Faith-based health care 1

Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction

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At a time when many countries might not achieve the health targets of the Millennium Development Goals and the post-2015 agenda for sustainable development is being negotiated, the contribution of faith-based health-care providers is potentially crucial. For better partnership to be achieved and for health systems to be strengthened by the alignment of faith-based health-providers with national systems and priorities, improved information is needed at all levels. Comparisons of basic factors (such as magnitude, reach to poor people, cost to patients, modes of financing, and satisfaction of patients with the services received) within faith-based health-providers and national systems show some differences. As the first report in the Series on faith-based health care, we review a broad body of published work and introduce some empirical evidence on the role of faith-based health-care providers, with a focus on Christian faith-based health providers in sub-Saharan Africa (on which the most detailed documentation has been gathered). The restricted and diverse evidence reported supports the idea that faith-based health providers continue to play a part in health provision, especially in fragile health systems, and the subsequent reports in this Series review controversies in faith-based health care and recommendations for how public and faith sectors might collaborate more effectively.

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This is the first in a **Series** of three papers about faith-based health care

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Introduction

In 2002, World Bank President James Wolfensohn said "half the work in education and health in sub-Saharan Africa is done by the church…but they don't talk to each other, and they don't talk to us."[1] Somehow, faith-based providers of health and education had disappeared off the policy and evidence map. This situation occurred despite the fact that Islamic hospitals and Christian missionary hospitals were some of the first modern health-care providers to be established.[2] In many low-to-middle income countries, even after colonisation ended and despite massive health-systems reconfigurations, faith-based health providers (FBHPs) have maintained a strong presence. However, FBHPs have been neglected by the worlds of research and policy for decades, mainly as a result of a general refocusing on public health provision and also since the historical (and sometimes present) drivers of faith-based health provision have been treated with mistrust, especially in connection with the controversies around health care provided with the underlying intent to proselytise (see Tomkin's and colleagues review on controversies in this Series).[3] However, in the past decade, bilateral and multilateral donors, the UN agencies, and country governments have pushed towards better understanding of FBHPs.[3–5]

Here, we review the available evidence with a focus on sub-Saharan Africa and Christian FBHPs because little evidence is available for other contexts or other kinds of faith-based groups at present. Even with this focus, robust or systematic evidence is restricted, and substantial confusion and conflicting anecdotes exists in the published work on FBHPs.[6] Reports of the comparative advantages of FBHPs versus other public and secular providers (such as the possible reach, trust and access in communities, quality care, longevity, or service to poor people) are rarely substantiated and are usually balanced by reports of possible comparative weaknesses (such as poor human resource management, absence of financial sustainability, poor record keeping, or preferential service to particular religious groups).[7] The objective of this Series paper is to present what is

Search strategy and selection criteria

We based this Series paper on the assessment of peer-reviewed and grey literature that introduces some recognisable evidence to the specialty relating to the importance and unique characteristics of faith-based health providers (FBHPs) in Africa. We searched in Medline, Google Scholar, EBSCO, and World Bank data archives for publications in English and French between Jan 1, 2000, and May 31, 2014, with more than 40 search terms (variations of "faith" and "health") and a geographical focus on Africa and low-income and middle-income country contexts.

We also drew from three other more detailed systematic reviews in which some of the authors of this Series paper participated and on interviews and engagement with key researchers with an established record in this area. This report draws on the review and empirical work recorded in a three-volume collection that focuses on the role of FBHPs in Africa. From this work, the analyses of factors such as the satisfaction of patients, extent to which FBHPs reach poor people, and their cost for households were done. Additionally, material was taken from two systematic review projects in progress, one that has been collecting materials (peer reviewed and grey in English and French) relating to religion and HIV/AIDS since 2008, and the other that has been collecting material on religion and public health since 2006. These two databases include material from 1980, to 2014, with the search terms "religion", "public health", and "HIV/AIDS" (each with several variations), and each containing several thousand distinct entries.

Key messages

- Increased attention has been paid to faith-based entities engaged in health from a policy level during the past decade
- Little systematic and similar data is available relating to faith-based, non-profit health providers
- Data from household surveys suggest lower market shares than commonly assumed, but higher levels of satisfaction than in public facilities
- Faith-based health providers play an important part in many countries in Africa, particularly in fragile or weakened health systems
- However, many faith-based health providers show signs of weakness and little ability to adapt to their changed health systems contexts and financial constraints
- Appreciation of health providers' contribution to health care is tempered by lingering controversies tied to faith-based social engagement (which are discussed in more detail in later parts of this Series)
- Broad generalisations about faith-based organisations or the faith sector should be avoided
- More detailed health systems research is necessary (eg, research that unpacks how exactly faith-based health providers contribute [or don't] to universal health coverage at a country level)
- More detailed policy implementation strategies relating to faith-based providers are needed (eg, specific strategies for improved public–private partnership with faith-based providers)

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more strongly supported by evidence, as a background for other reviews that follow, and include the caveat that more detailed assessments of health systems interactions are preferable and urgently needed. We cover a broad terrain of evidence and introduce empirical analyses done by some of the investigators of this paper.[8–12] Our Series paper is followed by two more that discuss faith-linked controversies in global health, including sexual and reproductive health, harm reduction, violence against women, and end-of-life care; and five sets of recommendations for how public and faith sectors might collaborate more effectively to achieve health-related goals.

One of the main challenges to any kind of generalisable interpretation of faith-based health care is that the world of faith-based entities implicated in health is diverse and complex.[6,7] What is frequently termed the faith sector at a policy level includes, among others, faith-based civil society organisations, informal faith-based programmes, initiatives and community-based organisations, larger national and international non-governmental organisations, congregations such as places of worship, religious leaders, faith-based health-care facilities, and denominational and interdenominational health networks such as the Christian Health Associations, which are national umbrella networks of FBHPs. The bulk of evidence on the role of FBHPs in health is predominantly on their role in the response to HIV/AIDS,[13,14] which places restrictions on those seeking to understand specific health systems functioning or effects. At the turn of the 21st century, no one really knew how many faith-based entities existed or what they were doing towards health and development goals, and despite the launch of several mapping and scoping studies,[10] evidence is still fragmented.

The magnitude of faith-based health services in Africa

The first kind of evidence usually sought at a policy level in relation to FBHPs is their comparative magnitude against other health providers. The magnitude of the diverse faith sector can be counted in several different ways. For example, thousands of faith-based community-based organisations and non-governmental organisations have been reported to contribute to all aspects of HIV/AIDS response[15] (eg, WHO's 2004 World Health Report estimated that faith-based organisations [FBOs] account for about 20% of the agencies working on HIV/AIDS).[16] Basic self-provided estimates of health facilities owned by faith-based groups show a similar scale. For example, The Salvation Army provides health services in 124 countries through 73 hospitals, 56 specialist clinics, 135 health centres, and 64 mobile clinics.[17] In sub-Saharan Africa, the various Christian Health Associations operate and represent thousands of hospitals and clinics.[18] The Adventist Church operates 173 hospitals and sanatoriums, and 216 clinics and dispensaries worldwide.[19] The Catholic Church operates an estimated more than 5300 hospitals worldwide.[20–25]

At a local level, a few studies directly compare faith-based entities against their equivalent secular entities. One example is the mapping of the Mukuru settlement in Kenya[26] that reported 194 programmes working on HIV/AIDS, of which a third were classified as faith based. Birdsall analysed the South African National AIDS Database that lists registered organisations working in HIV/AIDS and about one in ten of those were self-identified as faith based.[27] More generally, faith-based entities have been identified as being active in all aspects of public health, such as immunisation,[28] antimalaria campaigns,[7] child and maternal health services,[15,29,30] and tuberculosis,[31] although the comparative magnitude of this activity is not known.

Local congregations and informal faith-based initiatives and volunteer groups engage in health care in a different way. The Pew Research Centre estimated that in 2012, 84% of the world's population considered itself as religiously affiliated,[32] and the world's main religions share a belief in the importance of caring for the sick (again, noting the controversies around drivers such as proselytisation, which often accompany this belief).[33] Congregations are an important entry point for primary care and support, as are informal and community-based volunteer initiatives.[34,35] For example, a study of the response of different local faith communities to orphans and vulnerable children in six African countries reported more than 9000 volunteers informally supporting more than 156 000 children within the study cohort.[34] In Zambia and Lesotho, a religious health-asset mapping study done

for WHO reported the expected FBHP facilities and faith-based non-governmental organisations but also reported hundreds of local and mostly informal initiatives in each site mapped.[9]

These examples depict a varied contribution of faith-based entities to health generally, but some clarity on the relative contribution of faith-based biomedical health provision versus other public and private provision exists. In most African countries, Islamic hospitals and Christian missionary facilities were among the first biomedical health-care providers and often established the first health systems.[35] This history is not without controversy in view of the complex connections between FBHPs, proselytisation, and ties to colonial powers. However, in terms of magnitude, at the time of independence from colonial rule, many FBHPs dominated the health systems in terms of number of facilities and magnitude of services.[18] However, since independence, FBHPs have experienced substantial shifts in this role. New national governments took a strong governance role and public systems expanded rapidly amidst a series of health sector reforms. Governance of most FBHPs was transferred from international denominational bodies to local churches, resulting in substantially reduced support from traditional sources and sometimes reduced growth of FBHP services.[18]

Despite these great changes, nowadays (panel) a (problematic) perception exists that anywhere from 30% to 70% of health-care services are provided by faith-based entities of various forms worldwide and in Africa. Although some historical and empirical basis for these statements exists, the origins of such estimates are poorly acknowledged, and these estimates are often overstated.[36–38]

During the past two decades, many attempts have been made to synthesise such evidence, especially for sub-Saharan Africa and anglophone countries.[23,29,35,46–56] These assessments of the role of FBHPs are based on partial datasets and usually rely on rough counts of the number of hospital beds held by Christian Health Association versus the public health system.[36] All of these investigators highlight the limits of such syntheses (table 1). The countries shown in this Series paper tend to have a representative national faith-based health network such as a Christian Health Associations, and the estimates are based on self-reports of the number of facilities or hospital beds networked by the Christian Health Associations versus the public sector. These figures rarely factor in the presence of the private for-profit sector and rarely include other FBHPs that are not in-network (such as the Islamic health providers that are largely invisible). These countries are African states that have a historically higher presence of FBHPs, which is why a Christian Health Association is present (table 1).

On the basis of little evidence, FBHPs are present in many countries in Africa, usually in countries with otherwise weak health systems (table 1). The graphic example of this is the Democratic Republic of the Congo, a fragile state where a consortium of local FBHPs and other partners operate more than half of the national health system.[29]

At a policy level, these poorly substantiated comparative magnitude estimates cause discord and have been detrimental to collaboration.[36] For example, when estimates for this particular set of countries are stretched to represent the whole of Africa, the figures are distorted (because the countries not represented in table 1 tend to have a lower market share), and this tends to result in immediate push-back at policy level. Limitations to comparisons based on number of hospital beds also exist because this might be misleading if levels of use differ between providers and do not take primary care into account.[51] Furthermore, what these market share estimates mask are other nuanced and important characteristic

Panel: **Past and often problematic examples of market-share estimates for faith-based health care**

WHO[16]
"Faith-based organisations…account for around 20% of the total number of agencies working to combat HIV/AIDS."

Christoph Benn (The Global Fund to Fight AIDS, Tuberculosis, and Malaria)[39]
"Faith-based organisations in many African countries provide between 30% and 50% of institutional health care."

Katherine Marshall and Richard Marsh (The World Bank)[40]
"Across Africa, for example, faith-based organisations provide up to 50% of health and education services, especially in poor, remote areas."

PEPFAR[41]
"In certain nations, upwards of 50% of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information services."

Tearfund[42]
"Faith groups provide on average 40% of the health care in many African countries."

Bandy and colleagues (WHO)[43]
"Faith-based organisations are major health providers in developing countries, providing an average of about 40% of services in sub-Saharan Africa…"

The United Nations Population Fund[3]
"Moreover, there is clearly an important parrallel faith-based universe of development, one which provides anywhere between 30–60% of health care and educational services in many developing countries."

The World Bank[44]
"In many African countries, you provide 30–70% of the health services, and in post-conflict countries, the majority of primary education services."

Vitillo (CAFOD)[21]
"Such strongly held values have inspired faith-based organisations to provide some 50% of health-care services in many developing countries. The Vatican's Pontifical Council on Health Care estimates, in fact, that at least 25% of all HIV/AIDS-related services are sponsored by the Catholic Church."

Summary from Olivier and Wodon[45] (note that the basis for these estimates are largely unknown).

	Self-declared NFBHN market share (beds)	Number of NFBHN hospitals	Number of NFBHN health centres	Number of NFBHN training facilities	Selected examples of estimates as used in secondary literature*
Benin	40%	6	20	28	The private sector (individuals, private for-profit entities and faith-based entities) is estimated to have provided 63% of the outpatient consultations carried out in the country, and faith-based facilities do half of those private visits[57]
Botswana	18%	2	6	2	None
Cameroon	40%	30	150	3	The private sector represents 40% of the national supply of care, of which most is held by three faith-based organisations[58]
Central African Republic	20%	2	62	19	The NFBHN provides more than 25% of the total health-care provision in the country[59]
Chad	20%	4	164	2	Faith-based care is ~20% of national health coverage, with 10% provided by facilities of the Catholic network[58]
Democratic Republic of the Congo	50%	89	600	20	Church related institutions represent 70% of health services;[60] faith-based organisations provide around 50% of health services provided and facilities owned[61]
Ghana	42%	58	104	10	All faith-based organisations (Christian and Muslim) provide 40% national health services;[62] the NFBHN represents 35–40% national health care[63]
Kenya	40%	74	808	24	The NFBHNs provides 40% national health services[64]
Lesotho	40%	8	72	4	The NFBHN represents 40% national health service[2]
Liberia	10%	6	67	3	The NFBHN represents about 46% national health sector[29]
Malawi	37%	27	142	10	The church provides 40% of health services[54]; the NFBHN owns 37% of health services[65]
Mali	2%	..	..	..	None
Namibia	..	6	..	..	None
Nigeria	40%	147	2747	28	The NFBHN represents 40% national health services[66]
Rwanda	40%	..	..	..	Church-affiliated facilities are 45% hospitals and 35% primary care[67]
Sierra Leone	30%	..	..	..	The NFBHN represents 30% of national health services[48]
Sudan	30%	4	..	..	None
Swaziland	..	3	27	1	None
Tanzania	42%	89	815	24	The NFBHN represents 48% of the national health service[2]; the NFBHN represents about 26% of all health facilities, 40% of hospitals, and 50% of health services in rural areas[68]
Togo	20%	3	39	0	None
Uganda	50%	47	541	19	The NFBHNs together own 50% beds, 60% hospital services, 42·3% hospitals, 22% lower-level health facilities, and 70·7% nursing/midwifery schools;[69] the Christian NFBHNs provide 50% national health service;[2] the diocese and parishes provide 70% of all private non-profit (lower-level units and hospitals)[70]
Zambia	40%	36	110	9	The NFBHN represents 30% of all health services;[71] the NFBHN represents 50% of rural health-care provision and 30% of total health-care provision[72]
Zimbabwe	35%	80	46	15	The NFBHN represents 45% of national health service;[2] Christian hospitals provide 68% of total bed capacity[39]

*Not including the role of private secular for-profit or non-profit provision. Summary drawn from Dimmock and colleagues,[18] based on a survey done in the Christian Health Associations from 2010–11. The figures for numbers of facilities are based on limited and varied data. In some countries, more than one NFBHN exists (when possible, these have been amalgamated) and other networks only represent one faith group. For example, the Democratic Republic of the Congo figures are representative of the Protestant church network only; the Cameroon figures have only one Christian NFBHN despite there being other known faith-based providers that are not networks; and the Uganda figures amalgamate two Christian networks and one Muslim network.

Table 1: **Basic data on estimated national faith-based health networks (NFBHN) market share by country**

differences, such as differences in patterns of governance or access. For example, many anecdotes suggest that individuals might walk past cheaper public facilities to access FBHPs,[9] but there are only a few severely outdated analyses of user preference or comparative access to interrogate or verify such anecdotes.[73–75]

In the absence of more up-to-date access-related data, analysis of household surveys can provide a piece of the puzzle about the patterns of choice and use between different components of the health system.[37,45,76] The Mainstay International reference and the US Demographic and Health Surveys do not separately identify FBHPs from other private providers, although some efforts have been made to extrapolate the FBHPs out of this large sample (which is inclusive of markets for self-medication, traditional practitioners, and drug peddlers).[37] More precise data are available for a subset of countries where multipurpose household surveys separately identify

FBHPs from other private "secular" providers.[37,45] In the 14 African countries in which this differentiation is possible, analysis reported the pooled average use-based market share of FBHPs was at about 6%. However, this estimate is almost certainly on the low side because some countries where faith-based provision is large, such as the Democratic Republic of the Congo, are missing from the sample. Also, household surveys might underestimate the market share of FBHPs if households do not know whether a provider is public or private, or whether it is faith-based or not, and mistakenly assume that a FBHP is a public provider (common with FBHPs that frequently act more public than private, often receiving public funding and taking on the responsibilities of a district hospital). When looking through this very different lens of understanding health-care use (where the entire representative sample is larger and includes more entities, so the portion held by all parties is automatically smaller), the estimates tend to be much lower. Despite these caveats, engagement with household datasets of this sort is one of the only systematic and comparative data methods available at this time. This approach highlights the massive array of actors to consider in policy discussion about the faith sector engaged in health.

These different ways of viewing the magnitude of faith-based health provision are not really comparable; bed counts cannot be adjusted by broad household-use estimates. However, by consideration of these different kinds of data, some important points emerge for those seeking to understand the importance of FBHPs in Africa.[37,45] First, estimates based on hospital bed counts often do not factor in private secular hospital beds because these are often not known, even to the government. Second, the popular estimates based on comparison of numbers of hospital beds does not adequately measure primary health-care level or community outreach. Third, estimates of market share based on facilities-based care does not account for the role of a wide range of other private providers of care such as shops or markets for self-medication, traditional (religious) practitioners, and drug peddlers. Such considerations are important in view of the high use of such providers in these health systems.[77] Fourth, the present estimates for magnitude of faith-based health care in Africa and the world are based on a select group of countries that have a strong historical footprint of faith-based provision. When estimates are provided for Africa, or the world, these seldom include the countries that have a low prevalence of FBHPs (eg, many Muslim-majority countries or South Africa, where FBHPs were nationalised into the public system), suggesting that regional or worldwide estimates in particular should be treated with caution. Finally, some of the post-conflict countries where FBHPs are known to have a large footprint owing to government failure, such as the Democratic Republic of the Congo, are not yet properly represented.

These factors suggest that overestimation and underestimation are common, so care is warranted when using such figures. The suggested comparative advantage factors that are sometimes said to be characteristic of FBHPs cannot be examined through such estimates. Consider whether the number of facilities owned by a faith group is more or less important than whether they are providing quality health care to poor people in support of goals such as universal health coverage? If even a handful of FBHPs were present, but were managing to provide a particular kind of access to a particular population, this would be important. But such consideration would need a vastly different evidence base than is available at present. We recommend a refocusing away from estimates of comparative magnitude, first towards the establishment of basic comparative and systematic evidence and, second, towards more complex systems analysis.

Financing and other support

Most FBHPs have experienced major changes in their health systems configuration and their financial resourcing in the last decades.[18] Around the time of independence, most African FBHPs have had to source new support from local governments and international donors because their traditional funding pools dried up (mainly as a result of the independence movements within local religious bodies).[18,38] FBHPs now commonly finance their services with a combination of government resources, user fees from patients, development assistance from bilateral and multilateral donors, and funding and in-kind contributions from within-country faith groups and local communities.[7,78] Although this diverse landscape undoubtedly affects how FBHPs operate, the services they offer, and who they serve, little comprehensive tracking of these funding streams exists. Information systems are often weak in these contexts (FBHPs are usually reluctant to share financial data) and the highly decentralised nature of FBHP networks makes reliable resource tracking only possible when it is done at the facility level.[35] A key source of funding, the user fees received from patients, is totally hidden at an evidential level.

Although some FBHPs are reluctant to align themselves too closely with governments[2,35] most are now becoming more integrated with their national health systems through alignment of priorities, contracts, and service-level agreements.[58,79] In most cases, a closer financial relationship with the government, usually through the Ministry of Health, has resulted in improved public–private awareness, if not always robust partnership. For example, partnership agreements have been forged between the Ministries of Health and several Christian health associations such as those in Chad, Malawi, Uganda, Tanzania, Zambia, Lesotho, Benin, Ghana, Kenya, and Cameroon.[18,58] These agreements usually state the terms of a reciprocal relationship, where

the FBHPs commit to supporting public health sector goals and priorities (in particular, serving poor people in hard-to-reach areas), and in return, the government commits to some kind of financial compensation, often in the form of salary support, and usually negotiated to match bed-based market-share estimates. However, in many of these countries, partnerships are strained, for example when service-level agreements are not fulfilled or finance and human management systems do not work together.[58]

Development assistance for health from abroad can come to FBHPs through national strategies from bilateral and multilateral donors. The Christian Health Associations of Zambia has been a primary recipient of The Global Fund to Fight AIDS, Tuberculosis, and Malaria.[78] Such funding can also flow from international non-governmental organisations to FBHPs. Although no assessment has been made of international funding flows to FBHPs, some efforts are being made to track finances from and to faith-based organisations in general. For example, a basic analysis suggested that at least US$1·53 billion of development assistance for health flowed from faith-based non-governmental organisations receiving funds from the US Government, Bill & Melinda Gates Foundation, or the Global Fund to fight AIDS, Tuberculosis, and Malaria; however, this figure cannot be verified so it mainly shows that this funding flow exists.[80] Similarly, the assessment of financial flows to FBHPs (as opposed to the broader range of faith-based non-governmental organisations) is restricted and relies on simple analyses.[78,81]

Donations by other faith groups (local or from abroad) are an important source of support. Anecdotal reports of informal and often unrecorded flows of funds from congregations abroad exists. In 2008, US churches were estimated to have raised $4 billion for overseas ministries, some of which was health focused.[82] Cash and in-kind contributions from local communities and groups are important, and research shows that many Christian FBHPs depend on irregular emergency support from their local governing denomination.[55,82] Several studies have emphasised that the informal community levels are where substantial religious health assets lie, visible in capacities such as volunteering and small financial and material grants.[9,34,83] A study of faith-based HIV/AIDS initiatives in six African countries reported that more than half of the initiatives identified were run without any external support.[34] In countries where Islam is prevalent, Zakat and other direct payments from Islamic communities play a part in the funding of such initiatives (noting the substantial controversies sometimes linked to this kind of support, in particular the possible ties to politicised Islam). In Christian Zambia, a health mapping study reported a local Islamic group paying for the upkeep of a wing of the local government hospital, which shows the various forms health-care support can take.[9,35]

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	14·5	17·0	19·7	23·0	25·8	100·0
Faith-based	17·3	17·0	18·4	24·6	22·7	100·0
Private secular	14·1	16·3	18·2	21·3	30·2	100·0
Total	14·5	16·9	19·0	22·5	27·1	100·0

Estimate from national household surveys adapted from Wodon and colleagues.[93] Data are based on the household survey question "where do you go for care when sick or injured?" The term private secular is acknowledged to be problematic; however, no standard way of differentiating between such clusters exists (and non-faith-based is simply awkward). The analysis is based on 15 nationally representative household surveys for 14 countries: Burundi, Cameroon, Chad, Ghana (two surveys), Kenya, Malawi, Mali, Niger, Nigeria, Republic of Congo, Senegal, Sierra Leone, Swaziland, and Zambia. The questionnaires in those surveys are sufficiently detailed to identify separately public, private secular, and faith-inspired health-care providers.

Table 2: **Use of facilities-based health care by wealth quintile, average for 14 African countries (%)**

Reach to poor people and cost for households

A preferential option for poor and vulnerable people is often a central stated tenet of the major faiths[33] and also a worldwide priority of universal health care and public health. Many FBHPs were established with the stated intention to serve poor people in hard-to-reach locations, although this intent is at times controversially linked to other missionary drivers such as proselytism. Whatever the intent, some evidence substantiates the resulting presence of FBHPs in remote rural areas in Africa. More than 20 years ago in a World Bank analysis, De Jong noted that mission-based health facilities were located in poor, remote areas, either because of a commitment to serve the underprivileged or because they were filling a gap in areas not already met by government services.[46] Similar statements have been made at a high level, especially in relation to sub-Saharan Africa,[18,52,84] including in policy dialogue on Burundi,[51] Ghana,[63] Kenya,[85] Malawi,[86] Senegal,[87] Tanzania,[68,88] Zambia,[54,72,89] and Zimbabwe.[49,90] However, whether FBHPs can prioritise provision to the rural poor in the face of their present financial and systems contexts is a growing question.

Household surveys from the 14 African countries mentioned in this Series paper can be used as a basic first assessment of the extent to which FBHPs manage to reach poor people.[91,92] In table 2, each row shows the share of the services provided by a specific type of provider that is used by households in five quintiles of wellbeing, from the poorest to the richest. None of the three types of providers (whether public, faith based, or private secular) serve poor people more than wealthier groups in absolute terms. However, although the household's use of facilities-based health care by wealth quintile shows private secular providers are the least pro poor, FBHPs seem to serve poor people slightly more than public providers (with 17% of patients in the poorest quintile).

These results are affirming for modern-day FBHPs, especially when one considers the resource constraints they now face. However, policy-level dialogue that

suggests FBHPs serve only poor people is being challenged. FBHPs often find themselves in a changed health system, with public sectors increasingly oriented towards serving poor people and developing public primary care in remote areas. Also, although many FBHPs might have been historically located in remote and poor areas, profound changes have occurred in the geography of poverty in many countries.[93] Faith-based clinics and hospitals that were established in rural areas find themselves surrounded by urban (sometimes wealthier) communities as a result of the combined effects of migration and population growth and because mission settlements often transformed into commercial community hubs.

Another key consideration is cost recovery (sometimes described as Robin Hood payment mechanisms). Many FBHPs need to recover a large share of their costs through user fees and, as such, could become (on average) more expensive for households than public facilities, which might be a barrier for very poor people (note, however, that FBHPs often have sliding-scale cost recovery mechanisms). We looked at the cost ratio for households for each type of provider (based on the same data and analysis as table 2), and on average FBHPs were more expensive for households than public facilities (table 3).[93] These figures can in part be explained by the fact that FBHPs usually do not benefit from the same level of subsidisation from the state. They are also shown here to be more expensive than the category of private secular providers, but this might be expected in such surveys as this category also includes traditional healers, peddlers, chemical stores, and other low cost health-care providers to which poor people might turn to. This heterogeneity in the private secular sector explains why the average cost of care in that sector is low and also why the sector's use in very poor people is substantial.

These broad comparisons of use and costs for households are across all types of facilities within one of the three sectors (public, faith based, and private secular) and across all types of consultations.[93] The fact that different providers have different services explains part of the differences in cost. Although faith groups were involved with conceptualising primary health care in the 1970s, in practice they tend to be heavily hospital centric, which makes FBHP systems (and services) more expensive.[17] The comparative cost ratio of FBHPs is lower for the bottom three quintiles than for other groups (table 3). This result might support the argument made by FBHPs that they are making efforts to keep their costs affordable for poor people through cost-recovery strategies.[91,93] But this claim is only lightly shown, and again, the lesson is that more robust evidence is needed in relation to the routine systems functioning of FBHPs, which might include activities to keep costs low and services accessible to poor people in resource-constrained environments. We also advise steering away from the broad question of whether all FBHPs in the world have a preferential option for poor people or not, as this is largely futile in the face of local differences.

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	1·19	0·78	0·94	0·86	0·96	0·89
Faith based	1·04	0·95	0·55	2·03	1·52	1·71
Private secular	0·79	1·24	1·10	1·12	1·01	1·09

Estimate from national household surveys adapted from Tsimpo and Wodon.[89] The analysis is based on a subset of the surveys mentioned in table 2 for Burundi, Cameroon, Ghana, Nigeria, Malawi, Sierra Leone, Swaziland, and Zambia. The analysis provides estimates of the cost ratio for households for each type of provider compared with the average cost of consultation across all cost providers, so a ratio greater than 1 implies that costs are higher than average.

Table 3: **Average cost ratio for households of health-care providers by household wealth quintile for eight African countries (%)**

Quality of services

Understanding of the characteristic nature and quality of services provided by FBHPs is crucial, eclipsing magnitude as a policy issue, since even small pockets of quality provision to poor people in areas where other services do not reach would be a more important concern than whether they compete in size or number of beds with the public sector across the whole system. In the absence of other systematic data, quality can be proxied in a rudimentary way by rates of patient satisfaction. Although satisfaction is only a partial measure of quality (and not as robust as other measures such as clinical outcomes, which are not available), it is important because it affects access and the demand for care in households. A systematic review of published work on comparative satisfaction with faith-based versus other health-care providers in Africa noted that most of the available empirical evidence showed FBHPs enjoying higher satisfaction rates from their clients than other health providers (particularly other public facilities), although this evidence was varied and usually qualitative.[93]

Household survey data can again provide some clues, with data from six countries where FBHPs enjoy higher satisfaction rates than both public and private secular facilities (table 4). These data support the anecdotal evidence of perceived higher quality of care that can be found in FBHPs.

What drives the higher satisfaction rates with FBHPs? Most studies show that it might not directly be religion that makes the difference. Although FBHPs have in the past been accused of religious favouritism (only serving clients of the same religion), this is not apparent in present studies, suggesting that direct proselytism is restricted (or at least has been constrained by integration with the public system), and access is not commonly denied based on religious terms.[94] Few indications suggest that patients are choosing FBHPs by their own religious affiliation. But the secondary effects of religion

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	65·4	67·4	64·0	65·5	67·4	66·0
Faith-based	73·0	84·3	77·9	80·0	64·0	78·0
Private secular	75·2	75·1	75·3	72·2	76·0	74·9
Total	70·5	70·9	68·6	69·3	71·6	70·2

Estimate from national household surveys adapted from Wodon and colleagues.[37] The analysis is based on a subset of the surveys mentioned in table 2 for Burundi, Ghana, Mali, Niger, Republic of Congo, and Senegal.

Table 4: **Average satisfaction rates with health-care services across wealth quintiles in six African countries (%)**

and in particular a religious organisational culture in these FBHPs does seem to have an effect. For example, in Burkina Faso, the reasons that led patients to choose FBHPs are not immediately related to religion itself, but seem to be driven by lower out-of-pocket costs for households and then by perceptions of a higher quality of service than public health providers.[94] In Ghana, perceptions of high quality are by far the most dominant factor for patients and also for health workers' choice of employer.[37,95] In many of the available studies, the quality of the services provided is perceived as high because of a particular attention paid to the dignity of patients, sometimes articulated as more compassionate care than received elsewhere, such as in other public health facilities. Again, this comparison of quality care is poorly substantiated, as are its drivers or causes. One study in Uganda did find that FBHPs have a higher performance than that of staff in other public facilities, attributed mainly to their intrinsic motivation, with staff driven to work for longer hours and sometimes for less pay, by the faith-based organisational ethos.[96] Several other hypotheses have been suggested, such as different governance structures, community ownership, intrinsic values and organisational cultures promoted among the health workers, or low patient–health worker ratios enabling more time to be spent per consultation.[7,55,58,93,96] However, the connection between faith-based values and health systems performance needs substantially more attention to be able to inform policy-level action.

Conclusion

This Series paper has deliberately focused on the growing evidence of the nature of health care provided by faith-based health providers in Africa. The comparative weaknesses and potential negative effects associated with some FBHPs should be known. For example, contrasting with the above emerging evidence, published work commonly states that FBHPs can be of poorer quality than their public counterparts in some locations and that they sometimes have weak governance (such as financial and human resource management) as a result of managers being hired because they are a said to be good Christians rather than skilled health-service managers.[35] Additionally, although religion is described mainly as a positive value, when theology mixes with health-service policy, negative health effects have been noted, most strongly documented in relation to sexual and reproductive health.[15,79] However, the slowly emerging evidence on FBHPs suggests that they are not simply a health systems relic of a bygone missionary era, but still have relevance and a part to play (especially in fragile health systems), even if we still know little about exactly how they function.

The main conclusion is that more and improved data are needed to provide support at management and policy levels on every aspect relating to how FBHPs routinely function within their health systems. We need to move away from broad generalisations of the magnitude and character of FBOs and instead find out how different kinds of FBHPs operate within different contexts and systems. Rather than relying on basic proxies, we need to understand in a more complex manner, the interactions of management practice, organisational culture, pharmaceutical supply, cost recovery, and human resource management, and how these affect (clinical) quality, satisfaction, and use, and then how this affects access, reach to poor people, and broader goals such as universal health care.

For the presence of FBHPs to be invisible in some contexts is no longer acceptable, in particular fragile and post-conflict states where their role seems to be potentially important. Non-Christian providers, non-mainstream religious groups, and non-anglophone contexts are worryingly absent from the present analyses (particularly as there seems to be a substantial growth in Muslim health-care provision in some regions of Africa).[97] Furthermore, increased information gaps are found in regions such as South and Central America, Asia Pacific, and eastern Europe.

This missing information is urgently needed if FBHPs are to align with their national governments in a way that strengthens the system.

Contributors

JO and QW jointly conceptualised, wrote, and edited this Series paper, as well as the group of studies on which this paper is based (a World Bank programme) to which CT, RG, MS, HC, FD, and MCN contributed substantive content. EJM, JLD, and AH contributed to the review of this paper and HH to the organisation of the work. All authors reviewed and approved the final version.

Declaration of interests

The authors declare no competing interests.

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