



# Lancet series on the contribution of faith-based health providers: a call for greater accountability

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## Introduction

In July 2015, *The Lancet* published a series of articles examining the role of faith-based health providers (FBHPs).<sup>1,2,3</sup> The three papers examined the scope of FBHP work (focused on Africa where more research has been undertaken), described the controversies associated with FBHPs, and outlined how to better strengthen partnerships between FBHPs and the public sector. This commentary gives a summary of the series and suggests three areas that faith based groups can consider to better describe, document, and integrate their work within national health systems.

## Paper 1: Understanding the roles of faith-based health care providers in Africa

The first paper begins with a rationale for the series, namely that FBHPs deliver a significant proportion of services; have significant reach, particularly in settings where government services are weakest; and yet are often treated with distrust due to many past and present controversies, particularly around proselytising agendas or constrained care due to religious prohibitions on particular services. The paper then focuses on Africa, where more documentation is available, to try and measure the magnitude of service delivery, how these services are financed, their reach, particularly to the poor, and the quality of services provided by faith-based groups. Two limitations are recognised: most of the available literature is drawn from the

HIV sector, and the focus is primarily on Christian FBHPs.

The authors, many of whom have led significant previous systematic reviews in the area, articulate the challenges well:

- Defining FBHPs is difficult as they can extend from small congregational efforts to large national coalitions of multiple FBHPs.
- The magnitude of the contribution by FBHPs is variably reported as between 30-70% of all health services in Africa, and the basis for these estimates is vague and maybe overstated. Yet FBHPs do provide a greater contribution where government systems are weakest.
- In the move towards universal health coverage and an increasing proportion of health services funded by governments, FPHPs, who usually need to manage cost recovery through user fees, are becoming more expensive for households, even where subsidies are provided for the very poor.
- Evidence of increased quality of care is mixed. Provider satisfaction is greater for FBHPs and is attributed to more compassionate care as result of the values of faith-based institutions, but this requires further substantiation. Yet FBHPs may also provide poorer quality care than public providers in contexts where hiring policies prioritise the religious character of an employee over their health care competency.

## Paper 2: Controversies in faith and health care

The second paper summarised 11 issues where religious positioning has meant that health services delivered by faith-based organizations (FBOs) have differed from those of the public sector or advocated by global best practice. These issues include family planning; abortion and artificial reproductive technology; child marriage; female genital mutilation (FGM); immunisation; stigma and sexuality; harm reduction and HIV; violence against women; gender; faith healing; and end of life issues.

The articles begin with the recognition that 80% of the world's population report having a religious faith. The authors outline the four principles of humanist ethics: autonomy of the individual who has intrinsic value and dignity; the obligation to assist those in need; the do-no-harm principle; and the principle of distributive justice or equitable access to services and posited that faith-based ethics are not dissimilar but may give differing weights to these principles. For example, the right or autonomy of an individual may give way to beliefs about the sanctity of life in end of life issues or in abortion service delivery.

A striking factor in the article was the varying responses between and within faiths to particular issues and the reflection that these were not static positions. For many of the issues, including FGM or child marriage, attribution to religious belief distinct from cultural traditions is not possible. This is reflected in the article's emphasis on pragmatism, *i.e.*, what each faith is seen to be doing rather than trying to summarise doctrinal positions on each issue, which was beyond the scope of the series. Important conclusions included the acceleration of change when religious leaders support a particular issue (*e.g.*, eliminating FGM or care for people affected with HIV) and the call for greater collaboration between health professionals, faith leaders, and policy makers

to overcome some of the entrenched suspicion and distrust that is largely based on assumption or hearsay.

## Paper 3: Strengthening of partnerships between the public sector and faith-based groups

The final paper in the series is a call for closer partnerships between faith-based organisations and government groups. The paper begins by outlining four development trends that should foster engagement with FBHPs: common goals to end extreme poverty that are increasingly supported by economic investment; a focus on ending preventable child and maternal deaths, an area that FBHPs have traditionally emphasised; donors, governments, and multilateral agencies explicitly seeking to increase their own faith literacy; and increasing investment in health in low and middle income countries to provide opportunities for more formal engagement with FBHPs, particularly as FBHPs play an important part in providing care to remote and hard to reach areas.

Increasing collaboration is not without challenges. The authors describe some successful national models of cooperation, and examples where this has led to significant increases in coverage of health interventions. However, there are important complexities in government-FBHP cooperation, and the onus is on the FBHP community to work together to provide a mechanism (*e.g.*, forming a coalition such as the Africa Christian Health Association) for meaningful engagement. The underinvestment in FBHPs by large multilateral donors is disappointing, particularly considering the proportion of care they cover. The example given of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding, which sought to prioritise FBHPs) in Kenya, demonstrated disproportionately low disbursements to FBHPs, and the proportion invested by The Global Fund and World Bank is lower again. However, when all development assistance is

measured, FBHPs continue to receive substantial investment, although much is from the faith based donor pool.<sup>4</sup> The authors conclude that increasing engagement between FBHPs and the public sector requires attention to five areas:

1. Better documentation and accountability, including scope of services and evidence generation, to identify areas where FBHPs constrain care, improve care, and what, if any, distinctive qualities they contribute.
2. Consultation between FBHPs and secular providers to develop mutual respect and greater understanding of each other's strengths. Greater transparency is critical for FBHPs who wish to partner with the public sector, and more research funding is required to better understand the role of FBHPs.
3. Investment in FBHPs. The authors call for greater representation by FBHPs in health planning and policy processes, but this requires FBHPs to work together and to provide a platform for meaningful participation through developing coalitions or coordinating mechanisms. These coalitions themselves will require funding to create and sustain.
4. Building core competencies and developing the health literacy of religious leaders. Examples of successful change as a result of advocacy and leadership development were instructive (e.g., 390,000 local faith leaders reached through World Vision's Channels of Hope) and demonstrate the potential of supporting FBHPs to mobilise religious leaders.
5. Commitment for both FBHPs and secular groups to base health care on public health evidence rather than ideology. Considering the contro-

versies outlined in paper two, this last point is the most challenging, but at the very least the onus is on FBHPs to be very explicit about what services they can and cannot provide and commit to ongoing re-evaluation of these parameters.

The authors conclude that not all FBHPs will want to collaborate with the public sector, and, conversely, many FBHPs are too small, too ideological, or too fragmented to be suitable partners for the public sector. But the size of the FBHP sector means that excluding them from public sector health planning overlooks an important resource in the drive to universal health coverage.

## Discussion

The Lancet series provides a welcome focus on a significant dimension of health care provision in low and middle income countries. The authors recognise that despite the significant contribution by FBHPs, they have often been excluded from research and policy forums and that, ultimately, this limits the potential for engagement and entrenches the mutual mistrust that has largely defined the relationship between FBHPs and the public sector to date.

The quote from President James Wolfensohn of the World Bank (2002) that was cited in the first paper "half of the work in education and health in sub-Saharan Africa is done by the church. . . but they don't talk to each other and they don't talk to us" is a clear call for both greater accountability and greater collaboration.

The challenges for those working as FBHPs can be summarised as follows:

### Greater accountability

FBHPs need to invest in the resources required to document the services they provide and to evaluate them. Assumptions regarding the quality of care provided need to be tested. FBHPs are explicit about the

values that underpin their work, yet need to document if and how those values affect the quality of care and the health outcomes of those they serve.

### Increased integration into government systems

FBHPs can no longer work in silos serving their local communities' health needs. There is the responsibility to keep informed about national health policy and to explore integration with government services, and, where appropriate, consider moving from a direct health provision role (in settings where government services are in a position to provide that care) to being an advocate for quality services that reach everyone. The series focused on Africa, where the roles of FBHPs are more widely accepted. The challenge for places where the FBHPs come from minority religions in their settings is problematic and not really addressed in the three articles. Yet these same services should be open to scrutiny and be able to stand on the care they give. There is the risk that without better integration with the public sector and the potential to receive public sector financing, FBHPs will be unable to sustain care for the very poor.

### Modelling faith in action

FBHPs continue to play a significant role, particularly in fragile states and in reaching the very poor or the very remote. For most major faiths, the care of the sick and the poor is a natural outworking of the basis of belief and will continue. This is very different from using health services as a means for proselytising. The challenge is in being prepared to review and consider changes to the scope of services, particularly in the more sensitive areas of sexual and reproductive health. FBHPs need to critically

examine where practice guidelines are constrained more by culture or indeed culturally influenced interpretation of religious texts. This calls for real dialogue between FBHPs and theologians, an area that has been under-researched and under-resourced.

### Conclusion

The Lancet series is a valuable contribution and provides an avenue to open the discussion between FBHPs and the public sector. I congratulate the authors and look forward to FBHPs taking up the challenge to better monitor, measure, and engage with the wider health systems of the populations they serve.

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