

# Understanding the roles of faith-based health-care providers in Africa:

## Review of the evidence with a focus on magnitude, reach, cost, and satisfaction

*Jill Olivier, Clarence Tsimpo, Regina Gemignani, Mari Shojo, Harold Coulombe, Frank Dimmock, Minh Cong Nguyen, Harrison Hines, Edward J Mills, Joseph L Dieleman, Annie Haakenstad, Quentin Wodon*

### Faith-based health care 1

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At a time when many countries might not achieve the health targets of the Millennium Development Goals and the post-2015 agenda for sustainable development is being negotiated, the contribution of faith-based health-care providers is potentially crucial. For better partnership to be achieved and for health systems to be strengthened by the alignment of faith-based health-providers with national systems and priorities, improved information is needed at all levels. Comparisons of basic factors (such as magnitude, reach to poor people, cost to patients, modes of financing, and satisfaction of patients with the services received) within faith-based health-providers and national systems show some differences. As the first report in the Series on faith-based health care, we review a broad body of published work and introduce some empirical evidence on the role of faith-based health-care providers, with a focus on Christian faith-based health providers in sub-Saharan Africa (in which the most detailed documentation has been gathered). The restricted and diverse evidence reported supports the idea that faith-based health providers continue to play a part in health provision, especially in fragile health systems, and the subsequent reports in this Series review controversies in faith-based health care and recommendations for low public and faith sectors might collaborate more effectively.

#### Introduction

In 2002, World Bank President James Wolfensohn said "half the work in education and health in sub-Saharan Africa is done by the church...but they don't talk to each other, and they don't talk to us." Somehow, faith-based providers of health and education had disappeared off the policy and evidence map. This situation occurred despite the fact that Islamic hospitals and Christian missionary hospitals were some of the first modern health-care providers to be established. In many low-to-middle income countries, even after colonisation ended and despite massive health-systems reconfigurations, faith-based health providers (FBHPs) have maintained a strong presence. However, FBHPs have been neglected by the worlds of research and policy for decades, mainly as a result of a general reticence on public health provision and also since the historical (and sometimes present) drivers of faith-based health provision have been treated with mistrust, especially in connection with the controversies around health care provided with the underlying intent to proselytise (see Tomlin's and colleagues review on controversies in this Series).<sup>1</sup> However, in the past decade, bilateral and multilateral donors, the UN agencies, and country governments have pushed towards better understanding of FBHPs.<sup>2</sup>

Here, we review the available evidence with a focus on sub-Saharan Africa and Christian FBHPs because little evidence is available for other contexts or other kinds of faith-based groups at present. Even with this focus, robust or systematic evidence is restricted, and substantial confusion and conflicting anecdotal claims in the published work on FBHPs.<sup>3</sup> Reports of the comparative advantages of FBHPs versus other public and secular providers (such as the possible reach, trust and access in communities, quality care, longevity, or service to poor people) are rarely substantiated and are usually balanced by reports of possible comparative weaknesses (such as poor human resource management, absence of financial sustainability, poor record keeping, or preferential service to particular religious groups).<sup>4</sup> The objective of this Series paper is to present what is

#### Search strategy and selection criteria

We based this Series paper on the assessment of peer-reviewed and grey literature that introduces some recognizable evidence to the specificity relating to the importance and unique characteristics of faith-based health providers (FBHPs) in Africa. We searched in *Medline*, *Cochrane*, *ERIC*, and *World Bank data archives* for publications in English and French between Jan 1, 2000, and May 20, 2014, with more than 40 search terms, variations of "faith" and "health" and a geographical focus on Africa and low-income and middle-income country contexts.

We also drew from three other more detailed systematic reviews in which some of the authors of this Series paper participated and on reviewers and engagement with key researchers with an established record in this area. This report draws on the review and empirical work recorded in a three-volume collection that focuses on the role of FBHPs in Africa. From this work, the angles of factors such as the satisfaction of patients, extent of outreach to FBHPs, reach to poor people, and their cost for households were done. Additionally, material was taken from two systematic review projects in progress, one that has been collecting material (peer-reviewed and grey literature) relating to religion and HIV/AIDS since 2008, and the other that has been collecting material on religion and public health since 2006. These two databases include material from 1980 to 2014, with the search terms "religion", "public health", and "HIV/AIDS" (each with several variations), and each containing several thousand distinct entries.

# Often Problematic Data Gaps & Estimates

**"Half the work in education and health in sub-Saharan Africa is done by the church ... but they don't talk to each other, and they don't talk to us"**

***(James Wolfensohn, WB, 2002)***

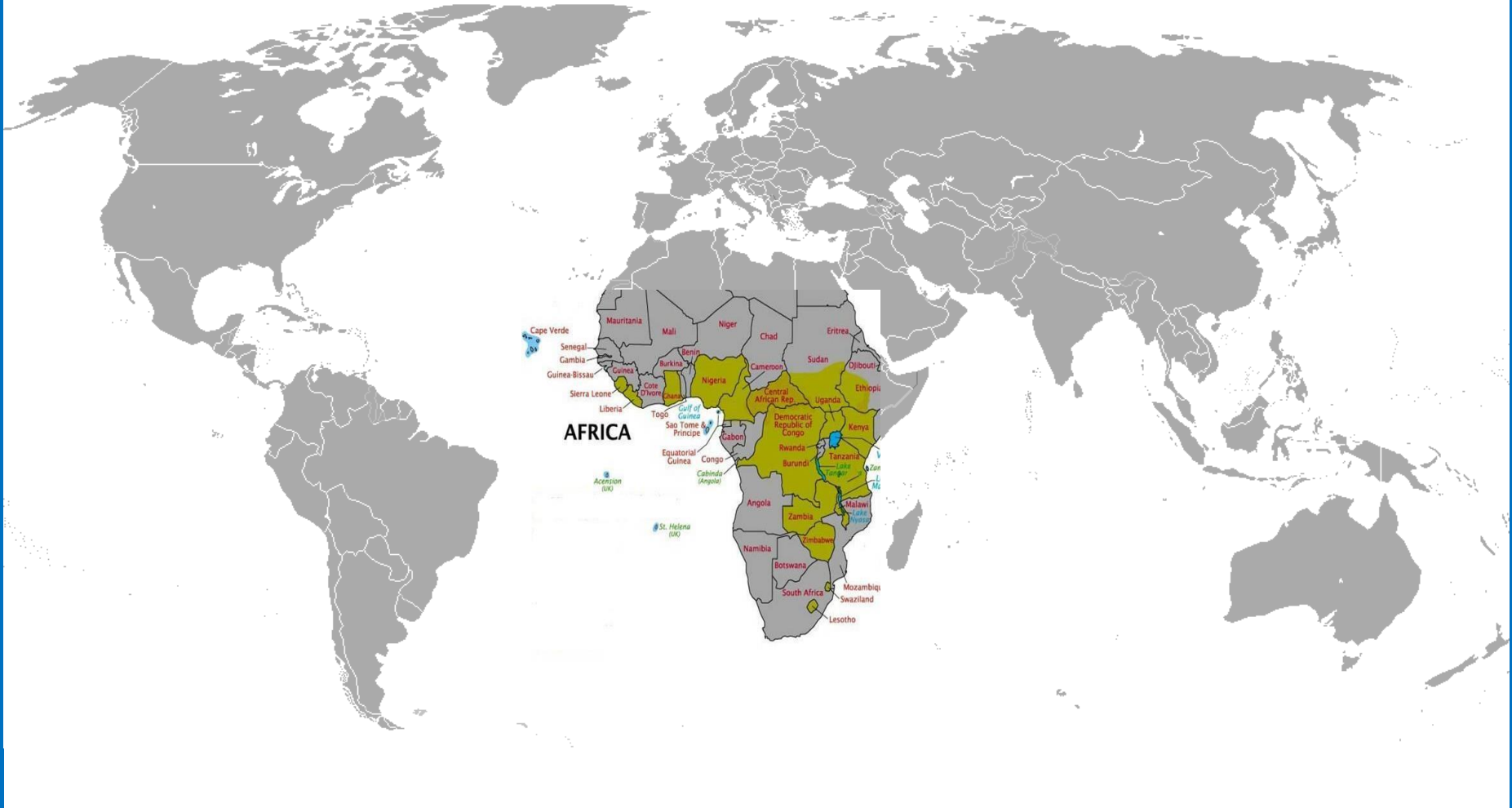
**"In many African countries, you provide 30 to 70% of the health services and in post-conflict countries, the majority of primary education services"**

***(Graeme Wheeler, WB, 2010)***

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# (Biomedical) FB health providers in Africa



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Country	Self-declared NFBHN share (beds)	NFBHN hospitals	NFBHN health Centers	NFBHN training facilities
Benin	40%	6	20	28
Botswana	18%	2	6	2
Cameroon	40%	30	150	3
CAR	20%	2	62	19
Chad	20%	4	164	2
DRC	50%	89	600	20
Ghana	42%	58	104	10
Kenya	40%	74	808	24
Lesotho	40%	8	72	4
Liberia	10%	6	67	3
Malawi	37%	27	142	10
Nigeria	40%	147	2747	28
Tanzania	42%	89	815	24
Togo	20%	3	39	0
Uganda	40%	47	541	19
Zambia	40%	36	110	9
Zimbabwe	35%	80	46	15

**E.g. Estimates of market share of FBNPs vs public health system**

*Note: based on hospital beds and facilities*

*Note: e.g. of African countries with more substantial share*

# (More) Useful to Look at:

## *Access, Utilization, Cost, Satisfaction, Reach to Poor etc...*

- Data from household surveys suggest **lower market shares** than commonly assumed...
- But **higher levels of satisfaction** than in public facilities
- Faith-based health providers play an important part in many countries in Africa, particularly in **fragile or weakened health systems**

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# (More) Useful to look at:

- Appreciation tempered by awareness of **controversies** of faith-based social engagement and lingering weakness (of some FBHPs) in **quality and adaptability** to health systems conditions (eg **financial constraints**)
- **All broad generalisations** about faith-based organisations or the faith sector should be avoided
- **Health systems research** is necessary (eg: that unpacks how exactly FBHPs contribute/don't to UHC at a country level)
- More detailed **policy implementation strategies** for improved PPP/engagement with FBHPs are needed

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