Faith-Inspired Health Care in Sub-Saharan Africa: An Introduction to the Spring 2014 Issue

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This special issue of The Review of Faith & International Affairs is comprised of seven articles aiming to strengthen the evidence on faith-inspired engagement in health in sub-Saharan Africa. The field of enquiry is diverse, with few foundational texts, few standardized frameworks for reference, and a wildly varied terminology. In fact, this variation in terminology often results in a nearly impenetrable field of acronyms for the uninitiated, ranging from religious entities, faith-inspired institutions (FIIs), faith-based organizations (FBOs) and the like (for more see Olivier and Wodon 2012d). That variation is part of the puzzle, and as a result, newcomers tend to struggle to find the points of access. And, generally, substantial time and resources are spent in costly meetings re-treading introductory ground, rather than pushing the debate and evidence further. This logically results in repeated calls for more systematic research and more theoretical structuring of the field of inquiry.

As a result of such calls, more research has recently been undertaken, mainly around two questions: (1) how does faith or religion affect individual health-related behaviors, and (2) what tangible infrastructure is held by faith-inspired groups that can be better leveraged for health and development. The objective of this special issue, which is in part based on a three-volume collection of working papers (Olivier and Wodon 2012a,b,c) is to make available some of the recent research on the second of the questions, namely the role of faith-inspired health care providers, with a focus on sub-Saharan Africa.
Previous Literature

In his seminal book, *The Quest for Health and Wholeness*, James McGilvray (1981) described ground-shaking events for faith-inspired institutions (FIIs) from the 1960s to the 1980s. These include the changes brought by political independence and the role of the Christian Medical Commission (CMC) and the Tübingen meetings in shaping new thinking on faith-inspired health services, the vision of primary health care (PHC), and the formation of the Christian Health Associations (CHAs).

McGilvray also described the state of the evidence on FIIs—mainly based on studies by the CMC in 1963-1964. He provided what would become pioneering national estimates of medical facilities contributed by church groups: “43 percent of the national total in Tanzania, 40 percent in Malawi, 34 percent in Cameroon, 27 percent in Ghana, 26 percent in Taiwan, 20 percent in India, 13 percent in Pakistan and 12 percent in Indonesia.” Although he then immediately added, “However, one should not read too much into the above ratios because, at the time of the surveys, this church-related sector was a very disparate group which, with few exceptions, had no collective existence” (McGilvray 1981, 39).

While these estimates could be debated (and are in this issue of the journal), the core questions McGilvray reported from the 1960s and 1980s are still relevant and mostly unanswered today. These are questions about the nature of FII’s engagement in health, their role in facilities-based versus primary or preventative care, what it means to be a faith-inspired or Christian provider, whether it is possible to bear the costs of a “pro-poor” mission, whether FIIs can continue to be sustainable given new financial contexts and constraints, and queries about
the value-added of FIIs. All these questions have long been identified, but how far we have come
to answering them with solid evidence over the last half century remains an open question.

To a large extent, the literature from the 1960s to the 1990s still holds relevance for those
seeking to understand the engagement of faith-inspired communities and institutions in health
intervention in Africa today. Many faith-inspired providers remain deeply connected to the aims
and traditions forged in the early health systems that they often created. For example, important
lessons can be found in the literature addressing mission-based health services and the changes
they faced as African countries became independent and national health systems were
restructured. This literature emphasizes the effect of different colonial administrations—for
example contrasting the English and French approaches—on the development of FIIs.

In the 1990s the literature showed an increased interest in faith-based organizations
(FBOs) and the newly divided public and private health sectors, with FIIs being recognized as
significant, and usually clustered as private-not-for-profit (PNFP) providers. Review suggests
four main characteristics of this literature from this period: (1) recognition of the role FIIs
historically played in health provision, although not aligned with national systems; (2) “market
share” estimates indicating that FIIs provide a high share of health care; (3) reports of
weaknesses of FBOs such as dogmatic resistance to particular health strategies, lack of
management capacity, or resistance to evaluation of finances; and (4) claims of possible added
value such as unique reach, trust and access into communities, resources such as volunteers and
community leadership, networks, and means to motivate staff and sustain quality services.

Several of those questions are revisited in this issue. But apart from discussing the role of
FIIs in health service delivery through facilities-based care, the issue also includes a focus on
non-institutionalized initiatives and strengths that lie in local faith communities. The last decade
has seen a substantial expansion in the literature on this area, with some gaps remaining, but also with the emergence of isolated informational nodes. This literature aims to assess how these mostly informal initiatives can be mapped, understood and leveraged for better health and development, and how they interact with facilities-based care.

The role of non-institutionalized or informal community initiatives on health and development is most evident in the area of HIV/AIDS. The impact of the HIV/AIDS pandemic on research and data relating to religion and public health cannot be over-estimated (see Olivier and Wodon 2012d). The civil society response to HIV/AIDS and a skewing of vertical funds and FII’s focus towards HIV/AIDS have contributed to the emergence of a large, diverse literature addressing the religious response to HIV/AIDS in Africa. This literature reflects multiple approaches and lenses on the poorly defined “faith sector”—sometimes incorporating all HIV/AIDS-engaged faith-inspired institutions and initiatives, and at other times focusing only on faith-inspired nongovernmental organisations (NGOs), civil society organizations (CSOs), community-based organizations (CBOs) or congregational activities. Yet while the role of informal groups and the potential for large networks of faith communities to make a difference has often been advocated, it has rarely been demonstrated through robust empirical evidence. It is also possible that the intense focus on the religious response to HIV/AIDS in Africa has been at the cost of an improved understanding of the daily and holistic health and development activities of faith-inspired institutions and initiatives, and especially of local faith communities.

Whether one considers facilities-based care or informal community health-related activities, there has also been a growing emphasis in recent years on context- and country-specific evidence, recognizing that broad generalizations are rarely useful for strengthening policy or implementation. African states have starkly different histories resulting in unique
patterns of civil society and public health engagement, as shown by Schmid et al. (2008) in comparing Mali (where FBOs are few and Islam does not often manifest through formal health services) to countries such as Zambia which are inundated with a complex range of FIIIs engaged in healthcare. There is better recognition of the complexity of the effect of religion itself—for example the pluralistic health-seeking behaviors of patients simultaneously utilizing traditional, religious, and medical systems. Work has also focused on the provision and utilization of pharmaceuticals by FIIIs—with the Ecumenical Pharmaceutical Network (EPN) and the World Health Organization (WHO) conducting key early baseline studies.

While encouraging, these new pockets of literature do not yet generate a sudden wealth of evidence. Even today, most work on religion, development, and public health in Africa ends with caveats that the missing evidence-base demands more research. During literature landscaping reviews by the African Religious Health Assets Programme (see ARHAP 2006; Schmid et al. 2008) efforts were made to collate existing data from ministries, large studies, and expert advisors with standard bibliographic searches. This demonstrated the obstacles FIIIs and stakeholders face: in-country datasets were often missing, not electronically available, or only accessible through personal relationships. Even for data that was accessible, challenges remained. More is known about FIIIs in countries that have Christian Health Associations (CHAs) in place. Less is known about health-engaged faith-inspired NGOs, CSOs, and congregations. More is known about Anglophone countries and about large FIIIs than about district and community level initiatives whether connected to FIIIs (such as mobile health services) or not (such as informal community care groups). Significantly more is said about Christian health providers than the health activities and services that emerge through communities of other faiths.
It is important to note that the interest in FIIs—operating at whatever level—is not located in one specific discipline, and available evidence is often difficult to use comparatively, with most studies resorting to a qualitative integration of data. There are few standard measures applied to the “faith sector,” and no shared typology or classification of FBOs. In addition, many FIIs have been propelled from not having to monitor their funding streams (trusting in historical partnerships), to being suddenly faced with calls for harmonization and standardized monitoring and evaluation (M&E) requirements. While generalization is not fair, it has been noted that many FIIs lack M&E capacity, leaving little time for additional research to make the case for the comparative value of FIIs.

To sum up, the landscape of research in this field is progressively changing. Faith-inspired health providers have forged stronger collaboratives and thereby a stronger voice and presence—as can be seen through the emerging role of the CHAs in Africa. More researchers have begun to focus on faith-inspired engagement in health—albeit from a number of different perspectives: some looking at local initiatives and others focussing on specific responses, such as those of faith-inspired communities and institutions to HIV/AIDS. More work has also now been completed through qualitative lenses, for example anthropological perspectives on health-seeker behaviors, user preferences, and health worker motivations. And there has also been an increase in quantitative data relating to FIIs from Ministries of Health and the CHAs. Questions relevant to FIIs have recently been included by the WHO in their Services Availability Mapping survey—although it will take time before this data becomes available. Data from nationally representative household surveys have now been used in a systematic way to measure the market share, reach to the poor, cost, and satisfaction with FIIs as compared to public and private secular providers. While many household surveys distinguish between private and public providers, some now also
permit the identification of faith-inspired providers specifically, a feature that has been relied upon by several contributions in this issue.

Articles in this Issue

Our purpose in this special issue is to provide a series of articles that illustrate various analytical perspectives and emerging research on faith engagement in health in sub-Saharan Africa. What is shared is a common interest in uncovering what might be distinctive about faith-inspired health initiatives and institutions. While we mainly focus on sub-Saharan Africa, the questions that are raised are likely to be of interest for other regions as well. The authors of the various articles rely on different kinds of research strategies and perspectives. This issue consists of seven articles which focus on the presence of faith-inspired providers as they are faced with rapidly changing and increasingly complex national health systems.

The first article, “Market Share of Faith-Inspired Health Care Providers: Reach to the Poor in Africa,” relies on facilities and household survey data to estimate the market share of faith-inspired institutions in the provision of health care services in Africa. Much of the evidence used to-date to back up statements about the market share of faith-inspired providers of health care in sub-Saharan Africa comes from data on health care facilities, and especially on the share of hospital beds held by Christian Health Associations in the countries where these associations operate. In those countries, estimates of the market share of faith-inspired health care providers based on hospital beds or similar measures are often in the 20 percent to 40 percent range. However, the evidence available from multi-purpose integrated household surveys (that ask households where they go for health care and that identify specifically faith-inspired providers in survey questionnaires), tells a different story, with a much bigger system of health providers
being taken into account and as a result a lower market share for faith-inspired facilities, typically at less than ten percent. A number of potential explanations for these large differences in market share estimates are provided. Both types of estimates suffer from limitations, but a more balanced view is obtained by viewing them side by side.

In the second article, “Contracting Between Faith-Based Health Care Organizations and the Public Sector in Africa,” the authors report on a study conducted on behalf of Medicus Mundi International from 2007 to 2009 on contractual arrangements between faith-based hospitals and public health authorities in four sub-Saharan African countries: Cameroon, Tanzania, Chad, and Uganda. The authors note that faith-based health providers have historically not been contractually recognized or established within government or public health systems. They regard contracting as a critical step towards the development of effective and equitable health care delivery systems, and the ultimate integration of faith-based facilities in public health systems. The article describes several different contracting experiences between faith-based facilities and the public health sector at the national level. Although experiences are varied, the authors note that comparative analysis can identify common features, providing an interpretative lens for the assessment of contracting policies between faith-based and public sectors in sub-Saharan Africa. They conclude that the success of the relationship between faith-based facilities and public health authorities appears to lie more in the quality of the partnership processes at the central level, than in the operational contracts themselves. They note the need to raise awareness among stakeholders on the crisis in the current contracting landscape, and the need to improve knowledge and expertise in designing, implementing, and monitoring contractual arrangements.

In the next article, “Making Quality Care Affordable for the Poor: Faith-Inspired Health Facilities in Burkina Faso,” the authors use a nationally representative survey to show that cost
of care remains a major impediment for households to access care. The authors suggest on the basis of qualitative fieldwork conducted in 2010 that one of the key reasons for individuals to seek care in faith-inspired health facilities is the fact that the cost of care in those facilities may be lower than in public facilities. The other reason is that faith-inspired facilities are perceived to provide better quality of care. Yet faith-inspired facilities receive only limited financial support from the state to provide their services, mostly in the form of salaries for part of their staff. The ability of the facilities to make quality care affordable for the poor is often maintained thanks to support in kind and in cash from religious groups and other donors. This model contributes to the availability of affordable quality care in the communities where the facilities are located, but higher state support for the facilities would help for expansion.

The starting point for the fourth article, “HIV/AIDS Prevention Strategies within a Catholic NGO in Tanzania,” is the fact that faith-based organizations play a large role in HIV/AIDS care and prevention in sub-Saharan Africa. The theological and health challenges inherent in issues surrounding HIV/AIDS and sexual behavior, however, have meant that the faith-based response to HIV/AIDS prevention has been controversial. Many issues pertinent to HIV/AIDS prevention, such as condom promotion, sex outside marriage, and the prevention of HIV among high risk and vulnerable groups, can clash with religious doctrine. There are a variety of different types of FBOs, however, and this clash can put faith-based service delivery organizations in particular in a difficult position. Such organizations are often staffed, for example, by health professionals whose own understanding of HIV/AIDS and HIV/AIDS prevention may conflict with official religious doctrine. The article describes the HIV/AIDS prevention strategies implemented by staff within a Catholic service delivery organization in Tanzania in response to this conflict. Such strategies included: distinguishing between condom
education and condom promotion, emphasizing individual choice, and framing issues in a way that circumvented religious moral or ethical arguments. These strategies ensured that HIV/AIDS prevention within the organization was in line with both individual professional understandings of HIV/AIDS and the Catholic Church.

In the fifth article, “Increased Funding for AIDS-Engaged Faith-Based Organizations in Africa?”, the authors review the evidence on the comparative extent to which faith-based civil society organizations (FB-CSOs) have benefited from increased funding related to the HIV/AIDS response in Africa. First, the available literature is reviewed looking at whether FB-CSOs have benefited from such funding. The authors find the arguments vigorous, but the evidence inconclusive. Next, the article provides fresh analysis of a survey carried out in six Southern African countries to compare the profile and sources of funding of FB-CSOs against CSOs that are non-religious or “secular.” It is important to be aware of the at times artificial distinctions made between faith-based and secular structures, given the often integrated presence of religion in the lives of civil society actors and their institutions—especially in Africa. However, it is still useful to consider this particular distinction, impacting as it does on current policy discussions and strategies for civil society engagement. While the data of this particular study is mostly representative of a cluster of well-established CSOs, the evidence suggests that in this cluster, FB-CSOs have benefited from enhanced funding opportunities as much as other CSOs. The article concludes with a discussion of the challenges that remain for supporting smaller and less formal FB-initiatives operating at a community level.

The sixth article, “Mental Health and Psychological Support in Humanitarian Emergencies in Africa: Challenges and Opportunities for Engaging with the Faith Sector,” reflects on the rapid growth in the deployment of mental health and psychosocial support
(MHPSS) interventions in African humanitarian contexts over the last two decades. Faith-inspired non-governmental organizations—both international and national—have been very active in such development. A review of collated MHPSS resource documents confirms, however, that the language and understandings used to approach such work are generally secular and the engagement with the religious resources of local faith communities typically weak. This is despite the fact that research indicates the potentially significant influence of such resources on resilience and recovery. Data drawn from analysis of the role of religious belief and practice in the coping strategies of local faith communities following the Eritrea-Tigray conflict is used to demonstrate the potential for MHPSS programming to more effectively build upon such local faith capacities and strategies.

The last article, “Faith-inspired Health Care Provision in Ghana: Market Share, Reach to the Poor, and Performance,” looks at the provision of health services by faith-inspired providers in Ghana. Relying on administrative, household surveys and qualitative data, the authors ask four questions about the services of faith-inspired or “mission-based” health care providers: (1) what is the market share of faith-inspired providers as compared to other types of providers?; (2) are there differences in market shares among the poor between faith-inspired providers and other types of providers?; (3) how satisfied are patients with the services received?; and (4) why are patients choosing faith-inspired providers for care? Estimates of the market share of faith-inspired providers are lower with household survey data than with facilities data on hospital beds, and various factors influencing these differences are explained. Faith-inspired and public providers appear to be serving the poor roughly equally to public providers, while private providers tend to serve the higher socio-economic groups more than either faith-inspired or public providers. Qualitative data collected in six facilities suggests that the satisfaction with the
services received in faith-inspired facilities is high, especially in areas such as respect paid to patients. Finally, the authors note that the reasons that lead patients to choose faith-inspired providers appear not to be related directly to religion per se, but to the quality of the services provided, including the values of dignity and respect for patients that these facilities exhibit.

**Conclusion**

An increasing level of interest in the role of faith in development has generated much debate and dialogue at the international and national levels over the last decade. Despite difficulties in communication and differences in cultures within such debates, there has been a continued reaffirmation of the potential benefits that faith-inspired communities can bring towards efforts to achieve the Millennium Development Goals (MDGs) as well as contribute to the post-2015 agenda, especially in the area of health.

Yet the evidential field in this area is riddled with uneven data, informational gaps, mismatching frames of reference, and frequently conflicting opinions and agendas. The partial and fragmented nature of the body of evidence is one of the greatest obstacles to further cooperation at the policy level—given that policy recommendations often require systematic and sustained supporting evidence, which is rarely available. We hope that by providing a set of new contributions on this topic, this special issue will, in a small way, contribute to a better understanding of how the impact of religion and faith-inspired institutions is to be understood, measured, and how best practices may push health care forward.
References


1 Portions of this article are adapted from the Olivier and Wodon (2012a, b, c) collection of working papers.
2 Although "faith-inspired organization" and "faith-based organization" are sometimes used interchangeably (and both are used in this special issue of the journal), technically "faith-inspired" has a somewhat broader meaning than "faith-based."
3 This section is based in part on the systematic and scoping review conducted for the Olivier and Wodon (2012a, b, c) collection of working papers.