Health in Africa and Faith Communities: What Do We Need to Know?
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HIGHLIGHTS

Faith-inspired organizations (FIOs) and communities are important providers of healthcare in sub-Saharan Africa (as in other world regions). Quality can be high and the focus is often on serving the very poor and marginalized, but FIO work is rarely treated as a central part of national and global health strategies and systems. Uncertainties, misunderstandings, and stereotypes about faith roles in health matter because they hamper dialogue and partnerships, among faith institutions and governments, and also with non-profit and for-profit entities and multilateral institutions working on health.

With some 30 years of research and discussion, considerable information about the health work of faith-inspired organizations and communities and its implications for quality care has been amassed. However, this information is not systematic or comprehensive and much is difficult to find. Further, systems are diverse (tens of thousands of FIOs are engaged in healthcare) and often overlap with public and private services. This explains wide discrepancies in estimates of FIO roles and appreciations of their reach, quality, and impact. Documented evidence about effectiveness is especially weak.

This brief presents the key results of a 2012 review, undertaken as a partnership between the Tony Blair Faith Foundation and the World Faiths Development Dialogue. The resulting report, of which Lynn Aylward is the primary author, is entitled “Global Health and Africa: Assessing Faith Work and Research Priorities.”

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FIOs’ ENGAGEMENT IN HEALTH

There are good reasons to seek more precise numbers and qualitative assessments of FIO health work. Faith communities and organizations are important healthcare providers throughout Africa; while their exact market share is debated, it is large. In a resource-constrained environment, balanced information about faith health assets can promote better coordination and enhance the effectiveness of health policies and services. It can ensure that care reaches the “last mile” and the “fifth child”, that is, the poorest and most marginalized citizens. Such knowledge is important for many dimensions of global health and development (GHD). Balanced information can help to dispel common misunderstandings linked to sensitivities around culture, religion, morality, and colonial associations. Above all, faith communities and religion play influential roles in the lives of the vast majority of Africans, and knowledge about their work and approaches should inform comprehensive sustainable development strategies. For their part, FIOs argue that their work is undervalued and underfunded by governments and transnational organizations.

Data and information on FIOs’ engagement in health in Africa (and other regions) are scattered across different disci-
plines, organizations, and databases. Pockets of systematic and useful data do exist; for example, individual country Ministry of Health data, the World Health Organization Service Availability Mapping and Readiness Survey (SAM/SARA), and Demographic and Health Surveys (DHS) capture some data on faith-based facilities and religiosity of clients. Current data have been collected largely through mapping exercises focused on FIOs; some are highly-detailed and sometimes cover the work of smaller, community-based organizations, which otherwise tend to be overlooked. Their weakness is that they tend to provide snapshots that are not necessarily useful. Studies of FIO health work can also be found in private sector health assessments by, inter alia, the World Bank. The bottom line is that while significant information is available, it is often hard to obtain and assemble, and large gaps exist.

The literature review chose ten parameters to characterize FIO work; namely, the number, size, type, and faith affiliation of faith-inspired organizations working on health in Africa; their geographical distribution; the health services provided; market share and utilization by clients; financing: health service costs; and FIOs’ relationships with governments, other stakeholders, and each other.

Number, size, and type
A reasonable order of magnitude indicator is that there are some 100,000 FIOs doing health work in Africa. Faith-inspired large international nongovernmental organizations (INGOs) are few in number and account for a significant share of work, often relying on the smaller, much more numerous regional, national, and community-based organizations to implement INGO-led health programs. Small, community-based organizations such as Anglican Mothers’ Unions and the Equipas da Vida of Mozambique may be comprised of 25 members or less but do impressive work.

Geographic distribution
The numbers and nature of FIOs varies widely from one African country to the next, though countries with similar backgrounds share tendencies, for example, FIOs are more present in Eastern and Southern Africa than elsewhere in Africa. Christian organizations predominates in many countries, but organizations inspired by Islam and other faiths do important work and are undercounted. Pentecostal churches and African Independent Churches are growing rapidly, but their involvement in health work is still relatively modest (or unknown) compared to longer established faiths. Traditional medicine, important in many areas, varies widely in quality and no systematic assessments of its scope and impact exist.

Types of health service and market shares
FIOs provide the full range of health services, from direct medical care in hospitals and clinics to providing medical supplies, health worker training, behavior change communication, and advocacy. Their involvement in Africa’s major health challenges, especially HIV and AIDS, malaria, and maternal, newborn, and child health, is especially large. FIOs may account for some 20 percent of all HIV and AIDS work globally; the Catholic Church alone asserts that it provides 27 percent of all HIV and AIDS-related health services worldwide.

However, FIOs’ share of the health market in Africa is contested. The assertion that FIOs provide between 30 and 70 percent of healthcare in Africa is oft-repeated and given a World Health Organization imprimatur but in fact has a complicated basis. The range is based partially on estimates provided by the national Christian Health Association (CHAs), the Catholic Church, and other sources that seem to measure the total health sector as public and faith-affiliated facilities, but overlook other private health providers and traditional medicine. Recent studies that include for-profit and traditional medicine providers and use the demand-side data from health service-utilization surveys suggest smaller market shares for FIOs in several countries compared to earlier estimates—sometimes drastically smaller. Notwithstanding such discrepancies in numbers, FIOs are the dominant non-profit private sector health providers in many African countries, particularly in some fragile states, such as the Democratic Republic of the Congo where they manage 40 percent of the country’s public health zones for the government.

Financing and costs
From some perspectives, FIOs seem underfunded: churches in Europe and the United States have reduced their support for church health facilities in Africa over the last several decades. While there are many good examples of fruitful cooperation between the GHD community and FIOs—UNICEF and UNFPA reports document many years of partnerships with religious communities, FIOs receive only small shares of funding from some large health organizations. Estimates put the funds disbursed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria...
directly to FIOs in its first eight funding rounds at only three percent.

From a different perspective, some large US faith-inspired international development organizations such as Catholic Relief Services receive up to 70 percent of their funding from the US government. African governments at least partially fund FIOs’ health work in 75 percent of African countries, though often with shortfalls in promised reimbursements and delays in payment. New financing to fund African healthcare is flowing from newer, non-traditional sources, such as US evangelical churches.

Many faith-inspired health providers in Africa charge user fees, and broadly speaking, faith-inspired providers are sometimes more expensive than public services but generally less expensive than for-profit providers (note that cost studies vary in taking quality of care into account). Some FIOs use graduated fee scales as an approach to generating operating costs while maintaining focus on the very poor.

The cost effectiveness of FIO work is poorly documented. Anecdotal and partial research evidence suggests that it is high which makes sense given high motivation and capacity to mobilize large numbers of volunteers. Financing arrangements are obscure in many instances.

**Relationships with government and each other**

FIO relationships with governments range from health ministries with little knowledge of their activities to formalized memoranda of understanding, with Christian organizations often under the auspices of national CHAs and the sometimes separate associations of Catholic health providers. There is potential for greater coordination among FIOs as well, so that they work toward clearer and tighter integration into national health strategies and systems.

**Evidence on the effectiveness and distinctiveness of FIOs’ health work**

An important starting point is to understand how faith-linked healthcare works (that often means understanding the history of the individual denomination involved and the country). Getting a clear handle on how many FIOs operate, how much, where, what, and how is the next priority. Important questions center on their effectiveness and distinctiveness. Whether FIOs are generically as or more effective than the government or secular organizations is not an especially useful question. However, in dispelling misunderstandings, research demonstrating the high quality of certain specific FIO health systems and interventions can be useful. Most available research on the effectiveness, comparative effectiveness, and assets faith-based providers might bring to social work has been conducted on US domestic programs.

The results of the research broadly indicate that FIOs carry out effective health and social service programs. Faith-specific organizational and programming features/differences exist, can be detected, and are perceived by the beneficiaries of the service. However, differences in program outcomes among faith-based, secular, and public providers are often subtle and there is little evidence on overall trends. There is a good deal of overlap between program elements of FIOs and other types of providers. For example, secular implementers may run programs that include religious language or symbols, while FIOs may run programs that do not. Further complicating debates about relative effectiveness and distinctiveness is the overall dearth of rigorous evaluations in international development more generally (not specific to FIOs), a key finding at a USAID Evidence Summit held in early June 2013.

Stand-alone evaluations of health interventions in Africa where the implementer happened to be an FIO indicate effectiveness, but do not deal at all with the implementer’s faith affiliation. These evaluations tend to confirm that FIOS are effective providers of healthcare, but do not elaborate on whether specific faith factors shape health programs. Only a handful of comparative and faith-specific studies of health work in Africa were found. The most famous, by Ritva Reinikka and Jakob Svensson, stands out as specifying a model of FIO behavior and testing it to show credible evidence of comparative effectiveness (comparing religious health providers to public and for-profit ones), a faith factor (altruism) at work, and preferential service to the poor (a purported distinctive strength). Patient surveys
in World Bank private sector health assessments indicate that in some African countries, faith-inspired facilities are perceived as providing better service, though actual health outcomes have not been assessed. For other countries, no significant differences were identified in overall patient satisfaction among different provider types.

Comparative studies of differences in health outcomes between different types of providers could help identify organizational, programming, or other factors that contribute to good results for different diseases, in different settings. It would be useful to identify programs where religion seems likely to serve as a clear facilitating asset, such as with community-based and behavior change communication (BCC) health programs. For BCC interventions with individuals or communities to develop and disseminate communication strategies that promote healthy behaviors appropriate to the settings, messages of faith communities often resonate more strongly than those put out by secular programs (public or private) and may have more lasting effects.

IDEAS FOR FUTURE RESEARCH AND OPERATIONAL PRIORITIES

A first recommendation is to take clearly into account the central fact of diversity and local circumstances: the engagement and nature of FIOs, their health work, and their relationships with other stakeholders vary greatly from country to country.

More solid data on FIOs’ health work is needed, and the gaps deserve close attention at senior levels of global health entities. Reliable, rigorous information can help materially at many levels: for FIOs, governments, and international organizations, for a start. Timely and objective information (looking to weaknesses as well as strengths) can inform key policy issues (for example on user charges and priority needs) and enhance the impact of local programs.

Improving coordination among FIOs and with government and other stakeholders, especially for work centered in communities, is a priority. Well-designed and adapted evaluations of FIO health work with methodologies that better assess the faith aspects and distinctive features of that work and the impact on outcomes can inform effective strategies.

Involving communities in BCC efforts is a priority for governments, the GHD community, and faith actors. This is an area where it seems logical and likely that faith itself can make a big difference.

Efforts to bring to bear fresh perspectives and bold strategic thinking could transform stilted debates and open new avenues for action. Rapid and deep changes are transforming health systems worldwide and across Africa. Many current discussions and much research on FIOs seem quite static or even backward looking, seeking to prove the footprint and effectiveness of FIO health work. Rather than cataloging what they have been doing (a very demanding data exercise if done comprehensively and systematically), a step back to reflect on the possible directions that faith institutions can take in Africa’s evolving health landscape would be more fruitful.

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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.