WORLD FAITHS DEVELOPMENT DIALOGUE

Global Health and Africa:
Assessing Faith Work and Research Priorities

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Global Health and Africa

ASSESSING FAITH WORK AND RESEARCH PRIORITIES

FULL REPORT

WORLD FAITHS DEVELOPMENT DIALOGUE

TonyBlair FaithFoundation

FOREWORD

In both the past and present, and in virtually every world region, widely varied religious actors play crucial roles in health care. Nowhere is this more significant than in Sub-Saharan Africa. Today, in most African countries, faith institutions and groups run clinics, hospitals, and facilities that support families, orphans, handicapped people, the mentally ill, and older people. In communities, leaders and individuals communicate vital messages about health and provide sustained, hands-on care for the sick. The devastating HIV and AIDS pandemic has placed a powerful spotlight on these networks and their impact. With ambitious contemporary global health goals—notably combatting malaria, tuberculosis, and maternal deaths, but also making decent care for all a meaningful human right—faith leaders and communities can be vital allies.

Yet many international health institutions and some governments have paid scant attention to faith-inspired organizations (FIOs) and their potential impact has not been tapped in any systematic fashion. This is in part the result of gaps in knowledge. The "mapping" of faith-inspired work is patchy and even less is known about relative costs and effectiveness. The distinctive challenges and assets of these actors rarely figure into strategic thinking about public health challenges and delivery of services. This forms part of a broader phenomenon: a gulf dividing faith and secular actors plays out in many world regions and institutions.

These knowledge gaps matter and so do the unanswered questions. The Tony Blair Faith Foundation and the World Faiths Development Dialogue thus set out jointly to review rigorously what is and what is not known with a view to defining both research and action agendas. This report presents the results. Its aim is to bring together current academic literature, data bases, and evaluation reports in an accessible form that will allow a better understanding of the sector and thus pave the way for an exploration of priorities and for meaningful action.

Frankly, the report found more solid information than expected. However, much is in silos, inaccessible or unknown to key actors. And it is patchy with notable gaps. It also confirmed our rising appreciation for remarkably wide differences country to country and faith tradition to faith tradition. Thus, a key element is a series of short, preliminary case studies of faith health care in five countries— Gabon, Ghana, Mozambique, South Sudan, and Tanzania—that illustrate this diversity.

The report's principle author was Lynn Aylward, who led a team of contributors comprised of Molly Brady and Kari Nelson. The case studies were written by Lynn Aylward, Katherine Marshall, and Claudia Zambra, with research and writing assistance by Elizabeth Bliss and cover design and final edits for the WFDD edition by Alana Tornello. The report was prepared under the leadership of Hahna Fridirici Kimbrough and Katherine Marshall in close collaboration with the TBFF under Ian Linden and Jaclyn Andrasek. It was reviewed by a distinguished expert panel and benefitted from the contributions of many colleagues active in the field.

We hope the report will shed useful light on the roles that faith instituions play, gaps in knowledge and action, and opportunities for creative partnerships. We also hope it will spark a dialogue on why knowledge gaps matter and what more can be done to enhance collaboration. The goal is indeed to move purposefully towards the ideal of decent health care for all.

Katherine Marshall

Executive Director, World Faiths Development Dialogue

EXECUTIVE SUMMARY

Faith-inspired organizations have been important providers of health care in Sub-Saharan Africa for over a century. For some thirty years, their work and all its implications have been a topic of research and discussion. A substantial body of information is available on faith-inspired organizations (FIOs) working in health, and international organizations show growing interest in working with them.

Nonetheless, there is a lack of systematic, comprehensive information on FIOs. Nor is there rigorous evaluation of their effectiveness and purported distinctive strengths in health work. The shortfall derives in part from the diversity of the tens of thousands of faith-inspired organizations working in health. Their great variation, in nature, size, and structure, has created unresolved problems of definition and classification. Gaps in knowledge and understanding of FIOs' health work and its effectiveness generate uncertainties and stereotypes. These, in turn, impede health ministries, the international community, multilateral donors, and FIOs themselves, from making the best choices to improve public health in Africa. (1.1)

This study provides an extensive literature review covering available information from data bases, academic literature, international health organizations, FIOs, and evaluation reports. The report includes a Main and Background Paper. The Main Paper focuses on two topics: (i) the state of knowledge and key knowledge gaps on FIOs and (ii) evidence concerning their effectiveness and purported comparative advantages. The Background Paper presents four special topics in FIOs' health work in Africa (Supplement 1) and five country case studies (Supplement 2). A principal goal of the report is to define an agenda and priorities for research on faith-inspired health work in Africa.

State of knowledge on FIOs' engagement in health

Data are scattered across different disciplines, organizations, and databases; and are difficult to consolidate into a clear quantitative understanding of the various aspects of FIOs and their health work. The data sets that do exist can be divided into two types: (i) international health data not focused on FIOs per se but including some FIO data and (ii) FIO-focused datasets, often derived from mapping exercises. A strength of the former is that they represent high-quality contemporaneous data sets, comparable across countries; a notable example is the World Health Organization Service Availability and Readiness Survey (SAM or SARA). Weaknesses are that the data are only available with long lags and they do not provide much faith-specific data, though attempts have been made to address this omission. The strength of the FIO-focused data is that they are highly-detailed and sometimes capture the work of community-based organizations, which otherwise tend to be overlooked; the weakness is that this work, often mapping exercises, provides snapshots at a given moment in time of a specific region, faith, type of FIO, or health concern, covering a limited range of indicators, and having limited use for wider extrapolation about FIOs' health work. (2.3)

State of knowledge: ten key parameters of FIOs' engagement in health in Africa

The information - data, literature, and other sources - on FIOs can be assessed by considering ten key parameters of the organizations: number, size, type, and faith affiliation; geographical distribution; health services provided; market share and utilization; financing: health service costs;

and FIOs' relations with governments, other stakeholders, and each other. (2.4)

Information on number, size, and types of FIOs; faith affiliation; and geographic distribution

Some 100,000 FIOs are working on health in Africa. A relatively small number are faith-inspired large international nongovernmental organizations (INGOs). Many more are regional, national, and community-based organizations, with the INGOs sometimes relying on the smaller organizations to implement INGO-led health programs. There is great variation in the numbers and nature of FIOs present from one African country to the next, though countries with similar backgrounds share tendencies, e.g., FIOs tend to be more numerous and play larger roles in Eastern and Southern Africa than in other parts of the continent. Christian organizations predominate in many countries. Organizations affiliated with Islam and other faiths do important work and are probably undercounted. The implications of the rapid growth of two diverse African Christian movements, Pentecostalism and the African Independent Churches, for health work are not yet clear. (2.4.1-2.4.3)

Information on health services and market share and utilization

FIOs provide the full range of health services, from direct medical care in hospitals and clinics to supply of drugs, health worker training, behavior change communication, and advocacy. They are heavily involved in four main health challenges in Africa: HIV and AIDS, malaria, tuberculosis, and other major disease killers of children (Supplement 1). (2.4.4) But FIOs' share of the health market in Africa is contested. Many stakeholders believe that FIOs are under-funded and overlooked relative to the amount and quality of health services they provide. However, Olivier and Wodon (2011) have detailed the weaknesses in the oft-cited estimate that FIOs provide between 30 to 70 percent of health care in Africa. Recent studies that include for-profit and traditional medicine providers and use the demand-side data from health service-utilization surveys suggest that FIO market shares in several countries are smaller than earlier suggested. It is clear, nonetheless, that FIOs provide an important part of African public health care and are the dominant non-profit private sector health providers. (2.4.4-2.4.5)

Information on financing

There are no consolidated data or comprehensive studies of the financing of FIOs. From some perspectives, FIOs seem under-funded: churches in Europe and the US have reduced their support for church health facilities in Africa over the last several decades. Given that only 3 percent of funds disbursed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria in its first eight funding rounds went directly to FIOs supports claims of bias. On the other hand, some large US faith-inspired organizations receive up to 70 percent of their funding from the US government. Furthermore, 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.

Information on health service costs and user fees

Questions about the financing structure of FIOs spill over into questions about user fees and health costs. Provider-specific findings are mixed. Many faith-inspired health providers in Africa charge user fees, and broadly, faith-inspired providers are sometimes more expensive than public ones but generally less expensive than for-profit ones (though studies vary in taking quality of care into account). FIOs reportedly engage in "Robin Hood pricing," charging those who can afford to pay medical costs one fee and using this revenue to cross-subsidize lower fees for the poor. (2.4.6-2.4.7)

Information on FIOs' relationships with government, international organizations, and each other

FIOs' relationships with governments range from Health Ministries having little knowledge of FIOs' activities to formalized Memoranda of Understanding with FIOs, often through the auspices of the national Christian Health Association (CHAs) and the sometimes-separate associations of Catholic health providers. With or without these MOUs, **there is great potential for FIOs to coordinate better with each other and to work for clearer and tighter integration into national health systems.** (2.4.8)

Country case studies

Case studies' countries were selected primarily to illustrate diversity and differences in patterns and outcomes in terms of faith work on health. **The case studies bolster a major conclusion that country-specific analysis is critical to both understanding and action.** The members of Tanzania's Christian Social Services Commission account for almost 1000 health facilities, while there are only two faith-inspired/originated hospitals in Gabon, though one of them is arguably the world's most famous mission hospital, the Albert Schweitzer Hospital. Christian FIOs predominate across all five countries studied, though the important contributions of other faiths were evident. In Ghana, the Ammadiyah Muslim Mission contributes some two percent of non-profit service provision. FIOs are gen-

erally well-represented at the level of hospitals, but may be less well-represented among other types of health facilities from one country to the next; for example, in Ghana, less is known about FIOs' participation in "chemical stores," facilities that provide a large share of health care. The CHA of Ghana represented the faith-health sector during implementation of the country's sector-wide approach or SWAp, the partnership of the government and international donors to support the national health system. Mozambique nationalized faith-founded health facilities in the 1970s, and then allowed some to resume work; current government policy is for exclusive public control of the health sector but cooperation with FIOs is a pragmatic reality. As South Sudan struggles to build a national health system, the situation is essentially reversed: the civil society, a large share of which is faith-inspired, provides almost all health care.

Evidence on the effectiveness and distinctiveness of FIOs' health work

There can be a good deal of overlap between the program elements of FIOs and other types of providers, because secular organizations run faith-based programs (and vice versa) and sometimes incorporate religious language or symbols. (3.1-3.2) Stand-alone evaluations of faith-inspired health work in Africa show that FIOs are effective health providers. But stand-alone evaluations, assessments that do not compare FIOs with other types of providers or focus on faith-specific factors in organizations or health programs, provide little insight into FIOs' relative performance and purported comparative advantages. Only a handful of comparative and faith-specific studies of health work in Africa were found. One (Reinikka and Svensson 2003) 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 comparative advantage).

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. However, the rationale for comparative studies should not be to "prove" that FIOs are more effective than other providers. **FIOs ought not to feel particular pressure to be more effective than secular non-profits, public providers, or any other group; they just need to be effective at health care and, hopefully, to be coherent with national health strategies and international standards. The stand-alone studies confirm that they are.**

Studies of specific types of health programs likely to yield concrete results useful for policymaking include evaluations of faith-inspired community-based and behavior change communication (BCC) health programs. Existing information suggests that faith-inspired ways of these two types of health program are efficacious. **Rigorous evaluations of BCC projects, some of which are underway, seem particularly suited for exploring faith factors at work in health care.** More broadly, research that includes FIOs without focusing on them per se can be plumbed for insights. For example, private sector health assessments by the World Bank indicate that in some African countries, patient surveys show that faith-inspired facilities are perceived as providing better service, though actual health outcomes have not been assessed. For other countries, there are no significant differences in overall patient satisfaction among different provider types. (3.3) Regarding the purported comparative advantages of FIOs, in one country (Uganda) religious nonprofit healthcare providers were more likely than other providers to offer pro-poor services and exhibit greater worker motivation, two distinctive assets often attributed to faith-inspired actors. More studies along the same lines are needed. (3.4)

Conclusions and Future Research Priorities

Seven recommendations on future research priorities emerge from this study:

1. Pursue ways at the highest levels of global health cooperation to collect systematic data and map faith-inspired organizations; make such data a foundation for future research; and ensure that other data collection and mapping work responds to operational needs and is shared.
2. Support effective platforms for collaborative data gathering and knowledge sharing among FIO researchers and practitioners.
3. Explore the best means to improve coordination among FIOs and with government and other stakeholders, especially for community-based work.
4. Tailor research by sub-sector and country.
5. Highlight effective and appropriate evaluation for FIOs' health work and develop evaluation methodologies that better assess the faith aspects and distinctive features of that work and the impact on outcomes.
6. Expand and elaborate research on community-based health work and behavior change communication.
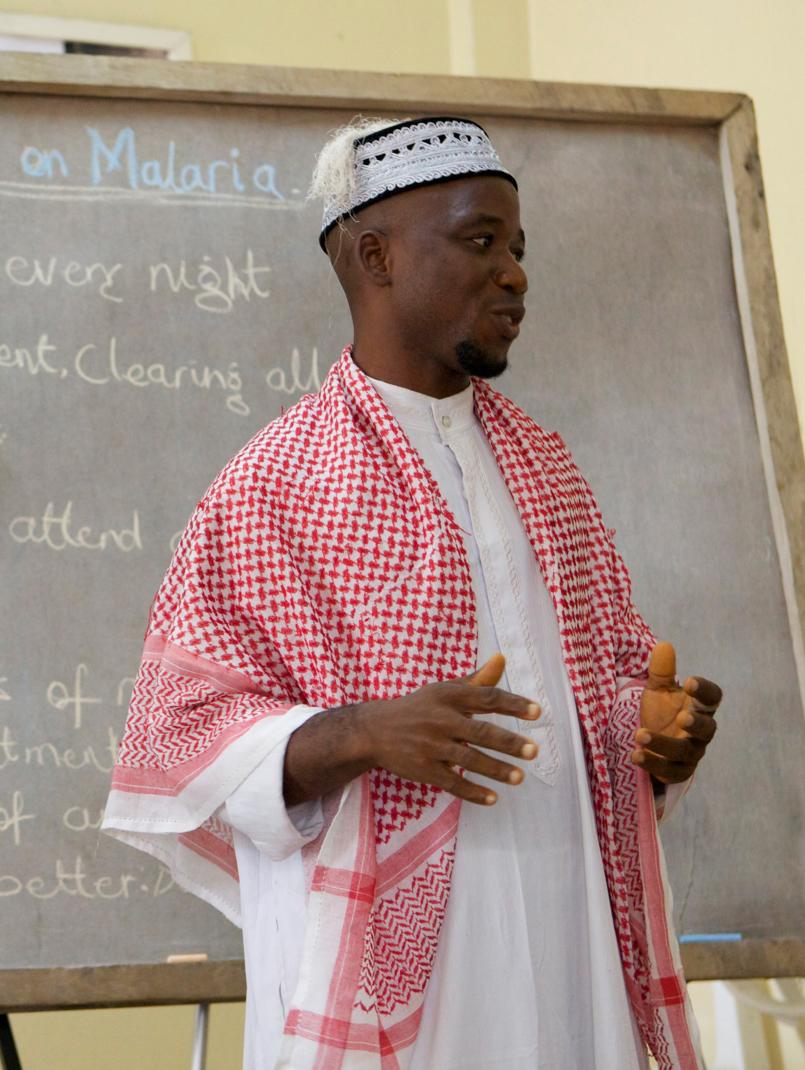7. Take a fresh perspective on FIOs in a rapidly-changing world.

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About this report

The Tony Blair Faith Foundation, which from its inception has highlighted both knowledge and action to enhance the role of faith institutions to benefit health in Africa, commissioned this review. Its aim is a stock-taking of what is known and what is not, and to contribute to formulating future research agendas. The report draws on WFDD and Berkley Center for Religion, Peace, and World Affairs, Georgetown University work on health and on extensive literature reviews and interviews with leading practitioners and researchers (some conducted for this purpose, others part of the Berkley Center series). It also draws on limited field investigation. The principal author of the report is Lynn Aylward. She also supervised a team comprised of Molly Brady, who contributed to Chapter 2 and Supplement 1, and Kari Nelson, who provided research assistance on Chapter 3. The authors of the case studies were Lynn Aylward, Katherine Marshall, and Claudia Zambra, with research and writing assistance on the South Sudan study by Elizabeth Bliss. The report was prepared under the leadership of Hahna Fridirici Kimbrough and Katherine Marshall. The review involved close collaboration with the TBFF with direction from Ian Linden and Jaclyn Andrasek. It was reviewed by an expert group including Dr. Michael Cappello of Yale University; Reverend Dr. Robert Dowd of the University of Notre Dame; The Reverend Canon Ted Karpf of the Boston University School of Theology; Dr. Mimi Kiser of Emory University; Dr. Bernhard Liese of Georgetown University; Professor W. Henry Mosley of Johns Hopkins University; and Reverend Monsignor Robert Vitillo, Special Advisor for HIV/AIDS at Caritas Internationalis.

The Tony Blair Faith Foundation

The Tony Blair Faith Foundation (TBFF) aims to promote respect and understanding about the world's major religions and show how faith is a powerful force for good in the modern world (See www.tonyblairfaithfoundation.org). One arm of TBFF is Faiths Act: a multi-faith global movement which inspires and mobilizes people of faith to take action towards the Millennium Development Goals. At the heart of Faiths Act is the belief that faith can be a Force for Good. Under the auspices of this aim and belief, TBFF funds research to highlight how organizations, communities and individuals inspired by faith are tackling the MDGs.

World Faiths Development Dialogue

The World Faiths Development Dialogue (WFDD) is a secular, academic, non-profit research organization based at Georgetown University. The WFDD has two central objectives: to reinforce, underscore, and publicize the synergies and common purpose of religions and development institutions addressing poverty; and to explore issues on which there is little consensus and where common ground is unclear among different faith traditions, within faiths, and between faiths and development institutions.

Acronyms	Definition
ACK	Anglican Church of Kenya
ARHAP	African Religious Health Assets Programme (the organization's name has recently changed to the International Religion Health Assets Programme or IRHAP)
ART	Antiretroviral Treatment
BCC	Behavior Change Communication
CBO	Community-Based Organizations
CCM	Country Coordinating Mechanisms
CGD	Center for Global Development
CHA	Christian Health Associations
CHAG	Christian Health Association of Ghana
CSSC	Christian Social Services Commission of Tanzania
CIFA	Center for InterFaith Action
CRS	Catholic Relief Services
DHS	Demographic and Health Surveys
DFID	Department for International Development
DOTS	Directly Observed Treatment Short course
DREAM	Drug Resource Enhancement against AIDS and Malnutrition
ECOSOC	Economic and Social Council
ELCA	Evangelical Lutheran Church in America
EPN	Ecumenical Pharmaceutical Network
ESD	Extending Service Delivery Project
FBO	Faith-Based Organizations
FIO	Faith-Inspired Organizations
GAIA	Global AIDS Interfaith Alliance
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIS	Geographic Information Systems
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.
IHFAN	International Health Facility Assessment Network
IHSN	International Household Survey Network
IMCI	Integrated Management of Childhood Illness
INGO	International Nongovernmental Organizations
INTRAC	International NGO Training and Research Centre
IRHAP	International Religious Health Assets Programme (also see ARHAP)
ITN	Insecticide-Treated Net
KANCO	Kenya AIDS NGO Consortium
LCMS	Lutheran Church-Missouri Synod
LFA	Logical Framework Approach
MKC	Major Disease Killers of Children
MDG	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results

MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Surveys
MOH	Ministries of Health
MoHSS	Ministry of Health and Social Services
MOU	Memoranda of Understanding
MTCT	Mother-To-Child Transmission
NGO	Nongovernmental Organization
NIFAA	Nigeria Interfaith Action Association
NORAD	Norwegian Agency for Development Cooperation
NPI	Nonprofit Institutions
NRO	National or Regional Organizations
PEPFAR	President's Emergency Plan For AIDS Relief
PIRCOM	Programa Inter Religioso Contra a Malaria
PLWHA	People Living With HIV and AIDS
PMI	President's Malaria Initiative
RAD	Religions and Development Research Programme
RHP	Religious Health Provider
SAM	Service Availability Mapping
SARA	Service Availability and Readiness Assessment
SPA	Service Provision Assessment
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TDI	Transformational Development Indicators
TMP	Traditional Medical Practitioner
UCMB	Uganda Catholic Medical Bureau
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	US Agency for International Development
WCC	World of Council of Churches
WCRP	World Council of Religions for Peace
WFDD	World Faiths Development Dialogue
WHO	World Health Organization

Chapter 1. Introduction to the Study

1.1 Background

Faith-inspired organizations (FIOs), which provide health care throughout the world, are particularly active in Africa. There is a large amount of information (as this study will detail) about the health work that faith-inspired organizations do, offering many different types of services, often under difficult conditions.

However, the information on faith-inspired organizations is not systematic or comprehensive, and there are many substantial gaps in knowledge about FIOs. A factor explaining these gaps is that there are tens of thousands of faith-inspired organizations working on health, representing different faiths and denominations, with great variation in size, structure, and other characteristics.

There are also shortfalls in the evidence about FIOs' effectiveness in carrying out health work and on the purported comparative advantages of FIOs, such as greater reach to the poor. While there are numerous "stand-alone" evaluations of certain types of FIOs' health work, few evaluations speak specifically to the faith-nature of the organizations and their health work, and the evaluation evidence on the whole displays weaknesses in analytical rigor and range.

These gaps of knowledge and evidence leave hanging some intriguing observations or beliefs about faith-inspired organizations: for example, that they provide higher-quality care than other health providers or do a better job of reaching the poor. Furthermore, the gaps are important because without solid information and understanding of important health care providers, national and international organizations cannot make optimal choices on health policy, practices, and investments. This is extremely important in Africa, where health challenges are enormous, resources are scarce, and public sector provision of health care is generally a work in progress.

These gaps in knowledge also tend to generate a number of uncertainties or even controversies about FIOs and their work. Indeed, it is a common assertion that thirty years after the health work of faith-inspired organizations became a field for research and inquiry by academics and other stakeholders, most of the early questions remain unanswered. As an example, it is often said that faith-inspired organizations provide 30 to 70 percent of the health work in Africa. If this estimate is accurate, it is reason alone for wanting more systematic information about FIOs, since they would constitute a huge share of the health sector in Africa. But as this study details, estimates of market share are still highly uncertain. Other uncertainties or controversies include whether FIOs are seriously underfunded in proportion to the amount of health work they do and whether parts of the international community are hesitant to work with faith-inspired organizations because of concerns about the potential divisiveness of religion, perceptions that proselytizing is integral to their health work, or other faith-specific considerations.

To address these gaps in knowledge and evidence, the Tony Blair Faith Foundation (TBFF) has launched a research project on the state of knowledge on faith-inspired organizations' engagement in health in

Africa and the evidence on their effectiveness and distinctiveness, partnering with the World Faiths Development Dialogue (WFDD).[1] The project's main output is a literature review–specifically, a review of the literature, data, evaluation reports, and other relevant information on FIOs' health work in Africa. The project aims to identify and reflect both on what is known about FIOs and their effectiveness and distinctiveness and what are the key gaps in knowledge, and to suggest future research priorities.

1.2 Outline and Scope of the Study

1.2.1 Outline of the Study

This study is composed of a Main Paper and a Background Paper. This, the main paper, has four chapters and a bibliography. Chapter 1 has four parts: the preface; this section presenting the outline and scope of the study; a section on essential framing information on faith-inspired organizations and health; and a section on the methodology for the study.

Chapter 2 presents the results of a survey of the literature, data, and other information focused on capturing the state of knowledge on FIOs and their engagement in health work in Africa. Chapter 3 presents results of a further review of the literature, drawing in particular on evaluation reports, and focuses on looking for evidence in two related but separate areas, one being the effectiveness of FIOs in terms of health outcomes and the second being purported comparative advantages of FIOs, such as reach to the poor. Chapter 4 presents recommendations on research priorities. A bibliography of sources completes the Main Paper.

The Background Paper has three sections. The first, Supplement 1, provides descriptive overviews of four important topics in FIOs' engagement in health in Africa. First covered in Supplement 1 are four of the main health challenges in Africa; namely, HIV and AIDS, malaria, tuberculosis, and the other major disease killers of children. Subsequent topics are traditional healing, interfaith initiatives, and behavior change communication. Supplement 2 presents case studies on five African countries; namely, Gabon, Ghana, Mozambique, South Sudan, and Tanzania. These descriptive narratives give a sense of how faith-linked health work in Africa actually operates on the ground and how historical events and differing policies have shaped very different health systems including roles of FIOs.

Supplement 3 contains two appendices, on evaluation in international development and a précis of a group of evaluation reports that is discussed in Chapter 3 of the Main Paper.

1.2.2 Scope of the Study

Since the study's main output is a review of the literature, data, and other relevant information, it tends to be encyclopedic. Therefore, delineating and sticking to the scope of the study seemed particularly important. Where a topic is relevant to FIOs and their health work but outside the scope of the study, there is an attempt to summarize the topic succinctly and refer the reader to key papers.

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[1] See the front matter for information on these organizations.

Please note that the expression "this study" is reserved to refer to this report, and "the team" always refers to the authors of this study.

The scope of this study is explained by considering each of three main "definers"-- namely, health, Africa, and faith-inspired organizations--in turn.

Health

Box 1.1 provides the definitions of health and health work used for this study. This study concentrates on physical health, though it also touches on mental health and well-being. It considers not just direct medical services but a full range of types of health work such as advocacy and social mobilization around health. This study pays special attention to four main health challenges facing Africa in Supplement 1. It does not explore every topic related to health (e.g., humanitarian relief and water and sanitation) due to limitations of time and space.

Africa

This study focuses on Sub-Saharan Africa, and uses the term "Africa" to refer to it. But it draws on literature on FIOs from the United States (US) and other regions, including North Africa and Asia. The team is keenly aware that Sub-Saharan Africa is composed of some 50 diverse countries, but for this study to be manageable and readable, reference is often made to Africa, in addition to individual African countries.[2]

Faith-inspired Organizations

Explaining the term faith-inspired organizations requires some elaboration. As noted, there are tens of thousands of faith-inspired organizations, working on health and international development, representing many faiths and present throughout the world; the great number and diversity helps explain why there are different terms, definitions, and categorizations for organizations with links to faith.

In the research field of faith and health/international development, classification issues are very important and not just academic fine points. As already noted, a reverberating theme in this field is that now, around the time of its 30th anniversary (more on this in Section 1.3), many key questions remain unresolved.

Defining organizations with links to faith that carry out health or other social or international development work is difficult for several reasons. The religious nature of organizations is not a binary variable of faith-based or secular, but rather falls on a complex continuum. Sider and Unruh (2004), leading scholars in the field, defined six degrees of religiosity of service organizations that range from faith-permeated, the most strongly faith-based, to faith-founded or faith-secular partnerships, which are

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[2] Different sources count the number of countries in Sub-Saharan Africa slightly differently, e.g., depending on whether Mauritius is included; the exact number is either 48 (excluding Mauritius) or 49 (including it), and we use the expression "some 50 countries" for convenience.

lesser degrees. They also distinguished organizations versus programs, since the religious characteristics of an organization can differ from that of the programs it operates. Secular organizations employ faith-motivated personnel (and vice versa) and sometimes employ religious symbols and references and run faith-based programs (Smith, Bartkowski, and Grettenberger 2006).

Box 1.1. Definitions

Faith-inspired organization. This study uses a WFDD definition: a network, organization, program, project, facility, congregation, community, small group of individuals, faith leader, or other individual with links to or inspired by religion or spirituality, and a faith or denomination and the structures or individuals within it, providing or supporting social services. The term focuses on identifiable organizations but can include, albeit rarely, individuals, e.g., a faith leader.

Health. This study broadly adopts the Merriam-Webster definition of health as the general condition of a person in mind, body, and spirit, usually meaning to be free from illness, injury, or pain. This definition was chosen over the World Health Organization definition —"a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity"—in order to encompass the spiritual dimension. The study focuses on physical health and on major global public health priorities, but touches on well-being and mental health, and gives examples of FIOs' work on physical health that also address well-being and mental health.

Health work. This study employs a broad definition of health work to include not just health care (the diagnosis, treatment, and prevention of illness, injury, and other physical impairments), but also the many other activities undertaken in order to improve human health. Health work thus also includes education and training of health workers; counselling related to well-being and mental health; behavior change communication, health education, and social mobilization; supply of pharmaceuticals and other health materials; and networking and intermediation, advocacy, and financing to support health outcomes. However, even though many diverse aspects of human welfare are parts of health (e.g., water and sanitation), the study focuses on physical health.

Another challenge is that faith-linked entities may not be formal organizations or physical facilities at all, but rather small groups of individuals or other community-centered formats, possibly acting without any formal ties to a religious organization but nonetheless motivated by faith.

There is also the question of distinguishing between, say, actual faiths or denomination and/or their hierarchies (e.g., the Catholic Church; the Lutheran Church-Missouri Synod (LCMS)) versus the (possibly many) organizations that may be associated formally with the faith or denomination (e.g., for the Catholic Church, inter alia, Catholic Relief Services; the many different Catholic orders; and individual Catholic parishes; for the Lutheran Church-Missouri Synod, LCMS World Relief and Lutheran World Relief, plus individual Lutheran parishes) versus other organizations that have, respectively, a strong Catholic or Lutheran identity but have weaker or formal association with the faith hierarchy (e.g., for the Catholic Church, the Catholic Medical Mission Board).

The reader is referred to a report by the Berkley Center for Religion, Peace, and World Affairs, with which the WFDD is affiliated and works closely, that overviews FIO classification issues (Marshall et al 2007) and to Smith and Sosin (2001), Sider and Unruh (2004), Clarke (2006), and many of the other papers on the websites of the Berkley Center, the International Religious Health Assets Programme (IRHAP),[3] and WFDD. Also, Figure 1.1 provides a useful schematic developed by the Center for Interfaith Action on Global Poverty (CIFA 2010). CIFA is an organization that promotes partnerships between the religious sector, governments and international institutions to integrate the leadership and behavior change capabilities of faith leaders into government-led health and development campaigns, emphasizing interfaith approaches. Its diagram indicates different types and levels of faith-inspired entities.

Figure 1.1 CIFA's Landscape of Faith Actors

Source: CIFA. 2010

It is beyond the scope of this study to review, let alone attempt to resolve, classification issues. This study mainly uses the term "faith-inspired organization," as defined by WFDD and presented in Box 1.1. When referring to a source that uses a different term or depending on the context, other related terms are sometimes used, such as the very common "faith-based organizations" or IRHAP's term of "religious health assets." This study also identifies main types of FIOs as follows, drawing on work by WFDD and on the CIFA diagram:

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[3] Recently, IRHAP changed its name from the African Religious Health Assets Programme (ARHAP). Both acronyms will be used in this study, especially since bibliographic references will be to publications put out by the Programme when its name was still ARHAP.

- Faith-inspired community-based groups and local congregations and their associated voluntary groups (CBOs)
- Faith-inspired hospitals, clinics, and related facilities
- Faith-inspired national or regional organizations, including local NGOs, national denominational structures, and organizations that provide representation, leadership, and/or coordination to FIO members, such as the Christian Health Associations in various countries (NROs)
- Faith-inspired international organizations, which include nongovernmental organizations (INGOs) and international movements, orders, networks, and religious/denominational hierarchies headquartered outside Africa.

These categories are not exhaustive or mutually exclusive. When the above acronyms are used in this study, the default is that they refer to faith-inspired organizations, and if, for example, a non-faith-inspired community group is being referred to, it will usually be specified as a "secular CBO."

A final point on the scope of this study is that it is very much about faith-inspired <u>organizations</u> and health, and not about personal faith and health per se. There is of course overlap between FIOs and individual faith, and some of the overlap is within the scope of this study, for example, whether and how the faith-inspiration of those who work for FIOs might impact the organizations' performance. But mostly, this study is <u>not</u> about how personal faith or religious practices interact with personal health. The reader is referred to the major review that found much evidence supporting a correlation between religious involvement and positive health outcomes (Koenig, McCollough, and Larson 2001) [4] and to the rebuttal of that review in Sloan (2006).

1.3 Essential Framing Information on FIOs and Health

This section covers three topics on which information provides crucial context for the rest of this study. The topics are a short history of FIOs and their involvement in international development and health; the question of group identity; and FIOs' purported comparative advantages or distinctive features.

1.3.1 A Short History of Faith-Inspired Organizations

The links between faith and health are ancient, strong, and numerous. Muslim hospices lined the major routes to the Hajj in the year 1000, providing care for pilgrims. The first written record of inoculation for smallpox, also around the first millennium, is attributed by different sources to either a Buddhist nun in China or to Hindu-inspired Ayurvedic texts. Indeed, for most of history, faith healing was the only kind of healing, and it is still in wide use, especially in sub-Saharan Africa (See Supplement 1).

There are many reasons for the strong links between faith and health. Before modern science developed, people looked to spirits for causes and cures of physical illness, and even now, people look beyond science in dealing with health problems. Much religious language, ritual, and regulation relate to physical as well as spiritual health. Also, health care fits fundamentally with the belief of the major world religions in compassion and care for the human person.

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[4] An updated version of this book is coming out in 2012.

FIOs have been active in health care in low-income countries for over a century, and missionary activities first launched modern health services in many countries (Marshall et al 2007). FIOs' engagement in health today remains strong, and not just in low-income countries. In the United States, the Catholic Church is the single largest private provider of not-for-profit health care, and Catholic hospitals account for 20 percent of US hospital beds (Fogel and Rivera 2003). The role of FIOs is smaller but still important in Europe, Canada, and Japan, where strong national health schemes have limited the reliance on them.

For a long time, the discipline of international development ignored or was even hostile to faith matters, even though FIOs were in the forefront of service delivery and social movements (Aiken 2010; James 2009; Petersen 2010; Rakodi 2007; Tyndale 2006). This was because of sensitivies around culture, morality and the colonial associations of FIOs. The same caution about dealing with faith pertained regarding health work, though a key exception is the engagement of the World Health Organization (WHO) and some other United Nations agencies with faith (see below).

Gradually, parts of the global health and development community are becoming somewhat more open to engaging with faith and faith-inspired organizations (Clarke 2006; Rakodi 2007). Development organizations have taken note of FIOs' vast networks and the high levels of trust they inspire (Marshall 2011). The WFDD was created by the then-President of the World Bank and the then-Archbishop of Canterbury in 1999, in recognition of the role religion plays in development. The events of 9/11 further increased realization of the centrality of faith (Kirmani and Davis 2010; Peterson 2010), also widening perspectives beyond a traditional focus on predominantly Christian FIOs. Evidence of greater engagement includes more funding from and engagement by national donors, examples being the Dutch, Norwegian, UK, and US international aid agencies. The US government alone almost doubled its funding for faith-based organizations from 10.5 to 19.9 percent from 2001 to 2005 (Clarke 2006).

WHO has a long, strong history of engagement with FIOs. In an issue of its magazine *Contact* marking the 30 year anniversary of focused work on faith and health, the World Council of Churches (WCC) reviews this engagement (Kurian 2011). Specifically, the WCC's Christian Medical Commission along with faith-based and civil society partners worked with WHO and UNICEF on the concept of "Health for All," culminating in the 1978 Alma Ata declaration that established the criticality of primary health care. The publication in 1981 of a highly-regarded book on mission health work by the first director of the CMC, James McGilvray, also covers some of this history. Since then, WHO has recognized the role of FIOs in health care in official documents and statements and commissioned work on FIOs' roles (ARHAP 2006; Bandy et al 2008) and co-hosted with CIFA a consultation titled, "NGO Mapping Standards Describing Religious Health Assets" (WHO-CIFA 2010). It is not clear what specific plans WHO has for further deepening its engagement with FIOs.

The United Nations Children's Fund (UNICEF) notes that "Long before there was a UNICEF, faith communities were among the greatest advocates for the world's neediest children." The agency has recently issued a guide for strengthening partnerships with religious communities (UNICEF 2012). The United Nations Population Fund (UNFPA) points to a 30-year legacy of partnerships with faith-based constituencies in the areas of reproductive health and population (UNFPA 2008) and the UN has an Inter-Agency Task Force on Faith-based Organizations and the Millennium Development Goals (MDGs).

The UNICEF guide (2012) makes the point that concerns about partnering pertain to both sides of secular and faith-inspired organization partnerships. While international development actors have had

hesitancies about working with FIOs, faith-inspired communities may have reservations about working within secular structures and being co-opted to achieve secular goals and about the goals, programs, and language of secular actors that may be in conflict with core religious beliefs and values.

Other organizations and sectors are also paying growing attention to the field of faith and health. Initiatives in addition to those already noted (e.g., CIFA, IRHAP, TBFF, and WFDD) include the Religions and Development Research Programme Consortium at the University of Birmingham (RaD); the annual European Conference on Religion, Spirituality, and Health; a 2011 conference on religion in health and healing at Heythrop College of the University of London; DIFAEM - German Institute for Medical Mission; the Center for Strategic & International Studies' 2012 project on the American faith community's contributions to global health; the Religion and Public Health Collaborative at Emory University; and Duke University's Center for Spirituality, Theology, and Health. Although articles and books on faith and global public health often comment that the field is over-looked and under-researched, and while the team agrees key questions remain unanswered, the many initiatives and institutes focused on the field are evidence that faith-inspired organizations' engagement in health is not a new, small, unexplored, or niche area.

1.3.2 Faith-inspired Organizations and Group Identity

Whether or not faith-inspired organizations constitute a group, with certain shared attributes or tendencies, is an important question for this study and for global health and international development. The team perceived some cognitive dissonance around the question. Many stakeholders seemed to affirm that FIOs do represent a particular class of development organizations that share tendencies toward some characteristics and are often perceived by themselves and by others as a group. Support for this includes, among other things, the programs or engagement targeted at FIOs that various large institutions operate, e.g., the Global Fund for AIDS, Malaria, and Tuberculosis (GFATM) or USAID. Rick James of the International NGO Training and Research Center (INTRAC), for example, states that faith identity can have profound organizational implications (James 2009). Moreover, pragmatically, if FIOs are not in any significant sense a group, the large amount of work devoted to faith and FIOs in health noted in the previous paragraph is perplexing.

But, returning to the cognitive dissonance, other involved parties—and sometimes the same stakeholders who in a given context frame FIOs as a group—question a collective identify for FIOs because of the great variety among them. Mark Chaves, Professor and Scholar at the Duke Center for Spirituality, Theology, and Health and Director of the National Congregations Study questions the sharpness of distinctions between religiously-based and secular and public social services (Chaves 2004) and WFDD Executive Director Katherine Marshall finds the idea of a "faith sector" problematic, noting that distinguishing FIOs from secular organizations may obscure common features and accentuate unnecessary and perhaps unuseful dichotomies (Marshall et al 2007).

Also relevant is a quick word on how FIOs are grouped with other sectors. FIOs may be classified as part of civil society, the private sector, the non- or not-for-profit sector, or even the public sector (when they receive significant amounts of public monies or are otherwise intertwined with government).

Notably, many of the issues that complicate the study of FIOs pertain for civil society as a whole. Consider this statement by Lester Salamon, Director of the Center for Civil Society Studies at Johns Hopkins University and leading scholar of the nonprofit sector:

"Despite the promise that this (sector) holds, however, the nonprofit or civil society sector remains the invisible subcontinent …poorly understood by policymakers, inadequately utilized as a mechanism for addressing public problems. One reason for this is the lack of basic information on its scope, structure, financing and contributions in most parts of the world."

The Center for Civil Society Studies, a leading initiative to put the civil society sector on the economic map, has found that if properly measured in national systems of accounts, civil society would be roughly the eighth largest sector in the world in terms of value, with the nonprofit institutions (NPIs, which would include most FIOs) of just 40 measured countries representing US$2.2 trillion in operating expenditure (Salamon 2010). Salamon (Ibid) found that NPIs are distinctive from other sectors in many ways, ranging from their production functions to staffing structures. The work of Salamon and the Center suggests to the team that a sector can have a group identity even with staggering variety within it. This forms the basis for this study's working approach, which is that it is valid to talk about FIOs as a group with the understandings that there is great variation within it and that observations about FIOs are in the spirit of central tendencies and not straitjackets. The Center's work also suggests that establishing definitions, typologies, and models and collecting data on a diverse sector is possible, even though highly demanding.

1.3.3 FIOs' purported comparative advantages or distinctive features

Another crucial question for this study—and one related although not identical to the question of whether FIOs constitute a group—is whether FIOs exhibit certain attributes linked to faith that make them particularly effective at health and international development work.

Such purported attributes are often referred to as "comparative advantages," though the term is controversial, as shortly discussed. A list of the commonly-cited comparative advantages appears in Box 1.2. It makes sense that religious actors would tend to possess these attributes; for one example, most of the world's religions extol compassion for and service to those in need and it makes sense that such values could enhance health work. For another, most faiths have active support from a committed constituency and strong, extended, long-lived grassroots networks. (For discussions of comparative advantages, see Bandy et al 2008; CIFA 2009; James 2009; Lipsky 2011; Marshall and van Saanen 2007; Rakodi 2007; and Vitillo 2009). Indeed, the increased engagement of the US government with FBOs was underpinned to some extent by the belief of some that FIOs were better at providing social services (See George W. Bush quoted in Johnson 2002).

However, many stakeholders, including FIOs, do not like the term "comparative advantages," because it implies that FIOs possess the properties in question to a greater extent than other non-religious organizations active in health or development. These stakeholders point out that secular development organizations and/or secular individuals (who might work in faith-inspired organizations)—not to mention public health providers—may be equally compassionate or highly-committed. Therefore, some prefer other terms such as the distinctive features of FIOs. This study uses both comparative advantages and distinctive features, usually modifying the former with "purported."

Regarding the terminology, the team observes that strictly speaking the term "comparative advantage" would not mean that FIOs possess a given factor and other organizations do not, or even that FIOs and

secular organizations might both possess a factor but FIOs are absolutely stronger or better at it.[5] Nonetheless, the term "comparative advantage" may be falling out of favor.

Box 1.2 Comparative Advantages Attributed to Faith-Inspired Organizations

Adapted from various sources, including the Berkley Center/WFDD (various) and CIFA(2010)

Compassion – The world's major religions broadly share fundamental values such as care and compassion for the poor and marginalized, respect for human dignity and the family, and pursuit of social justice.

Holistic approach to health – Faith actors' holistic approach to human health values social, emotional, and spiritual outcomes in addition to the physical health of the individual.

Ubiquitous presence – Faith entities are active in every country and at all levels of society. Faith entities serve even in the most remote areas where public or private service providers may be absent.

Durability – Churches and FIOs have been in place in some countries and situations long before governments or secular NGOs were factors.

Extensive networks – Faith entities have strong, extended grassroots networks within communities and that bridge borders and connect developed and developing countries.

Credibility and trust –Faith leaders and institutions have significant stature and influence, both within and beyond their congregations and communities. Recent studies show that faith organizations are more trusted than any other local institutions, including police, government, and NGOs.

Reach to the poor, rural, marginalized, and those living in conflict areas – FIOs provide services in areas or to communities that are otherwise underserved and remain in areas even in conflicts and disasters.

Highly-committed constituency – Motivated by faith, staff often work under difficult conditions with few resources and are resilient in the face of challenges and setbacks, while FIOS attract many volunteers who provide their services for free.

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[5] Rather (harkening back to the 18th century, David Ricardo, creator of the law of comparative advantage, and his two stylized economies making wine or cloth), "comparative advantage" would imply a factor that FIOs are relatively, not absolutely, stronger in, meaning relative to the full range of relevant attributes that FIOs and non-faith-inspired health providers might possess.

Assets for health and development – Faith institutions own and provide important physical assets and service delivery channels, including houses of worship, schools, clinics, training centers, and hospitals.

There are also things that FIOs might bring to health work that are faith-related or faith-distinctive but that do not fit as comparative advantages and may be viewed negatively by some, examples being proselytization, religious stances on specific health practices such as blood transfusions or the use of condoms, and faith healing in place of evidence-based medicine. A dismal chapter for faith in Africa and elsewhere is the stigmatization around HIV and AIDS that some churches and their faith leaders fostered in the earlier days of the health crisis. Religion has been a factor, though not necessarily the primary one, in some incidents of communities objecting to vaccination campaigns (Aylward 2011).

FIOs may also have comparative organizational weaknesses. Lipsky (2011) suggests that FBOs may be less accountable than other NGOs since they may owe allegiance to "their faith and God" in addition to funders or other earthly stakeholders (See also Salamon 1987 and Smith, Bartkowski and Grettenberger 2006). Moreover, to the extent that religion can be highly-divisive, cause conflict or violence, and promote questionable values such as unequal rights for women, this can reflect on faith-inspired organizations.

This study thus sometimes uses the term "faith factor" to cover any factor, positive or negative, that is a faith-related feature of an organization or health programs, including but not limited to comparative advantages/distinctive features.

1.4 Methodology of the Study

1.4.1 Overview of Methodology

In applying the methodology described below, the team drew on its collective backgrounds in the field of FIOs and public health and on WFDD's extensive work in these areas; for example, this background guided the team in compiling a list of experts to contact for interviews. The team also drew on IRHAP's path-breaking literature review (Olivier, Cochrane, and Schmid 2006).

One main methodology was searching and reviewing literature, data, and other information on FIOs and their health work (details are provided below). A second method was the interviews with experts mentioned above: the team developed a list of representative experts from different faiths and types of FIOs and interviewed those who were willing. The team also drew on the many interviews conducted by the Berkley Center/WFDD and published on its website, and on less formal exchanges with experts via e-mails and encounters at professional events. When such information is used in this study, the reference specifies "Interview," along with the name of the expert and the year when the interview was conducted or the other personal communication took place.

1.4.2 Methods for Chapter 2, State of Knowledge on FIOs

To capture the state of knowledge on FIOs' health work in Africa, the team searched for and reviewed data sources, public health literature, and other relevant information, e.g., from FIOs' websites; while this study sometimes uses the shorthand of a "review of the literature" or "literature survey," this refers to the broader search for data and information that went beyond review of academic literature.

For the literature survey, the team searched on the words Catholic, Christian, church, faith, faith-based, and faith-inspired, hospital, Islam, mission, Muslim, religion, and religious, and religious (searching on individual words and combinations, e.g., "faith-based organization" and "mission hospital") in PubMed, a database accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The original search did not include the terms "private" and "private sector" because these tended to return too many non-relevant studies but in retrospect, given FIOs are part of the private sector, though not always acknowledged to be so, these terms should have been included, albeit with filters. Related searches were also carried out in Google, in order to go beyond the academic literature. Returned articles or documents were reviewed for relevance and a snowballing approach was used by following up on the bibliographies of the returned articles. The team also searched the websites of a range of faith-inspired organizations for relevant, reliable (e.g., non-anecdotal) information. The team brainstormed to find other sources of information not part of the typical faith-health literature, e.g., World Bank studies on African private health sectors that contained information about FIOs.

The team also searched for data bases or sources that included data on FIOs' health work. The team started with databases or data sets of three premier sources, the WHO, MEASURE, and national Ministries of Health of African countries. It used these sources, Google searching, and networking with experts to find other sources of data touching on FIOs' health work, such as household surveys compiled by the World Bank and data sets maintained by institutions such as GFATM, the President's Malaria Initiative (PMI), and Christian Health Associations (CHAs) or other, e.g., Catholic, faith-inspired coordinating bodies.

With the literature and data review on the state of knowledge on FIOs complete, the team organized the accumulated information according to 10 parameters that the accumulated information suggested were important for characterizing the state of knowledge on FIOs.

1.4.3 Methods for Chapter 3, Evidence on FIOs' Effectiveness and Distinctiveness

As noted above, the objective of Chapter 3 was to look for evidence on the effectiveness of FIOs and on their purported comparative advantages or distinctive features. The team treated these as two distinct albeit related topics, with the first focusing on effectiveness in terms of achieving stated health objectives of a health facility or program and the second on evidence of FIOs' purported comparative advantages. For two reasons (the list of purported comparative advantages is relatively long and varies from one source to another; and the evidence on distinctive features is limited), the team focused on two distinctive features: (i) reach to the poor and other vulnerable groups such those living in rural areas or conflict zones or otherwise marginalized in society and (ii) greater commitment of those working for FIOs (whether staff or volunteers) or of a FIO as a whole to the mission of serving the sick and needy.

The team augmented the literature review described for Chapter 2 by searching also on the terms comparative advantage, conflict and conflict zone, effectiveness, evidence, marginalized, performance, poor, rural, and underserved. In addition, since the focus was on evaluation literature and such studies are not always captured in PubMed or Google, the team searched for information from major funders of international development, both national agencies, such as the UK's DIFD, and international organizations such as GFATM. It also searched for evaluations by consulting firms that carry out such evaluations and on FIOs' websites, whether authored internally or be third parties. The team also searched for evaluations through websites focused on international development evaluation such as that of the International Initiative for Impact Evaluation (http://www.3ieimpact.org/) and UK DFID's

Research for Development or "R4D" website (http://www.dfid.gov.uk/R4D/). The team found that many national aid agencies do not publish evaluations of individual health programs, a notable exception being USAID which aims to provide, on its "Development Experience Clearinghouse" website (dec.usaid.gov), all evaluations carried out on programs it funds. (As examples of its breadth, searches of the database yielded 351 results for evaluations of programs carried out by Catholic Relief Services and 291 results for World Vision, though some of the results seemed to be duplicates).

As further detailed in Chapter 3, the team sorted evaluations into three categories: stand-alone, comparative, and faith- specific assessments. As for Chapter 2, the team drew on interviews and other personal communications, in particular always asking experts what they considered good evaluations or other sources of evidence on FIOs' effectiveness or distinctive features.

1.4.4 Methods for Supplements 1 and 2

For Supplement 1, which covers four special topics on FIOs and health, the main methods were literature review and interviews, as described for Chapters 2 and 3, but with the search terms modified accordingly.

For Supplement 2, the team prepared descriptive narratives of how faith-linked services actually work in five countries. The countries selected were Gabon, Ghana, Mozambique, Tanzania, and South Sudan. The five countries were selected through discussion among the team with the objectives of achieving variety in terms of region, population, income, stability, and faith traditions, drawing on the team's backgrounds for reasons of efficiency but also steering away from some countries that are particularly well-reviewed, e.g., Kenya. The descriptive narratives were produced with a mix of desk research, interviews, and personal background, e.g., the author of the Ghana case study has written extensively on the country. In one case, for Gabon, field work was also carried out, because the author of that study was visiting the country for other reasons. The case studies address the country's health and religious profiles, summarize information on the FIOs at work on health, and cover some key features or issues of the faith-health work in the country.

Chapter 2. State of Knowledge on FIOs' Engagement in Health in Africa

2.1 Introduction

Despite the long history of and great current interest in FIOs and their health work, major gaps in data and information persist. The observation that "With increased attention and urgency to [the topic] comes the confounding realization that little is actually known about religious organizations or initiatives working in health," (Olivier, Cochrane and Schmid 2006) is echoed by others (Bohnett and Zambra 2010; WHO-CIFA 2010). This Chapter reports on the search for and review of the relevant literature, data, and other information on FIOs' engagement in health in Africa.

2.2 Literature Review

The review of literature and other information carried out per the methodology described in Chapter 1 yielded some 500 documents, ranging from academic literature in peer-reviewed journals to self-reports (non-peer-reviewed) by FIOs, often tending toward the style of descriptive brochures, to evaluations (which are covered in Chapter 3). The team was struck by the fact that new sources continued to emerge through various other paths, confirming the finding that there is much information available on FIOs and their health work that is not easily captured in conventional literature searches, because, for example, the information is on the websites of individual institutions (for example, the Uganda Catholic Medical Board has over fifty articles on its website http://www.ucmb.co.ug/) or because articles that address faith-based health facilities or programs are not key-worded to capture this. In the end, the team cited some 200 of the documents found via the information search in this study, and those comprise much of the bibliography, though some sources used for background are also cited therein. Section 2.4 presents the results of the information review, synthesized and organized according to ten main parameters. First, the results of the data review, a discrete aspect of the broader information review, are discussed.

2.3 Data Review

In an ideal world, data bases, sets, or sources would provide systematic data on FIOs and their health work, and while any given one of such hypothetical sources might not be comprehensive or complete, most would cover a population or representative samples thereof and collect data that would be comparable from one data set to the next. Taken as a group, these ideal data sets would cover many parameters of interest, for many regions and type of FIOs.

The reality is that the team found no data sets specifically focused on FIOs' health work that were even relatively systematic or comprehensive. There is in fact quite a lot of data on FIOs, but the data and information are scattered throughout different disciplines, organizations, and databases, and are difficult to consolidate within a country or across countries. Data derive from vastly different methodologies and indicators: there are differences in classifications of faith-inspired organizations and variations in coverage, such as inclusion or not of community-based efforts. The information is also incomplete due to the sheer number of organizations and projects and the fact that Africa is composed of 50 very diverse countries. Olivier (2011) notes that some data may be available only in-country, often

in non-electronic formats, and possibly accessible only through personal relationships. Moreover, useful data on FIOs may be "hidden" within databases or reports.

Despite these gaps, a number of relevant and useful data sets do exist. They can be divided into two types: (i) international health data not focused on FIOs but including some FIO data and (ii) FIO-focused datasets, often derived from mapping exercises. A strength of the former is that several are high-quality databases that are comparable across time and geography, and publically-available, albeit with long lags (e.g., the WHO data described below); the weakness of these sources is that, at least so far, they do not provide much faith-specific data. The strength of the FIO-focused data is that they are detailed; the weakness is that mapping exercises are snapshots of a specific region, faith, type of FIO, or health concern, covering a limited range of indicators, often not publically-available, and thus having limited use for wider extrapolation about FIOs' health work. Table 2.1 presents the results of the search for data sources on FIOs' health work in Africa, listing the source and information on its coverage. The most important data sources listed in the table are discussed below.

2.3.1 International health data not focused on FIOs

Considerable data and information are collected on countries' health systems. However, most does not identify FIOs and their work. Where FIOs' contributions are captured, it is generally through identification of ownership/management of facilities, and in many publically-available data sets, relatively few indicators are presented by ownership/management; for example, basic indicators such as number of facilities or beds may be broken down by ownership/management, which may include designations such as "faith-based" of "mission-operated" but more granular data, such as data on child services, are not, though there are exceptions as noted below. Even when ownership/management data specify faith-based providers, this information is sometimes "scrubbed" in published data, which would then only distinguish public and private providers. A major opportunity for those interested in accessing quality data on FIOs' health work would be to advocate with the various involved organizations for better capture of FIOs, and some work has already been accomplished in this regard, as noted below.

An entry point into the world of health system data collection is the International Health Facility Assessment Network (IHFAN), a multi-agency network committed to strengthening health facility-based data collection and use worldwide (http://www.ihfan.org/home/). Activities of this group include helping users better understand existing health facility assessment and the development of a core set of indicators for cross-country comparison of health systems performance. IHFAN membership includes major players in health system data: Ministries of Health in low-income countries, the WHO, UNICEF, USAID and its partner MEASURE, the World Bank, and others. IHFAN's networking function means information on the main global health systems data sources (SARA, SPA, and other main data sets that will be described below) are provided on its website, along with links to other global health data networks such as the Health Metrics Network (HMN) and the Routine Health Information Network (RHINO).

Each African country's health ministry collects and maintains health data and statistics. These country data sets cover a wide range of information such as number of facilities and beds, availability and use of maternal-child health services, disease incidence, hospital supplies, and other parameters, plus facility registries that usually provide location through addresses and sometimes GPS coordinates. These national data sets generally are weak at capturing CBOs and their quality and coverage vary by country.

For some countries, e.g., Kenya, the data sets are extensive and available on sophisticated web platforms (http://opendata.go.ke/page/health).

The WHO's Service Availability and Readiness Assessments (SARA) is a new health facility assessment tool and survey designed to assess the service availability and readiness of the health sector in a given country at the district level and generate data that are comparable across time and geography (See http://www.who.int/healthinfo/en/). SARA replaced the Service Availability Mapping (SAM), an earlier health data tool in use by the WHO until 2009. SAMs for eight African countries (and no SARAs, yet) are available on the WHO's website. [6] One of the first questions in the SAM and SARA questionnaires is on facility ownership or management, and one of the choices for this question is "faith-based/mission" owned or managed. The SARA goes on to collect data on service delivery, medical equipment, basic amenities such as water and electricity supply, essential medicines, diagnostic capacities, and on the readiness of health facilities to provide services related to family planning, child health services, obstetric care, HIV and AIDS, TB, malaria, and non-communicable diseases. Since SAM and SARA collect information on the managing authority (e.g., government, faith-based, private for profit, etc.), they can potentially be a rich source of data on FIOs' health work. Limitations are lack of consensus at present on how the SARA data will be presented; confidentiality issues around using SARA information for mapping and describing findings by type of facility; and long lags before data become available. However, researchers can request datasets that allow identification of facilities by GPS and by managing authority.

Since the WHO health data tools and surveys are so important, stakeholders wishing to improve FIOs' data have focused on encouraging the WHO to add more FIO-specific information to the SAM tool. CIFA and the WHO co-hosted a 2009 international consultation titled "NGO Mapping Standards Describing Religious Health Assets." CIFA reported in May 2010 that the consultation yielded agreement on revisions of SAM that include adding indicators for describing religious health assets as part of the minimum standard dataset and that the WHO tested and distributed the updated survey, along with guidelines to national governments regarding the importance of including religious health assets. The faith-based module, which WHO reports as still in draft, includes five questions, on (1) the faith affiliation of the facility and whether it (2) has a place of worships; (3) has spiritual care providers; and (4) is part of a network; the fifth question asks for the name of the network. CIFA reports that WHO is now using the survey tool consistently in their mapping work, after having good results from a pilot in Burkina Faso. WHO emphasizes that it is up to each country to decide if it wishes to use the faith-based module. Also, it could take up to a decade for results from the faith-based module to become public. Since WHO reports the module is still in draft, the team notes it may be worth re-evaluating whether the five questions in the current draft module are ideal or sufficient for the goals that FIO stakeholders have for the SAM/SARA data-gathering efforts, as well as whether SAM/SARA are the best or an exclusive modality, since these data tools do not focus on capturing information on health costs, quality of care, and other parameters that may be of interest to FIO stakeholders.

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[6] See http://apps.who.int/healthinfo/systems/datacatalog/index.php/catalog.

CIFA also reported, as follow-up to the 2009 consultation, the possibility of organizing a comprehensive mapping of religious health assets in one or more relatively well-mapped African countries, with expressions of interest by several institutions in participating in an international consortium to undertake a global RHA inventory in Africa, Latin America, and Asia in 2011. However, work on collecting FIOs' data has been transferred from CIFA to WHO.

Other major data sets are the Demographic and Health Surveys (DHS) and Service Provision Assessments (SPAs) produced by the Monitoring and Evaluation to Assess and Use Results, Demographic and Health Surveys (MEASURE DHS). MEASURE, which is funded by USAID, provides technical assistance and produces surveys and data on health and population trends and the health sector in developing countries. DHSs sample clusters of households, asking individuals about their health and healthcare. They include a few questions on religion, e.g., religious affiliation of respondents and the identity/affiliation of places where people obtain some specific services, notably HIV and AIDS, reproductive health, and child health services. SPAs are facility-focused surveys, and ownership/management information is collected, although the degree, consistency, and confidentiality of these data vary. Some SPAs provide quite useful information on FIOs; see for example, tables from Tanzania's SPA that are used on the MEASURE website to explain how to read SPA tables; these tables provide breakdowns of child health services by ownership of facility, including faith-based. [7]

Various household surveys carried out by the World Bank and others provide data on a wide range of socioeconomic areas; the International Household Survey Network (http://www.internationalsurveynetwork.org) provides a gateway to these data, which can be searched for faith- or religion-related variables. Olivier and Wodon (2010) have found that a third of household surveys include information on health services disaggregated by the ownership affiliation of facilities. Household survey data are important because, like DHSs, they provide data from the demand side, i.e., utilization data, while facility-focused surveys provide data mainly from the supply side.

2.3.2 FIOs-focused data

Registries managed by national and international bodies that collect information on civil society organizations where faith basis may be included or inferred from names are another source of data. For example, the UN maintains various registries of civil society organizations; GFATM maintains data specifically on the FBOs that have been recipients of its funding. However, such datasets usually only contain the name and country of the organization.

The CHAs and the sometimes separate Catholic health associations of Africa maintain lists of their members and reportedly have other data, but such data are not publically available on CHAs' websites. [8] Tanzania's CHA, the CSSC, has participated in a mapping exercise of its members' facilities; a report on the exercise has been published, and the data may be available upon request.

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[7] See http://www.measuredhs.com/pubs/pdf/DM13/DM13.pdf.

[8] Kenya, Uganda, DRC, Cameroon, Tanzania, Ghana, Zambia, Senegal, Sierra Leone, Liberia, Togo, Nigeria, Central African Republic, South Sudan, Zimbabwe, Malawi, and Lesotho. See www.africachap.org.

Some US datasets are noted here, as they touch on health or international development. The National Congregations Study is a large high-quality survey of a representative sample of US churches, synagogues, mosques and other places of worship. It gathers information on a wide range of characteristics and activities of congregations, including whether a congregation offers health programs or has members who have traveled outside the US to help people in need. The US National Council of Churches carried out a 2007 survey on the health activities of 84,400 congregations. The team searched for congregational studies for Europe and Africa. It found that UK congregational studies tended to focus on topics other than health, and that there are various congregational studies available for African countries and some touch on health issues, e.g., "the Malawi religion project" (Adams and Trinitapoli 2009) has been used to explore the impact of religion on HIV, AIDS, and family planning.

Mapping exercises have tended to be the main context for the most FIOs-focused data for African countries. Mapping in the social sciences context generally refers to the combination of Geographic Information Systems (GIS) or other means to produce geographical maps that on a stand-alone basis or combined with additional data and tools can be used to answer research or operational questions.

Mapping is considered crucial in public health, and since some stakeholders suspect that FIOs are underappreciated, overlooked, and underfunded relative to the amount of health care they provide (Bandy et al 2008; WHO-CIFA 2010), mapping is a natural undertaking in research on FIOs, and there is even a faith-inspired mapping firm, GMI (gmi.org), though its focus is not health maps.

While GIS technology has greatly advanced mapping applications, its basic premise remains the same as when first used in public health when Dr. John Snow mapped cholera deaths in mid-1850s London, layered them on a map of public water supplies, and identified the likely source of the outbreak. While layering of maps is a more sophisticated variant, for FIOs in Africa, mapping is often used in the first instance simply to identify and physically locate health facilities, workers, or other resources.

Not all so-called mapping exercises produce a physical map per se, and some blend into the related category of landscaping reports. A landscaping approach generally takes a specific focal point such as a specific disease or health subsector (community health workers) and characterizes the topic through description of a sample of projects, but does not attempt to provide comprehensive or geographic information. In WFDD work, for example, actual geographic position is not always the most critical issue in "locating" an entity or resource and so its mapping focuses on who does what, how, with what resources, for what purpose, and with what history and trajectory, often in a specific country or region.

Identifying faith-inspired assets and their geographical locations can help governments and international partners to understand where gaps or duplications in services are occurring and how to allocate resources, especially at local levels. FIOs, particularly religious coordinating bodies such as the CHAs, benefit from knowing the full extent of their activities when planning and allocating internal resources, advocating for external resources, and coordinating with other organizations involved in health activities. Maps of health assets layered on maps of disease burden or socioeconomic data help determine if those assets are targeted appropriately.

ARHAP, which has recently changed its name to IRHAP, is a leader in the field of religious health assets mapping (see IRHAP.org). ARHAP's mapped religious health assets for HIV and AIDS work in parts of Lesotho and Zambia for WHO (ARHAP 2006). This work found that religious entities are numerous; in the 3 districts mapped in Zambia, there were 263 identified. The exercise was important, among other

reasons, because it mapped the most local and smaller faith-inspired groups providing HIV and AIDS health work that are often invisible in other health surveys, e.g., congregations and church support groups, though the exercise also captured international, national, and networking religious or partner entities. The mapping identified the types of services that the religious entities provided but did not attempt to quantify the amount of services. ARHAP notes that it uses the term mapping in in its broadest sense: as a process using participatory tools to draw out and diagram community perceptions of religious and health entities and their relationships.

As noted above, member facilities of Tanzania's CSSC were mapped, with the data collected focusing on human resources and facility capabilities. While the exercise is impressive in its thoroughness—over 900 facilities were mapped—it is not clear to what extent or how the data have been integrated into CSSC's operations (Todd et al 2009). Several other CHAs (e.g., Zambia) or Catholic health associations (e.g., Uganda) also have maps of members' health facilities.

The Anglican Church mapped the Anglican response to HIV and AIDS in Africa (Anglican UN Office 2007). Its research found that through the Anglican Church of Kenya (ACK), for example, Anglican hospitals, schools, and churches often serve as the implementing structures for projects and programs funded through major donors such as USAID, UNICEF and GFATM. The research reported though that the Anglican sub-recipients are unaware of the source of funding which reaches them through other principal recipients, and that the funding partners are unaware that it is ACK that is implementing their programs at the grassroots level, resulting in a cloak of invisibility.

The Catholic orders undertook a mapping of the Catholic global response to HIV and AIDS (Union of Superiors General Men, and International Union of Superiors General Women 2008). A motivation for the mapping was to follow up on an earlier estimate by a Vatican official that the Catholic Church sponsors 26.7 percent of all HIV and AIDS-related services (Barragan 2006) by documenting the breadth and role of the Catholic religious orders and their lay volunteers. The mappers, the Union of Superiors General Men and International Union of Superior General Women (umbrella bodies of the Catholic religious orders), noting that the work of the orders and individuals involved is largely unrecognized and underfunded, sent a questionnaire to religious orders throughout the world and compiled data and maps that mainly provided data on the number, location, and types of services provided by health facilities and schools doing HIV and AIDS work.

The research conducted for this paper and information from Jill Olivier, research director at ARHAP, indicates that, very roughly, perhaps around fifty or so FIO-centered mapping exercises have been conducted in Africa (Interview 2011), though the exact number is not known and ARHAP is working to provide more consolidated information.

Other FIO-centered sources are CHAs or other church health associations representing other denominations of faiths, as data collection on members is one of their functions. However, their capacity varies, and the team did not find much data on CHAs' websites. While it may well be the case that some CHAs keep data on member-only internet pages, the team did not find articles using or citing CHA data much beyond total number of members or facilities.

2.4 State of knowledge: ten key parameters of FIOs' engagement in health in Africa

The rest of the chapter synthesizes the information obtained through the survey of data, literature, and other information, organizing it by the ten selected parameters of FIOs, which are: number, size, and types of FIOs (Parameters 1, 2, and 3); faith affiliation (#4); geographic distribution (#5); health services (#6); market share and utilization (#7); financing (#8); health service costs and user fees (#9); and relationships with government and others (#10). Each subsection on a parameter begins with the following "highlights":

- • Why information on the parameter is important
- • Main data sources and gaps
- • Headline numbers or facts
- • Trends

The highlights are followed by details and discussion on the parameter.

2.4.1 Parameters 1, 2, and 3: Information on number, size, and types of FIO

Why information on the parameter is important

Data on the number of FIOs working on health in Africa disaggregated by country and region and by FIOs' size and type would aid health system planning and policy by MOHs and international partners.

Main sources of data and gaps

Sources: MOH health systems data and registries of health facilities; CHAs, and mapping exercises. Gaps: Very little data on size and type of FIOs, with a particular lack on CBOs.

Headline numbers or facts

There is no comprehensive source on the number of FIOs working on health in Africa;

some CHAs provide a number of members and facilities. A rough estimate calculated for this study suggests that there are probably tens of thousands of FIOs at work on health in Africa, and a continent-wide total of 100,000 would not be surprising if the smaller CBOs were included, with INGOs probably accounting for less than 1 percent of these in number.

Trends

Globally, civil society is a large and growing sector, and FIOs exhibit the same trend. Both the number of nonprofit organizations in Africa and the number of religious organizations globally are growing.

Details and discussion

Number of FIOs

One approach to getting a feel for the number of FIOs working in health in Africa is to begin with global data. Petersen (2010) reports that of 3,183 NGOs with consultative status at the UN Economic and Social Council (ECOSOC)—a data set capturing mainly INGOs—320 or about 10 percent meet her definition of religious. McCleary and Barro (2008) report that of 510 private voluntary organizations that registered with the US government as active in international development in 2004, 170, or 33 percent, were faith-based. Both the Petersen and the McCleary and Barro studies conclude that the number of FIOs is growing. Petersen (2010) reports "a dramatic increase in the number and visibility of religion

organizations involved in development." McCleary and Barro note for the US that an earlier trend of faster growth in secular versus faith-based development organizations has reversed since 1994 (McCleary and Barro 2008).

Turning to African data, a Kenyan government registry includes some 6,000 NGOs, and another database for the country including all types of non-profits found some 350,000 registered non-profit organizations in the country in 2005 (Kanyinga and Mitullah 2007, using Johns Hopkins Comparative Non-Profit Sector Project data), with the vast majority being small community-based ones. While the latter data do not include reliable faith-nature data, if it were assumed that just 10 percent of these non-profits were faith-affiliated and doing some work related to health, this would imply 35,000 faith-inspired organizations in Kenya alone. Extending this estimate to Africa as a whole, and taking into account differences among countries in terms of population, religious history, the pattern of FIOs' distribution, and the likelihood that a certain share of registered organizations are defunct or exist in name only, a conservative assumption could be that there are perhaps on average 1,000 to 2,000 FIOs per country (with huge ranges, of course), suggesting very roughly that it would not be unreasonable to expect that there may be around 100,000 FIOs across 50 African countries. The rough, working average of 2,000 FIOs per country does not seem unreasonable based on the information review, e.g., mapping exercises that include CBOs find the number of FIOs in a few districts numbering in the hundreds and the mapping of facilities operated by members of Tanzania's CHA found 932 facilities (Todd et al 2009; Supplement 2). That said, certain countries in Africa such as Gabon and Mali have very few FIOs relative to other countries.

Size and Type of FIOs

Lack of data on the distribution of FIOs by size and type is a major gap. This study found no estimates of size distribution or market concentration for FIOs, either globally or at the country or district level. It is important to keep in mind that INGOs carry out many of their programs through NROs and CBOs, and hence not all of the smaller, local organizations are as invisible as the lack of data specifically on them or generated by them suggests. These partnering arrangements would need to be taken into account in any attempt to assign size to FIOs in terms of amount or dollar-value of services or programs provided or mediated. Broadly, given the marked lack of data, the team did not investigate and assess different ways of measuring FIOs' size, e.g., revenue or operating budget, number of staff, quantity of services provided, number of people served, etc., but it is an area worth exploring.

Global data on the size of the largest INGOs are available in the sense that information on revenue, expenditure on operations, number of employees, and other indicators of size is available for some INGOs on their individual websites, but there are no comprehensive or Africa-focused sources for these data. Data are available for some NROs, such as CHAs and other church health networks associations, while data on CBOs are hardest to come by. Many of the latter organizations may, for example, be composed of 10 or fewer individuals in a village who have come together through their church or individual beliefs in order to assist PLWHA, and they would not have offices, websites, or other "organizational paraphernalia". At the same time, some NROs and CBOs do provide impressive amounts of information on their operations on their websites, and the team was struck that, because of fragmentation in the faith-inspired "sector," this information often does not get used, based on how rarely such information is used or cited in the literature.

Suggestive of the potential cumulative power of smaller FIOs, Foster (2004a) reports that there are some two million churches, mosques, and traditional gathering places in Africa. The team's research could find no estimate for Africa comparable to one for the US that reports that almost 80 percent of congregations participate in social services of some type (DeHaven et al 2004). However, if one assumed that, say, just 5 percent of the two million African faith communities of various forms supported a single CBO activity, this would represent 100,000 entities.

Better data on CBOs are critical because the literature indicates that community-based activities are well-suited for (See Supplement 1) and effective at (See Chapter 3) addressing major health challenges in Africa. A World Bank Global HIV and AIDS has as its objective to build a more robust pool of evidence on the impact and added value of community-based activities. Though the project covers all CBOs and not just faith-inspired ones, many community-based organizations and programs are faith-based, and even the preliminary findings of the project confirm that they are reaching many people in need (Rodriguez-Garcia et al 2011). The project also reports that CBOs receive a fair amount of support from international organizations and churches and congregations in donor countries.

Reports from individual FIOs confirm the significant role that may be played by smaller organizations. Project Muso Ladamunen (Project Muso) in Mali reports that in just one year, its 24 community health workers performed 99,277 household visits and assessed 4,621 children in a malaria prevention project (https://www.projectmuso.org). Two hundred "equipas da vida" tied to Anglican parishes but also attracting many non-Christian supporters have quickly sprung up in Mozambique, providing assistance on a fully volunteer basis to thousands of people who would otherwise have no health care at all (Supplement 2).

2.4.2 Parameter 4: Information on faith affiliation

Why information on the parameter is important

Faith distribution data may be less of a priority than filling gaps on other parameters, because there is not great diversity in the data; except in a few countries, the vast majority of FIOs in Africa are either Christian or Muslim (Marshall and Bohnett 2009). Faith affiliation data are important where there are interfaith tensions (Wilmot Interview 2011) and where strong community links are important, for example faith-linked behavior change communication health work. Faith-affiliation data would help resolve the likely undercounting of Muslim organizations; provide information on the now-poorly-understood health work of newer denominations; inform interfaith initiatives; and aid international donors wishing to ensure more diversity and fairness in funding FIOs.

Main sources of data and gaps

Sources: MOH registries or individual mapping exercises. Gaps: Data on the health work of non-Christian FIOs.

Headline numbers or facts

Globally and in Africa, Christian organizations account for the vast majority of FIOs that are recorded as such.

Trends

The roles of Christian evangelical organizations and Islamic FIOs in international development work are growing. Pentecostals and African Independent Churches are newer, rapidly growing denominations in Africa, for which information is limited and there are some concerns around their engagement in public health.

Details and discussion

This study found no systematic sources of data on the share of different faiths in health work by country or for Africa as a whole. The vast majority of officially-counted FIOs in Africa (and in most other regions) are Christian (Rasheed 2009). Leaving out traditional medicine, which is widely practiced as detailed in Supplement 1, and drawing on a sense of the data and literature reviewed in the absence of firm data, the team estimates that of total FIOs doing health work in Africa, perhaps 75 to 80 percent or more are Christian and between 5 to 10 percent, Muslim, with the remaining share representing efforts by Baha'i, Hindu, Jewish, and other faiths. Thus, the team views as overstated Rasheed's statement that there is no other significant faith-based sector that works in health in Africa other than the Christian one (Ibid). Though, as explained below, the recorded shares of Muslim FIOs in health care in Africa are indeed in some cases in the order of one or two percent, under-reporting is likely, given the predominance of Christian and Western influences as well as the high-profile role of CHAs.

The Catholic Church is believed to be by far the largest provider of healthcare in Africa among Christian organizations, though its activities vary of course by country and organization. An emerging trend is the entry of individual Western evangelical churches into health work in Africa (McCleary and Barro 2008; Wuthnow 2009). In Mozambique, Catholic organizations tended to predominate, while a greater variety of Christian denominations operated in Tanzania and Kenya (Supplement 2). Mali has relatively few FIOs engaged in health care because of factors such as local resistance to French administrative rule and a strong Islamic presence; Christian FBOs did not gain a strong foothold there and Islamic entities tended not to intervene as directly and frequently in health services as Christian ones, at least in the past (ARHAP 2008a).

The faith-distribution of FIOs in Africa can be compared to estimates of the faith distribution of Africans themselves, which is reported, for Africa as a whole, as around 45 percent Muslim and 40 percent Christian, with the remaining share representing mainly traditional beliefs (Encyclopedia Britannica 2003). The estimated share of traditional beliefs is probably under-estimated, including because many Africans may practice syncretism or pluralism in religion. Mainstream religious distribution varies widely by country in Africa: the reported percentage of the population that is Christian in Somalia and Mauritania approaches zero, while the same is true for the share of Muslims in Angola and Lesotho (Ibid). Analyses suggest that Africans are generally open to using health facilities of a faith affiliation different than their own (Makinen et al 2011).

A critical trend with mixed implications for faith-inspired health work in Africa is the rapid growth of Pentecostalism. There were 107 million members of this Christian movement in 2008 (www.pewforum.org) and Pentecostalism is overtaking the African Independent or African Instituted Churches (AIC) which, now constitute the older "new" Christian movement in Africa—and the smaller one, with an estimated 60 million members. Both movements put theological emphasis on physical, spiritual, and mental health; embrace faith healing; and represent tens of thousands of different small denominations (Berkley Center 2008), but they are also sharply distinct. For example, Pentecostalism downplays indigenousness, while the AIC movement features it (Gifford 2004). While no central organization or hierarchy directs either movement, the Organization of African Instituted Churches (OAIC) represents some AICs and reports that some of its member churches provide health and community services. The size and theological ties to health of these two distinct Christian movements suggests they could be potentially powerful partners in health work in Africa, but there are also concerns. Pentecostalism has been reported to be associated with practices that are at the extreme

dangerous and pernicious, such as reports of the maiming or exclusion of child "witches" by Pentecostals in Nigeria (Oppenheimer 2010). Also, Pentecostalism (in the Americas as well as in Africa) puts great emphasis on "the Prosperity Gospel," the concept that a combination of being religious and tithing leads to wealth and well-being. The message of the Prosperity Gospel can be problematic when it influences how people respond to poverty and sickness in others or in themselves (Gifford 2007).

Though researchers have advocated for the past ten years for further data-gathering and analysis on Muslim FIOs and while it is known that their importance in international development is growing (Petersen 2010), this study found no systematic data on them. Islam historically tended not to manifest in direct intervention in formal health services (ARHAP 2008a). Most Muslim FIOs tend to be smaller than their Christian counterparts, which display a broader range of sizes; to work in countries or regions of countries with significant Muslim populations, though Islamic Relief Worldwide is an exception and works in a wide range of countries around the world; and to have access to a narrower array of financial sources than Christian organizations, though numerous Muslim FIOs in Africa receive overseas funding from Arab governments or wealthy individuals.

However, reports that include information on Muslim FIOs suggest that they make important contributions to health in some African countries, even though their aggregate role is smaller than Christian FIOs. The Aga Khan Development Network (AKDN), a nondenominational FIO founded by the Aga Khan, Imam of the Shi'a Ismalia Muslims, is highly-regarded for its organizational and program quality. Aga Khan Health Services is one of the largest private health care systems in the developing world, with over 325 hospitals, health centers, and community health initiatives (Marshall et al 2007). The Federation of Muslim Women's Associations provides health services in seven West African countries, and the Ahmadiyya Muslim Mission accounts for roughly 2 percent of non-profit service provision in Ghana (Makinen et al 2011; Supplement 2). In the database on NGOs with UN consultative status, 88 of 337 African NGOs included the word Muslim or Islam in the organization's name. As of 2010, for GFATM, based on a similar word search of organization name, none of the 44 FIO primary grant recipients were Islamic organizations, even in predominantly Muslim countries (GFATM 2011).

Regarding other non-Christian faiths, the Hindu community in Tanzania created the organization Shree Hindu Mandal in 1919 as a non-profit organization to serve all Tanzanians and runs, among other social services, the Shree Hindu Mandal Hospital in Dar es Salaam (Tanzania case study), and several different Hindu organizations run health programs in Mauritius (Haynes 2007). The Baha'i congregation in Tanzania also operates health clinics. The American Jewish World Service (AJWS) plays a special role in Africa by providing grants to many smaller NROs and CBO organizations, including Christian ones (http://ajws.org), and Project Muso benefits from support from Jewish faith-inspired funders. The AJWS and numerous other Jewish FIOs have been major funders and advocates of humanitarian causes such as Darfur and the East African famines.

2.4.3 Parameter 5: Information on geographic distribution

Why information on the parameter is important

Geographic distribution information is crucial because public health planning required district-level information. Such data would also be useful to be more specific about FIOs' market share and to answer questions about their reach to the poor, rural, and other underserved groups.

Main sources of data and gaps

Sources: Mapping exercises and MOH/WHO and CHA data. Gaps: Because mapping is data- and labor-intensive, relatively little geographic distribution data exist and aren't easily extrapolated to inform health-related decision-making.

Headline numbers or facts

FIOs tend to be more numerous and play larger roles in health care in Eastern and Southern Africa than in Northern and Western countries.

Trends

There are a great number of CBOs operating at the district level, carrying out large amounts of "low-tech" health care and gaining more prominence. New data and map-layering are addressing the issue of the location of FIOs to preferentially serve the poor, rural, or other vulnerable populations.

Details and discussion

WFDD (see Marshall et al 2007) provides some generalizations about the geographic distribution of FIOs in Africa. While Christian groups operate across the continent, their activities are strongest and broadest in southern and eastern Africa. Local Christian FIOs and CBOs, often led by clergy, are also strongest in southern and eastern Africa. Most Islamic FIOs tend to work in Muslim-majority countries such as Senegal or Mali, or in the Muslim regions of countries such as Ghana, Nigeria, and Tanzania (Islamic Relief Worldwide being an exception, as it operates widely). MOH registries, since they include facility addresses, provide geographic information even where they have not been linked to GPS tools. MEASURE DHS has mapped both facility- and community-based activities of FIOs in Kenya using the Kenya MOH master facility list. Frank Dimmock, who has worked for many years with CHAs, reports that CHAs of five countries (Kenya, Lesotho, Malawi, Tanzania, and Zambia) have provider directories that include GPS coordinates (Dimmock in WHO/CIFA 2010). As noted, the CHA of Tanzania has GIS data on 932 facilities operated by its members (Todd et al 2009).

As noted above, community-based organizations and projects have been studied in several mapping exercises. Using a participatory GIS mapping approach in Zambia and Lesotho, ARHAP mapped both tangible assets, such as health facilities, as well as intangible assets, such as hope, prayer, and mutual assistance, in the context of HIV and AIDS. The work identified approximately 500 religious and partner organizations, of which 350 were working at the local level (ARHAP 2006). The Interfaith Health Program mapped Mukuru, Kenya and found 194 programs and organizations, including 35 FIOs, working on HIV and AIDS in two villages of 600,000 people (http://www.ihpnet.org). Another project in Kenya created a publically-available database through open source mapping of Kibera, one of the largest urban slums in Africa (http://mapkibera.org/). The data include location, operating hours, staffing, and services offered at all health facilities in Kibera. The Kenya AIDS NGO Consortium (KANCO) has mapped community-based HIV and AIDS, TB service organizations. A mapping of CBOs' work with orphans and vulnerable children (OVC) in Tanzania found 735 involved organizations (Inglis in WHO/CIFA 2009).

Non-systematic information on geographic distribution of FIOs emerges from studying political and related developments in individual countries. In Mozambique, the FIO sector has ebbed and flowed with policy shifts as the post-colonial government adopted and then moved away from Marxism (Supplement 2). South Africa nationalized FIOs in order to bolster the public control of healthcare. The number of FIOs in Liberia has fluctuated in response to the conflict situation there (Baer 2008). In Gabon, due in

part to the relative prosperity there compared to other African countries, government and private-for-profit services supply a good share of health needs, albeit with disparities and shortcoming, and the faith-inspired health sector is small (Supplement 2).

2.4.4 Parameter 6: Information on health services

Why this information is important

Systematic information on the types of health services that FIOs provide, disaggregated at the level of organization or facility, is needed if FIOs are to be integrated into national health planning and systems. It would also be useful to CHAs and FIOs themselves and to international organizations.

Main sources of data and gaps

Sources: CHAs and individual FIOs, but data are partial. MOH/WHO/MEASURE and national disease surveillance programs provide quality data but FIO-identification and categorization varies. Individual mapping exercises. Gaps: Even rough country estimates of FIOs' involvement in broad categories of health care in Africa, e.g., preventative, curative, primary, facility-based, maternal-child, et cetera.

Headline numbers or facts

FIOs provide a wide range of health services in many African countries, ranging from the most sophisticated surgery to the simplest interventions by untrained, community volunteers. They are heavily involved in health training and pharmaceutical supply.

Trends

FIOs have shifted from an earlier focus on curative versus preventative health to a mix in line with other health providers.

Details and Discussion

Data on the health services that FIOs provide is available from MOH/WHO/MEASURE and related data when ownership/management of facilities is identified and used to categorize information. The number and diversity of FIOs complicates compiling systematic data on health services from different sources or countries, and much FIO-specific data is on health facilities rather than health services and programs.

FIOs' ownership and/or management of hospitals and health clinics, has traditionally been the best known service provided by FIOs in Africa. It is known that while FIOs also operate dispensaries or "chemical stores," they provide relatively fewer of these facilities, which tend to be the most common type of health facility and a very common source of health care in many countries. In countries such as Kenya and Tanzania where FIOs run district, reference, or other hospitals with similar MOH designations (See Supplement 1), FIOs are by definition providing the highest level of care available in a country. The Nairobi hospital supported by the Aga Khan Foundation has a Maternity Services Department accredited by the UK Royal College of Obstetrics and Gynecology and provides all the major sub-specialties of surgery. The faith-run Bongolo hospital in Gabon provides a full range of services including a dental and eye surgery clinics (Supplement 2). Saint Nicholas Hospital in Nigeria is charged by the MOH with responsibility for all kidney transplants carried out in the country (World Bank 2011). That said, the predominance of the mission hospital in FIOs' health activities has changed over time, as FIOs took a lead in decentralizing health care to the community level (Baer 2008).

Advocacy

FIOs at all levels are also involved in health advocacy. Most CHAs list advocacy as one of their core functions. INGOs are well-known for advocacy and fundraising campaigns that they carry out through their industrialized country headquarters, targeted to donor countries and domestic faith congregations. Several Protestant initiatives stand out in terms of advocacy and financing campaigns for public health. The United Methodist Church (UMC) has created its own anti-malaria initiative, Imagine No Malaria, and is raising a planned US$75 million; its announcement that it will provide US$28 million of these funds to GFATM made it the first faith-based organization to work in direct financial partnership with that organization. The UMC emphasizes that it brings to its anti-malaria campaign not just fundraising capability but also trusted networks in remote parts of the world. World Relief and the Lutheran Church–Missouri Synod also partner on malaria, with the Lutheran Malaria Initiative aiming to mobilize US$45 million (Aylward 2011).

Behavior Change Communication

Behavior Change Communication (BCC) is a process of intervention with individuals or communities to develop communication strategies to promote positive behaviors. Participants are provided with relevant information and motivation through well-defined strategies, using an audience-appropriate mix of interpersonal, group and mass-media channels and participatory methods. Messages can be disseminated through radio shows, sermons, street theater, or music videos. BCC, and the related activity of social mobilization, is often used to educate about and change behaviors related to health. BCC can be an efficacious and cost-effective contributor to disease prevention, treatment adherence, and other steps critical to addressing some of the greatest health challenges in low-income countries, as well as richer ones, and BCC programs that involve faith leaders and communities are among the most successful (UNICEF 2004).

An *a priori* reason to expect that faith-inspired BCC could be effective in Africa is that 95 percent or more of Africans are estimated to have a religious connection (Foster 2004a).

A Nigerian anti-malaria BCC project whose evaluation is covered in Chapter 3 has trained 10 lead faith leaders in each local government area in which the project was implemented. Each of the lead trainers trained 50 other faith leaders, each of whom was assumed to reach out to 200 congregants, meaning that training a single lead faith leader could, potentially, reach 10,000 congregants (www.cifa.org). In May 2011 after consultations with the country's religious leaders and the MOH, TBFF launched a national faiths' health messaging campaign against malaria in Sierra Leone in response to, among other things, a country survey that revealed that six months after distribution only 20 percent of three million ITNs were being used in a way that protected vulnerable children. The Ethiopian Orthodox Church (EOC) has partnered with United Nations Population Fund (UNFPA) and the Population Council to produce the "Developmental Bible," a resource that compliments the Metsihafe Gitsawie ("glossary of the day-to-day teachings of the Church"). Supplement 1 provides more information on faith-inspired BCC.

HIV and AIDS

More information exists on FIOs' engagement with HIV and AIDS than with any other health area (Olivier, Cochrane and Schmid 2006). FIOs are engaged in HIV and AIDS support across the full spectrum of prevention, treatment, and care, as a natural extension of their other health and community activities

(Vitillo 2006). FIOs are estimated to provide as much as 40 percent of all HIV and AIDS health services in Africa (CIFA 2010), and the Catholic Church estimates that it alone provides 26.7 percent of all HIV and AIDS work (Barragan 2006). A sign of FIOs' prominence in this area of health work is that UNAIDS has a strategic framework for partnership with them. The number of small CBOs that provide home-based care for PLWHA and their families and for orphans and vulnerable children affected by HIV and AIDS, often in areas where otherwise no or limited public care would be available and often on shoestring budgets, is highly noteworthy. The extensive involvement of FIOs in HIV and AIDS work is detailed in Supplement 1.

Malaria

Africa bears the highest burden of malaria in the world. Many FIO initiatives work with faith leaders who then educate their congregations on malaria prevention and treatment. For example, CIFA works with the Nigeria Interfaith Action Association and in Mozambique with the Programa Inter Religioso Contra a Malaria (PIRCOM) to mobilize faith networks and train pastors and imams to deliver messages about appropriate use of insecticide treated nets (ITNs) (Hipple and Duff 2010; Supplement 2). Supplement 1 provides more information on FIOs' engagement with malaria.

Major Disease Killers of Children

In sub-Saharan Africa, more than 70 percent of deaths of children under five years of age are caused by a few diseases, singly or in combination: acute respiratory infections, diarrhea, malaria, measles, malnutrition and neonatal conditions (asphyxia, prematurity, low birth weight and infections). FIOs are heavily engaged with the major disease killers of children (MKC), providing interventions ranging from immunization to food supplements, at health facilities and through community-based campaigns. Supplement 1 provides additional information on FIOs' involvement in MKC.

Maternal and child health

Several studies note that FIOs are heavily involved in maternal and child health services (Berkley Center-WFDD 2011; Chand and Patterson 2007; Woldehanna et al 2005). Chand and Patterson (2007) note that 90 percent of faith-inspired facility- and community-based programs offer maternal and newborn services. There is also extensive literature on FIOs' work in reproductive health, which is an area where there are sensitivities around faith and faith-related differences in health programming and the types of services provided.

Medical training

FIOs are major providers of medical training through management of or support to medical, nursing, and clinical officer schools; pre-service training of mid- and lower-level staff; in-service training in faith-inspired health facilities; and training of community health volunteers. The Sub-Saharan African Medical School Study portal (http://www.samss.org/) includes information on six FIO-supported training institutions, as well as links to relevant articles and reports on training, capacity building, and retention. The Capacity Project, a USAID-funded project to strengthen human resources in health in Africa, reports that FIOs provide 70 percent of nursing and midwifery training in Malawi and Uganda, and between 30 to 55 percent in Tanzania and Zambia (Pearl, Chand, and Hafner 2009). In Liberia and Uganda, FIOs run a significant number of lower-level health care worker training institutions (Barnes and World Bank 2010).

As always though, FIOs' activities vary across country: for example, it appears they do little health worker training in Ghana (Barnes and World Bank 2010; Supplement 2).

Mental health

The involvement of faith in mental health is noteworthy, even though information is very limited. Mental health needs are extreme, in part because pressing physical health needs take precedence; as an example, the ratio of psychiatrists to population in Africa outside of South Africa and Kenya is one to one million. Faith healers and traditional medicine practitioners handle most mental health problems (Ndetei Undated). Rasheed (2009) reports in a study of Ghana that mental illness is often ascribed to spiritual causes, e.g., possession by the devil, and "churches"(with no specific attribution as to which denominations) often send the patients to prayer camps where they are placed under the care of "the equivalent of a witch doctor," and may sometimes endure very poor treatment, though Ndetei (undated) provide a positive view of faith healers' and traditional medicine practitioners' treatment of the mentally ill.

Pharmaceutical and medical supply

Africa has very strong faith-linked medical supply networks. A survey of 15 faith-inspired drug supply organizations operating in 10 African countries found that they service an average of 43 percent of the population (Banda et al 2006). The largest body is the Ecumenical Pharmaceutical Network (EPN), a Christian faith-based, not-for-profit, independent organization that provides quality pharmaceutical services and supplies It operates worldwide and has members in some 22 African countries. EPN carries out many services around pharmaceuticals in addition to supplying them, such as helping countries build capacity and fundraising (Ecumenical Pharmaceutical Network 2010). The strong performance of EPN and other faith-inspired pharmaceutical groups such as the Mission for Essential Drugs and Supplies (MEDS) and the Central Pharmacy of the Cameroon Baptist Convention Health Department (WCC 2011) suggests that these initiatives provide a good model that could be adapted for other FIOs working on health in Africa and to strengthen coordination.

Traditional medicine

It is estimated that 70 percent of Africans use herbalists, diviners, and other spiritually-inspired health practitioners (Mills et al 2006), though the share of people that access traditional medicine varies by culture, access to other health care, economic status, and education level. A World Bank study found that traditional medical practitioners (TMPs) represent a large part of the private health sector in most countries (2011) and far outnumber orthodox medical practitioners in some. Zambia has 40,000 TMPs who garner about 60 percent of total household health spending (Ibid). Among the reasons that Africans rely heavily on TMPs is because many people lack access to conventional health facilities (Supplement 2). Supplement 1 covers this topic in detail, including the overarching challenge of whether and what extent to incorporate traditional medicine with public health systems and conventional evidence-based medicine.

Tuberculosis

Approximately a third of the global burden of tuberculosis (TB) is in Africa, with 4.1 million people infected and over 430,000 non-HIV patients dying from TB (World Health Organization 2010a). Most

faith-inspired health facilities include TB diagnosis and/or treatment in their curative services. Many of the largest INGOs work on TB, including World Vision, Catholic Relief Services (CRS), and Adventist Development and Relief Agency (ADRA), and FIOs add value to national TB programs through their reach to vulnerable populations, including in fragile/conflict areas such as the Democratic Republic of the Congo (DRC) and Somalia (Bohnett and Zambra 2010). FIOs' involvement with TB health services is further discussed in Supplement 1.

2.4.5 Parameter 7: Information on market share and utilization

Why this information is important

Facility-, service-, and program-focused market share data (more than aggregated data) would be useful to governments and international organizations for health planning, implementation, and integration of FIOs. More systematic and reliable market share data would be useful to FIOs to ensure financial support and voice in line with their contributions.

Main sources of data and gaps

MOH/WHO/MEASURE data; CHAs; household surveys; World Bank health sector studies; the work of Olivier and Wodon. Gaps: Data on service provision and utilization, rather than stock, supply-side data on facilities and number of beds.

Headline Numbers or facts

Recent analyses suggest that FIOs probably account for a lower share of health services than the oft-quoted "30 – 70 percent of health services in Africa" estimate.

Trends

Newer studies of market share measure the demand-side, rather than the supply-side, of health services and better capture the entire private sector, rather than just its nonprofit members.

Details and discussion

Estimates of the health market share of FIOs in Africa are contested and often sensitive. There is a concern and perception that some stakeholders—FIOs themselves or international agencies that emphasize faith-inspired work— may have a vested interest in higher estimates and vice versa (while secular organizations could downplay faith roles because of bias or habitual categorization). Longstanding estimates suggesting high shares for FIOs have gained currency through frequent repetition and circular referencing, including in official documents, often without a critical analysis of the estimates' bases or timeliness.

The most well-known estimate is that faith-based organizations provide 30 to 70 percent of health care in Africa. Olivier and Wodon (2010) provide an interesting deconstruction of how this famous estimate came into being and of its weaknesses, e.g., it was based on countries with high levels of FIO involvement and on data from the 1960s.

Estimates for the share of FIOs for individual countries tend to average around 40 percent (Table 2.2). The data from CHAs and related church health associations is heavily based on number of facilities and beds. Standing in contrast are studies of the private health sector in African countries and demand-side measures on the reported utilization of health services.

For example, official statistics for Ghana report that 3.6 percent of persons who underwent medical consultations in Accra utilized FIO facilities, rising to 12 percent in rural coastal areas (Ghana Statistical Service 2008), while Ghana's CHAG estimates that FIOs supply 35 percent of outpatient care (Rasheed 2009). In Kenya, 2003 MOH data show that 4.8 to 6.8 percent of outpatient visits are to FIOs (Barnes and World Bank 2010) but that 28 percent or some 1500 of the 5,334 facilities on the MOH's master facility list (http://www.ehealth.or.ke/facilities/) were managed by missions or NGOs (Noor et al 2009).[9] In contrast, the CHA of Kenya reports a 60 percent market share. Kyayise et al (2008) report that of Uganda's 4639 health facilities, 2154 or 46 percent are privately-owned for-profits.

Utilization estimates might well be lower in part due to misclassification, as respondents might not know or focus on whether they obtained services at a faith-affiliated or other type of facility, and this could particularly be the case in countries where FIOs are very active in health care, have strong relationships with the MOH, and hence may not be perceived as non-public by patients. Nonetheless, the World Bank study (2011) that collected quantitative and qualitative data on the private health sectors in 45 African countries concluded that for-profit private providers form the clear majority of the private health sector. It is important to understand that this finding is based on a multi-method analysis of the health market and not on utilization data alone. Translated into "FIO" terminology, the finding that for-profit providers form the majority of the health sector says that if one divides the health market in a country into the public sector and the private sector, and the latter into not-for-profit organizations, such as FIOs and other NGOs, and for-profit ones, the latter will on average constitute the majority of the private sector. The implication of this finding is that existing FIOs' market share estimates do not "add up." For example, if, say, a 45 percent market share is claimed for the FIOs in a given country, the World Bank finding would mean that the rest of the private sector is providing at least a 46 percent share (since self-financing private sector providers were found to be the majority private sector provider in most countries), leaving very little room or role for the public sector (e.g., leaving in this mathematical example, a 9 percent share for government). Some detailed findings that tend to back up the overarching statement on the size of the private for-profit health sector (as well as touching on questions of reach to the poor) are that in Chad, Niger, and Uganda, more than 40 percent of people in the lowest economic quintile who seek health care for children with acute respiratory infections do so from private self-financing providers (Ibid). It is also worth noting in terms of formulating views about the respective roles of the for-profit and non-profit providers that make up the private sector that the World Bank (2011) refers to the former as the "self-financing sector" to reflect that many ostensibly for-profit health providers do not make a profit even though that is their objective

Table 2.3 presents the results of a search for different sources of estimates of FIOs' market share. CHA or MOH data on the number of facilities and beds owned/managed by FIOs—the supply side—that are often the basis for the country market shares are generally sound data (though the ubiquity of 40 percent as a central tendency estimate of the faith-inspired share raises questions, given understandings about country diversity); Table 2.4 provides some data for selected CHAs. The CHA data often include only FIOs that are CHA members and, in any country where Catholic FIOs are not in association with the CHA, will leave out the often-large Catholic share. A greater data problem involves the denominator for market share estimates, and it may explain the discrepancy between starkly different estimates of FIOs'

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[9]Note that the master list did not include private facilities.

market share. It is likely for-profit private health providers may be left out of the calculation, so that the market share estimate for FIOs may be the ratio of FIOs' contribution to the sum of just the public sector plus the FIOs, rather than to the total health market.

As indicated above, newer analyses often do two things. One is to provide utilization data, whereby people are asked about the type of facility where they obtained a given health service. The second is to better measure the rest of the private sector, i.e., the for-profit segment. Table 2.2 indicates examples of market share estimates from different sources and types of analysis. For example, in Kenya, the FIOs' market share according to CHAK is 40 percent, while Barnes (2010) finds that not-for-profit entities as a whole own 16 percent of health facilities.

Table 2.3 specifically compares market share data from traditional versus health-service utilization data compiled by Olivier and Wodon (2011). Utilization data show a range from less than 5 percent to 20 percent of market share for FIOs in the selected countries, usually but not always noticeably lower than the estimates from traditional (mainly CHA) data sources. In some cases, utilization data indicate a comparable or higher share than the alternative country estimates, e.g., for Cameroon and Mali.

Despite the newer information, it is very much the case that FIOs provide a significant share of health care in Africa and are the dominant non-profit private sector health providers in many African countries (World Bank 2011).

2.4.6 Parameter 8: Information on financing

Why this information is important

Information on the financing of FIOs is needed to assess the viability and sustainability of these organizations. It would also help illuminate and address questions and controversies about the extent to which FIOs are (i) underfunded relative to their efforts and (ii) can mobilize additional financial resources.

Main sources of data and gaps

Sources: Annual reports or websites of individual FIOs provide financing data, often limited. International or national donor organizations provide some data on their financial flows to FIO. MOH expenditure data must exist on government transfers to FIOs but can be hard to find. Gaps: systematic data on the financing structure of FIOs.

Headline Numbers or facts

In 75 percent of countries in Africa, governments fully or partially fund FIOs health work. US churches spend around US$4 billion annually on overseas ministries (Wuthnow 2009). In 2009, Islamic Relief Worldwide, one of the largest Muslim development organizations, spent US$75 million on its programs; for World Vision, one of the largest Christian organizations, the 2010 figure is US$851 million.

Trends

The transfer of financial responsibility for health facilities from US and European-based denominations to African counterparts left many of the latter struggling financially, as the rising flows from US churches to overseas ministries tend to fund programs (often disease-specific) rather than facilities.

Details and discussion

This study found no comprehensive or detailed data on the financial structure of FIOs working on health in Africa, though it did find a good deal of information scattered across different sources and various strands of literature that address FIOs' financing conceptually or focus on specific components of it (see the next subsection on user fees and health costs). Also, the team found an excellent historical study of African FIOs' financial situations (Rookes 2009). Nonetheless, the observation that "It is shocking how few studies of faith-based organizations' financial structures exist," (Schmid, Olivier, and Cochrane 2006) still holds.

Ferris (2005) suggests that the share of funding that comes from religious sources is a criterion for defining an organization as faith-based, but provides no benchmark. Berger (2003) argues that how a FIO funds itself can play a major role in determining the character and agenda of a given institution. FIOs' access to funds from donors in the faith community or a parent church or other related religious organization can give them a financial independence that may be part of FIOs' organizational identity (Lipsky 2011).

Princeton scholar Robert Wuthnow (2009) reports, based on extensive surveys, that US churches raised US$4 billion for overseas ministries, with evangelical churches new and successful entrants to the field. (As a benchmark, Johnson (2002) reported that US FBOs provided US$20 billion of privately contributed funds to domestic social service delivery to over 70 million Americans). In the UK, Ferris (2005) notes that declining church attendance has forced some FIOs to look for donors beyond their faith-based constituencies. A major issue for African faith-inspired health facilities and programs is the reported diminished funding from churches in Europe and the US to church health facilities in Africa over the last two to three decades (McGilvray 1981; Adjei et al 2009; Rookes 2009).

INGOs, especially those that receive public monies, publish audited financial reports on their websites, and in the US, various charity rating agencies exist that assess the philanthropic quality and transparency of the finances of nonprofits, including FIOs. Much less data are available for local and smaller FIOs, though they sometimes make simple balance sheets available for donors. The smallest CBOs may operate without any financial inflows.

In 75 percent of countries in Africa, governments fully or partially fund FIOs' health work, through various modes, including budget support, service contracts, and seconding staff. Faith-based providers in some African countries are sometimes so intertwined with the public sector as to be indistinguishable from it, according to the World Bank (2011). That said, one expert saw FIOs' financing as distinctive inasmuch as, in his experience, recurrent cost financing in FIOs is more stable than in the public sector, be it via user fees, drug donations, or donor contributions (Liese 2012). Good data on the quantity and types of financial support from government to FIOs are particularly relevant given current emphases on public-private partnerships and contracting with the private sector, as governments and donors acknowledge that in Africa for the foreseeable future, the public health sector "doing it all" is not a realistic option (World Bank 2011). But government financing of FIOs and other NGOs raises other issues, such as whether it is unfair to private self-financing providers and the extent to which public health spending benefits the poor. FIOs face new financial arrangements with the public sector as countries implement National Health Insurance Schemes (Supplement 2).

While some FIOs do receive large amounts of private financing, those focusing on global public health may obtain even larger financial flows from international or national donor organizations. Data compiled for a year-long Boston Globe investigation indicated that 75 percent of USAID funding to FBOs in the period 2001-2005 went to just four organizations, all INGOs: CRS, World Vision, Mercy Corps International, and ADRA (Boston Globe 2006). McCleary and Barro (2008) report that CRS, for example, receives some 70 percent of its funding from the US government and that the share of US public international development money going to FIOs is growing relative to secular organizations. However, some FIOs do not accept government funding as a matter of policy.

Where consolidated data on flows to FIOs from international organizations is available, it tends to support the belief of numerous stakeholders that funding to FIOs is not commensurate with the amount of health work they provide (CIFA 2010). CIFA (2010) reports, for example, that FBOs provide around 40 percent of the HIV and AIDS treatment and care in Sub-Saharan Africa but obtained in the first eight rounds of GFATM funding only 3 percent of disbursed funds. Christoph Benn, the Director of External Relationships and Partnerships at GFATM, who has also worked as a physician at a mission hospital in Africa in addition to being a faith and health expert, notes that approved GFATM funding to FBOs has risen to 5 to 6 percent of funding (Benn in Cochrane, Schmid, and Cutts 2011). GFATM (2009) reports that it has supported 26 FIOs as primary recipients and over 461 FIOs as secondary recipients, although it should be noted that over 200 of these secondary recipients were in a single country, Zambia, reflecting that the CHA of Zambia was a primary recipient and is a well-functioning organization. The President's Emergency Plan for AIDS Relief (PEPFAR) directs on average around 10 percent of its total annual disbursement, US$7 billion in FY2010, to FIOs, but only a small share to local ones.

In a doctoral thesis, Rookes (2009) assembled information on what he calls the financial basis of church health services (CHS) from interviews with officials of twelve UK based mission organizations; a survey of church health services in thirteen countries, and case studies of church health service provision in Malawi and India based mainly on extensive interviews with selected stakeholders. Rookes says his research confirms that funds received by CHSs from mission organizations have declined and are now more often in the form of project funding. CHSs have, for the most part, continued to provide services for the poor in a variety of ways: first, by providing low cost services; second, by developing hi-tech tertiary services, the profits from which subsidize services for the poor; and third, by working more collaboratively with governments, for which they receive varying degrees of financial and other support.

2.4.7 Parameter 9: Information on health service costs and user fees

Why information on this parameter is important

Information on how much FIOs charge for health services compared to public and other providers is needed to understand (i) FIOs' cost structures and financial health; (ii) conflicting reports on whether FIOs tend to charge more or less for services and practice cross-subsidization; (iii) their reliance on user fees compared to other providers; and (iv) whether they preferentially serve the poor.

Main data sources and gaps

Sources: CHAs; World Bank health sector studies; individual research papers. Gaps: much information is anecdotal or for a small sample of facilities.

Headline numbers or facts

Africans pay a higher proportion of healthcare costs out-of-pocket relative to other poor and rich nations (World Bank 2011). Faith-inspired providers are sometimes more expensive than public ones but generally less expensive than

other private ones, and policy and actual practice on user fees varies widely (World Bank 2011).

Trends

African governments' growing interest in public-private partnerships and contracting out/in should eventually tend to narrow health cost differences across the public and private sectors, but at present, there are many differences in costs (and quality) of health services.

Details and discussion

Many faith-inspired health providers in Africa charge user fees. As Adeline Kimambo, the head of Tanzania's CHA explained, "FIOs must charge user fees because we do not have access to the public monies that government hospitals do"(Tanzania case study)—though as noted above, in 75 percent of African countries, faith-inspired facilities receive public funding. In several countries, FIO-operated hospitals bear official designations such as district designated hospitals (DDH) and in these cases, government payment for services provided is generally explicit. In Tanzania, DDHs receive full grants from government once their work plan is approved. However, Dr. Kimambo suggests that members of the CHA she leads do not operate on a level playing field that would allow a valid comparison of their health services' costs and quality with the public sector. This is because the government is not reimbursing FIOs fully or promptly under the various service agreements that pertain, and some government payments, such as the per-bed payment for DDHs, no longer cover actual costs. Individual FIOs report in many different circumstances that government makes its agreed payments with long lags and arrears (Interview CCIH Conference 2011). There are both anecdotal and documented reports (Sen 1994) that FIOs engage in "Robin Hood pricing," charging those who can afford to pay medical costs one fee, and using this revenue to cross-subsidize a lower fee charged to those the FIO deems cannot afford to pay. Project Muso's Solidarity Fund provides free health care to community members whose income/resources have been assessed as extremely low, and charges less impoverished ones.

Studies that have compared unit costs between faith-inspired and public providers have found inconsistent trends across countries. A 2003 study on costs for routine maternal health services at hospitals in Malawi, Ghana, and Uganda found that unit costs were higher at mission facilities, due to materials used, but delivery services were less costly at mission hospitals than public ones, due to fewer personnel (Levin et al 2003). Research in Kenya and Tanzania found that deliveries in private facilities, including mission ones, are up to four times as expensive as deliveries in public institutions, (Kruk et al 2008; Perkins et al 2009).

A study of district hospitals in Zimbabwe found that costs to the hospital per inpatient were 40-50 percent lower at the two faith-inspired, government-contracted hospitals than at the public ones (Mills, Hongoro, and Broomberg 1997). A 2011 study in Kenya found comparable inpatient and outpatient costs at faith-inspired and private-for-profit providers, which seemed higher than for public facilities but were difficult to compare directly (Mathauer 2011).

Even with the user fees charged to patients, faith-inspired providers often face financial difficulties. As FIOs make increasingly formal arrangements with government through Memoranda of Understanding (MOUs) (See the next subsection) or service contracts, FIOs' staff costs have increased as they bolster staff levels and take other steps to meet government standards (Adjei et al 2009). A 2006 study of a Presbyterian Church of East Africa hospital in Kenya found an 80 percent cost recovery level across nine

reproductive health services (Munguti et al 2006). Analysis based on 2005/2006 National Health Accounts of funding sources of faith-based hospitals in Kenya found that 61 percent of funding came from user fees, 24 percent from insurance, 14 percent from donors, and 1 percent from other sources (Mathauer 2011); a different paper reported the share of user fees in Kenyan FIOs' funding as 68 percent, which suggested to the authors that the FIOs were on an unsustainable financial footing given the country's poverty level (GTZ/CHAK/KEC 2007). Amone et al (2000), reporting on a study of 10 Catholic mission hospitals in Uganda, found 40 percent of revenue came from user fees, 10 percent from delegated funds, 28 percent from external aid, and 22 percent from other sources. As part of an effort to improve CHAs' ability to recover costs and negotiate partnerships with government, recent studies have determined the costs of reproductive health services at four CHA hospitals in Ghana and the costs of maternal and child health services in CHA facilities in Malawi (Beaston-Blaakman 2011; Boateng et al 2006). Dr. Daniele Giusti (1999) of the Uganda Catholic Medical Bureau (UCMB) analyzed the costs and productivity at four religious hospitals in Northern Uganda, drawing conclusions that despite the challenges of sustainability, the facilities were financially stable. The report by Dr. Giusti, easily accessible on the UCMB's website, is also proof that high-quality information on FIOs' financing structure is available but has not been sufficiently recognized or used.

2.4.8 Parameter 10: Information on FIOs' relationships with government, international organizations, and each other

Why information on this parameter is important

Relationships between governments and FIOs drive outcomes on many key parameters, e.g., health costs and the degree to which FIOs explicitly contribute to national health strategies.

Main data sources and gaps

Existing MOU for various African countries; several academic papers, notably case studies by Rasheed (2009). Gaps: information for countries without MOUs.

Headline numbers or facts

MOU exist between government and FIOs in Benin, Cameroon, Chad, Ghana Kenya, Lesotho, Malawi, Tanzania and Zambia (Rasheed 2009).

Trends

Growing recognition of for-profit health providers in Africa may challenge existing relationships between governments and FIOs, which might be regarded as unfair to non-religious providers. That said, even where MOUs exist, FIOs point to many challenges working with government.

Details and discussion

FIOs' relationships with governments range from the government having little knowledge of FIOs' activities to formalized MOUs with MOHs that specify legal arrangements for working relationships. MOUs are generally established between the MOH and a CHA or other religious coordinating organizations. MOUs specifically between government and CHAs exist in nine countries in Africa. The MOU between the government of Kenya and FIOs covers Catholic, non-Catholic Christian, and Muslim church-health umbrella organizations. Other countries collaborate with FIOs without an MOU. Another aspect of government-FIOs relations is government standards and regulations for the health sector, which are at present relatively weak. Shortfalls even in the basic registration of health facilities and providers, a first step or tool in regulation, lead to critical gaps in understanding "who does what" (World Bank 2011). In South Sudan, the hundreds of NGOs working on health clearly dominate the

minimal public health sector (Supplement 2); in DRC, FIOs to a large extent run the health system for the government but with a much clearer sense of the proper role of government leadership than in South Sudan.

Rasheed (2009) has undertaken case studies of the relationships between faith-inspired health providers and governments in four countries. HENNET, a network of civil society health care providers in Kenya and the German Agency for International Cooperation (GIZ) have partnered with the CHA of Kenya and other religious health associations there to produce a thorough study of FIOs and government relations in Kenya and other African countries (GTZ/CHAK/KEC 2007; HENNET 2008).

The case of Ghana illustrates how MOUs can add value by replacing and rationalizing ad hoc, looser, and atomized arrangements between governments and FIOs (Rasheed 2009; Supplement 2). Where CHAs are strong, FIOs may get a seat at the table for countries' health sector-wide approaches (SWAps), the arrangements in place in numerous African countries whereby donors partner with government on an agreed health strategy. FIOs are almost always represented on national HIV and AIDS commissions and all but two of the 51 African countries with GFATM country coordinating mechanisms (CCMs) have FIO representation on the CCM, with an average of 8 percent of CCM members representing FIOs (GFATM 2011). GFATM has an outreach effort dedicated to FBOs, while GAVI has one targeted more broadly to civil society, but with large FIOs' representation. In conflict/ post-conflict situations, NGOs (including FIOs) have established consortiums to exchange information and advocate with governments, such as the respective Somalia or South Sudan NGO Forums, though these do not necessarily resolve coordination and harmonization problems (Supplement 2).

A particular aspect of government-FIO relations concerns human resources. FIOs generally face challenges in recruiting, retaining, and affording staff. Even where MOUs exist, changes in government policies on health worker remuneration sometimes have sharply negative consequences for FIOs. Brain drain is a critical problem for FIO facilities, particularly in rural areas, both in terms of external drain to other countries and internal drain to the public sector or secular NGOs. Internal brain drain has increased in recent years as the public sector has received more resources from debt relief and donor agencies and can offer better salaries and benefits. Adjei et al (2009) discuss various steps for staff retention for FIOs but even with research efforts such as that of USAID's Capacity Project and Medicus International (medicusmundi.org) focused on FIOs' human resource challenges, the challenges persist.

Aid harmonization and coordination has been a focus for the development community since the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008). Fragmentation, overlap, and duplication of development efforts are a problem across donors and civil society. While there are no sources documenting that coordination is any worse for FIOs than other entities, as Katherine Marshall, WFDD Executive Director, pointed out at a 2009 development and faith leaders' meeting, silence on the topic at the meeting suggests that FIOs are not yet sufficiently part of the solution. The team for this study had a telling experience concerning coordination. One country expert interviewed stated that his/her organization's programs were virtually the only faith-inspired work taking place in the country in question. But in fact, the country is the flagship location for a high-profile, highly active faith-inspired organization. Moreover, a web search quickly found several mission hospitals of additional faith traditions operating in the country. This anecdote is not meant to question the knowledge of the expert (who was a highly-experienced and impressive practitioner), but rather confirms that since some FIOs are small, tend to be off the radar of large donors and players in global health, and operate with an

additional dimension of fragmentation—that of different faiths—there are likely benefits to be had from faith-inspired organizations taking more steps to coordinate with each other.

Interfaith initiatives can be viewed as a particular means or mechanism of coordination among FIOs. Katie Taylor, Executive Director of CIFA, explains the potential advantages of interfaith initiatives (Interview 2012). Interfaith initiatives can avoid the perception of proselytization, which can be a concern for community members, government officials, and international organizations. Likewise, interfaith action through its inclusive approach can circumvent legal and political concerns about governments' engagement with a particular faith tradition or religious community. Interfaith action can also be efficient, leveraging the diverse resources of FIOs in a systematic way, minimizing duplication of efforts by multiple FIOs at the same time in the same geographic locations. While a possible downside to interfaith initiatives is that if interfaith coalitions do not exist in a country, it is necessary to build them, in contrast to single-faith networks already in-place, investment in and creation of interfaith coalitions not only builds broad consensus around desired health behavior change, but also establishes a working interfaith mechanism that can be re-programmed to tackle other community needs in the future. Other advantages of and information on interfaith initiatives is presented in Supplement 1.

Table 2.1. Major data bases and data sources

Data source	Data included	Strengths / Weaknesses	Countries	Selected examples of information from the data source
WHO Service Availability Mapping (SAM) http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en/	SAM is a tool to rapidly collect and present basic information on health services focused on facilities, usually at sub national or district levels.	Standard questionnaire distinguishes between different types of ownership or management of facilities.	SAMs or SARAs ongoing in numerous African countries; see WHO website.	SAM Zambia 2005: Annex 1 lists all health facilities by district and services provided. SAM Tanzania 2005/6: "Some government employees are seconded to health facilities run by FIOs.
WHO Service Availability and Readiness Assessment	A health facility data tool that replaces SAMs.	As for SAMs, SARAs distinguish different types of ownership or management of facilities. There is a draft faith-based module.	FIO module has been piloted in Burkina Faso and possibly additional countries	Faith-based module includes questions on faith affiliation, network affiliation, places of worship in facilities, and spiritual care.
USAID/MEASURE Demographic and Health Surveys (DHS) http://www.measuredhs.com/about surveys/dhs/start.cfm	With USAID funding, MEASURE helps countries implement DHS, nationally-representative household surveys, which include data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition..	Respondent's religion is included in women's and men's questionnaires. For HIV, AIDS and reproductive health, churches are included as a potential choice for provision of specific	DHS surveys exist for 44 countries in Africa	DHS Working Paper on AIDS Stigma and Uptake of HIV: "In Zambia, the multivariate analyses show a strong association between religion and acceptance of HIV testing for men but not women. It seems that Pentecostal and Protestant leaders have done slightly better than traditional religious leaders in this area."

		services.		
USAID/MEASURE Service Provision Assessment (SPA) http://www.meas uredhs.com/about surveys/spa/start. cfm	MEASURE also helps countries implement SPAs, a nationally representative sample of health facilities to provide information on the characteristics of health services, including their quality, infrastructure, utilization and availability, focusing on maternity, newborn, and child care, family planning, sexually transmitted infections and other infectious diseases, and HIV and AIDS.	Standard questionnaires do not distinguish FIOs from other private providers, although countries have modified questionnaires to include FIOs as a separate category.	Egypt, Ghana, Kenya, Namibia, Rwanda, Tanzania, Uganda, Zambia	SPA Kenya 2010: Mission hospitals and dispensaries were described as more expensive but with far more reliable supplies of medicines. 24 percent of FIO facilities had all basic client amenities, regular water supply, and regular electricity supply or generator (versus 6 percent of government, 12 percent of NGO and 17 percent of private).
USAID/MEASURE Malaria Indicator Surveys (MIS) http://www.meas uredhs.com/about surveys/mis/start. cfm	The MIS collects national or regional data from household s about malaria prevention and treatment.	Respondent's religion is included. Standard questionnaires do not distinguish FIOs from other private providers of services.	Angola, Liberia, Nigeria, Senegal, Tanzania, Uganda, Zambia	Liberia 2009: "Approximately 25 percent of those with fever who sought treatment went to a government health clinic, while 20 percent went to a private hospital or clinic, and 12 percent each went to a pharmacy or shop."
UNICEF Multiple Indicator Cluster Survey (MICS) http://www.unicef .org/statistics/inde x_24302.html	Household surveys on health, education, child protection and HIV and AIDS.	Religion of household is included.	19 countries in Africa	

Source	Description	Limitations	Location	Examples
International Household Survey Network (IHSN) http://surveynetwork.org/home/	IHSN provides a central survey catalog, with health facility, world health survey, social welfare and income/ expenditure surveys, as well as links to national survey databases.	Requires familiarity with different household surveys, as health and faith data can be hard to find.		One third of sampled household surveys include information on health services disaggregated by the ownership affiliations of public, private for profit, and faith-based (Oliver and Wodon 2010).
National Ministry of Health (MOH) statistical abstracts	Many MOHs provide an annual overview of health data, e.g., demographics, disease burden, infrastructure, and services.	Often include statistics about faith-inspired health facilities.	Various African countries	Ghana 2009: FIOs run 57 (16 percent) of 349 hospitals and 148 (9 percent) of 1613 health centers.
MOH master facility lists	Lists or datasets that include location of all registered health facilities, and sometimes services provided and type of ownership/management. Can include hospitals, health centers, clinics, dispensaries, pharmacies, maternity and nursing homes, etc.	Rarely accessible online.	Kenya (http://www.ehealth.or.ke/facilities/)	Of 5,334 public health facilities on Kenya's master facility list,28percent or almost 1500 were managed by missions or NGOs (Noor et al 2009)
World Bank living standards measurement study http://go.worldbank.org/WKOXNZV3X0	Site includes 88 nationally representative household surveys spanning 26 years, and a survey finder that can search by topic and country.	Health utilization data can often be disaggregated by FIO versus other providers. Very few surveys including health information have		Zambia 2004:11 percent of the people in rural areas visited mission hospitals. Malawi 2004: Household questionnaire includes religion of household members, as well as where treatment was sought for illness in past two weeks (including choices of mission/church facilities or traditional

				healers)
		been completed in the last 10 years.		
Christian Health Association databases	Christian Health Associations (CHAs) maintain databases of member institutions which sometimes contain information on services provided, staff members, and infrastructure.	Rarely accessible online.	17 countries have CHAs.	The CHA of Kenya has a dataset with extensive information on outpatient and inpatient services, physical infrastructure and equipment, human resources, commodity supply chains, and health outcomes.

Table 2.2. Estimated Market Share for FIOs in Selected Countries in Africa

Country	Market Share Estimate	Source
DRC	FBOs provide 50 percent of health services in DRC and co-manage 40 percent of health zones.	Chand and Patterson 2007; Baer 2009
Ghana	Mission facilities alone were estimated to serve around 40 percent of the population, supplying an estimated 30 percent of beds and 35 percent of outpatient care. (But) the private for profit sector operates 31 percent of hospitals while the private not for profit sector, mostly missionary hospitals, account for 22 percent of hospitals and the public sector, 47 percent. 7 percent of health services are provided by faith-based sector when measured by self-reported utilization.	Rasheed 2009 Makinen and World Bank 2011
Kenya	Church health facilities provide up to 40 percent of the health services in Kenya. Many of these health facilities are located in rural and remote parts of the country. The Roman Catholic Church provides more than 25 percent of all care programs and related health services in the country. Faith-based facilities include 76 (15 percent of all) hospitals, 145 (7 percent of all) health centers, 1415 (41 percent of all) dispensaries. Not-for-profit entities own 16 percent of all health facilities,	Mokua 2006 Mwaura 2008 Mathauer 2011 Barnes and World Bank 2010

	comprising mostly dispensaries and health centers.	
Lesotho	40 percent of health-service delivery is provided by nine Christian hospitals and 75 health centers.	Foster 2004
	Nine of the country's 18 health districts are headed by mission hospitals, which carry out comprehensive health planning and management for their districts.	Gill and Carlough 2008
Malawi	The facilities provide about 37-40 percent of the health care service delivery in Malawi, and 80 percent of such in hard to staff areas.	CHA of Malawi
Mali	2 percent of health facilities are managed by faith-based organizations.	African Religious Health Assets Program 2008
Nigeria	40 percent of health services are Christian in Nigeria.	Nigeria CHA 2004
Tanzania	Christian Social Services Commission provides 40 percent of national health care.	Tanzania CHA
Uganda	25 percent of health care in Uganda is delivered by Catholic organizations. 50 percent of 2000 NGOs registered in Uganda are faith-based.	Marshall 2004
	Missions provide a third or more of clinical care.	Gill and Carlough 2008
	40 percent of hospitals have a faith-based connection. More than 30 percent of NGOs are faith-based.	Ssewamala and Ismayilova 2008
	Private not-for-profit (PNFP) facilities, of which 78 percent are faith based, accounted for	Dieleman et al 2007

	43 percent of the hospitals and 24 percent of the lower health care facilities, mostly in rural areas.	
Zambia	Mission hospitals and clinics, commonly located in rural areas and poorer districts throughout the country, provide about 30 percent of the health care in rural areas. Some 30 hospitals and 60 clinics are in operation.	Zambia SPA

Table 2.3. A comparison of selected market share and utilization data

Country	Conventional Market Share Data	Utilization Studies
Cameroon	40 percent	< 5 percent
Chad	20 percent	10 - 20 percent
Ghana	40 percent	5 - 10 percent
Kenya	40 percent	16 percent
Mali	2 percent	5 - 10 percent
Nigeria	40 percent	< 5 percent
Senegal	NA	< 5 percent
Sierra Leone	NA	<5 percent

Sources: Market share estimates are from CHAs; utilization data are from Olivier and Wodon (2011).

Table 2.4. Membership information on selected African Christian Health Associations

Country	Members
Ghana Christian Health Association of Ghana http://www.chagghana.org/chag/	19 Christian Churches in Ghana that broadly fall under the Ghana Catholic Bishops Conference, the Christian Council of Ghana and the Ghana Pentecostal Council . 182 Member Institutions: - 58 Hospitals - 76 Clinics - 19 Health Centers - 15 Primary Health Care programs - 3 specialist facilities - 10 Training Institutions
Kenya Christian Health Association of Kenya www.chak.or.ke	527 members as follows: - 22 Hospitals - 53 Health Centers - 363 Dispensaries - 56 Churches/church organizations - 23 CBHC programs - 10 Nursing Training Colleges
Lesotho Christian Health Association of Lesotho	6 member churches, with: - 8 hospitals - 70 health centers
Nigeria Christian Health Association of Nigeria http://www.channigeria.org/	~400 member institutions: - 140 hospitals - 187 clinics delivering maternal and primary health care - 23 rural health programs - 4 leprosaria In total, the MIs operate some 4,000 outreach health facilities, many of which are situated in remote rural areas.

Zambia Churches Health Association of Zambia http://www.chaz.org.zm/	16 different Catholic and Protestant churches, with 135 member institutions.

Chapter 3. Evidence on the Effectiveness and Distinctiveness of FIOs' Health Work in Africa

3.1 Introduction

This Chapter presents the results of the search for and reviews of the evidence on FIOs' performance in two related but distinct areas. The first area concerns evidence on their effectiveness in terms of health outcomes. The second concerns evidence supporting their purported comparative advantages. The two areas are related because it makes sense that the purported comparative advantages of FIOs would be important drivers of their effectiveness. But the two areas can be treated separately because FIOs' distinctives are not the only possible drivers of effectiveness in health results and also because performance in terms of specified health results versus performance in terms of, say, reaching the poor are distinct types of outcomes and can be supported by different types of evidence.

Evaluation reports constitute a specific segment of literature/information, and Appendix 1 in the Background Paper provides an overview of evaluation in international development. To summarize, assessing programs and projects for effectiveness is essential to finding out what works and it is receiving growing attention. Until recently, many evaluations were weak, with reports labeled as evaluations and assessments often only providing monitoring information such as counts of inputs and outputs. While there is no strong proof that, as some charge, FIOs are weaker at evaluation than other health providers, across health and international development service providers, a key to improving evaluation is that donors or other stakeholders require that implementers produce or otherwise support rigorous evaluations of their health work.

While this study focuses primarily on evidence on FIOs' health work in Africa, evidence from other countries is also reviewed, for two reasons. One is because work on the effectiveness and distinctiveness of FIOs has been particularly active in the US. This is due to government policies there to encourage greater participation by faith-inspired organizations in publically-funded domestic social and overseas assistance programs, policies influenced by a belief by some that FIOs are especially effective at social services compared to other providers (Johnson 2002). The second reason is because, as numerous authors have pointed out, there are few studies that systematically test the effectiveness of FIOs and attempt to identify and measure the "faith in faith-based"[10] (Aiken 2010; Amirkhanyan, Kim, and Lambright 2009; CIFA 2010; Fischer 2003; James 2009; Johnson 2002; Monsma and Soper 2003; Rakodi 2011; Smith, Bartkowski and Grettenberger 2006). Thus, since the cup of evidence on FIOs' effectiveness is not overflowing, the team drew on all sources.[11]

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[10] Johnson 2002.

[11] Tearfund, a UK- based FIO, has launched an ambitious "Joint Learning Initiative" whose goals are both to cast a wide net to gather better evidence and to ensure that the information is more widely available. After some two years of preparatory work, in early 2012 the effort was poised to start its work, so no outputs from it were available for this study.

3.2 Evidence on the effectiveness of faith-inspired organizations' health work in the US

Below, US literature reviews and individual papers are surveyed. It is worth noting that many of the individual US studies deal with social services (such as substance abuse or welfare-to-work programs) rather than physical health programs or facilities, and that arguably there is more room for faith to have an impact in the former than the latter, though it is relevant for both. One can see more room in, say, a substance abuse program for faith to affect programming, client perceptions and motivation, and outcomes, in contrast to, say, the performance of surgery or administration of a vaccine, where surgical skills and equipment or vaccine efficacy will play larger though not exclusive roles in outcomes.

3.2.1 Literature reviews

Robert L. Fischer, Co-Director of the Center on Urban Poverty & Community Development at Case Western Reserve University (Fischer 2008), provides a good "review of the reviews," describing four literature reviews on the outcomes of FIOs' US-based health and social service programs. The team notes that three of the four reviews he covers are indeed the most frequently-cited reviews of the topic. A brief synopsis of each is provided below.[12]

Johnson (2002) reviewed, in addition to the impacts of what he called organic religion (religious practices or involvement by individuals), the impacts of intentional religion, which is work carried out by faith-based organizations. He found 669 studies on organic religion that he said provided "impressive and mounting evidence" that higher levels of religious practice or involvement is linked to reductions in various harmful outcomes. But after an exhaustive search of online databases and direct contact with FIOs, he found just 25 studies on the effectiveness of faith-based organizations in health and social services. He also reported that the majority of the large, nationally known FIOs he contacted at the time had no empirical studies on the effectiveness of their health and social service programs, including well-known organizations that received hundreds of millions dollars of US government funding per annum. His main conclusions were that the overall body of work showed promising effects of FIOs in providing health and social services and that most areas of FIOs' services had not yet been the subject of serious evaluation.

DeHaven et al (2004) reviewed studies on health programs and clinics run by faith-based organizations in the US and their effectiveness. They found 53 such studies that covered programs dealing with cardiovascular health, cancer, mental health, and nutrition. Of 16 studies that reported a statistical test of outcomes against an un-served population (there were no tests against a population served by non-faith providers), 15 showed a significant difference supporting the efficacy of the faith-based intervention group. DeHaven et al conclude that faith-based health programs can produce positive effects on health, and that more evaluations are needed.

Ferguson et al (2007) conducted a systematic review of online databases and other sources using as key words "faith based" and "program effectiveness" across different types of health and social services

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[12] One of the literature reviews Fischer covers is on distinguishing different types of FIOs, and not on effectiveness , so it is not covered here.

carried out in the US. Their conclusion was that given the limited number and quality of studies that they found, the effectiveness of faith-based programs is open to question.

3.2.2 Individual studies

Monsma and Soper (2003) compared five different types of welfare-to-work programs: public, for-profit, secular nonprofit and two types of faith-based programs. They found no clear and consistent pattern of any one program type doing a more effective job in helping welfare recipients transfer to and keep jobs, but rather that each program type did particularly well on some measures and worse on others. Clients found the faith-inspired and secular nonprofit providers best in terms of staff and program empathy. For-profit programs did the best in terms of moving clients from unemployment to long-term employment, but faith-based and public programs were the best at helping already-employed clients stay employed. The authors conclude that the different strengths and weaknesses of the five program types suggest that an ideal program is one that involves collaborative or partnership approaches, and that the results provide no reason to exclude faith-based providers systemically from government funded programs.

Smith, Bartkowski and Grettenberger (2006) compared faith-inspired and secular nonprofit programs in three different social service categories via case studies, though they did not have outcome data to address objective effectiveness. They found that the FIOs studied strive to emphasize clients' individual rights and dignity; are reluctant to proselytize; and are more likely to approach their services as a moral endeavor rather than a more purely technical one. FIOs also tend to view the personal transformation of a client as crucial to attainment of program objectives, whereas secular agencies find the client achieving an appropriate mix of skills as crucial, and put greater primacy on hiring qualified staff. They found that two strong themes were the extreme diversity among faith-inspired organizations, with some FIOS operating wholly secular programs and some self-identified secular agencies offering programs with strong faith content, and the great interaction between the secular and faith worlds in matters of social service.

Reingold, Pirog and Brady (2007) case-matched FIOs and nonreligious organizations that provide social services to welfare recipients and the poor, analyzing agency differences in organizational capacity and responses to welfare reform, but not capturing outcomes. While there were some differences between FIOs and nonreligious organizations, they did not differ in significant ways organizationally or in self-rated performance. The authors say that their findings are consistent with Chaves' contention that "religiously- based social services are not, in general, an alternative to secular or government-supported social service delivery. They are, rather, part of that world" (Chaves 2004).

De Jong and Horn (2008) reported on participation by the US FIO, Gospel Rescue Missions (GRM), in a National Recovery Initiative pilot study that aimed to develop measures of the components of faith that permeate GRM's work at the organizational and service levels, notably on substance abuse treatment programs. The authors observed that the pilot lays the groundwork for answering how faith program components actually contribute to individual outcomes by highlighting the need for greater conceptual clarify, specificity, and operationalization of key measures of programmatic faith.

Turning to health facilities, McClellan and Staiger (1999) compared for-profit and non-profit hospitals in terms of patient outcomes and found no systematic difference once controlling for location, results confirmed by Sloan et al (2001) who found "not a dime's worth of difference" between the two types of

facilities in terms of costs to Medicare and patient outcome. Studies comparing faith-based and for-profit nursing homes in terms of patient outcomes and other indicators such as inspection violations and complaints from clients' families have found mixed results, some researchers (Ragan 2004) finding that the faith-inspired facilities perform better and others finding no differences (Amirkhanyan, Kim, and Lambright 2009).

3.2.3 Discussion

The above studies provide mixed evidence on the effectiveness and distinctiveness of FIOs. They confirm 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. Differences in program outcomes also exist, but are often subtle and there is no overall trend of greater or less effectiveness of FIOs. Finally, there is a good deal of overlap between the programs elements of FIOs and other types of providers, including use of religious language or symbols.

Regarding the mixed nature of the US evidence, it seems that the urging of Boddie and Cnaan in 2006 for new work to open the "black box" of faith-based service delivery still stands. They recommended work that would measure the extent of faith-based program elements in a particular service and track participant exposure to faith components, with outcome measures specific enough to link the faith-based aspects of a service to client-change over time. A related issue is the "dose of religion" that different programs offer: as discussed earlier, the degree of religiosity of an organization or program, along with the number of faith-tinged interventions, can vary significantly. If faith or faith factors are drivers of certain outcomes, then should more strongly religious organizations or programming produce better results, all other things being equal? Or, might the relationship of "dose of religion" and health outcomes constitute an inverse U-shaped curve, being beneficial only up to a certain amount or intensity of religion? The team found no US studies focused on comparing social service or health outcomes across FIOs of different faiths, but a study with this flavor exists for Africa (Davis et al 2011) and is reviewed below. Such comparative studies need not be as potentially sensitive as they sound, if they are investigating whether programmatic or organizational differences tied to different faith traditions impact effectiveness (and not which religion is more true or powerful!). Many authors do urge more comparisons of FIOs with public, for-profit and secular non-profit organizations (Smith, Bartkowski and Grettenberger 2006), and Lipsky (2011) thinks that comparisons of FIOs and secular NGOs could distinguish the impacts of faith versus non-religiously-motivated altruism.

3.3 Evidence on the effectiveness of FIOs' health work in Africa

3.3.1 Introduction

As noted in the methodology section, the team searched for evaluations from major international organizations, national aid agencies, FIOs, and third-party evaluators such as consulting firms, as well as searching the academic literature. The team found that many of the first group do not publish evaluations of individual health programs. Of the second group, only USAID and NORAD commonly publish individual program evaluations, and USAID stands out in providing all available evaluations on program it funds on its "Development Experience Clearinghouse" website (dec.usaid.gov). Most FIOs, even INGOs, do not provide self- or third-party evaluations of their work on their websites or otherwise

make them available, even when the team for this study contacted them to request evaluations; CRS is an exception. Rather, FIOs tend to provide, on their websites or otherwise, anecdotal or monitoring-type, i.e., input/output, information on their work. Evaluations by third-party evaluators are often commissioned by funders or FIOs, become their property, and are not published. Some otherwise excellent websites focused on international development evaluation are disappointing in terms of providing a range of individual health program or facility assessments (e.g., International Initiative for Impact Evaluation at http://www.3ieimpact.org/). While it is relatively easy to find reports about programs run by US Christian INGOs and for HIV and AIDS, it is hard to find reports for programs run by non-US and non-Christian FIOs and across a wide range of diseases. Thus, the public availability of evaluations is a mixed bag.

The team found it useful to put the evaluations and related articles into three groups, though there is room for overlap among them. The first group is designated stand-alone evaluations, and they are assessments that do not compare a FIO with another type of non-religious provider nor address in any substantive way the faith-inspiration or possible faith factors of an organization or its health work. The second group is designated comparative evaluations, and these do compare FIOs and non-religious organizations, but without explicitly addressing possible faith factors. The third group is evaluations that address faith factors, representing assessments that deal in some way with possible faith factors of organizations or their health work.

The team noted a dichotomy between evaluations of health programs versus health facilities. Many evaluation reports dealt with health programs that did not feature higher-level medical interventions and tended to be of a certain number of types, e.g., HIV and AIDS support services, child nutrition and health, and health education projects dominated. The team notes that these types of programs tend to yield different sorts of information on effectiveness than studies that assess the more traditional work of FIOs in Africa centered at hospitals and clinics, and are less likely to be comparative or delve into what drives effectiveness. A reason for this is because two hospitals, say, and/or some of the specific medical services they offer are easier to compare across different ownership/management (e.g., faith-based and public) than may be two health programs carried out in the field under changing circumstances. There is a large body of and literature on effectiveness, efficiency, and quality of care at health facilities or for specific medical interventions in low-income countries that sometimes includes evaluation-type information but tended not to show up in the search for this study because the papers do not focus on faith-inspired care. See, for example, Berman and Laura (1995) on "The role of private providers in maternal and child health and family planning services in developing countries;" Flessa et al (2011) on "Basing care reforms on evidence: The Kenya health sector costing model;" Hetzel et al (2007) on "Understanding and improving access to prompt and effective malaria treatment and care in rural Tanzania;" a series of studies on the website of the International Health Systems Program at Harvard University School of Public Health (http://www.hsph.harvard.edu/ihsg/ihsg.html), and a series of papers produced for the Rockefeller Foundation's 2008 project on the role of the private sector in health systems in developing countries (http://resultsfordevelopment.org/projects/role-private-sector-health-systems).

3.3.2 Stand-alone evaluations

Most evaluations of FIOs' health work in Africa fall into this category, e.g., the reports on the USAID evaluation site tend to be stand-alone evaluations. The team did quick scans of each returned article, but decided to select 15 evaluations for deeper review, picking those that were more rigorous and trying

to maximize diversity in terms of countries, health issues, and FIOs (though as noted, most evaluations are for Christian FIOs and for HIV and AIDS). The selected evaluations are listed in Appendix 2 of the Background Paper as well as in the bibliography and several of them are discussed below, but the discussion as a whole reflects the full range of evaluations returned from the search process.

A USAID/Access (2007) evaluation of a project working with FBOs in Uganda to prevent malaria in pregnancy found the program to be highly successful, and the evaluators attributed the effectiveness to the involvement of FBOs and noted that the MOH planned to replicate the program model in other parts of the country.

Schneider et al (2008) evaluated a USAID TB child survival program implemented in eight countries at the community-level by seven different NGO implementers, including secular and faith-inspired organizations. The evaluation provided quantitative evidence of the program's effectiveness, as well as room for improvement, but drew no observations that differentiated between the secular and faith-inspired organizations.

CRS (2009) conducted an evaluation of a child health program it carried out in Burundi; it noted outcomes such as 45 outpatient therapy programs created and supplementary rations delivered to over 71,000 malnourished children but made no mention of faith or other distinctive programming.

USAID evaluated a child survival program in Liberia implemented by the FIO Medical Teams International, partnering with Liberia's CHA. The rigorous evaluation, which included Lot Quality Assurance Sampling (a sophisticated analytical technique), confirmed positive changes in key child survival and maternal health behaviors. The report noted that even though the implementers were faith-based Christian organizations, the program was highly acceptable to Muslim communities.

The European FIO Norwegian Church Aid (2008) evaluated a home-based HIV and AIDS support project. The evaluation, a mostly qualitative assessment, reported that spiritual care was lacking among the project population.

Rutta et al (2006) provided evaluation of a USAID-funded project whose objective was to analyze availability and use of policies and guidelines for HIV and AIDS service delivery. This evaluation assessed five mission hospitals in Tanzania and found that all the hospitals had sound audit systems and that policies for care were available and appeared to be in regular use. The evaluation also found all the facilities had functional computers in daily use and offered continuing medical education. Weaknesses included shortfalls in pharmaceutical storage and stock records.

Chang et al (2009) evaluated the faith-inspired Reach Out Mbuya Parish HIV and AIDS Initiative in a peer-reviewed journal and found that 72 percent of the Mbuya patients maintained their regimens during the two year study period, with survival rates of 84 percent at year one and 82 percent at year two. Of those tested at the end of the evaluation period, 86 percent had undetectable viral loads (<400 copies/mL). Though the study lacked a control group, the authors noted that the results indicated a highly successful program when compared to international benchmarks, and they speculated on whether the faith-inspired networks or setting were factors in the success of the program.

Magnano et al (2009) evaluated the "Drug Resource Enhancement against AIDS and Malnutrition" (DREAM) program of the Community of Sant'Egidio, also publishing in a peer-reviewed journal (See

Keough and Marshall 2007; http://santegidio.org; and Supplement 2and). DREAM provides a comprehensive treatment approach to HIV and AIDS that includes ART, diagnostics, strategies for treatment adherence, attention to opportunistic diseases that co-exist with HIV and AIDS, and prevention of mother-to-child transmission (MTCT). DREAM may be the most rigorously studied faith-inspired HIV and AIDS program in the world, and the Community's website provides a list of the 100 or so papers on the program, many of them peer-reviewed studies attesting to its efficacy. Magnano et al found that 95 percent of DREAM patients knew how HIV was transmitted and 94 percent knew that it was necessary for them to take their HAART therapies at the same time every day. During the one year evaluation period, 87 percent of patients completed their treatments, and 84 percent had undetectable viral loads (<400 copies/mL) at the end of the year, compared with only 5.4 percent at the beginning of treatment, indicating a highly-effective program compared to relevant benchmarks. The article does not mention the faith-inspired nature of the program.

It is disappointing (though not unexpected) that the greatest amount of evaluation work falls into the stand-alone category. It is disappointing because while these evaluations indicate that FIOs do effective health work across various programs and countries, they provide virtually no insight into FIOs' relative performance or distinctives. The fact that there was scant mention of faith in these evaluations tends to confirm what was reported by FIO practitioners in interviews, namely that generally, FIOs do not employ (explicitly) or document faith programming in health projects carried out for secular funders or stakeholders. In fact, interviews with practitioners and other research suggested some "cognitive dissonance" in this regard. That is, FIOs often state that they bring faith-inspiration to their health work and that this provides something special, though not necessarily better. Yet, some FIO practitioners also suggest that in carrying out health programs funded by the government or secular international organizations, their programs will be, or even should be, essentially identical to those of secular providers. The review of stand-alone evaluations tended to confirm the latter view, by dint of scant reference to any faith-related approaches or programming.

When comparing the stand-alone evaluations on implementers that happened to be faith-inspired to those for secular implementers (See Part B of Appendix 2) as well as to other information obtained for the study as a whole, the team found no indications that FIOs tended to be less effective than other types of health providers.

3.3.3 Comparative evaluations

The team found two reviews and five individual studies that dealt with the comparative performance of FIOs in an African context. Also found was evidence from World Bank reports on the private health sector in Africa and other work that included information relevant for FIOs even though not focused on them.

In Widmer et al (2011), the authors, who have affiliations to WHO, UNDP, and Johns Hopkins University, reviewed five evaluations and one descriptive overview article on maternal and newborn health and concluded that faith-based organizations provide higher quality of care and engender better patient satisfaction in maternal/newborn services compared to government providers. The Widmer et al review confirms the scarcity of robust comparative studies of FIOs' performance, since the five evaluations on which it reports were gleaned from a search of the literature from 1989 to 2009. The conclusions of a review can, of course, only be as strong as the underlying analyses, and the team for this present study found the studies underlying Widmer et al relatively weak. For example, the finding of better care by

FIOs in one study is based on a satisfaction rate of 96.9 percent at government facilities versus 99.1 percent at FBOs, a difference that is probably not statistically significant. Moreover, in the underlying reports, sample sizes were very small. Gill and Carlough (2008) also surveyed the literature on maternity care by mission-based health providers, including two of the papers covered by Widmer et al and a few other reports that were not comparative evaluations per se. They concluded that the management and clinical care provided by FBOs are often of higher quality than that provided by government hospitals. They suggest but do not test that the findings could be tied to features of FIOs such as having more resources, greater access to expatriate staff, and flexibility in hiring and managing staff and procuring and managing medicines and supplies. In reading the underlying reports, the team for this present study felt that in some cases information was selected for inclusion in the review that tended to reflect positively on FIOs.

Sen (1994) carried out a case study of mosque societies in Egypt that began to offer health services in the 1970s in response to a sense that the poor were getting squeezed out of health care between the high cost of private health care and the perceived poor quality of public services. A case study of these societies found that they make an important contribution to health in the country (Sen 1994), providing lower-cost and better-quality care, as perceived by patients and through observations at the facilities. The health staff at one of these facilities, Aphgany Hospital, all held full time posts in public health facilities. The fees structure at Aphgany meant that doctors and nurses could considerably improve on their public salaries by working part time at the Hospital, and yet the mosque society either reduced or waived fees for poorer patients, plus and fees for the general patient population were nominal in comparison with those charged in the for-profit sector. All of the doctors at Aphgany cited service to the community and to the poor as the main reason for working at the mosque health facility, and none mentioned the financial incentives. A side-effect of the mosque society hospitals was that they displaced private for-profit practitioners, with numerous private doctors located near Aphgany going out of business over time.

The 2003 study by Reinikka and Svensson contrasting religious, privately-owned, and government health providers in Uganda is the most famous and highly-regarded analysis of the comparative effectiveness of FIOs. It stands out for specifying theoretical approaches to what drives the not-for-profit providers and testing models of the facilities' objective function via regression analysis. Since their work provides insights into comparative effectiveness, faith factors, and comparative advantages, it will be discussed several times in this Chapter, albeit briefly. Regarding comparative effectiveness, Reinikka and Svensson find that religious not-for-profit health care and privately-owned facilities provide better care than government providers and the religious not-for-profits charge lower prices for services than the privately-owned facilities.

Willey and Schellenberg (2009) compared faith-inspired and other facilities in five districts in Tanzania. The survey was undertaken to assess a new approach to malaria and anemia control in infants. The methodology involved interviewing health workers, checking the availability and functioning of equipment and drugs supplies, and collecting Health Management Information System (HMIS) data from the facilities. The study included visits to 133 health facilities including hospitals, health centers, and dispensaries that the authors described as being owned by the government, mission/NGOs, and privately. Ten or 7.5 percent of the 133 facilities were mission-owned. The authors found that staff availability, training, and supervision characteristics did not differ significantly between government and mission-owned facilities. Of 24 variables tested, mission hospitals were significantly better at four: they

were more likely to have a functional water supply, equipment for reading malaria blood slides, certain antibiotics, and certain drugs for treating severely-ill children. Mission hospitals performed worse on indicators concerning health data management. The authors note that the mission facilities were all hospitals, while the facilities of different ownership types were a mix of facilities, and since hospitals would be expected to have better equipment and supplies, regardless of ownership, this impacts how much the results say about faith-ownership as opposed to about hospitals versus other types of facilities. The authors conclude that FBO facilities make an important contribution to health care in a remote and rural part of Tanzania.

Davis et al (2011), of the RaD programme at the University of Birmingham, undertook a highly detailed and lengthy comparison of four FIOs (two Christian and two Muslim) and three secular NGOs engaged in HIV and AIDS work in Nigeria. Since the authors used a case study approach, the analysis is qualitative, but the level of detail supports a credible comparison of the different providers. The authors noted that the high degree of religiosity of Nigerians could limit the ability to discern differences between FIOs and secular organizations, e.g., the staff of both would be likely to be personally faith-inspired. However, they also noted that they selected organizations working on HIV and AIDS because it is a health issue where differences in FIOs' and secular approaches could be particularly clear.

The authors found that the NGOs had a predominantly material focus that emphasized physical wellbeing while FIOs combined physical and spiritual aims. Many patients felt that the FIOs had advantages over secular NGOs, and the list of their reasons for these perceptions comprised the standard purported comparative advantages of FIOs such as greater credibility and commitment. One of the FIOs, Al-Noury Specialist Hospital, is a Muslim facility that incorporates religious messages, practices and symbols in its program delivery. The authors report that this does not alienate non-Muslim clients who continue to use the facility because of the low health care costs and the confidentiality it guarantees to HIV and AIDS patients. The hospital's performance indicators are shaped by the Islamic beliefs, and include as positive indicators, conversion to Islam, more positive views of Islam by non-Muslims, or strengthening of the faith of Muslims.

However, the authors found no clear difference in the effectiveness of the faith-based versus secular organizations as measured by patient assessments of the quality of care. The authors conclude that government and funders should decide on using FIOs on a case by case basis and that FIOs and NGOs are not necessarily alternatives but might rather work collaboratively in religiously-sensitive contexts.

Leonard and Masatu (2007) compared NGOs (not distinguishing whether faith-inspired or secular) and public health providers in Tanzania and found that the former provide better quality of care including across the "urban-rural divide," a reference to the large drop in health care quality that occurs as one moves from urban to rural areas in low-income countries. Since data for Tanzania indicates that FIOs make up the large majority of the non-profit sector, the team considered that Leonard and Masatu's results speak to the comparative effectiveness of FIOs. The study stands out for its methods: researchers measured competence and performance, the latter via direct clinician observation.

The series of World Bank/IFC studies of the private health sectors of African countries cited in Chapter 2 provide nuggets of comparative effectiveness information, even though this is not the reports' focus. In the assessment of Ghana, patient exit polls indicated that the Christian Health Association of Ghana (CHAG) provided more courteous service than other secular providers and that private providers, a classification including CHAG members, offer shorter waiting times than public facilities (Makinen et al

2011). However, there are no significant differences in overall patient satisfaction among the different provider types. An IFC study of private health care in nine African countries found that the FIO health sector often provides quality of care comparable to the for-profit private sector, is frequently preferred by patients, and in some cases sets the benchmark for higher quality (IFC 2011). However, the team notes that no work has been done on how expressions of patient satisfaction correspond to actual health outcomes.

One obvious conclusion on comparative analyses of FIOs' health work in Africa is that their number is small. There are, no doubt, studies that the bibliographic search failed to capture. Still, since the team also asked all the experts that it interviewed for information on any comparative evaluation studies they were aware of and the only report ever suggested was Reinikka and Svensson, the conclusion on the scarcity of comparative studies seems valid. It seems very much the case that FIOs and funders do not undertake evaluations comparing the outcomes of faith-inspired and secular programs, and one must look to reports published in journals or produced by academic or other research institutes.

The reviewed analyses suggest that the FIOs studied are as or more effective than other providers, while, sometimes, charging less for health services, with effectiveness measured as patient satisfaction, health outcomes, or other quality of care indicators. It must be noted that such results tend to agree with the bulk of anecdotal information, with various practitioners making observations such as that FIOs always have drugs to treat patients, or that mission hospitals are generally regarded as providing better patient care; throughout this study, the team never heard an anecdote reporting less effective care in a FIO. Concerning the robustness of the existing comparative evaluations, a balance might need to be found between the work of Reinnika and Svensson, an outstanding and rigorous study but one of limited practicality for most evaluations and evaluators, and other approaches that are simpler but nonetheless methodologically and statistically sound.

3.3.4 Evaluations that address faith factors

As explained in Chapter 1, this study uses the term "faith factors" to cover any factor, positive or negative, that is a faith-related feature of an organization or health work, including but not limited to FIOs' purported comparative advantages. Wodon observes that a finding that FIOs perform better would have limited use for policy, since the more important questions are why do FIOs perform better, and how can this be replicated (Interview 2011). Thus, evaluations that attempt to identify and measure the faith-related elements of an organization or health work–"faith factors"–could go farthest to open up the "black box of faith inspired service delivery." However, for Africa, possibly the only robust and explicit study of faith factors is the Reinikka and Svensson paper (introduced above and discussed again below) which models and tests a faith factor, namely health worker altruism. Since the literature search for this study did not find any other explicit evaluations of faith factors, the team turned to evaluations of faith-inspired behavior change communication (BCC) work.

Like the Reinikka and Svensson work, BCC evaluations have implications as studies of faith factors and of purported comparative advantages, so they two will be covered twice in the remainder of this chapter. Specifically, when a BCC initiative is designed to involve faith leaders and communities, by definition it involves a faith factor. And, it seems generally accepted that BCC initiatives involving faith leaders and communities are implicitly drawing on purported comparative advantages of FIOs such as faith leaders' credibility, extensive networks, reach to difficult-to-reach populations, and individual commitment around faith, both by workers and volunteers working on a BCC initiative and by those receiving the BCC

message in a faith context. This is the case even though no current evaluations of BCC compared faith-inspired and secular health programs in Africa; the latter type of evaluation could be ideal for exploring faith factors.

Reinikka and Svensson (2003) develop a model for the behavior of religious health providers (RHPs) that includes altruism as a motivation and derive the implications for their choice of wages, prices, service mix, and quality of care. They then see if the data confirm the model, using also models of the behavior of the private for-profit providers (profit maximization) and the government providers (delivery of a minimum package of services). Their results are consistent with FIOs being motivated in part by altruism, with a key finding being that RHPs can hire qualified medical staff below the market wage.

Independent evaluation of the Nigerian InterFaith Action Association (NIFAA) and CIFA program to train religious leaders to disseminate malaria prevention messages found that it was highly effective compared to baselines and controls (Wise Solutions 2011; CIFA 2011). The interfaith program trains Christian and Muslim religious leaders in the country with the world's highest malaria burden with malaria control messages to deliver to congregants (See also Supplement 1). Evaluation data indicate a clear impact on knowledge and attitudes and reported net utilization. Comparison of reported net usage in a "NIFAA state" with a state in which NIFAA was not active shows a significant difference in reported net utilization: 51.6 percent of under-five children in a NIFAA state versus less than half of that in a non-NIFAA state, according to World Bank lot quality assurance sampling data. Ninety percent of the congregants of trained leaders reported hearing sermons with malaria-related content.

While results are not yet available, external evaluation will be carried out on TBFF's anti-malaria BCC program using faith leaders in Sierra Leone and on TBFF's similar program in Uganda, with the objective of producing quantitative measures of the significance of religious leaders instructing and passing messages through a faith community (Linden Interview 2011). Robert Dowd of the University of Notre Dame has work underway, supported by TBFF, comparing the effectiveness of religious leaders and local political leaders in encouraging the use of water purification tablets in Uganda (Dowd Interview 2012).

An evaluation of a USAID-funded project to increase the use of family planning services that partnered with the Kano, Nigeria Section of the Federation of Muslim Women Association of Nigeria (FOMWAN) found that the program was effective (Lane et al 2010). The Extending Service Delivery Project (ESD) aimed to reach young married women, their husbands, and mothers-in-law through household visits with information about the benefits of using family planning to practice healthy timing and spacing of pregnancy. A community survey implemented in June 2010 found high recall on the recommendations on timing and spacing of pregnancy and indicators of program efficacy.

One of the studies reviewed by Widmer et al (2011) was in fact an independent evaluation of a BCC program, namely Iyun's 1989 study of a maternity and child health education program run by the Ogbomoso Baptist Medical Centre in Nigeria. While Widmer et al note positive findings from the report, the evaluation also reports that the use of Baptist church structures for the health education alienated Muslims and non-Baptists and that reception of home health visits was "lukewarm" (Iyun 1989).

The above evaluations of faith-inspired BCC work suggest that this is a promising area where FIOs can make a faith-specific difference in health outcomes and where faith factors can be assessed. Studies such as Dowd's (2012) directly and specifically comparing the efficacy of faith-inspired BCC to

comparable secular BCC programs would be highly useful to understand or confirm the role of faith factors.

The team notes that there are also "real-life" cases where the presence and effectiveness of a faith factor is evident. Marshall describes how a government project to distribute two million ITNs in the DRC, the country with the world's worse malaria mortality, was interrupted by a politically-motivated rumor that the nets were poisoned. Remaining nets were distributed only after the Ministry of Health engaged local religious leaders to dispel the rumors in their congregations (ARHAP 2011).

3.4 Evidence on the Purported Comparative Advantages of FIOs

As noted in the methodology section, the team focused on searching for evidence on two of the comparative advantages or distinctives commonly ascribed to FIOs, namely, reach to the poor, rural, marginalized or those living in conflict zones, and greater commitment by FIOs collectively and/or by those working or volunteering for FIOs.

3.4.1 Reach to the poor and vulnerable

Many stakeholders suggest that FIOs have special reach to the poor, rural, and other vulnerable groups. For example, PEPFAR states that local FBOs remain an underutilized resource for expanding the reach of quality healthcare (PEPFAR 2008). World Vision, as a part of their Transformational Development Indicators, measures the extent to which they are serving the poorest households (http://transformational-development.org/). Saddleback Church emphasizes its objective of serving the poorest and most underserved in its Rwanda project (http://www.saddleback.com/). There is a fair amount of scattered evidence supporting this distinctive feature, but newer mapping information raises questions about it.

Turning again to Reinikka and Svensson (2003), their work finds that religious nonprofit healthcare providers in Uganda are more likely than other providers to provide pro-poor services and services with a public good element. The reader is reminded that some of the US studies also found that FIOs tend to serve a poorer clientele than non-religious organizations (Reingold, Pirog, and Brady 2007).

A study of polio eradication efforts in India and Pakistan (Obregon et al 2009) found that FIOs could extend the reach of immunization campaigns. For example, work by FIOs on an Indian immunization campaign focused on populations with the lowest access to health care, predominantly Muslim communities that tended to be both poorer than other groups and socially marginalized.

Various CHAs or researchers who study them report that CHA members' health facilities are mainly located in rural, remote, or other marginalized areas. For example, the Christian Health Association of Malawi reports that it manages health facilities in mainly remote rural areas of the country, and the CHA of Zambia says that while it accounts for some 30 percent of Zambia's total health care it accounts for 50 percent of rural health care (Nussbaum 2005, cited in Olivier and Wodon 2011). However, these estimates are not necessarily based on rigorous poverty and rural-area data.

It appears that in Africa, the private health sector as a whole, which includes both FIOs and for-profit providers, disproportionately serves the poor, while the better-off benefit more from public health spending, in part because the middle-class is more likely to live close to government health care. There

is some evidence that FIOs sometimes charge less than other private providers (World Bank 2011). Robert Dowd of the University of Notre Dame states that his work in the area of faith and health in Africa suggests that public institutions are more likely to serve the poor in urban areas because they charge minimal fees compared to FIOs and other private institutions that get little or no public funding (Dowd 2012), though as noted above, many African governments fund FIOs.

Reports from fragile states confirm the comparative reach of FIOs to those living in conflict zones. In the DRC, FIOs manage 40 percent of the country's 515 public health zones for the government (Baer 2008). In South Sudan, FIOs along with secular NGOs provide essentially all health services (Supplement 2).

Mapping exercises that layer poverty, population density, or other data with the location of faith-inspired health facilities or services should be able to provide fairly straightforward information on whether FIOs are indeed preferentially serving vulnerable populations. Oliver and Wodon (2011b) review whether faith-inspired providers target the poor. They note that many experts, both faith-inspired and secular, support the idea; many experts interviewed for this study emphasized personal observation of FIOs' preferential service to the poor. Oliver and Wodon (2011b) first note that many FIOs were established in urban areas linked to colonial administrative centers or ecclesial considerations, rather than an analysis of poverty. A growing public health sector in many African countries that post-dates the mission-centered health sector may have expanded more relative to FIOs, in particular in rural areas. When national comparisons of faith-inspired and public facilities are made, FIOs collectively do not appear to be as comparatively strong in rural areas as they might have been in the past. The authors make it clear that they are not contesting the great desire of FIOs to serve the poor and other vulnerable populations, but rather observing that little current data beyond anecdotal information strongly demonstrates it.

3.4.2 Greater commitment

That faith-inspired organizations and the people who work or volunteer for them tend to bring greater commitment to their health work is another purported comparative advantage of FIOs, with the commitment believed to translate into better health care. At the same time, many FIO staff and other stakeholders are quick to say that their secular NGO counterparts are also highly-committed to the sick and needy. Moreover, especially in Africa, the same medical professionals may work in the public, secular NGO, and FIO sectors, at different times or even at the same time, e.g., as in Sen's (1994) Egyptian case study. Also, the essentially ubiquitous individual religiosity of Africans may add to the difficulty of finding differences in commitment. Just as reach to the poor could be evidenced by location, amount of services, or cost or quality of service, greater commitment could evidence itself as staff working more unpaid overtime, accepting lower wages, working in/under less desirable conditions, such as rural health posts, or providing higher-quality care. Clear evidence of greater commitment might also need to take into account that staff at a given FIO might work harder because of some organizational feature that is not faith-related. Theoretical literature on how personal identity may affect job performance and how religious identify impacts economic behavior suggests that an individual's faith influences attitudes and values about work (Akerlof and Kranton 2010; Benjamin, Choi, and Fisher 2009).

Turning again to Reinikka and Svensson (2003), the authors provide evidence of greater commitment via their finding that religious health providers in Uganda can hire qualified medical staff at below the market wage, while still providing better care than public counterparts. Their results indicate that a

difference can be detected between faith-inspired and secular health providers, a finding against the more "universalist" view that most people who work in health care in Africa are motivated by compassion or altruism.

Other research shows that while faith might play a role in staff motivation, it is not the only or primary factor. In Malawi, staff attitudes and behaviors toward service improved after joining mission hospitals (Gill and Carlough 2008). But a study of health workers in Benin found that while 67 percent of health workers at private or NGO facilities assessed their level of motivation as "good to very high" versus 25 percent at public facilities, motivation seemed more linked to the medical professionalism of their environment rather than to personal values (Mathauer and Imhoff 2006).

In a study of health workers in Ethiopia and Rwanda, Serneels et al (2010) found that the likelihood that health workers would accept a rural health post was not primarily dependent on faith. A study of health care workers in Kenya found that only 6 percent preferred FIOs as employers, and the main reasons for continuing work with the current employer were good management, clean environment, and proximity to home (Mwenda 2011).

Further complicating the picture, faith has been shown to be a contributing factor in deciding to work for secular NGOs. In a case study of an international secular NGO working in Uganda, which was secular but included prayer as an integral part of the daily staff routine, staff members cited faith as their primary motivating factor, both to work for the NGO and to work extra, unpaid hours (Aiken 2010). In a study of humanitarian relief NGOs working in Europe and the Middle East, with the organizations being two-thirds faith-inspired and one-third secular, 50 percent of respondents mentioned spirituality or faith when asked how they came to work for their organization (Flanigan 2010).

Chapter 4. Conclusions and Research Priorities

This Chapter briefly summarizes conclusions and presents recommendations on research priorities.

4.1 Conclusions

Thirty years ago the health work of FIOs began to emerge as a specific area of study and discussion in global health. Despite much work, and notwithstanding repeated calls for more clarity, theoretical frameworks, data, and empirical evidence, there are still major gaps in knowledge. The gaps matter because they impede Africans, their governments, and the international community from making the best choices to improve public health in Africa. Notably, the gaps impede the integration of FIOs' work in national health systems and international health initiatives and funding.

Many articles and reports lament how little is known about faith-inspired health work, but this study found that substantial research, data, and knowledge exists. The problem is that information is locked into silos; driven by contending mindsets; compromised by problems of definitions; or is highly theoretical. Thus, much knowledge is not well used. It is time to take stock, reflect on critical questions, acknowledge the dynamism of health sectors in African countries, and reorient both research and operational agendas.

Many practitioners seem unaware of the work of others and of data that are indeed available. An example is research work that is not explicitly focused on FIOs (such as studies of private health markets in African countries) that can provide relevant information on FIO structure, costs, and effectiveness and comparisons with other health providers. Some of this work is of high analytical quality and has the advantage of perceived and actual objectivity because faith is not the centerpiece. Drawing on such research can counter the understandable tendency of some studies and reports to cheerlead for FIOs, which sometimes blurs the lines between analysis and advocacy. Overall, using (as opposed to creating) data deserves priority.

Many who research FIOs' health work in Africa stress the central importance of inter-disciplinary approaches to ground an appreciation of health and the role of faith. These admonitions are valid but not all work can or should be interdisciplinary. Another area that needs careful balance is between drawing on local institutions and communities, respecting the need for participation and empowerment, while also bringing to bear the best of international data and research tools.

Much heat has been generated about FIOs' market share. Validating or elaborating aggregate statistics (especially continent-wide) on FIOs is difficult and may add little to knowledge or, more importantly, coming to grips with operational needs. Characterizing a widely diverse and dynamic group in simplistic terms is not especially helpful. In contrast, obtaining more quantitative information about FIO operations and financing is feasible and useful.

This study found many instances of effective faith-inspired health work and cases where FIOs serve the poorest communities. However, and not surprisingly, the evidence of overall comparative advantages or disadvantage is limited and mixed. Comparative advantage at an aggregated level is not the central question. Sector, institution, or region-specific research is more likely to yield useful findings. That said, FIOs may have particular strengths and weaknesses that are worth keeping on the radar. For example, FIO- run community-based health and behavioral change communication programs seem to work well.

What has not been explored is how far CBO and BCC efforts work because (i) they leverage churches' networks and other spiritual capital, (ii) the program is designed with a faith inspiration and references; (iii) they draw on the personal religiosity of the individuals served—or because of something else. Nor have CBO or BCC health programs been compared systematically to those that rely more on secular networks and messages.

Rigorous evaluation of particular FIOs' health work will be useful for several purposes. Proving that FIOs are more, or less, effective than other types of health care providers is not the point. FIOs are major contributors to Africa's health care systems and are vital to meet current and future needs. Whether FIOs as a group are more effective than others is un-provable (given especially their diversity). Questions raised about the effectiveness of FIOs arise primarily from sweeping preconceptions but these detract from thoughtful policy-making. Few argue explicitly that FIOs perform less well than other groups, but prejudice does persist and may be evidenced in relatively low shares of funding going to faith-inspired actors. Better evidence will help to see issues, strengths, and weaknesses more clearly. The more important reason to do comparative studies of FIOs' work and health outcomes is that they can yield useful information for design and implementation of programs and policies across providers.

Lively debates surround use of terminology and categories. To appreciate the complexity and importance of FIOs in health, the range of different actors involved must be understood. FIOs are diverse and fragmented and analyzing the impact of faith raises particular sensitivities. Even so, fixing on definitions along the lines used in this report can help in describing and explaining FIO operations, thus making it easier to produce working models that can be tested empirically.

4.2 Research priorities

1. Pursue ways at the highest levels of global health cooperation to collect systematic data and map faith-inspired organizations; make such data a foundation for future research; and ensure that other data collection and mapping work responds to operational needs and is shared.

A research priority is to define what data on FIOs' health work are needed; how they could best be systematically collected, and how to involve leading global health institutions such as the WHO. Despite some good preliminary work, the status of efforts to collect more data on FIOs is murky, and this (the murky status) could be relatively easily addressed through a focused research project. Next steps, including agreeing what FIO information is essential and how and who can best collect it, are more challenging but feasible. Points to be worked out include whether SARA, which emphasizes data on service availability but not on quality, cost, user behavior, or other areas, is the best modality for collecting the data FIO stakeholders need; whether and why (or not) the existing inclusion of faith-ownership of facilities in the SARA questionnaire is yielding useful data; and how to address long lags in data availability.

Once systematic data begin to be available, they should be the bedrock for future research, so that claims about FIOs' parameters (e.g., market share or financing), effectiveness, and purported comparative advantages or disadvantages are, whenever possible, based on data and not on supposition.

The localized data collection and geographic mapping work undertaken in various countries have shown what is possible. Nonetheless, detailed "traditional" mapping can be difficult, for many reasons including

even hostility or fears of takeover. Difficulties are more pronounced in post-conflict zones and fragile states, where FIO networks are often the primary health service providers. Future research needs to harness new technologies, including GIS, Google maps, and cell phone technologies to overcome barriers. Now that the feasibility and benefits of collecting data on and mapping of FIOs are known, future efforts should link to systematic data collection efforts and build on specific operational needs.

2. Support effective platforms for collaborative data gathering and knowledge sharing among FIO researchers and practitioners.

Considerable available information on FIOs' health work in Africa is not used and shared as fruitfully as it might be. To complement the first recommendation above, one platform, ideally, should be identified for sharing information and data, collaborating, and networking on FIO health work. Discussion on policy and implementation-oriented research would help answer practical questions and thus help ensure that data gathering serves operational ends. Many faiths or FIOs have done major surveys of their health work, but it is not clear how the data have been used or maintained. A platform or other effort to better share data and knowledge could ensure that the right information is collected and the key questions answered.

3. Explore the best means to improve coordination among FIOs and with government and other stakeholders, especially for community-based work.

Many FIOs, other than INGOs, report difficulties in visibility, voice, and access to funding, vis-à-vis their own governments and international partners. Better coordination among FIOs and between FIOs and the MOH and international organizations can help to address these "invisibility" issues so that FIO health work is integrated within the national health system and on the radar of other stakeholders such as international health organizations.

Coordination presents major challenges for FIOs. CHAs offer a foundation to enhance coordination, with solid experience and MOUs in numerous countries. However, most CHAs (including the often separate Catholic health associations) represent only Christian FIOs (and sometimes not all of them), posing the challenge of interfaith balance. Moreover, in many instances MOUs remain aspirational documents that are not fully implemented. In some cases, supporting an interfaith umbrella organization or a secular network for civil society health providers (like HENNET in Kenya) might be a wise option, though some CHAs or CHA members object to perceived "erosion of Christian values" when government leads coordination. Defining clear objectives for coordination is imperative and quality of service is the primary goal. Visibility, voice, and predictable and adequate funding are important as are evaluation protocols and clear standards for certification. Coordination efforts can draw on existing models such as the Ecumenical Pharmaceutical Network, a gold standard of FIO coordination. Given the pervasive concerns about aid harmonization in the international community, concrete efforts to ensure that faith-inspired work and institutions are part of the effort make eminent sense.

4. Tailor research by sub-sector and country.

Research and policy analysis will be led by Africans, especially national health ministries. The health sector overviews of Supplement 1 and the country case studies in Supplement 2 highlight the importance of tailoring research to specific health challenges and to country circumstances. The case studies make clear that FIO health engagement in Africa varies far more than most appreciate. Sweeping

generalizations about FIOs can obscure important realities. Further research on the role of FIOs in health care provision in fragile states is a priority. In any country, knowing more precisely what FIOs do in a specified area on a chosen issue would be helpful in assessing potential partnerships. This simply underscores the obvious but nonetheless important need to tailor research to the priorities of the responsible African leaders, taking fully into account the voice and realities of those served. The resulting research agenda is likely to be highly varied and often place-specific. The challenges of engaging FIOs in malaria work differ from those relative to child immunization, as do the coordination issues for, say, the DRC compared to Kenya.

5. Highlight effective and appropriate evaluation for FIOs' health work and develop evaluation methodologies that better assess the faith aspects and distinctive features of that work and the impact on outcomes.

While some hesitate to give priority to rigorous evaluations, this view is plainly receding and most FIO actors recognize that evidence on effectiveness is essential. Priority concerns center on how useful evaluations will be to achieving core objectives. The shortfall of rigorous studies directly addressing faith in FIOs' health work needs to be addressed, and doing so in scientific and professional ways will demand better methodology. Examples of specific methodological challenges for such assessments include, among other things, the overlap between faith-inspired and secular facilities and programs; the continuum of different levels of faith intensity in organizations and programs, and linking the faith "dose" of interventions to patient outcomes. There are opportunities for selecting or refining good methodologies in areas other than evaluations, for example applying market-research-type cluster surveys to obtain data on where people in African countries obtain health services.

6. Expand and elaborate research on community-based health work and behavior change communication.

Since faith-inspired community-based and behavior change communication programs in Africa show particular promise, additional and sharper evaluation work on these deserves priority. The faith-inspired BCC programs featured in this study work well but even available evidence seems to fall on deaf ears. A better understanding of how, why, and when faith-inspired BCC works and how to evaluate it is needed. Faith-linked infrastructure and networks (churches, mosques, pastors' and imams' meetings, youth groups, mothers' unions) are major assets for many FIOs but engaging them appropriately in programs has yet to be taken to scale. Many CBOs rely on unpaid, volunteer inputs while government community health workers are paid. The practical and ethical issues that arise deserve attention.

7. Take a fresh perspective on FIOs in a rapidly-changing world.

FIOs and their health work may be at two different crossroads that call for new perspectives. Some current research on FIOs seems to be backward-looking, "fighting the last war." The priority is to have a forward-looking view of roles FIOs could and will play in Africa's future health systems and the data and tools that can help them to hone services and meet changing needs. For example, investing too much time or resources in "proving" the merits of faith-run hospitals may not be the priority if most health care is obtained in different kinds of facilities. The urgent need is information that can truly help FIOs to plan better, enhance accountability, and be better integrated with national health systems. Another priority is to ensure that the lessons from FIO experience are well reflected in health research and planning.

The first crossroads is the reality that a critical mass of good data on health and health systems in low-income countries is available or nearly available and new technologies offer the promise of rapid future improvements. Much can be downloaded at the click of a mouse, or transmitted via mobile phone. FIOs and their stakeholders should aim to ride the wave of data rather than being swept away by it. For example new data may challenge the traditional "30 to 70 percent" market share estimates or the assumptions that FIOs give preferential service to poor communities. Credible, nuanced data from reliable neutral sources should be taken as an asset. Knowing about changing health markets and providers affects how FIOs serve their beneficiaries and how they plan to deliver services. In a single image, map-layering techniques and data can provide evidence on FIOs' presence and purported comparative advantages. FIOs have the opportunity to establish themselves as eager to obtain and work with data.

The second crossroads involves rapid changes in both health and faith sectors in Africa that profoundly affect mission and sustainability. FIOs need to be aware of and prepared for the impacts of trends such as the growing African middle classes; how would it alter FIOs' sense of mission if they were serving many people not considered poor? FIOs must adapt to the current global consensus that strengthening national health systems is key, which has implications for the independence or separate nature of some faith-inspired health providers or facilities. National health insurance schemes and social marketing of health services and supplies are both a challenge and an opportunity for FIOs. Can CHAs maintain their "brand" that ideally stands for high-quality care that puts patients first? Also, FIOs need to balance cooperation and competition with for-profit providers, and be much more aware of this sector. Finally, changes in the religious composition of Africa and the growth of newer denominations may have strategic implications for faith-inspired health work.

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Background Paper with Supplements and Appendices

This Background Paper provides supporting research for the Main Paper and contains two supplements and two appendices.

The Background Paper has three sections. The first, Supplement 1, provides descriptive overviews of four important topics in FIOs' engagement in health in Africa, namely, HIV and AIDS, malaria, tuberculosis, and the other major disease killers of children (MKC). Subsequent topics are traditional healing and pluralistic health, interfaith initiatives, and behavior change communication. Supplement 2 presents case studies on five African countries; namely, Gabon, Ghana, Mozambique, South Sudan, and Tanzania. These descriptive narratives give a sense of how faith-linked health work in Africa actually operates on the ground and how historical events and differing policies have shaped very different health systems including roles of FIOs.

Appendix 1 is a brief overview of the topic of evaluation in international development; it provides additional background to Chapter 3 in the Main Paper.

Appendix 2 provides summaries of 15 evaluations of health work by faith-inspired organizations and 5 evaluations of health work by secular nongovernmental organizations; it is background information for the discussion in Chapter 3 of the Main Paper of the evidence from stand-alone evaluations of FIOs' health work.

Table of Contents for Background Paper, Supplements, & Appendices

Supplement 1: Special Topics

This Supplement addresses four topics on FIOs' engagement on health in Africa. Section 1 addresses FIOs' engagement in four main health challenges affecting Africa; Section 2, traditional medicine and pluralistic health; Section 3, interfaith initiatives, and Section 4, behavior change communication.

Section 1. FIOs' engagement in four main health challenges affecting Africa

This section addresses faith-inspired organizations' engagement in four of the greatest health challenges facing Sub-Saharan Africa: HIV and AIDS, malaria, tuberculosis (TB) and the other major disease killers of children (MKC). Many of the comparative advantages of FIOs that were discussed in the main paper have special relevance for these four health challenges. For example, for all four, intensive, community-level work and behavior change are important contributors to effective prevention and treatment, and FIOs are engaged at the community level and faith leaders can be good health message communicators. Also, the four challenges disproportionately afflict the poor and other marginalized communities, where faith-inspired institutions are purported to be particularly active.

HIV and AIDS

Sub-Saharan Africa bears the largest burden of HIV and AIDS in the world, with 22.5 million people infected with HIV and 1.3 million deaths from it in 2009 (UNAIDS 2011). The region is also home to 80 percent of all women in the world living with HIV and AIDS. While the burden of the disease and the resources required to address it are daunting, dramatic progress is being made. In 22 countries in sub-Saharan Africa, the number of new cases of HIV infection declined by more than 25 percent between 2000 and 2009 and access to ART, other treatments, and care and support has drastically increased.

HIV and AIDS work is a compelling area for analyzing interactions of faith and health because it is hard to think of another major disease for which issues related to religion are so prominent. The disease is most often spread through sexual contact, a topic often addressed in particular ways by religious doctrines. Some main means of disease prevention, such as abstinence and fidelity, are values for some religious structures, while for others, notably promoting use of condoms, are considered problematic. Gender relations is also an important aspect of the heterosexual transmission of HIV and AIDS, and an issue where religious views and traditions play a significant role.

FIOs are heavily involved in the response to HIV and AIDS, carrying out an estimated 20 percent of all HIV and AIDS health work. In part this is simply because the disease is such a large challenge and so much funding has been involved. But it is also because the physical, mental, and social effects of HIV and AIDS, including stigma and vulnerable orphans, resonate deeply with faith-inspired actors.

FIOs are engaged in HIV and AIDS support across the spectrum of care, as a natural extension of their other health and community activities (Vitillo 2006). The 2009 UNAIDS strategic framework for partnership with FIOs focuses on priority areas of prevention, treatment, care, and support for affected families, support for PLWHA, stopping violence against women and girls, and removing punitive laws, policies, and stigma (UNAIDS 2009). In general, FIOs most commonly provide prevention, awareness-raising, and care and support activities (Olivier, Cochrane, and Schmid 2006; Pan African Christian AIDS

Network 2010). Care and support extends to socio-economic, spiritual, and mental health support for HIV and AIDS patients and their families. Of 505 FBOs surveyed in six African countries, 64 percent provided care for orphans and vulnerable children affected by HIV and AIDS, and 60 percent of these FBOs were local congregations (Foster 2003).

Fewer FIOs are involved in treatment activities, although much of the available research detailing services precedes the increase in ART. A 2006 survey of 279 Catholic religious orders working on HIV and AIDS found that almost 100 percent provided education on the disease, while 39 percent provided ART (Union of Superiors General Men, and International Union of Superiors General, Women. 2008). SPA surveys in Kenya, Namibia, Nigeria, and Tanzania found that 9 to 21 percent of faith-inspired facilities provided ART, similar to the percentage of government facilities providing the treatment (www.meassuredhs.com).

HIV and AIDS projects, particularly at congregation and local NGO levels, are often developed in response to community needs and exist on volunteer support. Volunteerism was identified as the greatest human resource for HIV and AIDS, in eight out of the ten countries (Pan African Christian AIDS Network 2010). Many faith-inspired and secular NGO activities have included training of faith leaders on HIV and AIDS, and FIOs are recognized for their ability to combat stigma and discrimination related to the disease (Keough and Van Saanen 2007). The World Council of Churches (WCC) has provided training to over 12,000 church leaders and youth throughout Africa in a faith-based HIV and AIDS curriculum (WCC 2011). A 2007 study in three Muslim and three Christian congregations in Ghana found that individual congregation members were five times more likely to provide support to PLWHA if they had heard their congregational leader speak about the disease. Of the 20 percent of respondents who provided support, 35 percent prayed, 31 percent provided financial support, and 19 percent provided counseling or spiritual support (Bazant and Boulay 2007). Customizing and following up training is important however, as local congregation leaders have varied interpretations of HIV and AIDS health messages, based on differing religious traditions and theology (Ucheaga and Hartwig 2010).

Involving FIOs in prevention and awareness is not without controversy. In areas with generalized HIV epidemics, FIOs' theological views on marriage, extramarital sex, and condoms can put FIOs at odds with global strategic prevention approaches (Agadjanian and Sen 2007). While prevention has slowed the growth of the epidemic in sub-Saharan Africa, there remain challenges that many believe cannot be addressed by the 'abstinence and be faithful' focus of many FIOs, and FIOs' approaches to HIV and AIDS prevention rarely focus on discordant couples, sex workers, or injecting-drug users. Among the papers reviewed in the course of this study, the team saw just a few subjective mentions (as opposed to various factual statements on) of approaches to HIV and AIDS prevention that are perceived as particular to the Catholic Church, and these were all brief. Green (2003) quotes a private communication from an HIV and AIDS expert with "links to both camps" that the effect of such approaches, which would commonly be understood to not include condoms as a prevention method, has not been entirely negative as it has served to "increase the perceived threat of disease in risky sex." Rasheed (2009) says that in collecting negative views of FIOs' involvement in health in Ghana, references were made to prohibitions of condom use by Catholic institutions. Davis et al (2011) found that among patients/clients who used the services of either religious or secular NGO health providers in Nigeria, some preferred the focus on

abstinence and behavior and the religious context of the HIV and AIDS messages at the former while others felt the latter's approach to condom use is more likely to be effective. Numerous researchers have concluded that the hierarchal and male-dominated leadership of most faith communities has fostered a gender bias in messages and activities related to HIV and AIDS (Chikwendu 2004; Eriksson et al. 2010; Mwaura 2008; Otolok-Tanga et al. 2007). There are, it must be underlined, wide variations among faith beliefs, teachings, and practice concerning HIV and AIDS.

This textured context notwithstanding, the international community recognizes the large contribution of FIOs to global work and goals concerning HIV and AIDS. The UN has identified capacity development of faith-based organizations as a major HIV and AIDS priority. And PEPFAR calls local faith-based organizations an underutilized resource for improving the reach and quality of HIV and AIDS care, stating that FBOs, trained in program management and HIV and AIDS best practices, often design the most culturally appropriate and responsive interventions to the disease (http://www.pepfar.gov/).

Malaria

Africa bears the highest burden of malaria in the world and is thus a major focus of global health programs. On the continent in 2009, there were 212 million suspected cases of malaria and 801,000 deaths. Ninety percent of the global total of deaths from malaria occurs in Africa, mostly among children under five years and pregnant women. Ironically and sadly, the disease could be controlled for a fraction of its economic costs in Africa of US$12 billion. Delivery and use of insecticide-treated nets (ITN) has increased dramatically in Africa, with 42 percent of households owning at least one ITN and 35 percent of children sleeping underneath one in 2010 (WHO 2010b), and the announcement of the efficacy of an experimental malaria vaccine in October 2011 has raised hopes for the future. However, many of the high burden countries, such as Nigeria, DRC, and Sudan, have not yet reached 50 percent of the population at risk with prevention and treatment measures (Ibid).

Many FIO initiatives work with faith leaders so that they will educate their congregations on malaria prevention and treatment. CIFA works with the Nigeria Interfaith Action Association (NIFAA) and in Mozambique with the Programa Inter Religioso Contra a Malaria (PIRCOM) to mobilize faith networks and train pastors and imams to deliver messages about appropriate use of ITNs (Hipple and Duff 2010; Mozambique case study). These efforts are in conjunction with government efforts such as ITN roll-outs to communities.

Project Muso has incorporated Muslim and Christian leaders into community health worker referral networks (Project Muso Ladamunen 2010).

In 17 African countries, Nets for Life, an Episcopal Church organization, has engaged trained church members to distribute more than 6.3 million ITNs. The Mennonite Economic Development Associates helps ensure that ITNs are available in communities through a voucher program with 5000 local retailers (Mennonite Economic Development Associates 2010). In Namibia 43 percent of FBO and NGO facilities had ITNs, exceeding the share of public (29 percent) or private (2 percent) facilities (Ministry of Health and Social Services (MoHSS) and ICF Macro 2011).

The United Methodist Church has established Imagine No Malaria, a program that uses health boards in African countries to manage activities related to improving sanitation, upgrading Methodist-run health facilities, providing drugs, and training community health workers (www.imaginenomalaria.org). The Evangelical Lutheran Church in America (ELCA) works with companion churches in 10 African countries on community education, partner capacity building, malaria treatment, and health care worker training activities (http://www.ecla.org).

"Stop Malaria Now!" is a partnership of ten European and US faith-inspired and secular NGOs advocating to the European Union. The US government's 2009-2014 malaria strategy includes a commitment to continue partnerships with FIOs and NGOs, in part based on the good results from their community-based health delivery programs (United States Government 2010). US congregational networks, including The Lutheran Church – Missouri Synod, ELCA, the United Methodist Church, and the Union for Reform Judaism, have pledged over $60 million to the "Nothing But Nets" campaign. "Bite the Bug," Islamic Relief US's campaign against malaria, raises funds to support ITN distribution, treatment, and community education in Mali.

Tuberculosis
Approximately a third of the global burden of tuberculosis (TB) is in Africa, with 4.1 million people infected and over 430,000 non-HIV patients dying from TB (WHO 2010a). The largest challenges to TB control in Africa are the high incidence of TB/HIV co-infection (Ghebreyesus et al. 2010) and getting patients into appropriate treatment, notably DOTS[1], quickly.

Most faith-inspired health facilities include TB diagnosis and/or treatment in their curative services, which is no surprise based on their history working with communicable diseases, notably leprosy. Many of the largest INGOs work on TB, including World Vision, CRS, and ADRA, and FIOs add value to national TB programs through their reach to vulnerable populations, including in fragile/conflict areas such as the DRC and Somalia (Bohnett and Zambra 2010). Christian Health Associations in Nigeria, Zambia, and Zimbabwe have all been primary recipients of GFATM funds for TB work. However, SPA data for Namibia and Tanzania show that faith-inspired facilities are not necessarily part of government DOTS programs; offer DOTS services less often than government facilities; and evidence wide variety in terms of referring TB patients for HIV and AIDS testing.

Congregational networks in Africa also can be used to implement social mobilization activities and community-based DOTS treatment. WHO has endorsed the involvement of FIOs in TB programs through partnering with government in social mobilization campaigns (WHO 2008). Research has shown that treating patients through community-supervised treatment is less expensive to both governments and patients than purely public models (Sinanovic and Kumaranayake 2006; WHO 2010a). Given the extent of FIOs' involvement in community-based prevention and care for HIV, adding information and services for TB could be a natural extension for many faith-inspired community-based programs, as PASADA, a

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[1]DOTS stands for Directly Observed Treatment Short course, the internationally recommended strategy for TB control.

Catholic FIO, has done in Dar-es-Salaam by involving community volunteers and PLWHA in tracing TB treatment defaulters (http://www.pasada.tz.org).

However, compared to HIV and AIDS and malaria, FIOs are less engaged in global strategy, advocacy, or fundraising for TB. For example, the STOP TB 2009 progress report concluded that, of 1191 partners, only eight INGOs and nine local NGOs were faith-affiliated (WHO 2009). Bohnett and Zambra (2010) suggest that FIOs should be more engaged in transnational partnerships for advocacy, as well as fundraising through Western congregations.

Other Major Disease Killers of Children (MKC)

In sub-Saharan Africa, an estimated 4.6 million children under 5 years old die every year. More than 70 percent of these deaths are caused by a few diseases, singly or in combination: acute respiratory infections, diarrhea, malaria, measles, malnutrition and neonatal conditions (asphyxia, prematurity, low birth weight and infections). In countries with high HIV prevalence, HIV and AIDS may be the cause of up to 57 percent of under-five deaths (AFRO).

Challenges to child survival in Africa include weak health systems, political instability, poverty, food insecurity, lack of water and sanitation, poor living conditions, and inadequate child spacing. Many of the MKCs can be prevented with simple interventions, but many families cannot access health care due to distance to health facility or user fees.

The understanding and practice of religion by a family can play a role in the uptake of child survival services, though it varies by context. Analysis of DHS data for Ghana found no direct effect of religion on child survival after controlling for socioeconomic factors (Gyimah 2007). However, Antai et al. found that adherence to the Muslim faith was associated with risk of non-immunization in children in Nigeria after controlling for socioeconomic and other variables (Antai et al 2009). Preliminary results from a study of child survival in southern Mozambique showed that the mother's membership in a church increased the likelihood of child survival (Cau, Sevoyan, and Agadjanian Undated).

FIOs are primarily engaged with the MKC by providing interventions such as vaccinations and food supplements at health facilities and through community-based campaigns. In Ghana, Kenya, Rwanda and Uganda, at least 70 percent of not-for-profit health facilities, which are mostly faith-inspired, provide vaccinations (Aylward 2011). Faith-inspired INGOs often support training and support of networks of community health workers to improve access and coverage of child survival interventions.

FIOs also use their strong and credible networks to provide health education to mothers and communities on child survival. In Ethiopia, a coalition of FIOs and NGOs aim to increase children's immunization coverage not only by training health extension workers, but by mobilizing communities through training Orthodox priests to refer mothers and children to immunization and health services (GAVI Alliance 2010). In rural Nigeria, church-related activities seemed to be a factor in higher oral rehydration therapy knowledge and use among certain ethnic groups (Akpede, Omotara, and Shettima 1996). Taking advantage of the networks of local congregations, World Relief's Care Group community health programs in Mozambique, Malawi, and Rwanda not only train community health volunteers, but encourage the formation of pastoral care groups to share child survival health messages (Chand and

Patterson 2007). Increasingly, FIOs also are involved in efforts to advocate and fundraise specifically for clean water and improved sanitation, strongly linked to management of diarrhea. FIOs have become engaged in this area due, in part, to the sacredness of water in many religious rituals and, therefore, the natural link to raise awareness of global clean water issues during religious services (Berkley Center/WFDD forthcoming). [2]

Common themes from FIOs' engagement in the four main health challenges

A common challenge for FIOs that work on HIV and AIDS, malaria, TB, and the other MKC is to understand how best to integrate FIOs into national control strategies and large vertical, disease-specific programs. As less is known about the contribution of Muslim organizations to health work, surveys in Muslim-majority countries in Africa might illuminate how FIOs do and could further contribute to the four major health challenges. Another point is to learn from best and worst practices of FIOs, which is important since their work is so far relatively little-evaluated.

Since community-level efforts are so important in prevention, treatment, and care for the four health challenges, this raises the stakes on the need to build capacity in managing and evaluating programs and finances for smaller FIOs. Currently, many local FIOs implement short-term projects without an overall strategy and have difficulties securing less variable, more reliable funding streams. Knowledge about formal church policies and government strategies is often lacking, which can lead to disjointed or less effective responses.

Coordination among FIOs, governments, and other stakeholders could help ensure that resources are efficiently utilized and technical and programmatic knowledge is shared. However, it is unclear what the best forums are for integrating these programs. Sharing best practices among faiths and countries is necessary to increase the technical and programmatic knowledge of FIOs.

Section 2. Traditional healing and pluralistic health

Ed Mills, an epidemiologist at McMaster University in Canada who studies traditional healing, estimates that 70 percent of Africans use herbalists, diviners, and other spiritually-inspired health practitioners (Mills et al 2006). A World Bank study found that traditional medical practitioners (TMPs) represent a large part of the private health sector in most countries (2011) and far outnumber orthodox medical practitioners in some countries. Zambia has 40,000 TMPs who garner about 60 percent of total household health spending (Ibid). Among the reasons that Africans rely heavily on TMPs is because many people lack access to health facilities (Supplement 2).

The share of people that access traditional medicine varies by culture, access to other health care, economic status, and education level. For example, in Ethiopia, 87 percent of pastoralists in the Somali Regional State region went to traditional healers before TB diagnosis, as access to other health care,

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[2] Please see the main report for background information on WFDD.

both in terms of travel time and cost, was prohibitive (Gele et al. 2010). However, among rural patients in the Tigray region of the country, only 3 percent went to traditional healers before TB diagnosis, in part because 24 percent went to Orthodox Church healing services before going to medical facilities (Mesfin et al. 2009). In Nigeria, lower socio-economic groups use traditional healers most for treatment of adult malaria, while higher socio-economic groups use public and private hospitals (Onwujekwe et al 2011).

Traditional healers tend to be preferred to biomedical health care when the illness is presumed to have a spiritual or supernatural cause. In many African countries, people distinguish between malarial fevers that have a biomedical cause (and therefore should be treated in biomedical health facilities) and those caused by spiritual conditions, to be treated by TMPs (Beiersmann et al. 2007; Foster and Vilendrer 2009; Pilkington 2004).

Traditional healers often share some of the same purported comparative advantages of FIOs, such as credibility (Plummer et al. 2006). Given these characteristics, proponents argue that traditional healers are well placed to change behaviors of communities and improve health outcomes (Homsy et al. 2004). There is evidence that overall well-being can be improved by pluralistic care; for example, in Zimbabwe, quality of life for HIV and AIDS patients on ART was higher among those patients who also sought care from traditional healers than those patients who received only conventional care (Taylor et al. 2008). Well-being can also be improved through involvement of traditional healers in biomedical health projects. Traditional healers supervising directly-observed treatment short-course (DOTS) for TB patients in a pilot project in South Africa were as effective as health workers in terms of health outcomes. Furthermore, patients reported high satisfaction with the traditional healer supervisors as they were easy to access and had caring attitudes towards patients (Colvin et al. 2003).

However, there are concerns and challenges regarding engaging traditional healers, given the implications and results of downplaying evidence-based medicine (World Bank 2011). Consultation with traditional healers has negative aspects, such as delays in seeking biomedical health care. TB patients in sub-Saharan Africa who sought care from traditional healers were 3.5 times more likely to delay appropriate care than those that did not (Finnie et al. 2011). In Nigeria, traditional healers who did not refer severe malaria patients to orthodox care because they believe the cause of the illness is genetic or from evil spirits resulted in two-week delays of appropriate treatment (Okeke, Okafor, and Uzochukwu 2006).

Collaboration between traditional healers and government exists and requires further investigation to develop good practices and understand questions of trust and equal partnerships. UNAIDS recently published a strategy for collaboration between traditional medicine and government in HIV and AIDS national responses (UNAIDS 2005b). Orthodox and traditional healer collaboration groups on HIV and AIDS have been established in Uganda, Tanzania, Zimbabwe, Mozambique, South Africa and Cameroon. Kayombo et al (2007) found that involving traditional healer associations' leaders in HIV and AIDS work in Tanzania helped bridge gaps and could be improved by memorandums of understanding between the associations and the government, systems to exchange information on an ongoing basis, and involving communities in choosing genuine healers.

Pilot projects in many countries have trained traditional healers to detect and refer common communicable diseases, resulting in them functioning akin to community health workers. While many small-scale projects have increased traditional healer knowledge on HIV, AIDS, TB and/or malaria, they have had mixed results in terms of increasing referrals to the biomedical health care system (Harper et al 2004; Peltzer, Mngqundaniso, and Petros 2006). Despite these mixed results, experts still conclude that steps should be taken to involve traditional healers in partnership with health clinics and train them in detection, referral and drug distribution (Fawole et al 2007; Finnie et al 2011; Gele et al 2010; Kayombo et al 2007; Okeke, Okafor, and Uzochukwu 2006). Ongoing collaboration also exists in the laboratory testing of traditional herbs to determine if they are effective against diseases such as malaria (Fawole et al 2007; Kayombo et al 2007).

Finally, an emerging field of research is exploring faith healing as a third curative system that exists with both the biomedical and traditional healing systems. Faith healing is usually practiced alongside biomedical therapy; for example, a survey of patients on ARTs in South Africa found that 22 percent continued faith healing (defined as spiritual practices and prayer) after starting treatment (Peltzer et al 2010). However, some supposed faith healers or TMPs in Africa engage in dangerous and pernicious practices, such as those described by Rasheed (2009) concerning mental health treatment in Ghana or harming of supposed "child witches" (Supplement 2).

Section 3. Interfaith initiatives

Interfaith initiatives have scored important successes working on health in Africa. CIFA, which is a key proponent of interfaith action, along with the TBFF, believes that coordinated multi-religious action around a single, common cause has several potential advantages.

Interfaith initiatives can avoid the perception of proselytization. The fear of proselytization by FIOs can be a concern for government officials, faith leaders, community members, and international organizations; interfaith action through its inclusive approach can mitigate that concern. Likewise, interfaith action can circumvent legal/political concerns that governmental engagement with a particular FIO or religious community constitutes endorsement of (or favoritism to) that religion.

Multi-religious approaches can be efficient. An interfaith response to development challenges can leverage the diverse resources of FIOs in a systematic way, minimizing duplication of efforts by multiple FIOs at the same time in the same geographic locations. Inclusive initiatives can sometimes provide a stronger platform for achieving measurable development impact at scale than single-faith action.

As the main paper and the next subsection of this supplement indicate, faith-inspired behavior change communication (BCC) works well. CIFA believes that interfaith health/development initiatives have the ability to magnify the successes of any single-faith BCC initiative, through messages being heard/received from a variety of sources.

Interfaith action around a health challenge can leverage diverse religious assets to reach many people in a multitude of contexts. By synchronizing action, standardizing program execution, and remaining community-driven and community-owned, interfaith action likely increases the chances of sustainability

and scalability of health initiatives. Interfaith action can also improve social cohesion, in addition to having a positive health effect. Often, conflict emerges when people of diverse ethnicities, faiths, and backgrounds do not know one another or do not have the opportunity to work together on issues of common concern. When it becomes possible to work together to solve a particular community problem, social cohesion is built.

Multi-religious activity can also help build credibility and neutrality around public health and, more broadly, development. When faith leaders work together across religious lines to tackle a development issue, they demonstrate a universal belief in a cause and a common approach to addressing it. Unity of faith leaders, by example, can generate unity among secular and government partners. Furthermore, interfaith unity around a controversial issue can increase comfort levels of government leaders and civil society who are concerned about public reactions, and it can neutralize controversial challenges, with benefits extending to secular development institutions, the government, and the people.

Interfaith initiatives can also increasing the willingness of hesitant faith groups to participate: Just as interfaith action can build comfort and spur action by non-faith-based stakeholders, so too can an interfaith framework catalyze the participation of faith groups otherwise unwilling to tackle the issue at hand. For example, interfaith action may be especially useful to address reproductive health issues, particularly when religious leaders are afraid to take a stand unless other religious leaders do so as well (first-mover dilemma).

A potential weakness of interfaith initiatives is that if multi-religious coalitions do not exist in a country, it is necessary to build them, in contrast to single-faith networks already in-place. Such start-up costs and efforts can be important considerations. However, investment and creation of interfaith coalitions not only builds broad consensus around desired health-related achievements or outcomes, but also establishes a working interfaith mechanism that can be re-programmed to tackle other community needs in the future. An interfaith network created to tackle a particular health need may grow to address other concerns such as literacy or gender issues at the national or local levels, and CIFA notes that it has already witnessed this progression in Liberia and Nigeria.

A good number of interfaith initiatives are actually coalitions of different Christian denominations, but there are numerous Christian-Muslim initiatives in Africa. PIRCOM, CIFA's anti-malaria faith leader training program in Mozambique that was noted above, brings together the ten different faith communities, including Hindu, Baha'i, and other faiths in addition to Christian and Muslim. Islamic Relief and the World Council of Churches organized a conference in February 2011 on maternal and child health in Niger. This event convened different religious leaders, civil society and local authorities and culminated in a commitment to follow up with nine actions, including promoting maternal feeding, supporting education for girls and improving women's attendance at health centers.

Involvement of interfaith coordinating committees in health projects grew sharply with the HIV and AIDS crises. The International Religious Council of Mozambique is a coalition of several religious communities that is responding to HIV and AIDS with various kinds of interventions and advocacy. The Global AIDS Interfaith Alliance (GAIA) partners with religious organizations in resource-poor countries for

community-based HIV and AIDS prevention and care. Project Muso has a highly-regarded project involving Christian and Muslim faith leaders. APROMESTO is an association of Protestant health workers in Togo that exists to foster collaboration among Catholic, other Christian and Muslim communities to carry out health and humanitarian activities. It monitors health institutions, is designing a development plan for the faith- based health institutions of Togo, and is carrying out a needs assessment of Togolese churches, with a focus on HIV and AIDS and the possible creation of a drug supply network. (APROMESTO brochure). CIFA's on-line database on multi-religious collaborations currently includes 84 health projects, such as the Malawi Interfaith AIDS Association (supported by Norwegian Church Aid and Southern Africa AIDS Trust) and an ADRA project utilizing support from mosques and churches in the United Kingdom for the digging of water wells in Niger.

CIFA's work with NIFAA is detailed in the next section on BCC. The project is an interfaith anti-malaria initiative, with funding support from the Nigerian Federal Government and the World Bank, in addition to CIFA, and promotion by TBFF that included former British Prime Minister Tony Blair demonstrating ITN use in Abuja.

WFDD has convened leaders and FIOs of all the world's major religions to discuss and formulate recommendations and strategies for addressing many of the most pressing health challenges in Africa. Groups have been convened on malaria, tuberculosis, and maternal mortality, and on health-related topics such as poverty and water and sanitation.

Section 4. FIOs and Behavior Change Communication

Faith-inspired leaders and organizations can make a special contribution to global health through Behavior Change Communication (BCC) programs. BCC is a process of intervention with individuals or communities to develop communication strategies to promote positive behaviors. Participants are provided with relevant information and motivation through well-defined strategies, using an audience-appropriate mix of interpersonal, group and mass-media channels and participatory methods. Messages can be disseminated through radio shows, sermons, street theater, or music videos. BCC, and the related activity of social mobilization, is often used to educate about and change behaviors related to health. BCC can be an efficacious and cost-effective contributor to disease prevention, treatment adherence, and other steps critical to addressing some of the greatest health challenges in low-income countries, as well as richer ones, and BCC programs that involve faith leaders and communities are among the most successful (UNICEF 2004).

The effectiveness of FIOs in BCC health programming seems to depend on the purported comparative advantages of FIOs: notably the credibility of faith leaders and the well-developed religious networks. BCC projects that engage faith leaders are able to reach large amounts of people due to the hierarchical structures and grassroot networks of many faiths; for example, the NIFAA project described above trained 10 lead faith leaders in each local government area in which the project was implemented. Each of the lead trainers trained 50 faith leaders, who was assumed to reach out to 200 congregants, meaning that training a single lead faith leader could, potentially, reach 10,000 congregants (cifa.org). Due to the high degree of religiosity of Africans, including the breadth/frequency of attendance at

religious services, BCC can be especially powerful in Africa. It is reported that 95 percent or more of Africans are estimated to have a religious connection, and the President of Kenya once observed that 80 percent of Kenyans pass through the doors of a church or mosque each weekend (Foster 2004a).

BCC is also cost-effective, and when faith leaders and communities are engaged, the projects benefit from essentially free (volunteer) engagement of the human capital of the faith leaders and of the networks. World Bank faith and development expert Quentin Wodon observes that the issue of faith and behavior is at least as important as the issue of faith-based service delivery (Interview 2011). It should be kept in mind that that the effectiveness of faith-inspired BCC reflects and depends on the religiosity of individuals as well as the purported comparative advantages of FIOs.

Another important element of faith-linked BCC projects is that the health messages are developed and articulated to align with the values and contexts of the community. Faith-inspired BCC project include the use of religious principles, texts, and language to formulate and craft health messages, and the delivery of messages in religious contexts, e.g., in the mosque or at religious festivals. Of course, BCC projects can also feature non-religious community leaders and secular messages.

BCC has been used with success in Africa to address the four main disease challenges covered earlier in this section, as behavior change is critical in all of them. BCC is highly relevant to HIV and AIDS prevention and to other measures such as treatment adherence and emotional and mental health support for PLWHA, and HIV and AIDS is also an area where religious beliefs can determine what responses to the disease a person or community considers appropriate (Green 2003). HIV and AIDS provides in some ways a testing ground for different types or combinations of behavioral change and other approaches to disease prevention, with a well-known difference being the Catholic Church's objections to condoms as a means of HIV and AIDS prevention. Despite differences in approaches, many different faiths have implemented BCC programs around HIV and AIDS that appear successful.

Responding to, among other things, a survey in Sierra Leone that revealed that six months after the distribution of three million ITNs, only 20 percent were being used in a way that protected vulnerable children, the Tony Blair Faith Foundation launched in May 2011 a national faiths' health messaging campaign against malaria in the country, after detailed consultations with all of the country's religious leaders and the MOH. The project brings to bear the educational potential of the country's faith communities and their leaders to disseminate the MOH's five core messages on how to protect families from malaria. The project aims to reach 600,000 people in Sierra Leone, which represents 10 percent of the population.

The Ethiopian Orthodox Church (EOC) has partnered UNFPA and the Population Council to produce the "Developmental Bible," a resource that compliments the Metsihafe Gitsawie ("glossary of the day-to-day teachings of the Church"). The Developmental Bible covers some 45 development issues and provides messages on HIV, AIDS, early marriage, gender-based violence, FMC, adolescent and youth development. Since approximately half of the population of Ethiopia is Orthodox Christian, and since for many rural Ethiopian communities, religious structures may be the only sustained institutional contact in

a country with relatively few schools and medical facilities, the potential is great could radically improve the health and well-being of individuals and communities (www.ethotc.org).

Examples of the use of BCC in TB treatment and malaria prevention were provided above. Regarding MKC, in Madagascar, the Mormon Church organized the production of a jingle in native languages that advertised a measles vaccination campaign. CRS trains community workers to go door-to-door with preachers and evangelists of different faiths to educate people about immunization and other health interventions. In India, Muslim leaders allowed mosques to be blanketed with posters advertising a polio vaccination campaign and preached sermons that drew on the Koran to encourage Muslims to have their children vaccinated. In Cambodia, in collaboration with UNICEF, thousands of Buddhist monks and nuns have educated people about HIV, AIDS, avian influenza, and other diseases (Aylward 2011).

However, disseminating health messages through faith leaders is not uncomplicated. Marshall (private communication 2011) points out that successful faith-led BCC projects notwithstanding, there are mixed responses to some faith messages, for example that stigmatize and thus drive underground actual sexual behaviors that do include pre-marital sex and sex outside of marriage. Stigma against HIV and AIDS, extending to refusal to bury the dead in churchyards and ostracizing children born with HIV, is still reported. The evidence on effectiveness of abstinence programs is very mixed. Strayhorn and Strayhorn (2009) found that in the US, strong religiosity accurately predicts a high teen birth rate. The authors suggest that teens raised in religious homes are less likely to use birth control. One interpretation is that teens are acting on the message they hear in church to avoid artificial birth control but not on the one to avoid sex outside of marriage. The authors cite a study by Rosenbaum (2009) that compared adolescents who reported taking a virginity pledge with a matched sample of non-pledgers, and found that the two groups did not differ in lifetime sexual partners and age of first sex, but pledgers were less likely to use birth control. Long-term research in KwaZulu Natal, South Africa attempted to establish whether membership in any religious group affected risky sexual behavior, using as a measure the prevalence of extramarital and premarital sex. Pentecostals had the lowest level of risky sexual behavior, much lower than members of mainstream Christian churches (Garner 1999). However, Green argues that the latter group of denominations had marked success in influencing sexual behavior in Uganda and Jamaica (2003).

Supplement 2: Case Studies

This supplement to the main report presents five country case studies that provide a more in-depth look at how faith-inspired organizations operate in the health sphere in different African countries. The chosen five countries vary in terms of region, socioeconomic characteristics, and history as well as in their basic health profile, as Table 1 indicates: Gabon's and Ghana's under-five mortality rates are not much higher than the global average, while Mozambique's is one of the highest in the world. In Gabon, the role of FIOs is small in size (though rich in tradition: the world's most famous mission hospital being located and still in operation there). In contrast, in South Sudan, FIOs along with secular NGOs have been running the health show until now; the birth of a new country presents opportunities for "getting it right from the get-go" in terms of FIOs' coordination and integration with the government. In Mozambique, relations between the government and faith-inspired health organizations have cycled through several phases, while Ghana's public sector began strategic engagement with FIOs 60 years ago. Ghana and Tanzania both have strong Christian Health Associations and Memoranda of Understanding with the government, but the relationships work quite differently. The case studies demonstrate the diversity of, and some surprises about, the engagement of FIOs in health in Africa, yet again confirming that broad generalizations about the subject can obscure realities important for achieving better health in Africa, since much of health policy and most of implementation happens in a country and not on average.

Table 1. Selected Health Indicators for the Five Case Study Countries with Global and Regional Comparators

Country or Comparator	Human Dev. Lowest rank = 169)	Life expectancy, male years	Under 5 mortality per 1000 live births	Maternal mortality per 100,000 live births	Prevalence of HIV per 1000 adults	Prevalence of TB per 100,000 pop.
Global average	NA	66	60	260	8	201
Regional average	NA	52	127	620	47	475
Gabon	93	60	69	260	52	603
Ghana	90	57	69	350	18	329
Mozambique	165	47	142	550	115	323
South Sudan*	154	59 (64)	108 (72)	750 (320)	11 (2)	206 (174)
Tanzania	146	53	108	790	56	170

Source: All data are the latest available in the WHO Global Health Observatory, except for the Human Development Index, which is UN data.

* Note on South Sudan data: All data are for formerly unified Sudan as data are not yet available for South Sudan. The relevant regional comparators for Sudan are different (specifically, all are indicative of a better average health profile) versus those for the other case study countries, and are shown in parentheses after the relevant Sudanese indicator.

Case Study I: Gabon. Where are the faith actors?

The Challenge

Faith institutions and actors today play fairly limited roles in Gabon's health system, in marked contrast to several other countries in Central Africa, notably DRC and Cameroon. This was not always so. Healing was an integral part of Gabon's traditional belief systems, and to a degree that is still a factor in Gabonese people's approaches to health and health care, especially in rural areas. Christian missionaries brought more modern medicine to the region – indeed the Albert Schweitzer mission and hospital for a time defined understandings of religiously inspired health care in poor countries. But in today's Gabon, the government-run health care system predominates, complemented by private-for-profit health care. There do not appear to be large numbers of uncounted faith-inspired health facilities. In contrast, traditional medicine, though known to be important, is not well mapped or understood.

The formal faith health care system, such as it is, consists of the reputed, high quality Bongolo hospital in Lebamba, southern Gabon, a few small clinics and pharmacies run by Catholic sisters and evangelical churches, and traditional medicine. The Albert Schweitzer Hospital (ASH) is a private foundation receiving government support for about 40 percent of its costs; it has no religious affiliation today though its values are explicitly shaped by Schweitzerian philosophy and theology ("reverence for life").

The Bongolo Mission and ASH offer insights into both challenges and opportunities for faith-inspired health care but the Gabon health panorama also poses interesting questions as to why religious institutions have not been and are not more active. The answers seem to lie in Gabon's colonial history, and more specifically the focus and character of the Catholic religious orders that led mission work (especially the Spiritans or Holy Ghost fathers), the French colonial stance on missions and public services, and the combination of relative prosperity (hence less urgent need) and high cost of living, which tend to deter mission health care in contemporary Gabon.

Gabon's health profile

Gabon is noteworthy for its peaceful and stable post-colonial history (independence in 1960). With the world's longest ruling leader as part of its recent history, the country faces a range of governance challenges but with a newly elected president there are hopes for a new era of participation and commitment to the common welfare. Gabon is one of Africa's most prosperous countries, in per capita terms, and is counted as an upper middle income, reflecting its rich natural resources. Gabon is very much part of Francophone Africa, an active member of La Francophonie. It is also a member of the Organization of Islamic Countries. It has a small (1.5 million) and highly urban (85 percent) population, which large parts of the country sparsely populated and poorly accessible. Poverty is significant despite the country's wealth. Gabon is sharply divided between its sophisticated, wealthy face and the remaining population; an estimated third live below the national poverty line. Immigration is significant with communities from many African countries putting down roots in Gabon; the exact size of this population and its welfare are not well known.

Gabon ranks 93rd (out of 169) on the UN 2010 Human Development Index, which puts it in a different category from the majority of African countries (it is above South Africa, at 117, and the next highest ranking country of those covered in these case studies is Ghana, which ranks 130th). Some express doubts as to data quality, however. Two figures that appear to be sharply contested are the HIV prevalence rate and maternal mortality. A recent government health insurance plan helps to assure health care though its kinks have yet to be worked out. For Gabonese citizens generally, the quality of medical care is mixed and it is often expensive. The wealthy tend to look elsewhere when they need care (France, South Africa, and even neighboring Cameroon). Government spending on health care is given as 3 percent of budget.

The health care system consists of public hospitals and clinics, divided into three main categories: the public system (civil and military are parallel), the para-public system, and the private system, again divided between for-profit and not-for-profit. The latter is the faith-inspired segment, as there appear to be no other NGO-type organizations operating in health in Gabon. Table 1.1 provides data on health facilities by ownership/affiliation.

Table 1.1. Health facilities in Gabon by Ownership

Sectors	Public	Parastatal CNSS	Private for Profit	Private not for profit	Humanitarian	Total
General hospitals	12	2		2		16
Specialized hospitals	12	1				13
Clinics			19			19
Polyclinics		1	1			2
Medical centers	41	9				50
Local centers	51					51
Dispensaries	413			4		417
Health houses	157					157
Infirmaries	37				8	45
Offices			79			79
Laboratories			4			4
Pharmacies			33			33

Source: WHO Gabon Strategy 2008-2013

Although Gabon is relatively well equipped with medical care and has seen rapid increases in trained medical staff in recent decades, relatively high official health indicators, and considerable public spending on health, there is a broad consensus that the health care system has many shortcomings. This is especially true in rural areas. Access to clean water is widespread; to modern sanitation much less so. The dearth of these facilities is especially severe in rural areas.

In short, Gabon faces substantial public health challenges, particularly given its middle-income status, as its health situation is superior to many other Sub-Saharan African countries. Infectious diseases are still endemic: HIV, AIDS, malaria, and tuberculosis are all serious problems (one estimate gave the HIV and AIDS prevalence rate as 8.2 percent, while the official estimate is 5.3 percent, with some guesstimates significantly higher). Maternal mortality has not declined as hoped in national and international strategies, and Gabon is far from its MDG target. Fertility is still fairly high though it appears to have declined in recent years.

Gabon's religious profile

The large majority of Gabonese self-identify as Christians, and churches are omnipresent. There is freedom of religious belief, with no significant interreligious tensions or policy or social issues around faith, though one commentator was concerned that "aggressive evangelizing" by some churches could lead to problems. The Catholic Church counts the largest numbers of believers: an estimated 745,000 in 2000, versus 233,000 Protestants and 180,000 "independent Christians." Islam is recent and growing (estimates from 1 to10 percent of the population); Muslims include immigrants and Gabonese converts; most prominently, former President Bongo converted to Islam in 1973 and his son, current President Ali Bongo, is also a Muslim. The numbers and actual practice of traditional religions are not known but believed to be high, including those who self-identify as traditionalists and those who practice syncretism in some form.

With a mixed ethnic population (over 40 ethnic groups are counted), Gabon's traditional religions were varied but with some distinctive fairly well studied features and common or shared beliefs. The tradition was monotheistic, much influenced by the forest culture which, one source suggests, brought an element of mysticism, lack of focus on specific place, and awareness of the role of chance. Secret societies (Bwiti is a prominent example), veneration of ancestral spirits, and complex initiation rites, often using plants/drugs, and a focus on traditional healing were and to a degree are part of the Gabonese ethos. Part of the Bwiti tradition has merged enough with Christian ideas that it is counted as an indigenous Christian church.

Catholicism was the first missionary Christian presence in Gabon and indeed Gabon saw the first Catholic missionaries in West Africa; they tended to use Gabon as a base. The Italian Capuchin order began to work in the 17th century, and then was expelled by the Portuguese. The Congregation of the Sacred Heart of Mary came in 1841, and amalgamated with the Holy Ghost mission in 1848.The number of Catholics increased steadily and the faith was initially close to an established religion. The Spiritans/Holy Ghost fathers continue to play an important role. Several orders of religious Sisters work in Gabon. Even in this small country, though, the picture is not clear, even to the regional representative of the Vatican, concerning which orders are doing what.

Protestant churches were and remain significant and they come in many shapes and forms. The largest is the Evangelical Church of Gabon, which has its roots in a mission established by the American Board in 1842. The EEG provides almost 25 percent of all primary school education in Gabon, and runs seven secondary schools and a teacher training college. It has a theological school for the training of its pastors and lay people. The EEG is a member of various ecumenical organizations including the World Council of Churches. In 1934 the Christian and Missionary Alliance started activity in southern Gabon, and formed the Alliance Christian Church of Gabon in 1956. Indigenous churches include the Church of the Initiates, Eglise des Banzie, or Religion d'Eboga (Eboga is the drug used in initiation ceremonies). Many other churches including Jehovah's Witnesses, Adventists, and the Church of Latter Day Saints are active.

Faith-inspired organizations working on health

Boxes 1 and 2 focus on Gabon's two most active faith-inspired facilities.

Box 1.1. The Albert Schweitzer Hospital

Albert Schweitzer and his wife arrived in what is now Gabon in 1913, to work with the Paris Missionary Society. A Lutheran pastor and well-known theologian, at age 30 Schweitzer embarked on a new path, studying medicine deliberately so that he could serve as a missionary doctor in Africa. The Schweitzers' base was in the town of Lambarene, on a branch of the Ogooue River, then accessible only by river. Today, it is some four hours by car over difficult roads from Gabon's capital, Libreville. At one stage Schweitzer's ambition was to build hospitals in other places but he found more than enough work at Lambarene, and spent much of his life there until his death (at the Hospital) in 1965.

As Schweitzer put it, his life "was his argument" and the hospital was his life. Thus the Albert Schweitzer Hospital came to embody for him and for many others (reflected in the Nobel Peace Prize which he received in 1953) his life of service. And in a practical sense Schweitzer basically owned the hospital.

The links between Schweitzer and the French Protestant missionary society that was his initial base were complex. Initially barred from preaching in Lambarene (because he was considered unreliable theologically by the mission society) he did come to work closely with the missionaries and did preach. The hospital was imbued with his philosophy and theology, which he articulated as "reverence for life". Clearly and explicitly inspired by the example of Jesus, Schweitzer's spiritual framework was broader than most Christians of his time and he clearly did not accept institutional barriers to his work. He took responsibility on himself for fund-raising for the hospital, financing it in part by concerts (he was a brilliant musician also). Schweitzer directly oversaw the construction of the hospital (actually in three different locations) and gave it a distinctive character that it still retains.

The hospital has traversed various stages since Schweitzer's death in 1965, and these have included good times and bad. The hospital became a private foundation with his will, with formal ties (established initially around the time of Gabon's independence in 1960) to the Gabon government. A Foundation board includes international and Gabonese members, and has always included members of Schweitzer's family. At present, some 40-45 percent of the budget comes from the government; 40-45 percent from contributions raised overseas – mainly Switzerland and Germany – and some 15 percent from patient fees.

The hospital today draws patients and volunteer from many parts of Gabon and even other countries, attracted by its reputation and the lasting legend of "the Great Doctor. While the hospital faces financial challenges, its largest challenge may concern its mission. What is its 2011 purpose? To demonstrate excellence in public health? Training? Teaching? How does and should it relate to government strategy? What is the contemporary implication of Schweitzer's driving philosophy and theology? A new plan is in

preparation, geared to the 2013 centenary of Schweitzer's arrival in Lambarene, and it involves an ambitious mix of all these elements.

Box 1.2. The Bongolo Hospital

Missionary nurses with the Christian Alliance Church ran a small dispensary for local Gabonese for 20 years in Lebamba, in southern Gabon. Then in 1977, a team of missionary medical personnel arrived, that included Dr. David Thompson, currently the Hospital's leader. The small dispensary developed over the years into the Bongolo Hospital of the Christian & Missionary Alliance of Gabon. Missionaries along with over 70 local Gabonese personnel operate a hospital that serves the local province and all other provinces of Gabon, including patients from the country of Congo Brazzaville. The Bongolo hospital is a 158-bed facility, with an Outpatient department, Surgery, Adult Medicine, Maternity, Pediatrics, and Laboratory. There is also a Dental Clinic, Eye Surgery Clinic, and an AIDS/HIV Treatment Center. The hospital is an important training center for nurses and surgeons. It is today the main referral hospital for the southern part of Gabon. It stands out as the only hospital set up to treat the poor.

In February, 1996, a group of 15 missionary and African surgeons working indifferent hospitals met in Kenya to create the Pan-African Academy of Christian Surgeons. PAACS began in Bongolo in 1998 (for details on the program see http://www.bongolohospital.org/programs/paacs).

The Bongolo hospital sees its mission clearly as combining its health and evangelical missions. Bongolo hospital serves people of all faiths, but their staffs is Christian and its website makes clear this requirement (this for the surgical residency): "The requirements for perspective residents include an active Christian faith and graduation from a known African medical school." In practice this has prevented the hospital from receiving US government funds due to U.S. legal restrictions on using official funds to support institutions that discriminate on the basis of (inter alia) religion (communication from US Ambassador to Gabon).

The ethos and realities of Bongolo are well expressed in this gem from Dr. Thompson's website:

A Chinese road construction crew that is paving the main road from Lebamba to Ndende agreed to upgrade the airstrip for $20,000, and the Gabonese government donated the funds to the hospital. It actually cost the Chinese a third more than that, but after surgeon Keir Thelander performed an emergency colon resection on their boss, they decided to do the rest of the work for free, as a gift to the hospital and to the community".

Dr. Thompson's prayers are as follows:

"1. Pray that God will give us more opportunities to bless these Chinese workers and share with them the love of Jesus.
2. Pray for us as we develop programs to help the shopkeepers in Lebamba improve their businesses

skills and befriend them.

3. Praise God for getting our transformer moved to the center of our campus, and for helping our team safely move our huge back-up generator on inadequate equipment.

4. Pray that God will send us someone skilled in cutting down the big trees threatening parts of our station.

5. Praise God for our new laboratory! Pray that God will help us hire or train additional lab techs, and an X-ray tech.

Features and Issues

In reflecting on Gabon's health strategy and the potential for contributions by faith actors, some distinguishing features are worth noting.

- Gabon's high per capita income means first that it is ineligible for much international development assistance, but also that the government has the means to translate strategies and ideals into practice. Capacity limitations, (in the past) the absence of sustained commitment, and the significant health challenges of equatorial Africa are what have stood in the way of excellence in health care.
- Gabon's relatively small population also can work to its advantage, as it makes interventions with a pilot character more feasible and potentially rapidly scalable.
- Wide health disparities and inequities are a central feature. The MDG deadlines offer one organizing framework for galvanizing action to address them, as does the 2013 centennial of Albert Schweitzer's arrival in Lambarene.
- Exploring the potential which some see in traditional medicines could offer an interesting opportunity given Gabon's rich biodiversity and cultural history.
- Gabon faces the common strategic challenges of managing a public health care hierarchy of institutions efficiently. These challenges are of long standing (a visit to the Lambarene Hospital in 1962 reported in a book about Schweitzer found difficulties strikingly similar to those in August 2011 – underutilized facilities, insufficient personnel, limited use of facilities by patients)
- The Albert Schweitzer Hospital is a very special case, historically. Today, with its substantial research programs, international reputation and mystique, it has a potential as a non-governmental hospital to pioneer new approaches for Gabon and hopefully for the region.

References

The information presented in this Case Study was obtained by Katherine Marshall through a field visit to Gabon in August 2011.

Case Study V. Ghana: FIOs and the future

The Challenge

Ghana may be an ideal place to consider how the health sector in African countries may evolve in the future and what the implications are for faith-inspired organizations. Several developments indicate how Ghana's health sector is changing. In July 2011, the World Bank announced Ghana's achievement of (lower) middle-income country status, with its average GDP/capita now above $1000.Government expenditure on health has been increasing rapidly and some health indicators are closer to global averages than to those of the Sub-Saharan Africa region. However, many health challenges remain. Indeed, Ghana is experiencing an epidemiologic transition, with an increase in the non-communicable diseases that predominate in industrialized countries. In Ghana faith provided health is recognized and generally honored with one of the more elaborated formal frameworks for the role of Christian health providers, at least, in the national system and vis-à-vis government. Private sector health policy is relatively more advanced than in other African countries. The most pertinent question here is how FIOs might position themselves in a "post-development" health era?

Ghana's health profile

Ghana, a West African country with a population of 23.5 million and ranked 130 out of 169 on the UN 2010 Human Development Index, is considered one of the most stable democracies in Africa, and its government is pursuing an ambitious poverty reduction and growth agenda.

Ghana's contemporary health system that dates back to British colonial rule, with the first hospital built in 1868 for European and African civil servants. While many problems remain, the health sector has improved markedly in recent years, with strong political emphasis on the sector and significant donor support. The health sector's five year Program of Work (2007-2011) is closely linked to Ghana's Growth

and Poverty Reduction Strategy II, which emphasizes improved health care as crucial to sustainable growth.[3]

In 2001, Ghana Health Service (GHS) was created as a separate, independent government body in charge of implementing MOH policies; part of the rationale for its creation was to increase flexibility and decentralization of responsibilities, including managerial ones, to regional and district health services. The MOH continues to be in charge of health policy and monitoring and evaluation. Ghana's health system is divided into four main categories: public, private for profit, private not for profit, and traditional. Official healthcare policy covers the first three categories. Traditional doctors and healing practices, which are hugely popular throughout the country, are seldom integrated into mainstream practices.

The MOH developed a Private Sector Health Policy in 2003 to guide the work of private providers, which provide an estimated 40 to 50 percent of health services. The most prominent group of private providers, though not necessarily that with the largest market share, is composed of FIOs. Most Christian FIOs are represented by the Christian Health Association of Ghana (CHAG), a well-organized association that has a MOU with the MOH (See Box 1). There is no organized representation for non-CHAG private health providers, and thus less knowledge of their activities, though recent studies are correcting this gap. An official mapping by MOH in 2007 of private health assets counted 156 private hospitals, 688 private clinics, and 379 private maternity homes.[4] Contracting arrangements for service delivery are outlined in CHAG's MOU, but there is nothing comparable for other private providers—the only exceptions are service delivery contracts for donor-led HIV, AIDS, TB and malaria programs.[5] Private, non-faith-inspired providers are concentrated in urban areas.

A new and important component of Ghana's healthcare system is the National Health Insurance Scheme (NHIS), launched in 2004. Details on the NHIS are provided in Box 2. The National Health Insurance Authority (NHIA) reimburses public and accredited private providers for services used by its members.

In 2008, external partners agreed to switch their financial support for health from a SWAP (Sector wide approach program) arrangement to a Sector Budget Support mechanism; the aim is to give the government greater flexibility to allocate resources within the sector.

Ghana's religious profile
Ghana is a deeply religious country where faith permeates everyday life in important ways. A Pew Forum survey in 2010 reported that 83 percent of Ghanaians are Christian, 11 percent Muslim, and 4 percent adherents of traditional religions.[6] People in northern Ghana are predominantly Muslims. Though the number of self-proclaimed traditionalists is low, these practices are often intertwined with Christian and Muslim rituals and beliefs, and the use of traditional healers is widespread.

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[3]http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gha_en.pdf
[4] Ibid.
[5] Ibid.
[6] Pew Forum on Religion & Public Life, *Tolerance and Tension: Islam and Christianity in sub-Saharan Africa*, (Washington, DC: The Pew Research Center, 2010), 20.

Pentecostalism has been on the rise in Ghana, as elsewhere in Africa, and about a quarter of self-proclaimed Christians identify as Pentecostal. Many Charismatic-Pentecostal churches reach wide audiences through their own media outlets, including radio and television programs.

A 2005 Gallup survey found that religious leaders have more influence in Ghana than any other country in Africa, except Nigeria.[7] "In a country with over 90 distinct ethnic groups,[8] the intensity of religious observance serves to unite Ghanaians around a collective language. A 2010 survey found that three-quarters of Ghanaians pray every day. More than 80 percent of Christians attend church services weekly, and an estimated 99 percent of Muslims attend mosque, also weekly."[9]

Faith-inspired organizations working on health

Ghana's faith-inspired sector is a crucial component of the country's health system. Significant missionary health activity in Ghana started around 1920 (though missionary activity more broadly dates back to the period of Portuguese rule in the 15th Century)[10]; the first mission hospital, Agogo Presbyterian Hospital, was established in 1931.[11]Collaboration between FIOs and the public sector dates back to the 1950s; early examples include government-built hospitals that were handed over to faith-based groups to manage, also known as "agency" hospitals.[12] Though government-funded, agency hospitals "were able to reflect the religious nature of their managers."[13] The Jirapa Catholic Hospital and Bawku Presbyterian Hospital are two examples of hospitals that functioned under this arrangement.[14]

An assortment of faith-linked actors provide health services today; they account for about 22 percent of hospitals alone,[15] though less is known about their contributions at lower levels of service, such as the "chemical stores" that provide a large share of healthcare in Ghana. CHAG has 182 members comprising 58 hospitals, 76 clinics, 19 health centers, 15 primary care programs, 3 specialist facilities and 10 training institutions in 2011. [16]Notwithstanding the number of training institutions, FIOs' role in total healthcare training in the country is minimal

Islamic organizations also provide healthcare services. The Ammadiyah Muslim Mission contributes to roughly two percent of non-profit service provision, including specific medical aid programs and free

[7] Gallup International Association, "Religiosity around the World," news release, *Voice of the People 2005*, 16 November, 2005

[8] E. Gyimah-Boadi and Richard Asante, "Minorities in Ghana," (paper presented at United Nations Commission on Human Rights, Sub-Commission on Promotion and Protection of Human Rights, Working Group on Minorities, 12-16 May 2003), 24

[9] http://repository.berkleycenter.georgetown.edu/Faith_Ghana_with_Cover.pdf

[10] The World Bank. Private Health Sector Assessment in Ghana, 2011.

[11] http://www.who.int/buruli/events/agogo_hospital/en/index.html

[12] Rasheed 2009.

[13] Ibid.

[14] Ibid.

[15] Ibid

[16] http://www.chagghana.org/chag/

medical care on a temporary basis.[17] The Red Crescent Society of the Islamic Republic of Iran runs a clinic in Accra which has an explicitly religious character.[18]

Faith-inspired organizations have a voice in policy matters, on issues such as priorities for external assistance. During implementation of the health SWAp, CHAG was the official representative of FIOs. The Christian INGO Adventist Development and Relief Agency (ADRA) is the Principal Recipient for the GFATM Round 8 in Ghana.

Features and issues

The existing Private Sector Health Policy offers concrete guidance for next steps and improved collaboration with the private sector as a whole, which includes for-profit health providers and secular NGOs in addition to FIOs, but it has yet to be fully implemented. Issues deserving further attention include:

- Collaboration and competition: CHAG is a member of the private health sector but also stands apart from it, due to its special, arguably privileged relationship with the government, a recent example being rapid provisional accreditation under the NHIS. The private sector presents a major opportunity for further improvement and modernization in health in Ghana and one recommended step is formation of a collective voice for issues that cut across all of the private entities in the health sector (Makinen 2011). CHAG will need to consider how to relate to the rest of the private sector, balancing collaboration and competition. .

- Funding: Traditional sources of funding, such as churches abroad, have been on the decline for several years. As a middle income country, Ghana's access to donor funds will come at greater expense, which could affect the financial situation of FIOs. External partners may well eventually consider rebalancing some of their efforts to poorer countries. Oil revenues could offer the public sector much-needed funding to continue to expand health sector coverage, but there is need for improved coordination, financial management and M&E.

- Training: The faith-based health sector provides little in the way of training facilities for doctors. The government should explore deeper partnerships to increase support for, and the number of, training facilities, especially in rural areas.

- Staff retention: Rural health posts are generally unattractive given less than ideal conditions. Faith-based health providers have grappled with this issue for many years and provided valuable lessons to the public sector on retaining staff; further joint exploration with government on better incentive packages is one option.

- Costs of care and NHIS: The government should continue to improve NHIS systems for accreditation, coverage and reimbursements to lower costs and availability of health care at public and private facilities, especially in poorer and rural areas where health inequities are most evident.

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[17]http://www.ecoi.net/file_upload/90_1236873017_accord-health-care-in-ghana-20090312.pdf
[18] http://accra.icro.ir/index.aspx?siteid=215&pageid=9359

- Non-communicable diseases (NCDs): While, as in the rest of Africa, communicable diseases persist as the main health challenges in Ghana, the country may be one of the first where NCDs join communicable diseases as public health priorities. Since some NCDs can be more difficult and costly to manage than communicable diseases, the shift to attention to NCDs has implications for FIOs' operations. Researchers have evaluated the potential in Ghana to replicate the developed country model of church-run programs for primary prevention of cardiovascular disease (CVD) and cancer (Abanilla et al 2011). Five churches in Accra—one Pentecostal, one Charismatic, and three mainline Christian denominations--participated in a pilot that assessed whether having community health workers, including trained congregants, implement a CVD prevention program in churches would be effective. Leaders from all five churches saw their respective institutions as playing a significant role in promoting the health of Ghanaians and four of them already had church health committees. The researchers concluded such an approach has potential and saw as the important next step investigation of the partnerships between the FIOs, the MOH, CHAG, and the Ghana Pentecostal Council (which oversees the work of the Pentecostal and Charismatic churches).

Box 5.1: The Christian Health Association of Ghana

CHAG was established as an umbrella NGO in 1967. Its membership comprised Christian health institutions that were recognized by the MOH and represent three networks: the Ghana Catholic Bishops Conference, the Christian Council of Ghana and the Ghana Pentecostal Council, spanning 19 denominations.[19] CHAG's mission includes strengthening members' capacity to deliver health services; promoting partnership among Christian health services and other partners, such as government; assisting in the development and implementation of national health policies; and addressing the health needs of the poor and marginalized.[20]

As early as 1975, the government commissioned a report, known as the Adibo Report, to investigate the role of mission hospitals. The report suggested that salaries of Ghanaian staff at mission hospitals be paid by the MOH given their importance, and the recommendation began to be implemented.[21] Likewise, in the 1980s, church-run facilities saw significant reductions in their donations from abroad and sought financial support from the government.[22] As government introduced new fee and salary structures and removed drug subsidies altogether, the faith-based health sector was unable to compete with public facilities. To keep faith-based providers afloat, informal arrangements, including subsidies to faith-run facilities and seconded staff, were in place until 2003, when CHAG and the MOH signed an official MOU.

An addendum to the MOU was signed in 2006 with specific provisions for the role of faith-based providers vis-a-vis the public health system. Provisions for shared costs for human resources, financial management and oversight (only of public funds received by CHAG), regulation, etc. were outlined in

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[19]Rasheed 2009.
[20]http://www.chagghana.org/chag/
[21]Rasheed 2009.
[22] Ibid.

the addendum. In 2008, the number of staff on government payroll was 7254.[23] In 2007, a new provision was added allowing for public funds to support CHAG training facilities, in addition to staff and other operational costs.

The MOU is generally regarded as a success. In many ways CHAG functions as an extension of the public health system and claims to be the second largest provider of health services in Ghana. Although CHAG members historically served the poorest segments of the population, today their health facilities also cover urban areas, leading to tensions with the MOH given CHAG's supposed advantage and interest in covering rural and underserved areas, an assumption which underscores the partnership. The blurred line between public and faith-based facilities, and the frictions arising from it (limited government resources funding private providers, or faith-based health providers perceiving their efforts as being "watered down" or controlled by government), point to the need for increased capacity to improve and implement agreements with faith-based and private health providers, with a view to expanding and improving healthcare while providing appropriate incentives that will help ease the burden on government.

Box 5.2: Ghana's National Health Insurance Scheme

In the 1980s, Ghana introduced a cost-sharing system for healthcare by imposing user fees. The result was limited accessibility to healthcare and exclusion of the poor; community-based insurance schemes were created in some areas to help patients cover these fees, but the majority of the population was excluded from these arrangements.[24] In 2003, the government introduced a health insurance plan, the NHIS, to counter the existing cash and carry system which was especially detrimental to the poor, and take a step towards a universal healthcare system.

The degree of NHIS coverage, and its ability to effectively decrease healthcare costs, especially for the poor, are widely debated. NHIA figures cite over 60 percent coverage, while a 2011 independent study cites a mere 18 percent.[25] The fact that NHIS depends heavily on tax funds undergirds many doubts about its claims to be pro-poor, since proportionally these taxes are much more burdensome on the poor. To offset this, members are charged a one-time premium proportional to their level of income; the indigent are exempt from said premium. However, the process of verification of indigent status is a difficult one, and the condition is not applied across the board.[26] Moreover, many districts have simply resorted to charging the same premium to all members, rather than applying stratified premiums.[27]

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[23] Ibid.
[24] The World Bank. Private Health Sector Assessment in Ghana, 2011.
[25] Oxfam International 2011.
[26] The World Bank. Private Health Sector Assessment in Ghana, 2011.
[27] Ibid.

The NHIS provides coverage at all public healthcare facilities and also accredited faith-based and private providers. Due to the close relationship between the public sector and CHAG, all CHAG facilities were given provisional accreditation when NHIS was introduced. Although the NHIS has opened up private and faith-based facilities to poorer segments of the population, consumers are still more drawn to public facilities; it is unclear if this is because accreditation of private facilities is incomplete.[28]

The NHIS has had substantial impact on faith-based and private healthcare providers alike. Overall, most healthcare providers agree that NHIS has increased access to healthcare, though members continue to pay out of pocket for some services. However, the impact on faith-based and private providers has been negative in spite of larger patient volume—many are highly indebted due to delayed reimbursements by NHIA, which also impacts their ability to hire additional staff to deal with more patients.[29] One study suggests that non-members are now faced with higher prices in some facilities to compensate for these deficiencies.[30]

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[28] Ibid.

[29] http://www.chagghana.org/chag/assets/files/COMMUNIQUe.pdf

[30] Oxfam International 2011.

Case Study II: Mozambique. Politics and partnerships

The Challenge

The evolution of and conditions in Mozambique's health sector reflect the country's difficult colonial and post-independence histories, notably the almost three decades of war, first of independence and then civil, that came to an end in 1992.

The Portuguese colonizers of Mozambique did not create much social infrastructure, developing no educational system and a health system that was mainly urban and curative (Keough and Van Saanen 2007). After the long war of independence ended almost five centuries of Portuguese rule in 1975, the Marxist government that succeeded the colonial administration took an anti-religion stance, nationalized church-run facilities, including health facilities, and ordered the withdrawal of foreign missionaries. Reflecting Portugal's religious heritage, Catholicism tended to be predominant in Mozambique, and the relatively limited activity by other faiths meant that when the Portuguese left, faith-inspired social activity other than traditional religion was severely reduced. Just two years after Independence, a brutal civil war commenced, lasting 16 years, and further decimated the limited health resources.

Since the civil war ended in 1992, the government's management of the health sector generally has been regarded positively by the international community, which provides 40 percent of health spending. But the health sector faces daunting challenges, including severe shortages of doctors and nurses; the obstacles of a dispersed rural population, lack of roads, and regular devastation from rains and floods; and a high HIV burden. Even the Portuguese language can be a barrier (Interview Vander Meulen 2011). Within its policies of secularism and exclusive public control of the health sector, the government partners with faith-inspired organizations (FIOs), which are less well-represented in Mozambique than in other Sub-Saharan countries but are nonetheless important providers of health care.

Mozambique's health profile

Mozambique (population 22 million) may be best known for its almost three decades of war, including a civil war during which one million Mozambicans were killed and four million were displaced. Mozambique, now a multiparty democracy with a Constitution that guarantees religious freedom, is a very poor country that ranks 165 out of 169 countries in the UN 2010 Human Development Index.

Mozambique has run a sector-wide approach (SWAp) for health since 2000, organized around the government's Strategic Plan for the Health Sector. As noted above, the health sector is highly dependent on donor funds; the 40 percent of health spending donors contribute can be compared to a Sub-Saharan average of 16 percent (USAID 2007). While USAID reported in 2007 that despite the very large foreign funding, per capita health expenditure was only $12 per year, compared with sub-Saharan Africa average of $49 (USAID 2007), WHO reports the level in 2009 (latest data available) as $50. The HIV prevalence rate is reported by UNAIDS as 11.5 percent, compared to neighboring South Africa's 17.8 percent; many other of the country's health indicators are dire and generally worse than regional comparators.

The health system has a typical pyramidal structure with four levels ranging from Level 1, the lowest level, to Level 4. Level 1 is composed of health posts and health centers that deliver at least 40 percent of all health services despite only 60 percent of them having trained staff (Keough and Van Saanen 2007). These facilities are typically the first, and often only, point of contact with the health system for a large portion of the population (World Bank 2004). The top level, Level 4, consists of the country's three referral hospitals (USAID 2007). Regarding the pronounced shortage of trained medical staff, the government created a cadre of "tecnicos de medicinas," lightly trained community health workers, not unlike the barefoot doctors of China.

Mozambique's religious profile

The religious profile of Mozambique is complex, with perhaps 500 different Christian denominations, a sizable Islamic community, and common practice of traditional African religion. It is also notably largely free of religious tensions (Keough and Van Saanen 2007). According to the most recent census conducted by Mozambique's National Institute of Statistics in 2007, 56.1 percent of the population is Christian, 17.9 percent, is Muslim, 18.7percentreportedno religion, and 7.3 percent adhere to "other beliefs." The 18.7 percent share claiming no religion is relatively high for an African country and may reflect the government's secularism. It is estimated that perhaps as much as 50 percent of the population also practices traditional religion (Keough and Van Saanen 2007). Christian and Islamic services incorporate many traditional practices, though there is also a competing movement of more orthodox worship. Fast- growing religious groups in Mozambique, as in much of the rest of Africa, are Pentecostals, the African Independent Churches (also known, and referred to by the Mozambican government, as Zionist Christian churches), and evangelicals (information attributed to Mozambique's National Directorate of Religious Affairs and reported on wikipedia.org; also reported by Vander Meulen (Interview 2011)).

Vander Meulen (Interview 2011) reports that while most Mozambicans do identify with a religion, in her view many wear their faith affiliation more lightly than in other African countries, possibly reflecting the government's secular stance.

Faith-inspired organizations working on health

In a World Bank review, Keough and Van Saanen (2007) report that faith groups were mostly responsible for founding modern health care in Mozambique, and over most of the country's history, have played a significant role, often together and sometimes in tension with the government. In addition to the Catholics, the Anglicans were present via the British colonization of neighboring Malawi, and Methodist missionary doctors arrived in the early 1900s. As noted above, the government nationalized all health institutions after independence. Today, however, while firmly committed to comprehensive public control of the health system, the government works in partnership with FIOs and other civil society actors under the Kaya Kwanga Commitment, a code of conduct guiding such partnerships[31], and management of several key institutions has reverted to faith groups, who co-administer them with the Ministry of Health (MOH).

The Methodist-run Chicuque Rural Hospital and the Catholic-run Chokwe Hospital are two large faith-affiliated facilities. Adding to the public-cum-faith-inspired nature is that both hospitals receive support from secular Columbia University in the US via the university's HIV and AIDS program supported under PEPFAR.

Chicuque Rural Hospital is an example of a mission hospital now part of a mainstream national health system. Founded in 1913 by the Methodist Church, it remained a project of the denomination until nationalization. In1986, during the civil war, the Ministry of Health invited the Church to jointly manage and support the hospital, and the partnership continues today (Keough and Van Saanen 2007).

The Chokwe hospital is run by the Catholic Vincentian Daughters of Charity. In addition to running the hospital, this religious order is the largest field partner of the DREAM initiative (see Box 1), running the program at the public Carmelo Hospital in Chokwe. One of Mozambique's two medical schools is also faith-inspired, the Catholic Medical College of Mozambique.

A compelling faith-health development involves the rapid growth of Pentecostalism and AICs. Pfeiffer (2011) finds that in the peri-urban parts of Mozambique where HIV and AIDS rates are the highest, as much as half of the population may be members of Pentecostal or AIC churches. He observes that this suggests that creative strategies should be developed to include these movements and communities in HIV and AIDS programming. The team for this study notes that engaging these denominations for health initiatives including behavior change communication, presents challenges as well as opportunities. Established stakeholders and programs are focused more on mainstream and less on local faith traditions. Moreover, some reported practices of these newer, local denominations, such as the maiming or exclusion of child "witches" by Pentecostals in Nigeria, are deeply problematic (Oppenheimer 2010).

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[31]Available on WHO's website in English by searching Kaya Kwanga Commitment.

Because most Mozambicans lack access to health facilities, they also rely to a large extent on traditional practitioners (Keough and Van Saanen 2007) even when there is access to modern health practitioners. Traditional systems have special importance in Mozambique and deserve attention, but, as is the case for much of the rest of Africa, they also raise challenges in terms of their incorporation into the public system, e.g., traditional healers can delay those with HIV and AIDS seeking the correct treatment. The MOH has made some efforts to collaborate with traditional healers (Keough and Van Saanen 2007).

Features and Issues

Despite (or perhaps even because of?) the political shifts and turmoil FIOs have faced, there are many faith-inspired health initiatives in Mozambique that stand out for their effectiveness, grass-roots origin, interfaith nature, or other features. Two faith-inspired programs are featured in Box 1 and 2.

Box 2.1 DREAM

The Community of Sant'Egidio began in Rome in the 1960s as a Catholic student movement committed to serving the poor and working for peace. The community has grown to 40,000 member volunteers working in more than 70 countries, on a wide array of community level interventions to alleviate poverty, provide social services, and foster peace (Keough and Marshall 2006; http://santegidio.org).

The Community has deep roots in Mozambique. It began working there shortly after independence and remained active during the civil war. The Community helped achieve the Peace Agreement in 1992 that ended the long conflict.

The Community responded to the HIV and AIDS crises by developing an impressive and highly successful treatment and care program known as "DREAM" and convening 13 African ministers of health and other leaders in May 2004 to sign a joint declaration affirming that to receive HIV and AIDS treatment is a human right. DREAM stands for "Drug Resource Enhancement against AIDS and Malnutrition." DREAM, which is financed by the World Bank, provides a comprehensive treatment approach to HIV and AIDS that includes antiretroviral therapy (ART), diagnostics, strategies for treatment adherence, attention to opportunistic diseases that co-exist with HIV and AIDS, and prevention of mother-to-child transmission (MTCT).

The Community launched DREAM in Mozambique in 2002 and has since extended it to 10 other Sub-Saharan African countries. The program has been highly successful, achieving 90 percent adherence to treatment programs, reductions in HIV-1 transmission rates similar to the levels in high-income countries; and decreases in MTCT (Palombi et al. 2007). DREAM is probably the most rigorously studied faith-inspired HIV and AIDS program in the world, and the Community's website provides a list of the 100 or so papers on the program, many of them peer-reviewed studies attesting to its efficacy (http://dream.santegidio.org/public/Bibliografia/x__BibliografiaNS.asp). A recent report from the Community reports the latest quantitative data on the vast numbers/amounts of patients served, tests performed, and drugs provided (Community of Sant'Egidio 2011).

Further strengthening the long association between Mozambique and Sant'Egidio, on July 14, 2011, the MOH signed a new agreement with the Community to further extend DREAM.

Box 2.2 Equipas da Vida and the Community Health Project[32]

Equipas da Vida–teams of life, when the name is translated from Portuguese into English–are bringing preventative information on HIV and AIDS and care for PLWHA to rural populations that might otherwise have no such support, and they are doing it on a shoestring.

The Equipas mainly operate in one of two Anglican dioceses in Mozambique, Niassa. Niassa covers the four Northern provinces of the country, a highly rural area that is less developed and poorer than the southern parts of the country. There are some 200 of these community response groups across the 350 congregations in the Diocese, each with about 20 members. The Equipas were initially focused on prevention and treatment of HIV and AIDS, but they now provide broader help to community members with the disease, such as farming for them. The Equipas operate on a fully volunteer basis. One of the most striking features of the Equipas is that membership keeps growing, swelled by non-Anglicans, including Muslims, traditional religion adherents and seculars (Interview Vander Meulen 2011). In addition to the Equipas' contributions to health, Vander Meulen observed that the Equipas demonstrate agency, that is, that these impoverished, isolated rural people are both eager to and fully capable of taking successful action to help their communities. Moreover, the Equipas are a highly sustainable health intervention. Parents teach their children, who are likely to stay in the area, how to help their community. Vander Meulen also said that people now see the Equipasas a fundamental part of "what their church is, just like having a choir," and so, she believes, the communities will keep the Equipas going. Finally, Vander Meulen observed, the Equipas represent true international development, going beyond addressing atomized health indicators to strengthen both the quality and capacity of life of the poor.

The Diocese also runs an extensive Community Health Project (CHP) in conjunction with the government in Lago, one of Mozambique's 350 districts. The CHP has built and operates about nine health posts in areas where people had no access to health services and would have had to walk up to 200 kilometers in order to have access to ART. The health posts have benefitted from some outside funding, but much of the effort for constructing and operating the posts is by volunteers. The government supplies medicine, and the volunteers advocate with the government to ensure that Lago receives its proper share of ARTs. Volunteers are trained by the Anglicans but approved by the government. A British physician Margaret Cumberland who works with the CHP has reported that child mortality has dropped sharply in the district since CHP took root (http://www.ipsnews.net/africa/nota.asp?idnews=48476).

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[32]Much of the information in this Box comes from an interview in August 2011 with Rebecca Vander Meulen, public health expert and Program Director, Anglican Diocese of Niassa, Mozambique. See also on Anglicord's website, http://www.anglicord.org.au/index.php?page=mozambique-hiv-and-aids-testing-and-treatment.

The Diocese has accomplished the two main endeavours of the Equipas da Vida and the Community Health Project with 20 paid staff members. Vander Meulen notes that the initiatives highlight issues of volunteerism. For example, she suggested that one of the best inputs to the health programs in Mozambique would be training more community volunteers. Such training would represent "one level up" from current community-based initiatives with very slightly trained or untrained volunteers. However, she observed that training opens up payment problems. Volunteers in Mozambique, Vander Meulen said, are accomplishing a great deal, educating children, farming for the sick, constructing facilities, and more. Notwithstanding the great need for income-generating activities in Mozambique, it may be the case that a new cadre of lightly trained HIV and AIDS community health workers paid by the government could impact incentives and motivation for volunteers. The success of the Equipas to date may be dependent on the great enthusiasm and dedication of volunteers, and it is not inconceivable that the opportunities payment introduces for corruption and for tensions among different groups could impact the effectiveness of volunteer-based programs.

Other notable initiatives are:

• World Relief, a Christian INGO, runs a group care model in Vurhonga. It has created a network of mothers who become behavior change agents teaching their communities about child health (http://worldrelief.org/Page.aspx?pid=1334; WFDD forthcoming report on Maternal Mortality 2011). Evaluation found evidence for the effectiveness of the program in indicators such as prompt seeking of treatment for pneumonia symptoms and child mortality rates (Grau et al. 2008).

• The Programa Inter Religioso Contra a Malaria or Together Against Malaria program (PIRCOM is the Portuguese acronym and TAM, the English one) brings together national leaders from the top 10 faith communities in Mozambique, including Christian, Muslim, Hindu and Baha'i faiths, to fight malaria. PIRCOM's main activity is training of faith leaders across the country with key malaria prevention and control messages (http://www.cifa.org/about-cifa/background.html). The faith leaders in turn transmit repeated anti-malaria messaging to their faith communities. PIRCOM has trained over 21,000 faith leaders, who have reached more than 1.5 million Mozambicans. The program is supported by, among others, the President's Malaria Initiative, Adventist Relief and Development Agency, and the Center for Interfaith Action on Global Poverty. The program appears to be the largest and most successful multi-faith initiative against malaria to date (WFDD Malaria 2009).

• Kubatsirana is an ecumenical organization started by 35 Christian churches coming together in 1995 to reduce new HIV and AIDS infections and improve the quality of life for PLWHA in the Manica province of Mozambique (http://kubatsirana.org). Through a participatory community approach, Kubatsirana develops the capacity of churches and other Christian groups to provide basic health, food, and educational support to households affected by the disease.

For all the health challenges that exist in Mozambique and amidst the pluses and minuses of FIOs needing to work within the public sector, the country features a dynamic faith-inspired health sector, which several commentators have observed could be much more greatly leveraged by the MOH and

donors to address HIV, AIDS and other health challenges (Agadjanian and Sen 2007; Interview Vander Meulen 2011).

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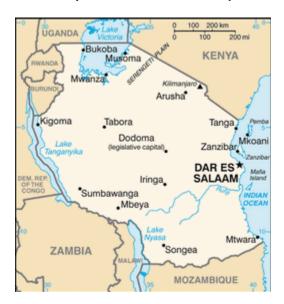
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Case Study III: Tanzania. Does CHA plus MOU spell A-OK?

The Challenge

Tanzania's Christian Social Services Commission (CSSC) is an ecumenical body, founded in 1992, that represents Christian faith-inspired organizations operating almost one thousand facilities in the country. It is one of the stronger of the 17 Christian Health Associations in Africa, even though not as strong as the CHA of Ghana. The CSSC negotiated a Memorandum of Understanding (MOU) with the government of Tanzania in 1992 that seems to work well, with the Ministry of Health and Social Welfare (MOH) and FIOs entering into service-level agreements that provide public funding for FIOs' health work. But the health statistics in Tanzania are challenging and the CSSC feels it operates on an uneven playing field (Interview Kimambo2011).

Tanzania's health profile

Tanzania, a democratic and politically stable country in East Africa (population 43 million), became independent from Britain in1961. One of the world's poorest countries, it ranks 148 out of 169 nations on the UN 2010 Human Development Index.

The MOH is currently operating its third Health Sector Strategic Plan (for 2009-2015) and has made many important advances. But, as the selected health statistics in Table 1 show, the health situation in the country is very challenging. Average life expectancy is 45 years of age and the disease burden is heavy, with high incidences of HIV, malaria, tuberculosis, and the major childhood killers. While Tanzania performs well on some indicators relative to peer groups of Sub-Saharan African and low-income countries, such as rates of immunization and antenatal visits, it under-performs with respects to others, such as maternal mortality.

Tanzania's health system has three pyramidal components: (i) at the bottom of the pyramid, a district-level component (comprising district hospitals, health centers, dispensaries, and community health services, with district councils); (ii) in the middle, secondary and tertiary hospitals and other institutions such as teaching hospitals, and (iii) the centralized level, at the top of the pyramid, featuring the MOH.

Under the first post-independence government and its philosophy of Ujamaa (African socialism), Tanzania promoted free universal health care and education. It also nationalized all health facilities and schools, and banned private medical practice. However, the country was not able to maintain a socialist economy in practice. Health services were supposedly free but often not available. A market economy was re-introduced in the early 1990s.

Health services are mostly provided by the government and faith-inspired organizations (FIOs), with secular NGOs, parastatal organizations, private-for-profit organizations, and traditional healers providing the balance.

The CSSC estimates that it provides 35 to 40 percent of all health care in Tanzania, and that its members represent the vast majority of FIOs working in the health sector. There are no estimates of the amount of health work provided by other faiths in Tanzania, and while it is probably quite small in market share terms, these efforts make special contributions to health and well-being in Tanzania. CSSC members operate 87, or 40 percent, of the country's 220 hospitals, and account for the same share of bed capacity. The 40 percent hospital share can be compared to historical information that at the time of independence, half of the country's hospitals were mission hospitals. CSSC members also run 28 nursing colleges, while the government runs 27. However, FIOs run just 13 percent of the dispensaries that account for the bulk of Tanzania's health facilities.

Just as for other African countries, FIOs' market share estimates are being revisited due to newer analyses. Health service utilization data suggest that Tanzanians spend just 15 percent of total out-of-pocket health expenditures on services from not-for-profit providers, with 72 percent of expenditures going to public providers and 13 percent to private-for-profit providers. The finding that expenditure and other types of survey data do not align with the relatively high health-market shares of FIOs reported on other bases is not uncommon in other countries, and there are various possible and sometimes competing explanations (See Section 3, Main Report).

Indicative of the CSSC's institutional quality is its status as a member of the GFATM country coordinating mechanism for Tanzania, and Tanzanian FIOs are among the most active recipients or sub-recipients of GFATM funds. CSSC has also participated in mapping of its members' health assets; operates under a strategic plan; and produces and commissions studies to help improve its members' operations. The quality of health care provided by FIOs is considered high. Leonard and Masatu (2010) found that in rural areas of Tanzania, the quality of care received by patients visiting government facilities in rural areas is sub-par compared with that provided in urban areas, while NGO facilities provide better and more consistent care across the rural-urban divide. Since it is a safe assumption that FIOs account for a large share of the health care provided by NGOs, these researchers' work speaks to the quality of care provided by FIOs.

Tanzania's religious profile
Data on religious affiliation in Tanzania are considered educated guesswork, specifically with regard to the share of Christians and Muslims. The national census has not asked for religious affiliation since 1967 as the religious balance is seen as a sensitive topic. The Handbook of World Religions reports a

break-down of: 40 percent, Christian; 35 percent, Muslim; and 25 percent, followers of various indigenous religious groups, including some 5 percent of the population that is mainly following traditional beliefs.

Muslim communities are concentrated in coastal areas of the mainland, with a large majority being Sunni, except in Dar es Salaam, the country's largest city, where Shia predominate. The island of Zanzibar is about 97 percent Muslim. Islam was introduced to the area as early as the eighth century.

The Christian population is diverse, including Catholics, mainline Protestants, evangelicals, Adventists, Mormons, and other denominations. Christianity was introduced to the region now known as Tanzania mainly via colonization and mission activities concentrated in the nineteenth century. Among the Protestants, the presence of Lutherans and Moravians reflects the country's earlier German colonial past, while high numbers of Anglicans reflect the later British colonization.

Tanzania has active albeit small communities of Hindus, Baha'is, and Buddhists.

Faith-inspired organizations working on health
While Islam pre-dated activities by other faiths in the region by several centuries, organized health care was not a feature of the Muslim community in earlier times. Generally, in the development field, it appears to be the case that Muslim entities in sub-Saharan Africa do not organize to provide health care in the same ways or to the same extent that Christian ones do. Notably, Muslim organizations may be more involved in communication and education, often through imams and mosques, rather than in direct health services. Tanzania's Muslim community has been organized since 1968 under the National Muslim Council of Tanzania or BAKWATA. BAKWATA carries out some health work, usually in communication and education, such as its National HIV and AIDS Program, which aims to mobilize faith leaders to address the disease. Aga Khan Health Services (AKHS), an agency that is part of the Aga Khan Development Network (AKDN), provides both primary and curative health care in Tanzania through a hospital, and also provides technical assistance to the government on health service delivery.

The history of Christian missionaries in the region that became modern-day Tanzania is quite colorful. Catholic missionaries intending to evangelize arrived in Zanzibar with Vasco Da Gama in 1499 but did not gain a foothold. The next groups of Europeans to show an interest in the region were missionaries of the Church Missionary Society who reached Kilimanjaro in the late 1840s, almost half a century before German colonization. Their missionaries created the famous map that stimulated the explorations of Richard Burton. A series of primarily geographic explorations of the region were followed by David Livingstone traveling to the region now known as Tanzania in 1866, on his last journey, in order to expose the horrors of the slave trade. Spurred on by Livingstone's work, more missionary societies took an interest in East Africa, many with the objective, in addition to evangelization, to fight the Arabian slave trade, sometimes in conjunction with the European powers. In the mid- eighteen hundreds, Catholic priests opened villages for freed slaves, provided education, and made it a priority to create a local clergy. More German Lutheran missionaries arrived alongside German colonization in the 1880s. After the First World War and as the region became a British colony, many more, diverse missionary groups arrived. Indeed, the early missionary history included denominational competition among

Christian groups sometimes so strong that the colonial government had to create exclusive areas for the different denominations to avoid possible violence. However, a more positive feature of the competition was that different denominations raced to build more schools and health facilities. And after independence, the Christian denominations began to cooperate, including on social services, notably leading to the creation of the CSSC

A Hindu community was established in Tanzania through Indian worker immigrants, and this community created the organization Shree Hindu Mandal in 1919 as a non-profit organization to serve all Tanzanians. This organization runs, among other social services, the Shree Hindu Mandal Hospital in Dar es Salaam. Another important health facility is the Hindu Union Hospital in Mwanza, which originated as a small community health care center in a make-shift building in 1981. The Sri Sathya Sai Society of Tanzania, a branch of a global group that follows a religious teacher who promoted a mix of Hindu and Muslim teachings, operates as a service contractor to the government, providing meals and other services to the blind. The Baha'i congregation established in Tanzania in 1950 has established health clinics and provided health education. The Tanzania Buddhist Temple and Meditation Center in Tanzania is the oldest Buddhist temple in Africa. Established by Sri Lankan workers in 1915, it does not provide physical health services per se, but does provide opportunities for meditation practice.

One of the earliest initiatives of the World Faiths Development Dialogue (WFDD) (see Main Paper for more information on the WFDD) was an effort to coordinate the health work of Tanzania's religious bodies more closely with the government. In 1999, the Government of Tanzania welcomed the offer from the WFDD of the services of a multi-faith network in drawing up an essential inventory of health care in the hands of faith-inspired organizations. However, no updated information on outcomes or maintenance of this initiative was found via an internet search.

Features and Issues

Health Costs and Financing

Total heath expenditure on health in Tanzania is equal to 5.1 percent of GDP (WHO 2009 data). Public expenditure accounts for about half of total health expenditure, including the 21 percent of total health expenditure provided by external donors. Thus, households provide the other half of health expenditure out-of-pocket. Health expenditure data are complicated by the distinctions between on-budget and off-budget spending, and by the fact that for some diseases, such as HIV and AIDS, there is massive spending through vertical programs whose inclusion in government data can vary.

In 1999, the MOH approved the National Health Insurance Fund Act, establishing a compulsory social health insurance scheme for formal sector employees. The scheme presently covers about 3 percent of the population. To address the needs of informal sector and rural populations, the MOH established in 2001 Community Health Funds, providing community-based health insurance to 48 districts. Churches and cooperatives run micro-insurance schemes. Private health insurance is available but limited.

Relationship between the Government and FIOs

Collaboration between the government and FIOs in the health sector is solid. Collaboration existed even amidst the ban on private medical practice and the nationalization of schools and hospitals, subsequent to the 1967 Arusha Declaration, that pertained until the resumption of a market economy in the early 1990s. Indeed, in 1972, when the decentralized structure of the health system was created, a contract model between the government and the FIOs was instituted that continues to apply today, even as it evolves. The MOU negotiated between the CSSC and the government in 1992 officially recognized the role played by FIOs in the health sector and importantly established a principle of additional financial support for the FIOs, as well as offering protection against further nationalization. Since then, the MOH has issued other strategic plans that recognize the need for public-private partnerships in order to meet the health needs of the country. Since 2007, the MOH works with FIOs through service level agreements through which CSSC and other voluntary groups receive public funding for contracts that specify outputs such as the number of pregnant mothers seen or doses of vaccines administered. Twenty-three FIO-operated hospitals are district designated hospitals (DDH) because there is no public sector alternative in the district in question. DDHs receive full grants from government once their work plan is approved. Also, some resources are allocated to hospitals according to bed capacity and FIOs' facilities can also apply for block grant funding. The government makes payments to FIOs under other schemes, notably for certain health services that the government guarantees to provide with subsidization. On the whole, the collaboration between the government and the CSSC and its FIO members is good. However, in practice, there are tensions and problems, and two main concerns are covered below.

A level playing field for assessing impact

The Executive Director of the CSSC, Adeline Kimambo (Interview 2011) believes that at present the organization and its members do not operate on a level playing field that would allow a valid comparison of the effectiveness and cost-efficiency of its health services with those of government. She indicated that this is the case because the government is not always reimbursing FIOs fully or promptly under the various service agreements that pertain, and some government payments, such as the per-bed payment for DDHs, no longer cover actual costs. Representatives of individual Tanzanian FIOs interviewed at the Christian Connections in International Health annual meeting in the US in June 2011 also said that the government makes its agreed payments with long lags and arrears. CSSC feels facilities operated by its members are put under stress by these financial problems and that the problems moreover disadvantage the faith-inspired health sector as it comes under pressure from all sides to demonstrate its effectiveness, without the shortfall in payments being taken into account.

FIOs in Tanzania trying to document their impact face challenges. For example, a project to implement a district health management information system to collect, store, and analyze accurate health data and to track the effectiveness of interventions, increase accountability, and track health trends in the district was established by a partnership of the African Inland Church of Tanzania, the Evangelical Lutheran Church of Tanzania, and the Catholic church of Mwanas. However, the project was impeded by severe, prolonged electricity problems frustrating efforts by the FIOs to improve the availability of accurate and timely data to inform Tanzanian health policymakers.

An internal drain brain

Similar to experiences in other African countries, CSSC members face serious human resource problems. The supply of health workers has been falling in Tanzania, while the health worker-salary gap between FIOs and the public sector has widened. CSSC estimates that, for example, the average salary of a nurse working for a FIO is about $ 122 per month, while a nurse working for the government might earn about $287. In 2005 when a new government initiative improved working conditions in the public sector, there was an exodus of health staff from FIOs since the organizations could not match the remuneration gains in the public sector.

CSSC is being pro-active in addressing what it calls an "internal brain drain." It participated in a human resource information system mapping exercise with several other partners in 2005.The objective was both to improve human resource management and to support CSSC advocating with the government to obtain more support. The mapping exercise has already yielded potential benefits, leading to the MOH establishing an agreement to second staff to FIOs. Unfortunately, though, in practice, the funding for this scheme is in doubt and it has not yet been implemented. CSSC recently commissioned international consultants to design an incentive package with a mix of financial and nonfinancial incentives to help retain health workers at FIOs, but does not yet have the financial resources to implement it.

Thus, while Tanzania possesses both a strong organization representing FIOs and a solid MOU between the government and the CHA, there are opportunities for better coordination between the MOH and FIOs and integration of FIOs that could improve the functioning of the health system.

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Case Study IV: South Sudan. A brave new world (of possibilities)

The Challenge:

In July 2011, the Republic of South Sudan became the world's newest country. Fifty years of violent conflict, where millions died and more still were displaced, took on religious dimensions, pitting the largely Christian South versus the largely Muslim north. International attention and a well-respected model of faith-based diplomacy (including the Sudan Ecumenical Forum and the World Council of Churches) helped the new nation to win its independence. The new Republic has rich natural resources but faces staggering challenges, none more daunting than large gaps in health and education. Among its resources is a vast array of faith-linked organizations, many with the resourcefulness and hard-won experience gained through working in remarkably difficult circumstances. During the conflict years these were de facto the primary service providers. The new government, which readily acknowledges that its capacity is weak, faces the good will of a host of external partners. While South Sudan can surely mobilize resources, it also faces a particular problem due to notoriously poor aid coordination and harmonization within the humanitarian aid sector, which includes a multitude of potential and actual external partners. Surely there is an opportunity in South Sudan, one that would call for purposeful leadership, to do better and, from the start, to map the faith-inspired resources and their experience in an intelligent way and to engage them in framing a pragmatic, bold, and creative partnership.

South Sudan's health profile:

Official data on virtually any topic relevant for development are weak to non-existent or not yet available for South Sudan. Formerly-unified Sudan ranked 154 out of 169 countries in the UN 2010 Human Development Index, and South Sudan's situation is far worse than the North. South Sudan's health system was run during the conflict period and continues to be run by a large group of international and local NGOs, many with faith links: a rough estimate is that 85 percent of health services are provided by faith-inspired and secular NGOs. Maternal and infant mortality rates are among

the highest in the world. Ministry of Health data for 2005 indicated that approximately 719 health facilities, with 255 doctors and three surgeons, served South Sudan's population of 8.2 million.

The new government has highlighted South Sudan's poor health conditions and lack of services as a priority but these needs compete with the many development and security challenges facing the new nation. The national budget of $2.3 billion is insufficient to scratch the surface of the needs of the new country, where 90 percent of the population survives on half a dollar per day.

South Sudan's health challenges are reasonably well known at an aggregate level but not in any specific detail. Childhood disease looms large as a challenge but essentially every tropical disease challenge is present. One question that arises is how far the global pattern of vertical funding and support (notably for HIV, AIDS, malaria, and tuberculosis) will drive the shaping of the new health system. Can South Sudan avoid some of the pitfalls involved and build a comprehensive system based on primary, community care? And how can the strengths of private largely non-profit and faith-linked actors contribute to the design and management of the system? Another question is the specific nature of traditional health care and whether these can be constructively engaged in the new system – for example traditional birth attendants.

Box 4.1: The spirit moves.

A post on South Sudan from The Economist's Africa blog:

 January 2nd, 2011, a Sunday, was the climax of campaigning for the referendum that started a week later and Archbishop Paulino Lukudu Loro travelled several hours from Juba to the town of Lirya. A new church had been built on a hill last year and plastic chairs covered the tiled floor. A generator was producing enough power to run fans, a rarity, and a gospel choir sang with all its might. Priests read a litany of saints and after each one the congregation exulted "pray for us". As the archbishop walked in he was joined by dancers in traditional dress, musicians and nuns.

Most of the town's thousand-strong population thronged in and around the church and still more could be seen arriving through swathes of tall grass. Tinny bells rang and drums rumbled. Women chanted, clapped and ululated. The archbishop said, "This is a great success for the church in Sudan." He meant the building of a new church and the ordaining of a priest, the reason for his visit that day. But everyone understood the political significance. A local village official came to the altar and read out an appeal to vote in the referendum. The archbishop endorsed it and amplified it. He said he was praying for peace and then, mixing pidgin Arabic and English, the two main tongues in Sudan, he said, "Killo vote"—that is, everyone vote.

South Sudan's religious profile
Religious difference and related prejudices played a significant role in the conflict between the north and the south of Sudan, with the stylized religious conflict being between Islam in the north and Christianity and Animism (traditional indigenous beliefs) in the south. Ethnic diversity is an overlapping reality with more than 200 distinct ethnic groups. The religious profile, however, is not well mapped, in

part because it is complex and dynamic. Interestingly, some scholarly and U.S. Department of State sources suggest that a majority of southern Sudanese maintain Animist beliefs with Christians an influential minority. However, estimates of combined Catholic and Episcopalian/Anglican adherents are projected at about 5 million, within a population of 8 million. The Catholic Church represents the largest and perhaps the fastest growing Christian body; it grew from 250 members in 1898 to 3.1 million in 2000 (World Christian Encyclopedia 2000). The Catholic Church is seen by many as the strongest institutional structure in the nation. It has great convening power is the primary unifying factor for South Sudan's diverse ethnic groups, which number over 200. A blog on Africa run by The Economist (2011) noted, "In a land where the state has yet to set up much in the way of infrastructure, the (Catholic) church with its simple but sturdy network is king. It is the only organization that survived decades of civil war intact."(See Box 4.1) The Episcopal/Anglican church is the second largest Christian denomination in South Sudan. Far less well known are numbers and the nature of service work of other Christian denominations, notably evangelical churches whose presence is newer and more decentralized. There are indications that with restraints to religious freedom and evangelization removed by independence, new churches are being established. Faith traditions with no or few congregants in South Sudan have been extremely active in humanitarian relief there, e.g., the Jewish Coalition for Sudan Relief.

Faith-inspired organizations working on health

A Christian Health Association of Sudan (CHAS) operates in Juba and Nairobi, Kenya, as an umbrella organization for the network of Christian-inspired health organizations. It was established in 2002, with support from the Sudan Council of Churches. CHAS aims to strengthen members' capacity to provide health services through partnerships with communities and the Ministry of Health and training programs for health workers and church leaders. Box1 provides an example of the work of a faith-inspired provider.

Features and Issues

NGOs in South Sudan do critical work, but currently, their significant role presents a challenge to the new government: how can it take on appropriate new responsibility for meeting the needs of its people, setting standards, and assuring reasonable coordination in a system built under adverse circumstances, in a highly fragmented manner. The de facto model of NGO service provision clearly needs to give way to a national system but the question is when and how. Jok Madut Jok described the situation in this way:

> "If we dictate how we use help from outside, we will be accused of being too
> controlling; if we let the donor community tell us what to do with our nation, we won't
> have a nation. It would be a nation conceived and delivered by foreigners; it will not be
> raised from within our own philosophies; something that we own, that will fit in our
> traditions and our culture, something that will be symbolic of us being a sovereign
> state." (PRI 2011)

One evaluation of coordination among NGOs concluded that coordination mechanisms are confused and confusing, with bodies created at different levels and in different sectors by the government, donors, UN agencies and NGOs, with no overall framework connecting them (Currion 2010). The NGO

Forum, a voluntary body established in 1996 and representing over 150 international and 180 local NGOs operational within Southern Sudan, exists to coordinate NGOs' work, but despite its good efforts, much of the supposed coordination effort is essentially confined to an information-sharing exercise.

South Sudan thus represents an opportunity for NGOs—and for FIOs in particular, given the lead role they have played to date-- to address charges of poor coordination and duplication of efforts that are often leveled at both faith-inspired and secular NGOs working in low-income countries.

Box 4.2: IMA World Health in South Sudan

IMA, the largest US-based, ecumenical, international health organization, has made major efforts to provide in-country support for the massive undertaking of creating a national health care system. Beginning in 2008, IMA established field offices in Juba and other locations in the south, and managed Sudd Health, a comprehensive program funded by the World Bank and Multi Donor Trust Fund to provide access to at least 50 percent of people in Jonglei and Upper Nile states to basic health services. IMA launched a one-year Southern Sudan AIDS Commission program in 2010 that selects medical facilities in Jonglei and Upper Nile to devote significant resources for comprehensive HIV and AIDS care. IMA also works to improve health information systems, providing information to field staff and medical teams on the availability and existence of needed resources. By gathering and analyzing health data, IMA's informational system offers a way to map revitalization efforts as well as manage the development of local and national health systems. IMA states that it partners with other NGOs and FIOs, often local church-run programs, and works with government to provide effective services rooted in local and national needs and views. (http://www.imaworldhealth.org/where-we-work/southern-sudan.html)

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Appendix 1: Evaluation in International Development

Evaluation methodology and practices

Evaluation and monitoring has been undergoing a boom across all sectors—public, corporate, and nonprofit--over the last two decades, with growing emphasis on truly measuring outcomes and impact, rather than just monitoring inputs and outputs. Analytical rigor and quantitative data to determine whether a program achieved intended outcomes is emphasized over subjective or qualitative information that describes the program but does not measure its impact. Evaluation departments have become a norm within respectable development institutions.

Evaluation has two audiences. One is the organizations and their financial supporters; evaluation tells them if programs are achieving their objectives. The second audience is all stakeholders, for whom published evaluations provide crucial information on how to improve outcomes. Evaluations can be done at the initiative of the organization carrying out an operation or that of a funder or independent researcher. They can be done internally or by third parties, by companies such as The Futures Group and Deloitte, which can lend an evaluation greater credibility, controlling for the incentives in self-reporting to find and feature positive results. A WFDD report (Marshall et al 2007, page 24; see main paper for citation) provides a useful table of three different types of organizations that evaluate FIOs. Nonprofit organizations, including FIOs, are mixed in terms of making evaluations of their programs publically available. GiveWell, a charity rating nonprofit, will not rate any organization that does not provide meaningful and systematic, as opposed to anecdotal, evaluations on their website. The aid agencies of many donor countries publish broad reviews of their efforts but not many individual program evaluations. USAID is rare in aiming to provide, on its "Development Experience Clearinghouse" website (dec.usaid.gov), all evaluations carried out on programs it funds. As examples of its breadth, recent searches of the database yielded 351 results for evaluations of programs carried out by Catholic Relief Services and 291 for World Vision.

A theme in international development is that more and better evaluations should be done. A key Center for Global Development report (Savedoff, Levine, and Birdsall 2006; see main paper for citation) asked why each year billions of dollars are spent on thousands of programs to improve health and education in the developing world but very few programs are rigorously evaluated to learn if they make a difference. The review identified as main constraints a lack of concentrated demand and funding for evaluations and misaligned incentives (implementers have reasons for seeking and reporting overly-positive results). But there is also an often unwritten though not unspoken argument among development practitioners that hundreds of millions of dollars are spent on marginally useful evaluation studies yielding limited practical information and the funds would be better spent helping the poor.

While there are many different types of evaluation methodologies, the basic aim of all is broadly the same: to assess the effect of an intervention on one group compared to the effect of no or a different intervention on another group, and/or to find the reasons why the interventions had different impacts, if they did. The common quantitative evaluation methodologies range from cross-sectional studies (least

rigorous) to randomized controlled trials (arguably, the most rigorous). The Logical Framework Approach (LFA) is a design rather than an evaluation methodology that provides a logical and explicit approach to program design and management, identifying the workings of a program—the "program theory" or "program logic." Until recently, many health projects for developing countries lacked good program logic. While many faith-inspired INGOs already use LFA, FIOs that posit faith-specific factors or outcomes in their programs but have difficulties pinpointing them could use some form of LFA to better pinpoint where faith enters their program logic.

Other types of non-quantitative or mixed quantitative-qualitative evaluations are available. Some health programs do not lend themselves to quantitative assessments, and so qualitative data, such as from surveys and interviews, or a mix of quantitative and qualitative information will be used. Such methods allow an evaluator to delve more deeply into a program and obtain detailed information that may help to contextualize observed change, though they may suffer from subjectivity and a lack of generalizability and rigor. Theory-based evaluation is a more in-depth understanding of program workings that need not assume simple linear cause-and-effect. Participatory evaluation is a partnership approach to evaluation in which stakeholders actively engage in developing the evaluation and all phases of its implementation.

Many types of evaluation involve creating and measuring indicators that represent health outcomes, e.g., rates of HIV infection or serum viral loads for an HIV and AIDS project. If the question is whether a FIO is better, or just as good, at an intervention intended, say, to decrease child deaths from diarrhea, the indicators are straightforward. But if a FIO engaged in health also aims to affect patients in other than purely physical ways, indicators are more difficult to define, construct, and measure.

FIOs have begun to respond to the challenges of developing indicators and otherwise identifying faith-specific inputs, outputs, and outcomes in health programs. Transformational Development (TD), a concept created by the INGO World Vision (http://transformational-development.org/), is a major initiative in this regard. TD is composed of five "domains of change" such as the well-being of children, their families and communities, and interdependent and empowered communities. Transformational Development Indicators (TDIs) include both secular and quasi- or wholly-faith-inspired parameters, such as to the extent to which the organization is reaching the poorest individuals and the commitment of the staff to foster spiritual growth, strong church relations, and serve as appropriate witness to Christ. World Vision created TD to assist in performing comparative evaluations across their international programs. Other FIOs have adopted the Transformational Development concept and other research on spiritual indicators is underway. As another example, Catholic Relief Services reports that subsidiarity, a Catholic social teaching that people should be empowered to make their own decisions and solve their own problems, is a faith framework that it brings to all its international development programs.

It is frequently said, including by leaders among the FIOs themselves, that FIOs are relatively weaker at monitoring and evaluation (M&E) than other types of organizations and need to improve their capacity (Bandy et al 2008; CIFA 2010; Johnson et al 2002; see main paper for citations). Anecdotal reports suggest a tendency for FIOs to protest that they are busy "doing" in crisis-type conditions and don't have time for M&E. Researchers suggest also that greater financial independence or sensitivities around religion and articulating the "value of faith"(Aiken 2010; James 2009; see main paper for citations) may

lead to less or weaker evaluation by FIOs. However, it is also the case that many FIOs have well developed M&E departments, and, as is detailed in Chapter 3 of the main paper, the team found numerous high quality evaluations by or about FIOs, including on community-based organizations. A key to more assessments and accountability by all program implementers is insistence by partners and other stakeholders that evaluations be carried out. Another is demonstrating that monitoring and evaluation is useful in improving the true development impact of programs and not just another "bureaucratic obstacle."

Appendix 2: Summaries of Selected Evaluations

This appendix provides summaries of 15 evaluations of health work by faith-inspired organizations and 5 evaluations of health work by secular nongovernmental organizations; it is background information for the discussion in Chapter 3 of the main report on the evidence from stand-alone evaluations of FIOs' health work.

A. Selected stand-alone evaluation reports for faith-inspired organizations

1. **Perry, Henry. 2009. Salvation Army/Zambia (TSA), Salvation Army World Service Organization (SAWSO), and TSA Chikankata Health Services, Chikankata Child Survival Project (CCSP), 2005-2010**: Final evaluation report. USAID (December). This report evaluated a child survival project in Zambia with the goal of reducing maternal and under-five mortality through innovative community-based behavior change communication strategies and improved health services. Fifteen of 21 indicators showed improvements of at least 10 percentage points or more relative to baselines, although only seven of 21 end-of-project goals were actually achieved. The most notable findings were for two high-impact indicators: exclusive breastfeeding and use of insecticide treated nets. There is no mention of faith except in terms of the population's reliance on traditional medicine.

2. **Catholic Relief Services. 2009. Burundi FY 2009 Results Report: Multi-Year Assistance Program (2008 – 2011) Award: FFP-A-00-08-00080-00CRS**. This CRS document reported results including 94 MOH staff trained in child growth monitoring; 45 outpatient therapy programs created; and supplementary rations to over 71,000 severely and moderately malnourished children in over 50 health centers.

3. **Medical Teams International. 2010. Grand Cape Mount Child Survival Program, Improved Child Health in a Transitional State through IMCI, October 2006 - September 2010, Final Evaluation Report. USAID (December)**. The goal of this project implemented in Liberia in the immediate post-conflict environment was to reduce morbidity and mortality of children under five and improve the health of women of reproductive age. The strategic objective of the project was improved health outcomes through appropriate household practices and use of quality health services within a supportive sustainable environment by 2011. Quantitative measurements at baseline, midterm (2008) and final (2010) evaluations confirmed that the MTI CSP achieved significant increases in almost all project impact indicators and significantly exceeded project targets in many cases. Annual Lot Quality Assurance Sampling (LQAS) measurements as well as qualitative triangulation during evaluations confirmed obvious changes in key child survival and maternal health behaviors. The report noted "Although MTI and CHAL are faith-based Christian organizations, the program and approach was highly acceptable to communities in a predominantly Muslim area of the country."

4. **Egge, K et al. 2007. CRS/Zambia: Palliative Care Nutritional Supplementation Targeting Evaluation: Final Report.** The objective of the project was to investigate the impact of nutritional supplements on HIV-positive home based care (HBC) clients not taking ARVs who met the criteria for targeted nutritional supplementation. Effectiveness of the program (reductions in malnourishment, weight gain, and higher

levels of satisfaction) was indicated by a quantitative study comparing results of two different nutritional intervention groups with a control group.

5. **TAABCO Consulting. 2011. Ecumenical HIV/AIDS Initiative in Africa: Impact Assessment, 2002-2009**. HIV and AIDS issues were incorporated into theological curriculums, training undertaken, and HIV and AIDS literature distributed. The report found "encouraging evidence of effectiveness" including with respect to stigmatization, but evidence was mostly qualitative and anecdotal.

6. **World Vision/Ethiopia. 2001. Final Evaluation Report: Shenkolla Child Survival Project**. Quantitative evidence was provided for the efficacy of a maternal/child health program: contraceptive prevalence increased from 6 percent to 36 percent; percentage of children with acute respiratory infections who received antibiotics increased from 18 percent to 89 percent. However, improvements in immunization coverage were "not impressive" nor was there an increase in the number of women who gave birth with a trained assistant. Nonetheless, evidence was provided that the project was able to make considerable progress in achieving its two goals to reduce under-5 and maternal mortality and morbidity and total fertility rates.

7. **TAABCO Consulting. 2007. Free Pentecostal Fellowship in Kenya, Embakasi Church, Uzima Center.** The project mainly concerned vocational training, but also included HIV and AIDS education. 43 percent of participants said that they had changed their behavior and 15 percent, their lifestyle as a result of the program.

8. **USAID/Access. 2007. Preventing Malaria in Pregnancy through Focused Ante-Natal Care: Working with Faith-Based Organizations in Uganda by Access to Clinical and Community Maternal, Neonatal, and Women's Health Services.** The project included IMA World Health and JHPIEGO working with the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Catholic Medical Bureau to increase uptake of intermittent preventative treatment to prevent malaria. The evaluation found significant improvements in clinic staff training, percentage of women receiving a mosquito net, the number of community health workers trained, clinic attendance, and percentage of women receiving IPT under supervision. Due to the effectiveness of program, which the evaluators attributed to the involvement of FBOs, the MOH plans to replicate the program model in other areas of Uganda.

9**. Norwegian Church Aid (NCA). 2008. Evaluation Report of Norwegian Church Aid Supported Home Based Care Project in Eritrea by NCA and MOH staff.** For this project addressing HIV, AIDS and nutrition, mostly qualitative assessment found that the education provided was very helpful but that people couldn't change their behaviors due to a lack of resources; e.g., lactating women with HIV and AIDS reported knowing that they should not breastfeed their babies, but they (and the program) lacked the resources to pay for infant formula. It was noted in the report that spiritual care was lacking among the project population.

10. **Magnano San Lio, M, S Mancinelli, L Palombi, E Buonomo, A Doro Altan, P Germano, N A Magid. 2009. "The DREAM model's effectiveness in health promotion of AIDS patients in Africa." Health Promotion International 24 (1) (March).** This evaluation provided results in terms of education,

adherence, and health outcomes for Sant'Egidio's DREAM model for HIV and AIDS prevention and treatment. 87 percent of the studied population completed the treatments during the study period; 84 percent had undetectable viral loads at the end of the treatment period.

11. **Chang, L. W, S. Alamo, S. Guma, J. Christopher, T. Suntoke, R. Omasete, J. P Montis, T. C Quinn, M. Juncker, and S. J Reynolds. 2009. "Two Year Virologic Outcomes of an Alternative AIDS Care Model: Evaluation of a Peer Health Worker and Nurse-Staffed Community-Based Program in Uganda." Journal of Acquired Immune Deficiency Syndromes 50 (3).** This academic journal article provided quantitative evidence of the effectiveness of the Reach Out Mbuya Parish community-based program, including a 72 percent patient retention rate; survival rates of 84 percent at year one and 82 percent at year two; and 86 percent undetectable viral loads. Researchers reported that CD4 counts and viral load count results were comparable if not better than those seen in industrialized country programs.

12. **Vitillo, Robert. 2006. A Faith-Based Response to HIV in Southern Africa: The Choose to Care Initiative by UNAIDS (December).** This study describes the work of the Choose to Care initiative of the Catholic Church in Southern Africa which began in 2000. It shows that effective scaling-up of programs in the response to HIV does not necessarily have to be the expansion of a single central service. Working through the diocesan and parish system, coordinated by the AIDS Office Southern African Catholic Bishops' Conference, and originally funded by the Catholic Mission Medical Board and other Catholic funding agencies, the Catholic Church scaled up service provision by the replication of smaller scale programs rooted in and responsive to the needs expressed by local communities in this five-country area. This study shows that such an approach is effective when undertaken within common guidelines and given central support. The report is in the UNAIDS "Best Practices Collection."

13. **Schneider, Rose, Fabio, Luelmo, and Diana Roses. 2008. TB child survival and health grants program evaluation. Global Health Technical Assistance Project (April).** The overall performance of a large USAID TB prevention grant program was assessed, covering the performance of seven implementing NGOs, including FIOs (e.g., CRS) and non-FIOs (CARE, PATH) in eight countries from Africa, Asia, Europe, and Latin America. The evaluation found quantitative and qualitative evidence of the programs' effectiveness and that they fill a need in TB control that complements national TB programs, particularly due to their community-based nature.

14. **Rutta, E., J. McCollum, and S. Mwakisu. 2006. Rapid ART Pharmaceutical Management Assessment in Five Mission Hospitals in Tanzania. Submitted to USAID by the Rational Pharmaceutical Management Plus Program.** The objectives of the program were to assess and evaluate availability and use of policies and guidelines for HIV and AIDS health services delivery. The study found that all the facilities had comprehensive HIV and AIDS care activities including voluntary counseling and testing, prevention of mother to child transmission, home based care, and ART. There were regularly scheduled systems for audits, and policies and guidelines for care were available and appeared to be in use. All the facilities had functional computers in use daily and offered continuing medical education. Weaknesses included a shortage of pharmaceutical staff and training and shortfalls in medicine storage and stock records.

15. **ADRA. 2001. Madagascar child survival XIV: Toamasina child survival project -- mid-term evaluation report, submitted to USAID**. The project focused on capacity building for the district health system to enable an integrated program of essential preventive, promotive, and curative health care. The mid-term evaluation provided quantitative evidence of progress in strengthening district health care.

B. Selected stand-alone evaluation reports for secular organizations

1. **Kittle, Bonnie L. 2009. Yallando Kleya Child Survival Project – Diffa Region, Niger. Submitted to USAID**. Helen Keller International's (HKI) child survival project in Diffa, Niger was implemented from October 2004 – September 2009, with the objective of improving the nutritional status of children and pregnant and lactating women. The project succeeded in attaining 13 out of 21 targets.

2. **Franco, Ciro et al. 2008. Evaluation of the Home Based Management of Malaria Strategy in Rwanda. Submitted to USAID.** One of the Rwandan government's key strategies to control malaria is increasing the percentage of children under five years of age that receive correct treatment for malaria within 24 hours of the onset of symptoms. To achieve this strategy, the Integrated National Malaria Control Program (INMCP) developed a strategy for home-based management of fever (HBM) in 2004, using WHO guidelines as a foundation. The evaluation assessed this public sector program and posed questions such as (i) are community health workers and private sector counter assistants performing according to standards; (ii) what are the factors that facilitate (or hamper) the performance of community health workers and private sector counter assistants; and (iii) what are the factors that keep the caretakers from seeking prompt treatment for their children. The evaluation concluded that HBM can be a successful strategy to assist the government to further control malaria in Rwanda.

3. **Kyayise AM, R Kyeyagalire, N Livesley, I Kirunda, B Tumwesigye, S Kinoti and D Katungu. 2008. Private-for-Profit HIV/AIDS Care in Uganda: An Assessment. Technical Report. Submitted to USAID by the University Research Company**. Of Uganda's 4639 health facilities, 2154 (46 percent) are privately owned for profits (PFPs). Of them, 36 are accredited to provide care and treatment to people with HIV and AIDS. However, little was known about the quality of care they provide. An assessment of 30 of the 36 accredited PFP sites was carried out; the study interviewed facility staff and reviewed the records of two patient cohorts—a pre-ART cohort and an ART cohort—at each facility. While the PFPs performed satisfactorily in some areas, numerous weaknesses in patient retention and care were also found.

4. **CARE Ethiopia. 2008. The Farta Woreda Child Survival Project**. The project aimed to improve the health of children under five and women of childbearing age by focusing on nutrition, pneumonia case management, and control of diarrheal disease. The project emphasized a BCC strategy that took maximum advantage of the presence of the Ethiopian Orthodox Church (EOC). The EOC's pervasiveness and high degree of authority led to almost 100 percent coverage of BCC messages with high credibility.

5. **AusAID. 2003. "Effectiveness review of Australian Government-funded NGOs in the Lao People' Democratic Republic. AusAID (February).** This report was selected for review by the team even though it dealt with Asia rather than Africa because it was fairly comprehensive and like the Schneider et al report on a TB project included above, it reviewed similar work carried out by both faith-inspired and

secular NGOs. Throughout this evaluation, there were no explicit or implicit indications of any distinctions between the secular and faith-inspired organizations in terms of their programming or effectiveness.