

Bibliographic Highlight

This bibliography forms part of an ongoing data collection and systematic review project by the International Religious Health Assets Programme (IRHAP). These Bibliographic Highlights are intended as a rapid resource – with each outlining key resources on a particular area within the broader field of study on *non-state, non-profit (faith-based) health providers* from a *health systems* perspective. For each Highlight, researchers have selected a set of 'Top 10' publications. Where no author/editor-provided abstracts are available, a summary has been developed (marked 'IRHAP summary'). Some abstracts have been abbreviated.

Additions and suggestions for future versions are welcomed.

Recommended reference: IRHAP. (2017). *Bibliographic Highlight: Mapping Faith-based Health Provider*. International Religious Health Assets Program, South Africa. www.irhap.uct.ac.za

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Mapping Faith-Based Health Providers

Understanding the scope and scale of the contribution of the faith based sector to health is vital. However, little information is available in this regard. The resources collected here represent a choice sample of research using various 'mapping' methods to assess the scale of the contribution of the faith-based sector to health, assess the distribution and accessibility of faith based health services to particular population groups, understanding the linkages and cross-referrals between faith-based and public sector facilities, and conceptualising the nature of the response of the faith-based sector to a particular health crisis (such as the HIV/AIDS crisis).

Blevins, J., et al. (2012). Community health assets mapping: a mixed method approach in Nairobi. Strengthening faith-inspired health engagement, Vol 3: Mapping, cost, and reach to the poor of faith-inspired health care providers in sub-Saharan Africa. J. Olivier and Q. Wodon. Washington DC, The World Bank, HNP Discussion Papers: 76-90.

This paper summarizes an innovative approach to health asset mapping in Mukuru, an informal settlement in Nairobi, Kenya. This particular approach combines a model for community based participatory research with a GIS mapping process. The essay provides background on the rationale for the mapping and of the characteristics of the Mukuru community, a summary of findings and insights gained from the mapping. [Abbreviated]

Coulombe, H. and Q. Wodon (2013). "Mapping religious health assets: Are faith-inspired facilities located in poor areas in Ghana?" Economics Bulletin 33(2): 1615-1631.

It has long been argued that faith-inspired health facilities serve the poor in priority in sub-Saharan Africa, in part by being located in remote and poor areas where the reach of government services may remain limited. Unfortunately, proper empirical evidence to back up such claims is rarely available. We use geographic poverty mapping techniques to assess whether the facilities located within the Christian Health Association of Ghana (CHAG) are located in poor areas. From the point of view of CHAG which may look only at the distribution of its facilities and hospital beds in the district where it is active, there is some evidence that it tends to serve poorer areas in priority. But from the point of view of a national government or outside observer looking at the distribution of CHAG facilities and hospital beds in the country as a whole, the relationship is weaker, in part because CHAG does not have facilities and hospital beds in some relatively poor districts. [Abbreviated]

De Gruchy, S., et al. (2006). Appreciating assets: The contribution of religion to universal access in Africa. Cape Town, African Religious Health Assets Programme (ARHAP) Report for the World Health Organization.

The study documents the contribution made by religion and religious entities to the struggle for health and wellbeing in Zambia and Lesotho, in a context dominated by poverty, stressed public health systems and the HIV/AIDS pandemic. By mapping and understanding these religious health assets, the study calls for a greater appreciation of the potential they have for the struggle against HIV/AIDS and for universal access and offers recommendations for action by both public health and religious leaders at all levels. [Abbreviated]

De Gruchy, S., et al. (2011). Participatory inquiry on the interface between religion and health: what does it achieve, and what not? When religion and health align: mobilising religious health assets for transformation. J. R. Cochrane, B. Schmid and T. Cutts. Pietermaritzburg, South Africa, Cluster Publications: 43-61.

In this chapter, the participatory mapping toolset PIRHANA (Participatory Inquiry into Religious Health Assets, Networks and Agency) is introduced as a research strategy. This toolset was used first in research done for the World Health Organization and since in a range of other international settings. It is particularly useful for gathering certain kinds of data, and its participatory richness has noteworthy kick-on effects in bringing key actors together around common concerns. The PIRHANA toolset can be used with a purely instrumental purpose; but then its value is reduced and some of its most important and powerful features undermined. [Abbreviated]

Dilger, H. (2014). "Claiming territory: medical mission, interreligious revivalism, and the spatialization of health interventions in urban Tanzania." Med Anthropol 33(1): 52-67.

Over the past decades, new religious actors have become involved in the provision of medical care in urban Tanzania. Muslim revivalist organizations and neo-Pentecostal churches in particular have established a range of health interventions that are tied to revisionist claims about religion, spirituality, and politics in society. In this article medical mission in Dar es Salaam is discussed in the light of (post)colonial histories of health service provision as well as with regard to inter- and intradenominational contestations over health and well-being, a morally acceptable life, and political participation. The nature of the inscription of revivalist organizations in urban space through health interventions depends on their structural location and their respective members' social and economic capital. This shows that the ongoing transformations of urban space through medical mission have become reflective of, as well as are triggering, moral interpretations of history and social inequality in contemporary Tanzania. [Abbreviated]

Garcia, J. and R. G. Parker (2011). "Resource mobilization for health advocacy: Afro-Brazilian religious organizations and HIV prevention and control." Social Science & Medicine 72(12): 1930-1938.

Brazil's national response to AIDS has been tied to the ability to mobilize resources from the World Bank, the World Health Organization, and a variety of donor agencies. The combination of favorable political economic opportunities and the bottom-up demands from civil society make Brazil a particularly interesting case. Despite the stabilization of the AIDS epidemic within the general Brazilian population, it continues to grow in pockets of poverty. We use resource mobilization theories to examine the role of Afro-Brazilian religious organizations in reaching these marginalized populations. The mobilization of resources from international donors, political opportunities, and cultural framings enabled local Afro-Brazilian religious groups to forge a national network. On the micro-level, in Rio de Janeiro, we observed how macro-level structures led to the proliferation of capacity-building and peer educator projects among these religious groups. We found that beyond funding assistance, the interrelation of religious ideologies, leadership, and networks linked to HIV can affect mobilization. [Abbreviated]

Kissah-Korsak, K. (2008). "Spatial accessibility to health care facilities in the Ajumako-Enyan-Essiam and Upper Denkyira Districts in the Central Region of Ghana." Norsk Geografisk Tidsskrift - Norwegian Journal of Geography 62: 203-209.

The article addresses orthodox and traditional medical practices in Ghana which are based on science, magic and religion. The role of both scientific and traditional health care practices is investigated. However, orthodox medicine, which was introduced in approximately 1868, has become the accepted official system in the country. This has resulted in the establishment of over 1200 health care facilities in the country. Due to the uneven distribution of the

facilities, the majority of the population, who reside in the rural areas, scarcely have access to formal health care, forcing them to use mainly traditional medical practices. The accessibility levels for the different settlements were studied based on data collected from a sample of 800 households from 16 settlements in the Ajumako-Enyan-Essiam and Upper Denkyira Districts of the Central Region in 2005. The findings indicate that increases in distance exert some influence on the use of the district hospitals, which are the referral points for people in the districts. As a consequence there is an over-reliance on the use of alternative facilities, sometimes with dire consequences for people's health. [Abbreviated]

Leurs, R., et al. (2011). Mapping the development activities of faith-based organizations in Tanzania. Unpublished. Birmingham, University of Birmingham.

This study provides an overview of the sale and scope of Christian and Muslim organizations' development activities in Tanzania. Systematic information on the nature, scale and development activities of FBOs in unavailable. The research in 2008-9 was based on semi-structured interviews with a snowball sample of key informants from nearly fifty religious and other organisations, but also drew on the limited NGO directories available, a 1993 survey of NGOs in nine districts and other secondary sources. The study reveals a wide variety of organizational arrangements. [Abbreviated]

Noor, A. M., et al. (2009). "A spatial national health facility database for public health sector planning in Kenya in 2008." *International Journal of Health Geographics* 8: 13.

Efforts to tackle the enormous burden of ill-health in low-income countries are hampered by weak health information infrastructures that do not support appropriate planning and resource allocation. For health information systems to function well, a reliable inventory of health service providers is critical. The spatial referencing of service providers to allow their representation in a geographic information system is vital if the full planning potential of such data is to be realized. A disparate series of contemporary lists of health service providers were used to update a public health facility database of Kenya last compiled in 2003. These new lists were derived primarily through the national distribution of antimalarial and antiretroviral commodities since 2006. A combination of methods, including global positioning systems, was used to map service providers. These spatially-referenced data were combined with high-resolution population maps to analyze disparity in geographic access to public health care. The updated 2008 database contained 5,334 public health facilities (67% ministry of health; 28% mission and nongovernmental organizations; 2% local authorities; and 3% employers and other ministries). This represented an overall increase of 1,862 facilities compared to 2003. 93% of the health facilities were spatially referenced, 38% using global positioning systems compared to 21% in 2003. 89% of the population was within 5 km Euclidean distance to a public health facility in 2008 compared to 71% in 2003. Over 80% of the population outside 5 km of public health service providers was in the sparsely settled pastoralist areas of the country. Expansion in public health care in Kenya has resulted in significant increases in geographic access although several areas of the country need further improvements. [Abbrev]

Olivier, J. and Q. Wodon, Eds. (2012). Strengthening faith-inspired health engagement, Vol 3: Mapping, cost, and reach to the poor of faith-inspired health care providers in sub-Saharan Africa. Washington DC, The World Bank, HNP Discussion Papers: 1-6.

As African governments, donors, and a wide range of organizations increase their efforts to reach the Millennium Development Goals (MDGs) and set the agenda for the post-MDGs era, the role of non-state providers of health care is gaining new attention. In Africa, the largest non-state networks of providers are often faith-inspired. But how important is the role of faith-inspired institutions in health care provision in Africa? How substantial are their market share and reach to the poor? How affordable are the services provided by FIs to households? How satisfied are households with these services? What are some of the interesting and innovative experiences that have been documented in terms of FIs providing quality services to underserved populations? Beyond facilities-based care, which types of non-institutionalized initiatives emerge out of communities of faith that are generative of health? How can these initiatives be mapped, understood and leveraged for better health and development? The objective of this edited series of three World Bank HNP Discussion Papers is to gather tentative answers to such questions. This third volume in the series focuses on ways to 'map' (in the different uses of that terminology) faith-inspired providers, and on assessment of their cost for patients and the extent to which they succeed in reaching the poor.

Nash, P. R. (2009). A mixed methods study of access and utilization of faith-based mental health support services for African-American consumers and their families. *Social Work*. Atlanta, Clark Atlanta University. DPhil.

The purpose of this study is to detail the availability and use of faith-based mental health services in Fulton County, Georgia. This study examines mental health service availability and use patterns that influence African-American's use and with satisfaction with urban mental health services. What emerged from the mixed-methods study that consisted of a survey, GIS map, and illustrative case study was a preference for culturally relevant mental health services but a disparity between service availability and accessibility. According to the results from the case study, the first hypothesis supports that consumers (and service providers) in the sample believe that faith-based organizations are more culturally sensitive to their needs. However, the second hypothesis, that FBO's increase access and utilization of mental health services to African American consumers and their families, are equivocal. According to data from the survey and GIS mapping, FBO's provision of mental health services is fragmented within and between FBO's and county-level systems of care. While GIS analyses confirm that FBO's are geographically closer to each other than local Fulton County mental health service providers; the survey results show that FBO's rarely share resources. FBO's provide referrals to county-level systems of care, but specific numbers of individuals that are referred by the sample population remains unknown. [Abbreviated]

Tabatabai, P., et al. (2014). "Public and private maternal health service capacity and patient flows in southern Tanzania: using a geographic information system to link hospital and national census data." *Glob Health Action* 7(0).

Strategies to improve maternal health in low-income countries are increasingly embracing partnership approaches between public and private stakeholders in health. In Tanzania, such partnerships are a declared policy goal. However, implementation remains challenging as unfamiliarity between partners and insufficient recognition of private health providers prevail. This hinders cooperation and reflects the need to improve the evidence base of private sector contribution. Objective: To map and analyse the capacities of public and private hospitals to provide maternal health care in southern Tanzania and the population reached with these services. DESIGN: A hospital questionnaire was applied in all 16 hospitals (public n=10; private faith-based n=6) in 12 districts of southern Tanzania. Areas of inquiry included selected maternal health service indicators (human resources, maternity/delivery beds), provider-fees for obstetric services and patient turnover (antenatal care, births). Spatial information was linked to the 2002 Population Census dataset and a geographic information system to map patient flows and socio-geographic characteristics of service recipients. The contribution of faith-based organizations (FBOs) to hospital maternal health services is substantial. FBO hospitals are primarily located in rural areas and their patient composition places a higher emphasis on rural populations. Also, maternal health service capacity was more favourable in FBO hospitals. We approximated that 19.9% of deliveries in the study area were performed in hospitals and that the proportion of c-sections was 2.7%. Mapping of patient flows demonstrated that women often travelled far to seek hospital care and where catchment areas of public and FBO hospitals overlap. We conclude that the important contribution of FBOs to maternal health services and capacity as well as their emphasis on serving rural populations makes them promising partners in health programming. Inclusive partnerships could increase integration of FBOs into the public health care system and improve coordination and use of scarce resources.

Todd, S., et al. (2009). "Human Resources-Geographical Information Systems Data Development and Systems Implementation for the Christian Social Services Commission of Tanzania: Final Report. The Capacity Project, USAID. Chapel Hill, NC: IntraHealth International." *HR-GIS Data Development and Systems Implementation for the CSSC of Tanzania, United State Agency International Development (USAID)*.

While most partners providing health care in sub-Saharan Africa agree that FBOs play an important role in providing health services, there are few comprehensive data about the scope and scale of their contribution. Additionally, the absence of up-to-date and compatible personnel information in both the public and FBO health sectors is problematic, obscuring development of a clear picture on these issues. Since 2006, the USAID-funded Capacity Project has engaged in programs designed to bolster more effective human resources for health information and facilitate more intrasector data-sharing. As part of the Capacity Project consortium team, IMA World Health with the Christian Social Service Commission developed a human resources-based geographic information system (HR-GIS) with a database containing multivariate information on 850 FBO health facilities and over 15,000 personnel. [Abbrev]