The distinctives of faith-based health providers for HIV and AIDS response

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[Webinar 3 in series of 4]

Learning Objectives

a) Describe the history of research on the distinctive characteristics of FBHPs

b) Summarize distinctive characteristics of FBHPs and their impact

c) Distinguish between anecdote and evidence

d) Considering useful messages on FBHP distinctives for various purposes

e) Build capacity for research (both formal research initiatives and informal efforts to document impact) that builds the evidence of faith-based distinctives.

Describing the history of research on the distinctive characteristics of FBHPs . . . Differentiating between evidence and anecdote

[AProf Jill Olivier]

A long history of statements and claims

"Half the work in education and health in sub-Saharan Africa is done by the church…" (James Wolfensohn, WB, 2002)

“(FBOs) account for around 20% of the total number of agencies working to combat HIV/AIDS” (WHO 2004)

(FBOs) provide some 50% of health care services in many developing countries. The Vatican…(estimates) that at least 25% of all HIV/AIDS-related services are sponsored by the Catholic Church (Vitillo 2005)

“FBOs (provide) an average of about 40% of services in sub-Saharan Africa” (Bandy et al 2007)

“In many African countries, you provide 30 to 70% of the health services…” (Graeme Wheeler, WB, 2010)

“Religious hospitals provide a significant portion of health services around the world, especially in rural areas” (Plewman et al 1998)

A long history of statements … with few robust statistics (a ‘discourse’)

- **Common statements: 40%, 30-70%, 25%**
- **Usually provided alongside other ‘commonly accepted’ but somewhat vague statements of ‘comparative value characteristics’ (e.g. reach to the poor, community trust)**
- **Major implications for policy** (e.g. fairness of funding portions globally and nationally)
- **Part of advocacy work from early 2000s – of ‘getting FBOs/FBHPs to the table’, or ‘making them visible’**
- **International and national faith-based networks particular drivers of the discoursse**
- **But also perpetuated by researchers (especially in summary reports and briefs) …**(be suspicious of unreferenced/generalising estimates!)

EXTRA READING: Olivier J, Wodon Q. 2012. Playing broken telephone: assessing faith-inspired health care provision in Africa. *Development in Practice*, **22**: 819-834

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

Common estimates of market share of FBHPs vs public health system

OWNERSHIP?

Number of Hospital Beds?

EXTRA READING: Olivier J, Tsimpo C, Gemignani R, et al. 2015. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet*, **386**: 1765-1775.

Comparing apples, oranges, and elephants

- **Unfortunately, a very fragmented evidence-base** … although slowly getting better
- **The measures are rarely clear – or comparative (e.g. % of what? Beds? Facilities? In/out patients? Drug dispensing?)**
- **When people start comparing the conclusions (from incomparable) studies – there is a huge outcry based on whether that 'feels' right, or if it helps/hinders a particular advocacy argument** (e.g. see Olivier et al 2015 – Lancet)
- **In public vs private – the private for profit (and the rest of PNFP) is usually forgotten**
- **All FBOs are not the same – and even all FBHPs are not the same (some are co-owned, some are 'somewhat-for-profit')**
- **Set of (mainly Anglophone) 'CHA' African countries used for global evidence**

EXTRA READING: Olivier J, Tsimpo C, Gemignani R, et al. 2015. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet*, **386**: 1765-1775.

Why is this a problem?

- **Over-estimates things tend to get challenged/debunked**
- **Other important things get under-estimated** (e.g. reach to the poor, or complexity of community-health system connection)
- **Rarely provides evidence that can be used for negotiation/advocacy – or that speaks to the urgent agendas of the day**
  - E.g. access (affordability, availability, acceptability), equity, universal coverage, rural/urban footprint (but vis-a-vis public system), reach to the poor, cost to household (user fees)…
  - E.g. quality of care, efficiency, utilization, user preference / satisfaction, retention to care, continuity of care, drug availability and supply chain sustainability, health promotion impact…
  - E.g. Resilience, responsiveness (eg dignity), special consideration for marginalised…
  - E.g. fragile and conflict affected countries, non-African settings…
  - E.g. Contribution to high quality HRH training, governance, community accountability…

There is a slow emergence of new evidence

- **But you have to look for it (often nested in a national study) – and it can seem overly specific**

RANDOM SAMPLE OF EXAMPLES

- Levin A, Dmytraczenko T, McEuen M, et al. 2003. Costs of maternal healthcare services in three Anglophone African countries. *International Journal of Health Planning Management*, 18: 3-22.
- Reinikka R, Svensson J. 2003. Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda. World Bank.
- Munoz-Laboy MA, Murray L, Wittlin N, et al. 2011. Beyond faith-based organizations: using comparative institutional ethnography to understand religious responses to HIV and AIDS in Brazil. *American Journal of Public Health*, 101: 972-928.
- Hirose A, Yisa IO, Aminu A, et al. 2018. Technical quality of delivery care in private-and public-sector health facilities in Enugu and Lagos States, Nigeria. *Health Policy and Planning*.
- Anugwom EE, Anugwom K. 2018. Beyond morality: Assessment of the capacity of faith-based organizations (FBOS) in responding to the HIV/AIDS challenge in Southeastern Nigeria. *Iranian Journal of Public Health*, 47: 70.

FBHPs doing more research (for themselves, or with embedded others)

E. Non-Profit and Not-for-Profit Status
List all sources of funding.

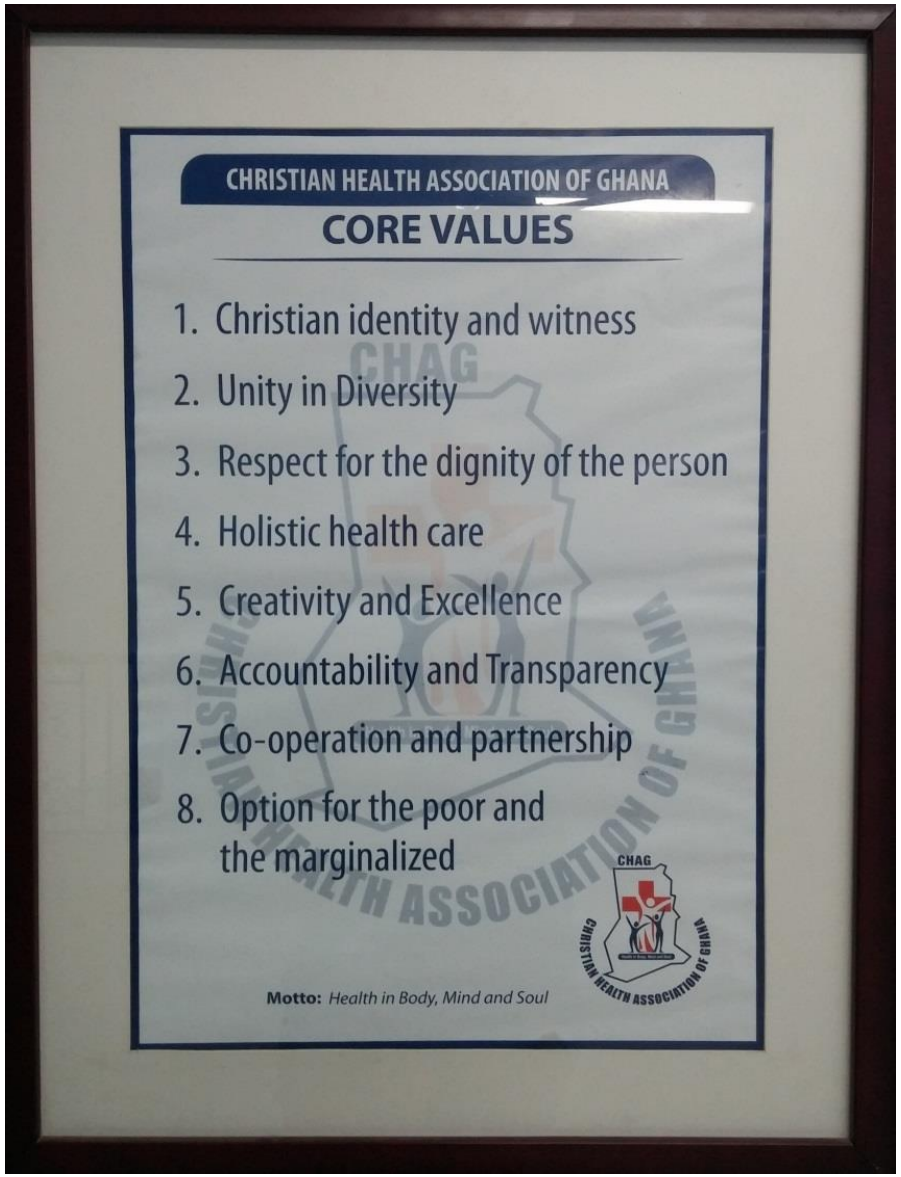
a._____ b._____
c._____ d._____
e._____ f._____

F. Existing Pro-Poor Measures (Practices)

1. Do you have a written policy or guide on services for the poor? Yes[ ] No[ ] **(Provide copy if yes)**
2. Is there a staff that is responsible for oversight of the poor? Yes[ ] No[ ] **(Provide details if Yes)**
3. Do you have current data on the poor served/supported? Yes[ ] No[ ] **(Provide evidence if yes)**
4. Annual reports contain data on services to the poor.
5. Evidence of specific proactive pro-poor community health activity/year

G. Certification/Regulatory Requirements (Provide documentation)

1. Duly registered with the Registrar General's Department. Yes[ ] No[ ]
2. Duly registered with Ministry of Health - Health Facility Regula
3. Duly credentialed by the National Health Insurance Authority (N
4. Duly registered with CHAG. Yes[ ] No[ ]



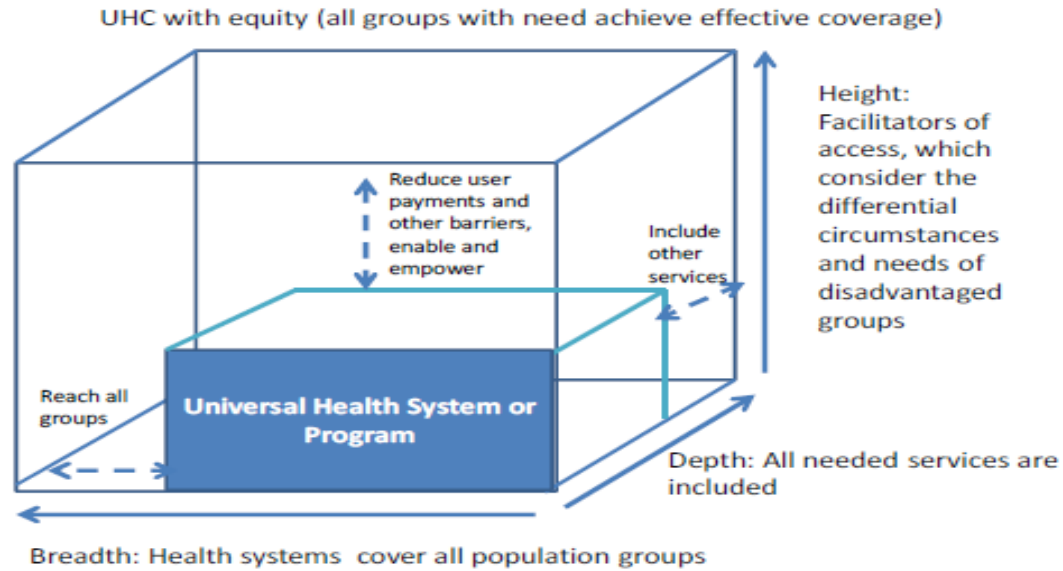
For FBHPs, CHAs, and International Institutions

- The need to get more PRECISE
- Less DEFENSIVE
- More STRATEGIC with advocacy messaging

For researchers (and those supporting research)

- Also need to get more PRECISE (CRITICAL)
- More SOPHISTICATED
- More SUPPORTIVE (of FBHPs)
- More RELEVANT (to global agendas and local questions)

Figure 1: Dimensions of universal health coverage with equity



Source: Adapted from www.be-causehealth.be

Response – from the perspective of a FBHP leader

[Mr Peter Yeboah – CHAG & ACHAP]

FBHPs: Building helpful advocacy messages and research capacity

John Blevins

The Nature of “Evidence”

- **There is a need for clear, concrete calculations of the contributions of FBHPs**
- **However, describing the contributions using other frameworks can be strategically useful for FBHPs**
  - Social capital
    - > Trust
    - > Norms
    - > Capacity
  - Motivation and longevity
    - > Reach to the poor
    - > Funding streams
    - > Organizational structures

Social Capital

- **Trust and Norms**
  - Various qualitative studies do indicate that faith-based providers enjoy greater trust when compared to providers from other sectors
    - > Lipsky, Alyson B. 2011. “Evaluating the Strength of Faith: Potential Comparative Advantages of Faith-based Organizations Providing Health Services in Sub Saharan Africa.” *Public Administration and Development* 31 (1):25-36.
    - > UNFPA (United National Population Fund). 2008. *Culture Matters: Lessons from a Legacy of Engaging Faith-based Organizations.* New York: UNFPA.
  - However, religion can also be a driver of stigmatization that some people living with or affected by HIV face– in effect, the social capital of religion can be used to support certain social norms in ways that contribute to social vulnerabilities for those outside those norms
    - > Epstein, Helen. 2007. *The Invisible Cure: Africa, the West and the Fight against AIDS*. New York: Farrar, Straus, and Giroux.
    - > Evertz, Scott. 2010. *How Ideology Trumped Science: Why PEPFAR Failed to Meet its Potential.* Washington, DC: The Center for American Progress and the Council for Global Equality.
    - > Abraham Kiprop Mulwo and Keyan G Tomaselli. 2010.“Sex, morality and AIDS: The perils of moralistic discourse in HIV prevention campaigns among university students,” in *Communicatio* 35(2): 295-314.

Social Capital

- **Capacity**
  - Services by FBHPs are supplemented by robust services at the community level and among local congregations
  - Congregations can mobilize volunteers for community initiatives but such initiatives can be difficult to coordinate and measure their effects is difficult
    - United Nations Children's Fund and World Conference of Religions for Peace. 2004. *Study of the response by faith-based organizations to orphans and vulnerable children.*

Motivation and Longevity

- **Reach to the Poor**
  - FBOs provide material support to poor individuals and families; most often through congregation structures.
    - United Nations Children's Fund and World Conference of Religions for Peace. 2004. *Study of the response by faith-based organizations to orphans and vulnerable children.*

- Do FBOs serve the poor in greater numbers than other providers?
  - Not necessarily.
    - Olivier, Jill and Wodon, Quentin. 2012. "Do Faith-Inspired Health Care Providers in Africa Reach the Poor More Often Than Other Providers?" in *Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Providers in Sub-Saharan Africa* (Washington, DC: The World Bank).
  - But they may provide program capacity to reach poor communities in contexts where governmental policies have presented structural challenges to providing care to the poor.
    - Blevins, John. 2016. Are Faith-Based Organizations Assets or Hindrances for Adolescents Living with HIV? They're Both. *Brown Journal of World Affairs* 22(2): 25-38.

Motivation and Longevity

- **Funding Streams**
  - Financial support of HIV programs is substantial. Faith communities are estimated to provide $5 billion for HIV programs annually, an amount that equals the combined funding of all bilateral and multilateral donors.
    > United Nations Children's Fund. 2012. *Partnering with Religious Communities for Children*.
  - Shifts in funding can be highly disruptive to FBHPs
    > Blevins, John, Christoph Benn, and Sandra Thurman. 2016. "Supporting Religious Health Providers Through Global Funding Mechanisms." *Review of Faith and International Affairs* 14, 2.
- **Organizational Structures**
  - The scope of services and the specific contributions of faith-based organizations vary greatly depending on type and structure.
    > United Nations Children's Fund and World Conference of Religions for Peace. 2004. *Study of the response by faith-based organizations to orphans and vulnerable children.*
  - Little is known about non-Christian religious traditions or about independent FBOs regardless of religious sponsorship.
    > Blevins, John, Emily Lemon, Ahoua Kone, and Mimi Kiser. 2017. "The Percentage of HIV Prevention and Treatment Services in Kenya Provided by Faith-Based Providers." Development in Practice 27, 5.

Key Points

- This brief survey points to some policy analyses and qualitative studies that demonstrate capacities and contributions (and the limits of each) outside of quantitative measures.
- The urgent need to move beyond anecdotal claims when speaking to funders, policy makers, and other providers.
- The importance of combining messages that highlight the evidence of FBO contributions with messages that resonate to other audiences (e.g., religious leaders and local faith communities.

Announcements

We invite you to join us for webinar 4. Generating Evidence on the Distinctives of Faith-Based Organizations in the HIV Response (Part 2)

This webinar will also focus on the distinctive characteristics of FBOs that can affect HIV services – but focusing on local faith communities and faith-inspired community organisations.

Please invite your colleagues within your organization or colleagues from other organizations to join us. The webinars are free of charge. Registration is required.

The webinars are being recorded so anyone can access content after it is completed.

Registration and recorded webinars can be found at: http://ihpemory.org/webinars/