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

John Blevins, Emory University
Jill Olivier, University of Cape Town
5 February 2019
[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 discourse

• But also perpetuated by researchers (especially in summary reports and briefs) …(be suspicious of unreferenced/generalising estimates!)

### Common estimates of market share of FBHPs vs public health system

#### OWNERSHIP?

#### Number of Hospital Beds?

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

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

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


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

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

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 Regulation and Accreditation. Yes[ ] No[ ]
3. Duly credentialed by the National Health Insurance Authority. Yes[ ] No[ ]
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)
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


• 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

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

Motivation and Longevity

• Reach to the Poor

• FBOs provide material support to poor individuals and families; most often through congregation structures.


• Do FBOs serve the poor in greater numbers than other providers?
  – Not necessarily.


  – 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.

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.
  – Shifts in funding can be highly disruptive to FBHPs

• Organizational Structures
  – The scope of services and the specific contributions of faith-based organizations vary greatly depending on type and structure.
  – Little is known about non-Christian religious traditions or about independent FBOs regardless of religious sponsorship.
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.)
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/