Satisfaction with faith-inspired health care services in Africa: review and evidence from household surveys

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SATISFACTION WITH FAITH-INSPIRED HEALTH CARE SERVICES IN AFRICA: REVIEW AND EVIDENCE FROM HOUSEHOLD SURVEYS

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Patient service satisfaction has become a critical concept, utilized both in the assessment of quality of care and to predict a range of health-related behaviors and outcomes. What can be said about patient satisfaction with faith-inspired institutions (FIIs) in the African context in comparison with other providers, and especially public providers? Our objective in this paper is first to review what evidence there is in the literature that might cast light on the comparative satisfaction of patients with FII-health services in Africa today. Second, we present new evidence from household surveys in six African countries on satisfaction rates. Overall, the results suggest that satisfaction with the services provided by FIIs is higher than with those provided by public facilities.

INTRODUCTION

In 1986, World Bank authors noted in a report on the African health sector that: *"In Nigeria and Uganda, mission hospitals and clinics have medicines and other supplies when public facilities do not. In Malawi, consumers walk miles past nearly free government health centers to get to mission clinics that charge many times as much…"* (World Bank 1986). After three decades of African health sector crises and reforms, such sentiments remain strong: it is typically believed that nongovernmental organizations (NGOs) and in particular *faith-inspired institutions* (FIIs) are preferred by users. Of course, it is widely recognized that FIIs are varied, and often have structural and quality concerns of their own. However, as in the 1986 World Bank report, there remains a perception that health-seekers often 'prefer' FIIs – sometimes because FIIs are located in rural and hardship areas in which there are no other services, but also in communities in which there are now (possibly cheaper) public services available.[1]

Indeed, there is a fairly strong discourse which argues that faith-inspired health care institutions have characteristic comparative values that enable them to provide better services to the population they serve, especially the poor. Similarly it is argued that FIIs have characteristic ways of operating, of providing 'compassionate care', or motivating their workforce differently. However, there is very little systematic evidence on such *comparative* advantages (or in some cases disadvantages) of FIIs versus other providers – including public, private-for-profit (PFP), or other nongovernmental (NGO) or private-

[1] This area of inquiry is a terminological minefield. Within the broad classification of public vs private – there are many varieties. Private is often split into private-for-profit and private-not-for-profit (PNFP). PNFP is also sometimes called 'nongovernmental (NGO) or 'voluntary' – and in the case of faith-inspired institutions: 'church providers', 'mission providers', 'faith-based organizations' and the like.

not-for-profit (PNFP) providers – especially the kind of evidence that can be utilized at a policy level. There *is* a steadily increasing body of literature which compares the quality of public and private providers in development contexts (see Berendes et al 2011). However, this literature most commonly groups FIIs together with other providers ('private' or 'NGO'). This of course makes sense from an aggregate perspective – but it does not enable any resolution of the questions about whether FIIs have a comparative advantage or disadvantage as a result of their faith-inspired or faith-affiliated nature. And it is even harder to assess whether the quality and operational differences often suggested, if they can be documented at all, are rooted in the FIIs' religious nature or practice, or other aspects of their culture which are not necessarily strongly tied to their faith.

The issue of comparative difference is complex – and needs to be addressed from a number of different angles as can be seen in other papers of this collection. It is beyond the scope of this particular paper to address all the different elements of comparative quality (for example, comparing structural, technical and competency measures) – although this is certainly where such discussion must lead.

In this paper, we address just one element: what can be said about patient service satisfaction with FIIs in the African context *in comparison with other providers*. Patient satisfaction has become a critical concept, utilized both in the assessment of quality of care and to predict a range of health-related behaviors and outcomes. There are significantly fewer assessments of patient satisfaction in developing countries than there are elsewhere – and certainly not enough in Africa where quality and service provision is so varied. Berendes et al (2011) provide a useful systematic review of studies which examines in a comparative way the quality of public and private ambulatory health care in low and middle income countries. In such literature, patient satisfaction is usually utilized as an outcome or process indicator relating to quality measures.

However, there is still an ongoing search for appropriate and reliable methodologies for measuring quality and also patient satisfaction. As Abiodun (2010) says, "*Satisfaction, like quality, is a multidimensional construct…overall service satisfaction is a construct with multiple indicators at the attribute level…"* As will be discussed in the literature review below, satisfaction is measured in many different ways - sometimes based on just a few indicators (such as willingness to return to that same facility for the same health problem), but more often as part of a more complex analysis which integrates multiple quality and contextual factors (for example, tracking the patient's exposure to a number of different service attributes such as cost, equipment, medication, attention from doctors, courtesy, convenience of location, or layout of facilities).

Bekeke et al (2008) demonstrate this more complex perspective, saying: "*Studies have shown that, satisfied patients are more likely to utilize health services, comply with medical treatment, and continue with the health care providers…Satisfaction is related to more partnership building, more social conversation, courtesy, clear communication and information, respectful treatment, length of consultation, cleanliness of facility, drug availability and waiting time. Measurement of patient satisfaction involves multi-dimensional aspects of patients' opinion on health care, identifying problems in health*

care, and evaluation of health care." Furthermore, patient satisfaction is particularly challenging being based on patient perceptions or their subjective understanding of the care received. When based on exit interviews (as is most common), there are unavoidable elements of self-selection bias among patients, that is, patients who choose to go to a particular facility are more like to be satisfied with the quality of care than the population as a whole, since those who are not satisfied are more likely to have sought care elsewhere (see Levin et al 1999).

Our objective in this paper is somewhat more modest than some of these more complex satisfaction analyses. We review what evidence there is that might cast light on the *comparative satisfaction of patients with FII-health services in Africa* today. In order to do this, we first systematically review the available literature – seeking out studies which comment on patient satisfaction, with data that distinguishes FIIs from other PNFP providers. Although there is a great deal of anecdotal and policy-level opinion about the comparative satisfaction with FIIs in Africa – there is little systematic evidence – and it is therefore necessary to parse out such findings from studies which are more broadly focused. Secondly, we present new evidence from household surveys to add a further layer to this discussion. For that part, we checked on the availability of data identifying faith-inspired providers in the main multi-purpose national surveys implemented in approximately 30 African countries. In about half of the surveys that we examined, there was enough information on the type of provider consulted by households to identify separately public, private faith-inspired, and private (non-FI) providers. And in six of those surveys, questions were asked to household members relating to whether they were satisfied with the services that they received from their provider, and if not, what the reasons for this dissatisfaction might be (with specific potential reasons provided). We present these findings for the six countries below (see also Wodon, 2013). However, this must be understood as a measure of broad popular satisfaction with health services based on household survey data. We present this here to add to the broader literature and discussion about the comparative characteristics of FIIs, recognizing the limitations of the measures we use.

It is also important to note that throughout this discussion we mainly address health facilities (hospitals, clinics, and health centers) – rather than the broader universe of often faith-inspired health providers such as traditional healers, faith healing 'clinics', or even chemical dealers. In the final section, we discuss a number of key issues that are suggested in the broader literature as being important characteristics of FIIs that are linked to satisfaction and quality - such as 'compassionate care', the availability of pharmaceuticals, and the suggested successful payoff being implemented by some FIIs between higher cost and higher satisfaction. There is, of course, a lot of heterogeneity among FIIs in the cost charged to patients - some FIIs are cheaper than public facilities, while others are more expensive - but the question is, when FIIs are more costly to households whether this is compensated by higher quality.

LITERATURE REVIEW: COMPARATIVE PATIENT SATISFACTION WITH FIIS

Digging out literature on patient satisfaction with faith-inspired health services in Africa is something of an adventure. Standard and systematic review methods do not reveal a substantial literature. Widmer et al (2011) have just released a systematic review of literature on the role of faith-based organizations (FBOs) in the area of maternal/newborn health care in Africa over a twenty year period (1989-2009) and found only six articles meeting their criteria. They do report, however, that based on the findings in these six articles, while "*maternal/newborn health services provided by FBOs were similar to those offered by governments…the quality of care received and the satisfaction were reported to be better.*" Schmid et al (2008) similarly conducted a broader scoping literature review on faith-inspired health care in sub-Saharan Africa, and noted a dearth of data and evidence which directly compared the scope or quality of faith-inspired health services (with FIIs usually 'hidden' among NGO or PNFP providers).

Overall, the absence of substantial comparative studies on quality or utilization of FIIs in Africa means that the main discourse on the comparative advantages or disadvantages of FIIs often appears to be anecdotal or at least not obviously tied to evidence-based analysis. We do not want to impose a particular bias on this discussion – but if you base your conclusions on the 'grey literature' of organizational and practitioner reports and best practice experience, public statements and conference presentations – then there is indeed a plethora of anecdotes and qualitative insights which report wide-spread preference for FIIs in Africa, including higher levels of patient satisfaction (see examples in the discussion below). Unfortunately, the data or more systematic evidence that might support such widely-held sentiment is largely absent, or severely outdated – especially considering the crises and reforms African health systems have faced in the last thirty years. This literature is also greatly fragmented, so that estimates across countries remain plagued by comparability issues. In table 1 we list some of the studies which have been identified as containing some comparative information on patient satisfaction in relation to FIIs in Africa.

Table 1: Sample of studies with elements relating to 'comparative satisfaction' with FB-health providers in Africa

Author-state	Focus	Method	Finding relating to 'comparative satisfaction'
1994 Gilson et al *Tanzania*	Community satisfaction with PHC services evaluated in the Morogoro region of Tanzania.	Focus groups/qualitative interviews: In each village: 3-6 key informants, 3-6 focus groups, 20 mothers and discussions, including perceptions about quality.	Church health care was generally perceived to be better than government care – but also considerable variation in community judgments and clear signs of poor quality church care.
1994 & 1995 Wouter et al *Senegal*	Relationships between quality of care and efficiency in the public and private sectors in Senegal. Adds survey data relating to quality of care to data collected in field surveys in Niger and Senegal.	Mixed-method (surveys/exit interviews): Comparative study based on provider, patient and household surveys (1992-1994). Nationwide sample of 95 (3 public hospitals, 23 health centers, 46 health posts, 23 health huts) and 57 private health facilities (30 Catholic health posts, 13 company clinics, 6 for-profit clinics, 8 'other clinics'). Patient quality perceptions from 20 patients and medical staff in each facility.	In private sector, for-profit and Catholics offered best care. Differences between patient and provider perceptions of satisfaction (patients more satisfied with care-received than providers were with care-rendered.) Overall patient satisfaction was high. In *public facilities,* over 80% of patients satisfied; except for hospitals (65%), 80% willing to return; 60% of staff perceived care to be average or below. *In private facilities,* almost 100% client satisfied with the exception of 'other clinics'; and staff perceived care to be good.
1995 Bitran *Senegal*	Study testing relative efficiency of non-governmental private sector provision of health services in Senegal.	Mixed-method (surveys/exit interviews): 46 public health posts vs 30 catholic health posts – various quality indicators (structure and process measures) including patient exit interviews on service satisfaction	Private providers highly heterogeneous but tend to offer better quality services with higher patient satisfaction. Catholic health posts were significantly more efficient than public and other private facilities, with higher drug availability, and similar patient fees to public.
1995 Kanji et al *Tanzania*	Testing whether voluntary agencies provide better quality of care than public facilities for primary curative outpatient services in Dar-es-Salaam.	Mixed-method (surveys/exit interviews): Sampling included 28 government facilities versus 15 PNFP/voluntary facilities (Catholic, Protestant and Muslim). Various aspects of quality – including patient exit interviews on service satisfaction.	Better clinical performance, interpersonal conduct and overall user satisfaction for PNFP providers as compared to government providers (although many PNFP consultations were outside established clinical practice).
1999 Levin et al *Uganda*	Evaluates provider and consumer costs of maternal health services, along with selected quality indicators at health facilities and among community practitioners in Masaka District of Uganda.	Mixed-method (surveys/exit interviews): Data relating to quality indicators collected in 1998 from 4 health facilities (1 public and 1 mission hospital, 1 public and 1 mission health center) and among community practitioners (17 private midwives and 20 TBAs) in Masaka District. Includes observation, provider interviews and (128) client exit interviews.	Overall impressions are satisfactory – with client satisfaction higher in the mission hospital and health center. Clients at the mission health center rate all aspects of their visit in the highest category. This may be related to the presence of a doctor, and perceptions that care from a doctor and more availability of drugs are preferable to care from a midwife or nurse (may be related to patients according higher value to the services received because of higher fees.)
2003 Levin et al *Uganda, Malawi, Ghana*	Compares costs of maternal health services in three Anglophone countries.	Mixed-method (surveys/exit interviews): Case studies plus client exit polls on costs and quality for maternal services at 1 public and 1 mission hospital; and 1 public and 1 mission centre in each country.	In all three countries the (6) mission facilities generally score higher on process indicators and client satisfaction than did the (6) public facilities.
2003 Lindelöw et al *Uganda*	Baseline survey on Ugandan health sector to validate data and check for discrepancies in reporting.	Mixed-method (surveys/exit interviews): Baseline survey (in 2000) of 155 PHC facilities (81 public, 30 PFP, 44 PNFP). The 44 PNFP facilities include 25 Catholic, 11 Protestant, 1 Muslim, 2 SDA, and 5 NGO). 1617 patient exit polls for qualitative	Satisfaction was found to be higher in private non-profit facilities (many of which are faith-inspired) than in public facilities in areas such as friendly service, information about ailment, prompt attention, and information about charges.

Author-state	Focus	Method	Finding relating to 'comparative satisfaction'
		measure of performance.	
2003 Mliga *Tanzania*	Relationship between quality of care and organizational structure of services in four types of health providers in Tanzania is examined: 1 public and 3 church denominations: SDA, Lutheran, and Catholic.	Mixed-method (surveys/exit interviews): Study carried out in Iringa and Arusha regions in 1996. 51 health facilities owned by the government (16), Lutheran (15), Roman Catholic (15), and (5) SDA church denominations were surveyed. Includes technically derived scores of quality (professional observation) and client evaluations of quality (patient interviews).	On technical measures and medicine stocks, church facilities performed better than public. Satisfaction rates were highest for clients of Lutheran facilities; then public; then SDA. Catholic facilities received favorable technical measures, but were least favored for a return visit. Clients valued the service provided by public facilities relative to the cost of those services, followed by the Catholics, then Lutherans. SDA services were thought to be too expensive (matching actual cost differences).
2006 ARHAP *Zambia, Lesotho*	Mapping study of faith-based health and HIV/AIDS activities in Lesotho and Zambia (2005-2006)	Focus groups/qualitative interviews: Mixed method study including 16 community focus-groups: 9 health-seeker and 7 health-provider (358 indiv.) Perceptions of community satisfaction gathered through participatory ranking, interviews and questionnaires.	Community focus groups consistently ranked local faith-based facilities higher – usually described as a result of additional quality of 'compassionate care'.
2009 Bazant & Koenig *Kenya*	Women's satisfaction with delivery care in a cluster or informal settlements in Nairobi	Household surveys: Data of 1266 women who delivered in health facilities (2004/2005): 63% gave birth in a nearby private facility, 31% in a public hospital, 2% in a public health center, 4% in a mission hospital located 20 km away.	Women's delivery care expenditures varied by facility type, with the cost of delivery at the mission hospital significantly higher (5 times the median expenditure at private facilities). However, dissatisfaction was greater among women who gave birth at government hospitals than at private facilities in the informal settlements. The mission hospital received the highest satisfaction ratings, "most likely reflecting the high-cost provision of care that was affordable to few women"
2010 Nwabueze etal *Nigeria*	Comparative assessment of patients' satisfaction with ambulatory HIV/AIDS care in a Catholic secondary hospital and public tertiary hospital in Anambra State.	Mixed-method (surveys/exit interviews): A descriptive comparative cross-sectional study based on interviews of 300 PLWHA-patients sampled from the two facilities.	More patients complained of a bad attitude of staff at the Catholic (SCBH) facility but overall patients' perception of care by all staff was significantly higher at the Catholic facility than the public one. Rating of patient satisfaction drivers like waiting time, confidentiality, hospital structure and environment were higher in the Catholic facility. Overall patient satisfaction with HIV/AIDS services was rated higher in the Catholic facility, despite more concerns about higher user fees.
2011 Babikako et al *Uganda*	Cross-sectional evaluation study (2007-2008) of satisfaction of adult TB patients attending public and private (Christian) hospitals for TB treatment in Kampala.	Mixed-method (surveys/exit interviews): Evaluation comparing satisfaction of adult TB patients at Mulago (the national TB center, and a tertiary public teaching hospital) and Mengo (a private Christian hospital with TB clinic, under the UPMB umbrella) - to understand how patient satisfaction differs by hospital setting.	Patients at public hospitals experienced significantly lower levels of satisfaction with technical quality of TB care, responsiveness to patient preferences and patients' understanding of potential problems of TB medicines. Differences in satisfaction suggest differences in public/private delivery with private healthcare possibly more patient-centered.
2011 Lievens et al *Ghana*	Study focused on health worker incentives in Ghana.	Focus groups/qualitative interviews: Some qualitative interviews with patients.	Quality of care judged higher in NGO facilities by both users and health workers: waiting times are generally shorter and staff is less absent. Transport for outreach activities is more

Author-state	Focus	Method	Finding relating to 'comparative satisfaction'
			available; staff is competent, has a positive attitude, is respectful towards patients.
2011 Makinen et al *Ghana*	Ghana health sector assessment	Household survey**:** GLSS4&5 household surveys (and community focus groups)	No significant difference found between provider types in relation to patient satisfaction. Consumers usually choose self-financed private providers for quality services, customer service, and short waits; Ghana Health Service providers for quality services, low prices, and availability of doctors; and Christian Health Association of Ghana providers for quality services, availability of doctors, and more courteous service.
2012 Gemignani and Wodon *Burkina Faso*	Satisfaction with services and reasons for choosing faith-inspired providers, comparing public, Christian and Islamic facilities.	Focus groups/qualitative interviews: In each of six faith-inspired facilities in two areas (one urban, one rural), in-depth interviews with patients and clinic/hospital staff plus other key informants, as well as community focus groups.	Better satisfaction with faith-inspired providers; one key reason for choosing faith-inspired facilities is lower cost of service, especially for Catholic providers due to lower cost for the poor. Other key reason is better service and relationships between clinic staff and patients.
2012 Shojo et al *Ghana*	Satisfaction with services and reasons for choosing faith-inspired providers, comparing public, Christian and Islamic facilities.	Mixed methods: Household survey analysis as well as focus groups and qualitative interviews faith-inspired facilities in two areas (one urban, one rural); this included in-depth interviews with patients and clinic/hospital staff plus other key informants	Quantitative analysis of household survey does not suggest substantial differences between public and faith-inspired providers, but qualitative data suggests better satisfaction with faith-inspired providers, mostly due to better service and relationships between clinic staff and patients.

Source: Authors' compilation.

Note: We only list those studies which make a clear comparison between FII and public/other private providers – we do not include those that mention FIIs as a major part of the NGO sector under discussion, but without delineating this in the findings. We also do not include all studies which might distinguish FIIs, but do not directly address satisfaction, but might address issues related to quality measures (structural, technical or competence). See Berendes et al 2011 and Widmer et al 2011 for useful systematic review of these issues.

HIGHER SATISFACTION FOR FAITH-INSPIRED SERVICES

As noted above, the wide variety of methods and focus make comparison of these studies challenging. Speaking broadly, most of the studies which do contain some kind of comparative element observe higher levels of patient satisfaction with care received at FIIs: this is the case between FIIs and other kinds of private providers, but even more strongly so between FIIs and public (government) providers. We have listed the studies by year in Table 1, since it is important to assess satisfaction in relation to the changes that African health systems have undergone in the last few decades.

There is also some question as to whether the higher satisfaction or user preference is a historic hang-over from a previous era when mission-based providers were the mainstay of most African national health system, or whether that relevance and satisfaction is still prevalent today, given the more diverse health-seeker options available in many places. Another study not listed in table 1 by Bratton (2007) explores the determinants of public satisfaction (or dissatisfaction) with health and education services – reviewing health services in 18 African countries utilizing the Afrobarometer survey (of 2005). Bratton is not surprised that overall, given the high disease burden in these countries, 51 percent of all respondents had some problem with their health services, especially in rural areas, including longer waiting times and a lack of medicines. Interestingly, when asking about where responsibility for health services should lie – while in most countries the majority said the state, in Tanzania and Malawi, almost half the adult population stood ready to experiment with mixed public and private approaches. Bratton (2007) concludes that "*We suspect that these unusually liberal sentiments reflect mass disenchantment with the poor performance of government ministries in these countries, the availability of alternative providers like traditional healers and non-governmental organizations, and nostalgia among older people for the days when missionaries provided most social services*." Bratton is one of the few who raise the issue of 'nostalgia' in relation to mission services and how this might impact on perceptions of satisfaction with FIIs today – and certainly this is an area requiring more enquiry.

However, even the more recent studies described in Table 1 still indicate higher levels of patient satisfaction with FIIs than public services. For example, this is apparent in the two recent studies which directly compare a faith-inspired facility against a public facility – although both seem to select the FII more as a private provider, and less because they happen to be faith-inspired. Nwabueze et al (2011) compare patients' satisfaction with ambulatory HIV/AIDS care in a Catholic secondary hospital and public tertiary hospital in Nigeria; and Babikako et al (2011) compare the satisfaction of patients receiving TB services at a tertiary public teaching hospital and a private Protestant hospital in Kampala Uganda. Both of these fairly different studies found significantly higher levels of patient satisfaction at the faith-inspired facility than the public facility – even though in both cases the FII was a lower level facility with less structural or technical assets (such as equipment). Babikako et al (2011) conclude that the observed differences in satisfaction suggest differences in public-private healthcare delivery, and that this might be a result of the private care being more 'patient-centered'. Nwabueze et al (2010) conclude that this supports the view that interpersonal issues, such as health workers' concern for the

patient rate significantly higher than the medical sophistication of the facility, saying: "*This is aptly demonstrated here where NAUTH Nnewi, a federal government tertiary health institution with all her sophisticated equipment and array of specialists and reputed to be the best in comprehensive HIV/AIDS care in the south east Nigeria, is found trailing behind SCBH Onitsha, a resource-constrained faith-based secondary health institution in almost all the measured domains of patient satisfaction.*"

Of course, it is impossible to stress enough that there is high variety among FIIs – both within countries and in comparison across countries (see Schmid et al 2008). This is raised repeatedly in the studies in Table 1, where noted higher patient satisfaction for FIIs is followed by caveats that FIIs are often structurally weak and have huge organizational differences which impact on varied quality and satisfaction (Gilson et al 1994a, Mliga 2003, Wouter 1994). For example, based on a comparative study of providers in Senegal, Bitran (1995) found private providers to be highly heterogeneous - noting that although private providers tended to offer better quality and more efficient services (in particular an important group of Catholic health posts), "*policies to expand the role of the private sector need to take into account variations in types of providers, as well as evidence of both high and low quality among them.*" This variation makes broad scale comparisons possibly misleading. However, since we are seeking to gather as many different threads which relate to the issue of comparative patient satisfaction with FII services in Africa, we will now consider just some such surveys followed by further discussion of these concerns.

NEW EVIDENCE FROM NATIONAL HOUSEHOLD SURVEYS

As mentioned above, while there are many statements about FIIs providing better quality services resulting in more satisfied patients, much of the evidence comes from qualitative work and small scale surveys. The empirical evidence obtained from large nationally representative data sets remains thin. As can be observed in Table 1, we find only a handful of studies which utilize survey data in relation to health service satisfaction which also have some comparative evidence on FIIs (see Bazant and Koenig 2009, Lindelöw et al 2003, Makinen et al 2011, Sojo et al 2011). This may be due in part to the fact that Demographic and Health Surveys (DHS) do not typically distinguish between faith-inspired and 'non-religious' providers of care, and these are the surveys that researchers often use for applied empirical work on health in developing countries. That is, DHS distinguish between public and private providers, but not between faith-inspired and other providers within the private category. Yet other types of surveys can be used to assess the satisfaction of patients with the services received from different providers. The advantage of such surveys is that one may also look at satisfaction according to the socio-economic profiles of the users of services – say by quintiles of well-being based on measures of household consumption.

For this paper, instead of using DHS data, we checked on the availability of data identifying faith-inspired health providers in the main multi-purpose surveys implemented in approximately 30 African countries. In about half of these surveys, there was enough information on the type of provider consulted by households to identify

separately public, private non-religious, and private faith-inspired providers. And in six of those surveys, a question was asked to household members as to whether they were satisfied with the services that they received from their provider, and if not, what were the reasons for not being satisfied (with specific potential reasons provided). The list of the six countries and surveys is provided in table 2 (most surveys are based on the CWIQ survey design piloted by the World Bank, where CWIQ stands for Core Welfare Indicator Questionnaire, which has been translated in French as QUIBB or *Questionnaire des Indicateurs de Base du Bien-être*). While all of the countries are from West or Central Africa where the CWIQ-QUIBB survey program has been more active, they represent both stable and post-conflict countries, as well as countries where the market share of faith-inspired providers is substantial (in Burundi and Ghana especially), and other countries where that market share is much smaller. Thus, while it cannot be claimed here that the results are necessarily representative of sub-Saharan Africa as a whole, they are nevertheless representative of a diverse set of countries.

Table 2: Selected countries with household surveys identifying FIIs

Country (survey name)	Year of implementation	Country (survey name)	Year of implementation
Burundi (QUIBB)	2006	Niger (QUIBB)	2005
Ghana (CWIQ)	2003	Republic of Congo (QUIBB)	2005
Mali (QUIBB)	2006	Senegal (ESPS)	2005-06

Source: Compiled by the authors.

In table 3, data are provided as to the satisfaction of users with the services received in the six countries nationally, as well as for urban and rural areas and by quintiles of well-being, with each quintile accounting for twenty percent of the population, from the poorest to the richest.[2] In some of the countries, NGOs are included in the same category as faith-inspired providers. The two categories are aggregated in table 3, but the market share of NGOs is significantly smaller than that of faith-inspired providers, so that the category represents for the most part these faith-inspired providers. Although poverty estimates vary between countries, in most countries the bottom two or three quintiles can be considered as representing the poor.

The evidence from the six countries suggests that FIIs do appear to enjoy higher satisfaction rates than public facilities. Looking at the population as a whole, the satisfaction rate among faith-inspired providers is five percentage points above that of public providers in Burundi and Niger, while it is higher by 15 points in Mali, and more than twenty points in Senegal and the Republic of Congo. Only in Ghana is the national satisfaction rate comparable for faith-inspired and public facilities. In many of the countries, faith-inspired providers also do better than other private providers, although the differences tend to be smaller. In some of the countries, the differences in satisfaction rates are larger for the poor, suggesting that faith-inspired facilities may make special efforts to provide better quality services to the poor (we return to this below when

[2] The quintiles are based on measures of consumption per capita or per equivalent adult normalized by poverty lines accounting for differences in cost of living between areas within a country, in order to ensure consistency with poverty measurement techniques.

discussing the reasons for non-satisfaction in each country). Also, in several countries, satisfaction rates are higher in urban than in rural areas, and tend to increase with the quintile of well-being of households. This is not surprising given that urban dwellers and households who are better off tend to have more and better options for care than the rural poor.

Table 3: Satisfaction rates with the services received, selected countries (%)

	Residence Area		Welfare quintile					All
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
				Burundi 2006				
Public	46.6	37.8	36.8	35.5	37.5	35.1	44.0	38.0
Faith-inspired	47.4	43.0	46.6	43.7	34.6	48.1	42.6	43.2
Other private	47.7	39.3	34.9	41.8	43.3	35.9	43.2	40.0
Total	47.2	38.6	37.7	37.7	38.3	36.6	43.7	39.0
				Ghana 2003				
Public	73.4	73.2	70.6	75.7	75.0	73.0	72.1	73.3
Faith-inspired	73.1	72.9	67.2	76.0	74.3	73.0	74.4	72.9
Other private	83.2	83.8	83.2	85.7	84.3	82.5	82.3	83.5
Total	78.5	78.9	77.2	81.0	79.9	78.0	77.8	78.7
				Senegal 2005				
Public	71.1	57.8	67.1	65.8	58.5	63.2	65.9	64.0
Faith-inspired	86.9	86.6	92.8	86.2	79.3	85.9	90.9	86.8
Other private	71.9	66.1	66.7	64.1	65.4	70.9	74.0	69.2
Total	71.8	61.0	67.7	65.6	61.0	66.3	69.2	66.2
				Republic of Congo 2005				
Public	68.0	62.1	69.6	68.0	60.6	63.3	67.3	65.7
Faith-inspired	89.5	91.3	80.6	100.0*	79.2*	89.4*	100.0*	90.0
Other private	87.1	85.7	85.4	83.8	88.4	87.7	86.8	86.5
Total	78.4	75.4	78.3	77.1	74.6	77.1	78.5	77.2
				Niger 2007				
Public	90.7	91.8	93	96.1	91.7	92.3	87.6	91.5
Faith-inspired	91.9	97.3*	97.3*	100.0*	100.0*	98.6*	76.2*	96.1
Other private	92.7	93	96.5	93.2	93.5	89.5	93.1	93
Total	91.2	92.5	94.6	94.5	92.9	91.1	90.1	92.3
				Mali 2006				
Public	67.7	60.8	55.1	63.5	60.4	65.9	67.3	63.7
Faith-inspired	45.6*	85.0	53.6*	100.0*	100.0*	85.2*	0.0*	78.7
Other private	75.6	78.7	84.2	82.0	76.7	66.8	76.7	77.2
Total	70.2	66.1	67.2	69.3	65.1	66.4	70.3	67.8

Source: Authors' estimations using household surveys.
Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

On the basis of the reasons declared by households for not being satisfied, it can also be shown that in all countries, the fact that the cost of service was perceived as too expensive is the main reason for lack of satisfaction (we discuss the results on cost in the section immediately below). After cost, the second main reason for non-satisfaction is long waiting time, again in virtually all countries. This was an issue for 11.5 percent of patients in Burundi, 11.2 percent in Mali, 10.5 percent in Senegal, 8.2 percent in the Republic of Congo, and 3.9 percent of patients in Ghana (in that country, the complaint ranks third after unsuccessful treatment). On this issue, FIIs do not seem to have a

demonstrable comparative advantage. In some countries, complaints about long waiting times are higher among faith-inspired facilities than among public facilities, but in other countries, the reverse is observed. As for the other reasons why some households declare being unsatisfied, sample sizes among faith-inspired facilities are often too small to be able to make a valid comparison with public facilities.

COST, QUALITY, AND PATIENT SATISFACTION

Based on the household surveys outlined above, additional analysis suggests that for all countries, cost of service (as too expensive) was perceived as the main reason for lack of satisfaction with health services received. Cost is mentioned as an issue for 37.9 percent of patients in Burundi, 18.0 percent in Senegal, 13.1 percent in Mali, 11.4 percent of patients in Ghana, and 10.4 percent in the Republic of Congo. In Mali and Burundi, but not in the other three countries, cost is also mentioned more by households in the bottom quintiles of well-being than by household in the top quintiles, which makes sense.

What is striking, though, is the fact that in four of the five countries, cost is mentioned as being less of an issue for faith-inspired facilities than for public facilities. In the Republic of Congo, 14.6 percent of patients in public facilities declare that cost is an issue, versus 6.5 percent in faith-inspired facilities. In Burundi, the two corresponding figures are 37.9 percent for public facilities, versus 30.6 percent for faith-inspired facilities. In Mali, the comparison is 16.9 percent to 6.0 percent. Finally in Senegal 19.6 percent of users of public facilities complain about cost, versus only 2.9 percent in faith-inspired facilities. For Ghana by contrast, the proportion of users who complain about cost is similar in both types of facilities (it is actually slightly higher in faith-inspired facilities at 14.4 percent versus 13.2 percent in public facilities), but this is also the country where there are no substantial differences in overall satisfaction rates between public and faith-inspired providers. Thus, the evidence is strong that lower cost – probably through efforts to make care affordable for the poor – plays a key role in the higher satisfaction rates obtained by faith-inspired facilities (this was also found in qualitative work for Burkina Faso; see Gemignani and Wodon 2012). Note that in three of the five countries, complaints about cost were higher in other private facilities than in the faith-inspired sub-sector. The comparison with private facilities is however more problematic because more households going to private facilities may have formal insurance systems that reduce out of pocket costs.

In the broader literature reviewed, cost appears frequently as a key issue impacting on relative patient satisfaction and user preference.[3] There is some difference, however, between studies which note that patients are more satisfied with FIIs *because of lower patient costs*, and those that note that patients are more satisfied *despite higher patient costs*. As noted above in the introduction, the latter explanation is certainly prominent at the discussion level about the perceived comparative advantages of FIIs, although in our

[3] Mliga (2003) provides an interesting comparison between government, Catholic, Lutheran and SDA providers in relation to cost and satisfaction, which we do not unpack here, but does hint at significant variation between cost, satisfaction and perceived value for money.

data set for the six countries, the first explanation may well dominate. Still, the question of whether some households may prefer faith-inspired facilities despite higher cost is indeed interesting. There are certainly many such observations. For example, in Uganda during a discussion on the comparative quality and satisfaction with FIIs, a representative of the WHO noted that *"…in many cases clients expressed their 'vote' for PNFP services by making use of them despite their cost and even when there was a public facility 'less than 100m away'"* (stakeholder participant in Schmid et al 2008). Based on data from the 1993/94, 1995/96, and 1996/97 national household and community surveys in Uganda, Hutchinson (2001) found that both the poor and the nonpoor tend to prefer curative care from nongovernmental organizations (NGOs – mainly FIIs in Uganda) and private providers, even over less expensive government care, and even though government health units outnumbered all other providers roughly two and a half to one. Hutchinson (2001) notes that "*price, distance and government ownership all decrease the likelihood that the nearest modem facility will be used for curative care when ill…The result for government ownership supports the data presented earlier that individuals prefer private and NGO health care providers over government providers.*"

Indeed, most of the studies in table 1 (with one exception) indicate that even in cases where FIIs cost more to the patient than public services (which is frequent) – they are still preferred with higher patient satisfaction rates. For example, Levin et al (2003) compare costs of maternal health services Ghana, Uganda and Malawi, and find that in all three countries, "…*the six mission facilities generally score higher on process indicators and client satisfaction than did the six public facilities…*" – with both structural and process quality indicators generally better at the mission hospital than at the public hospital in all three countries. In addition, while there was no major difference between public and faith-inspired hospitals in the availability of drugs and equipment, for health centers, FIIs had better equipment in two out of the three countries, and clients were more likely to have received prescribed drugs at FIIs than public facilities. However, at these same health centers, in both Malawi and Ghana, the cost of cost of maternal health services was 30 percent higher at mission- than public health centers. The authors concluded that this higher cost was likely because more labor time and materials were used in service provision – therefore relating to higher quality and also satisfaction. That is, the mission hospitals in all three countries had more appropriate staffing for the number of maternal health services that they provided, and in the mission health centers used more materials than in public health centers. Therefore, although the studies noted that FIIs had many of the same inefficiencies as public facilities (such as underutilization of services), FIIs in this sample provided maternal health services at the same or better level of quality than public facilities, with costs that were slightly higher in health centers (but often lower in hospitals) – but with generally higher levels of satisfaction.

Bazant and Koenig (2009) quantify women's satisfaction with delivery care in informal settlements of Nairobi, Kenya. Of the 1,266 women who delivered in health facilities (2004/2005), 63 percent gave birth in a nearby private facility, 31 percent in a public hospital, 2 percent in a public health center, 4 percent in a mission hospital located 20km away. The women's delivery care expenditures were by far the highest at the mission hospital (KSh.5100 versus the KSh.1100 at private facilities, KSh.1800 at government

hospitals, or KSh.800 at government health centers – with US$15 at 74 KSh./US$1). However, the mission hospital received the highest satisfaction ratings (then private, then government hospitals, which had the highest dissatisfaction levels). Bazant and Koenig et al (2009) conclude that this higher satisfaction with the mission facility most likely reflects the high-cost provision of care that was affordable to fewer women.

The studies in table 1 also frequently note a higher availability of medicines in the same FIIs which receive higher satisfaction rates. In Tanzania, Mliga (2003) found that clients visiting public facilities did not receive the medicines that were prescribed to them: "*Church health facilities seem to have been better stocked with medicines than government facilities. Clients experienced the least difficulties in getting medicines at Lutheran facilities, then Roman Catholic followed by Seventh Day Adventists.*" In Senegal, Bitran (1995) found that while fees per patient were similar between public and Catholic health posts, the latter had higher drug availability (fewer stockouts of drugs, equipment and supplies, see also Wouter 1994). Bitran notes that while patient fees were similar, the Catholic health posts had higher staff costs (because they used more qualified doctors), and higher drug costs per patient – but also the highest labor productivity (visits per health worker per day). Bitran concludes that Catholic facilities provided higher quality health care than the public sector while supplying services to patients of similar social and economic status.

Of course, we cannot expand on this too far – as many FIIs in Africa have noticeable difficulties stocking and supplying medicines (see Gilson et al 1994). However, in the studies that are available, the higher patient satisfaction often appears to be linked to better availability of drugs/medicines. Some authors note that this may relate to the fact that some health seekers feel that the prescription of drugs is necessary for treatment – that is, satisfaction is directly related to whether drugs were received (or a prescribing doctor was available) – and that a consultation without prescribed drugs might be viewed as a waste of time. For example, Nshakira et al (1996) conclude that many users will choose a health facility where they expect to find drugs all the time, such as private clinics. Levin et al (1999) make a similar observation – when finding that the two mission health facilities studied in Uganda had more drugs available and perform more lab tests than the public health facilities. Only about half of the clients at the public facilities said that they had received prescribed drugs at the public facilities, while all mission clients said they had received the drugs prescribed for them. The mission facilities here tended to have significantly higher costs to patients – and also higher satisfaction *"…(with) client satisfaction higher in the mission hospital and health center. Clients at the mission health center rate all aspects of their visit in the highest category. This may be related to the presence of a doctor, and perceptions that care from a doctor and more availability of drugs are preferable to care from a midwife or nurse."* Levin et al (1999) also note that this may be related to the fact that patients accord higher value to the services received *because* of the higher fees.

Given the limited evidence, we are not able to go too much further in unravelling the bundle that is comparative quality and satisfaction with FII's services, and our understanding of how frequently reported higher comparative satisfaction with FIIs may

relate to other aspects of quality care (such as cost, the availability of medicines and the like) is at best partial. There is, however, one further aspect which is raised repeatedly in the limited literature – and that is how patient satisfaction might possibly be tied to staffing and the nature of the relationship between patients and staff, and the care they provide - especially where staff and their provision of care are said to be intrinsically religious in nature or motivation.

COURTESY, TRUST AND PATIENT-CENTEREDNESS

There is another aspect widely described as a comparative value of FIIs which impacts on patient satisfaction – which is much harder to understand or quantify. That is the internal 'intangible' religious values specific to FIIs which might impact on the quality of care, and therefore on patient satisfaction.[4] While not speaking about FIIs or religion, Abiodun (2010) has noted that while studies have documented the importance of tangible elements of health care service, *"…customers' satisfaction derived from their perception of quality of service may be derived from their assessment of the intangible elements associated with the interaction between the customers and the health personnel during care. These intangible elements include such aspects as responsiveness, courtesy, competence, and access and availability of physicians and other hospital staff…Other process characteristics…included care givers' expressions of empathy…communication and interpersonal aspects of health caring have been found to rank most in importance to health care customers…"* The available literature strongly suggests that FIIs might be achieving the suggested higher satisfaction as a result of such 'intangible' elements of satisfaction.

Courtesy is an increasingly important concern. Bratton's (2007) Afrobarometer respondents counted lack of respect just as highly as long waiting times, high fees or shortage of medicines as reasons for not choosing a particular facility. In their study on the TB services in Uganda, Babikako et al (2011) note the strikingly higher levels of satisfaction in private (Protestant) hospital relative to the public facility. They note that the public facility got significantly lower scores on patient responsiveness – and suggest that the private FIIs *"may be more patient-centered compared to public institutions thus generating high satisfaction levels.*" In an assessment of the Ghana health sector by the World Bank, Makinen et al (2011), utilize GLSS4&5 household surveys and support this with community focus groups in Ghana. While they did not find significant differences between provider types in relation to patient satisfaction (there was a generally high level of satisfaction seen everywhere), consumers noted "*more courteous services is a distinguishing feature of CHAG (Christian Health Association of Ghana) providers."* A similar result was obtained in Ghana by Sojo et al (2012).

Of course, issues of respect, courtesy, empathy or patient-centeredness are not unique to FIIs, and are concerns for health care more generally. What is critical is to know whether such 'intangibles' can be understood as they operate in FIIs in a systematic manner – that

[4] See Schmid et al (2008) for discussion on what these 'intangible religious health assets' might be and how they might operate.

is, as a systematic characteristic of FIIs. Significant work has been done on the importance of 'trust' in health systems (see Gilson et al 2005). Gilson and colleagues have noted the importance of trust at an interpersonal level, influencing patient judgments about provider attributes and their technical competence, "*…judgments (that) are influenced by whether providers are rude or courteous, demand bribes or not, treat some people preferentially over others, listen to the patient's explanation of their complaint or give the patient too little time"* (Gilson 2005). However, Gilson continues and notes that *"…building a trustworthy health system is not simply about training providers to listen and talk empathetically to patients. Much more importantly, it requires the development of institutions that demonstrate the norms of truthfulness, solidarity and fairness—and that influence the range of actors (patients, providers, managers, insurers, etc.) linked through a health system."* Unfortunately, at this time to our knowledge, there has not yet been substantial work on whether there are characteristic system-wide or institutional characteristics in FIIs that result in higher patient satisfaction levels or quality, and this is another area which could benefit from urgent attention.

The issue of 'intangible' issues relating to satisfaction can be approached from other angles. For example, it has been suggested that faith-inspired staff are differently motivated to provide high quality care. Considering health worker motivation in Ghana, Lievens et al (2011) note that while basic salaries are the same in NGOs (which are mainly FIIs) as in the public sector, allowances are more common: "*Health workers usually live on the premises of the facility and have a comparatively heavy workload. Performance expectations are high, and supervision and workplace norms are strict. Health workers are unanimous that workers in the NGO sector are the most committed ones and are very patient-centered. The quality of care is judged higher in NGO facilities by both users and health workers. Waiting times are generally shorter and staff is less absent. The quality of care is generally judged higher in NGO facilities, by both users and health workers. Transport for outreach activities is often available; staff is competent, has a positive attitude and is respectful towards patients. Waiting times are generally shorter, and staff is less absent.*" As one rural service seeker in this study said, *"I prefer to go to the mission hospital because the nurses in the public hospital in this area abuse me whenever I visit the facility. When you go to a mission hospital the nurses are fine and don't abuse you. They also still attend to patients when nurses or doctors are on strike."*

Of course, higher workloads tend to impact negatively on courtesy – as one senior nurse in the Lievens et al (2011) study noted when she moved from a mission facility to a public facility that the staff there were less respectful: "*But later when I also worked there for some time I learned to appreciate their behavior. The workload was so high."* However, in contrast, another senior nurse noted, "*I know one nurse who works at the mission hospital, she arrives in the morning and sometimes stops at 9pm, and the following morning she is there again*." This sentiment that health workers in FIIs are motivated to work harder, even in hardship areas is strong. Reinekka and Svensson (2010) have argued that in Uganda, there was an altruistic effect to be found in FIIs which motivated staff to work longer for less pay. Serneels et al (2010) looking at health worker motivations to work in rural areas in Rwanda and Ethiopia find that health

workers with higher intrinsic motivation (measured as the importance attached to helping the poor), religious affiliation, and if they had grown up in a rural area - were significantly more willing to work in rural areas. The religious affiliation was demonstrated though a local bonding scheme operated by the Adventist community in Rwanda, and training that encourages rural service by a Catholic NGO in Ethiopia. *"Among these results, the effect of motivation stands out as a particularly strong and robust finding…the results on religious affiliation underline the important role of faith-based institutions in the health sector in Sub-Sahara Africa, and both the Rwanda and Ethiopia cases offer examples to inspire future policymaking. Of these three factors that affect health workers' willingness to work in a rural area, rural background is the more tangible, while the role of intrinsic motivation, and the context specific role of faith-based institutions, deserve more attention in future analytical work."*

Comparing health worker motivations in Uganda, Luboga et al (2011) note that a good working environment is more important than the level of health worker compensation. As one participant stated: *"Actually people are not looking for money when they go away (migrate), they are looking for good working environment…Take an example, people are working in mission hospitals, when you want to do a surgery, things to be done are there, when you have done your good surgery the nurses will follow up the patients very well and you become satisfied that the patients have recovered, you have come to a diagnosis with the all things that are required and you treat the patients and they recover very well. And those people are there not because they are given a lot of money - the health staff in mission hospitals is given half the pay of the nurse in public units - but they are there because the environment is good*."

There are again many unanswered questions about faith-inspired health systems: how quality of care and patient satisfaction emerges from the staff motivation and inter-personal care, or how the working environment (and institutional characteristics) affects the staff and the patients. Speaking broadly, it is often suggested that staff in FIIs tend to be more courteous, more patient-centered, and more respectful – even if they are working longer hours for less pay than in public facilities. However these are all more in the nature of tantalizing hints at some comparative differences than strong conclusions about either operational differences, or how the internal values or 'intangibles' potentially impact on satisfaction and quality – none of which can be proven here.

Finally, there is one related question to address, and that is whether our current methods of evaluating quality and satisfaction are adequately designed to pick up on internal or intangible factors that are *religious* in nature – which may provide some causal link between these elements of perceptions of satisfaction and quality of care. Qualitative studies tend to pick up on this issue more easily. For example, in an evaluation study of the Moravian-affiliated Masangane HIV/AIDS program in rural South Africa, health-seekers described a perceived satisfaction and higher quality of care at this FII (as opposed to the public provision of ART). While describing standard measures of good quality, health-seekers also described the greater credibility of the program by virtue of its affiliation with the Moravian church (for example, less corruption). In addition,

health-seekers described the actual ART as enhanced due to the way it had been integrated with the Moravian daily devotional practices (Thomas et al 2006).

Similarly, in an HIV/AIDS mapping study in Zambia and Lesotho (ARHAP 2006), community health-seekers were asked to rank (through participatory processes) the various health providers in their communities. In all communities, FIIs were consistently ranked higher, based on a number of different perceived quality aspects. For example, in Chipata, Zambia, despite the general hospital being more central, all participants preferred Mwami Seventh Day Adventist and St Francis hospitals to Chipata General Hospital. This was attributed to a combination of better facilities and better care, relating to staff having a greater purpose in their work. As one community member said, "*People prefer to go to the SDA hospital, rather than the general hospital because the facilities are better. There is excellent care there as well. The personnel give encouragement and pray for you, and that will give you more confidence and encouragement that you will get well there…that doesn't happen at the general hospital, nobody will pray for you there."* In the regional workshops, which included the public and private providers, one of the participants noted, *"…some of the people die (at Chipata General) because of lack of attention. There is also negligence at the general hospital, the nurses are just there for a career, they have no heart for the patient…"* (participant, Chipata Regional, 2006).

In fact, in all the community focus group workshops in this study, the most significant factor that was consistently attributed to the preference for and satisfaction with FIIs – was framed in religious terms: as the readiness to 'pray with' or tendency to provide 'compassionate care'. In Livingstone, Zambia, community health seekers argued that compassionate care was the main difference between faith-inspired and government hospitals. *"The difference is that the care done by church organizations is done with care, compassion and love, with encouragement - but in government hospitals, people just do it for money - no compassion, love or care"* and *"In government hospitals, people are treated professional, without emotional attachment, but religious organizations treat the person as an individual, they provide more quality care"* (participants, Zambia, 2006).

And in a different study, also in Zambia, key informants and focus group participants (including government and NGO stakeholders) focus group discussions showed a general perception that people preferred to go to FIIs because of a better quality of care in FIIs in Zambia, which was noted as being deeply rooted in religious aspects integrated into the care. As one participant said, *"…many people have a need for prayer, spiritual care to be part of the treatment they receive; coming to a mission hospital that will be provided…This gives a sense of security as they undergo their procedure, a feeling that they are experiencing this in God's presence*." It is therefore interesting to note that while there are several large scale studies in countries such as the USA on how religiously-infused health care impacts on patient satisfaction (see Williams et al 2011), there is barely any of that kind of research conducted in the African context – a context where religion is more frequently counted as a core part of the patients' everyday life and experience.

Again, it is dangerous to push some of these issues too far – especially if they are portrayed as only relating to FIIs. There are certainly motivated (and religiously motivated) staff working in public and private-for-profit facilities. As one community participant, who happened to be a nurse in a public hospital, exclaimed during the ARHAP (2006) study: *"we also pray with our patients!"* However, qualitative observations about the comparative differences of the compassionate care provided at FIIs are made repeatedly, and it certainly would be important to understand if and how such intangibles impact on healthcare provision at a systematic level. For example, whether there are patterns of religiously infused care that impact on patient satisfaction (even in strained African health systems); whether a holistic approach to healing is encouraged in FII facility environments therefore impacting on perceptions of satisfaction; or whether a religious mandate to serve the poor might impact on quality of services to the poor. Such questions, of whether FIIs have a comparatively higher satisfaction as a result of a specific kind of *religious* characteristic (e.g. that is different to other PNFPs), remain elusive. While health seekers continue to be vocal about these differences in qualitative studies, our current methods and measures of quality and satisfaction are not entirely adequate to pick up on whether there might be some faith-inspired intangible link between perceived higher quality and more technical and structural quality measures.

CONCLUSION

There are a number of related issues we have not been able to adequately address here. For example, whether there are satisfaction differences between rural and urban health services – an important concern for FIIs who are often perceived to be particularly important in rural and hardship areas. We have also mainly (inadvertently) addressed Christian FIIs here, simply because there are few studies which address Muslim or other providers in any sort of comparative way. There are only some hints available that Muslim providers might enjoy some of the same high levels of satisfaction. For example, in a descriptive report on FII child and maternal health, Chand and Patterson (2007) note a high satisfaction with Kibuli Hospital, an urban health unit under the Uganda Muslim Medical Bureau. *"The hospital has a high patient load from the surrounding Muslim population…The City Council Health Division awarded Kibuli Hospital 'Best Performer of the Year 2004/2005' for cleanliness, outreach and community services leading to reduced maternal mortality. The maternal mortality rates at this facility are lower than those of public health facilities nationwide."* Gemignani and Wodon (2012) in Burkina Faso, as well as Shojo et al (2012) in Ghana also find evidence towards higher levels of satisfaction in Islamic than in public facilities, much in the same way as what is observed with Christian facilities. We also do not adequately address the wider range of health-engaged FIIs, focusing here mainly on formal health facilities. There are several studies which point to higher satisfaction and user preference with other kinds of providers, for example 'faith clinics' working as birth attendants in Nigeria with a religious character (Adetunji 1992).

Still, having trawled through a number of different studies and teased out some aspects relating to comparative perceptions of satisfaction with faith-inspired health provider

services and care, triangulated, the evidence points in a clear direction. Based on these studies, and the results of the national surveys we have added here, there are strong indications that patients and health-seekers are still showing strong satisfaction with and preference for faith-inspired health facilities in Africa. Although the evidence is still patchy – and certainly requires a substantial amount of work before any policy-level action can be taken – there is enough in these studies to suggest that these perceptions of higher satisfaction are not a nostalgic hang-over for mission-based health services of the past. The perceptions are too strong and consistent for that, and nostalgia is not enough to make people in dire circumstances carry friends and family past (often) cheaper government facilities. There is a lot left to be understood about what faith-inspired health providers are, how they operate, and what internal values and characteristics they might have that make them different to other private providers, but there is a strong case to be made that something different is going on which urgently needs closer consideration.

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