Global Health and Africa

ASSESSING FAITH WORK AND RESEARCH PRIORITIES

FULL REPORT

TonyBlairFaithFoundation

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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.

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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.

[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

[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.

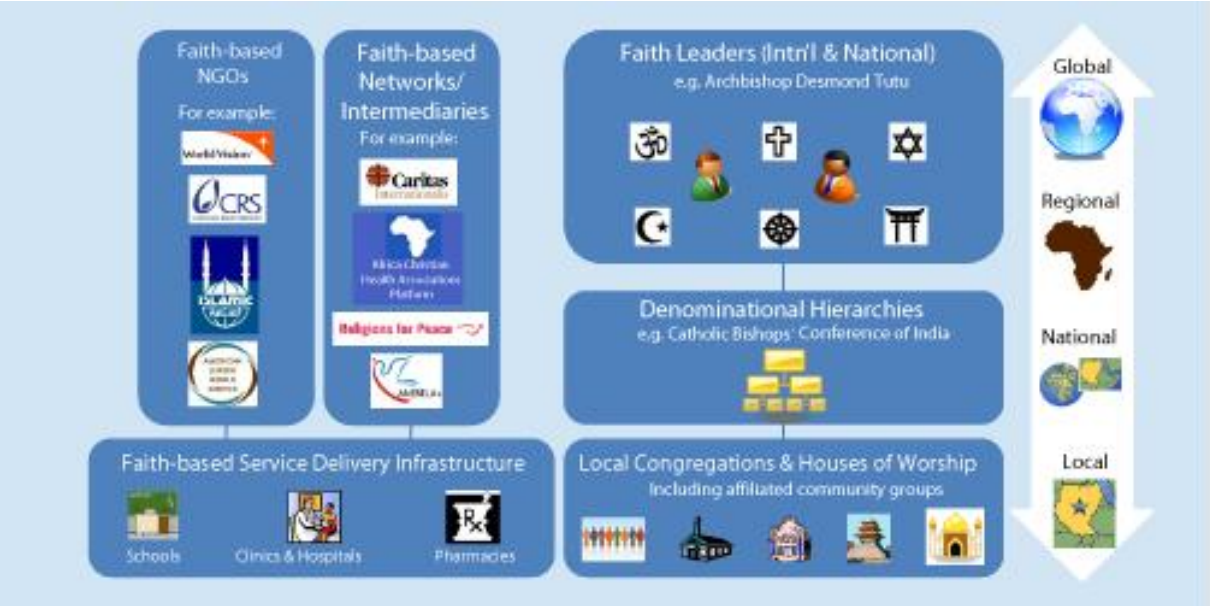
Health work. This study employs a broad definition of health work to include not just health care (the diagnosis, treatment, and prevention of illness, injury, and other physical impairments), but also the many other activities undertaken in order to improve human health. Health work thus also includes 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:

[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 organizations 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 not 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.

[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 sensitivities 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.

[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.

[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.

[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'

[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/aboutsurveys/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.measuredhs.com/aboutsurveys/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.measuredhs.com/aboutsurveys/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/index_24302.html	Household surveys on health, education, child protection and HIV and AIDS.	Religion of household is included.	19 countries in Africa	

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

		been completed in the last 10 years.		healers)
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. Nine of the country's 18 health districts are headed by mission hospitals, which carry out comprehensive health planning and management for their districts.	Foster 2004 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. Missions provide a third or more of clinical care. 40 percent of hospitals have a faith-based connection. More than 30 percent of NGOs are faith-based. Private not-for-profit (PNFP) facilities, of which 78 percent are faith based, accounted for	Marshall 2004 Gill and Carlough 2008 Ssewamala and Ismayilova 2008 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]

[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

[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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