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Religious Collaboration Enhances Patient Satisfaction among Faith-Based Groups and Health Facilities in Western Kenya

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Abstract

HIV and AIDS continue to be a major challenge in Kenya, especially in the Western region where, coincidentally, public and private health facilities are sparse, but with a relatively high number of faith based health facilities. This study seeks to examine whether and how collaboration among faith-based groups and health facilities in the provision of HIV prevention and treatment services for women ages 15-49 years is associated with high patient satisfaction. Using an embedded multiple-case study design, we purposively selected seven faith-based health facilities in Kakamega County. We conducted 33 in-depth interviews with HIV-positive individuals, 14 key informant interviews with health providers; and 8 focus group discussions with members of the community in the health facility catchment area. The findings indicated that, when health facilities demonstrated collaboration, there was a positive impact on patient satisfaction. Specifically, collaborations between faith-based organisations resulted in the improvement of HIV services.

KEY WORDS: HIV, Faith Based Health Facilities, Collaboration, Patient Satisfaction

"He has shown you, O mortal, what is good. And what does the LORD require of you? To act justly and to love mercy and to walk humbly with your God." Micah 6:8

Introduction

After more than thirty years, HIV continues to pose a great challenge to humanity. Nowhere has suffered more than sub-Saharan Africa, where AIDS has flourished (Mombe et al., 2012). The progress achieved over the past three decades is being threatened by donor fatigue and an apparent competition for scarce resources among faith-based groups and health facilities. This problem is further compounded by the dependence of faith-based health facilities on donor funding and government subsidies for their operations, which have declined over the years.

According to the 2014 Kenya Demographic and Health Survey (KDHS), Kenya continues to grapple with the challenge of HIV and AIDS with wide disparities in HIV prevalence across the country ranging from 0.2% to 27.1% (KDHS, 2014). The highest prevalence rates are clustered around Lake Victoria; however, rates in western Kenya remain high as well (range: 3.5% to 7.1%). In addition, western Kenya is particularly vulnerable because 66% of the population lives below the poverty line (Muga et al., 2005). There has also been notable inequality in the distribution of health services in Kenya. Most health facilities are found in Central province, while the least are in Western and Nyanza provinces. To compensate for the lack of public and private health facilities, there is a relatively higher number of faith-based health facilities in Western and Nyanza provinces (Berman, 2001; Wamai, 2009).

The World Health Organization (WHO) estimates that faith-based organizations provide approximately 40% of all health services in sub-Saharan Africa (cite). In remote locales and in areas affected by political crisis or conflict, faith communities are often the only functioning service providers (Olivier and Wodon, 2010). In Kenya, the government and the private sector account for 60% of the health services, while the Christian health service providers account for 40% of health service provision (ACHAP, 2008; Hafner, 2009). Both Catholic and Protestant health service provision date back to the early twentieth century. Currently, the Christian Health Association of Kenya (CHAK; Protestant) and the Kenya Episcopal Conference (KEC) oversee 970 health facilities accounting for 10 million patient contacts per year (AMHF, 2015).

Furthermore, due to the diverse religious presence in the Western province of Kenya, there are divergent ethical teachings on HIV, for example, whether condom usage is a morally acceptable prevention measure for HIV infection. A study conducted by Aluku (2015) revealed that Catholics are more prone to the risk of HIV infection as compared to their Protestant and Muslim counterparts. Because the Catholic Church does not permit the use of condoms and conventional birth spacing methods, whereas the Protestant churches do, this study found that the Catholic Church is silent on the use of condoms among people living with HIV and AIDS, including discordant couples (i.e., couples where one partner is HIV-infected and the other is not). With these differing approaches, it is essential to assess whether these teachings create a competitive or collaborative atmosphere in the uptake of HIV prevention and treatment services at faith based health facilities. Lehrer (2004) notes that the extent to which religion may influence individual's behaviour may depend on the specific doctrines and beliefs of a particular religious group and the extent to which the individuals are committed to their religion and have integrated denominational teachings.

In order to account for the cultural, religious, and political environments as determinants of health service utilization, we employ the Behavioural Model of Health Service Use, which combines elements of the external environment with attributes of the health care system (Andersen, 1995). The theoretical model of health service use will allow us to embed HIV prevention and treatment services in the context of a theological framework that emphasizes liberation through collaboration and innovation. In order to test our hypothesis in this context, our study looks retrospectively at the successes and failures of faith-based groups and health facilities in delivery of HIV prevention and treatment services.

Hypothesis

This study is designed to address the impact of religious collaboration on African society, specifically among faith-based groups and health facilities in western Kenya. In the context of health service delivery, it is critical that there be religious collaboration (not competition) in order to improve patient satisfaction with health services, restore the social fabric of communities, and enable innovative strategies to strengthen HIV prevention and treatment services within faith-based groups and health facilities. In the spirit of the dialogue of action (i.e., when Christians and others collaborate for the integral development and liberation of people), religious institutions that work together to serve the common good of society have the potential to have a greater impact on HIV prevention and treatment. Competition and division can arise among faith-based institutions due to doctrinal discrepancies regarding how to handle social issues, such as sexual behaviour.

Specifically, we seek to examine how collaboration among faith-based groups and health facilities in the provision of HIV prevention and treatment services for women ages 15-49 years (and their partners) is associated with high patient satisfaction. It has been shown that integrating care for the prevention of mother-to-child transmission (PMTCT) of HIV with other maternal health services was critical to the satisfaction of HIV-positive women in Malawi (Levy, 2009). This evidence suggests that better coordinated care will improve women's satisfaction with health services. Therefore, coordinated efforts are needed to reach women most in need as well as follow up with those who are HIV-positive. Collaboration among religious institutions helps coordinate care as well as reduce the competition for funding to provide necessary services, which allows providers to be better compensated, more satisfied with their jobs, and engender a better relationship with those who are seeking their services. We posit that collaboration among religious institutions to provide HIV prevention and treatment services leads to greater patient satisfaction because the services are better coordinated, patient follow-up is more consistent, and patient-provider relationships are more fruitful.

Methodology

Study Site

To select the most appropriate county in western Kenya for the study, we conducted a health facility assessment in two counties with high rates of HIV and AIDS, namely Kakamega and Busia. Key informants from each faith-based health facility in the two counties were interviewed in order to determine the level of collaboration and/or competition in the delivery of HIV and AIDS services in the area. Based on these initial interviews, Kakamega County was selected for this study, based on the prevalence of HIV and AIDS, the relative poverty compared to other counties in Kenya, and the proportion of faith-based service providers. According to the Kenya National Bureau of Statistics (Census, 2009), Kakamega County has a diverse religious affiliation with Catholics representing 20.5% of the population, Protestants 49.2%, Muslims 5.5%, and Traditionalists 0.4%. Based on the initial assessment, seven faith-based health facilities were selected for the study based on the availability of HIV and AIDS prevention and treatment services.

Study Design

In order to compare the provision of HIV and AIDS prevention and treatment services between faith-based health facilities with religious collaboration and faith-based health facilities with religious competition, we used an embedded multiple-case study design (Yin, 2009). An embedded design allows us to examine multiple units of analysis within each case. We defined each case at the health facility level; therefore, an embedded design allowed us to assess the domains of interest at the individual, health facility, and community level.

Questionnaire Design

The research team developed three qualitative interview guides to collect information about patient satisfaction with HIV and AIDS prevention and treatment services for each case, or health facility: (1) in-depth interviews with HIV-positive individuals, (2) key informant interviews with health providers; and (3) focus group discussions with members of the community in the health facility catchment area. The in-depth interviews covered a variety of topics, including the availability and quality of health services and health providers; availability of information; ease of scheduling; and confidentiality (Tran and Nguyen, 2012). The key informant interviews focused on collaboration and conflict between health facilities when providing HIV and AIDS services. The focus group discussions covered topics related to collective action, social solidarity, trust, and conflict in the context of HIV and AIDS services (Krishna and Shrader, 2000; Story et al., 2015). The interview guides were reviewed by experts in HIV and AIDS and qualitative methods. After the interview guides were complete, the investigators facilitated a two-day training with four research assistants in Nairobi, Kenya to cover case study methodology, pilot test the questions, revise the questions, and complete the data collection protocol.

Data Collection

Within each case, or health facility, we used purposive sampling techniques to gather information from individuals living with HIV, representatives of health facilities, as well as community members who are part of organizations and associations within the health facility catchment area. Research assistants interviewed 33 HIV-positive patients from each of the selected health facilities, ranging from two to seven per health facility; two key informant interviews with health facility providers (i.e., registered nurse, clinical officer, doctor, or administrator) from each of the seven health facilities for a total of 14 interviews; and two focus group discussions within the catchment area of four health facilities (one for women and one for men) with approximately six individuals in each group for a total of eight FGDs. Before the in-depth and key informant interviews, a research assistant met with the administrator at each health facility, carrying an ethical review permit from the National Commission for Science, Technology and Innovation (NACOSTI). She introduced herself and the project to the administrator at a pre-determined time. For the in-depth interviews, the administrator referred the research assistant to the respective department (e.g., HIV counselling centre or support groups at the facility) where she asked them to arrange for up to seven HIV-positive patients to be ready for interviews on a specific day. On the day of the interviews, the research assistants met with potential respondents and read to them the introduction to the project and asked them the screening questions about religion, age, and the facility that they frequently visit. If the respondent met our selection criteria (between the ages of 15 to 49 and Christian), then the research assistant proceeded to obtain informed consent.

For the key informant interviews, the research assistant asked the administrator and at least one other health provider to participate in the key informant interviews. Once the respondent agreed to participate, they were given the opportunity to sign the informed consent document. For the focus group discussions, the research assistant worked with the health facility administrators to connect to faith-based groups in the catchment area of the health facility. A community facilitator was identified within each faith-based group and the facilitator invited an equal number of men and women within the faith-based groups to participate in separate focus groups.

For each interview or focus group, the research assistant explained the purpose, methods, and the potential risks and benefits of participation and asked the respondent if they had any questions or concerns about the research project. The research assistant also reiterated that the information the respondent provided through their interview was completely confidential and reminded the respondent that they were free to refuse to be audio-recorded for any reason, but the interview would conclude at that point. If the respondent was willing to be audio-recorded, the research assistant obtained consent to conduct the interview by the signature of the respondent (or thumb print if the participant was unable to sign).

Data Analysis

All interviews and focus group discussion were transcribed and translated into English. The transcripts were used to develop a case report for each of the sampled health facilities listed in Table 1. The case reports focused on the theoretical proposition that collaboration among religious institutions to provide HIV prevention and treatment services led to greater patient satisfaction, which, in turn, led to improved compliance to treatment. After each case report was developed, a cross-case report was written, which addressed the overall trends from each of the seven case reports in response to our theoretical proposition. The results are based on the findings produced in the cross-case report.

Results

Accessibility

The study revealed that preference for accessing health services is mainly based on proximity rather than quality of services. Patients living far away from the sampled facilities seek services from the facilities mainly through referral and not by original intention. Long distances to facilities limits accessibility and adversely affects patient satisfaction. In some instances, patients travelling for long distances to the facilities can miss appointments or come late when drugs stocks are depleted which worsens their health status.

Cost

While all health facilities were accessible; most patients, accessing services from the sampled health facilities, however, complained of high cost of services (mainly service charges which are not applicable in public facilities) compared to public health facilities. Patients lamented over user-charges that shift their preferences and desires for public facilities, which have free services. User-charges have resulted in an increase in defaulters and forgoing services provided by faith-based health facilities and opting for public health facilities located far away from their residential homes. As one patient remarked: '…even

the patients that were taking medication from here left and went to other facilities run by the government. I think if we get a government facility it will be better so we are able to see changes….'

Drug Stock Outs

Patients expressed dissatisfaction with drug stock outs, though this was not a common occurrence as noted by a patient, 'No, a lot of times they cannot all be available here. When the services are not available they tell you to wait as they look for the service and then they will call you'. Stock outs demotivate patients and affect treatment efficacy. In most of the sampled health facilities, drugs supply logistics are efficient and effective. In cases of stock outs, drugs are re-stocked within a very short period of time, which encourages patients to visit the facilities. However, in some sampled health facilities, stock outs result in patients purchasing medication and/or coping with no treatment, which worsens their health status.

Patient-Provider Relationship

Patients appreciated the quality of services and improved staff relationships and friendliness with the patients resulting in improved customer-client loyalty. The findings indicated that staff were perceived to treat patients with respect and dignity irrespective of their HIV serostatus, which improves adherence and service utilization. Subsequently, patients are highly comfortable and open in disclosing their status to the staff.

The study also revealed that patients are seen privately and on an individual basis and their information is kept private. There is no movement of patients or providers in and out of consultation rooms. Sufficient privacy and information confidentiality is provided during service delivery. Patients have trust and confidence in the staff's ability to keep their information secret from the public and other people. Consultation rooms in five of the sampled health facilities had sufficient privacy. One patient remarked: 'Yes. It's a secret between me and the doctor. For the past few months I have come here I have never heard from others talking about my issues. They also give me a call in case am needed. They respect my privacy. The doctor talks to patients one on one in a closed room without distractions of others walking in and out….' Another patient noted that: 'I know it is private because for me and the others who take our ARVs we have never heard anyone talk about our status unless we decide to disclose….'

Patients also reported that staff were caring, empathetic, friendly, loving, polite and supportive to patients, which enhanced their satisfaction. Staff provided patient-based supportive guidance resulting in increased patient loyalty, openness, and treatment adherence and service satisfaction. Patients were highly comfortable in most of the health facilities under study and open in disclosing their status to the staff because there were not dismissive, judgmental or discriminative; they had a positive and caring attitude towards all patients. As seen in the comments from a number of different patients:

> '…When the staff are attending to me they are friendly, they treat you as a close person to them.…'
> '…Staff stay with me when talking. They treat me like their sister….'

> '…If one is bedridden, health workers come and look after you and bring you to the facility then care for you until they can be able to nurse you to health as far as they can'.

On the other hand, a few patients expressed dissatisfaction with the patient-provider relationship. They described some providers as harsh, quarrelsome and not empathetic. Others were unfriendly and impolite to patients who missed their appointments and those not adhering to treatment or keeping to their treatment schedules. They did not exhibit a caring and understanding approach to the situation and did not provide supportive guidance to patients, especially those who lacked fare and food, which compromised their ability to take ARVs and cope with side effects of medication. As one patient noted: '…some are harsh and some are polite. I was supposed to come yesterday but I did not have transport but when I explain that to them they tell me harshly you must come pick medicine. . . .'

Emergency Relief Services

Availability of supplements in most of the health facilities was good. In some of the health facilities, HIV patients are at times provided with food supplements—especially flour—resulting in reduced cases of malnutrition. One patient commented: '…I get medicine, they give me flour if my children are malnourished, guiding and counselling, attend AIDs day functions…. '

However, the study revealed that HIV patients are not regularly provided with relief services such as food supplements (flour) and mosquito nets that adversely affects their health status and treatment outcomes, especially the poor and less privileged. As one patient stated: 'services they give are all accessible except the one I said if they have any relief or any other service aside from medical care as I had told you like mosquito nets, flour, or any other relief, that will be appreciated….'

Outreach Programs

Patients expressed their satisfaction because some of the health facilities had community outreach programs, such as mobile clinics and Voluntary Counselling and Testing (VCT) programs, which have improved access to both services and information. HIV counselling services are an integral part of the management process of the illness. Counselling services enable people living with HIV and their families to adjust in line with the health situation. As a patient remarked: '…they teach us a lot such as being open and free with our partners so that if you are late, your partner can even come and collect your ARV supply on your behalf….'

HIV Counselling Services

The study further revealed that there were periodic patient counselling sessions at the health facilities and support group level which improved awareness, adherence, and increased patients motivation to live positively and refresher trainings as cues for reminders for treatment adherence. As one patient commented: '…I was 60kg but now am 73kg. I took in their advice and now am doing fine. They give me counsel, that even if I got separated with a man, people use this medicine, follow advice, exercise and eat well. Pastor advices us that he is also positive and tells everyone to accept themselves and avoid discrimination….'

At the same time, there were cases in which patients felt information provided during counselling sessions was inadequate hence expressed need for more information on HIV and AIDS, such as side effects of treatment. Some patients reported poor and ineffective appointment scheduling resulting in more than one patient appearing during service delivery. They noted that this threatens their feeling of confidence, trust and security which impacts negatively on satisfaction.

Referral Systems

Additionally, the findings indicated that there were effective and well-coordinated referral services to higher-level health facilities for critically ill patients, which, in cases where key services were unavailable, eliminates delays in medical interventions. There also exists effective referral systems from community to the health facility especially for defaulters, critically sick and those with special needs.

With regards to inter-facility relationships, across all sampled health facilities, effective referral systems between faith-based organisations (FBOs), private, and government facilities have been recorded. This may have contributed to the reduction in mortality and morbidity related to HIV and AIDS and in managing complex and advanced care for the patients and other services which are not available at the facilities. As one key informant noted in an interview: 'We link in all ways, but we really need to know if we referred a patient that they have reached those stations and whatever we have recommended is done and vice versa. They get in touch with us, we get in touch with them. We actually have a tool where we get, I know whom I can refer….'

The study revealed the presence of effective communication structures such as contact persons to follow up on referred patients, get feedback and hence assist in providing continued care to returning patients which has improved patient experiences and satisfaction. As a key informant noted in an interview: '…we usually refer patients to other facilities, including faith-based facilities, when we have a client who has tested positive and they want to go to that facility. We write a referral, that's all and then we follow-up….'

This referral pattern occurred despite there being no written and standardized guidelines for referring clients to other facilities as recorded in some facilities. As one key informant remarked: '…we don't have any guidelines. We don't have any guidelines in case you have any client you want to refer there you just refer and you just call there….'

Religious Diversity and Collaboration

Across the sampled health facilities, there was evidence of recruitment and involvement of staff and providers from diverse religious backgrounds and denominational values, which has helped demystify conflicting values and religious beliefs in HIV service delivery thereby increasing service utilization and acceptance of people living with HIV and AIDS (PLWHA). As a key informant noted: '…in this, of course I am a Christian, I am not actually a Catholic. I belong to Salvation Army church but our staffs over here are from other denominations. We have got Catholics, we have KAG (Kenya Assemblies of God), okay, all of them. We are not biased when it comes to employing the staffs because we also need diversity….'

In many instances a diverse workforce has successfully championed the demystification of HIV and AIDS by instilling values and practices that support positive

behaviours and lifestyle changes which improve positive living and acceptance. This is an example of the team-based approach in service delivery by the staff.

There exist good coordination and collaboration between the health facility and other facilities (FBOs, private, and government) on many aspects of HIV service delivery irrespective of their religious affiliations, including provision of antiretroviral drugs (ARVs) to referred patients, treatment and capacity building. They hold joint meetings to share innovative ideas for prioritized problems and share resources. This practice has improved the quality of service delivery and adoption of effective preventive approaches. As a key informant noted: '…when we get patients in transit we have to help them get medicine and if we do not have then we have to contact the nearest facility to give us or we refer the patient where they can get the medicine….'

However, there are also cases of rivalry and competition for clients, especially among other FBOs, which causes strained relationships and an inability to cooperate in service delivery. This has been a sensitive issue affecting collaboration and partnership primarily because donors support facilities based on the number of clients/patients attended. One key informant remarked: '…the major source of conflict is when facilities compete to have many clients. Some go as far as contacting clients and offering them incentives so as to change facilities. They promise clients fare and food as a result patients change facilities without getting a referral letter….'

In addition to the competition for patients, there are some denominations with conflicting beliefs and values which discourage treatment of HIV and AIDS patients, encourage stigma, and limit adoption of appropriate positive living such as proper nutrition and enrolment in support groups. This causes non-disclosure of status, which hinders prevention and control successes. Religious institutions and denominational cohesion is often affected by differences in teaching and faith values that denominations uphold, for example practice of safe sex, formal health care treatment, and inheritance of wives.

Collaboration between all religious institutions—especially churches and communities—in advocating and spearheading prevention and control of HIV and AIDS has yet to build strong mechanisms and structures which will be key in addressing the threat posed by the pandemic. This has limited VCT, encouraged stigma and reduced adoption of effective community-based prevention approaches especially those designed on principles of acceptance and community integration. As one key informant stated: '…I should talk about HIV, so that we reduce that issue of stigma and such things. So I hope that Christians will talk about HIV, even in church they should talk about HIV….'

There is perceived partiality and discrimination of FBOs in regards to trainings, grant management and drugs supply. Government, and to some extent top FBOs in the community, are prioritized in attending and/or providing trainings, implementing sponsored projects and drug stocking which creates rivalry and feeling of being sidelined to lower facilities which receive little or no support. This adversely affects coordination and cooperation which affects quality of service delivery at the expense of patients. As a key informant made clear in an interview: '…sometimes, donors give some grants to facilitate different facilities pertaining to HIV and AIDS and you find that those who are the upper hand are those who are considered first, and you get that the lower facilities….'

Stigma and Discrimination

A few respondents felt there was stigma and discrimination of PLWHA, which limited their integration with the community. PLWHA were stigmatized at the family, religion, and community levels despite the peaceful coexistence and integration within the community due to conflicting religious and community values on HIV and AIDS prevention, control and management. They were not accepted as part of the valuable assets of the community, rather they were perceived as liabilities and risks to the community health. As a result, they did not disclose their status easily. As a FGD Discussant noted: '…People are individualistic in my village, everyone minds their own business. HIV positive people are stigmatized….'

Adults and children living with HIV were stigmatized even in social places, such as schools. There are also community disputes and conflicts fuelled by land and other household issues which threaten community solidarity and integration of HIV prevention and control as they limit collective action and efforts on important health priorities such as HIV. It has also emerged that problems in managing HIV and AIDS patients who are stigmatized by society due to the conceptualization of the disease as an ailment associated with sexual deviants, such as prostitutes and the immoral, are on the increase.

HIV Awareness Creation

The patients affirmed that there was improved community awareness on HIV-related services provided by the health facilities and the church created through community awareness campaigns, sensitization trainings, and seminars. A key informant noted, '…Church leaders are allowing seminars to be held within church premises to educate people about HIV and AIDs….' Further, relevant and sufficient information was provided on treatment, adherence, prevention and control. The main source of information was the health care providers who advice and counsel patients on proper nutrition, treatment adherence, infection prevention and health issue.

Discussion

There are many attributes of faith-based health facilities and service provision that lead to patient satisfaction. Our study used a unique case study approach to identify individual, health provider, and community perspectives on the quality of care and patient satisfaction with HIV and AIDS prevention and treatment services. When health facilities demonstrated collaboration, there was a positive impact on patient satisfaction, which, in turn, has the potential to improve compliance with prevention and treatment options.

Access to good quality health services is vital for the improvement of many health outcomes, such as those targeted by the Millennium Development Goals – now the Sustainable Development Goals (Dussault and Franceschini, 2006). A study by Aluku (2015) revealed that distance to health facilities was a significant factor that prevents women of reproductive age (15-49 years) from accessing and utilizing sexual and reproductive health services in Kakamega County. Without access to appropriate HIV prevention and treatment services, patients will either seek more easily accessible medications—including counterfeit medications (Cohn et al., 2013)—or default on medication compliance.

In addition to access, it is critical to improve the affordability of HIV treatment. Some notable barriers and challenges to the improvement of women's sexual and reproductive health have focused on financial accountability and the removal of financial barriers that result in the denial of or delays in receiving necessary sexual and reproductive health services (KNCHR, 2012). There is a need to continue to advocate for affordable treatment and provide equal access to affordable treatment across both the public and private sectors. This level of coordination will also help with drug stock-outs so that patients can continue their treatment without missing doses or stopping treatment altogether (Kranzer and Ford, 2011).

Patient-provider relationships have a substantial effect on patient satisfaction with HIV and AIDs prevention and treatment services. Health workers are the element of the system that makes health care both acceptable to clients and therefore more likely to be effective, or can act as a deterrent to people seeking care (Palmer, 2008). AIDS puts heavy demands on social support systems as well. People living with HIV and AIDS not only require quality care at the health facility, but they also need practical support to manage themselves and their households, securing and preparing food (especially in food insecure settings), and caring for the dependents, particularly children in their care (Trinitapoli and Weinreb, 2012). Health facilities that are able to meet the physical, emotional and spiritual needs of their patients are more likely to have positive patient-provider relationships, which can lead to better compliance with both prevention and treatment. In addition, health facilities that provided emergency relief services and outreach services to the community—such as VCT services and other counselling services—were also viewed more favourably by patients, which can create a culture of trust and compliance.

The study also found that there were effective and well-coordinated referral systems between lower and higher level health facilities for critically ill patients, which helped to eliminate delays in medical interventions, especially for critically ill patients. Although the referral process was informal, it seemed to be functional and useful for patients, especially when services were not available at one facility and a referral was necessary to get access to care. There is a need to continue to improve upon and streamline referrals in order to improve treatment compliance.

One of the most interesting findings was the level of religious diversity and collaboration among the health facilities in our sample. Many of the health facilities employed staff from multiple denominations and viewed diversity as a positive attribute. The patients also benefited from this religious diversity because they were offered more prevention and treatment options. However, health facilities that competed for patients or allowed doctrinal differences to stand in the way of collaboration were also the same health facilities that discouraged treatment of HIV and AIDS patients, encouraged stigma, and limited adoption of appropriate positive living practices. This competitive atmosphere prevented many HIV-positive individuals from disclosing their status, which has implications for both future prevention and treatment.

Stigma and discrimination, such as that described above, has been named as one of the major social challenges against the management of the HIV pandemic (Plummer, 1988). Furthermore, the perception among some Christian denominations that AIDS is God's retribution for man's evils when experienced on a large scale, or as a punishment to the individual for immorality (Sontag, 1989) has impacted patient satisfaction. This is evident in some Christian teachings through the doctrine of purity and holiness (Deuteronomy 28:1-24) – used by some religious leaders to teach about AIDS. This kind of teaching is

contrary to the life of Jesus Christ as portrayed in biblical teachings on love and compassion for neighbours. This thought process is however slowly being replaced by more progressive thinking as 'AIDS is not a punishment from God' as well as the statements on stigma 'stigma is sin' or 'the body of Christ has AIDS' all highlighted in the Anglican statements on HIV and AIDS in 2001 and 2003.

In order to combat stigma and discrimination, there is a need for additional HIV awareness creation, especially among church leadership. According to Judge and Schaay (2001), silence about HIV and AIDS permits inaction and is the breeding ground for stigma. Church leadership has to be bold and compassionate to prevent infection and care for all the ill and dying. By so doing, the church leadership will serve as a model for leadership in government, and all civil society. The church as a spiritual home plays a vital role in addressing the plight of African Christian women in this era of HIV and AIDS (Phiri et al, 2003:125).

Conclusion

In summary, collaborations between like-minded health facilities and faith-based organisations have resulted in the improvement of service, access, availability, quality (including reduction in waiting times and improved service timeliness), effective referrals, good patient-provider relationships and enhanced patient privacy and information confidentiality. This has been linked to improved patient quality resulting to higher patient satisfaction levels, which has the potential to significantly reduce default rates and improve treatment adherence. We acknowledge that there are other factors that play a key role with regard to provision of HIV services. Such factors include the political economy, cultural inhibitions and literacy, about which we recommend further study.

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