The role of faith-based organizations in maternal and newborn health care in Africa

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A R T I C L E   I N F O
Article history:
Received 4 February 2011
Received in revised form 22 March 2011
Accepted 25 May 2011

Keywords:
Faith-based organizations
Maternal and newborn health
Millennium Development Goals

ABSTRACT
Background: Global disparities in maternal and newborn health represent one of the starkest health inequities of our times. Faith-based organizations (FBOs) have historically played an important role in providing maternal/newborn health services in African countries. However, the contribution of FBOs in service delivery is insufficiently recognized and mapped. Objectives: A systematic review of the literature to assess available evidence on the role of FBOs in the area of maternal/newborn health care in Africa. Search strategy: MEDLINE and EMBASE were searched for articles published between 1989 and 2009 on maternal/newborn health and FBOs in Africa. Results: Six articles met the criteria for inclusion. These articles provided information on 6 different African countries. Maternal/newborn health services provided by FBOs were similar to those offered by governments, but the quality of care received and the satisfaction were reported to be better.

Conclusion: Efforts to document and analyze the contribution of FBOs in maternal/newborn health are necessary to increase the recognition of FBOs and to establish stronger partnerships with them in Africa as an untapped route to achieving Millennium Development Goals 4 and 5.

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1. Introduction

Eight Millennium Development Goals (MDGs) were established at the 2000 Millennium Summit to accelerate global progress in development [1]. More than 23 international organizations and 192 United Nations (UN) member states agreed to achieve these goals by 2015. Millennium Development Goals 4 and 5 focus on reducing child mortality and improving maternal health, respectively [1].

According to the WHO, maternal conditions are leading causes of death and disability in low-income countries [2]. The latest estimates indicate that more than 300,000 women die from pregnancy-related conditions each year and 4 million newborns die within the first 4 weeks of life [3,4]. Almost all of these deaths occur amongst the poorest and most disadvantaged population groups and are largely preventable through timely prenatal care, skilled delivery, postnatal care, and emergency care in the event of complications [5].

The improvement of women's and children's access to needed care and the achievement of MDGs 4 and 5 require innovative approaches to service delivery and the establishment of inclusive partnerships [6]. The recently launched UN Global Strategy for Women's and Children's Health [7] provides a comprehensive list of clear actions to reverse decades of underinvestment and increase the efficient delivery of services. The list includes a recommendation for national governments and bilateral and multilateral donors to make a concerted effort to align their priorities, increase their commitment to women and children, and invest in the establishment of effective collaborations with existing and new partners. In particular, the Global Strategy calls for civil society to play a role at the community level by educating, engaging, mobilizing, and strengthening the capacities of the community, and advocates increased attention to and investment in women and children.

A potential strategy for reducing maternal and child mortality in high-burden countries could be the development of strong partnerships between faith-based organizations (FBOs) and the broader public health community including policy makers [8]. According to a study by the Pew Charitable Trusts [9], the vast majority of people in sub-Saharan Africa identify themselves as adherents of Christianity or Islam, the world's 2 largest religions. Other evidence indicates that approximately 75% of Africans trust their religious leaders [10]. These findings indicate that leveraging the influence of religious leaders and promoting faith-based or faith-inspired health services could be an effective means of addressing the challenges in maternal and child health in Africa, where a growing proportion of maternal and child deaths occur.

For centuries, FBOs have played a key role in the global effort to promote health and well-being, especially among the most disadvantaged populations. Owing to insufficient local resources, FBOs originally
A comprehensive review of FBOs' contributions to maternal and newborn health in Africa revealed a significant role of faith-based organizations in a wide range of activities. These activities include reproductive health care, including family planning, maternal health care, and newborn care. FBOs have taken on roles that complement and support government efforts, particularly in underresourced areas.

The review highlighted that FBOs are actively engaged in providing services in a variety of settings, including rural communities and remote areas. These services range from basic health education to complex medical interventions. FBOs are particularly active in providing services in regions where government services are either absent or inadequately available.

The review also noted that FBOs are involved in addressing maternal mortality and morbidity through initiatives such as improving access to skilled birth attendance and postpartum care. They are also involved in addressing newborn mortality through interventions like improving access to clean water and sanitation.

FBOs are also engaged in addressing the spread of HIV/AIDS, providing care and support to those affected by the disease. They are also involved in advocating for policies that support maternal and newborn health.

The review concluded that FBOs play an important role in maternal and newborn health in Africa. Their contributions are significant and should be acknowledged and supported.

In terms of methodology, the review used a combination of electronic searches and manual screening processes. The electronic searches were conducted in MEDLINE and EMBASE, and the final decision on inclusion/exclusion was made by two reviewers.

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immunization levels among women and children than similar government services implemented in the area.

The second article [18] published in 1992 reported on a 2-stage study in Yoruba, Nigeria. Yoruba has a local government maternity center and 7 mission (FBO) clinics run by African churches. The first stage of the study involved interviews with mission-trained midwives, pastors, government nurses, the local government dispensary, store operators, private clinic owners, women, and male farmers to compare delivery services provided in government and faith-based clinics. The main reasons given for using FBO clinics for labor and delivery included the cleanliness of the facilities and the expectation that the outcomes would be positive (a healthy mother and infant). Hospital and clinic records were also examined to calculate the number of births that occurred during 1983–1990. The second stage consisted of a survey of 837 women from 427 randomly selected households to determine where births took place during the time period 1983–1990. The results showed that 40% of the women delivered in FBO clinics, 43% in the government maternity center, and 17% at home.

Gilson et al. [19] assessed the quality of services provided by a random sample of government and church dispensaries and health centers in Tanzania. The church dispensaries provided higher-quality curative care and delivery services, whereas the government dispensaries offered higher-quality health education and immunization services to women and children.

Lindelöw et al. [20] reported on a survey conducted in 2000 on 155 facilities (dispensaries with and without maternity units) in Uganda. District and facility records were also reviewed. The facilities included government-owned, private for-profit, and private not-for-profit facilities (90% of these were FBOs). There were no major differences in the types and quality of services provided at the facilities. However, laboratory services were reported to be better in the not-for-profit facilities. The FBO facilities also offered a better working environment and were more likely than private for-profit facilities to provide services accessible to the poor, for example by charging lower prices for services.

Levin et al. [21] published a case study examining the costs and quality of key maternal health services in different types of health facilities (public and mission hospitals and health centers) in Ghana, Malawi, and Uganda. They found that the availability of drugs and equipment did not differ measurably between public and mission (FBO) hospitals. However, at the health center level, equipment availability and client satisfaction were higher at mission facilities than at public facilities in 2 of the countries. Mission facilities also provided maternal health services at the same or better level of quality than public facilities did.

Lastly, Chand and Patterson [22] reported on faith-based program models that were effective in improving maternal/newborn health outcomes in Mozambique, Tanzania, Uganda, and the Congo. These programs included the delivery of services such as prenatal care, prevention of malaria and sexually transmitted infections, nutrition counseling during pregnancy, and newborn care by religious medical offices and specific religious hospitals. A before/after evaluation showed that effective implementation of these programs reduced maternal, newborn, and child mortality and increased the number of women attending prenatal care visits, using a skilled birth attendant, and breastfeeding exclusively. The programs also increased the number of pregnant women taking preventative treatment for malaria, the number of people attending follow-up services for malaria, and the immunization coverage.

4. Discussion

The present findings are consistent with recent UN and other reports [7,8,23] that acknowledge the critical role faith-based or faith-inspired institutions can play in the delivery of maternal and newborn services. The contribution of FBOs in addressing service needs for pregnant women and newborns could be particularly relevant in sub-Saharan Africa, where more than 70% of the population self-identifies as religious [14], access to health care is often limited and inequitably distributed, and the frequency of negative maternal and newborn health outcomes tends to be the highest in the world. Hospitals and facilities run by FBOs have historically been established where service needs are greatest and often remain active regardless of political
changes or humanitarian crises. They are usually well-perceived and trusted by community members even though services might not be sufficiently funded to offer state-of-the-art care.

The present review shows that maternal and newborn health services provided by FBOs in Africa tend to be similar to those offered by governmental providers. The review also indicates that the quality of the services provided by FBOs in Africa tends to be similar to those offered by governmental providers.

Table 1
Characteristics of included studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>FBO</th>
<th>Design and objective</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iyun 1989 [17]</td>
<td>Nigeria</td>
<td>Ogbomoso Baptist Medical Centre</td>
<td>Survey of all women of reproductive age to evaluate a rural health program, which included the training of VHW in taking care of women and children in the community</td>
<td>The program included 820 women. 74% received information on maternal immunization (37% in communities that did not participate in the program). 69% received immunization from VHW during pregnancy (37% in communities that did not participate in the program). 27% received prenatal care from VHW. 15% were assisted by VHW at delivery (VHW were male). 14 facilities were studied or surveyed, 19% of which were faith-based. 40% of births occurred in faith-based clinics. 43% of births occurred in the government maternity center. 17% of births occurred at home. Women preferred FBO-run services because the facilities were cleaner and the pregnancy outcomes better.</td>
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<tr>
<td>Adetunji 1992 [18]</td>
<td>Nigeria</td>
<td>Christ Apostolic Church</td>
<td>Cross-sectional facility-based study to describe the mode of operation of faith clinics in Efon Alaye Stage 1: Assessment of the number of births recorded in facilities and child-rearing practices. Stage 2: Survey of births that occurred outside the maternity center and FBO clinics</td>
<td>The study included 155 randomly selected facilities (81 government, 30 private-for-profit, 39 FBO, 5 private not-for-profit) were surveyed. 28% of the facilities were run by FBOs. 70.5% of the FBO and 85% of the government facilities provided delivery services. 88.6% of the FBO and 98.7% of the government facilities provided prenatal care. 96.9% satisfaction at government facilities. 99.1% satisfaction at FBO facilities.</td>
</tr>
<tr>
<td>Gilson et al. 1995 [19]</td>
<td>Tanzania</td>
<td>Catholic Church</td>
<td>Service availability mapping to assess the structural quality of primary health services against expected standards developed on the basis of existing Tanzanian supervision checklists and experience from other countries.</td>
<td>The study included 155 randomly selected facilities (81 government, 30 private-for-profit, 39 FBO, 5 private not-for-profit) were surveyed. 28% of the facilities were run by FBOs. 70.5% of the FBO and 85% of the government facilities provided delivery services. 88.6% of the FBO and 98.7% of the government facilities provided prenatal care. 96.9% satisfaction at government facilities. 99.1% satisfaction at FBO facilities.</td>
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<tr>
<td>Lindelow et al. 2003 [20]</td>
<td>Uganda</td>
<td>Catholic Medical Services, Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau, Seventh-day Adventist Church</td>
<td>Survey of facilities to provide baseline data for the future evaluation of reforms and policies in the health sector and in public expenditure.</td>
<td>In each country, 1 district was studied; the study included 1 public hospital, 1 mission hospital, 1 mission center, and 1 public center. Public and mission hospitals provided similar services. Maternal health services were more expensive at mission facilities. Costs related to obstetric complications were higher at public facilities in Malawi and Ghana; in Uganda, they were higher at the mission hospital because more materials and staff time were used. Service quality and structure were better at mission facilities. Staffing at mission facilities was more appropriate for the number of maternal health services provided.</td>
</tr>
<tr>
<td>Levin et al. 2003 [21]</td>
<td>Ghana, Malawi, Uganda</td>
<td>Mission hospitals (religion not specified)</td>
<td>Case study to estimate the costs of key maternal health services and to determine the factors that affect costs.</td>
<td>In each country, 1 district was studied; the study included 1 public hospital, 1 mission hospital, 1 mission center, and 1 public center. Public and mission hospitals provided similar services. Maternal health services were more expensive at mission facilities. Costs related to obstetric complications were higher at public facilities in Malawi and Ghana; in Uganda, they were higher at the mission hospital because more materials and staff time were used. Service quality and structure were better at mission facilities. Staffing at mission facilities was more appropriate for the number of maternal health services provided.</td>
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<td>Chand and Patterson 2007 [22]</td>
<td>Uganda, Tanzania, Mozambique, DRC</td>
<td>Protestant Church, Catholic Church, Muslim organizations</td>
<td>Descriptive report on FBO programs that have been effective in improving maternal and neonatal outcomes.</td>
<td>Kasene District, Uganda: Pilot study that included 3 FBOs to increase uptake of malaria IPT using the prenatal care platform; uptake increased from 43% to 94% for the first course and from 28% to 76% for the second course of IPT. Kibuli Muslim Hospital, Uganda (very active referral hospital): Maternal mortality in this hospital was lower than in public health facilities nationwide. Shree Hindu Mandal Hospital, Tanzania: Handles an average of 200 births per month and deals with labor and newborn complications. Care Group model developed by World Relief in rural Mozambique: Volunteers were trained in personal hygiene, breastfeeding, and immunization; child mortality was reduced by more than 50%; religious leaders and pastoral care groups were a critical link with the community. Congregation-based health programs, Malawi: Churches and/or mosques promoted women's and children's health through their women's groups; a malaria prevention program was established in 2000; a survey in 2004 showed 81% of the respondents were aware of the benefits of bed mosquito nets.</td>
</tr>
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</table>

Abbreviations: DRC, Democratic Republic of Congo; FBO, faith-based organization; IPT, intermittent preventive treatment; SANRU, Santé Rurale; VHW, village health workers.
of care delivered may be better in FBO facilities. This finding could be explained by the fact that FBO facilities and providers are the only form of organized healthcare available in some locations in Africa. In other places, FBOs are large institutions integrated into the national healthcare infrastructure [24] and their services are sometimes considered to be the best in their respective regions [17,22,24]. More studies are needed to explore the reasons why maternal and newborn health services provided by FBOs in Africa might be of higher quality than governmental services. All articles included in the present review focus on institutionalized health care. Relatively little is known about the role of African-based FBOs in assisting women with deliveries at home, where most births still occur. Chand and Patterson [22] describe how the introduction of a community-based health program in rural villages in Mozambique resulted in improved maternal mortality outcomes, indicating that the potential role of FBOs in providing needed care at the community level needs greater exploration.

The present review, even if limited to 6 studies, provides further evidence that governments and development partners should consider how to better integrate FBOs into governmental health programs in the context of MDGs 4 and 5. In places where mission hospitals are the only hospitals available, for example, governments could enter into a public–private partnership in which FBOs deliver health care on behalf of the government. This would ensure better alignment of policies. Collaborative and coordinated activities between government and mission hospitals would enable FBO hospitals and staff to become more broadly included in healthcare planning at the regional and national level and to increase awareness of their critical contribution to safe motherhood [25]. Evidence collected through interviews and audits of national plans shows that many FBOs in Africa are neither fully recognized nor well-supported through public funds [14]. Stronger partnerships between FBOs and governments could be an effective way of addressing this problem and result in increased budget allocations to FBOs.

The number of studies that met the inclusion criteria for the present review was limited, indicating that there has been little systematic monitoring of the involvement and effectiveness of FBOs in the area of maternal and newborn health. More independent research on these facilities and increased reporting in the scientific literature from FBOs on their successes and challenges is needed [22]. Such research will contribute to the evidence base on the role of FBOs in maternal and newborn health. From there, strategies could be developed to improve the quality and accessibility of healthcare services for the mothers and newborns most in need through fostering stronger partnerships between FBOs and the public health community.

5. Authorship disclaimer

The authors are solely responsible for the views expressed in this publication, which do not necessarily represent the decisions or policies of the WHO.

Conflict of interest

The authors have no conflicts of interest.

References


