Making quality care available for the poor: faith-inspired health facilities in Burkina Faso

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MAKING QUALITY CARE AFFORDABLE FOR THE POOR: FAITH-INSPIRED HEALTH FACILITIES IN BURKINA FASO

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Based on the results of qualitative fieldwork conducted in 2010 in Burkina Faso, this paper suggests that a key reason for individuals to seek care in faith-inspired health facilities is the fact that the cost of care is lower than in public facilities (the other reason being that faith-inspired facilities appear to provide better quality of care). Yet faith-inspired facilities receive only limited support from the state to provide their services. The ability of the facilities to make quality care affordable for the poor is maintained thanks to support in kind and in cash from religious groups and other donors. This model contributes substantially to the availability of affordable quality care in the communities where the facilities are located, but higher state support for the facilities would help for expansion.

INTRODUCTION

Faith-inspired institutions (FIIs) play an important role in improving health care in many African countries through the delivery of facility-based care, training of the health workforce, involvement in community-based activities, and participation in health promotion campaigns. FIIs represent a wide array of faiths and diverse motivations and goals. While a number of factors shape the approaches taken by FIIs in planning their activities, an often expressed priority is to serve the poor for whom care often remains unaffordable. Many faith-based providers also aim to provide preventive and/or curative care to those who are at a disadvantage or marginalized (see for example Wodon 2013).

In the case of Burkina Faso, significant progress has been achieved to facilitate access to care, among others the construction of new facilities, vaccination campaigns, and the reduction or elimination of selected fees. As a result, many health statistics such as the rate of assisted childbirth, the use of health services, vaccination, and infant mortality have improved (WHO 2009, USAID 2009). Nevertheless, available household survey data suggest that apart from cases when an individual does not seek care because there is no need for it, or self-medicates when ill or sick, the main reason for not seeking care is cost. Our estimates presented in this paper suggest that care remains too expensive, and is cited in national surveys by one third of those not seeking care when in need. Pokhrel (2010) also provides empirical evidence on the barrier to care that cost represents using data from Nouna Health District, confirming previous results obtained by Baltussen et al (2002), suggesting that high costs of healthcare play a central role in lowering patient

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satisfaction with services. In addition, due to gender inequities in access to household resources, women are often at a disadvantage in respect to healthcare utilization (Faye 2008, Hampshire 2009). Nikiema et al (2007) describe the burden on women in Burkina Faso who are faced with negotiating access to healthcare despite their limited bargaining power.

To the extent that FIIs pay special attention to making care affordable for the poor, they may help in facilitating access to care, including for women. There are comparatively fewer FIIs involved in health care in Burkina Faso than in other countries (WHO identified 60 faith-inspired facilities in the country), but these facilities may play a very important role in the communities they serve. Based on the results of qualitative fieldwork conducted in six facilities in 2010, this paper suggests that indeed a key reason for individuals to seek care in faith-inspired health facilities in Burkina Faso is the fact that the cost of care is lower than in public facilities (the other reason being that faith-inspired facilities appear to provide better quality of care).

But how do faith-inspired facilities do it? While most faith-inspired facilities in Burkina Faso operate independently from the government, they are integrated within the national health system. This means that they receive various forms of support, in material resources (such as vaccines and mosquito nets) as well as human resources (e.g. training of personnel and salaries for a limited number of government health workers). They are also subject to quarterly inspections from district health officials. Nevertheless, faith-inspired facilities tend to receive only limited core support from the state to provide their services. The ability of the facilities to make quality care affordable for the poor must thus be maintained thanks to support in kind and in cash from other sources, such as religious groups and donors. Apart from documenting why faith-inspired facilities tend to be the preferred choice of provider among households living in areas where the facilities are located, the second objective of the paper is to discuss how the facilities, while receiving limited support from the state, do manage to make care more affordable.

The paper is structured as follows. In order to provide context, section two summarizes findings from an analysis (including both statistics and regression analysis) of a nationally representative 2007 survey showing that cost is indeed a major obstacle to care, especially for the poor. Section three presents results from in-depth qualitative research conducted between April and July 2010 in six (two Protestant, two Islamic, and two Catholic) health facilities showing that households indeed value these facilities especially because of their ability to provide affordable care. Section four then provides administrative data from the facilities in terms of costs, budgets, and population served to show that support from religious groups as well as donors is key for the ability of the facilities to provide affordable care. Section five discusses some aspects of the collaboration between the facilities and the state. A conclusion follows.

QUANTITATIVE DATA AND ANALYSIS

To what extent is cost a major factor reducing the demand for care in Burkina Faso? To answer this question, it is best to start with data from the nationally representative 2007 extended QUIBB (in French: 'Questionnaire Unifié des Indicateurs de Base du Bien-être') survey. This is the main multi-purpose household used in Burkina Faso for analyzing household well-being. While the survey unfortunately does not identify separately faith-inspired health care providers (nor do the Demographic and Health Surveys), it still provides useful information in its health module. Here, we are interested in cost as a barrier to the demand for care in the population.

Table 1 provides the share of the population who sought treatment for illnesses or injuries. Among those who were ill or injured in the past 15 days, 62.4 percent consulted with a health service provider of some type (broadly defined, including traditional healers), but the proportion was only 53.1 percent in the lowest quintile of well-being (as measured through an index of wealth based on the assets owned by households), 70.7 percent in the highest quintile. A large majority of those in the wealthiest group (62.5 percent) did not seek health services because they chose instead to self-medicate, and that was also the main reason for the poor not to get a consultation, although for a lower share of the population in that group (53.8 percent). But the second most important reason for not seeking care was cost, for more than a third of the population overall, but less so in the top quintile. Other reasons for not seeking care included the fact that it was perceived as not necessary (16.5 percent of those not seeking care), or the fact that the facility was too far away (8.0 percent of those not seeking care). As suggested by these data, cost is a major obstacle to care, especially for the poorest groups.

Table 1: Decision to seek care and reasons for not using health services, 2007 (%)

	Sex		Residence		Well-being - Quintiles					All
	Male	Female	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Share seeking care										
All	5.9	6.6	9.3	5.6	4.4	5.1	6.1	6.6	9.1	6.2
Population ill or sick	62.9	62.0	65.4	61.4	53.1	56.6	61.2	65.9	70.7	62.4
Reasons for no care										
Not necessary	17.9	15.8	16.0	17.0	18.8	16.1	12.2	21.0	16.0	16.8
Self-medication	56.4	54.7	61.7	53.7	53.8	56.4	54.7	49.9	62.5	55.5
Too expensive	32.0	34.9	29.0	34.9	35.4	37.3	38.3	34.8	21.7	33.5
Too far	9.4	6.9	0.5	10.2	14.1	9.0	5.4	10.0	1.2	8.0
Other reason	0.7	2.5	0.8	1.9	2.1	0.6	1.3	0.5	3.9	1.7

Source: Authors' estimates using 2007 QUIBB survey.

Another way to look at the data is to conduct regression analysis, and see which characteristics of households and individuals are correlated with the decision to seek care. This is done in table 2 through standard probit regressions, and we are reporting marginal effects (as opposed to coefficient estimates) for ease of interpretation. Given our focus in this paper on care provided in health facilities, we consider the demand for 'formal' health care when sick or ill, which thus excludes traditional healers. The analysis is done for the full sample at the national level, as well as for urban and rural areas separately, and for men and women also separately.

The first variable in the regression is the primary sampling unit leave-out-mean consultation rate when ill or sick. This is the share of those in a specific geographic area that are consulting when ill or sick, with the share computed on all individuals living in that small geographic area except the individual himself/herself. This variable captures a wide range of factors which are not observed in the survey, such as cultural attitudes towards facilities-based care, as well as the quality level of the care that is provided, since these influence the extent to which individuals in an area will seek care. As expected, the impact of that variable is positive, large, and statistically significant, with a value of one (indicating all other patients in an area apart from the individual seeking care when ill or sick) increasing the probability of seeking care for the individual by close to 40 percent in most cases. Next comes the quintiles of well-being of the households to which individuals belong. As was already apparent in the basic statistics presented in table 1, those in the wealthiest quintiles have a higher probability of seeking care, although the differences between the first four quintiles are in most case not statistically significant, perhaps because with about half of its population in poverty, and a substantial additional segment of the population at risk of falling into poverty, most of the individuals in the bottom three or four quintiles tend to have limited means to pay for care, and not only the poorest of the poor.

There are also substantial differences in the likelihood of seeking care according to location in terms of regions, although not according to whether the household lives in rural or urban areas once one controls for regional location as well as for the distance to facility. The impact of the distance to the nearest health facility becomes statistically significant especially when the nearest facility is located at more than an hour away from where the household resides, in which case the likelihood of seeking care is reduced by approximately 15 percentage points in most cases (For research on geographical accessibility to care and its relationship to child mortality in Burkina Faso, see Schoeps 2010).

As for the characteristics of the household head, and those of the individual who has fallen ill or sick, two main results emerge. First, there is some evidence that the likelihood of seeking care is lower when the household head is female, which may suggest a higher level of vulnerability for these households which limits their ability to pay for care (our quintiles of wealth are an imperfect measure to assess the vulnerability of many households since this is a stock variable, while shocks such as loss in incomes or other revenues may also affect the demand for care, and may be more likely to affect especially female headed households in a country such as Burkina Faso given that the absence of a male head suggests fewer potential earners in the household). In addition, the younger the child, the less likely that a visit to the health centers or health professional will be sought, possibly because small children fall sick more easily, with many episodes of such illness likely to be benign and not necessarily requiring a visit to a professional.

Table 2: Correlates of decision to seek formal care in past 15 days when ill or sick

	National	Urban	Rural	Male	Female
	dF/dx	dF/dx	dF/dx	dF/dx	dF/dx
PSU LoM consultation rate	0.3963***	0.1933	0.3965***	0.4500***	0.3802***
Quintile of well-being					
Poorest (Q1)	Ref.	Ref.	Ref.	Ref.	Ref.
Q2	-0.0699	0.0592	-0.0780	-0.1007	-0.0256
Q3	0.0040	-	0.0270	0.0081	-0.0156
Q4	0.0765	0.1393**	0.0734	0.0620	0.0747
Richest (Q5)	0.1019*	0.1997***	0.0804	0.0187	0.1744**
Region and location					
HB	Ref.	Ref.	Ref.	Ref.	Ref.
BM	0.0923	0.0298	0.1955***	0.0654	0.1164
SH	0.1495**	0.0984	0.2513***	0.0931	0.2031**
East	0.0135	-0.1107	0.1370*	-0.0373	0.0858
SO	0.1339**	-	0.2398***	0.0719	0.2166***
CN	0.1545**	0.1867**	0.2477***	0.1909**	0.0885
CO	0.1755***	0.0220	0.3039***	0.1141	0.2485***
PCL	0.0411	-	0.1669**	0.0077	0.0885
Nord	0.1505**	0.0073	0.2590***	0.0835	0.2047**
CE	0.2143***	0.0134	0.3557***	0.2054***	0.2395***
Centre	0.1001*	-0.0470	0.3563***	0.0732	0.1590**
Cas	0.0128	0.0602	0.0657	-0.1630	0.1735
CS	0.1490**	-	0.2578***	0.1050	0.2188**
Urban location	0.0632	-	-	0.0950	0.0579
Characteristics of head					
Age	-0.0030	0.0133	-0.0098	-0.0125*	0.0075
Age squared	0.0000	-0.0001*	0.0001	0.0001	-0.0001
Female	-0.0916*	0.0608	-0.1858***	-0.1834**	-0.0393
No education	Ref.	Ref.	Ref.	Ref.	Ref.
Primary education	0.0189	-0.0453	0.0707	0.0502	0.0125
Secondary education	0.0605	0.0345	0.0549	0.0315	0.0741
Higher education	-0.0150	-0.0094	-	0.1127	-0.1230
Characteristics of individual					
Age	-0.0692***	-0.0762***	-0.0660***	-0.0718***	-0.0671***
Age squared	0.0042***	0.0045***	0.0040***	0.0040***	0.0044***
Female	-0.0274	-0.0340	-0.0105	-	-
Handicapped	-0.0712	-0.3041	0.0382	-0.4291***	0.1848
Below 16 and orphan	-0.0916	-0.0374	-0.1341	-0.0557	-0.1626*
Time to nearest facility					
0-14 minutes	Ref.	Ref.	Ref.	Ref.	Ref.
15-29 minutes	-0.0964**	-0.1004*	-0.1027*	-0.0631	-0.1118*
30-44 minutes	-0.0355	-0.0013	-0.0506	-0.0046	-0.0324
45-59 minutes	0.0015	-0.0926	0.0200	-0.0808	0.1049
60 minutes or more	-0.1582***	-0.1788	-0.1529***	-0.1687***	-0.1181*
Number of observations	1505	467	1034	784	721

Source: Authors' estimation. Probit estimation reporting marginal effects.
Note: Levels of statistical significance: *** p<0.01, ** p<0.05, * p<0.1.

What can be concluded from this brief analysis of the survey data? Perhaps the most important conclusions from a health policy point of view are the fact that cost remains a barrier for many to seek care, while lack of access in terms of distance to facilities is also a constraint. Lack of access however seems to affect only a minority of the population,

that is, those located more than an hour away from the facility. By contrast the issue of cost is a more widespread problem if one compares the lower demand for care in the bottom four quintiles or eighty percent of the population to the higher demand observed in the top and wealthiest quintile. This conclusion is also supported by the basic statistics presented earlier in table 1, where cost was mentioned as the main reason for not seeking care by 33.5 percent of the population nationally, as compared to 8.0 percent mentioning the distance to facilities as the reason for not seeking care.

QUALITATIVE DATA AND ANALYSIS

In order to dig deeper into the issue of cost as a constraint to care, and of the role of faith-inspired facilities in making care affordable for the poor, we conducted in-depth qualitative research between April and July 2010 in six (two Protestant, two Islamic, and two Catholic) health facilities. Three of the facilities were very small with fewer than 12 workers, two were mid-sized with 30-40 workers, and one was a larger hospital with 213 workers. The three rural facilities are designated by the state as a CSPS (clinic) and the three urban facilities are considered as CMAs (hospitals). The facilities were selected by health ministry officials and the research team on the basis of their being located in areas where both public and faith-inspired healthcare options are available, so that we could compare both types of facilities. This would allow respondents to discuss the advantages and disadvantages of the different facility types.

A semi-structured questionnaire was used to interview 48 patients in the six facilities (eight in each facility). This is admittedly a small sample size, but we were more interested in-depth analysis than statistical representativeness. Because assessments of facilities by respondents were converging to a very large extent, we are confident in the findings obtained from the interviews. The questions focused on patients' views and motivations concerning healthcare, their evaluation of the faith-inspired health centers and the comparison with their experiences in public centers, and the way in which cultural and religious values shape decision-making. Opportunistic sampling was used and the sample was gender stratified with an equal number of male and female patients. An attempt was also made to stratify the sample by religion, according to the percentages of different religious groups attending each facility (if half of the patients were Muslim then 4 respondents were Muslim, if three-quarters Muslim, then 6 respondents were Muslim). Interviews were conducted by a Burkina Faso based research team in French and local languages (Moore, Dioula, Peulh), depending on the primary language of the respondent.

Semi-structured interviews were also conducted with two health center leaders including the director and a doctor or head nurse. A total of 24 focus groups in faith communities in one rural and one urban area provided an opportunity to further investigate the intersections between faith and health. Focus groups were conducted in Ziniare, a rural town 40 kilometers from Ouagadougou, and in the city of Bobo Dioulasso. The groups were conducted with Muslims, Catholics, Protestants and Traditional Religious groups, and within each religious community, men, women and religious leaders each had their own discussion.

The qualitative data confirm that cost is a major obstacle to care, but in addition, it suggests that faith-inspired facilities have a comparative advantage in this area versus public facilities through their ability to provide lower cost as well as higher quality services. The question of the quality of the services is discussed in a companion paper (Gemignani and Wodon 2011). Here, we focus on cost, documenting both how high costs reduce the demand for care, and how faith-inspired facilities appear able to reduce at least some of the cost burden for their clientele.

The majority of respondents in our fieldwork explain that they attend the faith-inspired facility in large part because these providers offer care at a lower cost than secular clinics and hospitals. They describe significant cost differentials for both services and medication. When asked about the main advantage of faith-inspired health providers as compared to public facilities, 54 percent of respondents mentioned lower cost of care. This response was common across gender, religion and location (rural/urban). It also came up strongly in testimonies provided by respondents: *"The sisters do not threaten the patient. Instead they help the patient because they do their work for God. As soon as we arrive, very sick, they start to look after us. There are four of them and all four put themselves at the service of the patient. They are not quiet, as long as the suffering of the patient continues. Then, two or three days later when your health has improved, that is when they tell the family the cost of the treatment. Elsewhere you cannot have emergency care without paying. It is sure that you will die then, because no one pushes themselves to take care of you and it seems that death no longer means anything to them"* (female patient, Catholic clinic). Quality was also mentioned as very important and a comparative advantage for faith-inspired facilities. But in addition, another perceived advantage of faith-inspired centers is that they provide counseling or other services for those who would like to benefit from them: *"For one year since I've come to this center for maternity issues, I haven't spent anything. My child and I are nourished and cared for free of charge. I had 11 children and 9 have died. Currently I receive care for one of my surviving children. The two of us are taken care of at the center. The pastor meets with me regularly for prayers and provides counsel for my maternity problems. I didn't have any of these advantages at the other CSPS's which weren't able to do anything to save my children…. It is ignorance and the lack of visits to good health centers which cause us to have these problems"* (patient at Protestant clinic).

Some respondents felt a lack of transparency among some public providers and suggested that excessive prices are charged for certain supplies and services**.** Others list the many costs incurred in attending a health center, and the lack of payment options for the poor. For some, the public health system seems to represent further health and financial woes rather than a place which offers viable treatment options. The following illustrate respondents' views regarding healthcare costs: "*When the women go to give birth in the CSPS, the government says that it is free but… one must pay for gloves, bandages, compresses, etc. Here, even if one pays, it is not in an exaggerated way because the price is low and within everyone's reach"* (male patient, Muslim clinic); "*Last year I sent my wife to give birth at [CMA]. They made me spend a lot of money. They said that it is a public hospital directed by the state and that the ministry covered most of the expenses,*

but that was not the case because I had to purchase many products. And now I prefer to come here because not only is it closer to my residence but also when I come here, the care and the drugs cost less… I no longer want to visit [CMA], because there one does not seek to know if you are poor or not, and one does nothing but prescribe you ordinances without knowing if you have the means. So if you go there and you have nothing, you are just going there to die" (male patient, Muslim clinic); "*I once stayed at the public hospital… Every morning I paid the ordinances. There was no progress but I noted that the health personnel were swindling me. Every day they required me to purchase products sold at a high price. That really marked me, and I haven't returned to that hospital for care. Here, the health personnel are not corrupt, and they are friendly and respectful"* (female patient, Protestant clinic); "*My husband no longer complains of the medical ordinances because, for 6 years now, I have seldom received them. He believes that the CSPS in our area exists simply to sell its drugs, that it is not a medical centre but a business established in order to market drugs"* (female patient, Protestant clinic).

There is thus a perception – which may or may not be valid - that some public facilities are affected by petty corruption, whereby the prices of consultations or drugs are inflated for the benefit of staff. It is also perceived that public facilities simply function as sellers or services in a market, without as much attention paid to patients and especially the poor. Whether this is true or not is unclear, and it may be that the association of faith-inspired facilities with religious aims gives them an advantage in terms of not being likely to be perceived as taking advantage of patients. But the difference in perceptions is still clearly there: "*Unlike the public clinics, one does not prioritize money in the religious clinics, because it is God who is central to the healing. Thus the services are given in a way that is social and humane. It is to help the poor, the disadvantaged groups"* (female patient, Protestant clinic); "*If you go to the CMA, people might as well start to cry for your corpse. They do not have pity even for people who are seriously ill. First they want to know how much you can give to the nurse for dealing with you. It is like at the market, between the salesperson and the customer… Sometimes the disease is very serious and [the sisters] advise the family to go to the CMA and we are sad because we know what awaits us. For this reason we pray to God that the sisters will be able to care for the patient so that all is limited to the center"* (female patient, Catholic clinic); "*Over there [CMA], the health personnel are dishonest. They steal from the patients by charging high prices for consultations and medicines. This practice is common at [CMA]"* (male patient, Muslim clinic).

There are also indications that while all services must be paid for in public facilities, this is not always the case in faith-inspired facilities, where efforts are made to keep care affordable for the poor, which means sometimes giving them a break on payment for care. This also means that the same service is provided to the poor and the better off in faith-inspired facilities, which may not always be the case in public facilities. A few examples illustrate the perceived differences well: "*This pharmacy has become an important resource for everyone. One gets their ordinances at [CMA], but gets the drugs in the sisters' clinic. Otherwise, certain ordinances are never going to be paid"* (male patient, Catholic clinic); "*I am not the only one who complains about other CSPSs*

because of their attitude toward patients and the negligence in consultation and treatment…. In some CSPSs, we also find that one is treated differently, depending on whether one is wealthy or poor" (male patient, Catholic clinic); "*In a religious medical center, they work for God and those who work for God know that they must help the poor…The places where God's name is absent, you go only because you don't have the choice and you know what awaits you. It is necessary to pay for everything; it is necessary to wait a long time; it is necessary to bribe the personnel if you want them to receive you or propose quality care to you. With us peasants, they often like to tell us to go sell our livestock and bring the money and we will look after you. And if we don't agree to do this, we will die"* (female patient, Catholic clinic).

The issue of cost has important gender dimensions, since many women are not able to afford healthcare on their own and depend on the willingness of their husbands to pay for their health needs. For example, one woman who had travelled an hour to the faith-inspired clinic described the inability of many women in her village to afford the services at the local CSPS as follows: "*At our health center, we find that behind each instance of health care is hiding a financial expenditure so that our husbands prevent us from attending the centers. It is only when the situation worsens that they take the woman there. The journey is difficult. One must go by bicycle, [donkey] cart, or motorbike and this is why we lose our pregnancies"* (female patient, Protestant clinic). Another woman explained: "*Before, women didn't give birth in the centers due to the costs. Then, the sisters met with groups of women and told us that they will no long ask expectant mothers to pay for [prenatal] consultations. Only at the time of childbirth is it necessary to pay 900F and for one year after childbirth, the mother and the newborn will receive free care. When we had this information, the problem of childbirth in our village was solved. Now all is done in the center"* (Catholic clinic). The lower costs of care thus improve husbands' support for the care of their wives. Indeed, several women described how their husbands who once complained of their medical expenses now approved them and even encouraged clinic attendance: *"The men have noticed that we have fewer health problems now that we are attending the health center during our pregnancy and the first weeks after the birth of the child. Our husbands accompany us and some witness our consultation and pay attention to the message given by the health worker"* (patient at Protestant clinic); *"When I used to attend [CMA], my husband did not accompany me. In contrast, he himself advises me to visit the sisters' health center and very often accompanies me there"* (patient at Catholic clinic).

Many households do not go to the health centers due to both cost and cultural practices (such as relying on traditional healers, or simply not seeking care until absolutely necessary). By reducing the cost barrier, faith-inspired facilities also help reduce cultural barriers to the demand for care: *"There are cultural practices that have a negative effect on the health of the population. For example, there are many people who do not see the doctor until they are gravely ill….Here we have the habit of saying 'When it gets hot" which means that when the person is in risk of death, that is, when we take them to the hospital. For some people, visiting the hospital is the last resort. This is because of certain beliefs, sociocultural biases, and also because of the lack of financial means to buy medicines at the pharmacies"* (female patient). And again, as already mentioned, the

affordability of care also helps in changing men's attitudes towards care: "*When it was necessary to go to the CMA of [town], I can say that very few among us went there for the consultations because our husbands would say that we want to bring him problems. As long as a woman is not confined to bed, she is not regarded as a patient. But with the opening of the center of the sisters, everyone knows that it is free. It is known that there is a sister who will take care of us and our husbands are not opposed. It is when money is needed for care that the battles erupt in the family. This is why a suffering woman, even if she is pregnant, is afraid to alert her husband. He will only see the financial expenditure"* (Catholic clinic).

ADMINISTRATIVE DATA AND ANALYSIS

Budget analysis

The qualitative analysis presented in the previous section makes it clear that faith-inspired facilities are able to provide services to the poor at lower cost than public facilities. At the same time, faith-inspired facilities tend to receive less support from the state for their operating and other costs than public facilities. This begs the question as to how faith-inspired facilities can remain financially sustainable with their practice of subsidizing the poor. In this section, we use partial data on costs and revenues for the faith-inspired facilities visited during the fieldwork to try to better understand how they are indeed able to implement what appears to be a preferential option for the poor (this is a Christian term, but focusing on the poor is also part of Islam).

A detailed comparison of the costs of faith based and public health care was not included as part of this study. But we did ask administrators in faith-inspired centers to provide the cost of a general consultation. These ranged from 150–1000 F CFA. This is lower than the 2000 F CFA often charged at the public hospitals, but the same or slightly more than the fee at the public CSPS, which is approximately 200 F CFA (the public fee for simple delivery, 900 F CFA, and complex delivery, at 1800 F CFA, are also similar to the fees in faith-inspired centers). On the other hand the faith-inspired centers we visited did appear to provide free care to those in need – often waiving consultation fees. It was also apparent from our discussions that the basic fees for consultation and deliveries are not the only cost of concern. Respondents emphasized a multitude of additional charges due to the need to purchase medicines and supplies, for example for childbirth. Basic supplies and generic medicines at the faith-inspired centers were apparently available at low prices and again, the poorest were not required to pay. Respondents also pointed out that since medical personnel are focused on the patient's ability to pay, they avoid writing long ordinances listing numerous medications that are not essential to the treatment.

It is also useful to consider some of the operating costs (e.g. employee salaries) at the faith-inspired centers, in order to determine if providing higher quality care entails larger costs which then must be passed on to the clients. Table 3 shows salaries for various categories of faith-inspired and public health workers. It is important to note that the salaries for public sector employees are starting salaries, while the faith-inspired salaries are based on the average of current salaries earned in the various categories. The average length of employment for the faith-inspired health center employees is 9 years. Given that

inflation is limited in Burkina Faso due to the peg of the F CFA with the Euro, even if raises are provided with seniority, `we would not expect salaries for government health workers to increase extremely rapidly over time.

Table 3: Health worker monthly salaries in faith-inspired and public facilities

	Average Salary: All faith-inspired	Average Salary: Protestant	Average Salary: Muslim & Catholic	*Starting* Salary: Government
Head of clinic	383,362	436,586	356,750	--
Doctor	284,300	350,000	262,400	146,000
Health officer	169,382	169,382	--	140,000
Registered midwife	122,691	138,885	98,400	110,000
Registered nurse	114,094	146,111	88,480	110,000
Licensed nurse	94,912	122,824	67,000	100,000
Itinerant health agent	92,088	134,175	50,000	70,000
Nurse's aide	98,238	98,238	--	--
Orderly	53,268	66,428	31,333	55,000
X-ray technician	160,000	160,000	--	110,000
Laboratory technician	113,186	150,780	--	110,000
Midwife (*matron*)	100,994	100,994	--	--
Birth attendant	72,500	--	72,500	70,000
Caregiver (infant)	30,004	30,017	30,000	--
Accountant	101,931	138,261	65,600	--
Other (cashier, guard)	69,712	81,625	47,375	--

Source: Compiled by authors.

Note: Starting salaries are provided for government workers, while workers in faith-inspired centers have an average of 9 years experience. The starting salary for government doctors represents the average of "specialist" (160,000 F CFA) and "generalist" (132,000 F CFA). The list of salaries from the faith-inspired centers includes 94 workers, but the total number of workers in these six centers is 204 (due to the lack of easily retrievable records, the 6 centers did not provide a complete salary list). Only the workers whose salaries are paid directly by the faith-inspired centers are included in these figures and in the statistics above (not those paid by the state).

As shown in table 3, salaries for doctors in the faith-inspired centers after an average of nine years of experience were significantly higher than starting salaries in public health centers. There were no doctors in the Catholic centers or the Protestant CSPS, but the doctors in the Muslim centers earned 80 percent more than starting government salaries. In the Protestant hospital, doctors earned more than double the government salary (when we inquired about these large differences, we were told that this was due to the long hours the private physicians were required to work in the hospital). However, for other categories of health workers, the divergence from government salaries was much smaller. In the Muslim and Catholic centers, the salaries of workers such as midwives and nurses appear to be less than the official government starting salaries. For the Protestant health centers, there is a modest increase in salaries. For example, registered nurses and midwives (*Infirmier d'Etat* and *Sage Femme d'Etat*) made 33 percent and 26 percent more than government starting salaries. Overall, it is this not clear that faith-inspired facilities would enjoy a comparative advantage (or disadvantage) in terms of cost structures due to salary structures that would differ markedly from those of government workers (although the fact that some nurses do not benefit from the same salaries does matter, as discussed below).

Tables 4 and 5 provide some idea about broader costs of operations in faith-inspired facilities by presenting estimates of annual revenues in relation to capacity for five of the six facilities. The smaller clinics earning only about 9 million F CFA annually (approximately $20,000) have 10-12 staff, 20-27 beds, and are able to serve about 150 people per week or 8,000 clients annually, which is very substantial and highly cost effective. This ability to reach so many with very limited financial resources is largely due to the sisters' financial support as well as the donations of equipment and medicine from congregations or other support groups. The mid-size facilities have revenues around 120 million F CFA (around $270,000) and have 32-42 staff members, 40-63 beds and serve about 800 clients per week or 42,000 per year. Finally, the larger hospital has about F CFA 900 million in total revenues (approximately $1,800,000), 50 beds, and 160 permanent staff and serves some 2102 clients per week or 109,304 annually. This larger hospital thus has two to three times more patients than mid-size facilities but seven to eight times more revenues. The relatively high revenues are possibly related to pharmacy, laboratory and imaging services. Since the hospital could not provide a record of total patients served across the various departments, an estimate was calculated from the annual number of patient consultations and medical procedures such as childbirth and surgeries. Those who are filling a prescription, or referred to the hospital for an x-ray or laboratory test are not included in the number of patients served. In addition, the cost per patient may be higher in a larger hospital due to more complex procedures It is also important to note that in recent years a significant portion of revenues for this specific hospital has gone to construction projects and the expansion of the health center facilities.

In order to check if these estimates provided to us by the centers made sense, we computed the 'cash cost' per patient in the five centers by simply dividing estimates of total revenues (not including salaries paid by the government or living stipends paid by congregations) by the number of patients served each year. The two clinics with the lowest cash costs were the Catholic facilities run by sisters, at respectively F CFA 1304 and F CFA 1803 per patient (or approximately three to four US dollars per visit). The fact that these facilities had the lowest cost per patient is not surprising given the availability of sisters not paid in the same way as other health professionals. Two other facilities had cash costs near F CFA 3000 per patient. Only the last facility had a higher cost per patient (F CFA 8180), but as mentioned above, this is likely due to the more complex procedures offered in the hospital as well as the revenues from the pharmacy and laboratory, and the fact that part of the resources have been used to expand facilities. The fact that the cash costs per patient for the first four facilities are of a similar order of magnitude is reassuring for the validity of the data.

Table 4: Health center data on revenues, staff size, and number of patients served

Faith	Amount received from patients (F CFA)	Support from relig. groups and other orgs. (F CFA)	Support from state	Total revenues	No. MDs	No. nurses and health officers	No. other workers	No. state workers	Total Staff	No. of patients per week (Male)	No. of patients per week (Fem.)	No. of patients per week (total)	No. of beds	"Cash cost" per patient (FCFA)
Musl.	54 million	75,400,000	4 nurse salaries	129,400,000 + 4 nurses	4	9	15	5	33	286	633	919	40	2708
Cath.	9 million	Sisters receive support, room & board, etc.	--	9,000,000 + sisters' financial support	0	3	9	0	12	42	54	96	27	1803
Cath.	8 million	Sisters receive support.	1 nurse salary	8,000,000 + 1 nurse + sisters' support	0	3	6	1	10	42	76	118	20	1304
Prot.	107 million	5,141,462	600,000	112,739,860	0	15	27	0	42	249	442	691	63	3136
Prot.	800 million	94,086,027	50 worker salaries	894,086,022 + 50 state workers	7	68	38	50	163 + 50 temp. workers	--	--	2102	50	8180

Source: Compiled by authors.

It is striking to see in table 4 how large support from religious groups and other organizations is in comparison to cost recovery fees from patients and support from the government. Consider for example the first (Muslim) clinic. Its support from religious and other groups is equivalent to 1.4 times its revenues from patients, while support from the state is rather limited given the salaries reported in table 3. Support from the state is also very limited in the next three facilities in the table, and is substantial only for the last facilities through payment of salaries for 50 health workers. In the Catholic facilities, as already mentioned, the fact that the sisters tend not to be paid as professional and received support from their congregations helps a lot as well. Overall, support from religious groups as well as others donors helps in enabling the facilities to provide subsidized care for the poor, given that such support is large versus payments by patients.

Table 5 compares the overall budget of the facilities with their costs. Note that for some facilities, revenues are being used to expand facilities. All facilities tend to benefit from donated medicine, equipment, and supplies, although we do not have data on the value of such transfers. It is also interesting that several facilities seem to have a budget for social assistance. Possibly those funds are used to make care more affordable for specific groups, but it is also likely that some of the funds are being used to make additional services available to some families (such as food prepared for young children when parents consult), as suggested by the qualitative work.

Table 5: Overview of facility budgets

	Facility 1	**Facility 2**	**Facility 3**	**Facility 4**	**Facility 5**
Resources (annual):					
Monetary	129,400,000 +4 nurse salaries	9,000,000 + Financial support for sisters	8,000,000 + 1 nurse salary	112,480,252	807,872,000 + 50 state worker salaries
Non-monetary	Donated medicine, equipment & supplies	Donated medicine, equipment & supplies	Donated medicine, equipment & supplies	Donated medicine, equipment & supplies	Donated medicine, equipment & supplies
Expenses (annual):					
Salaries	14,400,000	6,612,000	5,400,000	56,796,403	192,000,000
Supplies	500,000	300,000	50,000	2,621,208	243,000,000
Utilities	600,000	1,000,000	200,000	1,173,425	20,000,000
Maintenance	300,000	100,000	75,000	1,890,119	10,000,000
Other	37,785,600 (misc. including social assistance and new construction)	150,000 (social assistance)	400,000 (social assistance)	49,806,695	118,000,000 (construction) 34,000,000 (social assistance) 4,000,000 (training)

Source: Compiled by authors.

Collaboration with the state

During an inauguration at a Protestant medical center in 2010, then-Prime Minister Tertius Zongo stated: *"What is most important is to see that the private or religious [health centers] can provide quality healthcare alongside the efforts of the state"* (Burkina Faso Prime Minister's Office 2010). This is indeed the spirit in which faith-inspired facilities seem to be working. The analysis of our data suggests that faith-inspired facilities perform a valuable service for the communities in which they are operating. According to their leaders, the centers were actually established in areas that had (at the time of creation) limited access to the health system. There is also a strong focus on providing services to the poorest even when facilities are located in urban areas, and this is found across the different types of providers (Catholic, Muslim and Protestant). One clinic leader described their target zone as follows: "*This health center is located in the densely populated neighborhoods. We also serve the peripheral or unincorporated area which is densely populated as well. In the entire zone, there is only one public CSPS. This explains the large numbers who visit this clinic. Also the majority of the people who live in the areas that I have just described are poor and live in conditions that are not at all decent. In the unincorporated areas, there is no infrastructure including tap water, gutters and garbage disposal… The patients' economic situation is catastrophic because the families depend on odd jobs in the informal sector - selling various items, masonry, itinerant salesman of cigarettes - and on small agriculture… Most are without school instruction. They are unaware of all the rules of hygiene, the questions of family planning, and the advantages of [Western] medicine."*

All of the health center leaders provided similar descriptions of their target population. Several described a greater focus on women and children, with emphasis put on maternal care and preventative care for infants and children. Most administrators also said that they are integrated into the national health system and they tend to be fairly satisfied with their relationship with the state. One official at a public clinic, however, described realistically a sense of competition between public and faith-inspired services, and a negative view toward the free or low cost care that faith-inspired centers are able to offer to patients and which may in some cases significantly lower the client base in the public sector. That some competition exists is indeed clear.

Still, while faith-inspired facilities benefit from support from religious groups and other donors, the health center leaders strongly emphasize the importance of support provided by the state. According to the administrators, the provision of personnel is the most important support they receive from the state. The numbers of state personnel varied according to the size of the facility, with one staff member provided to a small clinic, five state employees at mid-sized clinics, and fifty state employees at the large faith-inspired hospital. All of the leaders interviewed stated a desire for more state support in the area of personnel. For example, a leader at a Muslim clinic stated "*More midwives and nurses trained by the state should be provided to us. Unfortunately this is not done and the situation creates blockages in the operation of our services. It also creates an overload of work and our personnel is always overwhelmed by the large numbers of patients who do not always understand and tolerate the long lines and waiting periods."*

Leaders also described their desire to improve and expand their facilities and the ongoing need for equipment and supplies in many areas of care. At all the smaller clinics, they described "making do" with what is on hand. One Protestant clinic was well funded, and a Catholic clinic had recently secured financing for a significant expansion, but for the most part, there is a notable lack of resources. Some clinics reported lacking even basic supplies such as thermometers and blood pressure monitors. One clinic described their futile attempts to attain a vaccine refrigerator. A Catholic clinic known for its pre- and postnatal care in the villages described the lack of basic equipment in the maternity ward.

Nearly all of the leaders to whom we spoke reported positive relationships with the government: "*In recent years, the government has made an effort to work with us and our collaboration is fruitful. They recognize our strengths and although they don't provide many resources for our functioning, they do a lot."* Although they were not provided with large amounts of human and material resources, what they did receive was well appreciated and they had very few negative comments about the collaboration itself. In addition to providing the health centers with state health workers, the state provides other resources to certain facilities including medical supplies (e.g. vaccines, mosquito nets), equipment (e.g. refrigeration systems), support for the nutritional health centers (CREN), and periodic trainings for personnel. Trainings were viewed as very useful for building the skills and knowledge of the staff: *"I really appreciate the successful collaboration between the district and the private medical structures. There is a desire to work together to answer the health problems of the population. The [Medical District Head Physician] is very attentive to the quality of services of this center and said that he wants to provide us with qualified health personnel."*

Government inspection teams regularly visit the health centers and all of the leaders said that they viewed this in a positive way: *"Each quarter we receive an inspection team from our health district. They come in order to supervise us and provide advice on operations. They discuss our strong points and our weak points, and then we try to apply their recommendations. This works out well and I appreciate this type of support…. We have discussed many of our clinic's problems with them. Their concern to communicate with us is already a type of collaboration and it is positive. The government has set themselves up like a partner who does the work of evaluating our activities. This enables us to correct our weaknesses and improve our services."*

In return for support received, the health centers provide monthly, quarterly, and annual reports of their operations. The centers are seen as providing valued services that reach the poor and this aspect of their work is recognized by state health authorities. When asked about how they would improve their relationship with the state, about half of the leaders said that they would like to see greater support from the state in the future. More frequent training was one suggestion and many of the leaders hoped that more personnel could be provided: "*The only negative aspect of our collaboration is the level of support. We are a social center with a non-lucrative goal. Our goal is to build and equip the medical center. But we must pay most of the personnel... With our thin resources we pay the water and electricity bills and most of the workers... I have 33 workers here and 5 are*

paid by the state… We are the only nongovernmental structure to provide care under SONU (free childbirth services)… Other nongovernmental structures refuse to assume responsibility for this care. We try to satisfy the needs of the population of the poor and should receive more support through the supply of personnel." One larger clinic also felt that it is unable to realize its full potential for health care provision because state policy does not allow a CSPS to provide certain kinds of services designated for the district hospitals and surgery centers. Examples included blood transfusion and cataract surgeries. Their future plans include training some of their personnel to become doctors so that they can change their status (from CSPS to CMA) and expand the provision of services.

CONCLUSION

This paper has described the role of faith-inspired health providers in Burkina Faso. Quantitative results from the national survey were combined with in-depth qualitative research and administrative data in order to understand the successes of faith-inspired services especially in terms of their ability to subsidize care for the poor, as well as some of the current challenges they are facing. Some of the topics covered here include utilization of formal health care and barriers to access, the unique contributions of faith-inspired services, the level and nature of collaboration with the government, and some of the external and internal limitations to healthcare provision.

Faith-inspired healthcare in Burkina Faso is still in an early phase of development, but the contributions of the religious organizations are noticed not only by the state but by the many patients who extol the benefits of their approach. One unique aspect of this in Burkina Faso is the fact that a majority of faith-inspired health centers appear to be reaching poor members of society and that they are viewed as equally or more affordable than even the most basic public health centers (CSPS), which itself is made possible through the support that the centers get from religious groups and other donors. This does lead to some competition with public facilities, but it also increases the availability and quality of the care being provided. The qualitative research suggests that patients place a great deal of emphasis on the quality of care they receive in the health centers. Interpersonal relations in the faith-inspired centers are viewed as very important and many contrast the sense of compassion, trust and "bonds of friendship" with the more impersonal and sometimes hostile environment of public clinics and hospitals, as patients perceive it.

While the administrators of faith-inspired health centers view their basic support from the government in a favorable light, they also state their need for further assistance in order to meet their expenditures for staff, training, medical supplies and other costs. They view their role in addressing the needs of the most disadvantaged members of society as a calling and service to others and in so doing they operate with a great deal of flexibility. At the same time, many note the disparities between available resources and demand for services and they also hope to expand their ability to meet the many health needs in the communities. As one director stated, *"the resolution of one need creates another need."* Acknowledging the important contributions of these institutions and increasing their

funding and other supports through enabling policies in a way that would not be seen as threatening for public facilities could make a significant impact toward improved community health in Burkina Faso.

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