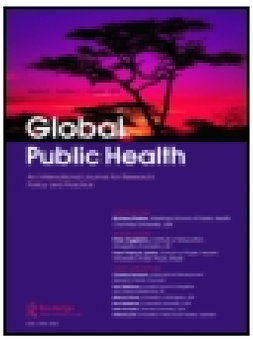

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The role of faith-based health professions schools in Cameroon's health system

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ABSTRACT

Faith-based health professions schools contribute to the training of staff in many Sub-Saharan African countries. Yet little is known about these actors, their role in the health system, potential comparative advantages and challenges faced. This is a qualitative study drawing on 24 qualitative interviews and 3 focus group discussions. Participants included faith-based health professions schools, staff at faith-based health professions schools, Ministry of Health officials and donors. Thematic analysis was used to analyse the data. The findings reveal that understanding of faith-based health professions schools held by donors and the Ministry of Health rest on a set of assumptions rather than evidence-backed knowledge and that knowledge on key aspects is missing (not least on the market share of such actors). This suggests that collaboration with and oversight of these non-state schools is limited, raising questions about the balance of state regulation and control in the public-private mix for training health workers. Linked to this weak oversight, the findings also raise concerns over a number of problematic activities at these schools, unaccredited training programmes and the presence of missionary volunteers whose presence and actions are rarely interrogated.

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Health professions education in low and middle income countries; faith-based health professions schools; faith-based organisations; private sector training; Cameroon

Background

Over the past two decades, the critical importance of the role of the health workforce in delivering health improvements linked to the millennium development goals (MDGs), the sustainable development goals (SDGs), and other global health initiatives has been given increased attention by academics and policy makers. A sufficiently trained and well-motivated health workforce is critical to the maintenance of strong, responsive health systems, to ensuring accessible and equitable treatment, for public health initiatives and – as the world has been given a potent reminder of in the first six months of 2020 – responding to global, national and local health crises. Ongoing challenges in ensuring the health workforce is adequate to the scale of the task, motivated to remain in service, and allocated across countries and regions in appropriate ways and numbers, are one of the key impediments in meeting

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universal health coverage (UHC) as well as specific targets under the SDGs (WHO, 2016). The current progress on recruitment and retention is likely to leave a shortfall of around 15 million health workers by 2030 (Liu et al., 2016). And whilst countries at all socioeconomic levels have issues in the education and training, deployment, retention and performance of their health workforce, regions such as sub-Saharan Africa face particularly sharp challenges in ensuring their health workforce is sufficient, capable and resourced to meet demands of SDGs and UHC.

Health worker training is a critical element to meet the targets for the global health workforce, with all countries committed to the establishment of accredited mechanisms for health training by 2030 (WHO, 2016). The challenge for many countries in sub-Saharan Africa has been how to scale up medical and health professions training to the appropriate level given limited public facilities (Frenk et al., 2010; Mullan et al., 2011). Health workforce education in Africa faces a number of core challenges including weak physical infrastructure, the absence of accreditation systems, student selection and faculty recruitment and retention (Burdick, 2007). Since the 1990s, the inability of many governments to meet the demand for medical training has led to an increased role for the private sector. In Bangladesh, Chile and Nepal, for example, more than half of medical schools are private; in Brazil, private universities account for 56% of the medical schools, and over half of enrolments (Evans et al., 2017). In sub-Saharan Africa, there has been a quickening trend to non-public medical school training during the 2000s: in South Africa, 45% of nurses graduated from private institutions in 2001; 66% just three years later. By 2009/10, 35 out of Kenya's nursing schools were private (Evans et al., 2017).

However, the privatisation of medical and health professions training has not been without criticisms, notably over the quality of training in some private institutions, and the level of government oversight and regulation of private training. In Thailand, for example, there is some evidence that private-institution trained graduates are of lower quality than those from the country's public institutions (Reynolds et al., 2013); and in India, around 61% of nursing colleges were deemed to be offering unsuitable training (McPake et al., 2015). The trend towards privatisation has been largely attributed to the shift towards a market-oriented approach by donors and international development organisations (especially the World Bank) from the mid-1980s who pushed for models which rolled back direct public provision in favour of public-private partnerships and private sector engagement in delivering health care (including medical training). In Tanzania, health sector (and wider economic) reforms in the 1990s overturned a 1977 ban on private practice in health, and pushed the government to open the sector to private actors and public–private partnerships (Sirili et al., 2019). By 2015, 8 out of 11 medical training institutions were private, and account for the majority of medical graduates have (Sirili et al., 2019).

The expansion of non-state actors in health workforce training landscapes in sub-Saharan Africa has raised additional, and particularly sharp, challenges around maintaining effective governance and quality assurance (Bischoff, 2016; Mullan et al., 2011). There is a debate over the extent to which increased privatisation of medical and health professions education is increasing access and ensuring targets for recruitment of health workers can be met, and is in line with global trends in wider education; or whether the commercialisation of education, and removing direct state controls over an area in which quality control is critical, is potentially undermining national health systems (Mullan et al., 2011).

Faith-based medical training and health professions education

However, there is more to this narrative than the fact of the privatisation of medical training alone. In Tanzania, five of the private medical schools are not-for-profit institutions linked to faith organisations (Sirili et al., 2019). This dominance of faith-based and faith-linked medical training and education is common across sub-Saharan Africa where the voluntary service sector is almost entirely faith-linked. In Kenya, institutions linked to the Christian Health Association of Kenya are the primary educators of health workers in the country (Appiah, 2013). In Malawi, colleges

linked to the Christian Health Association of Malawi train up to 80% of the health workforce through 12 training institutions (CHA, 2020). Similar representative organisations in Ghana and Zambia run 19 and 11 medical training schools respectively (CHAG, 2016; CHAZ, 2018). In Mozambique, The Catholic University, a faith-based, not-for-profit school founded in 1995, trains a substantial number of high calibre health professionals (Mullan et al., 2011). This faith-based health professions training school is a model of successful collaboration with the Government of Mozambique, the Catholic Church, and international organisations (Mullan et al., 2011). Similarly, findings from Uganda show many faith-based health providers are also training centres for the health workforce who produce an estimated 60% of the nursing cadres (Schmid et al., 2008). Although Christian organisations are the dominant providers of medical training in sub-Saharan Africa, institutions are not exclusively so. In Kenya, the Aga Khan Medical School provides training for east African health professionals; and the Omduran Islamic University in Sudan has a large medical school.

However, the role of faith-based providers of medical training is still something of a lacuna in the literature and amongst policy-makers, and as a result has mostly been framed within discussions around the impact of the growth of private (for-profit and voluntary) providers since the 1990s. Yet many faith-based providers have been undertaking the health professions training of African health workers across the sub-continent for around a century (Jennings, 2013). We define faith-based health professions schools as institutions that provide paramedical training at the undergraduate and postgraduate level (for paramedical staff, including nursing, midwifery, and medical technical professions), describe themselves as faith-based,[1] faith-inspired, or faith-linked, and are not for profit. Faith-based health professions schools are usually linked to faith-based health providers, where the clinical training takes place.

The role of faith-based health providers – where health professions practical training takes place – in health systems has been well documented in the literature, and has long been the subject of donor and international organisation gaze (Grieve & Olivier, 2018; Olivier, 2011; 2016; Olivier et al., 2015; Olivier & Wodon, 2012; Schmid et al., 2008; Whyle & Olivier, 2017). This provision has a deep history to it, pre-dating in some cases the creation of the state itself (Jennings, 2015). Faith-based health providers play an important role in many health systems in sub-Saharan Africa, although there remain significant gaps in detailed mapping of their national and regional extent (Olivier et al., 2015). While the level of faith-based providers' integration into the health system varies from country to country, in many contexts they are officially integrated into the health system through contractual agreements or understandings (Boulenger & Criel, 2012; Whyle & Olivier, 2017). There is a broad range of literature on the role of faith-based actors within national health systems, especially over questions of access, equity and whether faith institutions can offer the broadest range of key services, some of which might compromise taught faith values (Kagawa et al., 2012; Morgan et al., 2013; Olivier et al., 2015; Tomalin, 2011; Tomkins et al., 2015). Despite the scale of faith-based provision, especially in sub-Saharan Africa, the potential for exclusion of some groups as issues such as gender- and sexuality-rights compete with religious teaching, faith-based actors remain controversial, even if they are long-standing parts of many national health systems.

But less attention has been paid to the role of faith-based medical training and education. This paper offers a perspective on an important (and growing), long-standing (almost a century in some African contexts) and critical (in terms of developing the human resources essential to provide services) area of activity. The knowledge gap on faith-based health professions schools includes evidence on the quality of education offered by faith-based actors; the level, extent and rigour of collaboration and linkages with governments; and over who can access training in such facilities and on levels of retention in comparison with public medical schools. Just as the literature has sought to understand what impact faith plays in determining what services are available, in what way and to whom, understanding how faith values shape teaching is also a significant knowledge gap. Here, this paper seeks to contribute to filling in some of these gaps through a consideration of how the faith-based health professions education is perceived in Cameroon, looking at the

perspectives of faith-based health professions schools, the government and donors who collaborate with them.

Faith-based health providers and health professional schools in Cameroon

In Cameroon there is a chronic shortage of staff. There are approximately 0.9 physicians (UNDP, 2019) and 7.8 nurses and midwives per 10,000 people (WHO, 2010) in a total population of 25.3 million people (The World Bank, 2020). Cameroon also presents some of the worst health indicators in the world with a systematically underfunded health system. The under-5 mortality rate lies at 84 deaths per 1000 children (UNDP, 2020), and maternal mortality, at 596 per 100,000 live births, is amongst the highest in the world (UNDP, 2019). Cameroon spends only 5.1% of the country's GDP on health and depends heavily on foreign aid. Therefore, efforts to improve effectiveness and efficiency in human resource for health training are a public health priority. With limited public resources, engagement with non-state educational actors, including faith-based health professions schools, is seen as essential.

Christian faith-based health providers play a substantial role in Cameroon's health system. Although data on actual provision of care is not precise, it is estimated that faith-based providers constitute 40% of the national health system (Boulenger & Criel, 2012; Herzig van Wees et al., 2020b; Olivier et al., 2015). Many of these providers have operated since before independence and are no longer dependent on international funding. There are three faith-based networks: one Catholic, one Protestant, and a private faith-based network (although their level of functionality have been previously questioned) (Herzig Van Wees, 2019). Within these broad networks, there is a large diversity of faith-based providers in Cameroon: within the Protestant network alone there are 11 sub networks with differing Christian denominations and levels of functionality. Faith-based health providers in Cameroon are officially integrated into the health system, although the relationship between the government and the Ministry of Health has been described as fragile and difficult (Boulenger & Criel, 2012; Herzig Van Wees, 2019). Over the past ten years, faith-based health providers and their schools have been made beneficiaries of substantial amount of funding from international donors (Herzig Van Wees, 2019, 2020a). This has not been entirely unproblematic because some of these activities have bypassed the state. Important questions have been raised about what sets faith-based providers apart from other providers in a country where the majority of the population is religious (Olivier, 2016; Tomalin, 2012). Roman Catholics account for 38.5% of the population, Protestants 26.3%, Muslims 20.9%, other Christian denominations 4.5%, with the rest animist of 'non-believers'.

Faith-based health professions schools in Cameroon train nurses, assistant nurses, midwives, laboratory technicians, medical technicians, specialist nurses, and pharmacists. There are faith-based health professions schools with Catholic, Baptist, Evangelical and other Protestant denominations (Herzig Van Wees, 2019). Some of the schools are independent, for example the Catholic University, while others are integrated into a faith-based health provider, for example Shisong Health training school and Baptist hospital – both located in the North West region (Budzee et al., 2010; Herzig Van Wees, 2019).

Reports from the Ministry of Health and Ministry of Higher Education show that there are five public medical faculties, 24 private medical faculties and 11 faith-based faculties in Cameroon (MoHE, 2017). In 2017, the public faculties trained 11,361 students studying medicine and other related health sciences. The private schools trained 13,048 students and the faith-based trained 6052 students (MoHE, 2017). In addition to medical faculties, there are health professions schools that train paramedical staff and usually focus on a specific cadre of personnel, for example nursing and midwifery schools or laboratory technician schools. Reports from the Ministry of Health indicate that there are 117 health professions schools of which 41 are public and 77 are private (DRH, 2020).

In 2019 the government recruited 7470 paramedical trainees to complete their training following the completion of the national entry exam (MoH, 2019). Despite the fact that the governments' list is incomplete, 28% of student placement are offered by public health professions schools and 72% by private health professions institutions (MoH, 2019). Of the private providers, approximately 11.5% are faith-based health professions schools.[2]

Figures for the exact number of faith-based health professions schools in Cameroon are difficult to obtain given gaps in official records. This is arguably related several challenges. Firstly, data on health professions training is collected separately under the remit of the Ministry of Higher Education and the Ministry of Health. Tensions between those Ministries are a documented problem in other similar settings (Frenk et al., 2010; Mullan et al., 2011). Moreover, neither of the ministries separates their data between faith-based health professions schools and private schools, with both operating under the same legal basis (Herzig Van Wees, 2019). Given that many private schools have religious names, it is further difficult to distinguish between faith-based which are not for profit and those for profit.

A further problem with this data is that it excludes a number of faith-based health professions schools for reasons that are unclear. The Baptist Health Convention, for example, which trains a significant number of staff every year, do not figure in this official data, although they have a memorandum of understanding with the Ministry of Health and are officially part of the national health system. While a mapping study would be important to provide clarity over the actual contribution of these actors to the health system and higher education system, this was not possible to conduct. Instead, this research took a qualitative approach to explore the role of health professions schools in the health system from the perceptive of donors, the schools, teachers and staff and the Ministry of Health.

Methods

Design and setting

This is a qualitative study drawing on focus group discussions and in-depth interviews. The aim of the study was to investigate the role that faith-based health professions play in Cameroons health system. Cameroon was selected because there is very little knowledge about faith-based organisations in the country (as there is in francophone speaking countries in sub-Saharan Africa more generally). Cameroon makes an excellent case study because donors have recently significantly increased their engagement with faith-based organisations, including faith-based health professions schools, despite this lack of knowledge. The data was collected in Yaoundé, Cameroon while several directors of faith-based health professions schools attended a meeting at the Ministry of Health. The schools included in this study are situated in 5 out of 10 regions in Cameroon. Data collection also took place at 3 faith-based health professions schools some of which included the Anglophone region.

Study participants

This study used a mixture of focus group discussions and in-depth interviews to explore new themes and ideas. Purposive sampling with an element of snowball sampling was applied. Participants were faith-based health professions schools, employees and teachers at faith-based health professions schools, as well as Ministry of Health officials and international donors funding faith-based health professions schools. Recruitment, initially through telephone and email, was conducted by EB a Cameroonian health systems researcher and SHvW. Three focus group discussions were held, alongside 24 in-depth interviews. Table 1 provides an overview of the sampling frame. The names of the schools and their locations have been omitted given that participation in this study was predicated upon guarantee of protection of anonymity.

Table 1. Study participants by data collection method.

	N = 35 (100%)
Focus group discussions	
Directors of 5 faith-based health professions schools	4
Teachers in 5 faith-based health professions schools	4
Clinicians teaching at faith-based health professions schools	3
Interviews	
Directors faith-based health profession schools	7
Donors	8
Ministry of Health	4
Teachers faith-based health professions schools	5

Data collection

Data collection took place by SHvW between 2015 and 2018 with an interruption in data collection due to the civil unrest in the Anglophone regions. Interviews and focus group discussions lasted approximately one hour. Thirty-five participants were involved (see Table 1). Data collection took place in French and English in which the authors involved in data collection are fluent. Focus group discussions explored narratives about faith-based health professions schools. Interviews allowed for individual in-depth discussions, some taking place after the focus group discussion. The research question explored perceptions on the relevance of and problems with health professions schools in the Cameroonian health system. Four main themes were covered in the topic and interview guide: the perception of the role and attributes of faith-based health professions schools in the broader health system; their relationship with the state; their relationship with other faith-based health training schools; and challenges of providing health professions training. These topics were informed by literature presented in this study. Some emerging themes such as controversies in midwifery curriculum and the presence of missionary volunteers were added during the process of data collection. Initial recruitment was done by EB and SHvW contacting previously known participants via telephone or email, upon which data was collected at three faith-based health professions schools. In the second round, a significant number of participants were recruited at a meeting for faith-based health professions school at the Ministry of Health in Yaoundé. Policy documents were also included in the data analysis. AS assisted with the analysis of the policy documents.

Ethics

Information and consent was obtained from all participants. The study obtained ethical clearance from the Cameroonian Research Ethics Board in Yaoundé (Nr. 2015/08/638/CE/CNERSH/SP).

Data analysis

The interviews were transcribed verbatim. Transcripts were first read through several times to gain an understanding of the material by paying attention to repeated patterns of meanings in the interviews. Data were analysed using thematic analysis (Braun & Clarke, 2014) with the assistance of Nvivo11. An inductive approach was used to analyse the data. There were four rounds of coding (Saldaña, 2015). Extensive coding led to the creation of categories (also referred to as sub-themes). A revision of the categories led to the development of themes. The coding tree was jointly agreed upon by the authors. The three themes derived from the analysis are presented in the results section.

Limitations

The findings presented in this study are drawn from qualitative interviews and therefore present a subjective perspective. In that sense, this study provides an insight into perspectives of those working at

faith-based health professions schools and collaborating with them, it does not provide evidence on their quality, although some participants may have views on this. Not all faith-based health professions schools in Cameroon wanted to participate in this study and since there is no complete list, some are left out. The findings are specific to those participating in the study although inferential generalisation could be drawn to Cameroon as a whole and potentially similar contextual settings.

Reflexivity

This research was conducted by a team of Cameroonian and British researchers. There are implications to conducting research as an outsider or with a so-called foreign gaze. In some instances, it could be argued that an outsider cannot fully capture the complexity of a local reality. Moreover, the data collection process may be biased and influenced by the history (in this case of colonialism) and gender imbalances (for example it may be challenging to get a senior official to talk to a young white researcher). While the background of the researcher has arguably influenced the data collection, certain factors mitigated these limitations. There are also limitations of collecting data as a Cameroonian. It may be, for example, more difficult to access data due to hierarchical challenges, often influenced by job position but also ethnicity. In that sense a foreign gaze can facilitate access to data. One of the British researchers was an employee of the German Bilateral Cooperation from 2009 to 2012 in Yaoundé, Cameroon. Consequently, a solid network of researchers has collaborated with several people in this study. Moreover, years of experience in the health sector in the Cameroonian context has allowed this researcher to exercise the foreign gaze while also having a good understanding of the contextual specificities. Access to in-depth findings from donors – many of whom were known to some extent for many years – led to the fact that they were open to share their challenges and thoughts.

Results

The qualitative data analysis revealed three themes and 11 categories as summarised in Table 2 and presented in this section.

Assumptions about faith-based health professions schools (FBHPS)

Faith-based health professions schools are highly valued by the Cameroonian Ministry of Health because of their reputation, their contribution to the training of health workers and because of their assumed comparative advantages. For example:

> The management is better than in our public schools and they do it wholeheartedly. They do not target the personal benefits because maybe their faith plays a role, whereas in the public side the managers tend to focus on their own benefits and profits … [Interview8, MoH[3]]

Table 2. Coding tree: Themes and categories following qualitative analysis.

Themes	Categories
Assumptions about FBHPS	Comparative advantages
	Donors like FBHPS
	Assumptions about schools
Limited collaboration between government and FBHPS	Government does not supervise
	Government cannot support schools in reality
	Rare exchanges
	FBHPS not heard
	Isolation – no exchange with other institutions
Hiding behind the faith moniker	Lack of audit and inspections
	Presence of unaccredited training programmes
	Powerful presence of missionary volunteers

FBHPS, faith-based health professions schools.

There is a narrative that faith-based health professions schools do things more *wholeheartedly* than others. It is claimed that faith attributes make them more empathetic and trustworthy than their public counterparts. In a similar vein, donors argue that they make very good counterparts because they are well established and it is easier to collaborate with them: 'Collaborations with them [name of faith-based health professional school] is easier because we can get fast results' [Interview15, donor]. Moreover, faith-based health providers are a good training ground for students because of the continuity of staff (although they struggle to ensure sufficient staff numbers, continuity levels are generally high): 'Some of the staff stay there forever. It makes it easier to train students in those circumstances' [Interview11, donor].

Despite this positive narrative, donors and the Ministry of Health also contradicted their own expressed views, and it was clear in the evidence that there is comparatively little knowledge about faith-based health professions schools at the central level. The Ministry of Health could not provide a list of faith-based health professions schools: 'It would probably be good to know how many they are' (Interview8, MoH). Moreover, there are rarely any supervisory visits by the government. 'We should supervise them yes, but what can we supervise, they are centres of excellence [laughs]' [Interview8, MoH]. The positive reputation of faith-based health providers has culminated in very irregular supervision by the Ministry of Health and an assumption that these sites make excellent training grounds. Similarly, donor praise the high quality of care provided at health professions schools, while also consistently raising concerns about not including modern family planning in the curriculum:

> They should follow the national standards and that is to include modern family planning. But we know that not all of them do that or can do that because they send the students to Catholic facilities to train. [Interview15, donor]

Assumptions as to the quality and content of the training programme is arguably also difficult to assess given that it is not inspected. This can allow for serious gaps in training. For example, a teacher at a faith-based health professions school made it clear that modern family planning would definitely not be taught in the nursing and midwifery programmes because it goes against the Catholic faith [Interview1, health professiona1; FGD1]. Other midwifery programmes try to organise placements outside of Catholic hospitals, for example, but this is very difficult from an organisational perspective. In the words of a teacher: 'We are willing to adapt a bit but it's difficult when we don't collaborate' [FGD1 FBHPS].

These extracts show that the narrative that these schools enjoy is not necessarily based on evidence that the Ministry of Health and donors have about the schools' quality of care and efficiency but rather constitutes a narrative based on assumptions about assumed comparative advantages.

Limited collaboration between government and FBHPS

Limited collaboration between faith-based health professions schools and the public sector emerged as a further strong theme from the interviews and focus group discussions. Faith-based health professional schools technically operate within the framework of the national standards and norms set by the Ministry of Health and Ministry of Higher Education, and a key role of the Ministry of Health is to monitor and inspect the quality of training provided [Interview8, MoH]. In theory, this is done through supervision trips once a semester and the managers of the schools are invited to the Department of Human Resources for Health once a year to discuss any further matters. The government is expected to provide subsidies to the faith-based health professional schools.

Whilst the government claims that the collaboration is friendly and praises the faith-based health professional schools for their contribution to training health professions staff for Cameroon, they highlight that in practice there are no funds to provide supervision and enforce regulation, as such 'there is no regular link between the faith-based health professional schools and us. It would be good to do that, to see what they do and exchange' [Interview8, MoH]. Moreover, the government has

been unable to pay subsidies to the schools for several years. Faith-based health professions schools argue that they should be involved in national calculations of estimated need of allied health professions, since they train a significant number of national health professional staff and also absorb many: 'We train so many nurses and other health workers but they never ask us how many we think are needed' [FGD1 FBHPS[4]].

Some donors have expressed concerns regarding the practical collaboration between faith-based and public health professions schools and their training sites. For example, one donor attempted to collaborate with a faith-based training programme and hospital:

> We wanted to send them our top 5% of [public] students so that these would be exposed to the high-quality infrastructure … We also wanted to include them [the faith-based hospital] in a project to strengthen infrastructure for midwifery training … but we have tried many times and they have not shown any interest. [Interview22, donor]

The reasons for this lack of engagement vary: there may be a limited willingness of faith-based health professions schools to break out of their 'bubble'; alternatively, students from their own schools and faith-based networks may be prioritised. Some faith-based health professions schools have highlighted that collaboration with public facilities and their training programmes is extremely difficult because the culture of education is very different.

> In faith-based health professions schools, much emphasis is placed on developing high morals among students and on their principles, based on the teachings of the Christian faith. Whereas, students from public health professions training programmes have a reputation of being disruptive and not taking the profession seriously. [FGD3, FBHPS]

Although interaction between faith-based health professions schools and the public health professions programme is limited, on some occasions all health professions training programmes are invited to work on specific tasks. Such collaboration is usually funded by a donor; for example, all directors of the public, private for profit, and faith-based training programmes were invited to contribute to the development of the national midwifery curriculum. Whilst this has created a platform where all schools formally collaborate, directors of faith-based midwifery programmes have expressed much frustration about their role in such forums. One participant presented an example to illustrate this further:

> … with the curriculum they [MoH] said each student midwife should do at least 80 episiotomies, so if we have 25 students times 10 schools that is 250 students, so if they are each doing 80 episiotomies how many women will have episiotomies? Is it a good practice? No, not at all! … We discussed and agreed against, but the Ministry kept the 80 episiotomies per student … [Interview19, FGD2 FBHPS]

Moreover, a participant adds, 'so you discuss something in a meeting but meanwhile they have already decided. So contributing, yes, but accepting the contributions no [laughs]' [FGD2, FBHPS]. Consequently, faith-based health professions schools may in practice have little interaction with the Ministry of Health, and when they do – and as shown in the example above, – they feel undermined by the government.

Interviewees further expressed concern regarding the lack of a stimulating learning environment due to isolation from the rest of the health and education system. In the words of a health professional who worked in both public and faith-based providers:

> So, you are in the hospital, there is no networking—I worked in the [faith-based] hospital for one year … by design or by error, I never met another physician. For one year! How can we learn and develop when we can't talk to each other [Interview2, health professional at FBHP]

Not being able to discuss patients and have a platform that allows for discussion of difficult medical cases could significantly affect quality of care. An absence of such structures makes it very difficult to provide an environment that facilitates good quality health professions education at all levels.

Hiding behind the faith moniker?

Lack of audit and inspections, limited collaboration and the sense of isolation described in the previous two themes are linked to the third theme revealed from the qualitative analysis, which highlight concerns over unregulated activities at faith-based health professions schools and providers. Despite the positive perspectives on faith-based health providers and health professions schools, participants consistently expressed a number of concerns about the quality of care at these faith-based providers and how this may impact the quality of training during practical placements. For example, staff at placement sites are not always qualified to perform the tasks they are performing due to shortages of staff:

> The people who work there [at a faith-based provider], they are mostly task shifters, task sharers– for example, after this foreign surgeon left [who did all the surgeries], the person providing surgical care was a nurse. [Interview24, health professional FBHP]

Faith-based health providers in Cameroon are dependent on funding from missionary networks and attract high numbers of foreign volunteers, many of which are missionary workers (Herzig Van Wees, 2019, 2020a). Participants expressed concerns about how this affects the working and teaching dynamics in the clinical setting because the foreign doctor holds a strong position of power. As described by a health professional working at a faith-based provider that serves as a training site for health professions:

> When I went with him [the foreign doctor] to the theatre [operating theatre] I realised that in terms of standard of care he was really … I would say terrible and did some scary things … nobody questioned what he was doing because of the way these institutions function—there is no system where an external auditing system can come in … The staff around him are not aware that it's a malpractice because all of them are in-service trained, and probably trained with him. [Interview2, health professional at FBHP]

Another example was shared by a participant who questioned the remit of the international volunteer.

> I don't think he [the volunteer] had any specialty training, his curriculum vitae said he was a GP [general practitioner] but he was doing surgeries and teaching everyone. Everyone trusted him because he was a white doctor. [Interview4, health professional at FBHP]

Some faith-based health professions schools and their faith-based health providers are often located in very rural areas and suffer from staff shortages. This is one of the main factors that has forced these institutions to create their own health professions training programmes that allow for fast track training of staff because they avoid the national bureaucracies. These programmes are not usually accredited by the Ministry of Health. Some participants have expressed concerns about these programmes, their quality and how they interact with the accredited ones.

> It is not clear what they do and what they teach. Some students have been given a training opportunity because the church tries to help them. But are they really competent … I don't know. [Interview21, Health professional FBHP]

Concerns have also been expressed about the role of donors in supporting this culture of unaccredited programmes. For example, The Pan-African Academy of Christian Surgeons (PAACS) is a not-for-profit programme that trains surgeons in Africa. It funds five-year surgical residency programmes in 10 faith-based hospitals throughout Africa, including Cameroon. Its aim is to train surgeons as well as to proselytise the Christian gospel. It, therefore, includes both an academic curriculum and a spiritual curriculum (PAACS, 2018). Mbingo Baptist Hospital benefits from funding and training of PAACS and offers a five-year PAACS surgical residency and a one-year head and neck fellowship. Mbingo Hospital also hosts a four-year internal medicine residency funded and organised by the Christian Internal Medicine Specialists (CIMS) and directed by an international board member of the Cameroon Baptist Convention Health Board. The PAACS is accredited by The College of Surgeons of East, Central and Southern Africa (COSECSA), which is an independent

body that fosters postgraduate education in surgery and provides surgical training throughout the regions of East, Central, and Southern Africa. However, it is not yet accredited by the West African College of Surgeons or the Cameroonian National Medical Council, Cameroon's medical education accreditation body. In other words, it is an unaccredited training programme. In the words of a participant:

> If we have one programme that is not accredited then people think it's ok to create new programmes that are not accredited. And they can teach what they want. PAACS could do what they want. They do a lot of Christian teachings; I am not sure that is a necessary part of a surgeon's education. **Who knows what they do?** [Emphasis ours, Interview Health professional FBHP]

Discussion

The findings echoes research that shows that there are assumptions about faith-based health providers, and that donors and the Ministry of Health often engage with these actors without fully understanding them (Herzig Van Wees, 2019; Jones & Petersen, 2011; Olivier & Wodon, 2012; Tomalin et al., 2019). The isolation of the schools described in this study further confirms findings on the challenges of fueling a parallel system through the engagement of faith-based entities (Boulenger & Criel, 2012; Green et al., 2002). Concerns over quality of faith-based health providers further echo studies and the need to challenge assumptions about quality provided at such hospitals (Olivier et al., 2015). For example, in Uganda and Zambia the quality of service at faith-based health providers was affected by severe staff shortages and under-qualified health workers (Schmid et al., 2008).

As noted at the start of the paper, debates on the privatisation of medical training in sub-Saharan Africa since the 1990s has tended to become polarised around the issue of private vs public provision, and the potential dangers (or efficiencies) that come from applying New Policy Agenda ideas to health sector reforms. But as this paper has shown, faith-based health professions schools occupy a strange position within Cameroon (and sub-Saharan national systems more widely). They are private (albeit voluntary) providers, and their expansion is linked to health sector reforms that have diversified the provider landscape since the 1990s. However, many are also long-standing national institutions, having played a key role in health delivery for decades. Their position, and perceptions that attend to their role, their effectiveness, their comparative advantages, owe a significant debt to their 'faith' status, and faith's role as a public authority within the country.

This presents a dilemma for thinking about the role of faith-based health professions schools, and for implications for wider policy debates. To what extent are some of the challenges and opportunities identified in the evidence presented here due to their status as private non-state actors, and what to their faith foundations? What might be attributable to the wider non-state medical and health professions training sector, and what is particular to the faith-sector?

We argue that these three findings presented in this research are indeed reflective of issues related to the faith character of these institutions, and the perceptions held by government actors and donors of the benefits and potential challenges of faith actors. Faith health actors in sub-Saharan Africa are often presented as having improved management and governance systems that make them more flexible, are more efficient, are more trusted by users and less likely than public providers to require unofficial payments (Leonard, 2002; Leonard & Leonard, 2004). As highlighted in the evidence in this paper, such perceptions of a 'wholehearted' commitment to public good drive understandings of faith-based actors (although as we also note, there are questions as to how solid the evidential foundations for such perceptions are).

However, this positive perception of faith-based medical training institutions highlighted in the evidence needs to be placed against another finding: that actual knowledge, rather than general perceptions, about individual institutions is limited, and this has consequences for creating a unified medical training system under which private (for- and not-for-profit) and public facilities operate

to common standards and curricula. As a result problems of how the medical training architecture is regulated and monitored, and the level and type of overall state oversight is important.

This matters not just from the perspective of the capacity of the state to ensure quality education across all institutions, but to ensure all elements of the system are integrated and can collaborate. The evidence in this research also suggested that some faith-institutions felt 'isolated', and were actively looking for higher levels of collaboration. In countries like Tanzania, faith-based medical schools acknowledge the importance of links with the public system for training their students, making use of facilities and giving vital experiences of operating within the public health system that many will go on to work in (Sirili et al., 2019). Where faith-based institutions operate in their own bubble, whether of their own choice or due to the lack of strong linkages created by weak government oversight, there is a danger that collective effort to meeting national priorities can be weakened and even stalled.

The result is that there is a sense that the health professions school architecture in Cameroon is fragmented, with individual elements choosing to (or left-to) work independently; and with the formal systems that should ensure cooperation and oversight limited through lack of resources and will. Summerskil and Horton cautioned that the faith moniker should not be used to excuse shortcomings (Summerskill & Horton, 2015). In this sense, the evidence suggests faith may be acting as an obstacle to greater cooperation in two key ways. Firstly, the perception held by governments and donors that faith-led institutions are better run, have strong ethical foundations, and may be more likely to do the right thing, so to speak, perhaps lessens the perceived need for stronger oversight. Secondly, the ability of faith-based actors to draw on resources from global faith networks could give a degree of independence that greater reliance on state resources would allow for.

The three findings coalesce around this question of collaboration and cooperation, which in turn rely on stronger oversight and linkages. Not least because, as the evidence also makes clear, many perceptions (positive and negative) about faith-based providers are based on assumptions rather than actual data. A better understanding of the activities of these schools requires a stronger and more effectively functioning regulatory mechanism and process. But it also asks questions about how health sector reforms and donor-driven policies have distorted earlier patterns of cooperation between faith-based medical providers, including in medical training. The price voluntary agencies paid for integration into formal health systems (including as medical trainers) in the 1950s, and for gaining access to government finance, was stronger regulation and an acceptance that the state was the lead agency. The current public-private partnership model, by undermining the power of the state, has created gaps in knowledge, weaker oversight and linkages. Health sector reforms of the 1990s arguably weakened the ties that bound the different public and private (non-profit) parts of the health system, and in doing so weakened the regulatory power and oversight function of the state.

These have practical implications for the policy makers, practitioners and donors. The first recommendation is for a thorough mapping exercise for the non-state health profession schools sector, with a particular focus on faith-based providers, their relationships with the public system and other non-state (for-profit) elements. This is essential for the second recommendation, which is to establish a clearer set of processes for regulation and oversight for the entire sector, with a central aim of ensuring common standards and practices under a compulsory accreditation system (which would also allow for the regulation of international volunteers, whether formally or informally attached to institutions). The final recommendation, drawing from our evidence, is for further research on donors and their role in supporting particular initiatives, programmes and institutions, which can strengthen or weaken health profession training across all sectors. In particular, donors should be cautious in supporting non-accredited programmes. Instead, resources should be invested in ensuring a comprehensive regulatory framework for non-state actors providing health professions education.

Conclusion

The aim of this research was to gain perspectives from the Ministry of Health, donors and faith-based health professions schools on the role of faith-based health profession schools in Cameroon's health system. The overarching finding is that limited engagement with the state has driven a lack of knowledge and data about the sector, and a set of understandings based largely on assumptions. This shapes the nature of some of the concerns about the faith-element, and their role in the wider health system. Health professions schooling needs to be expanded in order to meet the 2030 targets for health human resources and the public health challenges of sub-Saharan Africa. But the unconstrained expansion of the private (voluntary and for-profit) sector has brought with it new challenges. It is essential to develop a fuller, richer and data-driven understanding of how each element in the health architecture operates, with what constraints and opportunities; and how donors, states and non-state actors can collaborate to achieve universal health coverage and the highest possible quality of care, including the contribution of health professionals schooling.

Notes

1. This paper focuses on the Christian faith only because faith-based health professions schools in Cameroon are primarily Christian (the schools that were interviewed fall within the Protestant and Catholic group).
2. This is an estimate that the authors made from counting the number of faith-based health professions schools. The data stems from a national communique that released the number of students that passed their exam in 2019. Given that we were unable to obtain detailed information about these (especially since we do not have every institutions perspective of whether they identify as faith-based but instead derived that information from their websites), this figure is merely an estimation.
3. Ministry of Health (MoH).
4. Faith-based health professions schools (FBHPS)

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical approval and consent to participate

Ethics approval and consent to participate was obtained from the Cameroon Board of Ethics (Comite National D'Ethique de la recherche pour la santé) Nr. 2015/08/638/CE/CNERSH/SP. Written Consent was obtained from all participants.

Consent for publication

Written informed consent for publication of their individual details was not obtained from all participants due to the sensitive political context. Some participants made clear that they only participate if their details are kept completely anonymous. Measures were taken to anonymise all data and no table of participants is included to protect their anonymity.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available. We do not have consent to share interview transcripts from participants. We have ensured anonymity of all participants. Due to the specific context (small donor community Ministry of Health and FBO community), individuals could be identified from reading the transcripts.

Authors contributions

SHvW conceptualised the study. EB added comments and suggestions and supported data collection. SHvW, EB and MJ were involved in the analysis. SHvW wrote first draft, EB contributed with comments and updated data from most recent sources. MJ contributed to analysis and writing. MS contributed to data collection and writing. AP contributed to data collection.

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