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## REVIEW ARTICLE

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

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## 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

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concentrated on building hospitals and clinics and training healthcare workers to improve access to affordable health and rehabilitation services. The scope of FBO-run activities has expanded over time and FBOs are now considered important providers of health care, particularly in low-resource settings. Fifteen years ago, the World Development Report [11] called for the greater use of nongovernmental organizations (NGOs), particularly FBOs, to improve service quality and fill existing gaps in healthcare services [8]. This call was repeated in a 2006 assessment of the impact of religion and religious entities on achieving universal access to services in the context of the HIV epidemic in Zambia and Lesotho [12]. This assessment—carried out by the African Religious Health Assets Programme at the Universities of Cape Town, Witwatersrand, and KwaZulu Natal—stressed the need for greater appreciation of the contribution FBOs can make in the fight against HIV/AIDS in high-prevalence countries [12], a sentiment that should be expanded to include maternal and child health services.

In 2009, an international consultation on NGO mapping standards co-hosted by the WHO and the Washington-based Center for Interfaith Action on Global Poverty [13] concluded that FBOs need to be more actively engaged in the collection, management, and dissemination of health facility data to increase their visibility to government partners, donor agencies, and their own communities. We, as public health specialists in maternal and newborn health, agree that such activity would be an important step towards increasing the evidence base of the contribution FBOs make to maternal and newborn health, particularly in Africa.

The WHO estimates that 30–70% of the sprawling healthcare infrastructure across the African continent is owned or run by FBOs, with percentages varying within this range in different countries [14]. The first census in Africa on the not-for-profit healthcare sector conducted by Uganda in 2001 [15], for example, showed that 70% of all private not-for-profit health facilities in Uganda are owned by autonomous diocese and parishes. A multicountry study carried out in 2003–2005 by the Ecumenical Pharmaceutical Network in collaboration with the WHO [16] similarly found that approximately 40% of the healthcare infrastructure across sub-Saharan Africa is operated by FBOs, and that faith-based drug supply organizations are fundamental to the provision of essential medicines to rural and remote areas, particularly when bottlenecks occur in the management and procurement of government supplies.

These reports clearly indicate that there is an extensive network of FBOs in Africa. The present systematic review of the literature was performed to assess the work of FBOs in the area of maternal/newborn health care in Africa during the past 2 decades, with the aim of better understanding their contribution in this field and evaluating the extent to which FBOs are featured in the scientific literature.

## 2. Methods

MEDLINE and EMBASE were searched for articles published from January 1, 1989, to December 31, 2009, on maternal/newborn health and FBOs in Africa. A similar baseline year was used by other tracking efforts to monitor progress towards the achievement of MDGs 4 and 5. The search strategy was developed with the assistance of an expert in search strategies at the WHO.

In step 1, EMTREE terms and key words were searched for using the following search string: 'Childbirth'/exp OR 'pregnancy'/exp OR 'prenatal development'/exp OR 'puerperium'/exp OR 'obstetric care'/exp OR 'maternal health service' OR 'maternal mortality'/exp OR 'pregnancy disorder'/exp OR 'midwife'/exp OR 'maternal care'/exp OR 'perineal care'/exp OR 'breast feeding'/exp OR 'newborn nursing'/exp OR 'newborn nursing'/exp OR 'childbirth' OR 'child birth' OR 'pregnan\*' OR 'prenatal development' OR 'puerperium' OR 'obstetric care' OR 'maternal health' OR 'maternal mortalit\*' OR 'pregnancy disorder' OR 'breast feed' OR 'breastfeed\*' OR 'perineal' OR 'newborn OR 'midwife' OR 'birth attendant'.

In step 2, religion-related terms were searched for in the address fields of the articles retrieved in step 1. The following search string was used: Churches:ad OR church:ad OR Aglipay\*:ad OR Amish\*:ad OR Anglican\*:ad OR Apostolic\*:ad OR Assembl\*:ad OR God:ad OR Baptist\*:ad OR Calvary:ad OR Catholic\*:ad OR Christadelphian\*:ad OR Christian\*:ad OR Jesus\*:ad OR Christ:ad OR Mormon\*:ad OR Coptic\*:ad OR Orthodox\*:ad OR Evangel\*:ad OR Iglesia\*:ad OR Cristo\*:ad OR Jehovah\*:ad OR Lutheran\*:ad OR Methodist\*:ad OR Monophysite\*:ad OR Nestorian\*:ad OR Apostolic\*:ad OR Pentecost\*:ad OR Brethren\*:ad OR Presbyterian\*:ad OR salvation:ad OR Adventist\*:ad OR Shaker\*:ad OR Disciple\*:ad OR islam\*:ad OR sunni\*:ad OR shite\*:ad OR sufi\*:ad OR druze:ad OR muslim\*:ad OR hindu\*:ad OR budhh\*:ad OR sihk\*:ad OR judi\*:ad OR bahi\*:ad OR jaini\*:ad Or shint\*:ad OR zoastr\*:ad OR unitar\*:ad OR rastifa\*:ad OR mennonit\*:ad OR Episcopal\*:ad OR Presbyterian\*:ad OR anabapt\*:ad.

In addition, the reference lists of all selected articles were screened and African-based FBOs working in the field of health care were asked if they were aware of any published or unpublished studies on the topic of interest.

All studies providing information on FBO facilities in Africa that were responsible for providing maternal/newborn health services (prenatal, delivery, emergency, or postpartum care provided to mothers and/or newborns) were considered regardless of the studies' methodologic approach. Studies reporting on specific activities carried out by FBOs in Africa that were related to maternal/newborn health were also included. Studies describing activities carried out in non-African countries or services provided to other population groups were excluded. The present review had no language restrictions.

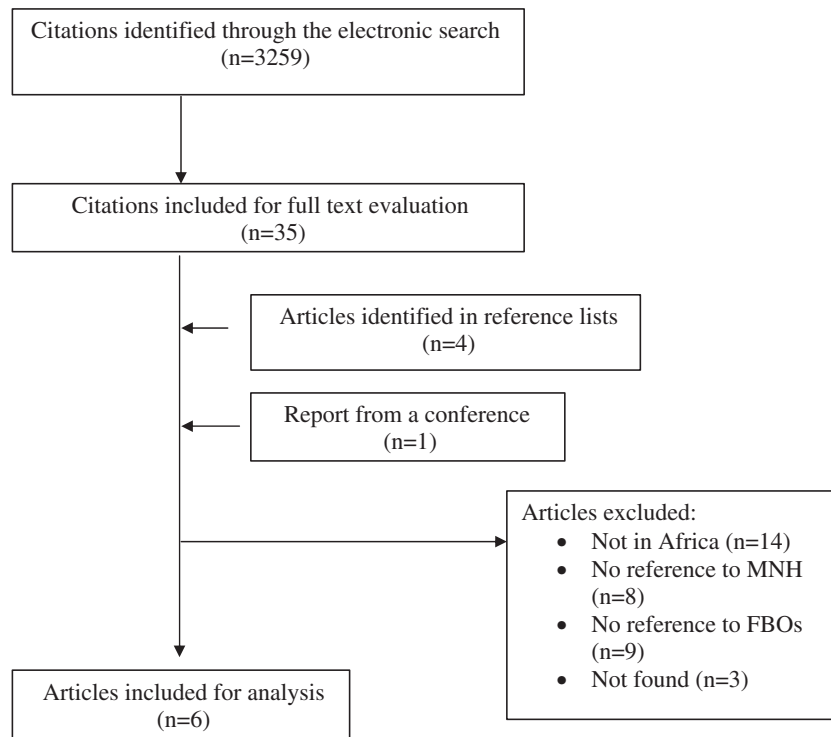
All citations identified by the electronic search were downloaded into Reference Manager version 10 (Thomson Reuters, Philadelphia, PA, USA). The citations were organized into a single data set and all duplicates deleted. One investigator (MW) independently screened the results of the electronic search to select potentially relevant citations based on their titles and abstracts. Full texts for all potentially relevant citations were retrieved and evaluated. Full texts were also retrieved if the title and abstract provided insufficient information for making a final decision on inclusion/exclusion. Authors were contacted if full-text articles were not found. All articles selected at the first screening were assessed by 2 reviewers (MW and APB).

The information extracted from each article included: Country and city reported on; type of FBO(s); study design; study objectives; and information and/or conclusions related to maternal/newborn health.

## 3. Results

The electronic search identified 3259 citations. In the first screening, 35 citations were selected for full-text evaluation. Four additional papers were identified through the reference lists of other articles and 1 report was obtained at a conference. Of these 40 total citations, 6 were included in the present review (Fig. 1). These citations provided information on FBO activities related to maternal/newborn health in the following African countries: Ghana, Malawi, Mozambique, Nigeria, Uganda, and Tanzania. The publication year varied from 1989 to 2007.

Table 1 presents key information extracted from the 6 studies. The first study [17] was a survey evaluating a rural health program that was organized by a mission hospital in Ogbomoso, Nigeria. The community-based program was implemented in Ogbomoso and 43 surrounding villages. It included the training of village health workers in key health topics, the conduction of home visits, the management of selling drugs, and the provision of health education and church teachings. The village health workers were expected to inform women about a variety of health issues including the causes and prevention of common childhood diseases and maternal complications. The authors reported that the mission program achieved higher



**Fig. 1.** Flow chart of study selection. Abbreviations: FBO, faith-based organization; MNH, maternal/newborn health.

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 dispenser, 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

**Table 1**  
Characteristics of included studies.

Study	Country	FBO	Design and objective	Results
Iyun 1989 [17]	Nigeria	Ogbomoso Baptist Medical Centre	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	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 <1% were assisted by VHW at delivery (VHW were male)
Adetunji 1992 [18]	Nigeria	Christ Apostolic Church	Cross-sectional facility-based study to describe the mode of operation of faith clinics in Efon Alaaye 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	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
Gilson et al. 1995 [19]	Tanzania	Catholic Church	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	14 church and 40 government dispensaries (randomly selected) and 4 health centers were studied The strength of church dispensaries was in curative care, the strength of government dispensaries was in health education Government dispensaries had more staff Church dispensaries were better supplied
Lindelöw et al. 2003 [20]	Uganda	Catholic Medical Services, Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau, Seventh-day Adventist Church	Survey of facilities to provide baseline data for the future evaluation of reforms and policies in the health sector and in public expenditure	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
Levin et al. 2003 [21]	Ghana, Malawi, Uganda	Mission hospitals (religion not specified)	Case study to estimate the costs of key maternal health services and to determine the factors that affect costs	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
Chand and Patterson 2007 [22]	Uganda, Tanzania, Mozambique, DRC	Protestant Church, Catholic Church, Muslim organizations	Descriptive report on FBO programs that have been effective in improving maternal and neonatal outcomes	Kasese 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 SANRU project in DRC (partnership between ministry of health and Congo Church of Christ Medical Office): 50% of hospitals in DRC are now owned and managed by local churches, and FBOs co-manage 40% of the health zones; attendance of prenatal clinics increased from 73.2% in 2001 to 86.2% in 2004; assistance from skilled birth attendants increased from 45% in 2001 to 64.3% in 2005

Abbreviations: DRC, Democratic Republic of Congo; FBO, faith-based organization; IPT, intermittent preventive treatment; SANRU, Santé Rurale; VHW, village health workers.

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 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 healthcare 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.

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