial advantages and disadvantages of FBHP partnership with governments will also be discussed with a focus on Ghana. This all provides important background and comparative context for the study (focusing on South Africa) that follows.

Review method and objectives

This literature review is divided into two main sections: The importance and history of FBOs and FBHPs in Africa – focusing on the history and presence of FBHPs in Africa; as well as the significance of FBHPs in SSA countries and the effect of their presence within this framing through a mini case (Ghana).

The search for articles and resources was done using Google Scholar and PubMed as primary electronic platforms. The World Health Organization (WHO) website as well as national and governmental websites

PART B: Historical case study on nationalization & privatization of FBHPs in SA were also searched to find policies relating to FBHPs and their role in health care. A general Google search was also conducted to find grey literature on the subject. Additionally, a reference list search was conducted to identify journal articles, books and other literature which speak to the role and positioning of FBOs and FBHPs in SSA health systems. The keywords that were used in this search included the following with various combinations of the following:

Subject	Variations
Faith	mission*, faith-based, FBOs, collaborat*, partnership*, religio*, church* mosque, faith, FBHP
Health	hospitals, health facilities, privat*, public, health system archit*, private for-profit, private not-for-profit, health care, service providers, provision, nationalization
Place/date	Africa, sub-Saharan Africa, South Africa, 1940s to 2000s, Ghana, coloni*, histor*
PPP	public-private partnership (PPP), relationship

Across the different search platforms, the goal was to identify articles, documents and data that spoke to the contribution of FBHPs in and across SSA health systems. In order to be included in the study, results needed to speak to the presence of FBHPs, their significance in health system strengthening or their role health care or service provision. Identified data results were not excluded based on dates, although it is noted that most electronic results were published in English and published after 1990.

The history and importance of FBOs and FBHPs in Africa

FBOs, referring here to charitable or humanitarian organizations that have their values based on a particular faith or belief (Bielefeld and Cleveland 2013), are historically argued to have been at the forefront of global service delivery and social development (James 2009). ‘Faith’ is used here instead of ‘religion’ as it refers to the non-congregational beliefs from which the organizational leaders, staff and volunteers come (Bielefeld and Cleveland 2013; Ferris 2005). Hence, FBOs are represented in most faiths such as the Christian, Islamic, Jewish, Hindu, Buddhist and traditional faiths (James 2009).¹

In some cases, FBOs are locally active grass-root organizations, focused on providing justice for the poor and those afflicted by disasters, persecution and/or war (Ferris 2005). However, there are also many national and internationally recognized aid agencies that are part of global networks – particularly in the Christian and Islamic faith communities (James 2009).

FBHPs, a specific type of health-service-providing FBO, have a long history of responding to people’s needs and play an important role in providing routine health services (Ferris 2005). As a result, FBHPs have become allies in health system strengthening (Fowe 2012) especially in weak or fragile health systems by contributing to the provision of health care across the world and especially in SSA (Olivier and Wodon 2012a) – often with complex links to social development and education activities as well.

¹ Traditional faiths, specifically in Africa are highly diverse ethnic beliefs and practices that are observed by an estimated 10% of the population of the continent.

According to Robinson and White (1997) and Schmid et al. (2008), FBHPs such as church/mission-based hospitals and clinics, emerged in pre-colonial periods in most SSA countries (such as Ghana, Zambia, Malawi and South Africa). The extent and formation of their role during colonization varied depending on the particular colonial policies and strategies employed in that area (Olivier and Wodon 2012b). However, in most SSA countries, at the time of independence (in the 1950s-1960s), FBHPs usually had a significant presence, and left a legacy of church involvement in health and social services (Ferris 2005).

Since the independence of most African countries in the mid-1900s, their health systems have undergone major changes. These changes were a result of political transformations as well as major international health policy strategy and reforms (Barnard 2016; Coovadia et al. 2009; Ityavyar 1987; Wamai 2009). Significant reforms included the World Health Organization's (WHO) 1978 Alma Ata "Health for All by the Year 2000" (HFA) strategy, which called for a shift in health care delivery from the hospital system to a primary health care system, emphasizing community involvement. Also important was the World Bank's model, detailed in *Financing Health Services in Developing Countries: An Agenda for Reform* (1987) which gave momentum to the introduction of user charges, the development of the insurance system, increased use and development of the non-governmental (NGO) sector, and decentralization of health services.² Most critical, was the general emphasis on the public (government-owned) health sector – as most international opinion was that national health systems 'should' be primarily built around a robust public sector (with the government as primary accountable for provided access to health services) (WHO 2008).

With the changing political, social and economic landscapes of national governments in these SSA countries and the transformations in the international health community, the role of FBHPs began to evolve. Each country dealt with the presence of FBHPs differently. In most countries (like Chad, Ethiopia and Benin), FBHPs continued to maintain a major presence, becoming part of the 'private sector' (Olivier and Wodon 2012b). In other countries such as South Africa, it was decided to nationalize FBHPs into the public sector (Robinson and White 1997; Schmid et al. 2008).

Although, as already discussed, FBHPs have left a legacy of social development and administration in Africa (Ferris 2005; James 2009; Olivier and Wodon 2012b); this has not always been a positive legacy. It has been noted that FBHPs have sometimes played controversial roles in health and social development (James 2009; Tomkins et al. 2015).

These controversies include (but are not limited to) viewpoints on family planning, abortion and artificial reproduction, immunization and sexuality (Tomkins et al. 2015) where these faith beliefs and practices can negatively influence health care provision by health practitioners and affect health seeking behaviour by the community (Boulenger and Criel 2012; Oberoi et al. 2016; Tomkins et al. 2015). Tomkins et al. (2015) also notes that faith-based viewpoints can be different to those of national and international policies resulting in varying and/or limited health services between FBHPs and state-run facilities.

² These reforms focused on the funding and health provision for the public sector.

The different priorities of some FBHPs (to those of their governments) could lead to a difference in health resource allocation and create unbalanced health services based on their faith priorities (Asamoah-Baah et al. 1992; Gilson et al. 1994). The governance and management of FBHPs can also have negative effects if accountability and motivation are not rooted in the similar (local) structures (Bielefeld and Cleveland 2013; Gilson et al. 1994). Poorly perceived 'value for money' and low utilization of FBHP services can have a lower technical efficiency compared to than government services (Gilson 1992) – and all these factors can play a role in how FBHPs face challenges in health service provision.

The differences in religious beliefs and faith denominations can also impact on the service provision profile of FBHPs, with each faith group and organization sometimes having different priorities and understandings of how they can fulfil their purpose in health care provision and delivery (Ferris 2005). FBHPs have previously directed their efforts towards meeting the spiritual, social and cultural needs of the communities they serve (Bielefeld and Cleveland 2013), but are sometimes challenged by their ability to be inclusive within their faith identity (James 2009). It is in this light that FBHPs are sometimes seen as 'anti-developmental' (James 2009). FBHPs' faith identities can affect how they operate and relate to others (internally and externally) as well as how they build their capacity and that of others (James 2009).

In the broader literature, FBHPs are often been perceived to have better quality health services than government-run facilities (Gill and Carlough 2008; Gilson et al. 1994). However, Gilson (1992) and Dambisya et al. (2014) warn this may not always be the case, as weaknesses in health worker performance, fewer outreach activities as well as insufficient funding and resources can lead to health service delivery that is weaker than that of those provided by the government.

There is also a strong belief that FBHPs can add value because religion and faith is central to their work (James 2009) – that they are more trusted by communities, and their health care professionals are intrinsically motivated by their faith ethos (Barmania and Aljunid 2016; Olivier et al. 2015). There is equally a counter-argument that faith can interfere with service provision and staffing (Esbeck et al. 2014; Messner 2014).

Irrespective of the conflicting opinions in the literature, the broad opinion appears to currently conclude that FBHPs provide a useful contribution to national health care provision in LMICs (Haakenstad et al. 2015; Olivier et al. 2015).

TABLE 1: Studies done on the history of FBHPs in SSA

Reference	Country of Focus	Type of study	Main findings about the evolution of FBHPs in SSA
Boulenger & Criel 2012	Cameroon, Tanzania, Chad & Uganda	Case study	FBHP have 'survived' many periods of turmoil and have played an important role in African health systems, particularly rural areas in rural and isolated areas throughout this time
Dimmock et al. 2012	DRC, Liberia, CAR, Sierra Leone, Togo, Rwanda, Sudan, Zimbabwe, Malawi, Uganda Chad, Tanzania, Zambia, Lesotho, Benin, Ghana, Kenya, Nigeria, Cameroon, Mali, Swaziland, Namibia, Botswana	Review	FBHPs have moved from working independently to forming CHAs allowing for a collaborative and recognizable presence in health care provision
Chand & Patterson 2007	Uganda & Tanzania	Review	FBHPs not only provide health care services but are beginning to play a role in health care promotion focusing on behavioural change
Root 2011	Swaziland	Empirical	FBHPs are beginning to adapt from facilities to home-based health care providers
Dambisya 2014	Uganda	Case study	FBHPs have acquired lot of experience and independence in governance and health care delivery but require more financial support from governments
Green et al. 2002	Ghana, Kenya, Lesotho, Malawi, Tanzania, Uganda, Zambia & Zimbabwe	Review	The majority of FBHPs originated as part of the missionary movement and were largely funded by external support however, they have now become reliant on government funding
Blevins & Griswold 2014	Kenya	Empirical	FBHPs are becoming more involved in specialized health programs (advocacy) and not just primary and tertiary health care delivery
Jennings 2014	Tanzania	Case study	FBHPs historical trajectory has a legacy of fragility, fragmentation and structural weakness as well as an unwillingness to work with governments. However now, they rely on state collaboration
Sönderlund et al. 2003	Dar es Salaam & Kampala	Empirical	Policy makers need to be mindful of the reach of FBHPs and should be consulted when making policy decisions. FBHPs can no longer work in parallel to governments

Source: author

African countries are reported to have a seemingly significant portion of FBHPs. The WHO (2010) once published estimations that FBHPs account for between 30% and 70% of health services in Africa, and at times, are the only health providers in some areas. However, this estimation has been challenged due to lack of sufficient quantitative and comparative data (Olivier and Wodon 2012b), but continues to be widely circulated in the literature (Olivier et al. 2015; Widmer 2011). Therefore, it is important to be aware of the information that is available with regards to the FBHPs and the relationships they have with local governments.

At present, the majority of FBHPs in Africa are represented by a national faith-based health network – such as the Christian Health Associations (CHAs) – most common in central Africa and SSA as shown below in Figure 1 - although these are not the only FBHPs on the continent. CHAs were established in several countries across Africa soon after independence (from the 1960s) as a means of unifying the role and voices of FBHPs, and for aligning themselves with national health systems (ACHAP 2014). Over time, “CHAs have evolved into a particular kind of collaborative effort with a very specific role. CHAs now network FBHPs and facilities; advocate for a proper recognition of their work; negotiate with governments; build capacity among members; and in some cases now channel and report on substantive fund” (Dimmock et al. 2012), with their role, reach and size varying across countries. There are currently an estimated 23 robust CHAs in Africa (Dimmock et al. 2017). Some have formalised agreements with the government (such as a Memorandum of Understanding), while others engage in a less formal manner (Schmid et al. 2008). It is noted in Dimmock et al. (2012) that FBHPs in countries where there is a strong CHA do not operate in isolation but are more aligned with their national systems and have established specific roles for themselves (networking, advocacy, negotiation and capacity building).

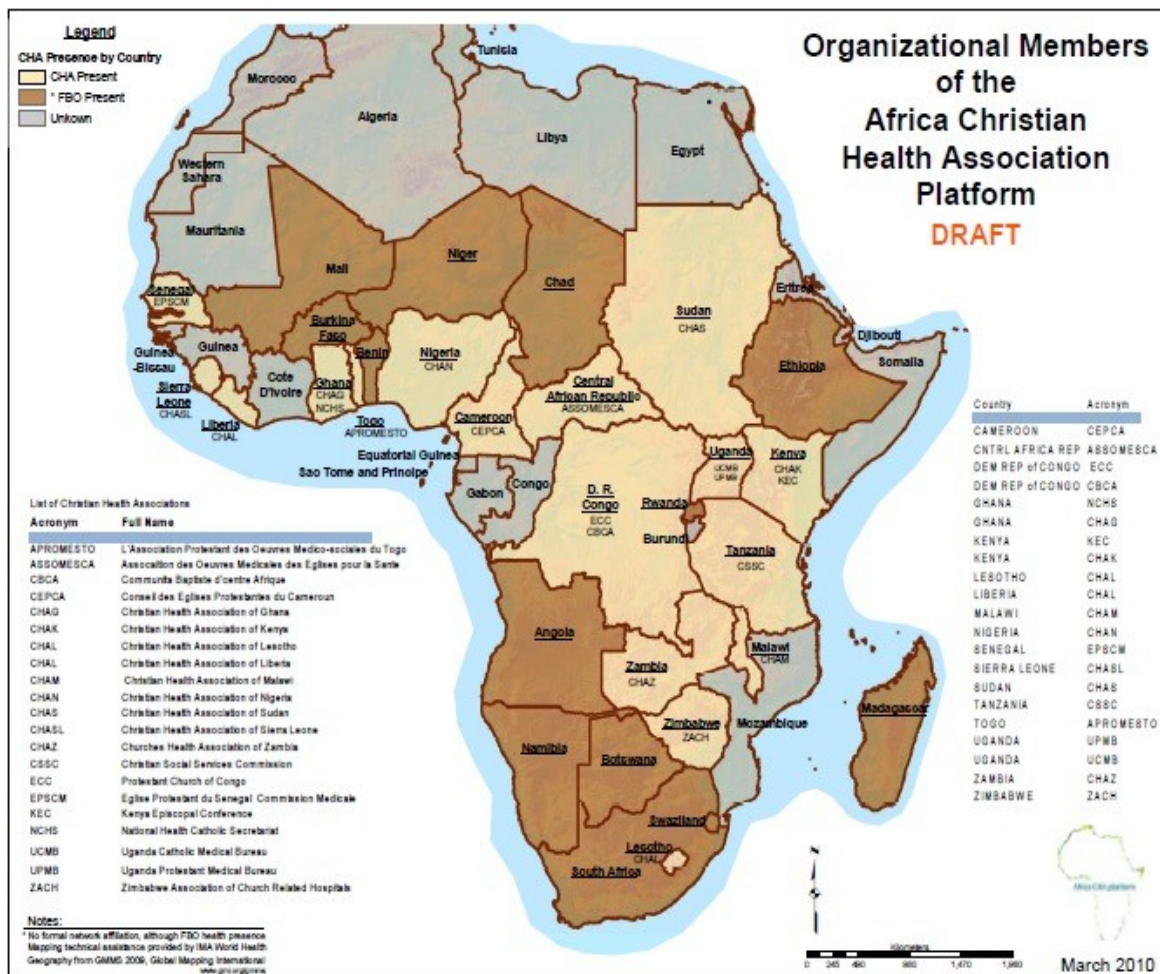


Figure 1: CHAs and government partnerships across Africa

Source: IMA World Health 2010

Countries in North Africa usually have a Muslim majority and this can account for the absence of Christian FBHPs or CHAs there (Boulenger & Criel 2012). According to Schmid et al. (2008), the Islamic tradition is currently less frequently oriented towards direct health service provision, which would account for greater presence and knowledge of Christian FBHPs. Still, the Muslim community has established networks that are present in countries such as Uganda through the Uganda Muslim Medical Bureau (UMMB), which was established in 1998, and there is also an interfaith platform in Cameroon that also includes non-governmental organizations (NGOs, Dimmock et al. 2012). Islamic health providers are also present in Ghana, Mali and Benin but have a much smaller presence, and therefore a weaker relationship with their governments (Dimmock et al. 2012; Schmid et al. 2008).

Public private partnership between FBHPs and their governments

The private health sector, a heterogeneous group of all providers who exist outside the public sector (which includes large and small commercial companies, groups of individuals and people, national and international non-governmental organizations as well as individual providers, Waters et al. 2003) – has seen considerable growth in LMICs in recent years (Mills et al. 2002). The growth of the private sector contributes to around 50% of health expenditure in SSA (Marek et al. 2005; Spreng et al. 2011). They have an important influence in LMICs because they are an available resource used in even the poorest communities in many countries (Berman 2000), and are actors in strengthening health service delivery (Green et al. 2002). The private health sector, together with the public health sector are encouraged to form public-private partnerships (PPP), which can be vital in overcoming challenges and strengthening health systems as PPPs are “initiatives that establish a contract between public agency and private entity for the provision of services, facilities and equipment” (WHO 2013). Table 2 below shows the presence of FBHPs in African countries in both a private and public networking capacity.

Table 2: Data on estimated national faith-based health networks (NFBHN) by country

	Self-declared NFBHN market share (beds)	Number of NFBHN hospitals	Number of NFBHN health centres	Number of NFBHN training facilities
Benin	40%	6	20	28
Botswana	18%	2	6	2
Cameroon	40%	30	150	3
Central African Republic	20%	2	62	19
Chad	20%	4	164	2
Democratic Republic	50%	89	600	20
Ghana	42%	58	104	10
Kenya	40%	74	808	24
Lesotho	40%	8	72	4
Liberia	10%	6	67	3
Malawi	37%	27	142	10

PART B: Historical case study on nationalization & privatization of FBHPs in SA

Mali	2%	--	--	--
Namibia	--	6	--	--
Nigeria	40%	147	2747	28
Rwanda	40%	--	--	--
Sierra Leone	30%	--	--	--
Sudan	30%	4	--	--
Swaziland	--	3	27	1
Tanzania	42%	89	815	24
Togo	20%	3	39	0
Uganda	50%	47	541	19
Zambia	40%	36	110	9
Zimbabwe	35%	80	46	15

*Not including the role of private secular for-profit or non-profit provision. Summary drawn from

Dimmock and colleagues, based on a survey done in the Christian Health Association from 2010-2011.

Source: Olivier et al. 2015

Although FBHPs and public health providers can work independently, a successful partnership between public agencies and private entities should yield greater health coverage (Gilson et al. 1994; Gilson et al. 1997). This is possible when the public and private sector pursue a common goal and vision and contribute to its development (WHO, 2013). The most common type of PPP in Africa (between FBHPs and the government) is the partnership arrangements between CHAs and governments in Africa (see above, Dimmock et al. 2012).

Currently, when the basic needs of half of the world's population are becoming *increasingly* difficult to provide for, the United Nations Populations Fund (2009) believes that it is important to acknowledge the parallel faith-based development universe that reaches communities and provides services that governments have not yet been able to reach. Olivier and Wodon (2012b) argue that one of the difficulties facing FBHPs in some countries is that they are not always properly aligned with national health systems, with faith- inspired, other private and public health sectors operating in parallel to each other. With the decline of available funding pools, efforts towards of collaboration between FBHPs and governments have intensified (Boulenger et al. 2002; Green et al. 2002). It has been shown in countries such as Zambia and Ghana that strong PPPs between public health sectors and FBHPs can be financially and socially of mutual benefit - as the burden of cost is shared, and there is a growing desire in providing increased quality and quantity of health services (Dimmock et al. 2012). However, these partnerships (and the development of policies) require time and compromise to be established and maintained (Dambisya 2014; Dimmock et al. 2012; Jennings 2014).

FBHPs in a SSA health system: with Ghana as an example

Part of the acknowledged challenge in the literature is that it is difficult to talk generically about all FBHPs

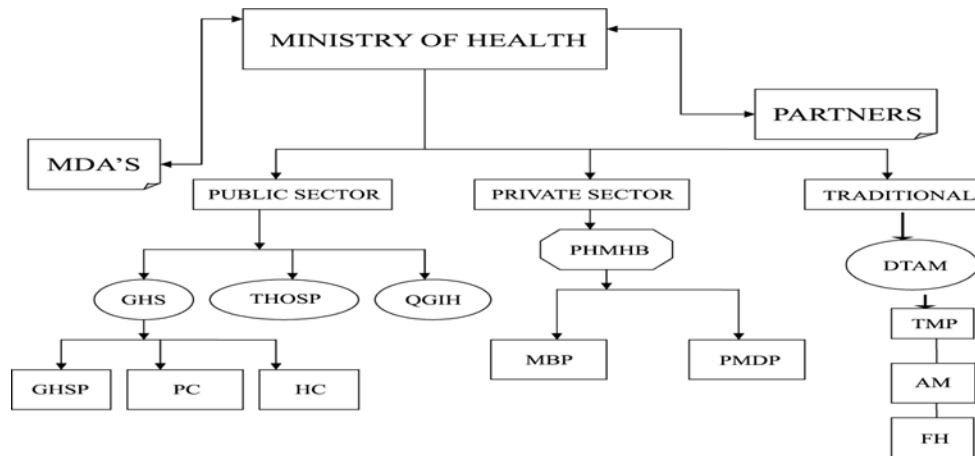
PART B: Historical case study on nationalization & privatization of FBHPs in SA in SSA, given the massive diversity of conformation and experience – and it is more useful to assess FBHPs at a country level (Olivier et al. 2015). In the next section, we provide a mini-case, reviewing the role and presence of FBHPs in Ghana, which exemplifies the above argument. Although Ghana will not be thoroughly explored, the presence continuous research highlights the need for a similar understanding to be considered in other SSA countries, particularly those with a different FBHP structure.

Ghana has a significant presence of FBHPs, specifically the Christian Health Association of Ghana (CHAG) that has a network organization of 183 health facilities and training institutions owned by 21 different Christian Church denominations that forms part of the private health care sector of the Ministry of Health with whom they have been in partnership with since 1967 (CHAG 2017). The function of these faith facilities is aimed at serving the poorer populations and communities by complementing the role of the Ministry of Health and Ghana Health Services (CHAG 2017). CHAG contributes structurally to the health care system and this underpins a positive relationship between the government and CHAG (Yeboah and Buckle 2017). According to Dimmock et al (2017), Ghana has been relatively successful in achieving a strong relationship between FBHPs and the Ghanaian government – primarily through CHAG, which is described as a positive example of PPP in the region, although this relationship is not without its challenges (Dovlo 2005).

Ghana gained independence from colonization in the mid-1950s (Brady 1956) and at this time, the colonial governments capacity to provide adequate health care was ‘virtually non- existent’ (Yeboah & Buckle 2017). Churches began ‘filling the gap’ in rural communities by establishing health facilities and programmes and have, since then, developed and expanded into semi-urban towns and cities (Yeboah & Buckle 2017). Over time, the Ghanaian government increased their health service ability and capacity allowing FBHPs to adapt and find their place in the socioeconomically changing environment (Yeboah & Buckle 2017).

The work done by FBHPs was so significant, the government had to negotiate and integrate them into the national health system. FBHPs were said to have positively changed the communities they were present in by promoting rapid development and urbanization (Yeboah & Buckle 2017). CHAG was formed in response to church-related medical bodies needing to collectively build networks and be represented at a national level in order to support and complement the national health services (CHAG 2017). This association unites the mission of several churches and coordinates implementation amongst the members while considering their denominational decision-making differences (Rasheed 2009). CHAG receives some financial assistance from the Ghanaian government but also seeks financial aid from the health department and international donors (CHAG 2017; Dimmock et al. 2012)

Figure 2: The Ministry of Health Organisational structure of Ghana showing MBPs as part of the private health sector



Key:

MDA's – Ministries Departments and Agencies
 GHS – Ghana Health Service
 THOSP – Teaching Hospitals
 QGIH – Quasi Government Institution Hospitals
 PHMHB – Private Hospitals and Maternity Homes Board
 DTAM – Department of Traditional and Alternate Medicine
 GHSP – Government Hospitals
 PC – Poly Clinics
 HC – Health Centres
 MBP – Mission Based Providers
 PMDP – Private Medical and Dental Practitioners
 TMP – Traditional Medical Providers
 AM – Alternative Medicine
 FH – Faith Healers

Note: CHAG facilities are grouped under the term 'MBP' in this diagram – Mission Based Providers Source: WHO 2014.

Although they are active in health service delivery, CHAG also has aims play a role in the development of Ghana's health policies through health research, development of human resources as well as the development of health technologies (CHAG 2017).

Conclusion

In SSA countries where there are still significant numbers of FBHPs, in the face of constant challenges, and limited resources, the question is frequently raised – *is there a place for FBHPs in modern SSA health systems, or should these services simply be handed over to the government?* Although this question has been raised by several authors (Dimmock et al. 2017; Gill & Carlough 2008; Olivier and Wodon 2012; Olivier et al. 2015), there are no immediate conclusions. As shown in this review, FBHPs have partnered with their governments across almost half of the African continent. While these partnerships look different (some having MOUs and some not; some having similar focuses in terms of health care delivery while others like in Swaziland, choose to focus on community health care and home-based care, Chand & Patterson 2007), FBHPs remain under financial strain and are increasingly dependent on government funding and support (while retaining their faith-based character and ownership).

In stark contrast, in South Africa, FBHPs were nationalized (handed over to the national government) in the 1970s. The South African historical case therefore provides a very useful retrospective lens on what can happen to FBHPs (and the health system) if such a decision was taken in these other countries. This may provide some useful insights to the South African health system but may also be relevant to some SSA contexts on what to do with FBHPs.

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Part C: Journal Article Manuscript

The story of FBHPs in South Africa: their past, present and potential future in the South African health system

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Journal Article Targeted: *Journal of Religion and Health*

Abstract

Faith-based health providers (FBHPs) are an important part of the South African health system history. Historically, FBHPs (specifically mission hospitals and clinics) are known to have played a vital role in establishing the early health system in South Africa. Despite this apparent significance, these mission health facilities were nationalized by the South African national government in the 1970s with some of these facilities closing their doors. This historical case study draws on primary and secondary archival data collection, as well as eight expert in-depth interviews focusing on the establishment of mission hospitals in the country, and the reasoning behind the decision to nationalize them. We find that FBHPs were nationalized for financial and political reasons in the Apartheid era with the effects of the decision still being felt in the late 1990s. Their absence in the current health system has resulted in the re-engineering of some of these FBHPs into orphanages, the establishment of faith-inspired clinics and the slow emergence of privatized and more modern health facilities. With the South African Department of Health searching for ways to strengthen the health system, the growing presence and variety of new smaller faith-inspired health facilities could be important for health system strengthening and could speak to the possible roles of FBHPs in other low to middle-income countries (LMICs).

Key words: *faith-based health providers, mission hospitals, nationalization, faith inspired institutions, faith based communities, South Africa*

Introduction

The role and presence of faith-based health providers (FBHPs) in South Africa has seen significant changes in the past century with the most noticeable period being between 1960 and 1980. In the 1970s, the national government took the decision to nationalize FBHPs (such as mission hospitals) despite their reported substantial presence in key areas and their reliability in South African health care provision since the 1600s (see below, Coovadia et al. 2009; Digby, 2006); however, this process has not been well documented. With the resurging interest in non-state providers and FBHPs in LMIC settings (Olivier et al.

¹ Instruction for authors in Appendix VII, authors' contribution and information are excluded. For the purpose of this thesis, the student is the sole and first author of the work.

PART C: Historical case study on nationalization & privatization of FBHPs in SA 2015; WHO 2007), it is useful to track the integration of FBHPs into the South African health system, and to reflect on how this policy and health systems architectural decision impacted the system. At present, as South Africa is looking at ways of improving health service delivery by improving intersectoral engagement, and amid a growing private for-profit health sector which is expensive to most people (Test 2010), it is important to be aware of FBHPs past, present and possible future role with regards to health system strengthening.

In addition, several other sub-Saharan Africa (SSA) countries have not nationalized FBHPs and still have them as a significant part of the private sector of their national health system structures (Boulenger and Criel 2012). Though an estimated half of the 54 African countries have a partnership/agreement/relationship between FBHPs and their national governments (Dimmock et al. 2017), most (if not all) FBHPs are under strain and rely on their government for funding and support (Dimmock et al. 2012; Olivier et al. 2015). Many of these countries are now questioning whether FBHPs should hand their facilities and services over to the government – or retain ownership through their faith groups (Dimmock et al. 2017; Gill & Carlough 2008; Olivier and Wodon 2012; Olivier et al. 2015). South Africa's decision to nationalize its FBHP sector (and in retrospect the effect this had on the national health system) is of immediate relevance to understanding the South African health system, and also may provide an alternative option to these other settings.

Methods

A historical (single) case study was conducted in South Africa in 2016 and 2017, which reports on the key events and decisions that led to the nationalization of FBHPs (so the case study period is from 1936 to 2015). It considered whether this policy decision can be said to have generally been a positive or negative change towards health system strengthening (in retrospect). The study utilized a mixed methods approach as is common in case studies. This approach was used to allow for the understanding of a complex and interconnected history that cannot easily be 'measured' (Crowe et al. 2011). This method also allowed for better analysis and appreciation of the policy implementation in the health sector to be observed (Thomas 1998). A case study approach is appropriate when a unique story has to be told (Neale et al. 2006), which is the case for the changing role of FBHPs in the South African health system. The nationalization of FBHPs took place in a complex social and political climate in the mid-1900s, which, over time, gave rise to the health system structure that South Africa has today. In understanding the current absence of a large FBHP sector in South Africa, it is necessary to narratively track key health system developments over the time of nationalization, as this has had a particular impact on the changing roles of FBHPs. Health systems architecture is a very complex structure that plays to multiple stakeholders in the government (Gilson et al. 1994). In the 1970s, as in other countries, FBHPs provided a wide range of health resources in addition to service delivery, including management, development and staff training (Coovadia et al. 2009).

This mixed methods study consisted of two sequential phases: a scoping literature review (see Part B) followed by a case study in which FBHPs in South Africa are the case. The study purposefully identified and interviewed 8 'elites' (or experts, see Harvey 2011), selected for their expected knowledge of this case, and their varying connections and relations to the nationalization process at which point conceptual saturation point was reached. These interviews were important in understanding the sociopolitical environment of South Africa at that time. An interview guide (Appendix II) was used to identify the level of knowledge participants had on the case.

Consent was obtained for all the interviews (all participants preferred to be anonymized, and not to be recorded). All interviews were conducted in English after which all hand-written notes were typed and coded with no personal identifiers. All scripts were coded and re-organized manually with respect to the emerging themes and the analyst and author practiced reflexivity to manage author bias. The experts also provided further primary and secondary documents for analysis. This study was approved by the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (HREC reference number: 374/2016).

Background

The impact of FBHPs in sub-Saharan Africa has found some renewed interest with respect to the role they have had, and continue to play in health system strengthening (Chand and Patterson 2007; Gilson et al. 1997; Green et al. 2002; Kagawa et al. 2012; Olivier et al. 2015; Vogel et al. 2012; WHO 2007). FBHPs (such as mission hospitals) emerged and became a prominent feature in many African health systems during the colonial period – especially in countries such as Ghana, Tanzania, Kenya, Malawi and South Africa (Good 1991). Post- independence (largely between the 1950s and 1960s, Birmingham 1995), these SSA health systems have undergone major structural changes – often with a continued legacy of FBHP (church owned) health facilities (Coovadia et al. 2009; Ityavyar 1987; Wamai 2009). In many SSA countries (in 23 countries in Africa, see Dimmock et al. 2017), this has resulted in FBHPs continuing as a distinct part of the private health sector² (Olivier and Wodon 2012). In these contexts, FBHPs have been recognized as partners in health system strengthening as well as an important alternative to government-run facilities (Ferris 2005), often providing important access for those most in need (Berman, 2000).

There are conflicting assessments of FBHPs in SSA (mainly because of the variation in data, see Olivier et al. 2015). For example, it has been argued that FBHPs in SSA are both highly trusted and 'close to community' (Barmania and Aljunid 2016; James 2009). Conversely, they have also been known to provide poor service due to financial constraints (Dambisya et al. 2014; Songstad et al. 2012), and might have controversial non-health-promoting aspects to their services (James 2009; Tomkins et al. 2015). However, the general lack of

² A diverse group of all providers who exist outside of the public sector (Waters et al. 2003).

PART C: Historical case study on nationalization & privatization of FBHPs in SA
 consistent data makes such general assessments (of all FBHPs in LMICs or SSA) difficult (see Olivier et al. 2015). What is clear is that the history of FBHPs in SA is distinct from the other SSA countries where FBHPs remain prevalent, and this provides a useful ‘outlier’ case for comparison. **Table 1** summarizes the key events of what happened to FBHPs in South Africa.

Table 1: Summary of key events leading to the nationalization of mission facilities

	Key Events in the SA Health System	Key Events Relating to FBHPs in SA
1900-1960 Pre-	<p>1919: Health Act established the first Public Health Department</p> <p>1944: National Health Services (Gluckman) Commission proposed and called for a change in existing health structures in 1945</p> <p>1945: Provincial government of Transkei announces plans to change financial structure of hospitals and introduce free hospitalization for all</p>	<p>1936: Formation of Christian Council of South Africa (CCSA), replacing the General Missionary Conference (formed in 1904), brings together missionary groups</p> <p>1942: CCSA appeals for urgent and strong consideration of mission hospitals to be integral part of a national service subsidized on the same bases as public hospitals in exchange for some government control</p> <p>1943: CCSA asks government for adequate recognition through financial subsidy of services for all people, particularly native South Africans, and for more properly organized health services</p>
1961-1980 Nationalization	<p>1962: Committee re Planning of Health Services in Bantu Administration (ministry for native people) approaches the Anglican Archbishop with questions about missionary activities and mission facilities – re-funding and a unified Bantu Health Service</p> <p>1965: The consequences Bantu control is discussed (aiming to hand over hospitals to African people)</p> <p>1969: Department of Bantu Administration and Development (DBAD) and State Health (DOH) announce changeover of all maintenance matters to Bantu Administration and plans to ‘control’ missions</p> <p>1970: Nationalization: DOH in respect of Health Services in the Bantu Homelands releases policy to unify all health services including all mission hospitals subsidized by the government from 1 April 1970</p> <p>1972: Deputy Minister of Bantu Administration and Development announces takeover of mission hospitals in Transkei by government on 1 April 1973 despite assurance of ‘no takeover in the foreseeable future’ in 1971</p> <p>1975: First Transkei hospital taken over followed by individualized takeover of other hospitals</p>	<p>1963: CCSA Conference on medical work: the purpose of FBHPs and the impact they have on the people</p> <p>1964: Transkei and Ciskei Association of Mission Hospitals formed (TCAMH) to help mission hospitals be a part of developing the health system</p> <p>1966: The church is forced to decide if they want to be dependent or independent of the state</p> <p>1973: The church is divided on takeover issue to their detriment</p> <p>1975: Natal opposes mission hospital takeover</p> <p>1976: Consultative Committee of South African Council of Churches (CCSAMM) is dismantled</p>

	Key Events in the SA Health System	Key Events Relating to FBHPs in SA
1981-2017 post-nationalization	<p>1977: Health Act perpetuated the fragmentation with curative services being a provincial responsibility</p> <p>1994: African National Congress Health Plan built on principles of primary health care</p> <p>1980-6 Browne Commission: advocated a national health policy prioritizing preventative and primary health care also promoted the privatization of health services</p> <p>1996: New Constitution with comprehensive Right to Health for all</p> <p>2004: National Health Act legislates for a national health system incorporating public and private sectors and the provision of equitable health-care services.</p> <p>2008: National Health Act</p>	<p>1988: Formation of Catholic health care association (CATHCA) to combat HIV/AIDS by operating clinics, hospitals, old age homes, home-based care and community programs.</p> <p>1997: Formation of the National Religious Association for Social Development (NRASD) by representatives of the Baha'i, Buddhist, Christian, Hindu, Islamic and Jewish faiths to strengthen existing activities</p> <p>2001: Launch of Christian AIDS Bureau of South Africa (CABSA) by the DRC to provide health information and resource services</p> <p>2002: Formation of churches united against HIV & AIDS in (CUAHA) eastern and southern Africa to assist in combatting HIV/AIDS</p>

Source: CABSAs 2017; Coovadia et al 2009; Ingle 2010; NRASD 2015; Phillips 1990

The early history of FBHPs in the SA Health System: Pre-1960

FBHPs have been recorded in South Africa from as early as the 1800s and were primarily established by early Dutch missionaries near Cape Town (Frescura 2003). In 1841, well-known medical missionary David Livingston travelled across southern Africa exploring the land and recording his travels in Africa (Seaver 1957). Over the following years, due to his reports to the European community, there was an influx of Christian Missionaries to South Africa (Frescura 2003). One of the first known FBHPs, was a missionary hospital, Elim Mission Hospital, built at Bechuana Mission Station (in the now Limpopo Province) pioneered a by Swiss missionaries Ernest Creux and Pan Berthoud in 1899 (Jeannerat et al. 2011).

Figure 1: A) Dr Macvicar and his assistants at Victoria Hospital in Lovedale and B) the hospital and doctor's house³



A



B

Source: Wells 1908

³ Dr Neil Macvicar was the superintendent of Lovedale Mission Hospital and considered 'an ideal medical missionary. Victoria Hospital is well known for the training of black nurses and was well-funded because it was on the same funding scale as public provincial hospitals.

In the following years the Methodist Church, Dutch Reformed Church, Anglican Church, Presbyterian Churches and missions from France, Germany, Sweden and Norway⁴ all made contributions to the mission field in South Africa building churches, schools, hospitals and clinics all over the country (Frescura 2003; Louw 2006).

Figure 2: Picture of Elim Hospital in 1938⁵



Source: Jeannerat et al. 2011

By the late 1800s the Swiss mission hospitals (such as Douglas Smit Mission Hospital, Masana Mission Hospital and Elim) were well-known in the mission circles, to the colonial governments as well as to the local public for the efficiency of their work, the training of nurses in their training schools (Jeannerat et al. 2011), and for their clinics and dispensaries (Hinchliff 1968; Jeannerat et al. 2011). At this time, most of the missions operating in South Africa drew their funds (in whole or in part) and governance from overseas faith-based organizations and churches (Horwitz 2009; Jeannerat et al. 2011).

The initial mission facilities were built to care for and support families of the missionaries that travelled from Europe through basic health services specifically in the 1800 as well for the Dutch and British governments that were present in the country (Horwitz 2009; Jeannerat et al. 2011). By the early 1900s with the emergence of segregation and through their high-volume of growth, mission facilities began caring for the black, Indian and coloured (mixed-race) populations (Digby 2006; Jeannerat et al. 2011; Parle and Noble 2011) because they were marginalized and under-serviced by the Afrikaans political government (Coovadia et al. 2009). This was made easier by the change in focus and location of mission

⁴ There were a number of mission groups that were present such as White Fathers, Bremen.

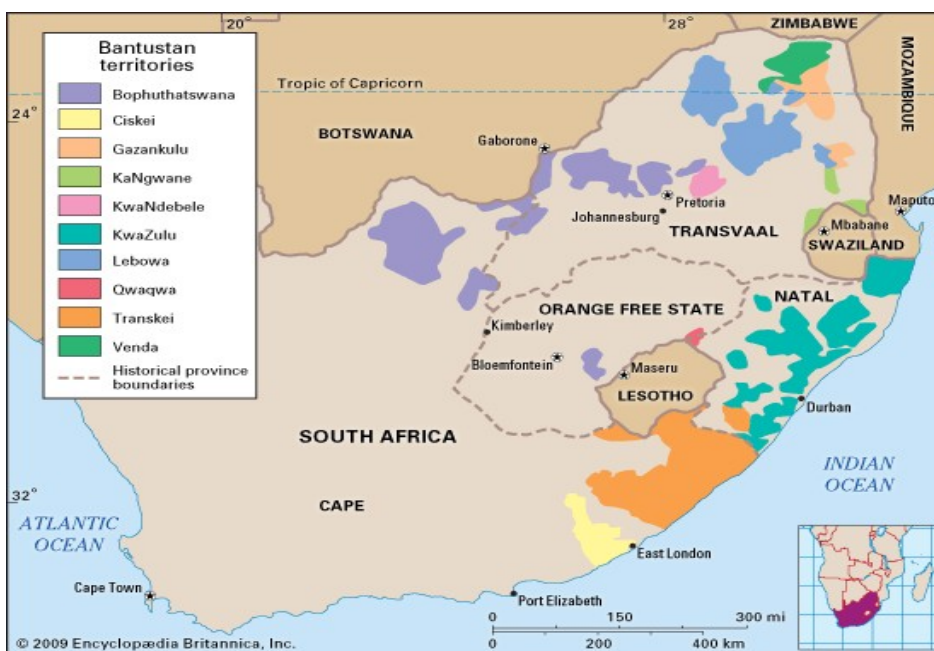
⁵ Elim Hospital was built in Elim- a mission station in Limpopo. Elim Mission Station was originally a Moravian mission station founded by German missionaries and dates back to 1824 and was enlarged in 1865 to accommodate the hospital, schools and churches that were later built. The mission village is now a national monument.

PART C: Historical case study on nationalization & privatization of FBHPs in SA facilities from the Transkei, Natal and Cape – the white population lived in the main cities and towns – to the Transvaal near Bantustans which is where a large number of the native population were forced to live (Coovadia et al. 2009) as shown below in **Figure 3 and 4**. Over the years, FBHPs, although not initially, cared for and trained all populations in all areas as the national health facilities were built for and catered to the white population.

In the early 1900s, there was a prolific growth of mission hospitals of varying denominations with a total of 109 FBHP facilities recorded in 1972⁶ (Ingle 2010) (see **Table 2**). According to Bosch, a member of the Dutch Reformed Church (1973): “By 1967, however about 10% of all Mission Hospitals [in the world] in 1967 were to be found in South Africa. The total number of mission hospitals in the world had by then (since 1910) decreased by 50% - in South Africa however it had increased by 3000%”.

In this quotation, Bosch is claiming that in 1967, 10% of all known mission health facilities (worldwide) were in South Africa. This means that while mission facilities across the world were decreasing, they were increasing exponentially (in a short amount of time) in South Africa.

Figure 3: Map of South Africa with representing historical provinces and Bantustans



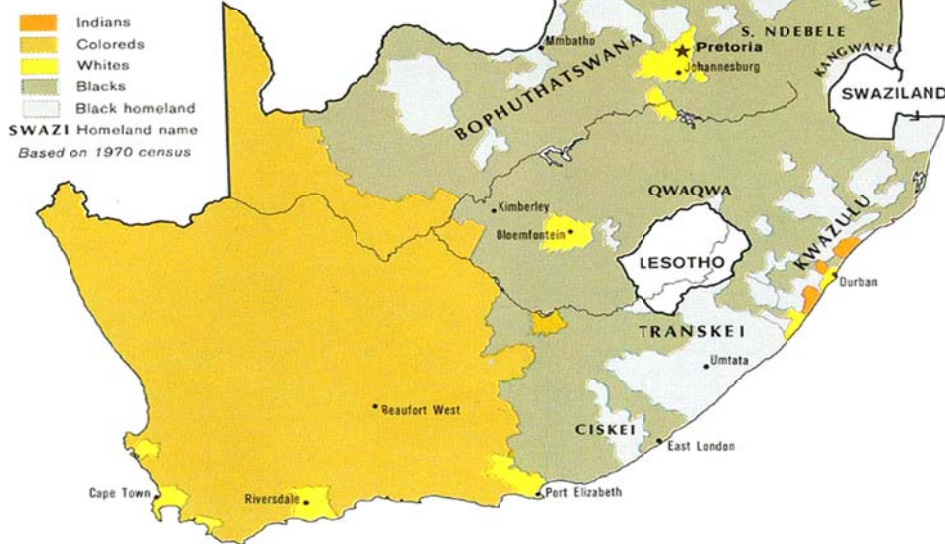
Source: Africa Open Data 2013

⁶ This number excludes some clinics and mission training facilities of which there were several across the country particularly amongst Swiss Missionaries and the Methodist and Catholic churches. Mission hospitals that were small homes/buildings are included.

Figure 4: Racial demographic of South Africa in 1970**Racial Concentrations and Homelands**

Racial concentrations of 30% or more by magisterial district

NOTE: Portions of Colored, Indian, and white areas may also have an equal or slightly larger percentage of other racial groups. Black areas have no other racial groups as high as 30%. Homelands are traditional areas set aside by the South African government for specific black ethnic groups. All have a black population in excess of 90%. Bophuthatswana, Transkei, and Venda have been granted nominal independence by South Africa.



Source: CIA 1979

Table 2: Mission Hospitals in South Africa recorded in 1972

Church Denomination	Number of Hospitals
Roman Catholic Church	31
Dutch Reformed Church	27
Gereformeerde Kerk	1
Methodist Church	4
Church of the Province (Anglican)	13
Church of Scotland	3
Swiss Mission	3
Evangelical Lutheran Church	13
Swedish Mission	4
Other Denominations or Missions	10
Total	109

Source: Ingle 2010

By the 1940s mission hospitals in South Africa were in dire financial trouble – mainly because the national provinces⁷ did not recognize their service in health provision despite them doing the same work as that of public hospitals (and also servicing some of the white population in larger districts) (Jeannerat et al. 2011).⁸

At this time, government gave mission hospitals a small once-off grant every year, recognizing them as

⁷ South Africa had 4 provinces between 1910 and 1994: Cape of Good Hope, Natal, Orange Free State and Transvaal.

⁸ The Conference of Mission Societies met in 1936 to discuss how medical mission work could be subsidized for work among the natives.

'native hospitals' and forcing some mission hospitals to raise money from private patients (Ingle 2010; Jeannerat et al. 2011)⁹ despite Christian Council of South Africa (CCSA) having asked government for adequate recognition through financial subsidy of services for all people, particularly native South Africans, and for more properly organized health services in 1943 (Ingle 2010). By this stage, CCSA had asked the government to be considered as integral actors of the health system in exchange for some government control (Ingle 2010). In the 1940s, South Africa was moving towards Apartheid (a system of institutionalized racial segregation and discrimination between 1946 and 1991 based on white supremacy and black suppression) and the South African government did not recognize the rights of African citizens to health care (as part of the Apartheid system). The fact that mission facilities served mainly poor black citizens resulted in constrained resources (Jeannerat et al. 2011).^{10 11} Although there was still some external funding received by mission facilities at this time, it was not enough to finance the work that was being done (Ingle 2010).

From the 1940s, the number of black and coloured patients in these hospitals was increasing because of their low cost and accessibility (Good 1991). Regular appeals were made by mission hospitals to the Hospital Boards for greater grants (CCSA 1936; Ingle 2010; Jeannerat et al. 2011), and from 1943, the CCSA¹² appealed to the provincial and national government for funding and adequate recognition as well as for properly organized health service to be included for 'native South Africans' (AMMCT 1946; Ingle 2010).

It can be said that mission facilities were in a difficult situation during this time in that they were positioned in a confrontational relationship with the Apartheid government. The government's concerns were financial as well as racial. Mission facilities were using the money they received from the government to provide health access to serve a part of the population the government discriminated against and this tension would have been difficult to negotiate and overcome. Mission facilities would also have found it difficult reneging on their ethos of serving and providing health access to all whilst the national government served those they chose with less concern for the black and coloured populations (Digby 2006; Ingle 2010). Appeals to the government for higher grants would only serve the discriminated communities further and take away from the 'financial responsibilities' of the 'white priority' of the government. The small funding to mission facilities allowed the government to appear to be serving the black and coloured population. Mission facilities therefore challenged the responsibility of the government

⁹ This payment was for the "Maintenance of Mission Hospitals" and in 1847 this was calculated as 'the average cost per patient per day in respect of the hospital provided such cost does not exceed half of the daily average cost in the general hospitals of the Province.

¹⁰ The government at this time compensated Mission Hospitals more for their service of White people than black people. This was financially difficult for Mission Hospitals as the number of Africans were drawn to Mission Facilities because of their general care and treatment several medical missionaries expressed the African population the reason for their relocation.

¹¹ It is important to note that Mission Hospitals were not always without racial issues. The treatment and pay of Africans in some areas was discriminatory and as per systematic, political and social injustices.

¹² This organisation was formed in 1936 as the replacement of the General Missionary Conference formed in 1904, which served to bring together missionary groups to discuss and act upon common issues. In 1968, the CCSA changed its structure and name to The South African Council of Churches.

PART C: Historical case study on nationalization & privatization of FBHPs in SA and their commitment to providing health services to the whole population of the South Africa.

In the early 1940s the board and national government proposed two solutions to the strained relationship between mission facilities and the government. Either, they could leave mission hospitals out of the national health system (see more below). This would mean that the government would service the whole population and take no account of mission hospitals – but missions could (if they wished), continue to maintain their hospitals entirely at their own expense or could use their buildings for other purposes. This is difficult to consider as racial segregation was built around the neglect of the native populations and the government being solely responsible for this group would be of dire consequences. Alternatively, the government could selectively take over hospitals and compensate them for their services (Ingle 2010) which although was the desire of the CCSA pre-Apartheid, would have different consequences in the late 1940s. This was the origin of nationalization in South Africa and an easier consideration as the government could control the level (quality and access) of health services to black and coloured people without much objection or resistance .

In 1944, Dr Henry Gluckman, leading the Health Service Commission (a commission to establish the future of the South African health system), proposed the creation of the National Health Service which was to be funded through taxation and provide primary health care to “all sections of the people of this country according to their needs and not according to their means” (Gluckman 1947). This Commission recommended that the South Africa health system’s re-organization should be fast tracked (Kautzky and Tollman 2008), and allow for mission hospitals to be adequately compensated so all populations were cared for (Jeannerat et al. 2011). In a report on the Deputation to the Administration of the Cape, The Minister of Native Affairs stated that the welfare of a large section of the community (black people) would be gravely affected if mission hospitals were in any way curtailed, and noted their importance and efficiency. This Commission occurred before the introduction of Apartheid, with some in the government having the intention of providing health services that served all population groups equally without any racial or financial bias. According the Association of Medical Missions of the Ciskei and Transkei (AAMMCT) (1946), Dr Gluckman greatly admired mission hospitals, and stated that he hoped that they would remain under the control of their respective churches.¹³ In this way, they would render a greater service but due to insufficient funding, mission facilities faced considerable difficulties (Kautzky and Tollman 2008). By forming a national health service, health care in the country would ultimately be in line with the global call of ‘health care to all’ (Alma Ata 1978).

The nationalization of FBHPs into the South African Health System: 1960s-1990

There is one existing account of the nationalization of the FBHPs – a small (relatively inaccessible) book

¹³ This statement was made at the Conference of Methodist Church in East London on 24 October 1946.

PART C: Historical case study on nationalization & privatization of FBHPs in SA containing a first-hand account by Ronald Ingle's: 'An Uneasy Story: The Nationalizing of South African Mission Hospitals 1960-1975: A Personal Account' – written 40 years after the events. Ingle explains that nationalization took over forty years of negotiating between three important actors, namely those who were concerned with keeping the hospitals as institutions for Christian witness; those who saw the appropriateness of the absorption of hospitals into national and comprehensive health service; and the government who were indecisive (2010). Although in most SSA countries, the decision of what happened to FBHPs was taken post-independence (Birmingham 1995), in South Africa, it was made during the Apartheid era which brought additional challenges to the negotiation process particularly round segregation and discrimination (Digby 2006; Ingle 2010).

The journey of nationalization was not without obstacles and resistance, particularly from local churches¹⁴ and the community – the discussions began in the early 1960s however it was eventually set in motion in 1975 (by the early 1970s, most mission facility ownership had been handed from international to local churches).

In 1962, the national government formed a committee to plan and unify health services in Bantu Administration areas and systematically underfund their health facilities (Ingle 2010) – the majority were mission hospitals. In response, the local churches (Methodist Church, Catholic Church, Anglican Church, Dutch Reformed Church) formed the Transkei and Ciskei Association of Mission Hospitals (TCAMH) in 1964 – an advocacy group for mission hospitals who wished to be a part of developing the health system (Ingle 2010; Jeannerat et al. 2011). In the late 1960s, the Department of Bantu Administration and Development (DBAD) and department of health (DOH) announced the changeover of all maintenance matters from national government to the Bantu Administration and made further plans to 'control' FBHPs in the Bantu areas (Ingle 2010). The DOH in the Bantu Homelands released a policy to unite all health services including all mission hospitals subsidized by the government from 1 April 1970 (Ingle 2010). This was followed by an announcement by Deputy Minister of Bantu Administration and Development of Mission Hospitals' takeover in Transkei by government on 1 April 1973 – despite an earlier assurance of 'no takeover in the foreseeable future' in 1971 (Ingle 2010). In the early 1970s, the DOH as an agent for the Department of Bantu Administration (DOH in Bantustans) was in control for the health care of the homelands, despite missions providing nearly all the services in hospitals and some clinics (Ingle 2010).

The first step towards complete control was to financially subsidize the operating costs of mission hospitals rather than duplicate health services (Ingle 2010).¹⁵ According to Michael Gelfand, a missionary doctor in Natal, the announcement left little doubt that this decision would effectively hand the missionary health services from local churches to the government.

¹⁴ Churches (the owners of mission hospitals) did not want to be left out of the health system and through the CCSA challenged these decisions and provided alternative solutions. However, this was difficult as they relied on the government for financial support.

¹⁵ A similar decision was made in most other African countries around the same time – with subsidization usually resulting in payment of missionary facility staff salaries by government.

“On 1 April 1973, the South African government began taking over all mission hospitals in the Homelands, prior to handing them over to various Bantustan governments. The department of Bantu Administration and Developments with the Department of State Health as its executive authority took control of all hospitals in Bantu homelands.” (Jeannerat et al. 2011)

Although most of the documented evidence shows financing as the main reason for the nationalizing of mission hospitals, it also believed that the government was motivated by political authority in addition to financial concern (Mooney and McIntyre 2008). According to a former Bishop in the Methodist Church:

“Back then, the government didn’t care about black people, worse they didn’t like what mission facilities were doing for black people; caring and educating them. At that time churches did all things the government wasn’t doing and the community was unhappy with the decisions. It has less to do with health and more to do with disempowering the marginalized.” (Participant 9036, 15 November 2016)

Political authority would have driven the Apartheid government. During this time (mid-1960s and 1970s) the country was over two decades into Apartheid and showed no sign of handing over power, unlike the trend in Africa (colonization ended in most African countries in the 1950s and 1950s). The government had complete control. The Apartheid system was effective in its implementation of segregated resources which applied to education, housing, as well as health despite being condemned by the international community (which eventually led to international sanctions in 1962) (Davenport 2000). The international health community was moving towards ‘Health care for all’ (Alma Ata 1978) but by controlling FBHPs, the government could use the reach of mission hospitals to suppress health care as they did education and housing programs.

Despite nationalization being announced in the mid-1970s, the takeover of mission hospitals took many years (see **Table 1**). Jeannerat et al (2011) argue that this was because mission hospital administrators (churches) were reluctant to hand over their assets and staff to government. The delay was also due to insufficient discussion and preparation with regards to the imposition of hospital authority (Ingle 2006). The staffs in mission hospitals were also unhappy with the takeover, as many of them came with the mission to minister and treat the vulnerable through the church (Jeannerat et al. 2011). It was this uncertainty that exacerbated integration problems – many of which remained unresolved (Digby 2006; Ingle 2006). As already noted, the transition plan was almost non-existent – and this solidified the concerns of many stakeholders, who felt that the government had ulterior motives and that the mission facility takeover was mainly a reinforcement of Apartheid laws (so focused on racial politics, rather than an orientation towards ‘health for all’). As an expert interviewee said:

“During Apartheid, the powers that be did not want to share health facilities and wanted to control the treatment of black and coloured people” (Participant 2062, 23 November 2016).

This belief was echoed by Ingle (2010) – although he noted that he did not want his account to dwell on the social-political situation:

“It would have been essential to go inside government archives to test the ‘duplicity’ theory that in the course of so-called negotiations, government disguised their agenda. So I decided that this would be a personal account.... This limitation should explain why I do not include the political context of those years of Apartheid rule. It has been said the opposition’s offer to nationalize from within our ranks was also political....” (Ingle 2010)

Despite the motivation of mission facilities to not be nationalized, it is important to recognize that mission facilities could not completely satisfy the need of the whole population, especially not in the so-called Bantu homeland states (where they were mainly based), and which had a particularly low service coverage (Phillips 1990). Mission facilities required intervention – and were mainly seeking financial support from the government (rather than from other international resources). Ingle (2010) argues that FBHPs’ primarily aimed to secure maximum possible benefit for the ‘native population’ – and their standing (as a sector) was less important (Ingle 2010). While some remained skeptical – several missionary providers were convinced by the nationalization argument, believing that the takeover would result in the government (rightfully) taking responsibility for the full population, and gaining full control of the health system (for more effective governance and management). For example, Bosch (1967), a member of the Dutch Reformed Church argued that the takeover of mission hospitals was for the benefit of all. In his presentation to the Transkei and Ciskei Association of Mission Hospitals (TCAMH), he addressed the ‘Aims and presence of Christian Medical Work in South Africa Today’. Bosch argued that nowhere in the world were governments subsidizing mission hospitals as substantially as the South African government – and that ‘the church’ did not need mission hospitals to do the work they wished to do and that rather, they were a legacy of the colonial era (Bosch 1967).

A doctor whose career originated in the mission sector, and who is now a member of the Provincial government said:

“I was trained and worked in a mission facility and churches were struggling to adapt to what was happening. Although there were some international donors, the churches had to adapt or risk their financial support. The problem was that once they did take over, the hospitals lost their ethos and that is what they did not want to lose” (Participant 3532, 28 November 2016)¹⁶

Finally, there were also several concerns relating to human resourcing – which made churches and missionary providers concerned for the success of the nationalization plan. For example, even in nationalized facilities, they felt that the Apartheid government was unlikely to provide adequate hospital

¹⁶ Although is true in some cases, many nationalized Hospitals such as Mseleni Hospital in Kwa-Zulu Natal and Lethaba Hospital in Limpopo have not lost their Christian ethos. Several Hospitals are still being run by Christian staff with some even holding weekly prayer meetings.

PART C: Historical case study on nationalization & privatization of FBHPs in SA and health services without missionary doctors – and that missionary doctors could not realistically work in government facilities.

Post-nationalization of FBHPs into the South African Health System: 1990s – now

As mentioned, the process of nationalization of mission facilities took several years. In 1977, the new Health Act of 1977 perpetuated the fragmentation of health services making curative care the responsibility of the provincial governments (Coovadia et al. 2009). By this time only a few mission facilities had been nationalized (Jeannerat et al. 2011). The establishment of distinct administrative authorities for each racial group and ‘ethnic homelands’ resulted in 14 separate health departments operating independently in different areas of South Africa. As a result, the health system inherited from the Apartheid regime in the early 1990s was highly fragmented with the early focus of reform being on structurally integrating the health sector (Kautzky and Tollman 2008). Although disbanding the individual health departments and realigning them in a unitary Ministry of Health was accomplished relatively easily, the integration of local and provincial health systems at the district level was fraught with ‘unexpected obstacles’ (Kautzky and Tollman 2008).

With the advantage of hindsight – it can now be assessed that nationalization of the mission facilities resulted in the closure of many of these facilities (see **Table 3**). Although a few were absorbed and continue to be run by the national government, a number of facilities changed function, or no longer exist (Jeannerat et al. 2009; Larsen 2010). We have conducted a simple assessment of known previous ‘missionary facilities’ against the national list of health facilities (Blaauwberg 2017) – although it should be noted that data is not complete, and it is impossible to ascertain the reasons for the closure of these facilities (within the scope of this study).

Table 3: The establishment of some FBHPs and what happened to them after nationalization

Establishment year and name of mission facility	Year of nationalization and name change
1800s Mount Coke Mission Hospital	1994 Mount Coke
1889 Elim Hospital	Closed
1909 McCord Zulu Hospital	2014 McCord Hospital ¹⁷
1927 St. Mary’s Hospital	St. Mary’s Hospital is run by St Mary’s Catholic Mission Hospital Trust
1930 Charles Johnson Memorial Hospital	1975 Charles Johnson Memorial Hospital
1936 Mosvold Mission Hospital	1978 Mosvold Hospital ¹⁸
1937 Bethesda Mission Hospital	1982 Bethesda Hospital

¹⁷ McCord Hospital was only handed to government in 2014 with the understanding that it will run with the same Christian ethos. This was after years of threatening to close its doors due to financial difficulties.

¹⁸ The Kwa-Zulu government purchased the building allowing the land around it to remain a Mission. The Hospital still runs with the ethos of the church.

1937 St Margaret's Hospital	2007 St. Margaret Hospital
1937 Christ the King Hospital	1984 Christ the King Hospital
1948 Manguzi Methodist Mission Hospital	1981 Manguzi Hospital
1956 Zithulele Sending Hospital	1976 Zithulele Hospital
1957 Mbuma Mission Hospital	Still open
1943 Douglas Smit Mission Hospital	Closed
Holy Cross Nursing Home	Closed
Mogalakwena Sendinghospitaal	Closed
St Konrad's Hospital	Closed
Luwambe Lutheran hospital	Closed
Assissi Mission Hospital	Closed

Faith-based communities shifting attention to other areas of need

So, from the 1970s-1990s, missionary health facilities were formally designed out of the South African health system. However, this is not to say that religiously affiliated health activities totally ceased. Many religious groups shifted their energies into new activities. Some of these activities resulted in the establishment of new 'non-governmental organizations' such as primary care clinics. Others established 'faith-based organizations' (FBOs)¹⁹, which often fall under the governance of the Department of Social Welfare and Development in South Africa, rather than the Department of Health (Merwe et al. 2009). This is important, as although missionary facilities in the traditional (hospital-centric) form gradually disappeared – what emerged in its place was a myriad (and fairly complex) array of health and development activities. James (2009) argues that these activities enabled South African faith communities to continue serving their beliefs and mission to serve those in need (James 2009). Since the nationalization of the mission facilities – the array of organizations and programs that have emerged out of South African faith communities tend to be more flexible and adaptable – and they have been able to see an immediate need and act (Ferris 2005; Fowe 2012; James 2009) – see below for more on this.

According to Koegelenberg (2001), movement under the leadership of the Ecumenical Foundation of Southern Africa (EFSA) and the National Religious Association for Social Development (NRASD) convinced the government to acknowledge faith groups and FBOs as a unique and separate sector in civil society and to enter them into a specific partnership with this sector that would entail funding for social development projects. Additionally, a Memorandum of Understanding (MOU) between the government and religious leaders was signed in 2005, allowing the possibility of the government to make funds available to the religious sector for certain projects and programmes for social development and allowing the provision for joint projects between the government and the religious sector (Koegelenberg 2007).

The nationalization policy effectively diverted the energy and resources of South African faith communities

¹⁹ The term 'FBOs' is used here because some of the facilities that emerges are not engaged in health but are rather faith-based facilities or organisations that are inspired by faith institutions.

PART C: Historical case study on nationalization & privatization of FBHPs in SA more strongly into 'civil society' – compared to the SSA countries where as mentioned earlier, the main resourcing continues to be on hospitals (see Dimmock et al. 2017). This is an important consideration. As international attention shifts from 'health service' to a more inclusive 'health system' – it is interesting to speculate whether the added faith-community energy into South African civil society might not have benefitted the 'health system'. Instead of expensive tertiary hospitals, facilities were re-engineered into primary care centres, feeding projects, old-aged homes and orphanages (CATHCA 2015; Goemans and Wilson 2010; Simmermacher 2011). In effect, faith-community energies were diverted to the things at the 'periphery' of the South African health system. For example, The Catholic Health Care Association was founded in 1988 as an umbrella organization for Catholic health facilities in South Africa, Botswana and Swaziland (CATHCA 2015). While some of the hospitals (in Botswana and Swaziland) were retained, in South Africa, the focus was on Catholic clinics, hospices and community health organizations – all with the aim of providing accessible and holistic healthcare (CATCHA 2015).²⁰

An area of particularly rapid and adaptable response from the South African faith community was to the HIV/AIDS epidemic in the 1990s (Mash and Mash 2013; Norder et al. 2015; Thomas et al. 2006). The HIV/AIDS epidemic saw many FBOs re-engaging in health care provision, especially from around 2004. For example the Catholic Church is renown for the antiretroviral (ARV) treatment services it provided, as well as advocacy role they played (Hogan and Orobator 2014). FBOs have also played an instrumental role in community-based care through not only the distribution of ARVs but also through social interactions relating to stigma and support (Kelly 2009; Thomas 2005). This rapid response of the South African faith community came in the shape of health facilities (FBHPs), FBOs, community-based organizations (CBOs) and programmes (Kelly and Birdsall 2010). The faith community also engaged strongly in advocacy – for increased resources towards treatment and prevention (Bompani 2011).

Health-engaged faith-based institutions in South African today

Nationalizing mission facilities in South Africa has left the government in charge of health provision for the population together with a small but growing private and NGO sector in which FBOs are a part (Jobson 2015). Since the 1980s, private for-profit health care has been a growing sector (McIntyre et al. 1995; NDHPD 1986). Currently South Africa has a dual health system, a public sector that serves over sixty percent of the country's population with forty percent of the resources and a private health sector that caters to less than fifty percent of the population with sixty percent of health resources (McIntyre 2014). As a result, FBHPs have adapted as faith communities have changed the way they engage and deliver health services.

²⁰ CATHCA receive funding form the National Lottery Bristol Myers Squibb, the Canadian International Aid Commission, Misereor, the Global Fund Against Tuberculosis, Malaria and HIV/AIDS, and from a major anonymous donor in the Netherlands.

Outside of the Christian-faith, Muslims, Sikhs and Jews also play a significant role in caring for the health of the country's population through food and medical provision through clinics through their places of worship such as the Nizamiye Mosque in Midrand Johannesburg (Mapumulo 2012). The Gift of Givers, an Islam founded foundation, is internationally known to provide relief, medical supplies and food and water not only to local communities but communities abroad such as Somalia, Haiti and Syria (Gift of Givers 2013). Their partnership with government and other organizations allows them to play an active role in funding and supporting health care clinics (Gift of Givers 2013).

Despite nationalization – there *are* in fact examples of FBHPs present in South Africa today. While these are no longer large tertiary hospitals, there are many primary-level centres, HIV-centres, home-based care programmes, palliative care clinics – and the like (Holdcroft 2014). For example, in Cape Town, Jubilee Health Centre, a faith-based primary health clinic is run by Jubilee Community Church²¹ and offers free primary health care to the needy including voluntary counselling and testing for HIV, and a pregnancy help centre (Jubilee Community Centre 2016). Mosaiek Church in Randburg, Johannesburg, has a wellness centre on its premises open to the public that caters primarily to mental health concerns (Mosaiek 2016). QualiHealth, a primary health care facility in Diepsloot provides care for local residents (QualiHealth 2017). Although such organizations do not form part of the formal health service sector, they can be said to be part of the health system. Church facilities have also been noted to be in support of community health projects such as those in Mamelodi, Pretoria, which allow for the vulnerable and elderly in their community to receive medical assistance in their buildings twice a week and promote physical exercise and healthy nutrition to mothers and children (The Times 2014). FBOs also frequently provide palliative health care as well as rehabilitation and sub-acute facilities (step-down clinics) (HPCA 2014) showing their versatility by not only providing health services but providing what might be considered as 'basic needs' in their services. This includes their ability to advocate for communities and individuals as with HIV/AIDS service provision (in those areas where government has less service). Although through nationalization, some facilities were lost, others emerged to support the health system in a different ways.

Discussion: The effects of nationalization of faith-based providers on the SA health system

A well-known Reverend in the Methodist Church stated:

"I don't think that it is necessary to have the old style of FBHPs back in the health system. I think there are several other ways the church can be involved in health provision. Maybe in advocacy, training or health education? Now that time has passed, those kinds of FBHPs bring forth a high expectation and sometimes a huge distortion of religion and in today's context; it may not be a good idea." (Participant 2881, 3 December 2016)

²¹ Jubilee Community Church is not a 'traditional' denominations, but new emerging religious communities are seeking to engage in health care too.

This study highlighted how complex the presence and eventual nationalization of mission hospitals has been on the South African health system. Their presence today shows the resilience and adaptability of the faith community in supporting health in the country. This allows for a wider reach and variety of services that range from diseases protection to health care provision and thus can be viewed with a health system perspective as “health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health” (WHO 2007).

Nationalization removed the missionary facilities from the health system – and perhaps that can be considered a ‘good thing’ from some perspectives. Their absence has freed up local faith-community capacity to respond more flexibly to issues and need such as HIV/AIDS (compared to Ghana and Zambia where the faith community has continued sinking masses of resources into funding high level tertiary facilities). By FBHPs not being bound by policy, they are free to ‘fill in the gap’ by being advocates, allies and partners to the local and greater community by not only supporting health care delivery (by providing home-based care) but also in responding to the social determinants of health by providing food and housing to those in need (orphanages and shelters).

However the decision-making process and process of nationalization may have been to the detriment of health access for many at that time (and can be argued today as well). As mentioned, FBHPs had a reach and trust that the national government did not at the time and the closing of FBHPs in some rural and underserved communities created a greater need – many of these areas continue to be the ‘weakest’ regions of the South African national health system. These health facilities were lost entirely and this resulted in inadequate access and services for (predominately) the black and coloured populations forcing them to travel to cities/town for health care. The current national government has tried to increase health care access across the country (Ataguba and Akazili 2010), but the influence of these facilities has largely been lost.

Furthermore, in countries where the faith sector is still present in the health system, the government is held to account by them. According to Yeboah and Buckle (2017), they can only do this from a position of strength because they own a significant portion of the health system. Both sectors have a role and responsibly in health care provision and accountability is important in improving and sustaining health care in a country. In South Africa, where the national government is the main provider of healthcare, the government is accountable only to the public (and even then, not significantly) (Cleary et al. 2013), allowing them to make independent decisions with little engagement.

The loss of FBHPs has also resulted in the loss of FBHP training facilities. These facilities trained nurses and funded the studying of doctors – important human resources needed in the health system. Without these training facilities, health training has been left solely to the national government (which has proven to be expensive) resulting in a shortage of health workers across the country (Becker 2017; James 2016) and ultimately affecting health access and quality.

Nonetheless, as noted above, the faith community has remained an asset to the health care sector, as they have not disappeared. Although their impact and responsibilities are unlike other SSA countries, their flexibility and 'grassroot level approach' perhaps means less is spent on tertiary level facilities and has ignited a lot of civil society activity.

If one were to consider a health systems approach rather than a health service approach, nationalization has been beneficial for South Africa. 'Freeing' FBHPs to bring attention to, and support health care issues in the country has been vital in health prevention and support. Their direct relationships and access to the communities they serve has helped FBHPs maintain their ethos of faithful serving and provides them with the ability to find nuanced answers. Although South Africa does not have an organized health community like other SSAs, their history and present relationship with the public allows them to still have a significant voice. FBHPs do not only do what government health facilities do – they do more.

A large proportion of countries in SSA still have a significant part of FBHPs in their health system architecture (Schmid et al. 2008; Sonderlund et al. 2003). These FBHPs provide valuable health service to the government. Still, some of these countries such as Uganda and Tanzania although have experienced constraints with regards to health system financing and ultimately service delivery (Dambisya et al. 2014; Dimmock et al. 2012; Olivier et al. 2015 Songstad et al. 2011; Witter 2017). A number of these countries have considered nationalizing their FBHPs and taking ownership of all health services,

It is with this in mind that the idea of nationalization should not be discussed with fear by SSA but should rather be considered as a whole-system response. South Africa has shown that the adaptability of FBHPs and the various ways they can assist in health system strengthening does not depend on their presence in the health system structure. It would also be interesting to consider the possibilities of partnerships between the modern FBHPs and the national health system – how that would work and look like today.

Although the author was reluctant to see the benefits of FBHP nationalization as their absence in the health system saw the closing of several health facilities serving poorer communities and the closing of training facilities may have resulted in the shortage of health workers, it is worth considering that they have not lost their importance in the betterment of the health system in South Africa. FBHPs need not be a part of the health system architecture to play a vital role in health service provision and delivery and ultimately health system strengthening. They have been and remain a significant part of SSA history and present. FBHPs evolved in the mid-1950s into what they are now and it is with little doubt they will continue to evolve irrespective of the social and political decisions taken nationally or internationally.

Limitations

This paper was the result of a small study where information gathered was through general information available and accessible to the public together with a small number of key interviews. It speaks to the

PART C: Historical case study on nationalization & privatization of FBHPs in SA
general evolution of large FBHPs in South Africa and makes little mention of smaller faiths, no mention of those that left South Africa or those that have left the health system entirely. An in-depth study is needed in order to access the qualitative and quantitative data on the presence and absence of FBHPs in South Africa and SSA.

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APPENDICES

APPENDIX I: Information Sheet & Informed Consent Form for Semi-structured Interview

THE ROLE OF FAITH-BASED HEALTH PROVIDERS IN THE SOUTH AFRICAN HEALTH SYSTEM: A HISTORICAL CASE STUDY ON THE NATIONALISATION AND PRIVATIZATION OF FBHPS

Background and Context:

The South African health sector has undergone some interesting changes over the past 100 years with the most noticeable changes being in the past 60 years (1940s-2000s). In 1940- 1970, private hospitals and the private sector in general were limited to mission facilities and hospitals however over the following 15 years (1980-2000s), for-profit privatisation increased and initiated a growing private sector in the country through government policy as per the international trends leaving FBHPS out of the health system architecture.

Unlike in South Africa, many African health systems (Ghana, Zambia and Zimbabwe) still have prominent FBHPS present and they play a role in their health system strengthening although their presence and role in health system strengthening have not been definitively proven. In South Africa, FBHPS were nationalised in the 1970s, and later reengineered and left out of the health system post 1994, meaning at present they do not formally form part of the public or private sector of the national health system. Instead, the large FBHP facilities were handed over to the state and some faith-based institutions were restructured and began providing health as part of civil society.

This means that FBHPS form part of the non-profit non-governmental health providers and are not distinctly part of the health system but rather could fall under the department of development. Their absence in the health system architecture could impact their value in health system or their influence in health system strengthening in the way the WHO had hopes. Clarke and Jennings (2008) have observed that over time, FBHPS have gone from being at the forefront of service delivery and social development and have been degraded their 'faith' in order to survive in the health market as donors, although not all have gone this route (James, 2009).

I. Who is carrying out this study?

The researcher from the University of Cape Town School of Public Health and Family Medicine is a Master in Public Health student Ms. Dineo Maitisa. If you have any questions about this study contact her via email: dmaitisa@gmail.com /mtsadin005@myuct.ac.za or phone: 0767593532

The Principal Investigator for this study is: Dr. Jill Olivier University of Cape Town, School of Public Health and Family Medicine, Faculty of Health Sciences Anzio Road, Observatory, 7925 Tel: +27 (0) 21 406 6489 Fax: +27 (0) 21 448 8152 E-mail: jill.olivier@uct.ac.za

II. What is the purpose of this study?

The study is part of my Masters of Public Health at the University of Cape Town. The research focuses on the journey of FBHPS by retrospectively describing the role of FBHPS in the South African health system over the last 65 years in order to build a chronological and historical timeline of their nationalisation and privatisation. This study will take place over 4 months (September- December 2016).

III. Why are we doing this study and why should you take part in this study?

In order to understand how and why there are no FBHPS in the current South African health system, it is important to narratively track key health systems developments over time that had a particular impact on their role. Your insight as leader and actor in faith and health- knowledgeable in their interaction and relevance- can give comment to the decisions that were made, what was taking place in the country at that time as well as the effect of these decisions. This is important in helping us understand the architecture of the South African health system and if FBHPS could still have a significant impact. 10-15 interviews will take place with the research forming part of my master's degree thesis which I aim to get published.

IV. What would I have to do?

I would like to have an interview with you that will take about 45 minutes of your time, at a time that is convenient for you, preferably telephonically or over skype/email chat. The interview will be casual and like a conversation. During this conversation, I will ask you some questions on the nationalization and privatization of FBHPS and your opinions on these

decisions and the result this has had on the health system. With your permission, I would like to record the conversation. The recorded information will later be typed up and I will be the only one to do that.

V. Study results

After the interview, the researcher will share the important points/themes that emerged during the interview for clarification and further comment. Once the research is completed, it will be presented as a master's thesis as well as a publishable academic journal article which will be shared with you.

VI. Is there any way that being in this study could be bad for you?

This study will not pose any harm to your person. If you do not want to answer particular questions, we will move on to the next question. Before agreeing to talk with me, you are encouraged to ask questions and discuss with me any of your doubts or fears. We may discuss sensitive issues, but confidence will be respected and all efforts will be maintained to keep your responses anonymous and unidentifiable. I will not write your name or contact details on interview sheets however, due to the possibility of your identity being recognized, there is the potential of damaging relationships due to the releasing of confidential information.

VII. What are the benefits of participating in this study?

Your participation will not benefit you directly, but will benefit the health sector by providing information and understanding on the changing role and presence of FBHPs in the South African health system as a non-state health provider.

VII. How will your identity be protected and your privacy maintained?

Upon request, your name will not be included in the study and recordings and transcripts, however, due to the nature of the research topic and the question, your anonymity cannot be guaranteed as you may be identifiable. This is because you are a specialist in the field and due to organization/institutional affiliation and/or position and views, readers may identify you despite your name not being mentioned. To protect your identity and privacy, a list of people I interview along with the code number and consent forms will be stored separately from the data and placed solely in the researchers' possession. All audio recordings and written transcripts (in the possession of the researcher) will be locked in cabinet or on a password protected computer and will be deleted within 3 years' research conclusion. For clarification, I will check with you later that I have written what you said and meant accurately.

IX. Will you be paid for your time/ taking part in this research study?

You will not be paid for the time you take to be in this study.

X. Who can you contact if you have questions about the study?

If you have any questions or concerns about what we are asking you, please contact myself or my supervisor. The names and telephone numbers are listed at the top of the second page of this form.

XI. Who can you contact if you have complaints or concerns about the study?

If you have any complaints about your treatment or rights as a research subject, you may contact the *University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee, Room E54-24 Groote Schuur Hospital Old Main Building, Observatory, 7925, Telephone: +27 21 406 6492 Fax: +27 21 406 6411*. The research Ethics Board comprise of staff of the University of Cape Town who see to it that all humans participating in research do so devoid of harm or coercion. They ensure that participants' rights are protected.

These group of people have reviewed and approved of this study and will be happy to respond to your questions if you have any doubts.

XII. Participant consent

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact. You may refuse to answer any question you do not wish to respond to. You may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed

If you agree to participate, please sign the attached consent form.

I understand the information Dineo Maitisa has explained to me concerning this study and I agree to take part. I understand that I am volunteering to talk, but I can decide at any time to stop the conversation. If I do not want to continue and there will be no problem. I may refuse to answer any specific questions or I may stop the interview at any time if I feel uncomfortable continuing. I understand that some of my exact words may be used in the final print form which the general public may have access to later, but my name will not be used. I have been assured that I can ask questions, and that all questions I have will be answered to my satisfaction. I understand that I will give approximately 45-60 minutes of my time for our conversation.

I have either read or had the consent read to me and have had all of my questions answered. The study has been explained to me and I understand that completing the interview indicates my consent.

I agree to let you: take notes during the interview / Record the interview [circle as appropriate]

Signature and name of participant:

Signature: _____ Name: _____

Signatures and name of person who sought consent (principal researcher): Signature: _

_____ Name: _____

Date: _____

We greatly appreciate your participation in this study and will be respectful of the information you provided.

Should you not agree to participate, we thank you for letting us tell you about the research.

APPENDIX II: Interview Guide

INTRODUCTION

Introduce yourself, the study (guided by the Information Brief) and walk the participant through the consent form.

- Who you are (ensuring they have your contact information)
- That this is Masters level thesis run by a University of Cape Town Public Health Student
- Seeks to chronologically narrative the history of SA health system over the past 65 years and the role of FBHP during this time seeking to strengthen evidence and health systems integration
- Please reassure the participant that we are very serious about ethics, and that the ethical consent forms are there to protect the participant:
- All these interviews are confidential. Although we will use your interview in developing our broader understanding, we will not be telling other people what you said specifically and we will not link anything you have said to your name in our reports^{3/4}
- “I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign this confidentiality form to confirm your agreement to talk to me. I will leave you with the Information Brief and the first page of this form.”
- That we will ensure that all information we gain comes back to participants for review and confirmation (please ensure you have email addresses and contact details where appropriate)
- *Depending on the discussion, you may want to reiterate:* that there are no direct funding consequences of this interview (either reimbursement, or funding decisions)

QUESTIONS

The questions need to be shaped to the institutional context and the actor, for example, if you are interviewing someone at a national level, ask them about the national system and their role, if it is a facility level about the facility and their role. Please always be careful of asking a persons' religious affiliation, and only ask this if it does not come up in conversation.

Questions will be asked in an open-ended format:

Please tell me about your job/occupation or role in your organization or institution.

- When and why did you become connected to the health system?
- What is your role or link to the health system?
- Your training/background, what is your (religious affiliation)? History of the health sector and FBHPs
- I am trying to understand the history of the South African health system- what can you tell us about its history or development?
- What were the key events in the development of the health system?
- Why do you think FBHPs have been left out of the national health system architecture?
- What was the role of FBHP over this time?
- What *policies* influence how this institution (HS and FBHPs) operates, and your work (noting that by policy we include all government, district, funding and theological policies)?
- Do you feel FBHPs still do or can have an active role in health systems (strengthening)?
- How?
- If they cannot be included, is there another way they can be included?
- Who do you think are the main actors or decision makers in the public-private partnership?
- How does the history of the country play a role in the current presence of FBHPs?

- What role can FBHPS have in the health system and its architectural structure?
- Should SA adopt FBHPS into the national system like other LMICs?
- Why?

Other comments

- Anything relevant to share?
- Would you mind if I followed up with you again later with any further questions or for clarification?
- I commit to sharing the research article that emerges from this study with you when it is complete (please share the appropriate email or address to do so)
- Thank you!

APPENDIX III: Steps of the Thematic Analysis Step 1: Code Material

- i) Devise a coding framework
- ii) Dissect text into text segments using the coding framework

Step 2: Identify Themes

- i) Abstract themes from coded text segments
- ii) Refine themes

Step 3: Construct Thematic Networks

- i) Arrange themes
- ii) Select Basic Themes
- iii) Rearrange into Organizing Themes
- iv) Deduce Global Theme(s)
- v) Illustrate as thematic network(s)
- vi) Verify and refine the network(s)

Step 4: Describe and Explore Thematic Networks

Step 5: Summarize Thematic Networks

Step 6: Interpret Patterns

APPENDIX IV: Data Extraction Sheet

In order to complete this retrospective case study, archival records will be researched to build a chronological timeline of events and decisions that lead to the national and privatization of FBHPs in South Africa in the 1970s.

What information will be extracted from archival records and why

1. Policy documents:	Evidence of changes in law and practices with dates and timelines
2. Newspaper articles	Information given to the public and their response to the changes. These could also provide dates
3. Personal accounts in books and journals	Thoughts of those present at the time of the nationalization and privatization of FBHPs and how it impacted on the system and the people-particularly from FBHPs, health workers and the church
4. Articles on the social, economic and political climate	Evidence as to what could have led to the decision to nationalize FBHPs. This will also include information from international organization
5. Research on other LMICs with integrated FBHPs	To provide some understanding as to the PPP and compare the contexts. Are FBHPs viable in SA?

APPENDIX V: Primary & Secondary Documents Collected

<i>Name of Document</i>	<i>Information</i>
The Story of Christian Missions in South Africa	13 Pages of stories, notes, prayers and letters from the early Missionaries on their journey, letting and mission
Missionary Travels and Researches in South Africa 1813-1873	Stories by David Livingstone on his travel to South Africa
Methodist Society (Book)	The early story of Methodist missionaries with copies of correspondence between churches
Swiss Mission Records	Correspondence between Swiss Mission and Swiss government on their progress, challenges and triumphs (some translated), letters to missionaries
Swiss Mission in South Africa	History of the development of Swiss Missions
CCSA letters	14 letters of correspondence between the CCSA, Public Hospital Advisory Councils, the Union of South Africa, Office of the Administration, McCord Hospital of Transvaal, South African Institute of Race Relations dated Swedish Alliance Mission, Church of Scotland 1936-1967
Bridgeman Memorial Hospital	Newspaper Articles, correspondence, financial reports, constitutions
History of Missions in the Eastern Cape	The Era of the Establishment of Missions and Churches
Social History of Bethesda Hospital	
The Association of medical Missions of the Ciskei and Transkei	Letters on maintenance, meetings

APPENDIX VI: Approval Letter from Faculty of Health Sciences Human Research Ethics Committee



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

18 October 2016

HREC REF: 374/2016

Dr J Olivier
Public Health & Family Medicine
Room 1.36
Falmouth Building-FHS

Dear Dr Olivier

PROJECT TITLE: THE ROLE OF FAITH-BASED HEALTH PROVIDERS IN THE SOUTH AFRICAN HEALTH SYSTEMS: A HISTORICAL CASE STUDY OF THEIR NATIONALISATION AND PRIVATISATION (MPH candidate- Dineo Maitisa)

Thank you for your response letter dated 26 September 2016, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 October 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student, D Maitisa will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC 374/2016

APPENDIX VII: Instructions to Contributors: Journal of Religion and Health

MANUSCRIPT SUBMISSION

Manuscripts, in English, should be submitted to the Editor-in-Chief via the journal's web-based online manuscript submission and peer-review system:

<http://jorh.edmgr.com>

Inquiries regarding journal policy, manuscript preparation, and other such general topics should be sent to the Editor-in-Chief:

Curtis W. Hart, M.Div.

Editor-in-Chief, Journal of Religion and Health e-mail: cuh9001@med.cornell.edu

Tel.: (347) 752-7421

The online system offers easy straightforward log-in and submission; supports a wide range of submission file formats [such as Word, WordPerfect, RTF, TXT, and LaTeX for manuscripts; TIFF, GIF, JPEG, EPS, PPT, and Postscript for figures (artwork)]; eliminates the need to submit manuscripts as hard-copy printouts, disks, and/or e-mail attachments; enables real-time tracking of manuscript status by author; and provides help should authors experience any submission difficulties.

Manuscripts should be checked for content and style (correct spelling, punctuation, and grammar; accuracy and consistency in citation of figures, tables, and references; stylistic uniformity of entries in the References section; etc.), as the typesetter is instructed to follow (accepted) manuscripts as presented. Page proofs are sent to the designated author for proofreading and checking. Typographical errors are corrected; authors' alterations are not allowed.

Books for review and inquiries about book reviews should be sent to the Editor-in-Chief at the above address.

- www.jorh.edmgr.com
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Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to Springer Science+Business Media, LLC is required. Upon commencement of typesetting, the contact author will receive an e-mail directing him/her to a webpage where the transfer-of-copyright form can be signed online. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

MANUSCRIPT STYLE

Type double-spaced using generous margins on all sides. The entire manuscript, including quotations, references, figure-caption list, and tables, should be double-spaced. Manuscript length, except under unusual circumstances, should not exceed 25 double-spaced pages. Number all pages consecutively with Arabic numerals, with the title page being 1. In order to facilitate masked (previously termed "double-blind") review, leave all identifying information off the manuscript, including the title page and the electronic file name.

Appropriate identifying information is attached automatically to the electronic file. Upon initial submission, the title page should include only the title of the article.

An additional title page is to be uploaded as a separate submission item and should include the title of the article, author's name (with degree), and author's affiliation. Academic affiliations of all authors should be included. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. The title page should also include the complete mailing address, telephone number, fax number, and e-mail address of the one author designated to review proofs. A brief autobiographical paragraph, preferably no longer than 100 words, that includes highest degree, academic affiliation, expertise, projects, etc. (in that order) should be included on the title page.

An abstract is to be provided, preferably no longer than 100 words.

The names, institutional affiliations, and e-mail addresses of three (or more) suggested potential reviewers should be included on the additional title page.

A list of 3–5 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

CONFIDENTIAL MATERIAL

If your article contains any reference to material obtained under the HIPPA regulations regarding the use of Protected Health Information (PHI), to guarantee the privacy and confidentiality of this information, the author is required to do the following to be in compliance with HIPPA regulations:

1. Obtain from the subject(s) a signed and dated Release of Information Form which states explicitly that the subject(s) is giving his/her informed consent to have his/her Protected Health Information published in the *Journal of Religion and Health*. This form should include the title of the article to be published and should contain the original signature of the subject(s) and it should remain securely contained in the author's possession in perpetuity.
2. Submit to the Editor-in-Chief of the *Journal of Religion and Health* an Authorization Form to be obtained from the Editor-in-Chief with the original signature of the author, indicating that the author has the permission of the subject(s) to publish his/her material and authorizing the *Journal of Religion and Health* to publish the article in compliance with HIPPA regulations regarding Protected Health Information. This form will also be signed by the Editor-in-Chief of the *Journal of Religion and Health* and the original form will be placed in a locked file under the auspices of the Editor-in-Chief in perpetuity. A copy of this form will be mailed to the author for his/her files in an envelope marked: "Personal and Confidential" .
3. The author will make every effort to protect the identity of the subject by using pseudonyms, and changing any information that might make it possible for the reader to identify the subject. This would include any illustrations, including photographs, that might reveal the subject's identity.

ILLUSTRATIONS

Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals and cited in numerical order in the text. Photographs should be high-contrast and drawings should be dark, sharp, and clear. Artwork for each figure should be provided on a separate page. Each figure should have an accompanying caption. The captions for illustrations should be listed on a separate page.

Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

REFERENCES

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. References should include (in this order): last names and initials of all authors, year published, title of article, name of publication, volume number, and inclusive pages. The style and punctuation of the references should conform to strict APA style—illustrated by the following examples:

Journal Article

Plante, T. G., & Aldridge, A. (2005). Psychological patterns among Roman Catholic clergy accused of sexual misconduct. *Pastoral Psychology*, 54, 73–80.

Book

Levin, J. (2002). *God, faith and health: Exploring the spirituality–healing connection*. New York: Wiley.
Contribution to a Book

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