



Malaria and Faith: Building Strong Partnerships

Katherine Marshall

HIGHLIGHTS

A global program to combat malaria has attracted major international funding and is showing promising progress. A wide range of faith actors (notably major faith-inspired organizations and community leaders well-primed on anti-malaria strategies, alongside anti-poverty advocates) play significant roles in both program execution and advocacy, at global, national, and community levels. The potential for stronger partnerships is nonetheless substantial.

This brief, drawing on a 2009 Berkley Center/World Faiths Development Dialogue report, “Malaria: Scoping New Partnerships,” highlights important priorities for action, including more purposeful efforts to engage faith communities in global partnerships, a focus on better mapping and evaluation work as a foundation for networking, coordination, and identification of encouraging best practices and significant lessons and obstacles. A significant dimension of current programs is their encouragement of inter and intrafaith cooperation and alliances that have malaria as their central focus.

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WHY FOCUS ON MALARIA?

As many as 500 million people contract malaria every year, and about one million die annually from the disease. Children represent almost 90 percent of these deaths. As many as three billion people in 109 countries are at risk of infection today. Malaria was common in many world regions including the United States in the past, but today it is a disease centered almost entirely in poorer, less developed regions.

Some 80 percent of the malaria burden is in sub-Saharan Africa. In terms of lost productivity, malaria costs this region about US\$12 billion each year. An infectious disease caused by the Plasmodium parasite that is carried in humans and transmitted via mosquitos, malaria infects and destroys red blood cells, causing severe anemia, obstructing blood flow, and leading to severe organ damage. History shows that the disease can be addressed and malaria eradication, though a far off goal, is not unrealistic.

Given the enormous global health burden of malaria and its strong links to poverty and human capabilities, it figures explicitly and indirectly among the eight Millennium Development Goals (MDGs). The sixth MDG is, by the year 2015, to have begun to reverse incidence and death rates due to malaria (as well as HIV and AIDS and tuberculosis). The fourth and fifth goals—a two-thirds reduction in child mortality and a three-quarters reduction in maternal mortality—are unattainable without significant progress to reduce malaria’s impact.

To realize these goals, several global campaigns center on malaria as their mission. These include, at the UN level, Malaria No More, and in the US, the President’s Malaria Initiative. The latter was launched in 2005, with the aim to reduce malaria deaths in 15 focus countries, most of them in sub-Saharan Africa. As of 2011, total PMI funding had reached US\$1.86 billion.

WHY IS RELIGION RELEVANT?

Many different religious organizations are actively involved in combatting malaria, but these efforts have not featured prominently in most strategic analysis on the topic, or in global policy discussions. Most faith-inspired work on malaria to date is concentrated in individual organizations or denominations. However, given the paramount importance within global malaria programs of coordination, and the notable fragmentation of many faith-led programs and systems, there is a strong case for more active promotion of interfaith approaches and programs and for more purposeful engagement of faith communities of many kinds in global anti-malaria efforts. The hope is that more active engagement with faith communities and leaders can mobilize communities to action in ways that are cost effective, in part because they involve substantial volunteer support.

WHAT ARE PRIORITIES FOR MALARIA CONTROL?

Well-established approaches to malaria control involve a combination of treatment and mosquito control. A feature of the disease is the need for saturation interventions in large areas to reduce the pool of infection. This dictates concerted and well coordinated programs that are often national and multi-national in scope.

Treating malaria is a current focus and priority but presents significant challenges. Effective medical infrastructure is needed, as practitioners must support the patient so that she/he does not succumb to dehydration, shock, or organ failure. Important supportive measures, such as administration of intravenous fluids and oxygen, can be difficult in the rural, resource-poor settings where malaria predominates. Resistance to malaria is a serious and growing problem. A central challenge is to encourage parents, especially mothers, to recognize symptoms of malaria in their children and to seek treatment promptly.

The central thrust of anti-malaria efforts is to prevent the spread of the disease by controlling infected mosquitoes. Mosquito nets are a practical, low cost, and effective defense against the disease. Sleeping under a bed net significantly reduces mortality from malaria, especially in children under five. A recent study from Kenya, for example, cites a 44 percent drop in child mortality from malaria following a large-scale free bed net distribution. Bed nets are most effective at reducing the communi-

ty-wide malarial burden when they are treated with a long lasting insecticide, distributed for free or at substantially reduced cost, and actively used by greater than 80 percent of the population. Another important program element is Indoor Residual Spraying (IRS) that involves the spraying of insect repellent inside homes to reduce mosquito infestations. Some controversies surround DDT, the chemical that is often used in the intervention.

WHAT DISTINCTIVE FEATURES CHARACTERIZE FAITH INVOLVEMENT IN MALARIA TREATMENT AND PREVENTION?

The major assets that faith-inspired organizations bring to the anti-malaria efforts are their deep roots in communities (they can support community-based interventions), the trust that communities have for religious institutions and leaders (key messages can be well transmitted), their many health facilities (foundation for malaria treatment), and the strength of the moral sway of religious institutions and leaders (advocacy).

Several successful development programs engage faith in promoting anti-malaria programs to their congregations. The most ambitious are ongoing and can point the way to larger scale interventions: the Center for Interfaith Action on Global Poverty initiative in Nigeria, and the Tony Blair Faith Foundation support for malaria programs in Sierra Leone. Both work at national scales through partnerships with government and international organizations, notably the World Bank and PAM.

Smaller scale programs also point to potential areas for expansion. Episcopal Relief and Development supports the Zambian Anglican Council (ZAC) in its nation-wide malaria prevention and treatment program. When the program was launched in 2006, knowledge about malaria transmission was poor and myths about the disease—that it was caused by eating cold food or unripe sugarcane—prevailed. ZAC's prevention and treatment programs, and the response to malaria in the nation as a whole, lacked the resources to address the problem in a comprehensive way. Through the program, ZAC trained 85 parish priests and a fleet of community health workers in malaria prevention. Now, there are priests who know as much about malaria as the community health workers who preach about prevention on Sundays. An independent observer indicated that knowledge about malaria transmission and the need and correct use of

the net, particularly by children under 5 and pregnant women, increased dramatically across areas affected—on average by 70 percent.

Compassion International, a US-based evangelical development agency focused on children's health, has been successful in providing healthcare services, including malaria prevention and treatment, through 5,000 church-based health facilities, including 1,200 in Africa. Compassion senior ministry advisor Dr. Scott Todd explains their success: "Churches serve as local, credible education and distribution points in prevention campaigns—teaching about malaria, distributing insecticide treated mosquito nets, and doing follow-up monitoring by home visits." 100,000 long-lasting insecticide-treated nets have been distributed so far. Some Compassion-funded country programs, such as the one in Tanzania, have adopted creative approaches to fighting malaria—like the strategic planting of mosquito-repellent trees.

With the wide diversity of faith communities and institutions, the scope for engagement extends to all dimensions of malaria campaigns, from advocacy to community level delivery. The most promising area for focus would appear to be behavior change within communities and families.

SECULAR NGO-FIO PARTNERSHIPS

Some secular development organizations have started to engage faith groups as sub-grantees or implementing partners for malaria programs at the local level. An illustration is Africare, a US-based development and relief organization that provides multi-sectoral assistance in 36 countries in Africa, and works in Senegal and Benin with churches and faith organizations.

INTERFAITH PARTNERSHIPS

The mission of combatting malaria has brought different faith communities together in interfaith partnerships. Interfaith organizations like the Nigerian Interfaith Action Association (NIFA) have played an integral part in improving healthcare. In this partnership, religious leaders reach out to communities about healthy behaviors and oversee distribution of mosquito nets to communities in need. This partnership has led to unexpected benefits, as tensions between Christian

and Muslim groups in Nigeria have historically led to violence. While this has meant challenges in building interfaith partnerships, joining together to fight a non-controversial issue like malaria shows some potential for supporting ongoing dialogue between the two communities, which can be an important step in the peace building process.

Another partnership, Together Against Malaria (TAM) in Mozambique is cited as one of the largest and most successful multi-faith initiatives against malaria to date. TAM directly engages local churches and mosques in Mozambique in delivering messages about mosquito nets, indoor residual spraying, and early diagnosis of malaria. TAM also uses houses of worship as training sites for community health workers and as infrastructure for bed net distribution. TAM created eight inter-religious councils and trained 3,836 faith leaders in its first year. These leaders have the combined potential to reach some 342,000 congregants. It is also estimated that the program reached an additional 333,000 non-congregation members primarily by working with schools and through peer-to-peer communication.

BARRIERS TO FUTURE SUCCESS

The most common barriers for faith communities in providing healthcare, or preventing malaria more specifically, are a host of capacity constraints. Many faith-inspired organizations suffer from both limitations in classic administrative skills and systems (procurement, monitoring, accounting, evaluation) and capacity constraints that block desired interventions to scale up operations to meet needs. Evaluating the many obvious capacity constraints is complicated by very patchy evaluation data and by the wide range of organizations and their widely varying capacities and managerial cultures.

Many faith-inspired health providers struggle with the organizational capacity required for eligibility for funding from global malaria initiatives. These requirements are straightforward, but not simple: the ability to develop project proposals, to assure proper use of funds, and to monitor and evaluate program progress effectively. Faith-based health ministries in malaria endemic countries have served their communities for decades, but for the most part have not been required to develop these capacities to the levels that are expected by international donors. Susan Lassen of Episcopal Relief and Development (ERD)

observed that, “[ERD] had a conversation with the Gates Foundation in 2006, and they used an interesting analogy: [faith-based health ministries] are like wheelbarrows trying to get onto the interstate. The Gates people said, ‘We’re trying to make a ramp for you, so you can get your speed up, but you’ve got to try to upgrade the wheelbarrow.’”

NEXT STEPS

Purposeful efforts to engage faith communities in fighting malaria are needed at many different levels. Faith leaders can be instrumental in educating their congregations on best practices to eliminate the spread of malaria. Churches, mosques, and other institutions can provide infrastructure for distributing long-lasting insect-repellent treated nets. They can serve as training centers for locals to identify the disease early on and refer to proper medical facilities. While FIOs are not a replacement for traditional healthcare centers, they can broaden the reach of healthcare service provision.

Networking and strategic coordination are key to future success and solid information is crucial for moving ahead in this direction. Faith-linked institutions work in remote regions where others will not, but tend to be

underrepresented in official statistical analyses of health services. Poor information sharing and coordination make their insights hard to quantify and redundant. One answer is to ensure that religious networks and faith-linked institutions are included in any mapping of resources to address malaria responses. With this information, secular development organizations can pool resources with faith actors in order to build a comprehensive malaria strategy.

Interfaith partnerships offer promise given the significance of plural communities, some facing interreligious rivalry, tensions, and conflict, in key malaria endemic areas. Interfaith malaria prevention efforts offer an efficient way to address the disease in a diverse community. By coming together in an interfaith partnership, faith communities can jointly manage resources and coordinate a plan of action to stop the spread of the disease. This will reduce redundant programs between religious organizations and foster a greater sense of community. Fighting malaria can serve as a readily agreed place to start an interreligious dialogue. Maintaining this dialogue and working together to better the community can help overcome other divisive issues. In some areas, intrafaith collaboration—for example Catholic/evangelical or Sunni/Shia—may be a priority goal.

The complete Berkley Center/World Faiths Development Dialogue 2009 review of faith and malaria is available at: <http://repository.berkeleycenter.georgetown.edu/MalariaFinalReport.pdf>.

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ABOUT THE WORLD FAITHS DEVELOPMENT DIALOGUE

The World Faiths Development Dialogue works to build bridges between the worlds of faith and secular development. Established at the initiative of James D. Wolfensohn, then president of the World Bank, and Lord Carey of Clifton, then archbishop of Canterbury, WFDD responds to the opportunities and concerns of many faith leaders who have seen untapped potential for partnerships.