Global report on integral human development 2022: measuring the contributions of Catholic and other faith-based organizations to education, healthcare, and social protection

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Global Report on Integral Human Development *2022*

Measuring the Contributions of Catholic and Other Faith-based Organizations to Education, Healthcare, and Social Protection

Quentin Wodon
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This report is a product of the volunteer-led Global Catholic Education project which aims to contribute to Catholic education and integral human development globally with a range of resources, including a blog, events, guidance on good practices, publications, and data. The report is co-sponsored by the four international organizations federating Catholic education at the global level, namely the International Office of Catholic Education (OIEC) for pre-primary, primary, and secondary education, the International Federation of Catholic Universities (IFCU) for universities, the World Organization of Former Students of Catholic Education (OMAEC) for alumni, and the World Union of Catholic Teachers (UMEC-WUCT) for teacher, as well as the International Catholic Child Bureau (BICE). The author is especially grateful to Alessandra Aula, Philippe Richard, François Mabille, José Ramón Batiste, and Giovanni Perrone for their encouragements and advice. The author works for an international development agency, but this report was produced on his volunteer time and should not be seen in any way as representing the views of his employer, its Executive Directors, or the countries they represent. The findings, interpretations, and conclusions expressed in the study are solely those of the author and may also not represent the views of BICE, OIEC, IFCU, OMAEC, and UMEC-WUCT. Any omissions or errors are those of the author alone.

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Cover photo: © BICE.
The cover photo was taken in the Democratic Republic of Congo in one of the programs supported by the International Catholic Child Bureau (BICE) for out-of-school children, many of which live in the streets. The photo was selected for the cover of this report because it illustrates the large role played by the Catholic Church and other faith-based networks in service provision for education, healthcare, and social protection in sub-Saharan Africa, especially for vulnerable groups.

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FOREWORD

The Catholic Church is the largest non-state provider of education, healthcare, and social protection services in the world. Through a global network of more than 325,000 schools and facilities, as well as through universities and other institutions of higher learning, the Church contributes in a significant way to efforts to achieve the Sustainable Development Goals and integral development, understood as the development of each man and the whole man. This is also the case for other faith networks.

This first Global Report on Integral Human Development from the Global Catholic Education project aims to measure the contributions of Catholic and other faith-based organizations to education, healthcare, and social protection. The first part of the report documents trends in the number of schools, health facilities, and social protection facilities managed by the Catholic Church. The second part of the report assesses the extent to which Catholic and other faith-based providers reach the poor, and whether they provide services of quality. For education and healthcare, estimates of the share of services provided to populations by the Catholic Church are computed. A brief discussion of the impact of the COVID-19 pandemic is also provided.

Because of data constraints, the report focuses more on the contributions of the Catholic Church, but when feasible it also discusses the contributions of other faith-based providers, including other Christian as well as Islamic institutions. While this report focuses on just one aspect of the contributions of faith-based organizations to integral human development – their contributions through facilities-based services, future reports will consider other types of contributions as well.

The report was produced by the volunteer team leading the Global Catholic Education project, which is an effort to inform and connect Catholic educators and those interested in integral human development globally. The project provides data, analysis, opportunities to learn, and other resources to help Catholic educators and others interested in integral human development fulfill their mission with a particular focus on the preferential option for the poor. Apart from this new series of reports on integral human development, the project also publishes annually the Global Catholic Education Report. We are thankful to Quentin for launching and managing the project and its website, and for writing the reports.

This report is co-sponsored by our five organizations: The International Catholic Child Bureau (BICE), the International Office of Catholic Education (OIEC), the International Federation of Catholic Universities (IFCU), the World Organization of Former Students of Catholic Education (OMAEC), and the World Union of Catholic Teachers (UMEC-WUCT). As recently noted by Pope Francis at the launch of the Global Compact on Education, the task of educating and forming new generations is one of the most crucial tasks we must undertake.

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François Mabille, Secretary General, IFCU
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EXECUTIVE SUMMARY: KEY FINDINGS

Faith-based service providers play a significant role in efforts to achieve the Sustainable Development Goals (SDGs) and promote integral human development, understood as the development of each man and the whole man. Faith also affects people's behaviors as it relates to investments in human development. Yet the role of faith and faith-based service providers remains insufficiently acknowledged in policy discussions. Similarly, policy discussions and the lessons learned by the international community on what works to achieve the SDGs and promote human development do not sufficiently reach faith-based organizations and faith networks.

This report is the first in a new series on integral human development that has two aims: (1) to make the experiences and role of faith-based organizations in contributing to integral human development better known by the international community; and (2) to bring to faith-based educators and all those interested in integral human development expertise and knowledge from the international community.

Given that this is the first report in a new series, its aim is simply to measure the contributions of faith-based organizations to integral human development with a focus on education, healthcare, and social protection[1]. Building on previous work by the author, and weaving in substantial new analysis, the report is structured in two parts. The first part consists of three chapters documenting the scope of service provision by the Catholic Church globally in education, healthcare, and social protection. Unfortunately because of data constraints, the focus in this first part is only on the Catholic Church using data from its statistical yearbooks. The second part of the report considers three questions for both Catholic and other faith-based providers of service: (1) to what extent do faith-based providers reach the poor?; (2) what is the 'market share' of faith-based providers?; and (3) why do some households rely on their services, what is their satisfaction with these services, and what is their quality? At the end of each chapter, a brief discussion is provided on the impact of the COVID-19 pandemic, including for the ability of faith-based providers to fulfill their mission. This executive summary summarizes key findings.

[1] Because of this focus, for education there is a bit of overlap between the themes in this report and those in the Global Catholic Education Report 2021.

PART I – TRENDS IN SERVICE PROVISION BY THE CATHOLIC CHURCH

Education

Globally, the Catholic Church estimates that 35.2 million children were enrolled in Catholic primary schools in 2019, with 19.4 million children enrolled in Catholic secondary schools and 7.5 million children enrolled at the preschool level. In addition, 6.7 million students were enrolled in Catholic higher education. Analysis of trends in enrollment in Catholic schools and universities is provided in the latest Global Catholic Education Report. For this report, to compare data across education, healthcare, and social protection, the analysis is done in terms of the number of schools managed by the Church rather than enrollment. Findings are visualized in Figures ES.1 to ES.4.

- Globally, the number of preschools, primary schools, and secondary schools managed by the Church increased by 54 percent from 1980 to 2019, from 143,574 to 221,144. The increase was largest for preschools (89 percent), followed by secondary schools (67 percent) and primary schools (31 percent).
- Most of the growth was concentrated in Africa where the number of schools more than tripled over that period due to high

rates of population growth and gains in educational attainment over time. In Asia and Oceania, the number of schools almost doubled. In the Americas, it increased by 28 percent, although there was a decline in the United States. In Europe, it decreased by 15 percent.

- Globally, primary schools account for 45.0 percent of Catholic K12 schools, versus 22.4 percent for secondary schools and 32.9 percent for preschools. There are large differences between regions in the share of schools by level. In Africa, primary schools account for 54.2 percent of the total number of schools, versus only 33.7 percent in Europe.
- In terms of enrolment, India has the largest number of students in Catholic K12 schools, followed by the Democratic Republic of Congo (DRC), Uganda, Kenya, and Malawi. When looking at the number of schools, after India and the DRC, the United States, France, and Germany round up the top five countries.
- The highest growth rate in the number of schools is for preschools. This is a positive development as research demonstrates that early childhood is a critical period in a child's education and investments in pre-primary education have high returns.

The number of preschools, primary schools, and secondary schools managed by the Catholic Church increased by 54 percent since 1980 to reach 221,144 schools in 2019. The increase was largest for preschools (89 percent), followed by secondary schools (67 percent) and primary schools (31 percent).

Figure ES.1: Number of Preschools

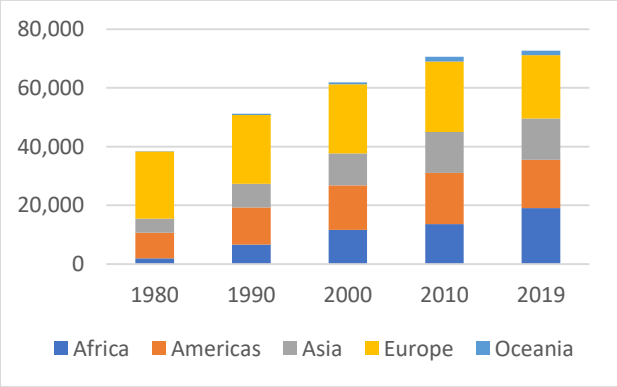


Figure ES.2: Number of Primary Schools

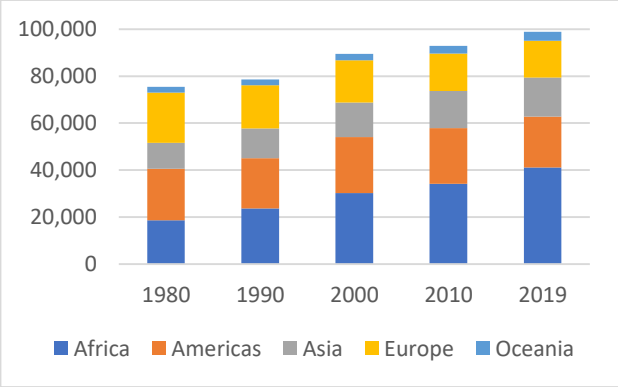


Figure ES.3: Number of Secondary Schools

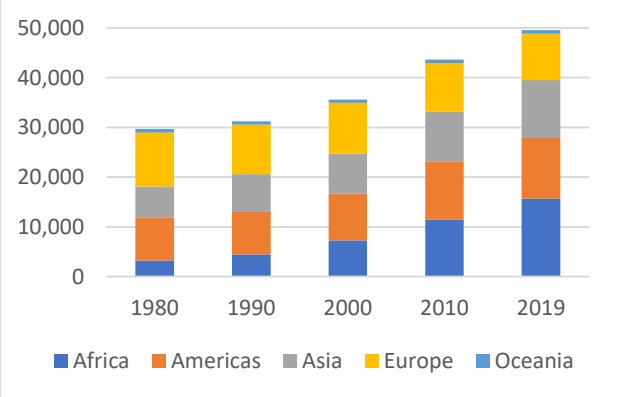
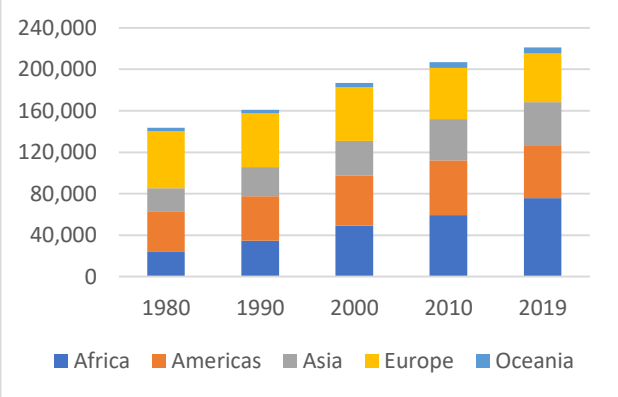


Figure ES.4: Total Number of K12 Schools



Source: Compiled by the author from the Statistical Yearbooks of the Church.

Healthcare

The Catholic Church also manages a large number of healthcare facilities, including hospitals, health centers, and leproseries. Findings are visualized in Figures ES.5 to ES.8.

- The number of healthcare facilities managed by the Church increased from 19,119 in 1980 to 24,031 in 2010, but this fell back to 20,740 facilities in 2019 due to a decline over the last decade in all regions except Africa and Oceania.
- The largest increase in facilities over time was again observed in Africa. This is not surprising given high rates of population growth and progress towards achieving universal healthcare for all.
- Globally, there has been a decline in the share of hospitals and leproseries in the number of healthcare facilities, while the share of health centers has increased.
- As for schools, India and the DRC are the two countries with the largest number of Catholic healthcare facilities. Germany, Mexico, and Brazil round up the top five.
- The recent decline in the number of facilities is observed for all facilities, but for hospitals and leproseries, most the decline took place in the first decade of this century, while for health centers it took place in the current decade.
- The recent decline in the number of facilities does not necessarily imply a decline in the number of patients served (i.e., existing facilities may serve a larger number of patients). This decline is however different from the overall trends observed for schools.
- In Africa, an important institutional feature is the presence of Christian Health Associations (CHAs) that federate healthcare facilities managed by the Catholic Church and other Christian denominations. CHAs are national-level umbrella networks that help improve coordination in service provision, reduce duplication, and provide a platform for dialogue with governments. Currently CHAs operate in more than two dozen countries and collaborate to share good practices through the Africa Christian Health Associations Platform (ACHAP).

The number of healthcare facilities managed by the Church increased from 19,119 in 1980 to 24,031 in 2010, but this fell back to 20,740 facilities in 2019 due to a decline over the last decade in all regions except Africa and Oceania. The decline over the last decade is observed for all types of facilities.

Figure ES.5: Number of Hospitals

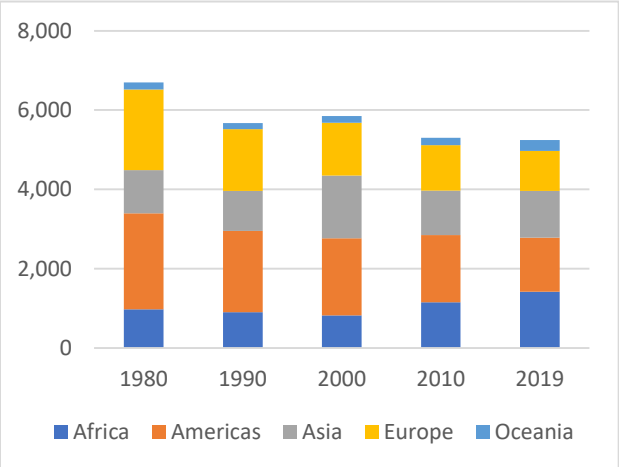


Figure ES.6: Number of Health Centers

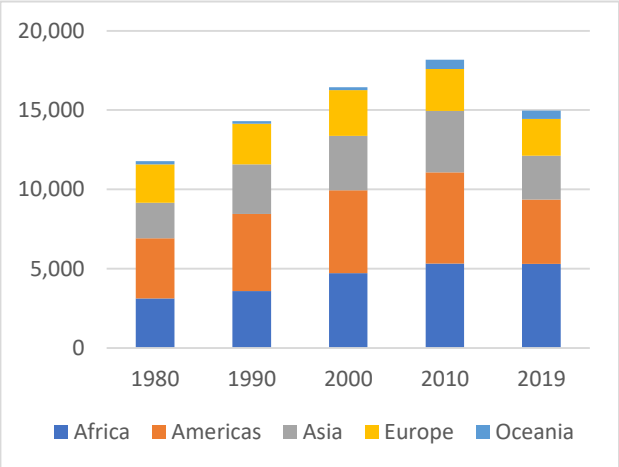


Figure ES.7: Number of Leproseries

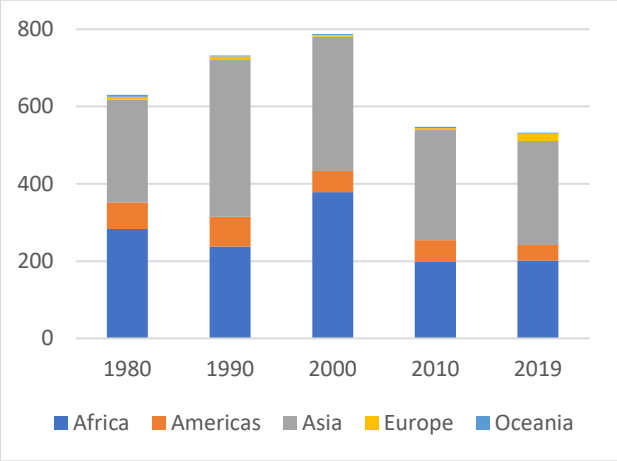
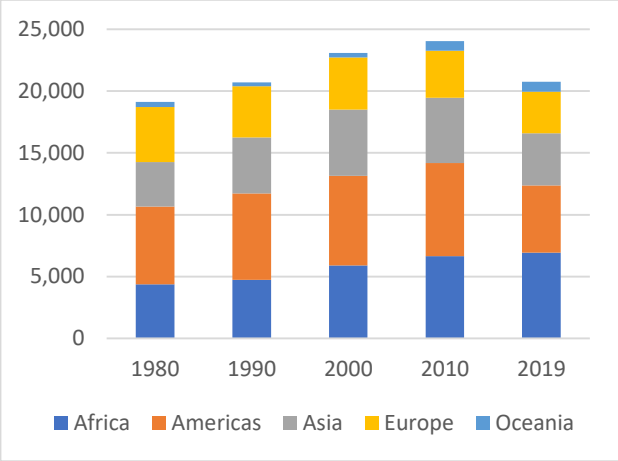


Figure ES.8: Total Number of Facilities



Source: Compiled by the author from the Statistical Yearbooks of the Church.

Social Protection

Data are available in the statistical yearbooks of the Church on six types of welfare institutions: (1) orphanages; (2) nurseries; (3) special centers for social education or re-education; (4) homes for the old, chronically ill, invalid, or handicapped; (5) matrimonial advice centers; and (6) other institutions (which may include many different types of activities and programs). For simplicity, we consider all these facilities as part of social protection, even if some may relate to other sectors. Findings are visualized in Figures ES.9 to ES.15.

- There was a large increase in the number of social protection facilities managed by the Church from 42,084 in 1980 to 97,533 in 2010, but the total number fell back to 84,872 in 2019. The recent decline was observed in all regions except Europe, but was larger in the Americas.
- While for K12 schools and healthcare, the increases over time in the number of facilities were concentrated in Africa followed by Asia (and Oceania but from a much smaller base), for social protection most facilities remain in the Americas and Europe, probably in part because the countries can afford to fund services beyond basic education and healthcare.
- The trends over time for the various types of social protection institutions are similar at least in the aggregate. Globally, there was a progressive increase in the number of facilities until 2010, and then a decrease by 2019. This is observed for orphanages, nurseries, homes for the old, chronically Ill, invalid, or handicapped, and matrimonial advice centers. For special centers for social education or re-education and other institutions, the trend over time is less consistent in part because there seems to have been a reclassification between these categories.
- Beyond these facilities, the Church is also actively involved in providing a wide range of other social protection services, including programs for the poor run out of churches as well as international humanitarian aid, for example for refugees. The scope of these activities is difficult to assess over time, but support provided by the Church to households and communities is substantial.

The number of social protection facilities managed by the Church increased from 42,084 in 1980 to 97,533 in 2010, but this fell back to 84,872 facilities in 2019 due to a decline over the last decade in all regions except Europe. The decline over the last decade is observed for most types of facilities.

Figure ES.9: Number of Orphanages

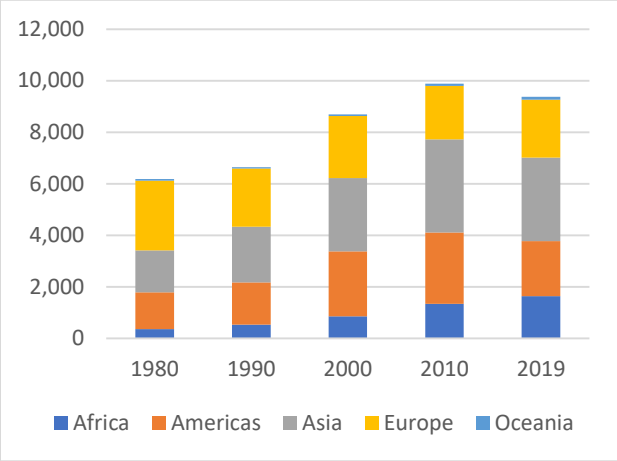


Figure ES.10: Number of Nurseries

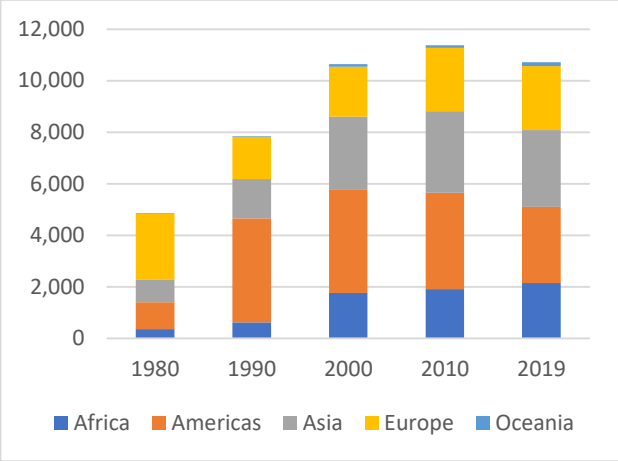


Figure ES.11: Number of Matrimonial Advice Centers

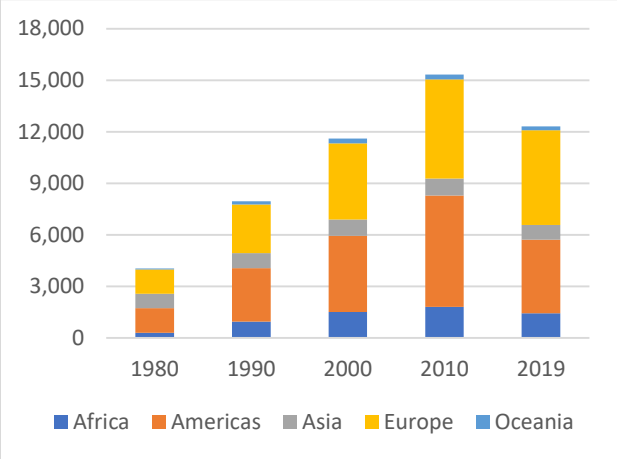


Figure ES.12: Number of Nursing Homes and Centers for the Chronically Ill or Handicapped

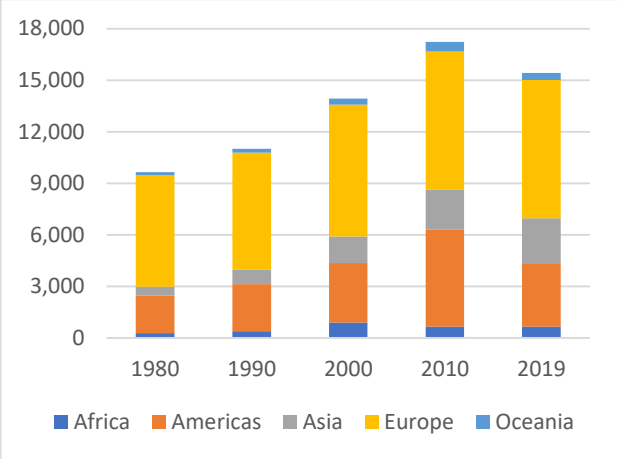


Figure ES.13: Number of Special Centers for Social Education or Re-education (*)

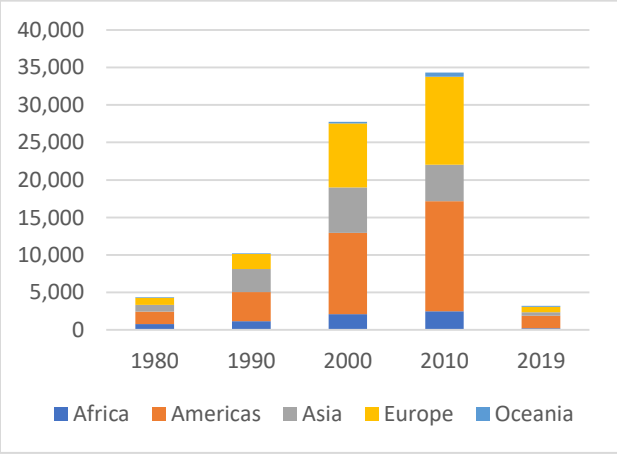
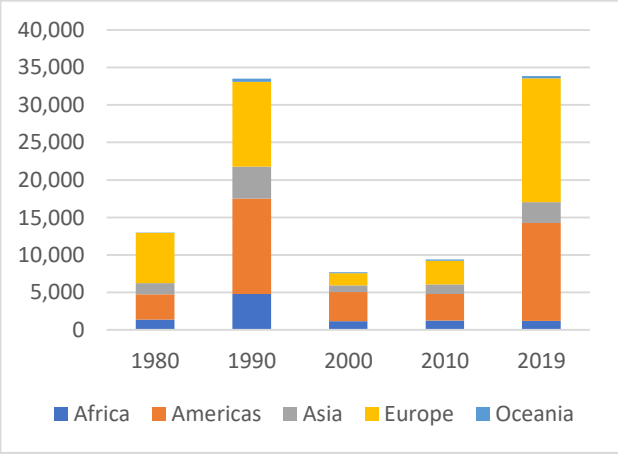


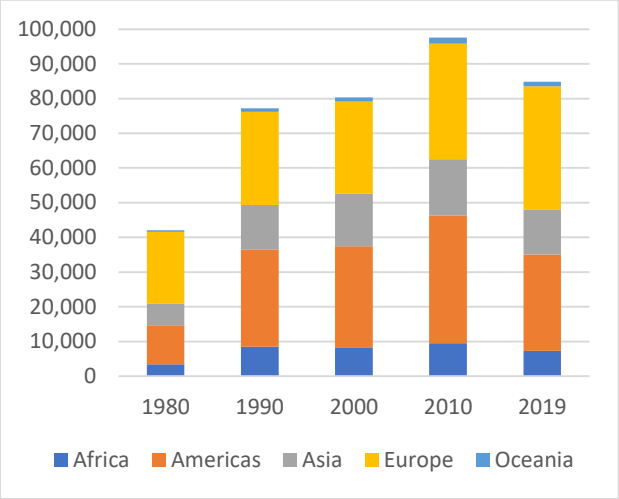
Figure ES.14: Number of Other Institutions (*)



Source: Compiled by the author from the annual statistical yearbooks of the Church.

Note: (*) There seems to be a reclassification of facilities in the last two categories between 2010 and 2019.

Figure ES.15: Total Number of Facilities



Beyond facilities-based services, the Church also contributes to social protection through other programs and activities. Locally, this includes programs in cash or in kind for the less fortunate, including through more than 220,000 parishes. Internationally, this includes humanitarian assistance, among others through members of Caritas Internationalis, a confederation of over 160 organizations working at the grassroots.

Source: Compiled by the author from the Statistical Yearbooks of the Church.

Box ES.1: Development and Humanitarian Aid

While this report focuses on facilities-based services provided by Catholic and faith-based organizations, faith networks contribute to integral human development in other ways. A recent report from CAFOD (Catholic Agency for Overseas Development), the aid agency of the Catholic Church in England and Wales and a member of Caritas International, suggests seven ways in which the Church makes a difference in development and responses to emergencies: (1) Rapid, local and inclusive humanitarian response; (2) Influencing social norms and behavior; (3) Peacebuilding, mediation and reconciliation; (4) Strengthening democratic governance through citizen participation; (5) Speaking truth to power, witnessing and accompanying suffering; (6) Providing quality and inclusive healthcare and education; (7) Supporting sustainable livelihoods. The report provides examples of projects from all over the world, including some in response to the COVID-19 pandemic. The report also notes that the Church is called to serve all people based on need, regardless of race, gender and religion, and to have a preferential option for the poor, for those people and communities that others may have overlooked, those who suffer discrimination, injustice or oppression.

PART II – REACH TO THE POOR, MARKET SHARES, AND QUALITY

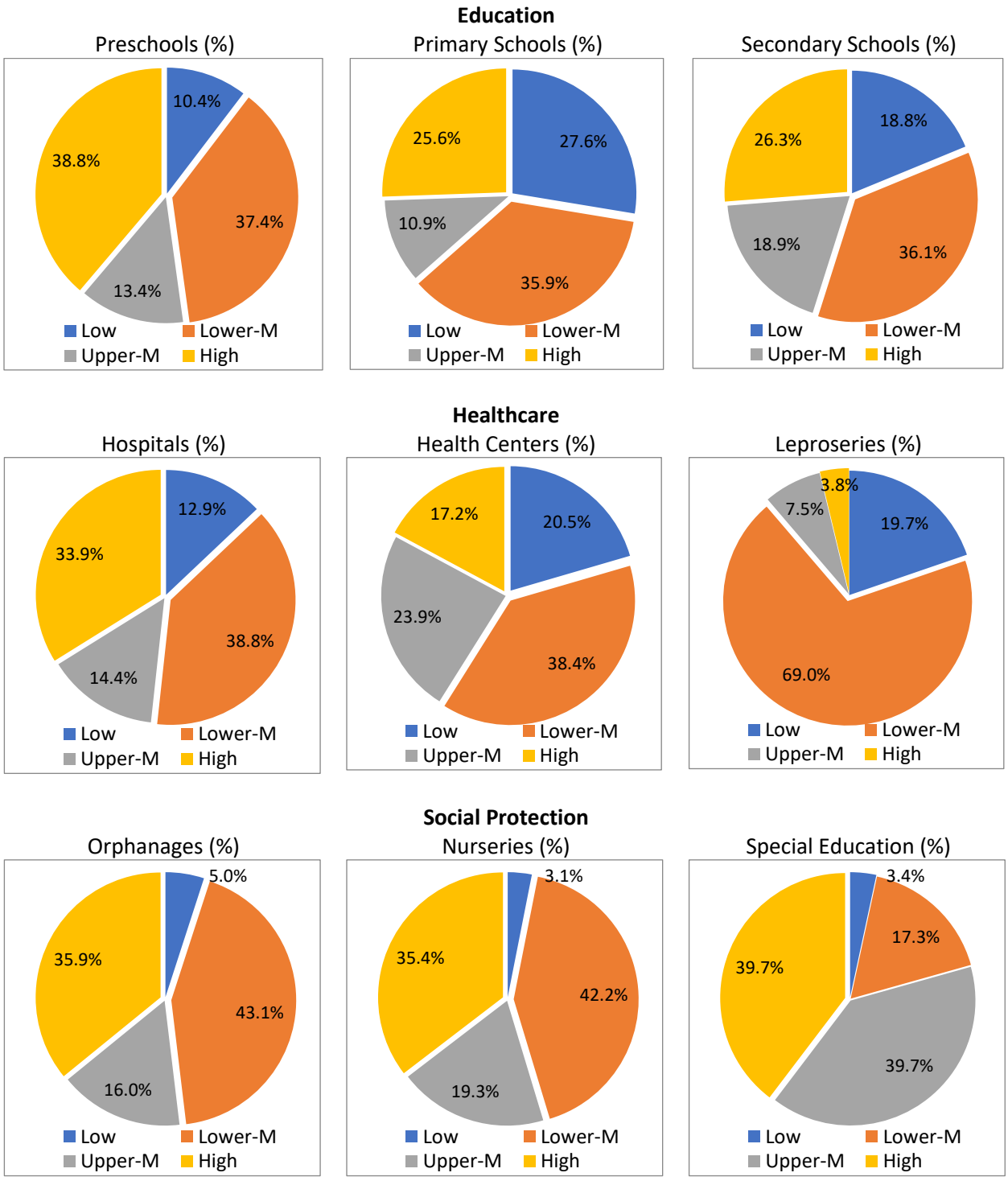
Reach to the Poor

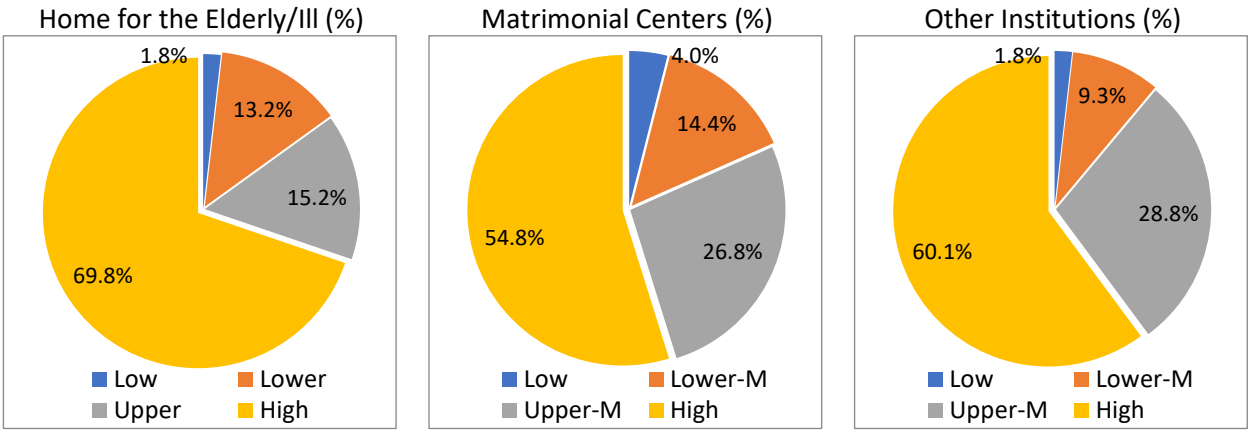
The preferential option for the poor has long been a core principle of Catholic social teaching, but the desire to serve the poor is also shared by other faith-based organizations. To assess the extent to which faith-based organizations reach the poor, the analysis proceeds in three steps. The first step considers the location of Catholic schools and facilities in terms of the level of economic development of countries (low, lower-middle, upper-middle, and high income countries). Selected findings are visualized in Figure ES.16.

- Most Catholic schools and healthcare facilities are located in low or lower-middle income countries. This is especially the case for primary schools and reflects the large role played by the Church in sub-Saharan Africa.
- For social protection, most facilities are located in upper-middle and high income countries, with the exception of orphanages and nurseries where lower-middle income countries account for more than 40 percent of all facilities.

Most Catholic schools and healthcare facilities are located in low and lower-middle income countries, especially in the case of primary education. By contrast, with the exception of orphanages and nurseries, most Catholic social protection facilities are in high (and sometimes upper-middle) income countries.

Figure ES.16: Shares of Catholic Schools and Other Facilities by Country Income Groups, 2019



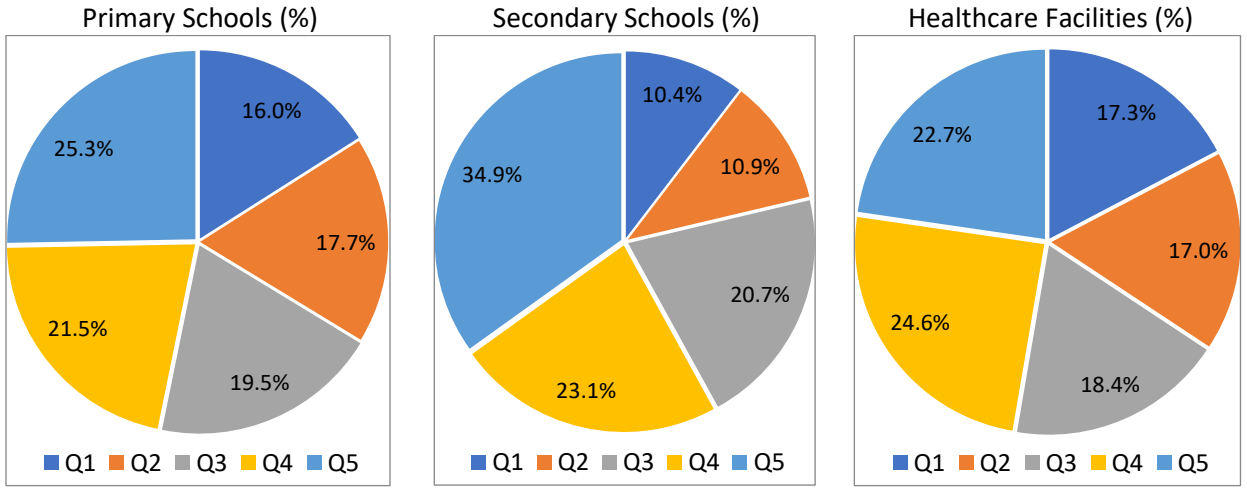


Source: Author's estimations.

Note: The four country income groups correspond to low, lower-middle, upper-middle, and high income countries as defined by the World Bank for its Fiscal Year 2022 and based on data on gross national income for 2020.

In the second part of the analysis, to assess how well Catholic and other faith-based providers serve the poor within countries, analysis is conducted with household surveys. The focus is on education and healthcare in sub-Saharan Africa. As shown in Figure ES.17, on average across 16 countries for education and 14 countries for healthcare, faith-based facilities tend to serve richer more than poorer households. For example, for primary education, 16.0 percent of students in faith-based schools are from the poorest quintile of well-being versus 25.3 percent from the richest quintile. The gap in benefit incidence between quintiles is larger for secondary education, but smaller for healthcare. In terms of comparisons across types of facilities, public schools serve the poor slightly more than faith-based schools, but there are few differences in the reach to the poor between faith-based and public healthcare facilities. Private secular facilities are titled much more towards serving better off households for both education and healthcare.

Figure ES.17: Benefit Incidence of Faith-based Services in sub-Saharan African Countries
(Share of users by quintile, with Q1 as the poorest and Q5 as the richest quintiles of well-being)



Source: Adapted from Wodon (2015, 2019).

Household surveys also provide information on out-of-pocket costs for households using different types of facilities. Key finding are visualized in Figure ES.18 where the average out-of-pocket cost for households of public facilities is normalized to one. Faith-based schools tend to be more expensive for households than public schools (in part because faith-based schools often receive no or only limited support from the state), but there are few differences for healthcare facilities. Private secular facilities are systematically more expensive. Note that the large differences in cost for primary schools result from the fact that primary education is supposed to be free in public schools, although households may still face expenditures for uniforms, books, parent-teacher associations, or other requirements.

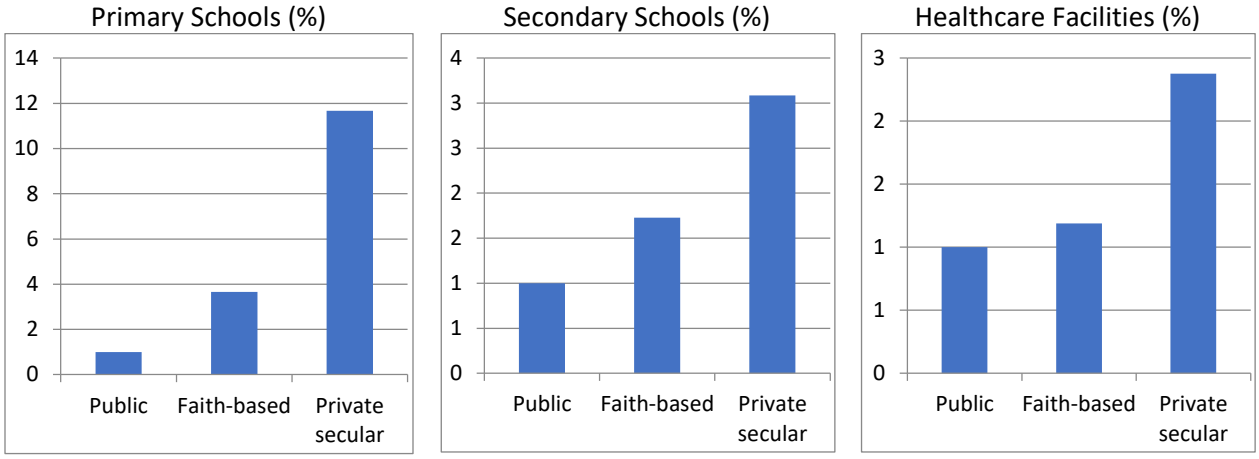
Similar preliminary results on out-of-pocket costs and reach to the poor for different types of schools are obtained from a recent survey conducted in ten West African countries.

The third and last part of the analysis focuses on the ability of faith-based providers to serve households in areas that are underserved. Case studies for Ghana and Uganda suggest that while in the past, faith-based schools and healthcare facilities may have been located in underserved and remote areas, this may not necessarily be the case anymore. In turn, this may limit the ability of schools and healthcare facilities to reach the extreme poor. While such results are context-specific, they illustrate some of the challenges faced when aiming to reach the poor while also ensuring the financial viability of the services being provided, especially when state funding for faith-based provision of services is limited.

Overall though, despite operational constraints and the fact that faith-based schools and healthcare facilities are often more expensive for households to use than public facilities, the analysis suggests that they do manage to reach the poor to a substantial extent. This also suggests implicitly that they provide services valued by households.

In sub-Saharan Africa, public schools serve the poor slightly more than faith-based schools, but there are few differences in reach to the poor between faith-based and public healthcare facilities. Private secular facilities are titled more towards serving better off households for both education and healthcare. Differences in benefit incidence are related in part in differences in out-of-pocket costs for households.

Figure ES.18: Relative Out-of-Pocket Costs of Services in sub-Saharan African Countries
(Cost of faith-based and private secular providers vs. normalized value of 1 for cost of public providers)



Source: Adapted from Wodon (2015, 2019).

Box ES.2: Reaching Vulnerable Children

The Global Catholic Education project conducts interviews with practitioners working with the disadvantaged. Interviews are a great way to share experiences in an accessible and personal way and they can be a source of inspiration. The first set of interviews was conducted with teams, supported by the International Catholic Child Bureau (BICE), an international network of about 80 organizations committed to the defense of the dignity and rights of the child around the world. BICE supports organizations working with children in need regardless of faith. A total of 15 interviews were conducted on projects in Argentina, Cambodia, Colombia, the Democratic Republic of Congo, France, Guatemala, India, Lebanon, Mali, Peru, Russia, Tajikistan, and Togo. Many interviewees worked for Catholic organizations, but others worked with non-sectarian NGOs or NGOs from other faiths. Most projects reached children from disadvantaged socio-economic backgrounds, but some also targeted other vulnerable children, including children with disabilities.

Market Shares

The term market share is not always welcomed by faith-based organizations which tend to be driven by altruistic motives, as opposed to gains in size or power. What matters to most faith-based service providers is to serve their target populations with good quality services. The term market is however used here because it is easily understood, and because it reflects the fact that there are markets for education, healthcare, and social protection services in which faith-based providers must compete, if only to raise the funds they need to operate. Market share estimates have at times been used as blunt instruments to advocate on behalf of faith-based providers. This however leads to perverse incentives to exaggerate the magnitude of the services being provided. This is not the intent here. The footprint of faith-based providers is documented so that their contributions are recognized.

To estimate market shares in education, analysis must be conducted in terms of student enrollment because cross-country data on the total number of schools are not available. Therefore, the analysis follows findings from the Global Catholic Education Report 2021. To compute market shares for Catholic schools, enrollment data from the statistical yearbook of the Catholic Church were compared with total enrollment data from the UNESCO Institute of Statistics. Estimates were also provided for higher education using a slightly different method. Findings are visualized in Figure ES.19.

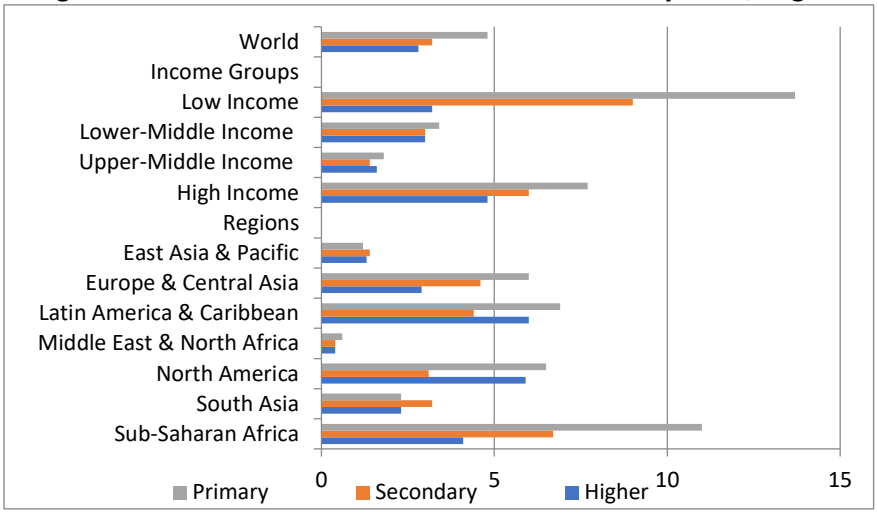
Globally, Catholic schools account for 4.8 percent of primary school enrollment and 3.2 percent of secondary school enrollment. At the primary level, the market share of Catholic schools is highest in sub-Saharan Africa (11.0 percent). At the secondary level, it is at 6.7 percent for the region. In low-income countries, Catholic schools account for one in seven students in primary schools (13.7 percent) and almost one in ten students enrolled at the secondary level (9.0 percent). The market share of Catholic schools is lowest in upper-middle income countries in part because China does not have Catholic schools.

The estimates of market shares for Catholic higher education are more tentative, but they suggest that it accounts globally for 2.8 percent of all students enrolled at that level. The market share is highest in Latin America and North America and lowest in the Middle East and North Africa. In terms of income groups, it is highest in high income countries and lowest in upper-middle income countries.

The Global Catholic Education Report 2021 also provides tentative estimates of the footprint of all Christian schools and universities taken together. Christian education institutions may serve at least 100 million students. As a result, the global market shares of Christian institutions could be about one and a half time larger than the estimates provided for Catholic schools. Another important segment of

education systems in many countries consists of schools associated with the Islamic faith. Analysis suggests that in sub-Saharan Africa, Koranic schools and various types of Islamic schools play an important role, although with substantial heterogeneity between countries as is the case for Christian schools.

Figure ES.19: Market Shares of Catholic Education by Level, Regions and Income Groups (%), 2018



Globally, the market share of Catholic education is estimated at 4.8 percent at the primary level, 3.2 percent at the secondary level, and 2.8 percent at the higher education level.

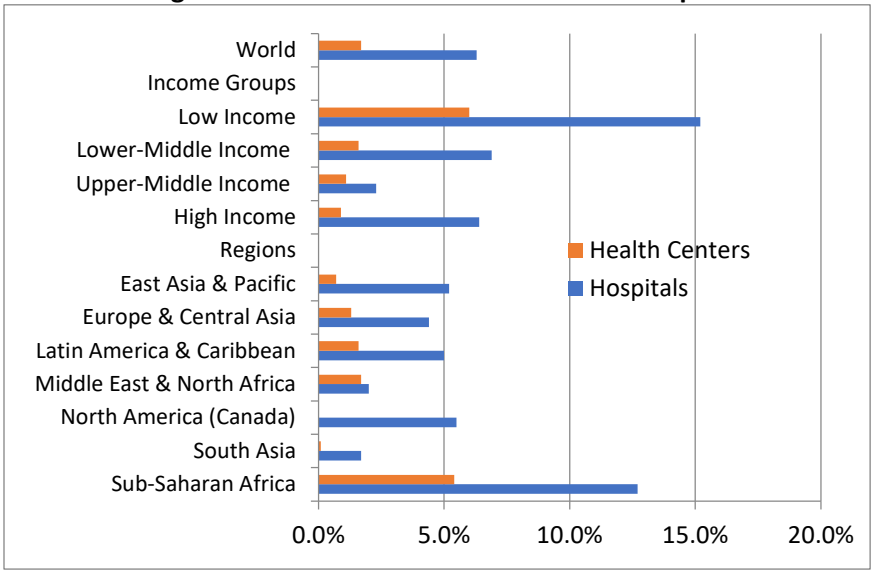
Source: Author's estimation.

Estimates of market shares for Catholic healthcare are provided next by comparing the number of facilities of the Catholic Church to the total number of facilities based on data from the World Health Organization for 140 countries. Globally, Catholic institutions may account for 6.3 percent of all hospitals and 1.7 percent of all health centres. Note however that a few large countries such as China and Russia are not included. If those countries were included, the market shares for Catholic facilities would be lower given no or few Catholic facilities in those countries. As for primary education, the market share of Catholic healthcare is highest in sub-Saharan Africa and in low income countries.

For OECD countries, market shares for Catholic healthcare can be estimated separately by comparing data from the Church's statistical yearbooks to OECD statistics for hospitals. For high income OECD countries, the market share of Catholic hospitals is estimated at 4.9 percent. This is slightly lower than the estimate obtained for high income countries with WHO data, but of a similar order of magnitude (the sets of countries included differ in the two datasets). For all OECD countries, the market share of Catholic hospitals is estimated at 3.8 percent.

In sub-Saharan Africa, data are available from CHAs in countries where they operate. According to CHAs, they may manage on average about a third of the hospital beds available in public and CHA hospitals (thus not including beds in private secular hospitals). The estimates are based on countries where CHAs have a large footprint; hence estimates for the region as a whole would be lower. Another approach to measuring the market share of faith-based healthcare consists in relying on household surveys, in which case faith-based facilities account for a much smaller share of all healthcare for two reasons. First, the market share of faith-based providers is lower for health centers than hospitals. Second, the survey estimates include services from a range of other healthcare providers, including pharmacies, traditional healers, and health professionals working outside of facilities.

Figure ES.20: Market Shares of Catholic Hospitals and Health Centers (%), 2019



Source: Author's estimation.

Globally, for 140 countries included in the analysis, the market share of Catholic facilities is estimated at 6.3 percent for hospitals and 1.7 percent for health centers.

Box ES.3: Beyond Facilities: Digitalizing the Distribution of Insecticide-treated Bed Nets

This report focuses on the role of faith networks in facilities-based services, but Catholic and other faith-based organizations also support national education, health, or social protection systems through projects. One example is a partnership between Catholic Relief Services (CRS) and Ministries of Health in African countries to improve the efficiency, quality, and coverage of community-based malaria interventions. With support from Unitaid, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Bill & Melinda Gates Foundation, CRS helped digitize mass campaigns for the distribution of Insecticide-treated bed nets in the Gambia, Nigeria, and Benin. Digitization has a number of benefits, including faster data collection and analysis for better monitoring and a reduction in the risks of errors in implementing campaigns. The data can also be used in integrated health approaches that rely on up-to-date information. CRS intends to continue to support national governments and partners in using the digital approach in more countries.

Preferences, Quality, and the Pandemic

Why do households decide to rely on services provided by faith-based facilities even though, at least for education and healthcare, the cost of those services is often higher for them than is the case for public facilities? The last chapter in the report explores this question.

For schools and universities, the Global Catholic Education Report 2021 emphasized the importance of education pluralism for the right to education. Education matters not only for the skills and competencies that students acquire, but also for the values that are shared from one generation to the next. Parents sending their children to faith-based schools – or the students themselves when choosing a faith-based university, often do so in part because of their values and faith. This was illustrated by two case studies, one for the United States and the other for Africa.

In the United States, data collected by the National Catholic Educational Association suggest differences in the motivation of parents sending their children to faith-based versus other types of schools. For all parents, the top five priorities for what children should learn in school relate to skills and success in college and

the job market. Priorities related to values and faith rank much lower. However, for parents with their youngest child in a Catholic school, values and faith are as important as skills and competencies. This suggests that for parents choosing Catholic schools, the emphasis placed on the transmission of values and faith in school makes it worthwhile for them to pay tuition to enroll their children in the schools[2]. Similarly, data on the motivations for students to go to a faith-based university suggest that values and faith play a role. Only 7.0 percent of freshmen in nonsectarian universities state that they are attracted by the religious affiliation/orientation of their university, while the proportion is 18.1 for those enrolled in Catholic universities and 35.8 percent for freshmen in other faith-based universities (including evangelical institutions). Other factors play a larger role for the choice of university, including its academic reputation or that of the intended major at the university, whether graduates get good jobs, and whether students are provided with financial assistance, but values and faith matter for some students.

In Ghana and Burkina Faso, two countries populations of different faiths, small scale surveys and qualitative work suggest differences in the reasons leading parents to choose various types of schools. Parents choosing Christian schools tend to do so for academic and teacher quality. Parents choosing Islamic schools emphasize the opportunity for their children to receive a religious education, with some mentioning academic and teacher quality too. In public schools, location is a deciding factor for the choice of the school for more than two thirds of parents, followed by academic quality and the lack of school fees. Other questions were asked to better understand why parents chose a specific school. One question was about the most important area of study for children. For parents of children in Franco-Arab and Islamic schools, religious education comes first, followed by moral education and academics (literacy). For parents at Christian schools, academics come first, as it does for parents at public schools.

Values and faith play an important role in the motivation of parents to send their children to faith-based versus public schools, and for students to enroll in faith-based universities. By contrast, faith is often not a key factor in the choice of a faith-based healthcare facility.

The emphasis on faith and values in faith-based schools does not mean that the schools do not accept children from all faiths. Interviews with school leaders in Ghana and Burkina Faso suggest that faith-based schools accept students from different faiths. Still, there are differences between schools. While many Muslims go to Christian schools, few Christians go to Islamic schools.

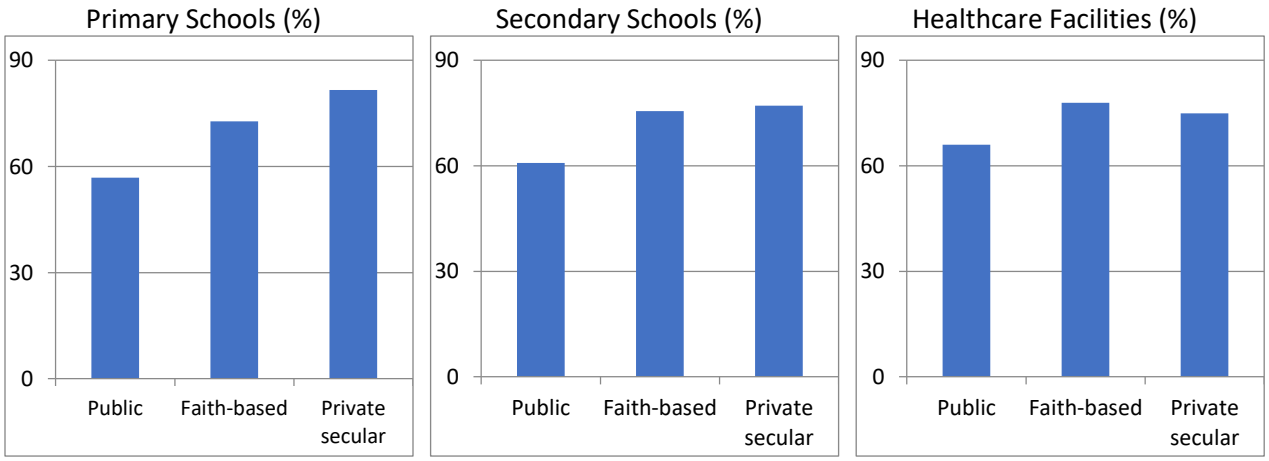
Do values and faith matter as well for the choice of healthcare providers? Not as much, according to the analysis carried in Ghana and Burkina Faso. Questions were asked to households as to why they choose different types of healthcare facilities, and how they perceive the care they received in those facilities. Patients in faith-based facilities were typically satisfied with the quality of the staff, the facilities' hygiene, and the relatively low cost of consultations. Satisfaction rates were lower for accommodation, technical equipment, and medicines, especially in Ghana for clinics not participating in the national health insurance scheme, which can lead to higher out-of-pocket costs for medicine. But contrary to what was observed for schools, the issue of religion was not a major reason for choosing faith-based facilities. Patients mentioned the importance of values and faith in general, not as a reason to choose a particular facility. When asked about the main advantages of faith-based healthcare, the quality of the staff and services,

[2] This does not imply that some parents care more about values than others. Parents not relying on Catholic schools may rely on other mechanisms than the schools to transmit their values to their children.

and for some proximity of the facility and assistance programs were mentioned more.

Are households satisfied with the services provided by faith-based organizations? While subjective satisfaction measures do not necessarily reflect the quality of the services being provided, they are still instructive to gauge household perceptions. Data from a half dozen household surveys for sub-Saharan African countries suggest that on average, households relying on faith-based and private secular schools and healthcare facilities are more satisfied with the services received than households relying on public schools and facilities (Figure ES.21). The gaps in satisfaction rates between faith-based and public providers are large, at respectively 16, 15, and 12 points for primary education, secondary education, and healthcare on average across countries.

Figure ES.21: Satisfaction with Services in sub-Saharan African Countries (%)



Source: Adapted from Wodon (2015, 2019).

In sub-Saharan Africa, parental satisfaction is higher in faith-based than public schools. The same is observed for patient satisfaction with healthcare facilities. Gaps in satisfaction rates between faith-based and public facilities are at 16, 15, and 12 points for primary education, secondary education, and healthcare.

Higher rates of satisfaction with faith-based providers do not however imply that the quality of the services being provided is sufficient. In the case of education, estimates suggest that in low and middle income countries, more than half of children age 10 are learning poor. This means that they not able to read and understand an age-appropriate text. In sub-Saharan Africa, the proportion is close to nine in ten. Some of these children are out-of-school, but many are enrolled in school and not learning enough. Catholic schools are not immune to the learning crisis. This may in particular be the case of Catholic schools that are part of the public education system. In Uganda, analysis of a Service Delivery Indicators survey suggests that in most schools, student performance is fairly low. In addition, student performance is higher in private schools, whether Catholic or not, than in public schools, again whether Catholic or not. But there are no major differences between public schools according to whether they are Catholic schools or not, and the same is true for the most part for the comparison of Catholic private schools with other private schools. After controlling for a wide range of factors affecting student performance, the same results hold.

For healthcare, issues of quality remain as well. As just one example, research on the

availability of basic equipment to care for visual impairment suggests that facilities associated with the Christian Health Association of Ghana have better equipment than public facilities, but still lack specialized equipment. This example suggests that even if some faith-based facilities have better equipment, they still often do not have the resources they need to provide care.

The pandemic is likely to have increased the difficulties faced by faith-based providers to provide quality services. This is clear for health facilities that have been stretched to the limit. The pandemic has weakened health systems and reduced life expectancy in many countries. It is also clear for schools that were closed for long periods of time. Initial estimates suggested that the COVID-19 pandemic could increase learning poverty in low and middle income countries by up to 10 percentage points. The estimates were later revised upwards. In addition, for faith-based schools and healthcare facilities that rely on cost recovery from household to cover their operating costs, higher levels of poverty threaten sustainability. In the United States, many Catholic schools closed in the 2020-21 school year due in part to the effects of the pandemic. Beyond this particular example, it is important to realize that the long-term costs for governments of the closing of faith-based providers in times of crisis may be larger than the short term cost of ensuring that the facilities are able to continue to operate.

CONCLUSION

Faith-based organizations play a key role in providing education, healthcare, and social protection services to populations all over the world, yet their contributions are rarely acknowledged in policy discussions. Similarly, lessons learned by the international community on what works to achieve the SDGs and promote human development do not sufficiently reach faith-based organizations.

This report is the first in a new series on integral human development. As is the case for the Global Catholic Education Reports, the report has two objectives: to make the experiences and role of Catholic and other faith-based organizations better known in the international community, and to bring to Catholic educators and all those interested in integral human development the expertise and knowledge emerging from the experience of the international community.

The focus of this first report on integral human development is more on the first than the second objective, as the aim is to take stock of some of what is known about the contributions of faith-based organizations in education, healthcare, and social protection. Future reports in this series will give more emphasis to the second objective, namely to share good practices from experiences and innovations on the ground, whether by faith-based or other organizations, so that the services being provided are of high quality and succeed in reaching the poor.

Box ES.4: The Global Catholic Education Project

Global Catholic Education is a volunteer-led project to contribute to Catholic education and integral human development globally with a range of resources. The website went live symbolically on Thanksgiving Day in November 2020 to give thanks for the many blessings we have received. Catholic schools serve 62.1 million children in pre-primary, primary, and secondary schools globally. In addition, 6.7 million students are enrolled at the post-secondary level (data for 2019). The Church also provides many other services to children and families, including in healthcare, social protection, and humanitarian assistance. The aim of the Global Catholic Education project is to serve Catholic schools and universities, as well as other organizations contributing to integral human development, with an emphasis on responding to the aspirations of the poor and vulnerable. If you would like to contribute to the project, please contact us through the website at www.GlobalCatholicEducation.org.

INTRODUCTION

Faith-based providers of education, healthcare, and social protection play an important role in efforts to achieve the Sustainable Development Goals (SDGs). They contribute to integral human development, understood as the development of each man and the whole man. Faith also affects people's behaviors, and thereby investments in human development. Yet the roles of faith and values in human development, and in particular the role of faith-based service providers, are still not sufficiently acknowledged in policy discussions[3]. Similarly, these policy discussions and the lessons learned by the international community on what works to achieve the SDGs and promote human development do not sufficiently reach faith-based organizations.

This report is the first in a new series on integral human development that has two aims: (1) to make the experiences and role of faith-based organizations in contributing to integral human development better known in the international community; and (2) to bring to faith-based educators and all those interested in integral human development expertise and knowledge from the international community. Given that this is the first report in a new series, its aim is limited: the goal is to measure the contributions of faith-based organizations to education, healthcare, and social protection[4].

The concept of integral human development emerged from Catholic social thought, but the vision of the person and of the process of development that it evokes is shared by many other faiths as well as by non-religious worldviews that place the dignity of the person and the importance of the community at the center of their approaches to development[5].

What is meant by integral human development? The term comes from *Populorum Progressio*, an encyclical on the development of people published by Pope Paul VI in 1967 where he stated that "the development of peoples must be well rounded; it must foster the development of each man and of the whole man." Integral human development is therefore understood as referring to "the development of each man and of the whole man."

> "The development of peoples must be well rounded; it must foster the development of each man and of the whole man" (Pope Paul VI, *Populorum Progressio*, 14.)

In 2017, at a gathering to celebrate the 50th anniversary of the publication of *Populorum Progressio* and the creation of a new Dicastery[6] for Integral Human Development, Pope Francis suggested that the verb "to integrate" could provide orientations for the work of the new Dicastery. The Pope delineated five aspects related to integration (Box I.1): the duty of solidarity, the need for viable models of social integration, the need to consider all aspects of development, the integration of the individual and the community as opposed to an approach anchored in individualism, and finally the integration of the body and the soul, which calls for spirituality.

[3] On the international community's engagement with faith actors, see the supplemental issue of the *Review of Faith & International Affairs* on USAID's 2020 Evidence Summit on Strategic Religious Engagement, including Seiple et al. (2021), Marshall (2021), and Marshall et al. (2021a, 2021b, 2021c). See also Mandaville (2021) on 'right-sizing' faith-based engagement from a government's perspective and Phillips (2021) on reflections about the summit.

[4] Because of this focus, for the analysis of education, there is a bit of overlap between the themes considered in this report and those discussed in the Global Catholic Education Report 2021 (Wodon, 2021a).

[5] For example, many aims of Catholic and other Christian schools are similar. See Barber et al. (2020).

[6] A Dicastery in the Catholic Church is similar to a Ministry in a national government.

Box I.1: Excerpts from an Address by Pope Francis on Integral Human Development

What does full or integral development mean – that is, the development of each man and the whole man – today and in the near future? In the wake of Paul VI, perhaps in the verb "to integrate" – a verb very dear to me – we can find a fundamental orientation for the new Dicastery. Let us look at some aspects together. It means integrating the different peoples of the earth. The duty of solidarity requires us to seek fair ways of sharing, so that there is no longer that dramatic inequality between those who have too much and those who have nothing, between those who discard and those who are discarded. Only the path of integration between peoples can permit to humanity a future of peace and hope.

It means offering viable models of social integration. Everyone has a contribution to make to the whole of society, everyone has a special feature that can be useful to enable us to live together, and no-one is excluded from contributing something for the good of all. This is both a right and a duty. And the principle of subsidiarity guarantees the need for the contribution of everyone, both as individuals and as groups, if we want to create a human society open to all.

It also means the integration in development of all those elements of which it is truly constituted. The different systems: the economy, finance, labor, culture, family life, and religion are, each in its own way, essential components of this growth. None of them can be rendered absolute and none of them can be excluded from a concept of integral human development which takes into account that the human life is like an orchestra that sounds good if the different instruments are in accord and follow a score shared by all.

In addition, it means integrating individual and community dimensions. It is true that we are children of a culture, at least in the Western world, which has exalted the individual to the point of turning it into an island, as if one can be happy alone. On the other hand, there are ideological views and political powers that have crushed the person, that have standardized it and deprived it of that freedom without man no longer feels human. This standardization is also due to economic powers that wish to take advantage of globalization, instead of encouraging greater sharing among men, simply to impose a global market of which they themselves set the rules and reap the profits. The self and the community are not in competition with each other, but the self can mature only in the presence of authentic relationships, and the community is generative when its members are, together and individually. This is even more applicable to the family, which is the first cell of society and where we learn to live together.

Finally, it means integrating the body and soul. Paul VI wrote that development cannot be reduced merely to economic growth (cf. n. 14); development does not consist in having more and more goods, enabling a solely material well-being. Integrating body and soul also means that no development work can really achieve its purpose if it does not respect the place where God is present to us and speaks to our hearts.

God has made Himself fully known in Jesus Christ: in Him, God and man are not divided and separated. God became man to make of human life, both personal and social, a concrete path to salvation. So the manifestation of God in Christ – including his acts of healing, liberation, and reconciliation that today we are called to offer in turn to the many injured who lie by the roadside – shows the way and the form of service that the Church intends to offer to the world: in this light, it is possible to understand what "integral" development means, a development that harms neither God nor man, since it takes on the consistency of both.

In this sense, the very concept of person, born and matured in Christianity, helps in the pursuit of a fully human development. Because "person" means relation, not individualism; it affirms inclusion not exclusion; unique and inviolable dignity rather than exploitation; freedom not coercion.

Source: Francis (2017).

Previously, the Pope noted in the Apostolic Letter *Humanam Progressionem* that created the new Dicastery[7] that "development takes place by attending to the inestimable goods of justice, peace, and the care of creation." He emphasized as areas of potential focus for the Dicastery "issues regarding migrants, those in need, the sick, the excluded and marginalized, the imprisoned and the unemployed, as well as victims of armed conflict, natural disasters, and all forms of slavery and torture". The concept of integral human development is broad, but the mission of the Catholic Church is to promote integral human development particularly among the poor and vulnerable and all those 'at the periphery'. While central to Catholic social thought, this emphasis on the less fortunate is also shared by many other faiths.

How do the Catholic Church and other faith-based organizations accomplish their mission? Their work towards integral human development and support to the less fortunate expresses itself in many different ways. The contribution of faith networks comes first and foremost from the lived experiences and actions of the faithful on a day to day basis (see Box I.2 on altruistic behaviors). Guidance from the faith leadership, including the Magisterium for the Catholic Church, also matters[8]. More than four in five people globally are affiliated with a religious tradition. They tend to trust faith leaders more than other leaders, especially at the local level[9]. As values and faith influence people's actions, faith leaders may contribute through their messages and actions not only to promoting solidarity and altruism, but also to encourage changes in behaviors that may lead to better human development outcomes. This is why faith networks and faith leaders are often considered by the international community as potential agents for social behavioral change[10].

Box I.2: Faith Affiliations, Religiosity, and Altruistic Behaviors

The relationships between faith affiliations, religiosity, and behaviors are complex. In some cases, they may be positive. In other cases they may be detrimental, including for behaviors towards adherents of other faiths. As one example of a positive relationship, analysis of data from the Gallup World Poll for more than 100 countries on charitable donations, volunteering, and help provided to strangers suggests that when controlling for a other factors that may affect altruistic behaviors, differences in behaviors by faith affiliation tend not to be large, and are often not statistically significant. By contrast, variables that suggest a higher level of religiosity tend to be associated with a higher likelihood of engaging in altruistic behaviors[11].

There have been several efforts over the years in the international community to promote a better understanding as well as a dialogue on the role of faith in development (see Box I.3). Yet it seems fair to say that the contributions of faith networks, and in particular their experience in providing much

[7] Francis (2016).

[8] Guidance comes from the Magisterium, but also from other faith leaders, including those engaged on the frontline of fighting poverty. In particular, the author was influenced by the thought of Father Joseph Wresinski (1983, 1984, 1985, 1986, 1987), the founder of the International Movement ATD Fourth World. See also Wodon (2018d).

[9] From the Pew Research Center, see Hacket et al. (2012) on estimates of the number of adherents to various religions, and Tamir et al. (2020) on differences between countries in perceptions of the relationship between faith, values, and morality.

[10] There is a large literature on social behavior change. See World Bank (2015) on the implications for development and Hallsworth and Kirkman (2020) for a broader introduction to the approach. There may be a risk of 'instrumentalizing' faith networks for purposes that may not be fully theirs, but considering the role of faith networks in efforts to achieve social behavioral change does not imply that they are necessarily being instrumentalized, Faith networks tend to be careful and fairly clear as to what they support, or do not support.

[11] Nguyen and Wodon (2018).

needed services to the population, often remain ignored in policy debates. To better document the role played by faith networks in human development, the focus in this report is on the role played by the Catholic Church and other faith-based organizations in managing networks of health, education, and social protection facilities, and some of the challenges they face.

Box I.3: International Development Agencies and the Faith and Development Nexus

Collaborative structures have been created by donors to explore issues related to faith and development. At the United Nations, the Interagency Task Force on Religion and Development has been operating since 2010 as a platform for UN agencies to work with faith-based civil society partners. The International Partnership on Religion and Sustainable Development is another platform funded by the German Federal Ministry for Economic Cooperation and Development and the United States Agency for International Development. At the World Bank, the work on faith and development has taken various forms, the latest of which was the Moral Imperative, an initiative launched with faith leaders in 2015. One interesting collaborative that has emerged from faith networks themselves is the Joint Learning Initiative on Faith and Local Initiatives.

Despite these various efforts, some of which have gone through ups and downs over the years, engagement by the international community with faith networks has remained limited, so that faith-based actors have not been the focus of policy discussions. One recent exception is UNESCO's Global Education Monitoring Report on non-state actors[12].

The report was written in the context of the COVID-19 pandemic. Vaccines provide hope that the pandemic will soon be better managed, but challenges remain, especially in developing countries where access to vaccines remains low. The rise of new variants of the virus is also a concern. The negative impact of the crisis on poverty and human development has been massive, and is likely to continue to be felt for years. The World Bank initially estimated that the crisis could lead to 150 million additional people falling into poverty in 2021, and as noted by UNICEF, children have been at risk of a range of negative impacts from the crisis[13].

The work of faith-based organizations is a key part of the response to the pandemic. The need to provide support to vulnerable groups is greater than ever, but the ability of some faith-based organizations to do so may be under threat. This is for example the case for Catholic schools in countries where they do not benefit from public funding. When parents lose their livelihoods, they may not be able to send their children to the school of their choice if they cannot afford tuition[14]. In other sectors too, for faith-based nonprofits depending on donations, the ability to maintain or expand services to respond to growing needs may be stretched.

At the same time, some of the strengths of faith-based organizations are that they are in communities for the long term and that they benefit from the support of communities. During hard times, communities count on these organizations to provide support and services. Individuals and groups mobilize themselves to support faith-based organizations in part through volunteering – contributing time and expertise. As a result, faith-based organizations tend to be resilient, and much can be learned from their experience on the ground by the international community.

A key strength of Catholic and other faith-based organizations is that they are present in communities for the long term and that they benefit from the support of the communities.

It is clear that the services provided today by faith-based organizations are broad. In

[12] See UNESCO (2021). The Global Catholic Education project contributed two background papers for UNESCO's report - see Wodon (2021o, 2021p).

[13] See World Bank (2020a) on poverty estimates that were revised since, and UNICEF (2020a) on children.

[14] See Wodon (2020b, 2020c, 2021a).

healthcare, one prominent example is that of Christian Health Associations which provide care to tens of millions of families in Africa, especially in East and Southern African countries[15]. In social protection, the Catholic Church and other faith-based networks manage large numbers of nurseries, orphanages, and other institutions. They also engage in humanitarian assistance, including for refugees, internally displaced populations, and migrants. In education, as noted in the Global Catholic Education Report 2021, Christian schools and universities may serve 100 million students[16].

But how large exactly is service provision by faith-based organizations? What are some of the characteristics of the services being provided? Do faith-based organizations reach the poor, as they profess to? The objective of this first global report on integral human development is to measure more precisely than has been done so far these contributions in education, healthcare, and social protection. The analysis has limitations given the available data, but the aim is to pull together results from various datasets in order to provide stylized facts. The report builds on previous work by the author[17], but it also weaves in substantial new analysis.

The report is structured in two parts. The first part consists of three chapters documenting the scope of service provision by the Catholic Church globally in education, healthcare, and social protection. The focus is on the Catholic Church because it provides in its statistical yearbooks data on the number of K12 schools, healthcare facilities, and social protection facilities that it manages globally and by country. Similar data are not available for most other faith-based organizations[18]. Still, even though the focus is on service delivery by the Catholic Church, interesting patterns emerge that are likely to be relevant or other faith networks.

The second part of the report looks in more details at three questions: (1) what is the market share of Catholic and other faith-based organizations in education, healthcare, and social protection?; (2) what is the out-of-pocket cost for households of using faith-based services in comparison to public and private secular services, and does cost affect the ability of faith-based providers to reach the poor; and (3) what is the quality of the services provided by fait-based organizations, and to what extent are households satisfied with those services? A brief conclusion follows.

Box I.4: The Global Catholic Education Project

Global Catholic Education is a volunteer-led project to contribute to Catholic education and integral human development globally with a range of resources. The website went live symbolically on Thanksgiving Day in November 2020 to give thanks for the many blessings we have received. Catholic schools serve 62.1 million children in pre-primary, primary, and secondary schools globally. In addition, 6.7 million students are enrolled at the post-secondary level (data for 2019). The Church also provides many other services to children and families, including in healthcare, social protection, and humanitarian assistance. The aim of the Global Catholic Education project is to serve Catholic schools and universities, as well as other organizations contributing to integral human development, with an emphasis on responding to the aspirations of the poor and vulnerable. If you would like to contribute to the project, please contact us through the website at www.GlobalCatholicEducation.org.

[15] See Wodon (2015, 2021a) and Olivier et al. (2017).
[16] Wodon (2021a).
[17] On sub-Saharan Africa, see Wodon (2014, 2015). For Catholic education, see Wodon (2020a, 2021a).
[18] This is a broader issue in the literature as the contributions of non-Christian faiths tend to be under-researched (Karam, 2021). In addition, much of the work on faith and development may suffer from a Western secular bias (Wilkinson, 2021).

PART I
TRENDS IN SERVICE PROVISION BY THE CATHOLIC CHURCH

CHAPTER 1
EDUCATION

Introduction

In the context of efforts by the international community to achieve the SDGs, faith-based organizations play an important role in the provision of education, health, and social protection services, and more generally in the promotion of integral human development. Many of these organizations are Christian, and among Christian organizations, in part for historical reasons, Catholic institutions tend to manage the largest networks of facilities.

This chapter focuses on the contributions of the Catholic Church to education. It follows closely the analysis of trends in enrollment in Catholic education provided in the Global Catholic Education Report 2021[19], but with two differences.

The first difference is that this chapter documents trends in the number of preschools, primary schools, and secondary schools managed by the Catholic Church globally based on data available in the statistical yearbooks of the Church[20]. By contrast, in the Global Catholic Education Report 2021, the analysis was in terms of trends in the number of students enrolled. The reason for focusing on schools in this chapter is that it makes it easier to compare trends for education with those for healthcare and social protection in the next two chapters. Indeed, in the statistical yearbooks of the Church, information is only available on the number of healthcare and social protection facilities managed by the Church, and not on the number of patients or individuals served.

Data on the number of Catholic preschools, primary schools, and secondary schools are available in the Church's statistical yearbooks.

The second difference is that the analysis is conducted here only in terms of K12 schools managed by the Church and not universities. This focus is due to the fact that the statistical yearbooks do not provide data on the number of universities and other institutions of higher education affiliated with the Church: they only provide data on enrollment in those institutions.

This does not mean that Catholic universities do not have a fundamental role to play for the well-being and growth of children, and more broadly the promotion of integral human development. Catholic universities play a leading role in many countries in training future teachers, nurses, doctors, social workers, and other professionals at the frontline of service delivery in human development. They also play a leading role in research to inform the work of schools, healthcare facilities, and social protection organizations. But in this chapter, the focus is on K12[21] schools (analysis for universities is available in separate reports from

[19] Wodon (2021a). Estimates for 2019 suggest that 35.2 million children were enrolled in Catholic primary schools, with 19.4 million children enrolled in Catholic secondary schools, and 7.5 million children enrolled at the preschool level. In addition, 6.7 million students are enrolled in Catholic institutions at the post-secondary level. On the Catholic Church's role in education globally, see Wodon (2018a, 2018b, 2019a, 2019g, 2019j).

[20] The latest yearbook was published in 2021 with data for 2019 (see Secretariat of State, 2021).

[21] The term 'K12' refers in the United States to education from kindergarten (preschool) to 12th grade (the end of secondary schools).

the Global Catholic Education project[22]). In what follows, a basic analysis of trends in the number of schools managed by the Church is provided. This is followed by a discussion of some of the implications of these trends.

Trends in the Number of Schools

Simply looking at trends in the number of schools managed by the Church does not do justice to the larger contributions of the Church to education, but it is a start. How has the number of pre-primary, primary and secondary Catholic schools evolved over the last four decades? In which parts of the world do we observe growth in the number of K12 schools, and where do we observe a potential decline? How are schools distributed between the pre-primary, primary, and secondary levels? Which are the countries with the largest number of Catholic schools? To answers these questions, this chapter documents trends in the number of Catholic schools from 1980 to 2019.

The analysis closely follows the Global Catholic Education Report 2021, except that as mentioned earlier, it is conducted in terms of the number of schools operated by the Church as opposed to enrollment in the schools. The data are from the latest statistical yearbook of the Church[23]. While the data are self-reported by the chancery offices of ecclesiastical jurisdictions that fill the annual questionnaire, they seem to be of sufficient quality to document broad trends over time. In a typical year, about five percent of the ecclesiastical jurisdictions do not fill the questionnaire, but this is the case mostly for small jurisdictions, so that the missing data should not affect the overall results substantially for most countries, or at the regional and global levels.

Table 1.1 provides estimates of the number of preschools, primary schools, and secondary schools, as well as the total number of schools for all three levels combined. Data are provided by decade from 1980 to 2019[24]. Estimates are provided by region – as defined in the yearbooks, and globally. In 2019, the Catholic Church operated 72,667 preschools, 98,925 primary schools, and 49,552 secondary schools, for a total of 221,144 schools. Although enrollment in K12 schools grew, this represented a decline of two percent in the total number of schools versus 2018 when the Church operated 225,851 schools. The decline was largest for the number of primary schools[25].

The Church operated 72,667 preschools, 98,925 primary schools, and 49,552 secondary schools in 2019. Although student enrollment grew, this represented a decline of two percent in the total number of operating schools versus 2018.

Figures 1.1 through 1.4 provide a visualization of the trends in the number of schools by region for five regions: Africa, the Americas, Asia, Europe, and Oceania. The analysis is kept at that level to keep the Tables and Figures manageable, but data are available at the country level in the statistical yearbooks. A number of interesting findings emerge from the data. Five findings are highlighted here[26].

First, even if there was a slight decline in 2019 versus 2018, the trends in Figures 1.1 through 1.4 suggest healthy growth in the number of schools over time by decade. The total number of K12 schools increased by 54 percent between 1980 and 2019 globally, from 143,574 to 221,144. Most of the growth in the number of schools was concentrated in Africa, and within that region, in sub-Saharan Africa (not shown in the Table). This is not surprising given high rates of population growth and gains

[22] See for example Wodon (2021n) on Catholic universities in the United States.
[23] Secretariat of State (2021).
[24] In the Global Catholic Education Report 2021, data on enrollment are provided from 1975 to 2018. For this report, given that data on healthcare and social protection are not included in the 1975 yearbook, the analysis is based on data from 1980 onwards.
[25] In 2018, the Church operated 73,164 preschools, 103,146 primary schools, and 49,541 secondary schools according to the yearbook for that year.
[26] The analysis follows Wodon (2021a).

in educational attainment on the continent. Rising demand for education led to the creation of new schools. Over the same period, enrollment in K12 schools doubled globally as many existing schools became larger apart from the fact that new schools were created.

By 2019, the Africa region had 75,844 schools. Of those, 19,098 were preschools, 41,124 were primary schools, and 15,622 were secondary schools. The region accounted for more than a third (34.3 percent) of all Catholic schools globally. The next three regions in terms of the number of schools are the Americas (50,334 schools), Asia (42,256 schools), and Europe (46,647). Oceania, with a much smaller population, had 6,063 schools. In proportionate terms from the base, apart from Africa, Asia and Oceania are the two regions where the number of schools increased the most over the last four decades. In the Americas, there was a smaller increase (with a decline in the United States, but growth in Central and Latin America), while in Europe there was a decline.

The largest gains in the number of schools are observed in Africa and Asia. This was expected given high rates of population growth and gains in educational attainment in those regions.

Table 1.1: Trends in the Number of Catholic K12 Schools

	1980	1990	2000	2010	2019
			Preschools		
Africa	1,954	6,646	11,672	13,600	19,098
Americas	8,684	12,675	15,078	17,502	16,394
Asia	4,889	8,000	10,905	13,935	14,119
Europe	22,771	23,481	23,528	23,963	21,567
Oceania	185	349	661	1,544	1,489
World	38,483	51,151	61,844	70,544	72,667
			Primary schools		
Africa	18,654	23,650	30,245	34,238	41,124
Americas	21,912	21,440	23,860	23,624	21,716
Asia	11,108	12,608	14,625	15,877	16,501
Europe	21,373	18,422	18,006	15,812	15,739
Oceania	2,407	2,428	2,721	3,296	3,845
World	75,454	78,548	89,457	92,847	98,925
			Secondary schools		
Africa	3,244	4,449	7,297	11,477	15,622
Americas	8,660	8,585	9,409	11,665	12,224
Asia	6,207	7,572	7,976	10,015	11,636
Europe	10,844	9,933	10,226	9,750	9,341
Oceania	682	661	651	684	729
World	29,637	31,200	35,559	43,591	49,552
			K12 schools		
Africa	23,852	34,745	49,214	59,315	75,844
Americas	39,256	42,700	48,347	52,791	50,334
Asia	22,204	28,180	33,506	39,827	42,256
Europe	54,988	51,836	51,760	49,525	46,647
Oceania	3,274	3,438	4,033	5,524	6,063
World	143,574	160,899	186,860	206,982	221,144

Source: Compiled by the author from the annual statistical yearbooks of the Church.

A second key finding is the fact that there are substantial differences between regions in the share of schools by level (see Table 1.2 and Figure 1.5). Globally, primary schools account for 44.7 percent of all Catholic K12 schools in 2019, versus 22.4 percent for secondary schools, and 32.9 percent for preschools (but these schools enroll only one in eight of all students in Catholic K12 schools because they tend to be smaller). In Africa however, primary schools still account for 54.2 percent of all K12 schools, in part because the transition to secondary schools is still weak in many countries (only about four in ten students in sub-Saharan Africa complete their lower secondary school according to the World Bank's World Development Indicators). By contrast, in Europe, primary schools account for a third (33.7 percent) of total enrollment in Catholic schools. This is due not only to substantial enrollment at the secondary level, but also to higher enrollment in preschools. In Oceania, perhaps surprisingly, the share of schools that operate at the primary level is even higher than in Africa, at 63.4 percent. Globally, there has been a progressive decline in the share of primary schools in all K12 schools from 52.6 percent in 1980 to 44.7 percent in 2019.

Figure 1.1: Number of Preschools

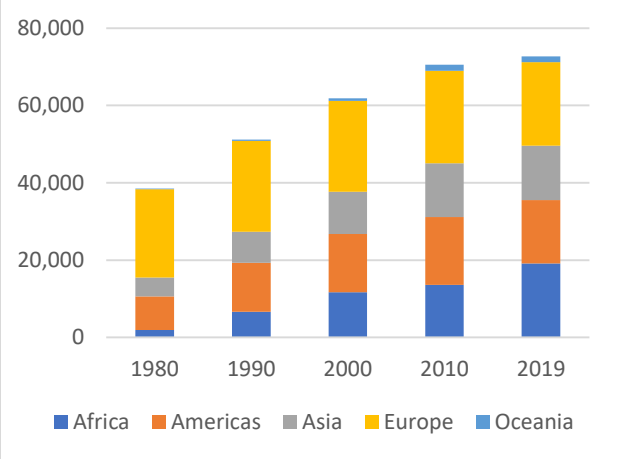


Figure 1.2: Number of Primary Schools

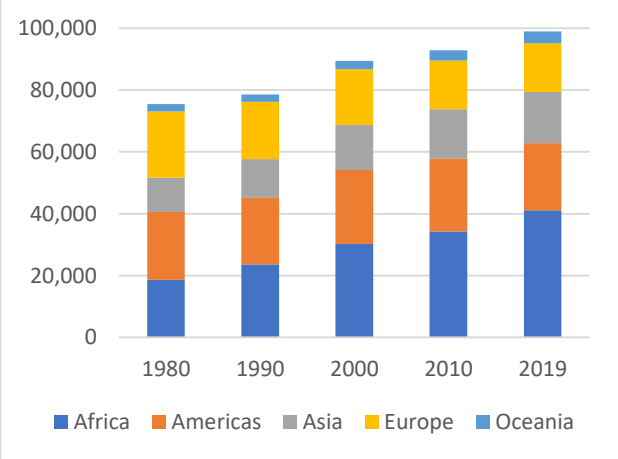


Figure 1.3: Number of Secondary Schools

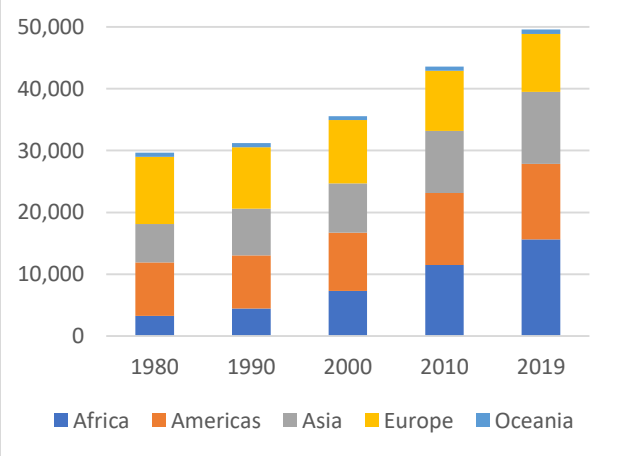
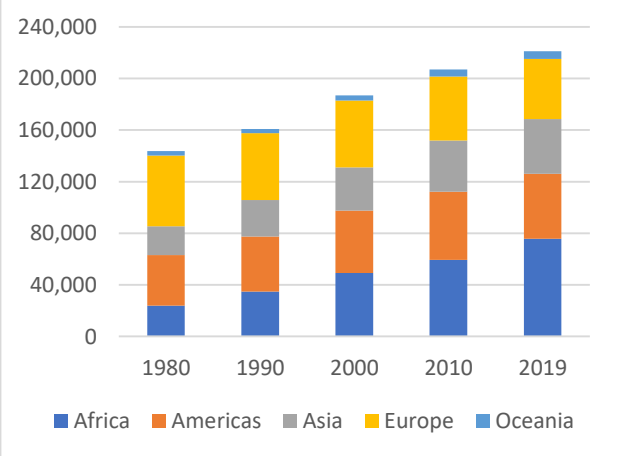


Figure 1.4: Total Number of K12 Schools



Source: Compiled by the author from the Statistical Yearbooks of the Church.

Box 1.1: More Schools or Larger Schools? Patterns of Growth in Enrollment in Catholic Schools

Data from the statistical yearbooks of the Church can be used to assess whether growth in enrollment in Catholic schools over time is mostly accounted for by larger schools, more schools, or both. Consider the period from 1995 to 2016[27]. Mathematically, the growth rate for enrollment is the sum of the growth rates in the number of schools and the growth rates in the average size of the schools. It turns out that for preschools, of the 1.9 percent annual growth rate in enrollment globally, 1.4 percent is attributed to the growth in the number of schools, and 0.5 percent to growth in the size of schools. For secondary education, annual growth in enrollment globally over the two decades, at 2.0 percent per year, is also due more to a higher number of schools (1.7 percent) than to an increase in the size of schools (0.3 percent). Only in the case of primary education is the contribution of changes in the size of schools to enrollment growth larger, at 1.0 percent, than the contribution of the increase in the number of schools at 0.6 percent. There are however differences between regions in these patterns.

Table 1.2: Proportion of Catholic K12 Schools by Level (%)

	1980	1990	2000	2010	2019
			Preschools		
Africa	8.2	19.1	23.7	22.9	25.2
Americas	22.1	29.7	31.2	33.2	32.6
Asia	22.0	28.4	32.5	35.0	33.4
Europe	41.4	45.3	45.5	48.4	46.2
Oceania	5.7	10.2	16.4	28.0	24.6
World	26.8	31.8	33.1	34.1	32.9
			Primary schools		
Africa	78.2	68.1	61.5	57.7	54.2
Americas	55.8	50.2	49.4	44.8	43.1
Asia	50.0	44.7	43.6	39.9	39.1
Europe	38.9	35.5	34.8	31.9	33.7
Oceania	73.5	70.6	67.5	59.7	63.4
World	52.6	48.8	47.9	44.9	44.7
			Secondary schools		
Africa	13.6	12.8	14.8	19.3	20.6
Americas	22.1	20.1	19.5	22.1	24.3
Asia	28.0	26.9	23.8	25.1	27.5
Europe	19.7	19.2	19.8	19.7	20.0
Oceania	20.8	19.2	16.1	12.4	12.0
World	20.6	19.4	19.0	21.1	22.4

Source: Compiled by the author from the annual statistical yearbooks of the Church.

[27] This is the period analyzed in Wodon (2019e).

A third finding is that in proportionate terms, as a percentage change from the base, the highest growth rates are also observed for Africa, as was the case for absolute gains in the number of schools. But growth rates are also high in Asia and Oceania. The annual growth rates for the period from 1980 to 2019 as well as by decade are computed taking into account compounding. They are provided in Table 1.3 and visualized in Figure 1.6. In Africa, the annual growth rates are estimated at 6.2 percent for the total number of preschools over the last four decades, 2.1 percent for primary schools, 4.2 percent for secondary schools, and 3.1 percent for the total number of K12 schools. These growth rates are two to three times larger than those observed for the number of Catholic schools globally. In Asia, growth rates in the number of Catholic schools are slightly above those observed for the world, at 2.8 percent for preschools, 1.0 percent for primary schools, 1.7 percent for secondary schools, and again 1.7 percent for the total number of schools. By contrast, in the Americas and in Europe at all levels, growth rates in the number of schools tend to be much smaller, and in some cases are negative, especially in Europe.

The highest growth rates in the number of schools are observed for Africa, as is the case for absolute gains in the number of schools. But growth rates are also high in Asia and Oceania.

For the Americas, a difference between the United States and other countries should be noted. While the number of schools continues to grow in some countries in Central and Latin America, there has been a decline in the United States[28]. This is due in part to a lack of public funding for schools which generates budget savings for the state, but implies out-of-pocket costs for parents[29]. The decline in enrollment and as a result in the number of schools has affected Catholic schools more than other faith-based and private secular schools[30].

Fourth, there is heterogeneity between countries in the size of their Catholic school networks. Table 1.4 provides the list of the 15 countries with the largest number of schools in 2019. Together, these 15 countries account for more than half of the total number of Catholic schools globally. The Table also provides the number of students enrolled in each country.

It would make sense to consider total enrollment in K12 schools as the key measure of the size of Catholic school networks, as done in the Global Catholic Education Reports[31]. In that case, after India which comes first due to the sheer size of the country, the Democratic Republic of Congo (DRC), Uganda, Kenya, and Malawi would be in the top five. Three of these four Africa countries are classified as low-income by the World Bank, while Kenya is a lower-middle income country, as is India. The fact that the Church has an especially large number of students enrolled in Catholic schools in low and lower-middle income countries is encouraging for one of its core missions, which is to serve the poor. This will be discussed in more details in the second part of this report.

It should be noted that in the DRC, Uganda, Kenya, and Malawi, most Catholic schools are actually public schools funded by the state, at least for operating costs[32]. In the DRC and Uganda in particular, Catholic and other faith-based schools have a large market share due in part to historical factors and the limited ability of the state to provide education services during periods of conflict[33].

As discussed in the second part of this report, the fact that enrollment in Catholic schools is large in low income countries is important for the mission of the Church to serve the poor.

[28] Wodon (2018c).

[29] On savings for the state in the United States and other countries, see Wodon (2019d, 2019f).

[30] Murnane et al. (2018).

[31] See Wodon (2021a).

[32] On benefits but also challenges that this may create, see D'Agotsino et al. (2019) on Kenya.

[33] Backiny-Yetna and Wodon (2009), Wodon (2017a).

Table 1.3: Annual Growth Rate for the Number of Catholic Schools by Level (%)

	1980s	1990s	2000s	2010s	1980-2019
			Preschools		
Africa	13.0	5.8	1.5	3.8	6.2
Americas	3.9	1.8	1.5	-0.7	1.7
Asia	5.0	3.1	2.5	0.1	2.8
Europe	0.3	0.0	0.2	-1.2	-0.1
Oceania	6.6	6.6	8.9	-0.4	5.6
World	2.9	1.9	1.3	0.3	1.7
			Primary schools		
Africa	2.4	2.5	1.2	2.1	2.1
Americas	-0.2	1.1	-0.1	-0.9	0.0
Asia	1.3	1.5	0.8	0.4	1.0
Europe	-1.5	-0.2	-1.3	-0.1	-0.8
Oceania	0.1	1.1	1.9	1.7	1.2
World	0.4	1.3	0.4	0.7	0.7
			Secondary schools		
Africa	3.2	5.1	4.6	3.5	4.2
Americas	-0.1	0.9	2.2	0.5	0.9
Asia	2.0	0.5	2.3	1.7	1.7
Europe	-0.9	0.3	-0.5	-0.5	-0.4
Oceania	-0.3	-0.2	0.5	0.7	0.2
World	0.5	1.3	2.1	1.4	1.4
			K12 schools		
Africa	3.8	3.5	1.9	2.8	3.1
Americas	0.8	1.2	0.9	-0.5	0.7
Asia	2.4	1.7	1.7	0.7	1.7
Europe	-0.6	0.0	-0.4	-0.7	-0.4
Oceania	0.5	1.6	3.2	1.0	1.6
World	1.1	1.5	1.0	0.7	1.1

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Figure 1.5: Proportion of Catholic K12 Schools by Level (Shares in %, 2019)

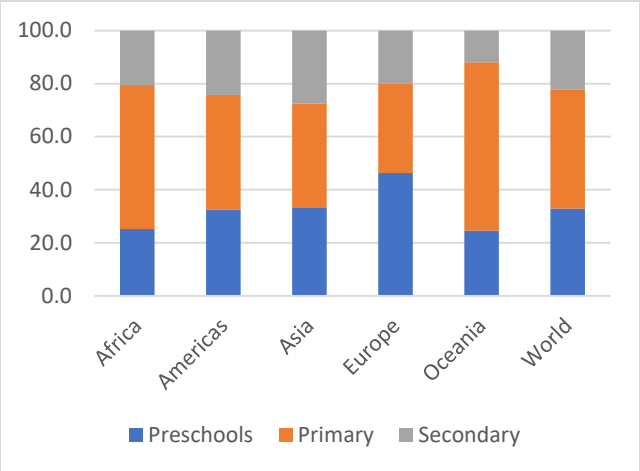
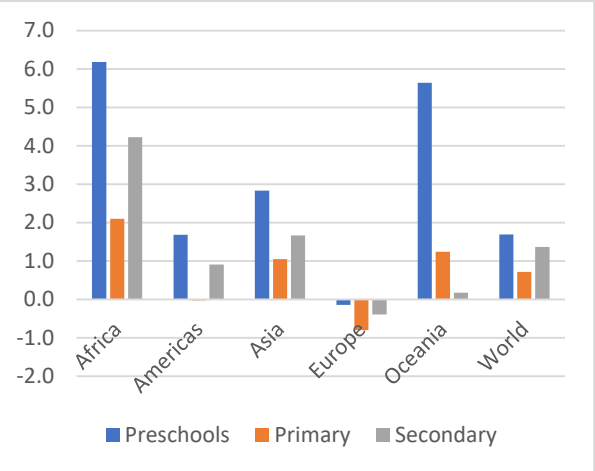


Figure 1.6: Annual Growth Rates in the Number of Schools (%, Over Four Decades)



Source: Author's estimations from the Statistical Yearbooks of the Church.

Table 1.4: Top 15 Countries by Number of Catholic K12 Schools and Enrollment Data, 2019

	Preschools	Primary Schools	Secondary Schools	Total K12 Schools	Enrollment
India	7,709	10,463	7,352	25,524	9,592,251
DR Congo	679	11,547	5,423	17,649	6,275,177
Kenya	4,804	5,383	2,189	12,376	4,156,409
United States	3,709	4,876	1,316	9,901	1,942,082
France	2,930	4,092	2,419	9,441	2,147,407
Germany	8,243	103	743	9,089	982,376
Mexico	3,319	2,437	2,405	8,161	1,188,253
Uganda	1,824	5,251	819	7,894	5,014,760
Madagascar	1,953	4,076	1,074	7,103	713,217
Italy	4,868	1,033	945	6,846	558,548
Haiti	2,081	3,433	557	6,071	454,530
Indonesia	1,544	2,697	1,461	5,702	895,271
Spain	1,821	1,946	1,897	5,664	1,385,364
Nigeria	1,944	2,088	1,119	5,151	1,053,377
Ghana	1,760	1,955	1,230	4,945	1,040,738

Source: Compiled by the author from the annual statistical yearbooks of the Church.

For comparability with rankings in subsequent chapters for healthcare and social protection facilities, the ranking in Table 1.4 is based on the number of schools, as opposed to total enrollment in K12 schools. This leads the United States, France, Germany (because of a large number of preschools), and Mexico to rank higher. These countries have a large number of schools, some of which are small especially at the primary level in comparison to the size of many schools in sub-Saharan Africa.

Most of the countries listed in Table 1.4 are relatively large in terms of their population. The main exception is Haiti, where most schools are Catholic schools. Ghana has a mid-level population. In terms of enrollment, Belgium ranks 12th, but it does not make the top 15 in terms of the number of schools and is therefore not included in Table 1.4. The country has a large number of students enrolled in Catholic schools in part because of a system that funds (almost) equally Catholic and public schools. In other countries, while the number of Catholic K12 schools and enrollment may be large due to population sizes, the market share of Catholic schools is often low, often due to limited or no state support leading to higher out-of-pocket costs for parents. This is for example the case in the United States and India.

Fifth, the fact that the highest growth rate in the number of schools is observed for preschools is good news, not so much for future enrollment in Catholic primary or secondary schools, but rather for the benefits for children enrolled in preschools. The literature suggests that early childhood is a critical period in the life of children and that investing in children at that time has high returns (and often higher returns than investments later in life). This is the case especially for the first 1,000 days in the life of children when brain development occurs, but also later, including to make sure that all children are ready to enter primary school[34]. Early stimulation and preschools have been identified as key interventions that governments and other organizations should promote when investing in human capital[35].

The fact that preschools have the highest growth rate is good news for children. Early childhood is a critical period and investing in children at that time has high returns.

[34] Black et al. (2017).
[35] Denboba et al. (2014).

Box 1.2: Challenges and Opportunities for Catholic Schools: Interviews with Teachers and Leaders

Beyond statistics on trends in the number of schools, what is the reality of Catholic education on the ground and what are the challenges and opportunities faced by schools? To give voice to those on the frontline, the Global Catholic Education project conducts interviews with practitioners. These interviews are a great way to share experiences in an accessible and personal way not only for educators working in schools and universities, but also for those engaged in non-formal education organizations that are essential to provide better opportunities for all, especially those in poverty or vulnerability.

Two series of interviews were recently conducted with educators. First, in order to celebrate the work of teachers for World Catholic Education Day, the Global Catholic Education project produced a compilation of 25 interviews with Catholic educators globally. The compilation is available here. Second, a separate series of interviews was conducted with national Catholic education leaders from sub-Saharan Africa and the Middle East and North Africa (MENA). As discussed in this chapter, sub-Saharan Africa is the region of the world with the fasted growth in Catholic schools, especially at the primary level. Enrollment is much lower in MENA, but Catholic schools in the region are emblematic of efforts to welcome students from all backgrounds since many students enrolled in Catholic schools in the region are Muslim. This is also the case for several West African countries represented in the collection of interviews. The interviews were based on a core set of questions: (1) You manage the Catholic school network of your country. Could you please tell us what your work entails?; (2) What do you believe are the current strengths of Catholic education in your country?; (3) In which areas could Catholic education in your country be improved and how?; (4) Have you observed recently interesting innovative initiatives in Catholic education in your country? If so, what are they and why are those initiatives innovative?; (5) How do you understand the call from Pope Francis for a new Global Compact on Catholic education? How do you think you could contribute to the Pope's vision?; (6) What events, projects, or activities could be suggested to strengthen a common identity for Catholic education at a regional or global level? What are your ideas?; (7) What are some of the priorities in terms of training and capacity building for school principals, teachers, alumni, parents, or other groups to strengthen Catholic education in your country?; (8) Could you please share how you ended up in your current position, what was your personal journey?; and (9) Finally, could you share a personal anecdote about yourself, what you are passionate about? This second compilation of interviews is available here.

Summing Up

The purpose of this chapter was to provide a basic analysis of trends in the number of Catholic K12 schools globally. The chapter is adapted from the Global Catholic Education Report 2021 which discusses trends in student enrolment as opposed to trends in the number of schools, but both trends are broadly similar. The focus on the number of schools as opposed to the number of students enrolled comes from the fact that for healthcare and social protection, the statistical yearbooks of the Church only provide data on facilities, not the number of people served. Hence the analysis in the first part of this report focuses on facilities as opposed to people served. A few concluding remarks can be made, following again the discussion in the Global Catholic Education Report 2021.

First, much of the growth in the number of schools has been observed in mostly low income countries in Africa[36]. This does not mean however that in those countries, Catholic schools succeed in reaching the very poor, even if many of the students they serve are likely to be poor. The risk for the schools to enroll

[36] For a more detailed analysis on Africa, see Wodon (2021b) and Wodon (2021c) for a comparison with health sector provision by the Catholic Church. On broad trends in the developing world versus the developed countries and some factors at work and implications, see Wodon (2021d, 2021e, 2021f).

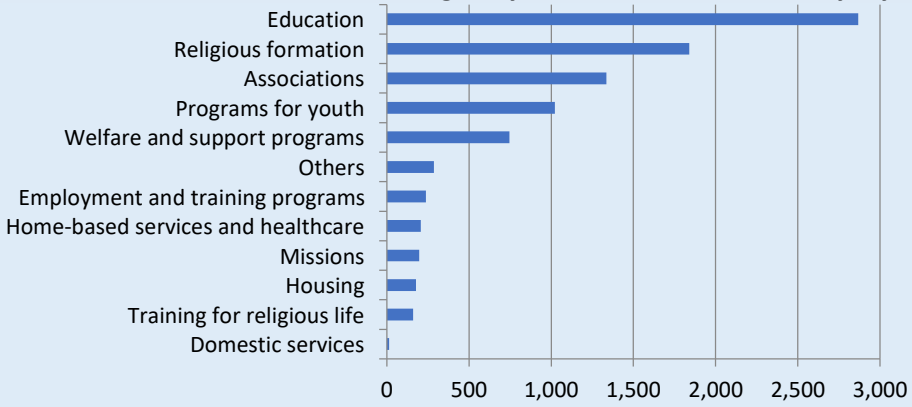
proportionately more children from the well-to-do has long been recognized. Congregations which used to be able to provide quasi-free education in their schools a few decades ago may not anymore have the personnel and resources to do so today. In the absence of state support, cost recovery may lead some of the schools to be unaffordable for the poor. These pressures may become more severe over time in countries where Catholic schools do not benefit from state funding.

At the same time, it is important to recognize that Catholic schools have historically served many children in poverty as well as other vulnerable groups. This includes the role played by congregations to provide education for girls, as illustrated in Box 1.3 for the Salesian Sisters of Saint John Bosco (the congregation is also referred to as Figlie di Maria Ausiliatrice or FMA, which in English means Daughters of Mary Help of Christians).

Box 1.3: Investing in Education for Adolescent Girls: Salesian Sisters of Saint John Bosco

Investing in girls' education is crucial for their future earnings in adulthood as well as their health and the health of their children. In particular, keeping girls in secondary school is one of the best ways to end child marriage and early childbearing, which in turn can reduce fertility rates in countries with high population growth and usher a demographic dividend. Education is associated with gains in women's health knowledge, ability to seek care, and psychological well-being. It reduces the risks of intimate partner violence and under-five mortality and stunting for their children, while increasing child registration after birth[37]. Catholic religious orders play an important role in providing education for girls. In particular, the Salesian Sisters of Saint John Bosco or FMA congregation founded 150 years ago has more than 11,500 Sisters managing thousands of institutions globally (Figure 1.7). Their work is featured in seven of the interviews compiled by the Global Catholic Education project for World Catholic Education Day (available here). Three of the Sisters work in Catholic education institutions. Two work in non-formal education settings. The last two are involved in advocacy work at the international level.

Figure 1.7: Number of Institutions Managed by the FMA Institute Globally, by Category



Source: FMA Institute (preliminary estimates).

[37] See Botea et al. (2017), Wodon et al. (2018), Onagoruwa and Wodon (2020), and Wodon, Male et al. (2020).

Second, while the analysis in this report was conducted separately for the three levels of schooling being considered, there are links between levels. While a larger number of Catholic preschools may not necessarily lead to higher enrollment in Catholic primary schools, the link between Catholic primary and secondary schools is stronger, with primary schools serving as feeder schools for secondary schools. Given the rise in the number of primary schools, and higher transition rates to secondary schools in many low and lower-middle income countries, despite the negative effects of the COVID-19 pandemic, growth in the number of schools (or at least growth in student enrollment) should continue for some time at the secondary level countries as larger cohorts of students enrolled in primary school complete their primary education. This has implications for strategy and planning. In much the same way that governments use simple forecasting models to assess the need for school construction and expansion based on projected trends in enrollment at various levels, this type of analysis could be beneficial for Catholic networks, including to assess budget and cost recovery requirements and to allocate new schools in areas that need them most.

Third, ensuring that Catholic schools have the ability in the future to accommodate more students where the demand for Catholic education is growing may require expanding existing schools or building new schools. This could be a source of concern because networks of Catholic schools may not always have the means to build new schools, especially at the secondary level where the cost of new schools is higher than at the primary or pre-school level. As governments and low cost for-profit providers expand the coverage of their secondary school networks in low and lower-middle income countries, even as enrollment in Catholic secondary schools may continue increase, the relative market share of Catholic schools at the secondary level could fall[38].

Fourth, in some countries Catholic schools may struggle between two priorities. On the one hand, the schools have a Catholic identity that they are aiming to maintain, or even strengthen. Investing in the spiritual capital of teachers and staff is crucial for this mission[39]. But on the other hand, the schools also need to ensure that students adequately learn while in school. Even if Catholic schools perform better than public schools as measured through national or international assessment data, it does not mean that they are performing well everywhere. The World Development Report on education and its companion studies demonstrate that many education systems are currently failing their students[40]. For basic literacy and numeracy in primary schools, the average student in low income countries performs worse than 95 percent of the students in high-income countries. Even top students in middle-income countries rank in the bottom fourth of the achievement distribution in high income countries. These gaps are likely to be observed for students in Catholic schools as well as those in public schools. This in turn has implications for the ability of students to become lifelong learners and acquire the socio-emotional skills that they need in life. As public schools raise their game in this area, so must Catholic schools. The point is not to pitch one mission of Catholic schools against the other, but simply to recognize that both missions are complementary, and that long-term efforts need to be undertaken in both areas.

[38] Se Wodon (2018a) on trends in market shares. Another challenge is to build secondary schools in poor areas. See Wodon (2020j) on Uganda. This will be discussed in the second part of this report.

[39] Grace (2002a, 2002b).

[40] World Bank (2018). Among companion studies, see Bashir et al. (2018) for sub-Saharan Africa.

Box 1.4: Has Catholic K12 Education Peaked?

Between 1980 and 2019, the annual growth rate in the number of Catholic K12 schools was at 1.1 percent globally. For enrollment, the annual growth rate was at close to two points. For most of the period, year-on-year growth rates have been positive. Yet since 2016 there has been a flattening in the total number of children enrolled in Catholic schools, and between 2018 and 2019 there was a decline in the number of schools. Some schools may be getting smaller, which may threaten their long-term sustainability. Recent changes in enrollment and the number of schools are small and could be due to statistical errors in reporting for some countries. But the COVID-19 crisis may have an additional negative effect on enrollment starting with the 2020-21 school year. Given the time lag in the production of the statistical yearbooks of the Church, it will take a bit more time before we can assess whether the loss in enrollment and in the number of schools was substantial. But some level of decline at least in enrollment in some countries is likely.

In the medium and long term however, global enrollment in Catholic education and the number of schools managed by the Church is likely to continue to grow, in part because of sub-Saharan Africa. The market share of Catholic schools in that region is high. As enrollment continues to grow in Africa due to population growth and gains in educational attainment, global enrollment in Catholic K12 education should increase even if enrollment and the number of schools drops in other parts of the world. By 2030, simple 'business-as-usual' projections[41] suggest that close to two thirds of all students in Catholic primary schools and more than 40 percent of students in Catholic secondary schools could live in Africa. Similar trends are likely to be observed for where Catholic schools will be located.

Finally, even though there has been growth in the number of Catholic schools as well as in enrollment over the past four decades, the competitive pressures faced by the schools should not be underestimated. They are likely to increase in the future as the market for K12 education is becoming increasingly competitive. This is the case in a number of developed countries where the market share of Catholic schools has been declining, but it is may also increasingly the case in developing countries. Public provision is expanding in low income and lower-middle income countries and the emergence of low cost private schools represents an additional source of competition. While many Catholic schools used to benefit from a comparative advantage in the form of skilled and low-cost teachers from religious orders, this is less the case today. School responses to rising competitive pressures will need to be based on local contexts, but it seems clear that the need to excel not only academically but also in other dimensions of the education being provided by Catholic schools may only intensify over time.

Given rising competitive pressures, the need to excel not only academically, but also in other dimensions of the education being provided by Catholic schools may only intensify over time.

[41] Wodon (2019b).

Box 1.5: Impact of the COVID-19 Pandemic on Education

The impact of the pandemic on students has been massive. Temporary school closures were near universal at the peak of the crisis, affecting 1.6 billion students. Student learning often suffers during recessions as well as school closures, and simulations suggest that learning poverty, defined as the proportion of children aged 10 who are not able to read and understand an age appropriate text may have increased substantially[42]. Past crises suggest that girls are especially likely to drop out of school, leading to higher risks of child marriage with implications for the rest of their life[43]. Simulations by UNICEF suggest that the number of out-of-school children may have increased by 24 million. The crisis may also have increased the number of children and students suffering from poor health[44].

As discussed in the Global Catholic Education Report 2021, the pandemic is likely to have affected Catholic schools especially in countries where they do not benefit from state funding. Because the latest data from the statistical yearbooks of the Church are for 2019, it is not feasible yet to assess the impact of the COVID-19 pandemic on Catholic schools globally, but there are indications that in some countries, the impact may be severe. In a survey implemented with OIEC in April 2020 with national Catholic school leaders, respondents were asked if they were anticipating losses in enrollment due to the crisis. In some countries no losses were expected (these were mostly countries where the state funs the schools), but in many others losses larger than 10 percent were expected, which could threaten financial sustainability for some schools. In the United States, enrollment in Catholic schools has decreased for some time[45], but the number of schools that closed in was higher than before[46].

Catholic school leaders were also asked if they were able to implement distance learning solutions for students, and if so, using which media. Schools in developed countries were able to rely on the internet, but in developing countries and especially in Africa, lack of connectivity has limited the ability to provide distance learning. Another question in the survey was about plans to adapt the curriculum or provide remedial education in the next school year to enable students to catch up, given that many suffered from losses in learning during school closures. The ability for Catholic schools in developing countries to adapt their curriculum and provide remedial education was again much weaker than in developed countries, especially in Africa. Cleary, Catholic schools and their students face major challenges from the COVID-19 crisis due not only to a lack of access to distance learning options, but also to limited options for remediation and adaptation of the curriculum.

[42] On learning losses during crises and over the summer, see Shores and Steinberg (2019), see Cooper et al. (1996); Alexander et al. (2007); Gerhenson (2013); Quinn and Polikoff (2017). For simulations of learning poverty, see World Bank, UNESCO, and UNICEF (2021). The latest simulations suggest largest increases in learning poverty versus previous estimates by Azevedo (2020, see also Azevedo et al., 2020). On learning losses in high income countries, see among others Kuhfeld and Tarasawa (2020), Dorn et al. (2021), and Engzell et al. (2021).

[43] UNDP (2015), Onyango et al. (2019), and Bandiera et al. (2019). See also World Bank (2020g) for a review, as well as Asfaw (2018) on Ethiopia, Dureya et al. (2007) and Cerutti et al. (2019) on Brazil, Lim (2000) on the Philippines, and Kassa et al (2019) more broadly. On child marriage and girls' education, see Wodon et al. (2016, 2017, 2018).

[44] On student health and well-being and the link with violence in schools, see Wodon, Fèvre et al. (2021).

[45] Several factors may have contributed to the long-term decline in enrollment in Catholic schools in the United States, but lack of affordability looms large (Murnane and Reardon, 2018; see also Wodon, 2018c, 2020a, 2020d for a comparison with the United Kingdom and Ireland. On private schools in the United States, including Catholic schools, see also Glander (2017), Broughman et al. (2019), and McFarlan et al. (2019).

[46] See NCEA (2021). A survey by Hanover Research (2020) suggests concerns for students' families struggling financially and for losing enrollment, especially among respondents working in Catholic schools.

CHAPTER 2
HEALTHCARE

Introduction

As done in chapter 1 for Catholic K12 schools, this chapter provides a basic analysis of trends in healthcare provision by the Catholic Church globally based on data on healthcare facilities from the annual statistical yearbooks of the Church. As for education, while simply looking at trends in the number of facilities managed by the Church does not do justice to the larger contributions of the Church to healthcare and well-being, it is a start.

The statistical yearbooks of the Church provide data on the number of health facilities managed by the Church at the country, regional, and global levels. While data on the number of patients served at these facilities are not available, trends in the number of facilities are still revealing of a number of shifts over time in the location of these facilities. In some areas, the footprint of the Church is clearly increasing, while in others it has stabilized or may be declining (although as noted in Box 2.1, a decline in the number of facilities may not indicate a decline in patients served).

The latest statistical yearbook was published in 2021 and provides data for 2019[47]. Data are available on the number of hospitals, dispensaries (we will instead use the term health centers here), and leproseries. Data are also available on facilities for the elderly and for people with disabilities[48], but these will be discussed in the next chapter. The focus in this chapter is only on the three categories of facilities that relate most closely to healthcare. To facilitate comparisons, the analysis follows the same format as that for K12 schools in chapter 1.

Box 2.1: Trends in Facilities vs. Patients Served

In most regions of the world except Africa and Oceania, the number of Catholic healthcare facilities has declined in the last decade. This does not mean that the number of patients served also declined, since facilities may have expanded their capacity, and some of the facilities that closed may have been merged into larger facilities. Overall, there are reasons to believe that the role of Catholic healthcare facilities is prominent. Unfortunately, data on the number of patients served are not available in the statistical yearbooks of the Church.

Data on the number of health facilities managed by the Catholic Church are available in its annual statistical yearbooks, with the most recent data pertaining to 2019.

Trends in the Number of Facilities

Globally, the Church estimates that in 2019, it managed 5,245 hospitals, 14,963 health centers, and 532 leproseries. While as for schools the data are self-reported by the chancery offices of ecclesiastical jurisdictions that fill the annual questionnaire, they seem to be of sufficient quality to document broad trends over time. As mentioned chapter 1, in a typical year, about five percent of the ecclesiastical jurisdictions do not fill the questionnaire, but this is the case mostly for small jurisdictions, so that missing data should not affect overall results substantially for most countries, or regional and global estimates.

How has the number of healthcare facilities operated by the Church evolved over the last four decades? In which parts of the world is growth observed, and where do we observe a plateau or even a potential decline? How are the facilities distributed between hospitals, health centers, and leproseries? And

[47] Secretariat of State (2021).

[48] Some of the terminology used in the yearbooks may appear outdated, but it helps in keeping labels consistent over time.

which are the countries with the largest number of Catholic health facilities? This chapter looks at trends in the number of health facilities managed by the Church from 1980 to 2019.

Table 2.1 provides estimates of the number of hospitals, health centers, and leproseries managed by the Church. Estimates are provided by region – as defined in the yearbooks, and globally. Figures 2.1 through 2.4 provide a visualization of the trends in the number of facilities for five regions: Africa, the Americas, Asia, Europe, and Oceania. The analysis is kept at that level to keep the Tables and Figures manageable, but data are available at the country level in the statistical yearbooks. Five key findings are highlighted here.

First, trends in Figures 2.1 through 2.4 suggest limited growth in the number of facilities over time, especially in comparison to the growth observed for Catholic schools. While there was an increase in the number of health facilities managed by the Church from 19,119 in 1980 to 24,031 in 2010, this fell back to 20,740 facilities in 2019 due a decline over the last decade in the number of facilities in all regions except Africa and Oceania. Over the whole period from 1980 to 2019, the number of facilities increased by 2,550, which is also the increase in the number of facilities in Africa. Apart from Africa, there were also gains in Asia (628 additional facilities), and Oceania (396 additional facilities), but there was a decline in the Americas (loss of 844 facilities) and especially Europe (loss of 1,109 facilities).

As for schools, the fact that Africa and Asia were the regions with large increases in the number of healthcare facilities is not surprising, given that these two continents have higher rates of population growth and that thanks to efforts to achieve universal health coverage, healthcare networks have expanded.

Also noteworthy is the fact that the number of hospitals has been declining for some time (probably in part because of consolidation or take-over by private secular hospital chains), while the decline in the number of health centers is more recent. As to leproseries, we would expect further decline in the future given the fact that the illness is much less prevalent today than it was in the past.

While there was an increase in the number of health facilities managed by the Church from 19,119 in 1980 to 24,031 in 2010, this fell back to 20,740 facilities in 2019 due to a decline in all regions except Africa and Oceania.

By 2019, the Catholic Church had 6,926 healthcare facilities in Africa. Of those, 5,307 were health centers. This accounted for 35.5 percent of all health centers globally. Similarly, Africa accounted for 37.8 percent of all leproseries. By contract, the share of all hospitals located in Africa was smaller, although still substantial, at 27.0 percent. The region with the second largest number of facilities is the Americas, with a total of 5,446 facilities, followed by Asia with 4,224 facilities and Europe with 3,346. Oceania has 798.

The largest gains in the number of healthcare facilities in both absolute terms and as a proportional increase from the base are observed in Africa. This was expected given high rates of population growth and progress towards achieving universal healthcare for all.

Table 2.1: Trends in the Number of Healthcare Facilities

	1980	1990	2000	2010	2019
			Hospitals		
Africa	978	898	819	1,150	1,418
Americas	2,420	2,055	1,946	1,694	1,362
Asia	1,089	1,005	1,584	1,126	1,180
Europe	2,030	1,565	1,330	1,145	1,014
Oceania	183	152	174	190	271
World	6,700	5,675	5,853	5,305	5,245
			Health centers		
Africa	3,115	3,591	4,715	5,312	5,307
Americas	3,801	4,863	5,224	5,762	4,043
Asia	2,241	3,117	3,427	3,884	2,775
Europe	2,418	2,564	2,893	2,643	2,313
Oceania	214	165	186	578	525
World	11,789	14,300	16,445	18,179	14,963
			Leproseries		
Africa	283	238	378	198	201
Americas	69	77	55	56	41
Asia	266	405	348	285	269
Europe	7	9	4	5	19
Oceania	5	3	2	3	2
World	630	732	787	547	532
			All facilities		
Africa	4,376	4,727	5,912	6,660	6,926
Americas	6,290	6,995	7,225	7,512	5,446
Asia	3,596	4,527	5,359	5,295	4,224
Europe	4,455	4,138	4,227	3,793	3,346
Oceania	402	320	362	771	798
World	19,119	20,707	23,085	24,031	20,740

Source: Compiled by the author from the annual statistical yearbooks of the Church.

A second key finding is the fact that there are some differences between regions in the share of facilities by type, although those differences are less pronounced than those observed for K12 schools. As shown in Table 2.2 and Figure 2.5, globally, hospitals account for 25.3 percent of all Catholic healthcare facilities in 2019, versus 72.1 percent for health centers, and only 2.6 percent for leproseries. In Africa, hospitals account for only 20.5 percent of all facilities, while health centers account for 76.6 percent of all facilities. By contrast, in Oceania and Europe, hospitals account for almost a third of all facilities. As for leproseries, they matter most in South Asia (6.4 percent of all facilities) and Africa (2.9 percent).

Globally, there has been a progressive decline in the share of hospitals and leproseries, while the share of health centers has increased between 1980 and 2019 in all regions except Europe. However, in terms of both the absolute number of facilities and the shares of facilities by type, the period from 2010 to 2019 shows changes at work with the number of health centers managed by the Catholic Church falling substantially in all regions except Africa.

Figure 2.1: Number of Hospitals

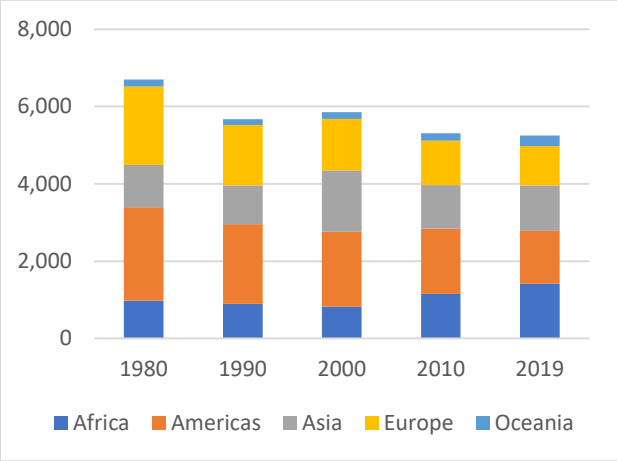


Figure 2.2: Number of Health Centers

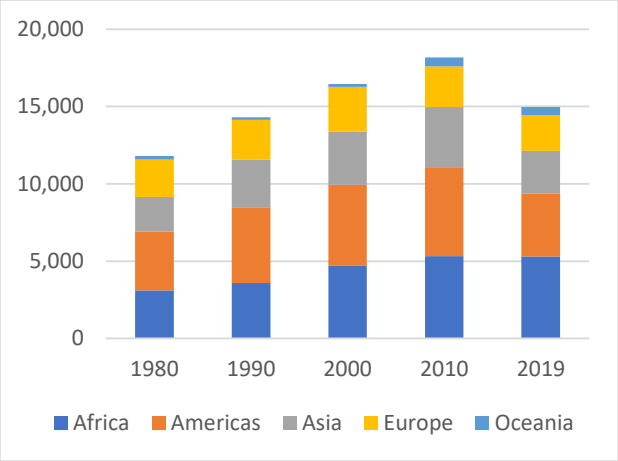


Figure 2.3: Number of Leproseries

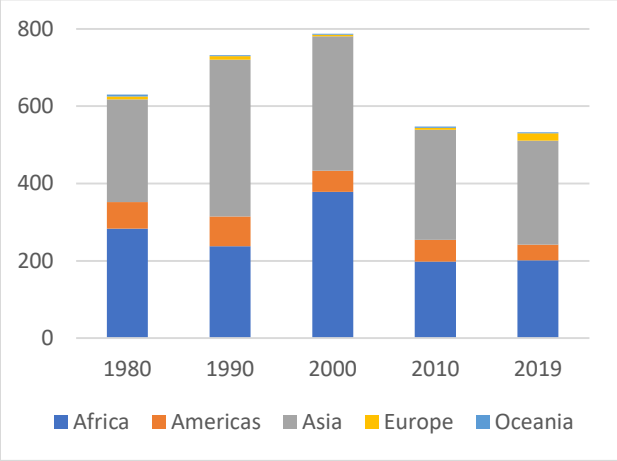
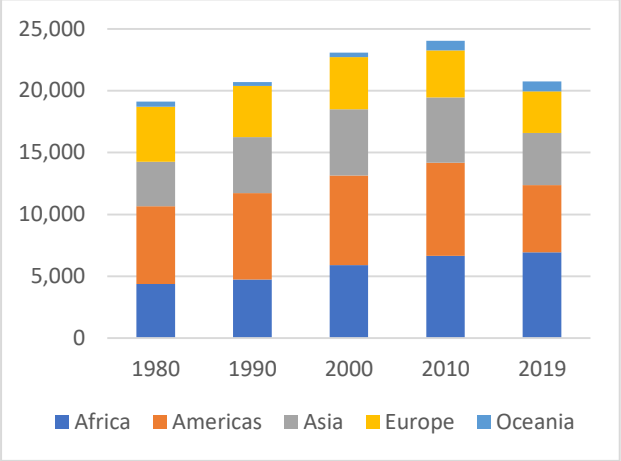


Figure 2.4: Total Number of Facilities



Source: Compiled by the author from the Statistical Yearbooks of the Church.

A third finding is that in proportionate terms, as a percentage change from the base, the highest growth rates are observed for Africa and Oceania, as was the case for absolute gains in the number of facilities. In the other regions, growth rates are typically negative. The annual growth rates for the period from 1980 to 2019 are computed taking into account compounding (10 years by decade, except for the last period for which nine years of data are available). They are provided in Table 2.3 and visualized in Figure 2.6.

In Africa, the annual growth rates are estimated at 1.0 percent for hospitals and 1.4 percent for health centers. There was a decline in the number of leproseries, but for all three types of facilities combined, the annual growth rate in the number of facilities is at 1.2 percent for the last four decades, or six times the growth rates observed globally. In Asia and Oceania as well, growth rates are positive, while they are negative for the Americas and Europe. This broadly mirrors what was observed for Catholic K12 schools.

The growth rates in the total number of healthcare facilities are positive for Africa, Asia, and Oceania. They are negative for the Americas and Europe. These broad patterns in terms of relative growth are similar qualitatively to the trends observed for Catholic K12 schools.

Table 2.2: Proportion of Healthcare Facilities by Type (%)

	1980	1990	2000	2010	2019
			Hospitals		
Africa	22.3	19.0	13.9	17.3	20.5
Americas	38.5	29.4	26.9	22.6	25.0
Asia	30.3	22.2	29.6	21.3	27.9
Europe	45.6	37.8	31.5	30.2	30.3
Oceania	45.5	47.5	48.1	24.6	34.0
World	35.0	27.4	25.4	22.1	25.3
			Health centers		
Africa	71.2	76.0	79.8	79.8	76.6
Americas	60.4	69.5	72.3	76.7	74.2
Asia	62.3	68.9	63.9	73.4	65.7
Europe	54.3	62.0	68.4	69.7	69.1
Oceania	53.2	51.6	51.4	75.0	65.8
World	61.7	69.1	71.2	75.6	72.1
			Leproseries		
Africa	6.5	5.0	6.4	3.0	2.9
Americas	1.1	1.1	0.8	0.7	0.8
Asia	7.4	8.9	6.5	5.4	6.4
Europe	0.2	0.2	0.1	0.1	0.6
Oceania	1.2	0.9	0.6	0.4	0.3
World	3.3	3.5	3.4	2.3	2.6

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Figure 2.5: Proportion of Healthcare Facilities by Type (Shares in %, 2019)

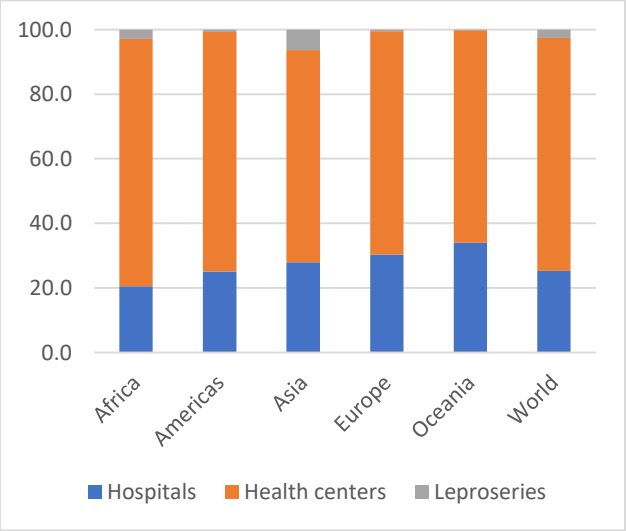
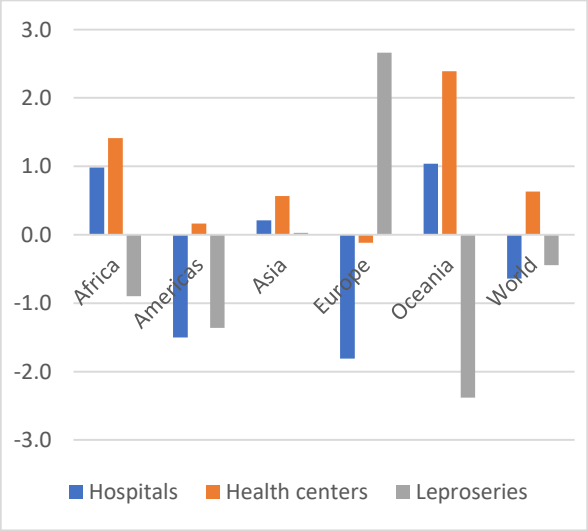


Figure 2.6: Annual Growth Rates in Facilities (%, Over Four Decades)



Source: Author's estimations from the Statistical Yearbooks of the Church.

Note: The high positive growth rates for leproseries in Europe is surprising and may be due to an issue of data or definitions. Ukraine has 10 leproseries in the latest yearbook, Belgium has 8, and Italy has one. There seems to be jumps in the data for leproseries at the country level from one year to the next, suggesting some data issues.

Table 2.3: Annual Growth Rate for the Number of Healthcare Facilities by Type (%)

	1980s	1990s	2000s	2010s	1980-2019
			Hospitals		
Africa	-0.8	-0.9	3.5	2.4	1.0
Americas	-1.6	-0.5	-1.4	-2.4	-1.5
Asia	-0.8	4.7	-3.4	0.5	0.2
Europe	-2.6	-1.6	-1.5	-1.3	-1.8
Oceania	-1.8	1.4	0.9	4.0	1.0
World	-1.6	0.3	-1.0	-0.1	-0.6
			Health centers		
Africa	1.4	2.8	1.2	0.0	1.4
Americas	2.5	0.7	1.0	-3.9	0.2
Asia	3.4	1.0	1.3	-3.7	0.6
Europe	0.6	1.2	-0.9	-1.5	-0.1
Oceania	-2.6	1.2	12.0	-1.1	2.4
World	1.9	1.4	1.0	-2.1	0.6
			Leproseries		
Africa	-1.7	4.7	-6.3	0.2	-0.9
Americas	1.1	-3.3	0.2	-3.4	-1.4
Asia	4.3	-1.5	-2.0	-0.6	0.0
Europe	2.5	-7.8	2.3	16.0	2.7
Oceania	-5.0	-4.0	4.1	-4.4	-2.4
World	1.5	0.7	-3.6	-0.3	-0.4
			All facilities		
Africa	0.8	2.3	1.2	0.4	1.2
Americas	1.1	0.3	0.4	-3.5	-0.4
Asia	2.3	1.7	-0.1	-2.5	0.4
Europe	-0.7	0.2	-1.1	-1.4	-0.8
Oceania	-2.3	1.2	7.9	0.4	1.8
World	0.8	1.1	0.4	-1.6	0.2

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Fourth, as for education, there is heterogeneity between countries in the number of facilities. Table 2.4 providers the 15 countries with the largest number of facilities in 2019. Together, these countries account for more than half of all healthcare facilities managed by the Church globally. India, a lower-middle income country according to the World Bank classification, and the DRC, a low income country, reach the top two stops, as was the case for K12 schools. In India, this is because of the sheer size of the country. In the DRC, it relates to the strong presence of the Church and funding provided by the state, as is the case for Catholic schools. Next is Germany, which is not among the top countries for schools, but has a large number of health centers. Mexico, Brazil, and the United States follow, with in the United States a large number of hospitals. The last four countries are all lower-middle income countries according to classification of the World Bank[49]. Overall, in comparison to schools, the footprint of Catholic healthcare is less tilted towards low income countries, but six in the top ten countries are low or lower-middle income countries, an encouraging observation for the mission of the Church to serve the poor.

The footprint of Catholic healthcare is today especially large in a number of lower-middle income countries as well as the DRC.

[49] Papua New Guinea, Kenya, Nigeria, Tanzania, and Tanzania are all lower-middle income countries.

Table 2.4: Top 15 Countries by Number of Health Facilities, 2019

	Hospitals	Health Centers	Leproseries	Total Number of Facilities
India	754	2,017	216	2,987
DR Congo	419	1,773	26	2,218
Germany	439	1,477	-	1,916
Mexico	149	1,316	3	1,468
Brazil	278	704	18	1,000
United States	551	238	-	789
Papua New Guinea	178	506	2	686
Kenya	95	454	21	570
Nigeria	287	200	15	502
Tanzania	68	414	7	489
Guatemala	15	338	-	353
Uganda	33	288	1	322
Cameroon	38	272	5	315
Poland	58	257	-	315
Madagascar	26	221	31	278

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Box 2.2: Beyond Healthcare Facilities: Digitalizing the Distribution of Insecticide-treated Bed Nets

This report focuses on the role of faith networks in facilities-based healthcare services, but Catholic and other faith-based organizations are also involved through particular projects in providing support to national health systems. One example is a partnership between Catholic Relief Services (CRS) and Ministries of Health in African countries to improve the efficiency, quality, and coverage of community-based malaria interventions. With support from Unitaid, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Bill & Melinda Gates Foundation, CRS helped digitize mass campaigns for the distribution of Insecticide-treated bed nets in the Gambia, Nigeria, and Benin. As mentioned in a CRS brief summarizing the experience[50], the approach included three main steps:

"(1) Frontline workers are trained to use a GPS-enabled mobile platform, allowing field agents to quickly register households, calculate SMC doses or ITNs per household and log their distribution, while allowing supervisors to monitor field activities remotely;

(2) All data is synced to an online platform for simplified reporting and analysis. The platform has various permission levels, ensuring sensitive information is only accessible by key personnel;

(3) During household registration and ITN/SMC distribution, CRS uses geospatial data to visualize and monitor in real-time households that have/have not been visited to ensure greater coverage than under paper-based systems."

Digitization has a number of benefits, including faster data collection and analysis for better monitoring and a reduction in the risks of errors in implementing these campaigns. The data can also be used in integrated health approaches that rely on up-to-date information. CRS intends to continue to support national governments and other partners use the digital approach, including in more countries.

[50] Catholic Relief Services (2021).

Box 2.3: Country vs. Global Estimates

For consistency across countries, this report relies on statistics on facilities as available in the statistical yearbooks of the Church. Episcopal conferences may rely on different data. For example, the statistical yearbook suggests that there were 551 Catholic hospitals in the United States in 2019, while the website of the United States Conference of Catholic Bishops (USCCB) puts the number at 645 for the year 2014 based on data from the Catholic Health Association of America. More recent data from the Catholic Health Association of America put the number at 668 in 2021.

How many people are served by these hospitals? Annually, Catholic hospitals provide more than 107 million outpatient visits and 20 million emergency room visits. They also deliver nearly 500,000 babies annually. Overall, more than one in seven patients nationally is cared for in a Catholic hospital according to the Catholic Health Association of America. Catholic hospitals employ close to 750,000 workers (about 526,000 full-time and 214,000 part-time workers). These statistics imply that in terms of market share, the role of Catholic hospitals is more prominent in the United States than that of Catholic schools.

Summing Up

The purpose of this chapter was to provide a basic analysis of trends over time in the number of healthcare facilities operated by the Catholic Church globally. As for schools, a few concluding remarks can be made.

First, limited growth has been observed over the last four decades in the total number of healthcare facilities operated by the Church. There was a steady increase until 2010, but a decline over the last decade. For hospitals, there has been a decline in the number of facilities managed by the Church globally for several decades. In terms of regions, the growth in the number of facilities observed between 1980 and 2019 can essentially be attributed to Africa, with growth in Asia and Oceania offsetting declines in the Americas and Europe.

The footprint of Catholic healthcare is today especially large in a number of lower-middle income countries as well as in the DRC, a low income country. In Africa, Catholic healthcare facilities tend to be members of Christian Heath Associations where those associations exist (see Box 2.4). Only one African country, the DRC, is in the top five countries in terms of facilities. The other four countries in the top five are India, Germany, Mexico, and Brazil. But in the next ten countries, six are from Africa: Kenya, Nigeria, Tanzania, Uganda, Cameroon, and Madagascar.

For Africa, only the DRC is in the top five countries in terms of healthcare facilities, but in the next ten, six are from Africa: Kenya, Nigeria, Tanzania, Uganda, Cameroon, and Madagascar.

Box 2.4: Christian Health Associations

Christian Health Associations (CHAs) are national-level umbrella networks of Christian health providers that help improve coordination in service provision, reduce duplication, and provide a platform for policy dialogue with governments. The members of CHAs are typically the individual health facilities in the country[51]. Currently CHAs operate in more than two dozen countries and share good practices through the Africa Christian Health Associations Platform (ACHAP). CHAs tend to be stronger and account for a larger share of healthcare facilities in Eastern and Southern Africa than in West and Central Africa. This is probably in part because the British colonial model favored decentralization and encouraged missionaries to set up hospitals, clinics, and schools, while this was less the case for the French colonial model. There are however exceptions in West and Central Africa, in particular for the DRC which was at the time a Belgian colony.

[51] Dimmock et al. (2017).

The strong presence of Catholic healthcare in a number of African countries is encouraging for the mission of the Church to serve the poor, but as for schools, there is a risk for healthcare facilities to serve proportionately more the well-to-do even if many facilities are located in countries with comparatively low levels of income. This risk has long been recognized as Catholic healthcare facilities face some of the same issues that affect Catholic schools in terms of their staffing and sustainability. Congregations which used to be able to provide quasi-free healthcare a few decades ago may not anymore have the personnel and resources to do so today. In countries where Catholic health facilities do not benefit from state support, cost recovery may lead the facilities to be unaffordable for some among the poor. In healthcare as compared to education, state funding for Catholic facilities is likely to be more common, yet competitive pressures may become more severe over time.

Second, while the analysis in this report was conducted separately for the three types of facilities being considered, there are links between these facilities, and especially among the first two which account for the bulk of all facilities. Catholic health centers provide primary care and may refer to Catholic hospitals for more advanced care. This link may not be as strong as it is for schools (primary schools often serve as feeder schools for secondary schools), but it is present. When establishing country-level strategies for Catholic healthcare, those relationships matter, including again to assess budget and cost recovery requirements and to consider where to allocate new health facilities to reach the areas with the largest needs.

Third, ensuring that Catholic healthcare facilities have the ability in the future to accommodate more patients where the demand for healthcare is growing (especially in low and lower-middle income countries) may require expanding existing facilities or building new ones. As for education, this could be a source of concern for the ability of Catholic networks of facilities to maintain their market share because Catholic organizations may not always have the means to build new facilities. This may be the case especially for hospitals where the cost of a new facility is much higher than for health centers. As governments and low cost private secular healthcare providers expand the coverage of their facilities in low and lower-middle income countries, even if the demand for healthcare may increase, the market share of Catholic facilities may not.

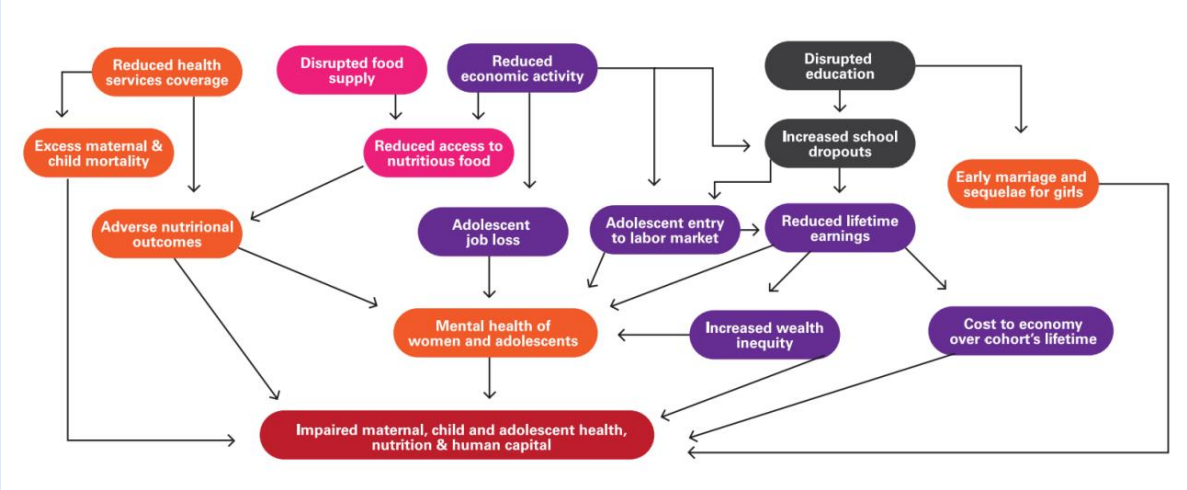
As will be discussed later in this report, there is a difference between education and healthcare in the reasons for choosing Catholic providers. For education, the transmission of values and faith through schools maters for parents choosing Catholic schools. For choosing healthcare, faith and values play less of a role.

Finally, as will be discussed later in this report, there is a fundamental difference between education and healthcare in the reasons for choosing Catholic and other faith-inspired providers. In the case of education, the emphasis on the transmission of values and faith through schools is often a reason for parents to enroll their children in a Catholic or other faith-based school. In the case of healthcare, faith and values play a positive role in the care being provided, but are not the key factor leading patients to choose a Catholic or other faith-based hospital: the quality of the services provided is a more important factor.

Box 2.5: Impact of the COVID-19 Pandemic on Health

The pandemic's impact on health has been severe. As of the end of 2021, more than 300 million people have been infected and close of 5.5 million died[52]. These statistics underestimate the full impact because of lack of testing and weak reporting in many countries. In the United States alone, the number of confirmed infections was at 59 million and the number of deaths was at 0.8 million. The pandemic led to a drop in life expectancy in the country of 1.8 years with COVID-19 becoming the third leading cause of death, accounting for one in ten fatalities[53]. Death rates were especially high for disadvantaged groups[54]. Globally, these impacts are however only the tip of the iceberg as they do not account for indirect effects (Figure 2.7). Estimates of the impacts of the pandemic on universal health coverage and financial protection in health are available from the World Bank and WHO[55].

Figure 2.7: Selected Indirect Health and Nutrition Effects of the Pandemic



Source: SickKids (2021).

Faith networks have mobilized to respond to the pandemic. A USAID compendium lists early responses from a range of organizations including Catholic Relief Services[56]. Faith leaders including Pope Francis have encouraged vaccination and called for better access to vaccines in developing countries[57]. Because the latest statistical yearbook of the Church provides data for 2019, whether pandemic had an impact on the number of Catholic healthcare facilities is no known, but the risk of closures may be smaller than for schools given high demand for health services and less of a comparative disadvantage versus public facilities for out-of-pocket costs paid by households. Still, as for public facilities, the capacity of Catholic facilities to provide adequate services has been stretched, and in Catholic as well as public facilities, the pandemic led to a substantial number of deaths among health and care workers[58].

[52] See data and maps at https://coronavirus.jhu.edu/map.html.
[53] Arias et al. (2021).
[54] See the COVID tracking project at https://covidtracking.com/race/dashboard.
[55] See World Health Organization and World Bank (2021a, 2021b).
[56] USAID (2020).
[57] On the role played by faith leaders for immunization and vaccination, see Momentum (2021). The statement by Christian health networks appealing for global equity and solidarity in access to Covid-19 vaccines is available here.
[58] World Health Organization (2021). Of a total of 3.45 million reported deaths due to COVID-19 between January 2020 and May 2021, 115,500 may have been health workers. This is likely an underestimation.

CHAPTER 3
SOCIAL PROTECTION

Introduction

Following up on the analysis conducted in the first two chapters for schools and health facilities, this chapter provides a basic analysis of trends in the provision of social protection services by the Catholic Church globally. The analysis is still based on data from the annual statistical yearbooks of the Church. Once again, while simply looking at trends in the number of social protection facilities managed by the Church again does not do justice to the contributions of the Church, it is a start.

To facilitate comparisons between chapters, the analysis follows the format used in the two previous chapters. The statistical yearbooks of the Church provide data on the number of social protection facilities managed by the Church at the country, regional, and global levels. While data on the number of individuals served at these facilities are not available, trends in the number of facilities are still revealing of a number of shifts over time in the location of these facilities. In some areas, the footprint of the Church is clearly increasing, while in others it has stabilized or may be declining (although as noted when discussing healthcare facilities, a decline in the number of facilities may not necessarily indicate a decline in the number of individuals served).

The latest statistical yearbook was published in 2021[59]. It provides data for 2019 on six categories of facilities: (1) orphanages; (2) nurseries; (3) special centers for social education or re-education; (4) homes for the old, chronically Ill, invalid, or handicapped; (5) matrimonial advice centers; and (6) other institutions which may themselves include many different types of activities and programs.

[59] Secretariat of State (2021).

Trends in the Number of Facilities

Globally, the Church estimates that in 2019, it managed 9,374 orphanages, 10,723 nurseries, 3,198 special centers for social education or re-education, 15,429 homes for the old, chronically Ill, invalid, or handicapped, 12,308 matrimonial advice centers, and 33,840 other institutions. All in all, the Church estimated that it operated 84,872 social protection facilities. As for education and healthcare, while the data are self-reported by the chancery offices of ecclesiastical jurisdictions that fill the annual questionnaire, the data seem to be of sufficient quality to document broad trends over time. In a typical year, about five percent of the ecclesiastical jurisdictions do not fill the questionnaire, but this is the case mostly for small jurisdictions, so that the missing data should not affect the overall results substantially for most countries, or at the regional and global levels.

Data on the number of social protection facilities managed by the Catholic Church are available in its annual statistical yearbooks, with the most recent data pertaining to 2019.

As for the previous two chapters, this chapter considers the same basic questions: How has the number of social facilities operated by the Church evolved over the last four decades? In which parts of the world is growth observed, and where do we observe a plateau or even a potential decline? How are the facilities distributed between the various types of services provided by the Church? Which are the countries with the largest number of Catholic social protection facilities? To answers these questions, the chapter documents trends in the number of social protection facilities managed by the Church from 1980 to 2019.

Table 3.1 provides estimates of the number of social protection facilities managed by the Church over time. Estimates are provided by region – as defined in the yearbooks, and globally. Figures 3.1 through 3.7 provide a visualization of the trends in the number of facilities for five regions: Africa, the Americas, Asia, Europe, and Oceania. The analysis is kept at that level to keep the Tables and Figures manageable, but data are available at the country level in the statistical yearbooks. A number of interesting findings emerge from the data. Five findings are highlighted here.

First, the trends in Figures 3.1 through 3.7 suggest substantial growth in the number of facilities over time, although there was a decline between 2010 and 2019. Specifically, there was a large increase in the number of social protection facilities managed by the Church from 42,084 in 1980 to 97,533 in 2010, but the total number fell back to 84,872 in 2019. The recent decline is observed for all regions except Europe, but is especially pronounced in the Americas. Nevertheless, for the last 40 years or so, the number of facilities almost doubled, which is a higher increase than observed for either education or healthcare.

There was a large increase in the number of social protection facilities managed by the Church from 42,084 in 1980 to 97,533 in 2010, but this fell back to 84,872 facilities in 2019.

For K12 schools and healthcare facilities, the largest increases in the number of facilities over the last four decades were observed in Africa and Asia (as well as Oceania, but at a smaller scale given the smaller population). By contrast, for social protection the largest increase in the number of facilities is observed in the Americas (despite the decline between 2010 and 2019) and in Europe.

There seems to have been a reclassification of some institutions between 2010 and 2019. In 2010, the largest category of facilities was that of special centers for social education or re-education. In 2019, there is a dramatic drop in the number of these centers, with a corresponding increase in what in other institutions[60]. What are those? The yearbooks do not provide detailed explanations on the various categories, but the introductory note for the yearbooks' chapter V on Welfare Institutions mentions that it covers "other charitable and welfare institutions (hostels catering for the young, etc.)". It seems likely that among the other institutions, facilities providing services to disadvantaged youth are included, with some of them previously classified as special centers for social education or re-education.

The trends over time for the various categories of institutions are broadly similar at least in aggregate terms. Globally, there is a progressive increase in the number of facilities until 2010, and then a decrease by 2019. This is observed for orphanages, nurseries, homes for the old, chronically Ill, invalid, or handicapped, and matrimonial advice centers. For the last two categories (special centers for social education or re-education and other institutions), the trend is less consistent given the issue of reclassification mentioned earlier. But while the peak for the sum of both categories was in the mid-1990s, there has been a decline afterwards. As was the case for healthcare facilities, it seems that the footprint of Catholic social protection institutions globally may have reached a peak, at least as measured by the number of facilities in operation.

The trends over time for the various categories of institutions are broadly similar at least in aggregate terms, although for special centers for social education or re-education and other institutions the trend is less consistent because of an apparent reclassification in the facilities.

[60] Looking at yearly data, there seem to have been several reclassifications over time between these two categories of facilities.

Table 3.1: Trends in the Number of Social Protection Facilities

	1980	1990	2000	2010	2019
	Orphanages				
Africa	358	533	859	1,345	1,646
Americas	1,431	1,640	2,516	2,770	2,133
Asia	1,629	2,165	2,851	3,606	3,233
Europe	2,709	2,257	2,411	2,078	2,247
Oceania	58	55	58	83	115
World	6,185	6,650	8,695	9,882	9,374
	Nurseries				
Africa	360	617	1,760	1,918	2,149
Americas	1,039	4,040	4,000	3,727	2,957
Asia	872	1,530	2,849	3,175	2,973
Europe	2,561	1,643	1,939	2,458	2,491
Oceania	28	20	92	101	153
World	4,860	7,850	10,640	11,379	10,723
	Special centers for social education and re-education				
Africa	780	1,169	2,105	2,508	249
Americas	1,688	3,868	10,817	14,661	1,630
Asia	868	3,105	6,084	4,867	490
Europe	964	1,963	8,514	11,720	725
Oceania	75	91	239	575	104
World	4,375	10,196	27,759	34,331	3,198
	Homes for the old, chronically ill, invalid, or handicapped				
Africa	281	402	890	655	659
Americas	2,189	2,730	3,465	5,650	3,642
Asia	519	835	1,548	2,346	2,674
Europe	6,485	6,812	7,679	8,021	8,031
Oceania	168	239	351	551	423
World	9,642	11,018	13,933	17,223	15,429
	Matrimonial advice centers				
Africa	295	955	1,503	1,812	1,433
Americas	1,435	3,101	4,440	6,472	4,289
Asia	847	882	945	987	864
Europe	1,403	2,837	4,434	5,787	5,504
Oceania	71	178	280	269	218
World	4,051	7,953	11,602	15,327	12,308
	Other institutions				
Africa	1,378	4,775	1,167	1,250	1,192
Americas	3,389	12,716	3,903	3,564	13,092
Asia	1,467	4,288	889	1,252	2,764
Europe	6,691	11,301	1,604	3,159	16,503
Oceania	46	409	140	166	289
World	12,971	33,489	7,703	9,391	33,840
	All facilities				
Africa	3,452	8,451	8,284	9,488	7,328
Americas	11,171	28,095	29,141	36,844	27,743
Asia	6,202	12,805	15,166	16,233	12,998
Europe	20,813	26,813	26,581	33,223	35,501
Oceania	446	992	1,160	1,745	1,302
World	42,084	77,156	80,332	97,533	84,872

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Figure 3.1: Number of Orphanages

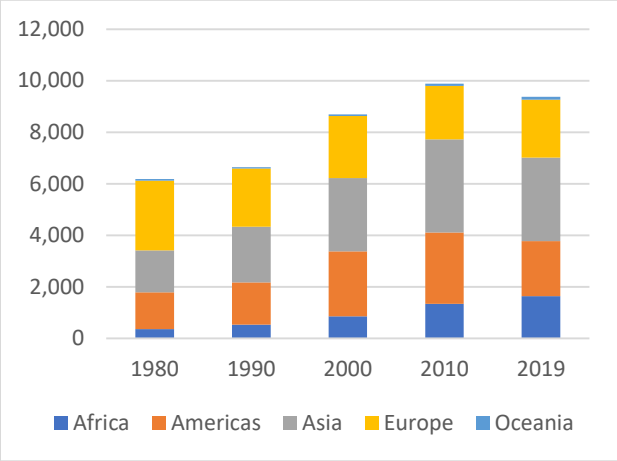


Figure 3.2: Number of Nurseries

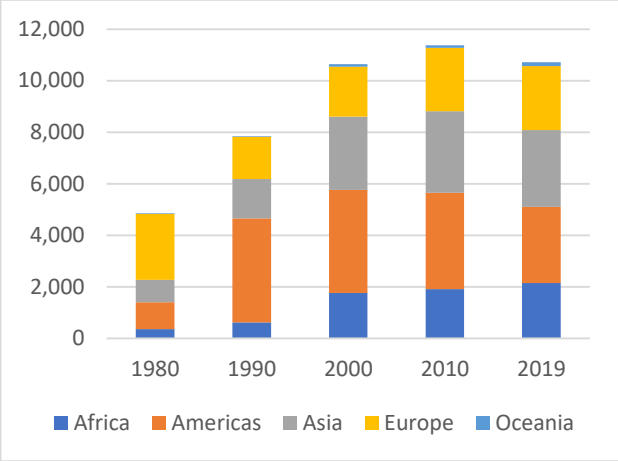


Figure 3.3: Number of Matrimonial Advice Centers

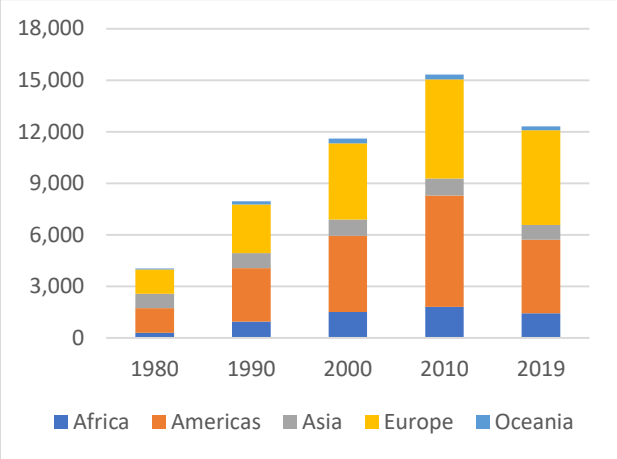


Figure 3.4: Number of Nursing Homes and Centers for the Chronically Ill or Handicapped

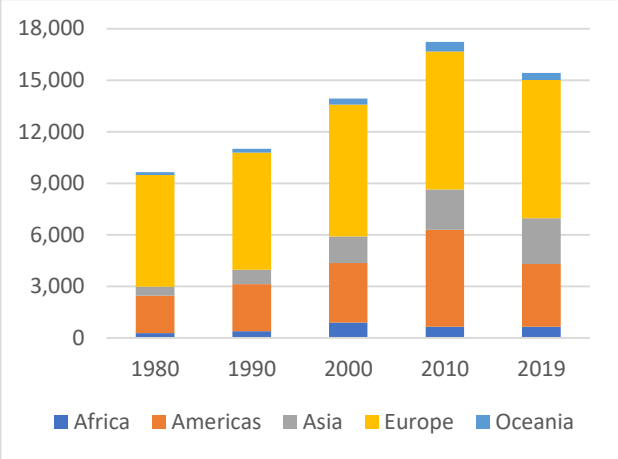


Figure 3.5: Number of Special Centers for Social Education or Re-education (*)

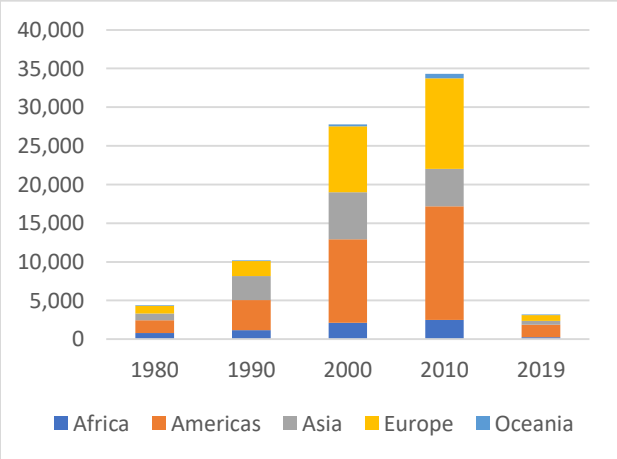
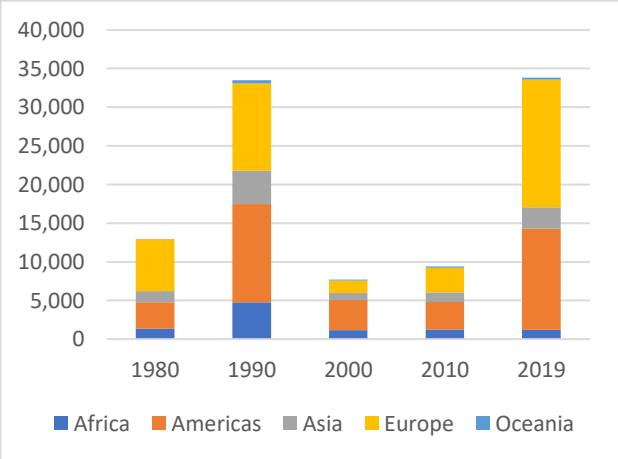


Figure 3.6: Number of Other Institutions (*)



Source: Compiled by the author from the annual statistical yearbooks of the Church.
Note: (*) There seems to be a reclassification of facilities between the last two categories between 2010 and 2019.

Figure 3.7: Total Number of Facilities

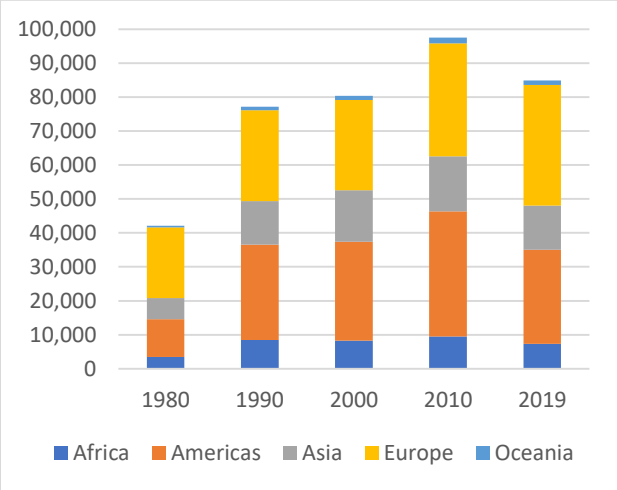
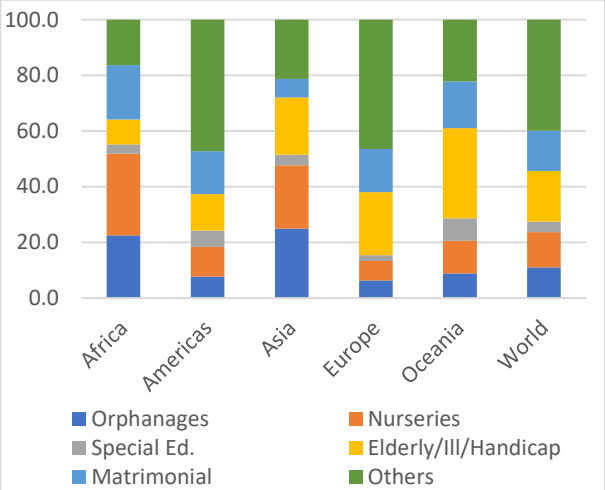


Figure 3.8: Share of Facilities by Type, 2018



Source: Compiled by the author from the Statistical Yearbooks of the Church.

Why are social protection facilities concentrated in Europe and the Americas (as well as Oceania, but at a smaller scale considering the smaller size of the population)? One potential explanation is that countries in those regions have the means to invest in social protection programs, whether they are funded by the state or through out-of-pocket costs from users or charitable donations. This is less the case in Africa and Asia, where providing basic education and healthcare services remains the priority. This is however only a conjecture that would warrant validation with more detailed data on the types of institutions included in the yearbooks, the level of their operating costs, and how they are funded.

The largest gains in the number of social protection facilities in absolute terms over the last four decades are observed in Europe and the Americas. This is a different pattern from what is observed for education and healthcare.

A second key finding is the fact that there are as expected differences between regions in the share of facilities by type. As shown in Table 3.2 and Figure 3.8, globally the share of facilities by types are as follows: orphanages (11.0 percent), nurseries (12.6 percent), special centers for social education or re-education (3.8 percent), homes for the old, chronically Ill, invalid, or handicapped (18.2 percent), matrimonial advice centers (14.5 percent), and other institutions (39.9 percent), although recall the reclassification mentioned between special centers for social education or re-education and other institutions.

When looking at regional patterns, orphanages account for a larger share of facilities in Africa and Asia, two regions where life expectancy for parents is much lower, in part because of the HIV-AIDS epidemic (although treatments have helped), but also due to poorly performing health systems. Africa, which has the youngest population of all five regions, tends to have fewer homes for the elderly, chronically ill, and handicapped. Centers for matrimonial advice are less common in Asia, probably because the share of the population that is Catholic is much lower. Nurseries account for a large share of all facilities in Africa and Asia, where needs are large as well given high rates of population growth and thus many young children. By contrast, the other institutions category accounts for a larger share of all facilities in Europe and the Americas, as these countries have more means to invest in such facilities.

Table 3.2: Proportion of Social Protection Facilities by Type (%)

	1980	1990	2000	2010	2019
	Orphanages				
Africa	10.4	6.3	10.4	14.2	22.5
Americas	12.8	5.8	8.6	7.5	7.7
Asia	26.3	16.9	18.8	22.2	24.9
Europe	13.0	8.4	9.1	6.3	6.3
Oceania	13.0	5.5	5.0	4.8	8.8
World	14.7	8.6	10.8	10.1	11.0
	Nurseries				
Africa	10.4	7.3	21.2	20.2	29.3
Americas	9.3	14.4	13.7	10.1	10.7
Asia	14.1	11.9	18.8	19.6	22.9
Europe	12.3	6.1	7.3	7.4	7.0
Oceania	6.3	2.0	7.9	5.8	11.8
World	11.5	10.2	13.2	11.7	12.6
	Special centers for social education and re-education				
Africa	22.6	13.8	25.4	26.4	3.4
Americas	15.1	13.8	37.1	39.8	5.9
Asia	14.0	24.2	40.1	30.0	3.8
Europe	4.6	7.3	32.0	35.3	2.0
Oceania	16.8	9.2	20.6	33.0	8.0
World	10.4	13.2	34.6	35.2	3.8
	Homes for the old, chronically ill, invalid, or handicapped				
Africa	8.1	4.8	10.7	6.9	9.0
Americas	19.6	9.7	11.9	15.3	13.1
Asia	8.4	6.5	10.2	14.5	20.6
Europe	31.2	25.4	28.9	24.1	22.6
Oceania	37.7	24.1	30.3	31.6	32.5
World	22.9	14.3	17.3	17.7	18.2
	Matrimonial advice centers				
Africa	8.5	11.3	18.1	19.1	19.6
Americas	12.8	11.0	15.2	17.6	15.5
Asia	13.7	6.9	6.2	6.1	6.6
Europe	6.7	10.6	16.7	17.4	15.5
Oceania	15.9	17.9	24.1	15.4	16.7
World	9.6	10.3	14.4	15.7	14.5
	Other institutions				
Africa	39.9	56.5	14.1	13.2	16.3
Americas	30.3	45.3	13.4	9.7	47.2
Asia	23.7	33.5	5.9	7.7	21.3
Europe	32.1	42.1	6.0	9.5	46.5
Oceania	10.3	41.2	12.1	9.5	22.2
World	30.8	43.4	9.6	9.6	39.9

Source: Compiled by the author from the annual statistical yearbooks of the Church.

A third finding is that in proportionate terms, as a percentage change from the base, some of the highest growth rates are observed globally for matrimonial advice centers and for nurseries. The estimates are provided in Table 3.3 and visualized in Figure 3.9. This is good news for families, as well as young children. In the case of nurseries, as mentioned in chapter 1, the literature notes that early childhood is a critical period during which investments in

children have high returns[61]. The growth rates for special centers for social education or re-education and other institutions are more difficult to interpret due to the reclassification issue, although they are higher than for orphanages and homes for the old, chronically Ill, invalid, or handicapped when the two categories (special centers and other institutions) are combined.

In proportionate terms, as a percentage change from the base, some of the highest growth rates are observed globally for matrimonial advice centers and for nurseries. This is good news for families, as well as young children.

Finally, there is again substantial heterogeneity between countries in the number of facilities, as was the case for K12 schools and healthcare facilities. Yet this time, a fairly different set of countries are in the lead. Table 3.4 providers the 15 countries with the largest number of facilities in 2019. Together, these 15 countries account again for more than half of all social protection facilities managed by the Church globally.

India ranks high again, which is not surprising given the size of the country. Other developing countries in the top 15 include Brazil, Mexico, Argentina, and Colombia, which are all upper-middle countries, as well as Kenya, a lower-middle income country. Still, many of the countries are high income, with Germany, the United States, and Spain in the top 5, as well as Italy, Poland, Portugal, the Republic of Korea, Australia, and Austria in the top 15. This is a very different situation in comparison to schools and healthcare facilities. The likely rationale for this difference was mentioned earlier. While in low and lower-middle income countries the priority has remained the provision of basic education and healthcare, in upper-middle and high income countries more investments have been made in social protection systems, including services for adolescent youth and married couples. Importantly, while the analysis in this report focuses on data on facilities, The Catholic Church also provides social protection in other ways (see Box 3.1 for a brief discussion).

The footprint of Catholic social protection facilities remains titled today towards upper-middle and high income countries. This was not the case for schools and healthcare facilities.

Box 3.1: The Role of the Catholic Church in Development and Humanitarian Assistance

This report focuses on facilities-based services, but faith networks contribute to integral human development in other ways. A new report from CAFOD, the Catholic Agency for Overseas Development (an agency from the Church in England and Wales), suggests seven ways in which the Church makes a difference in development and in responses to emergencies[62]: (1) Rapid, local and inclusive humanitarian response; (2) Influencing social norms and behavior; (3) Peacebuilding, mediation and reconciliation; (4) Strengthening democratic governance through citizen participation; (5) Speaking truth to power, witnessing and accompanying suffering; (6) Providing quality and inclusive healthcare and education; (7) Supporting sustainable livelihoods. The report provides examples of projects from all over the world, including some in response to the COVID-19 pandemic. The report notes that the Church is called to serve all people based on need, regardless of race, gender and religion, and to have a preferential option for the poor, for those people and communities that others may have overlooked, those who suffer discrimination, injustice or oppression.

[61] Black et al. (2017). See also Denboba et al. (2014).

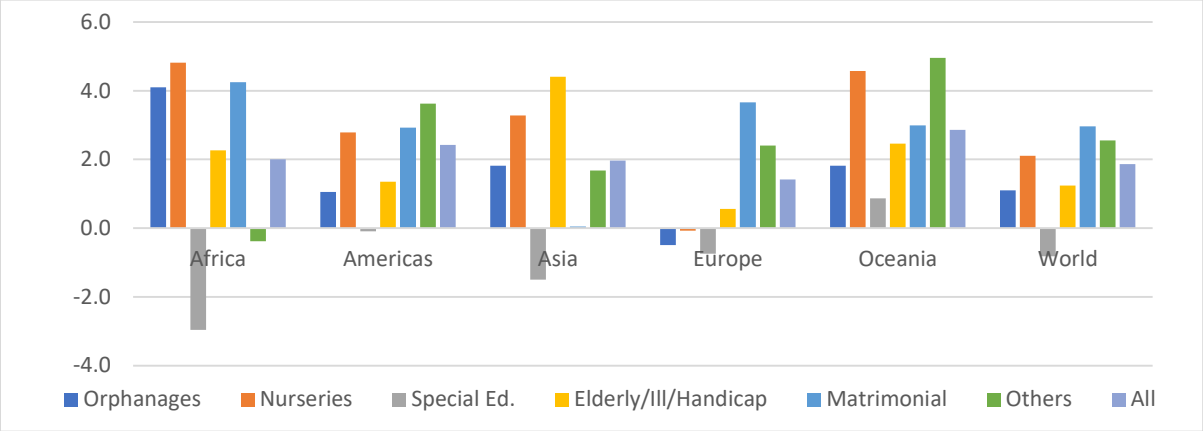
[62] CAFOD (2021).

Table 3.3: Annual Growth Rate for the Number of Social Protection Facilities by Type (%)

	1980s	1990s	2000s	2010s	1980-2019
			Orphanages		
Africa	4.1	4.9	4.6	2.3	4.1
Americas	1.4	4.4	1.0	-2.9	1.1
Asia	2.9	2.8	2.4	-1.2	1.8
Europe	-1.8	0.7	-1.5	0.9	-0.5
Oceania	-0.5	0.5	3.6	3.7	1.8
World	0.7	2.7	1.3	-0.6	1.1
			Nurseries		
Africa	5.5	11.1	0.9	1.3	4.8
Americas	14.5	-0.1	-0.7	-2.5	2.8
Asia	5.8	6.4	1.1	-0.7	3.3
Europe	-4.3	1.7	2.4	0.1	-0.1
Oceania	-3.3	16.5	0.9	4.7	4.6
World	4.9	3.1	0.7	-0.7	2.1
			Special centers for social education and re-education		
Africa	4.1	6.1	1.8	-22.6	-3.0
Americas	8.6	10.8	3.1	-21.7	-0.1
Asia	13.6	7.0	-2.2	-22.5	-1.5
Europe	7.4	15.8	3.2	-26.6	-0.7
Oceania	2.0	10.1	9.2	-17.3	0.9
World	8.8	10.5	2.1	-23.2	-0.8
			Homes for the old, chronically ill, invalid, or handicapped		
Africa	3.6	8.3	-3.0	0.1	2.3
Americas	2.2	2.4	5.0	-4.8	1.3
Asia	4.9	6.4	4.2	1.5	4.4
Europe	0.5	1.2	0.4	0.0	0.6
Oceania	3.6	3.9	4.6	-2.9	2.5
World	1.3	2.4	2.1	-1.2	1.2
			Matrimonial advice centers		
Africa	12.5	4.6	1.9	-2.6	4.2
Americas	8.0	3.7	3.8	-4.5	2.9
Asia	0.4	0.7	0.4	-1.5	0.1
Europe	7.3	4.6	2.7	-0.6	3.7
Oceania	9.6	4.6	-0.4	-2.3	3.0
World	7.0	3.8	2.8	-2.4	3.0
			Other institutions		
Africa	13.2	-13.1	0.7	-0.5	-0.4
Americas	14.1	-11.1	-0.9	15.6	3.6
Asia	11.3	-14.6	3.5	9.2	1.7
Europe	5.4	-17.7	7.0	20.2	2.4
Oceania	24.4	-10.2	1.7	6.4	5.0
World	9.9	-13.7	2.0	15.3	2.6
			All facilities		
Africa	9.4	-0.2	1.4	-2.8	2.0
Americas	9.7	0.4	2.4	-3.1	2.4
Asia	7.5	1.7	0.7	-2.4	2.0
Europe	2.6	-0.1	2.3	0.7	1.4
Oceania	8.3	1.6	4.2	-3.2	2.9
World	6.2	0.4	2.0	-1.5	1.9

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Figure 3.9: Annual Growth Rates in the Number of Facilities (%, Over Four Decades)



Source: Compiled by the author from the annual statistical yearbooks of the Church.

Table 3.4: Top 15 Countries by Number of Social Protection Facilities, 2019

	Orphanages	Nurseries	Special Ed.	Elderly/Ill	Marriage	Others	All combined
Germany	892	342	152	2,927	2,078	5,585	11,976
India	1,990	1,581	288	1,195	398	1,797	7,249
United States	579	790	301	1,125	803	3,027	6,625
Spain	186	308	129	827	252	4,631	6,333
Brazil	387	874	578	690	623	2,825	5,977
Mexico	201	67	315	315	1,970	2,687	5,555
Italy	379	497	213	1,462	515	2,414	5,480
Poland	276	21	36	170	1,937	1,540	3,980
Argentina	218	331	149	313	165	1,669	2,845
Portugal	84	589	33	962	126	870	2,664
Kenya	675	1,262	17	125	144	48	2,271
Colombia	128	382	64	422	87	553	1,636
Republic of Korea	170	105	47	566	88	207	1,183
Australia	104	138	77	389	151	206	1,065
Austria	8	456	10	113	77	363	1,027

Source: Compiled by the author from the annual statistical yearbooks of the Church.

Box 3.2: Reaching Vulnerable Children: Interviews with Project Teams supported by BICE

As noted previously, the Global Catholic Education project conducts interviews with those at the frontline to share experiences so that they can be a source of inspiration. The first set of interviews available here was with teams working with the International Catholic Child Bureau (BICE), a network of organizations committed to the defense of the dignity and rights of the child. A total of 15 interviews were conducted on projects in Argentina, Cambodia, Colombia, the Democratic Republic of Congo, France, Guatemala, India, Lebanon, Mali, Peru, Russia, Tajikistan, and Togo. Many projects reached children in poverty, but some also targeted other vulnerable groups, including children caught in the juvenile justice system and children with disabilities. As Svetlana Mamonova from Russia explained: *"The main goals of Perspektivy are to enable individuals with severe disabilities to have a normal life, to promote their inclusion in society, and to prevent 'social orphanhood' through support to families [….] Nobody, no matter what health problems a person may have, should be denied the opportunity to live a normal and full life. A child with developmental disabilities should be able to attend kindergarten or school. The educational system should be adapted for children with disabilities. When a person begins her adult life, s/he should have the opportunity to live in a family or an accompanying residence."*

Summing Up

Following the approach used for schools and healthcare facilities, the purpose of this chapter was to provide a basic analysis of trends over time in the number of social protection facilities operated by the Catholic Church globally[63]. A few concluding remarks can be made.

First, substantial growth has been observed over the last 40 years in the number of social protection facilities operated by the Church, even if there was a decline in that number over the last decade. While for schools and healthcare facilities much of the growth in the number of facilities was observed in Africa, social protection facilities remain concentrated in the Americas and Europe.

Second, even though a smaller share of the facilities are located in the developing world, because of the nature of the facilities, it is likely that many of them do serve the less fortunate. Beyond facilities-based services, it is important to also note that the Catholic Church contributes to social protection in other ways, including through humanitarian aid. This is done among others through the network of more than 160 agencies that are member of Caritas Internationalis (see Box 3.3 on the United States).

Third, the largest category of facilities is that of other institutions, which may include a large number of education and training centers given an apparent reclassification over time. Next are homes for the old, chronically Ill, invalid, or handicapped, matrimonial advice centers, nurseries, and orphanages. The number of special centers for social education or re-education is smaller after the reclassification. The five leading countries in terms of facilities are Germany, India, the United States, Spain, and Brazil.

[63] The term social protection is used loosely as many types of facilities are included, and for the largest set of facilities (other institutions), it is not fully clear what is included, although it is likely that many institutions provide services for the less fortunate.

Box 3.3: Beyond Facilities: Selected Statistics for Catholic Agencies in the United States

Because of a focus on global estimates, this report relies on data on facilities to assess trends in the contributions of the Catholic Church to social protection. At the country level, more detailed data are available. For illustrative purposes, below are statistics for the United States for Catholic Charities, Catholic Relief Services, and the Jesuit Refugee Service.

Catholic Charities serves vulnerable groups in the United States. It includes both a national and local agencies. The national agency fed 12 million people and provided 44 million meals in 2020. It provided $10 million in funding and $17 million in in-kind donations to agencies on the frontline. It distributed 5 million face masks and more than 15,000 gallons of hand sanitizer. The broader Catholic Charities network as a whole estimates that nationally, it provided US$5.1 billion in support through program services and in-kind donations, as well as $400 million in emergency assistance for food, PPEs (personal protective equipment), baby supplies and quarantine housing in the first six months of the year.

Catholic Relief Services is based in the United States but works globally. The development assistance and humanitarian aid agency works in 115 countries with 2,130 local partners. It estimates contributing to improving lives for 140 million people. Program services expenditures in fiscal year 2020 amounted to US$ 836 million, of which 42.8 percent was for emergency assistance, 25.3 percent for health, 9.6 percent for education, and 7.9 percent for agriculture. Other categories are smaller.

The Jesuit Refugee Service is also based in the United States, but its action is global. In 2020, it estimates that it served 1.0 million people served through education programs, more than 108,000 refugees through mental health and psychosocial support programs, and more than 560,000 refugee women and girls.

Box 3.4: Impact of the COVID-19 Pandemic on Social Protection

The need for social protection programs has been exacerbated by the pandemic. Initial predictions of economic impacts were dire[64] for both developed[65] and developing countries[66]. Over time some projections became worse. The first estimates of impacts on poverty by the World Bank suggested that more than 100 million people might fall into poverty due to the crisis[67]. Subsequent estimates[68] suggested that the pandemic could lead to 150 million more poor people in 2021. Some estimates were revised downward, but the order of magnitude remains above 100 million more people in poverty, of which about half are children. Apart from losses in labor income, many households lost remittance[69]. According to the World Food Programme, the number of people suffering from acute hunger may have doubled globally[70]. In particular, many children lost the benefit of school lunches when schools closed[71]. In the United States, the COVID-19 Impact Survey also suggested increases in food insecurity[72].

Faith networks mobilized resources to help those in need during the pandemic (see Box 3.3 on Catholic Charities in the United States). Whether the pandemic will affect the number of Catholic social protection facilities is not known since the latest data from the statistical yearbook are for 2019. But because most facilities are in high income countries, the pandemic's impact on the number of facilities may be limited. Some facilities benefit from state funding and philanthropy remained strong. In the United States, despite a declining share of the population giving to philanthropy, charitable giving increased to a record US$ 471 billion in 2020[73] with individual donors most likely to support human services and health organizations. A substantial share of individual giving is by high income households who were less likely to face employment loss during the pandemic and also benefited from capital gains in the stock market. Corporations also responded with increased giving and multi-year pledges[74]. This increase may however be short term. In the United Kingdom, after an increase in giving in 2020, there was a decline in the first half of 2021, and longer term charities may face the risk of a decline in donations in part due to an ageing donor population but also because of secularization[75].

As to the ability of local churches to help, there were concerns that due to temporary church closings, the pandemic could lead to income losses, forcing some parishes to close. This concern does not seem to have materialized, or at least not yet. Again in the United States, a small scale survey by the Church Network, an association of church business administrators, suggests that more congregations saw an increase than a decrease in income in 2020 versus 2019. The fact that churches were eligible for small business relief from the federal government may have helped reduce negative impacts. The Vatican was however affected with a loss in income of more than US$100 million due to less tourism.

[64] International Monetary Fund (2020).
[65] For Europe, see European Commission (2020).
[66] For sub-Saharan Africa, see World Bank (2020a).
[67] Vos et al. (2020).
[68] World Bank (2020b).
[69] World Bank (2020j).
[70] Food Security Information Network (2020). School lunch programs were also affected. These programs serve many children (World Food Programme, 2013).
[71] On the importance of school programs, see Alderman and Bundy (2012).
[72] See https://www.covid-impact.org/results.
[73] Giving USA (2021).
[74] Indiana University Lilly Family School of Philanthropy (2021).
[75] See https://www.economicsobservatory.com/how-has-covid-19-affected-charitable-giving.

PART II
REACH TO THE POOR, MARKET SHARES, AND QUALITY

CHAPTER 4
REACH TO THE POOR

Introduction[76]

The preferential option for the poor has long been a core principle of Catholic social teaching[77]. In the case of schools for example, the Congregation for Catholic Education already noted almost 45 years ago that due the need to be financially self-supporting, there was a risk that Catholic schools would be admitting mostly children from wealthier families, while the Church should first and foremost offer its educational services to the poor[78]. The desire to serve the poor is also shared by those managing Catholic healthcare and social protection facilities. And it is shared by other Christian denominations, other faiths, and many public institutions. But while Catholic and other faith-based schools profess to serve the poor, and certainly make efforts to that aim, do they succeed in doing so? This evidence is mixed.

As noted in contributions to the International Handbook of Catholic Education published more than a dozen years ago[79], the ability of Catholic schools to serve the poor may have been declining. Religious Congregations which founded schools, healthcare facilities, and social protection centers decades ago were able in the past to provide services to the poor at a nominal fee or at no cost at all. Today, many of these Congregations do not anymore have the personnel and financial resources to do so. At the same time, while public facilities used to charge fees especially in the developing world until relatively recently, they often do not do so anymore, especially in the case of basic education. Furthermore, in many countries, Catholic facilities have seen competitive pressures from low cost private providers[80].

The affordability of Catholics facilities for the poor has been affected by these trends, especially when Catholic institutions do not benefit from support from the state. This is the case not only in developing countries, but also in some developed countries. In the United States for example, Murnane et al. (2018) show that enrollment rates in private schools as a whole are much lower among the poor than among the middle class and the well to do. Due in part to affordability constraints for the less fortunate, high income households have been accounting progressively for a larger share of enrollment in private schools over time.

To provide a tentative assessment as to whether Catholic and other faith-based organizations reach the poor, the analysis for this chapter proceeds in three steps from the global to regional and national levels.

First, global data presented in the first part of this report on the location of Catholic education, healthcare, and social protection facilities are used to assess the extent to which these facilities are located in low and lower-middle income countries, as opposed to upper-middle and high income countries. The analysis suggests that Catholic schools and healthcare facilities are often located in low- and lower-middle income countries. Unless the facilities impose high costs on households for their

[76] This introduction is adapted from Wodon (2019c).
[77] See for example Pontifical Council for Justice and Peace (2004), Heinrich et al. (2008), and Francis (2015), and for Catholic schools McKinney (2018).
[78] Congregation for Catholic Education (1977).
[79] Grace and O'Keefe (2007).
[80] On education, see for example Heyneman and Stern (2014) and World Bank (2017).

services, it is likely therefore that these facilities will serve large number of households in poverty. By contrast, many social protection facilities tend to be clustered in upper-middle and high income countries. In those cases, the types of services provided can make a large difference in terms of reaching the poor.

Having schools or health facilities located more in low and lower-middle income countries does not guarantee however that the schools and facilities will serve households in poverty more than other households. And conversely, facilities located in upper-middle and high income countries may well serve the poor in priority in those countries. For example, at least some of the services provided by social protection facilities focus on disadvantaged populations even if the facilities are located in upper-middle and high income countries.

To assess the extent to which Catholic and other faith-based organizations reach the poor within countries, the second phase of the analysis relies of household survey data with a focus on sub-Saharan African countries given that these are the countries where the provision of services by the Catholic Church is growing the most. Two specific questions are asked. First, do Catholic and other faith-based schools serve the poor more than better of households? The answer to this question is no, in part because many households in poverty are not able to afford services, whether provided by faith-based, public, or private secular organizations. Second, do Catholic and other faith-based organizations serve the poor proportionally more than public and private secular providers? The answer to this question is mixed: Catholic and other faith-based service providers tend to reach the poor more than private secular service providers, but they do not necessarily reach the poor as much as public providers, especially for schools. This is likely again related in part to issues of costs, as Catholic and faith-based organizations may to be more expensive to rely on for households than public facilities.

The fact that within many countries, Catholic and faith-based service providers may not reach the poor more than other groups, and that they may be less pro-poor than public service providers, does not imply that they do not make efforts to reach the poor. But the constraints faced by faith-based providers are such that they are not, on average, pro-poor.

The last part of the analysis provides illustrative case studies to document a specific constraint faced by Catholic and other faith-based providers in reaching the poor: whether their facilities are located in poor areas. A brief conclusion follows.

Analysis[81]

Location of Facilities across Countries

The first part of the analysis considers the location of Catholic facilities by regions and country income groups. In the first part of this report, the analysis relied on geographic categories available in the statistical yearbooks of the Church. These groupings do not correspond to the regional groupings commonly used in international work. Therefore, we rely instead here on the regional groupings used by the World Bank, which classifies countries in six regions: East Asia and Pacific, Europe and Central Asia, Latin America and the Caribbean, Middle East and North Africa, North America, South Asia, and Sub-Saharan Africa. In addition, we provide data according to the World Bank's four income groups: low, lower-middle, upper-middle, and high income[82]. Tables 4.1 to 4.3 and

[81] This section is based on Wodon (2021i).

[82] In terms of income levels, for the World Bank's 2022 fiscal year, low-income countries are those with a Gross National Income (GNI) per capita calculated using the World Bank Atlas method of $1,045 or less in 2020. Lower-middle-income counties are those with a GNI per capita between $1,046 and $4,095. Upper-middle-income countries are those with a GNI per capita between $4,096 and $12,695. Finally high-income countries are those with a GNI per capita of $12,696 or more The income group in which countries are classified may change over time whether because of economic growth or because of changes in methodology or rebasing of a

the corresponding Figures provide estimates of the number and share of facilities by regions and country income groups.

Consider first the data for schools. As mentioned in chapter 1, much of the growth in the number of Catholic schools globally was concentrated in Africa, and in particular in sub-Saharan Africa. In 2019 the region accounted for 41.1 percent of all Catholic primary schools globally, and 31.0 percent of Catholic secondary schools[83]. For preschools the proportion is lower at 25.8 percent. After sub-Saharan Africa, Europe and Central Asia and Latin America and the Caribbean have the largest number of schools at the primary and secondary level, and for preschools these two regions are also at the top in terms of the number of schools.

More than a third of Catholic primary schools are located in low-income countries, with another 27.6 percent in lower-middle income countries. Less than 40 percent are located in upper-middle and high income countries.

In terms of income groups, 27.6 percent of Catholic primary schools are located in low-income countries, with another 35.9 percent in lower-middle income countries. Less than 40 percent of Catholic primary schools are located in upper-middle and high income countries. For preschools and secondary schools, the proportion of schools in low income countries is smaller, because educational attainment in those countries remains low and few children benefit from pre-primary education. Still, low and lower-middle income countries together account for more or less half of all Catholic schools at those levels. Overall it seems fair to state that at the primary level especially, the Catholic Church serves primarily children in countries with comparatively low levels of economic development. This is good news for the emphasis of the Church placed on the preferential option for the poor[84], but it also means in the context of the current crisis that Catholic schools are likely to have been affected severely by the COVID-19 crisis, since the ability of schools (and students) to cope with the crisis has been limited in those countries[85].

The profile of healthcare facilities by regions and income groups is similar to that of schools. For social protection, with the exception of orphanages and nurseries, most facilities are located in high income countries.

Similar data are provided for healthcare and social protection in Tables 4.2 and 4.3, and the corresponding Figures. For healthcare, the profile of facilities by regions and income groups is somewhat similar to that for schools, with many facilities located in sub-Saharan Africa and in low and lower-middle income countries. In the case of leproseries, nine in ten facilities are in low and lower-middle income countries, but these account only for a small share of all healthcare facilities managed by the Catholic Church. For social protection, the situation is different, as mentioned in chapter 3. For many services a large share of facilities are located in upper-middle and especially high income countries, with the exception of orphanages and nurseries where lower-middle income countries account for more than 40 percent of all facilities globally.

country's National Accounts. While Venezuela was not classified at the time of writing, the country is considered as upper-middle income for this report.

[83] For student enrollment at the primary level, sub-Saharan Africa accounts for an even larger share of all students in Catholic schools (Wodon, 2021a).

[84] On whether Catholic schools succeed in serving the poor for schooling and learning in sub-Saharan Africa, see Wodon (2014, 2015, 2019c, 2020g).

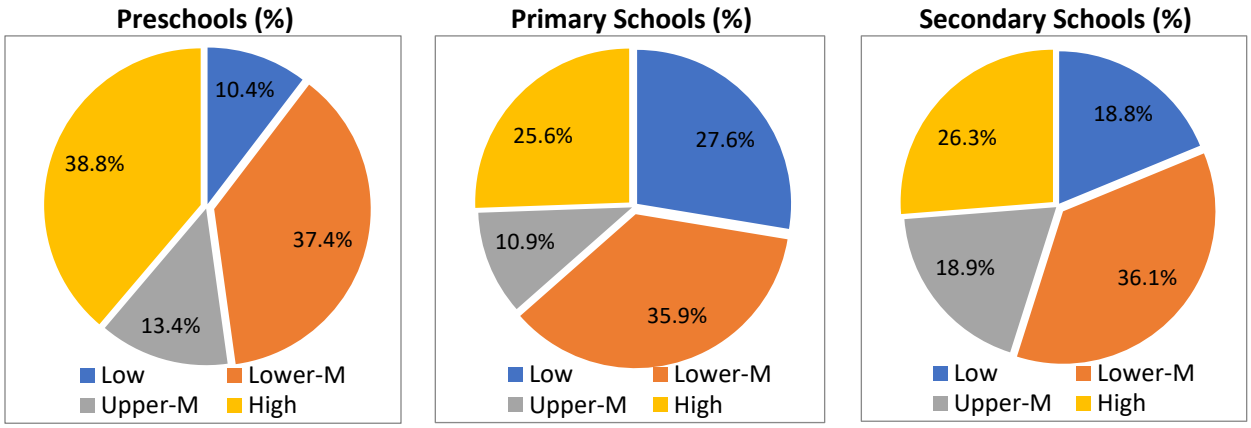
[85] See Wodon (2021a) for an analysis of the impact of the crisis on schools and students.

Table 4.1: Location of Catholic Schools by Region and Country Income Group, 2019

	Preschools	Primary schools	Secondary schools	All K12 schools
	Number of schools			
Regions				
East Asia & Pacific	6,854	8,445	4,261	19,560
Europe & Central Asia	21,610	15,800	9,366	46,776
Latin America & Caribbean	11,920	15,320	10,422	37,662
Middle East & North Africa	717	816	467	2,000
North America	4,440	6,348	1,781	12,569
South Asia	8,344	11,533	7,895	27,772
Sub-Saharan Africa	18,782	40,662	15,360	74,804
Income Groups				
Low Income	7,538	27,312	9,308	44,158
Lower-Middle Income	27,199	35,511	17,894	80,604
Upper-Middle Income	9,737	10,821	9,341	29,899
High Income	28,193	25,281	13,009	66,483
World	72,667	98,925	49,552	221,144
	Shares of schools			
Regions				
East Asia & Pacific	9.4%	8.5%	8.6%	8.8%
Europe & Central Asia	29.7%	16.0%	18.9%	21.2%
Latin America & Caribbean	16.4%	15.5%	21.0%	17.0%
Middle East & North Africa	1.0%	0.8%	0.9%	0.9%
North America	6.1%	6.4%	3.6%	5.7%
South Asia	11.5%	11.7%	15.9%	12.6%
Sub-Saharan Africa	25.8%	41.1%	31.0%	33.8%
Income Groups				
Low Income	10.4%	27.6%	18.8%	20.0%
Lower-Middle Income	37.4%	35.9%	36.1%	36.4%
Upper-Middle Income	13.4%	10.9%	18.9%	13.5%
High Income	38.8%	25.6%	26.3%	30.1%
World	100.0%	100.0%	100.0%	100.0%

Source: Authors' estimations.

Figure 4.1: Shares of Catholic Schools by Country Income Groups, 2019



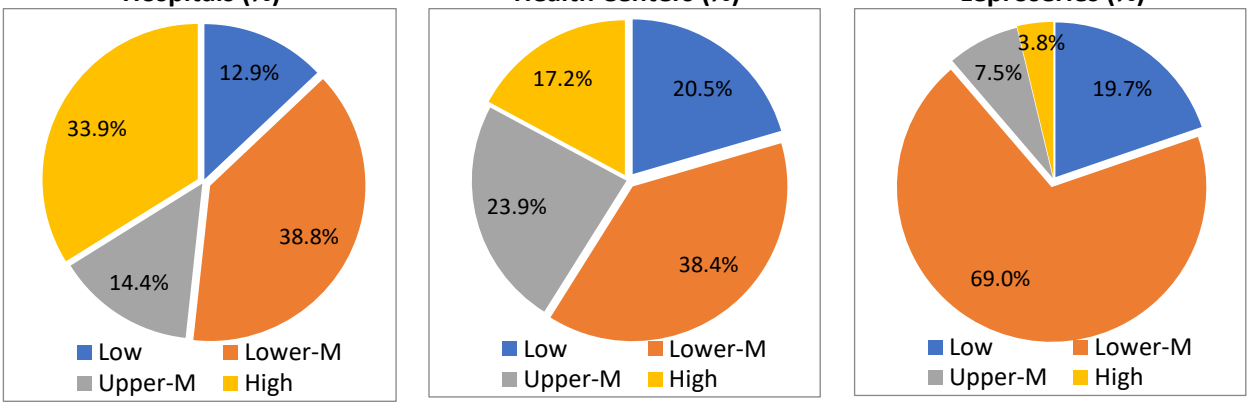
Source: Authors' estimations.

Table 4.2: Location of Catholic Healthcare Facilities by Region and Country Income Group, 2019

	Hospitals	Health centers	Leproseries	All facilities
	Number of facilities			
Regions				
East Asia & Pacific	609	1,008	40	1,657
Europe & Central Asia	1,023	2,315	19	3,357
Latin America & Caribbean	758	3,802	41	4,601
Middle East & North Africa	74	282	31	387
North America	598	241	0	839
South Asia	783	2,122	224	3,129
Sub-Saharan Africa	1,400	5,193	177	6,770
Income Groups				
Low Income	679	3,065	105	3,849
Lower-Middle Income	2,034	5,752	367	8,153
Upper-Middle Income	756	3,579	40	4,375
High Income	1,776	2,567	20	4,363
World	5,245	14,963	532	20,740
	Shares of facilities			
Regions				
East Asia & Pacific	11.6%	6.7%	7.5%	8.0%
Europe & Central Asia	19.5%	15.5%	3.6%	16.2%
Latin America & Caribbean	14.5%	25.4%	7.7%	22.2%
Middle East & North Africa	1.4%	1.9%	5.8%	1.9%
North America	11.4%	1.6%	0.0%	4.0%
South Asia	14.9%	14.2%	42.1%	15.1%
Sub-Saharan Africa	26.7%	34.7%	33.3%	32.6%
Income Groups				
Low Income	12.9%	20.5%	19.7%	18.6%
Lower-Middle Income	38.8%	38.4%	69.0%	39.3%
Upper-Middle Income	14.4%	23.9%	7.5%	21.1%
High Income	33.9%	17.2%	3.8%	21.0%
World	100.0%	100.0%	100.0%	100.0%

Source: Authors' estimations.

Figure 4.2: Shares of Catholic Healthcare Facilities by Country Income Groups, 2019



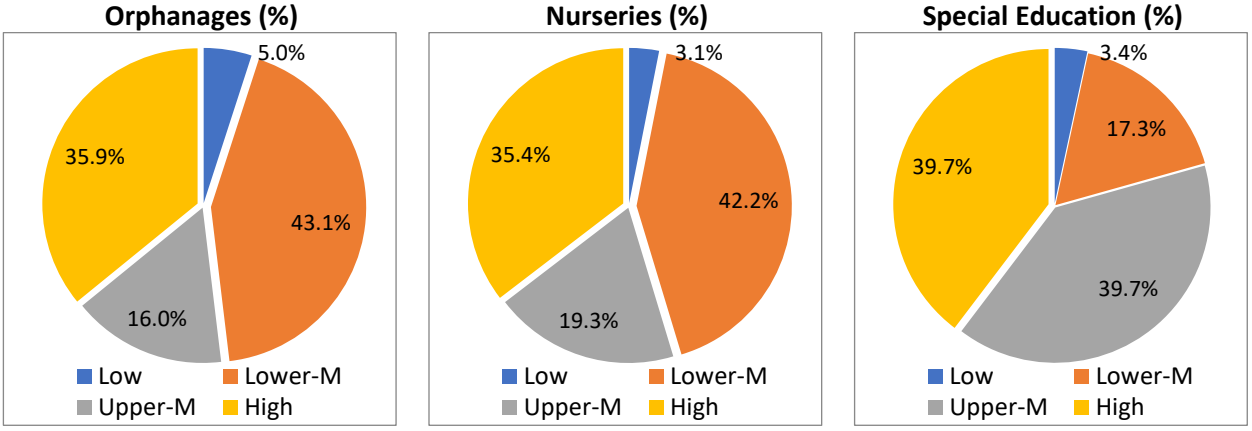
Source: Authors' estimations.

Table 4.3: Location of Catholic Social Protection Facilities by Region and Country Income Group, 2019

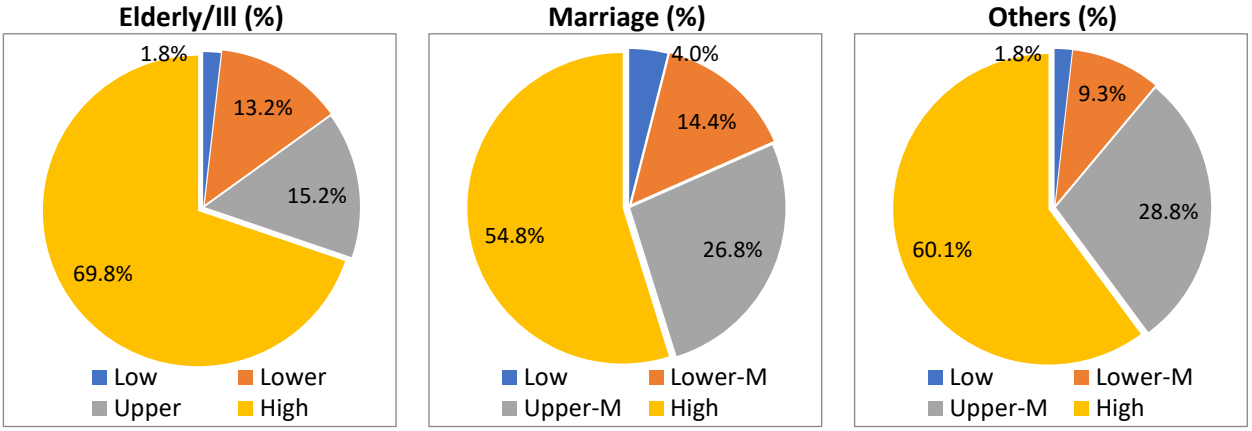
	Orphanages	Nurseries	Special Ed.	Elderly/Ill	Marriage	Others	All
	Number of facilities						
Regions							
East Asia & Pacific	1,732	1,104	1,227	574	273	1,026	5,936
Europe & Central Asia	8,046	2,248	2,498	5,518	718	16,526	35,554
Latin America & Carib.	2,371	1,523	2,141	3,413	1,300	9,982	20,730
Middle East & North Afr.	107	89	73	60	23	93	445
North America	1,258	607	815	872	330	3,110	6,992
South Asia	1,279	2,173	1,856	451	305	1,943	8,007
Sub-Saharan Africa	636	1,630	2,113	1,420	248	1,160	7,207
Income Groups							
Low Income	280	468	333	488	108	610	2,287
Lower-Middle Income	2,043	4,040	4,527	1,773	552	3,141	16,076
Upper-Middle Income	2,341	1,503	2,067	3,299	1,269	9,736	20,215
High Income	10,765	3,363	3,796	6,748	1,268	20,353	46,293
World	15,429	9,374	10,723	12,308	3,197	33,840	84,871
	Shares of facilities						
Regions							
East Asia & Pacific	11.2%	11.8%	11.4%	4.7%	8.5%	3.0%	7.0%
Europe & Central Asia	52.1%	24.0%	23.3%	44.8%	22.5%	48.8%	41.9%
Latin America & Carib.	15.4%	16.2%	20.0%	27.7%	40.7%	29.5%	24.4%
Middle East & North Afr.	0.7%	0.9%	0.7%	0.5%	0.7%	0.3%	0.5%
North America	8.2%	6.5%	7.6%	7.1%	10.3%	9.2%	8.2%
South Asia	8.3%	23.2%	17.3%	3.7%	9.5%	5.7%	9.4%
Sub-Saharan Africa	4.1%	17.4%	19.7%	11.5%	7.8%	3.4%	8.5%
Income Groups							
Low Income	1.8%	5.0%	3.1%	4.0%	3.4%	1.8%	2.7%
Lower-Middle Income	13.2%	43.1%	42.2%	14.4%	17.3%	9.3%	18.9%
Upper-Middle Income	15.2%	16.0%	19.3%	26.8%	39.7%	28.8%	23.8%
High Income	69.8%	35.9%	35.4%	54.8%	39.7%	60.1%	54.5%
World	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Authors' estimations.

Figure 4.3: Shares of Catholic Social Protection Facilities by Country Income Groups, 2019



Source: Authors' estimations.



Source: Authors' estimations.

Benefit Incidence within Countries[86]

A key conclusion from the previous section is that despite a substantial presence in upper-middle and high income countries, Catholic schools and healthcare facilities are more likely to be located in low income and lower-middle income countries. This is in part due to large networks of Catholic schools and healthcare facilities in India and a few populous African countries. This does not guarantee however that these schools and healthcare facilities serve households in poverty more than better off households.

How can we assess whether faith-based schools and healthcare facilities serve the poor, as they often profess? Clearly many are likely to have poor households in their clientele. But do they serve the poor proportionally more than public and private secular service providers? Do they serve the poor more than better of households? And do they make special efforts to reach the poor? These are three different questions. The first two can be answered with data from nationally representative household surveys. For the third question, it is best to rely on qualitative fieldwork (in-depth interviews and focus groups) to provide tentative answers.

Nationally representative multi-purpose household surveys cover the whole territory of nations, often with large sample sizes. It is common for 5,000 to 10,000 households to be interviewed, and in some cases sample sizes are larger. The surveys include a roster of household members, and ask questions on the types of schools and health services that households rely on to educate their children and seek care when sick or injured.

Some survey questionnaires include questions on the type of service providers – that is, whether households rely on public, private secular, or faith-based facilities. The surveys also include detailed data on the consumption patterns of households, which can be used to assess standards of living. Statistics can therefore be provided by poverty status, with a household considered as poor if its total consumption is not sufficient to meet the household members' basic needs. Statistics can alternatively be constructed by quintiles of well-being, from the poorest 20 percent of households (first quintile) to the richest quintile (fifth quintile). With these data, one can in principle assess whether faith-based schools as well as healthcare and social protection facilities reach the poor more or less than is the case for public and private secular facilities[87].

[86] This section is adapted from Wodon (2015).

[87] There are limits to the analysis. For example, in countries where Catholic and other faith-based schools have a large market share, many of faith-based schools are part of the public school system that benefits from state funding. As a result, parents may not be aware that the schools are faith-based. In Uganda as one case study, according to parental responses in household surveys, few children attend faith-based schools, but administrative data suggest

In this section, the analysis focuses on sub-Saharan Africa. Due to data limitations, it is carried for all faith-based schools and healthcare facilities taken together and not just Catholic institutions. In addition, the focus is on schools and health facilities because household surveys often do not provide detailed data on whether households rely on public, faith-based, or private secular social protection services.

Table 4.4 and Figure 4.4 provide data on the average benefit incidence by quintile of faith-based schools and healthcare facilities in comparison to public and private secular facilities in sub-Saharan Africa. The statistics are the share of students for a school or patients for a health facility that come from the five quintiles in the distribution of household (per capita or per equivalent adult) consumption, from the poorest to the richest. The analysis is based on data from nationally representative surveys and previous work by the author. For example, the value of 14.5 for the bottom quintile for public healthcare signifies that 14.5 percent of patients using the facilities belong to the poorest quintile. For healthcare, the statistics are based on data from 14 different countries. For primary and secondary education, estimates are from 16 countries. The regional statistics are based on a simple average across countries, not including population weights for each country in order not to have the largest countries dominate findings.

For healthcare, the benefit incidence estimate for faith-based facilities in the poorest quintile is slightly higher than is the case in the public and private secular sectors, but differences in estimates between public facilities and faith-based facilities tend to be small. This suggests that in comparison to public providers, the reach to the poor of faith-based facilities is similar. By contrast, private secular providers tend to be more tilted towards higher quintiles of well-being, as expected.

How do faith-based schools compare to public and private secular facilities on average across the 16 countries for education? For both primary and secondary schools, the benefit incidence by quintile for faith-based schools is less pro-poor that for public facilities, but the faith-based schools are more pro-poor than is the case for private secular schools.

In comparison to public providers, the reach to the poor of faith-based healthcare facilities is similar. Private secular providers serve better off households more. As to faith-based schools, they are less pro-poor that public schools, but more pro-poor than private secular schools.

A second question that can be explored with the same data is whether faith-based schools and healthcare facilities serve the poor more than better of households? The answer is also provided in Table 4.4. Although poverty estimates vary between countries, in most countries the bottom two or three quintiles can be considered as representing the poor. If the share of users of faith-based schools and healthcare facilities in those quintiles is above 20 percent, this suggests that they tend to serve the poor more than other households.

Consider the first quintile as an illustration of whether different types of schools or health facilities manage to reach the very poorest. On average, 15.3 percent of students in faith-based primary schools are from the bottom quintile. The proportion is 9.6 percent for secondary schools. Clearly, faith-based schools do serve the poor, but less than better off households, as is also the case for public and private secular schools. The only exception is for students in public primary schools where the first quintile is overrepresented. For health facilities as well, all types of service providers tend to serve the poor less than other households, despite efforts they make undertake to serve the less fortunate.

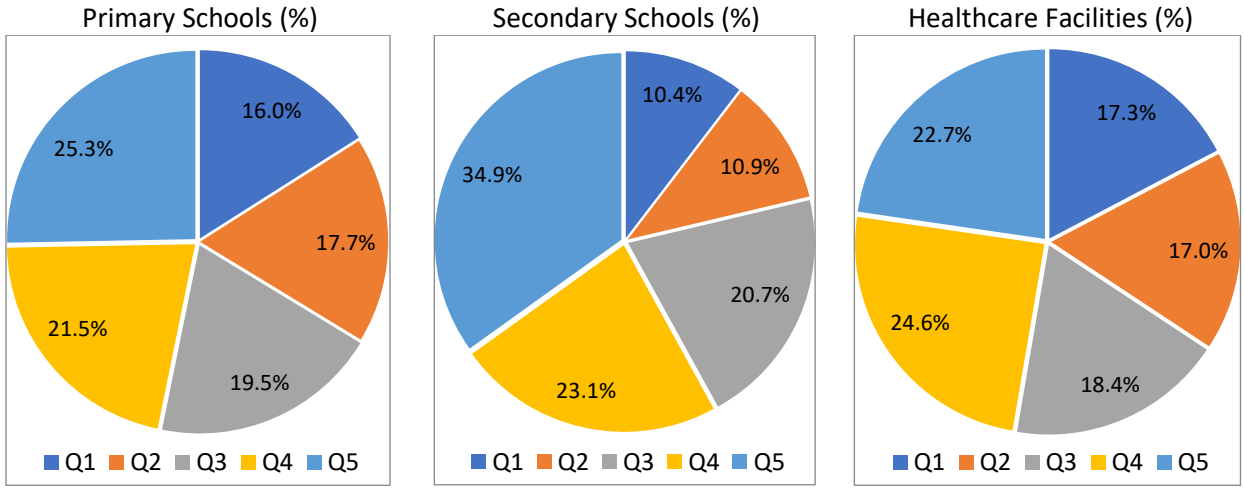
large market shares for faith-based schools, including Catholic schools. The likely explanation is likely that parents may consider many of those faith-based schools as public schools, since they are publicly funded and they follow the national curriculum taught in public schools. This may affect results for the benefit incidence analysis.

Table 4.4: Benefit Incidence of Service Providers by Welfare Quintile in sub-Saharan Africa (%)

	Benefit incidence by welfare quintile					All
	Quintile 1 (Poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Richest)	
	Primary education – Average for 16 countries					
Public	21.7	21.8	21.6	19.9	15.0	100.0
Faith-based	16.0	17.7	19.5	21.5	25.3	100.0
Private secular	8.5	11.8	14.2	21.6	43.9	100.0
All	20.0	20.7	20.8	20.3	18.2	100.0
	Secondary education – Average for 16 countries					
Public	12.3	15.7	19.0	23.8	29.2	100.0
Faith-based	10.4	10.9	20.7	23.1	34.9	100.0
Private secular	4.5	8.2	13.2	19.1	54.9	100.0
All	11.2	14.6	18.1	23.3	32.8	100.0
	Healthcare – Average for 14 countries					
Public	14.5	17.0	19.7	23.0	25.8	100.0
Faith-based	17.3	17.0	18.4	24.6	22.7	100.0
Private secular	14.1	16.3	18.2	21.3	30.2	100.0
All	14.5	16.9	19.0	22.5	27.1	100.0

Source: Estimation from household surveys. Adapted from Wodon (2014, 2015, 2019).
Note: All countries in the sample are treated equally when computing averages across countries.

Figure 4.4: Benefit Incidence of Faith-based Services in sub-Saharan African Countries
(Q1 as poorest and Q5 as richest quintiles of well-being)



Source: Adapted from Wodon (2015, 2019).

Why do faith-based schools often serve the poor less than other households? Cost is probably a key factor, both for the decision of schools for parents sending their children to school or seek care for a family member. When households are asked in surveys why some of their children are not enrolled in school, or why they did not seek care when needed, out-of-pocket costs are often one of the reasons mentioned the most often, especially for preschools and secondary education.

Many faith-based schools and healthcare facilities operate without financial support or with only partial support from governments. This forces them to recover their operating costs from households. Even if faith-

based schools and healthcare facilities manage to operate with smaller budgets than public schools, in part because they may be able to rely on members of the clergy and religious orders to reduce salary costs, they still typically cost more for households to use than public facilities. Furthermore, for both schooling and healthcare, apart from out-of-pocket costs using services has opportunity costs in time.

To compare out-of-pocket costs for different types of facilities, Table 4.5 and Figure 4.5 provide data based on data for nine of the 16 countries that were included in the benefit incidence analysis. On average, faith-based schools are more expensive than public schools, but less so than private secular schools. For healthcare, out-of-pocket costs are available for seven countries[88]. Instead of costs in absolute values, an index is used because costs do not necessarily represent the same services across countries. The index takes on a value one for visits to public facilities by households in the bottom quintile. Faith-based providers are again more expensive than public providers, but less expensive than private secular providers (index of 2.46 for faith-based providers versus 2.07 for public providers and 4.92 for private secular providers).

On average, faith-based schools and facilities are more expensive for households to use than public schools and facilities, but less expensive than private secular schools and facilities.

Similar preliminary results on out-of-pocket costs and reach to the poor for different types of schools are obtained from a recent survey conducted in ten West African countries[89].

Apart from cost, other factors may also play a role in who uses various types of services. One consideration is that of household preferences for different types of services – this will be discussed in chapter 6. Another consideration is location. For example, in the case of healthcare, many faith-based providers supply advanced care (this includes in sub-Saharan Africa many facilities that are members of Christian Health Association). These hospitals and clinics are often more expensive, which may reduce the ability among the poor to use them, but in addition they tend to be located in urban or semi-urban settings where the extreme poor are less likely to live, or at least may not represent the majority of the population. These geographic factors may contribute to the fact that statistically speaking, faith-based facilities may not strictly be pro-poor even if they try to reach the poor. This will be discussed in the next section with illustrations on the location of new facilities.

Finally, still another question is whether faith-based schools and healthcare or social protection facilities make particular efforts to reach the poor. This may be the most important question to account for the constraints in which service providers must operate. The good news is that there are clear indications that efforts are indeed made by faith-based service providers to reach the poor. There is a large literature on this topic, but one interesting example is provided by Reinikka and Svensson (2010) in their work on Uganda. The authors tested for altruistic behaviour by faith-based healthcare facilities that received untied small grants from the government. Facility managers could have used the grants for their own benefit or for the benefit of their staff by raising salaries or providing them with perks. Instead, analysis suggests that the funds were used to provide more services at lower cost to the population, with clear benefits for the poor[90].

[88] For healthcare, one country with data in Wodon (2015) was excluded from average values in Table 4.5 because some of the estimates are outliers.

[89] The analysis is still being undertaken and will be shared in the next Global Catholic Education Report.

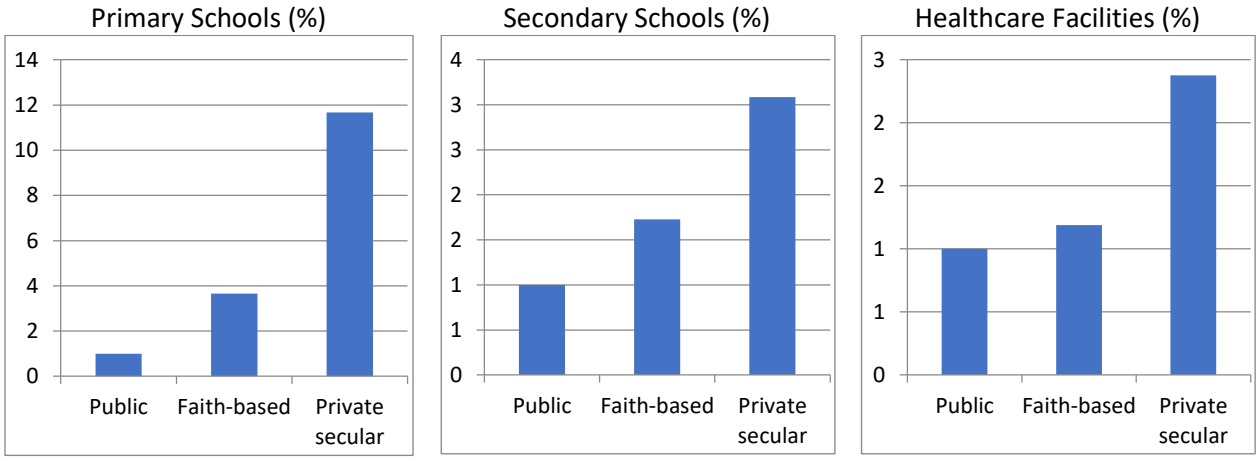
[90] In some cases, faith-based providers may opt not to seek state funding or may do so less than other private providers of services. This was the case for Catholic schools for a program in Uganda that provided capitation grants to private schools for expanding access to secondary education. See Wodon (2017b).

Table 4.5: Out-of-pocket Cost for Households of Service Providers in sub-Saharan Africa (US$ or index)

	Average cost by welfare quintile					All
	Quintile 1 (Poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Richest)	
	Primary education – Average for 9 countries (US$)					
Public	3.9	5	5.8	9.5	17.7	7.2
Faith-based	8	13.7	17	28	53.9	26.3
Private secular	16.2	26.8	38.6	50.5	143.6	84.0
All	4.8	7.4	9.8	17.1	56.0	16.3
	Secondary education – Average for 9 countries (US$)					
Public	25.5	35.5	44.7	59.8	95.3	54.6
Faith-based	63.7	63.6	52.6	90.9	141.5	94.4
Private secular	38.9	58.1	105.1	104.2	226.5	168.4
All	27.1	40.6	51.9	70.0	132.7	73.8
	Healthcare – Average for 7 countries (Index with a value of 1.00 for Q1 and public facilities)					
Public	1.00	1.29	1.45	1.80	3.58	2.07
Faith-based	0.99	1.19	1.93	2.24	3.82	2.46
Private secular	1.04	3.75	2.41	7.25	6.02	4.92
All	0.95	1.41	1.66	2.81	4.38	2.65

Source: Estimation from household surveys. Adapted from Wodon (2014, 2015, 2019).
Note: All countries in the sample are treated equally when computing averages across countries.

Figure 4.5: Relative Out-of-Pocket Costs of Services in sub-Saharan African Countries
(Cost of faith-based and private secular providers vs. normalized value of 1 for public providers)



Source: Adapted from Wodon (2015, 2019).

Case Studies on the Location of Facilities

While cost is an important factor leading faith-based schools and other facilities not to serve primarily the poor, location may also play a role. It is often suggested that faith-based schools and facilities are located primarily in poor areas, which would enable these facilities to primarily serve the poor. While this may have been the case several decades ago when new faith-based schools and healthcare facilities aimed to reach underserved areas, it may not necessarily be the case today, as illustrated with two case studies, the first for schools and the second for health facilities.

Consider first a case study on secondary school construction in Uganda[91], a country where there is a rapid increase in the demand

[91] Wodon (2020j).

for secondary education due to both population growth and gains in educational attainment. Uganda's education sector strategy emphasizes three main objectives, the first of which is to provide equitable access to relevant and quality education and training[92]. This requires massive investments in terms of school construction and the expansion of existing schools.

School construction should respond to a demand for schooling that is not currently met or a higher demand expected in the future. A simple way to measure this demand at the lower secondary level is to compare the number of children eligible to go to secondary schools to the number actually enrolled. In addition, to anticipate future unmet demand as opposed to current demand, estimates can be adjusted to account for year-to-year growth in student cohorts due to population growth or gains in educational attainment over time.

Using data from a recent census of secondary schools, an assessment of the location of new schools was conducted separately for public schools, Catholic schools (most recently created Catholic schools are private), and non-Catholic private schools. A total of 718 secondary schools were established between 2010 and 2016. This represents one fifth of all secondary schools in the country. Most new schools were private non-Catholic schools. About one in ten were private Catholic schools. Less than one in ten were public schools. The estimates underscore how the private sector has been the leading force behind the expansion of Uganda's secondary school network over the last decade.

Were new schools built in the areas that needed them the most? Not always. The areas with the largest needs benefitted on average from fewer new schools than better off areas. In particular, new schools were built more in areas with higher gross enrollment rates. This is not surprising, since most of the new schools built were private schools, and areas with higher enrollment rates also tend to be better off, with households more able to pay the fees required for children to attend private schools. But even for new Catholic schools, the location of the new schools was not in the areas that had the largest unmet needs.

In Uganda, new Catholic secondary schools built over the last decade are not necessarily located in the areas with the largest unmet needs. This is also the case for new private schools.

The fact that new Catholic schools were not located in priority in underserved areas does not imply that the schools did not reach the poor. It could be that the schools managed to serve the poor in slightly better off areas. But the results point to a major issue for the schools to reach those in need. In the absence of state support (virtually all the new Catholic schools built since 2010 were private schools), cost recovery makes it difficult for the schools to be an affordable option for the, which may in turn lead to school construction in better off areas where demand for the schools may be higher.

Consider next a case study on healthcare facilities based on data from the Christian Health Association of Ghana (CHAG)[93]. There is a common perception that many of these facilities are located in poor areas. Yet while some facilities may have been historically located in remote areas with high levels of poverty, this may have changed over time. Some of the coastal areas that traditionally had a large presence of mission-based facilities have seen their levels of poverty decrease in the past few decades. To assess whether CHAG facilities are located nowadays in poor areas, data on the location of the facilities were compared to a poverty map for the country.

The analysis suggests that the hospital bed rate for CHAG facilities tends to be higher in the extreme northwest and in a number of districts in the south of the country. There are exceptions to this pattern but overall, CHAG facilities do not appear to be located more in poor areas than in other areas. When areas are

[92] Ministry of Education and Sports (2017).

[93] Coulombe and Wodon (2012).

simply classified by quintiles of well-being, CHAG facilities tend to serve slightly more districts that have a higher level of well-being, but when the analysis is weighted by the population in each district, CHAG facilities tend to serve slightly more the poorer quintiles. Overall, these patterns reflect a broad distribution of facilities in the country in both poor and less poor areas. In addition, if one considers only districts in which CHAG has facilities, then the location of the facilities is pro-poor. But if one considers all districts, that relationship is weaker, in part because CHAG does not have facilities in many poor districts.

In Ghana, the facilities operated by the Christian Health Association of Ghana are located in poor as well as better off areas. They are not primarily located in poorer, more remote areas.

These results on the location of CHAG facilities run counter to the perception that CHAG serves primarily rural and poor areas. Yet as already mentioned, there have been profound changes in the geography of poverty in Ghana over the past two decades, with poverty being increasingly concentrated in the northern and rural savannah areas. Given that there are more CHAG facilities in the southern and middle belts than in the northern areas, with the exception of a few majority Catholic districts in the Upper West region, the changing patterns of poverty may have reduced the share of CHAG facilities located in poor areas. More than poverty, a variable that is more closely associated with the density of facilities and hospital beds of CHAG by district is the share of the population of the district that is Catholic. This does not mean that CHAG facilities serve only Catholics or that they do not aim to reach the poor. They serve all households regardless of faith and do strive to serve the poor, but the facilities are not necessarily located on average more in poor areas than in better off areas.

Summing Up

This chapter discussed the extent to which Catholic and other faith-based schools, healthcare facilities and social protection facilities are reaching the poor. The analysis proceeded in three steps. The focus was first on global data on Catholic schools and facilities, looking at the location of these facilities by regions and country income groups. More than a third of all Catholic primary schools are located in low-income countries, with another 27.6 percent in lower-middle income countries. Less than 40 percent are located in upper-middle and high income countries. This is good news for the ability of these schools to reach the poor, given much higher rates of poverty in low and lower0middle income countries. The profile of Catholic healthcare facilities by regions and income groups is similar to that of schools. For social protection however, with the exception of orphanages and nurseries, most facilities are located in high income countries.

The second step in the analysis consisted in using household surveys to assess whether faith-based schools and healthcare facilities in sub-Saharan Africa reach the poor. Two main questions were asked: do faith-based schools and healthcare facilities serve the poor more than better of households? And do they serve the poor more than public and private secular providers? The analysis suggested that faith-based schools and facilities are not strictly pro-poor. This is not surprising given that reaching the poor is hard. Given no or limited state funding for many facilities, cost recovery makes the services provided by Catholic and faith-based facilities less affordable for the poor. As a result, while Catholic and faith-based schools and healthcare facilities reach the poor more than private secular schools and facilities, they have on average a smaller proportion of their students and patients who are poor than is the case for public schools and health facilities.

Finally, using two brief case studies for Uganda and Ghana, the analysis illustrated than in terms of their location, faith-based schools and healthcare facilities are not necessarily

located today primarily in remote and poor areas even if this may have been the case in the past. This does not mean that faith-based providers do not aim to serve the poor. There are many examples showing that faith-based service providers and other faith-based non-profits make special efforts to reach the poor (see Box 4.1 on how this can be done). But this does not mean that they primarily serve the poor, as is sometimes claimed.

Box 4.1: Reaching the Extreme Poor: Insights from the International Movement ATD Fourth World

Reaching the extreme poor is not easy. While there is no magic bullet, insights from the late Father Joseph Wresinski, a Catholic priest who spent his life working with the extreme poor, and the organization he founded may help. In an analysis for UNICEF, the nonprofit highlights six points or principles of action that should be taken into account when trying to reach the poorest[94].

First is the need to build and share knowledge with the very poor. Often the poorest are excluded and out of reach. This exclusion and the poor's own efforts to emerge from poverty may not be known to an outsider. For the outsider to acquire an in-depth knowledge of the very poor, some basic conditions are required. Close proximity for sufficient time to build trust with the very poor may be necessary to be attuned to their aspirations. But for proximity to work, the very poor need a clear understanding of the intentions of those who want to help. Reciprocity and mutual understanding are some of the basic conditions to establish trust on which knowledge can be built and shared.

Second, actions should be based on the aspirations of the poorest instead of their problems. Projects that are the most successful in reaching the poorest tend to be based on their aspirations. In Guatemala, the poorest families in a village were the hardest hit by malnutrition and the death of young children. A project initially dealing solely with malnutrition failed in part because it accentuated the parents' feeling of failure. Reorienting the project around a pre-school helped rescue it because it did send to parents a strong message that others had, like them, faith in the future of their children.

Third, the value of cultural actions must be recognized. People require beauty and creative expression as much as they require food, clothing, and shelter. Artistic and cultural projects emphasize each person's creativity. Through them, the poorest may be able to discover their potential. They may gain the confidence necessary to dare speaking up and contributing to the well-being of their communities and to broader society. Cultural activities may also provide an atmosphere allowing people from different backgrounds, poor and non-poor, to express and share experiences as equals.

Fourth, the family must be strengthened. Families are the first line of resistance of the poorest against deprivation and social exclusion. While extreme poverty is destructive to family life, a poor person's family remains a powerful means of personal and social identification. Hence a basic question to be put forth when evaluating programs is whether they tend to reinforce the family or break it apart.

Fifth, it is essential to provide a role for the poor in identifying and helping others poorer than themselves. People in poverty are aware of others around them who are poorer than themselves. They can lead outsiders to the most hidden and downtrodden families. They can act as the bridge that will build confidence and trust, leading to mutual respect and partnership. This role for the poor is unique, and it constitutes a key element in the development of actions aimed at reaching the poorest.

Finally, projects should build on the potential for communities to unite around the poorest. Within each community, there are people who express their solidarity with the poorest. These people are not necessarily leaders, but they are essential in establishing a consensus to help those who are left out. They are also indispensable actors in the development of specific programs. Existing networks of solidarity constitute strengths on which to build: they should be sought before starting new projects.

[94] Redegeld (2001). See also the other contributions in Wodon (2001).

CHAPTER 5
MARKET SHARES

Introduction[95]

This chapter discusses estimates of the market share of faith-based service providers. It is worth emphasizing at the outset that many faith-based providers do not aim to increase their market share. They are often driven by altruistic motives, as opposed to size, power, or profit making. What matters to faith-based providers is typically to serve the population with good quality services and with a preferential option for the poor (a Christian term, but also often a core priority for other faith-based facilities). The term market share is not seen sympathetically by at least some faith-based organizations, but it reflects the reality that there are indeed markets for education, healthcare, and social protection services in which faith-based providers must compete.

Estimates of market shares are often used as a rather blunt instrument to advocate on behalf of faith-based providers, for example, to enable them to benefit from support from governments and donors. The problem is that if existing estimates are not based on strong evidence, such advocacy efforts may be more detrimental than useful. It seems better to base recommendations for support on evidence of good quality services and of reach to the poor than market shares. If support is obtained, it is likely to be somewhat proportional to the quantity of services provided anyway, as is the case when governments fund the salaries of staff from faith-based providers.

There have been a few publications in the international development community suggesting that faith-based providers may account for up to half of the education, healthcare, and possibly social protection services provided in some countries, particularly in sub-Saharan Africa. This is correct, but these countries tend to be exceptions. At the regional and global levels, the market shares of faith-based schools and healthcare facilities tend to be much smaller, and the same is likely to be true for social protection facilities.

Consider the case of healthcare where more work has been done in the literature on this issue than for education. Estimates of the market share of faith-based providers in healthcare have been suggested to be in the 30–50 percent range. The problem with this literature is that in many studies, the sources of the estimates are either not clear or outdated[96]. Studies simply tend to cite previous studies, often all the way back to seminal work done for a few countries in 1964 by the Christian Medical Commission[97] and reports for the World Bank's World Development Report on health[98]. Yet, the caveats and limits noted in the original works are ignored in subsequent citations, and the original studies may be outdated. There is a game of broken telephone being played, whereby the apparent consensus on the market share of faith-based healthcare is based on likely outdated and partial estimates which may have had some validity, but also limits, and may have been misquoted and distorted.

In particular, one of the issues with estimates suggesting large market shares for faith-based healthcare is that they are based on important yet limited data pertaining to the role

[95] For education, the analysis in this chapter is adapted from Wodon (2021a).

[96] Olivier and Wodon (2012a, 2012b, 2012c).

[97] The study for the Christian Medical Commission by McGilvray (1981) suggested that in Tanzania, Malawi, Cameroon, and Ghana, Christian health facilities accounted at the time for one fourth to half of all healthcare facilities (estimates were lower in South Asia). These estimates have often been used since to claim that up to half of all healthcare in Africa is still provided by faith-based organizations, but this claim does not stand up to scrutiny.

[98] De Jong (1991), World Bank (1993).

of some of the most prominent Christian Health Associations (CHAs) in a set of African countries where the CHAs play a large role. What is often available for countries with CHAs is the share of hospital beds owned by CHAs as a proportion of the total number of hospital beds owned by both the CHAs and the public sector— this share often being indeed in the 30–50 percent range. But this does not factor in a potentially large number of hospital beds owned by private secular organizations, and it also does not factor in the role of smaller clinics and health centers for which the market share of faith-based providers is often smaller. In addition, prevailing estimates of market shares do not account for the role of other healthcare providers, from traditional healers to pharmacists. Finally, the estimates tend to be based on data for CHAs, but those estimates are not valid for countries where strong CHAs have not emerged in part because the market share of Christian providers in terms of facilities is much smaller. When all these factors are taken into account, the market share of faith-based healthcare providers is smaller than suggested.

Consider next the case of education. The literature on the market share of faith-based schools is more limited, perhaps in part because most countries do not have faith-inspired education networks similar to the CHAs for healthcare. Yet some of the estimates suggesting large faith-based market shares for education are at odds with data collected from Ministries of Education by the UNESCO Institute of Statistics. In 2019, the market share for all private schools taken together was at 18.6 percent for primary schools globally, and at 27.0 for secondary schools. This is substantial and the market share of private schools has been growing. Just two decades years ago, the market shares of private schools globally were at 10.1 percent for primary education and 19.2 percent in secondary education in 2000. While some countries have played a particularly important role in this growth (India is one example), there seems to have been a rise in private school enrollment in many countries.

Yet faith-based schools account only for a minority of private schools globally. There is of course a lot of variation between countries. But while in the 1950s and 1960s, faith-based schools probably accounted for a large share of education services in developing countries as well as in some high income countries such as the United States, the share of students enrolled in the schools has dropped with the expansion of public and private secular schools and in some countries with the nationalization of faith-based schools after independence.

In order to provide more reliable (albeit still tentative) estimates of the market share of Catholic and other faith-based providers, this chapter focuses mostly on education and healthcare as these are the two sectors for which some data are available across countries. The analysis is provided in the next section considering mostly Catholic facilities because of data availability, but when feasible other facilities are also considered. A brief conclusion follows.

Analysis

Catholic Schools and Universities[99]

In chapter 1, data were provided on the number of schools managed by the Catholic Church. When looking at market shares, the analysis must however be conducted in terms of student enrollment because cross-country data on the total number of schools are not available. Therefore, this section provides estimates of the market share of Catholic schools based on student enrollment from the Global Catholic Education Report 2021.

To compute market shares, enrollment data from the latest statistical yearbook of the Church are compared with total enrollment in primary and secondary schools from the UNESCO Institute of Statistics[100]. Estimates are also provided for higher education. The

[99] This section is based on Wodon (2021a).

[100] Estimates of total enrollment are not available for pre-schools, hence this level is not considered.

resulting estimates for Catholic schools and universities are provided in Table 5.1 by region and country income group (see chapter 4 for the definition of income groups).

The market share of Catholic schools is highest for primary education in sub-Saharan Africa where almost one in ten students is in a Catholic school. In low-income countries, one in seven students is in a Catholic primary school.

At the primary level, the market share of Catholic schools is highest in sub-Saharan Africa (11.0 percent). At the secondary level, it is 6.7 percent for the region. In low-income countries, Catholic schools account for one in seven students enrolled in primary schools (13.7 percent) and almost one in ten students enrolled at the secondary level (9.0 percent).

Globally, Catholic schools account for 4.8 percent of primary school enrollment and 3.2 percent of secondary school enrollment. This is still large, but not as large as sometimes suggested. The market share of Catholic schools is lowest in upper-middle income countries in part because of the absence of Catholic schools in mainland China (by contrast, Catholic schools have a strong footprint in Taiwan).

The estimates of market shares for Catholic higher education in Table 5.1 are more tentative for two reasons. First, the UNESCO Institute of Statistics does not provide data on the total number of students enrolled in higher education as it does for primary and secondary education. This means that to obtain the denominator for the computation of market shares, we need to multiply the gross enrollment rate at the tertiary level by the population of the appropriate age, which requires a few manipulations. Given the additional variables and calculation involved, this may generate a (probably small) source of error. More importantly, it is not fully clear whether enrollment data from the statistical yearbooks of the Church correspond to the definitions of higher education used by the UNESCO Institute of Statistics. Still, despite limits in the available data, computing market shares provides a useful order of magnitude of the role played by Catholic higher education.

The resulting market shares for Catholic universities provided in Table 5.1 suggest that globally, Catholic higher education accounts for 2.8 percent of all students enrolled at that level. In terms of regions, the market share is highest in Latin America and North America, at respectively 6.0 percent and 5.9 percent, and lowest in the Middle East and North Africa, at 0.4 percent. In terms of income groups, the market share is highest in high income countries at 4.8 percent, and lowest in upper-middle income countries (probably in large part again because of China) at 1.6 percent.

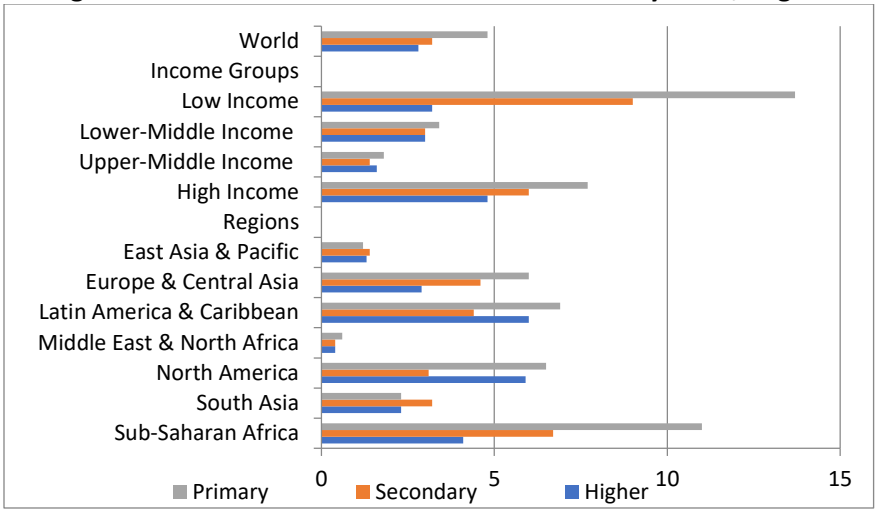
Are these estimates for higher education of the right order of magnitude? As a quick test, consider North America, which is dominated in terms of population size and enrollment in higher education by the United States. According to the website of the Association of Catholic Colleges and Universities and based on data from the National Center for Education Statistics, about 850,000 students were enrolled in Catholic higher education in 2018-19. The National Center for Education Statistics also reports on its website that total undergraduate enrollment in degree-granting postsecondary institutions in 2018 was at 16.6 million students, while 3.0 million students were enrolled in post-baccalaureate degree programs. This generates a total number of university students of 19.6 million students. Dividing the number of students in Catholic colleges and universities by the total enrollment at the undergraduate and graduate levels for degree granting institutions generates a market share of for Catholic colleges and universities of 4.3 percent. This is slightly below the estimate of 5.9 percent for North America in Table 5.1, but of a similar order of magnitude.

Table 5.1: Market Shares of Catholic Schools and Universities by Education Level (%), 2018

Regions and Income Groups	Primary schools	Secondary schools	Higher education
Regions			
East Asia & Pacific	1.2	1.4	1.3
Europe & Central Asia	6.0	4.6	2.9
Latin America & Caribbean	6.9	4.4	6.0
Middle East & North Africa	0.6	0.4	0.4
North America	6.5	3.1	5.9
South Asia	2.3	3.2	2.3
Sub-Saharan Africa	11.0	6.7	4.1
Income Groups			
Low Income	13.7	9.0	3.2
Lower-Middle Income	3.4	3.0	3.0
Upper-Middle Income	1.8	1.4	1.6
High Income	7.7	6.0	4.8
World	4.8	3.2	2.8

Source: Wodon (2021a).

Figure 5.1: Market Shares of Catholic Education by Level, Regions and Income Groups (%), 2018



Source: Wodon (2021a).

Globally, the market share of Catholic education is estimated at 4.8 percent at the primary level, 3.2 percent at the secondary level, and 2.8 percent at the higher education level.

The likely reason for the difference is that the category of students in 'higher institutes' in the statistical yearbook of the Church may include students who are not considered as enrolled in degree-granting institutions by the National Center for Education Statistics. Differences in enrolment in Catholic institutions in other counties in North America, and especially in Canada, may also play a role in the differences in estimates just mentioned. Still, with those caveats in mind, this simple comparison suggests that estimates in Table 5.1 do seem to provide an adequate order of magnitude for the market shares of Catholic higher education, although possibly slightly on the high side.

Other Faith-based Schools and Universities

The Global Catholic Education Report 2021 also provided tentative estimates of the footprint of all Christian schools and universities taken together. These estimates are tentative, but it is likely that Christian education institutions serve at least 100 million students. The analysis relies on both the number of Christians from different denominations and a parameter that captures investments in schools

and universities in proportion of the population for different Christian denominations[101]. The investment in education parameter is estimated at 5.7 percent for Catholics. This is simply the share of the Catholic population enrolled in Catholic schools and universities.

Projections using data from the Pew Research Center suggest that there may be 2,383 million Christians in 2020 globally, including 1,194 million Catholics, 284 million Orthodox Christians, 874 million Protestants, and 31 million other Christians. These values are slightly below estimates commonly cited. For example, it is often suggested that there are more than 900 million Protestants. Applying an annual growth rate to data on baptized populations from the statistical yearbook of the Church yields 1,354 million Catholics in 2020. Yet for both Catholics and Protestants, there is often a drop in faith affiliations between the time of baptism and adulthood. The fact that the estimates are a bit smaller than commonly cited figures may simply reflect that drop.

GPENreformation, the organization that federates (many) Protestant schools, suggests that there may be 25 million students enrolled in Protestant schools globally, of which 10.5 million are affiliated with GPENreformation. This generates a corresponding investment parameter in schools and universities for Protestants of 2.9 percent or half the value for Catholics. For various historical reasons, this seems reasonable. Note that the value of the parameter may vary substantially between various Protestant denominations. For example, for the Seventh-day Adventist World Church, a fast growing denomination that is very active in development work, data are available to suggest an investment parameter of 8.8 percent, which is much higher.

What might be the investment parameter for other Christian denominations? Apart from Ethiopia, most Orthodox Christians live in European countries that were under communist rule not conducive to faith-based schools and universities. Assume for simplicity that the investment parameter for Orthodox Christians is 0.50 percent. For other Christians, assume a parameter more in line with Protestants at 2.50 percent. This would result in a total of 95.4 million students in Christian schools and universities globally.

That estimates does not include students in non-formal education programs. That number should be at several million students globally. For example, on top of serving 0.8 million students in its primary and secondary schools, the Fe y Alegría network provides non-formal education and training to 0.5 million additional students. The Catholic Church also operates other types of education centres and the same is true for other Christian denominations. Overall then, including students in non-formal education programs, it seems legitimate to suggest that Christian institutions serve 100 million students globally, and possibly more. If this is correct, the global market share of Christian education institutions could be of the order of one and a half time the estimates provided for Catholic schools in Table 5.1, since roughly one and a half times more students are enrolled in Christian institutions versus the number enrolled in Catholic institutions.

Globally, at least 100 million are likely to be enrolled in Christian schools and universities. As a result, the global market shares of Christian institutions could be about one and a half time the estimates provided for Catholic schools.

When analysis is conducted at the country level, or for a subset of countries in a particular region, more detailed data may be available. Consider sub-Saharan Africa since this is the region of the world where the number of students enrolled in Catholic (and in all likelihood other faith-based schools) is growing fastest. Table 5.2 provides estimates of the share of primary and secondary schools managed by different networks in five countries: Cameroon, the Democratic Republic of Congo, Madagascar, Rwanda, and Tanzania. In the Democratic Republic of Congo and

[101] See Wodon (2020k) for details.

Rwanda, more than half of the schools are Church-run. In Cameroon and Madagascar, the shares are much lower. But in all four countries, the share of non-state religious schools is higher than that of other private schools. The situation in Tanzania is different in part due to a school policy in which Christian-run schools were permitted only after 1990. This led to a smaller market share for those schools. Differences in faith-based provision of education can often be explained at least in part by a country's history.

Table 5.2: Share of Different Types of Schools for Selected African Countries (%)

	State schools	Christian Schools	Of which Catholic schools	Of which Protestant Schools	Islamic schools	Non-state non-religious	All schools
	Combined primary and secondary schools						
Cameroon	68.0	14.0	8.6	5.4	1.8	16.2	100.0
DR Congo	18.9	64.1	21.7	34.4	2.1	14.1	100.0
Madagascar	61.6	15.9	10.9	5.0	-	22.5	100.0
Rwanda	27.5	60.9	38.9	20.4	0.8	10.7	100.0
Tanzania	87.0	3.0	2.4	0.5	0.1	9.9	100.0
	Primary schools						
Cameroon	NA	NA	NA	NA	NA	NA	100.0
DR Congo	18.1	66.4	24.1	34.3	2.0	13.5	100.0
Madagascar	78.1	15.2	8.1	7.1	-	6.7	100.0
Rwanda	25.6	61.5	39.4	23.7	0.7	10.3	100.0
Tanzania	90.4	1.1	1.0	0.1	-	8.6	100.0
	Secondary schools						
Cameroon	NA	NA	NA	NA	NA	NA	100.0
DR Congo	20.4	62.0	17.9	34.7	2.3	15.2	100.0
Madagascar	41.8	36.2	11.8	24.4	-	22.0	100.0
Rwanda	30.7	55.7	38.0	17.7	0.9	11.4	100.0
Tanzania	75.1	3.0	0.5	2.5	3.9	14.6	100.0

Source: Scheunpflug et al. (2021).

Note: In some cases the totals for do not state, Christian, Islamic, and non-state non-religious schools do not sum up to 100 percent due to rounding errors.

Another important segment of education systems in many regions of the world consists of schools associated with the Islamic faith. In the five countries listed in Table 5.2, Islamic schools have a relatively small market share, but in other countries, their market share is larger. Many of these schools are called madrasas. Literally, a madrasa (or merdersa) in Arabic means a school, a place where learning and teaching takes place. Traditionally, madrasas were schools through which Islamic religious knowledge and other forms of (scientific) knowledge were transmitted from one generation to the next. Some madrasas benefited from patronage by the elites to train generations of Islamic leaders and scholars as well as civil servants that could interpret religious texts for the population as well as rulers. The relevance and role of madrasas was however affected by the rise of the nation state and modernity. In classical Islam, madrasas were often the only institutions that would prepare the elites for positions in government or religious leadership[102]. Today, in most majority Muslim countries, most of the population receives its education from the formal education system, with students starting in primary school before continuing to secondary school and beyond. Yet the madrasa, in its various forms, has not disappeared. It continues to serve segments of the population.

[102] Hallaq (2009).

In West and Central Africa in particular, Arab-Islamic education encompasses a wide variety of institutions. Some schools are recognized by the state. They may be referred alternatively as madrasas or merdersas, or as Franco-Arab schools in Francophone countries. Various sets of schools often co-exist, with some schools emphasizing core Islamic topics more than others. As many of these schools are integrated into the formal education system, they may benefit from (partial) public funding. When this is the case, the schools typically teach not only traditional topics in Arabic such as theology and Islamic law, but also (to various extent depending on the school) secular topics such as mathematics, the national language (French or English depending on the country), and topics from the natural and social sciences.

By contrast, the term Koranic school or its equivalents (such as the daaras in Senegal) are often used to describe schools that are not part of the formal education system. Koranic schools typically place a strong emphasis on memorizing the Koran in Arabic, as well as on knowledge of Islamic religious education and practice, often without secular topics. Yet even among Koranic schools, there is quite a diversity of institutions[103]. Analysis of household surveys for nine countries suggest that the market shares for non-formal Arab-Islamic schools range from 1.5 percent in Côte d'Ivoire to 33.5 percent in Somalia[104].

Household surveys for nine West and Central African countries suggest that the market shares for non-formal Arab-Islamic schools ranges from 1.5 percent in Côte d'Ivoire to 33.5 percent in Somalia. In addition, many countries also have a various types of Islamic schools that are part of the formal education system.

The market shares of Koranic schools for Nigeria and Chad are towards the lower bracket at 3.5 percent and 6.8 percent, while those for the Comoros and Mauritania are towards the higher bracket at 15.4 percent and 23.1 percent. Estimates are also provided for Burkina Faso, Côte d'Ivoire, the Gambia, and Senegal –at less than five percent, except for the Gambia at 10.9 percent. As a result, Koranic schools account in some countries for over half of the children considered to be out-of-school. In Niger, another study suggest that depending on the data source, between 5.0 percent and 15.7 percent of all children aged 10 to 14 have a Koranic instead of a formal education[105].

What should be concluded from this analysis? If one considers sub-Saharan Africa, previous estimates by the author of the market share of faith-based schools suggested that across 16 countries, weighting each country equally, faith-based schools accounted for 14.0 percent of students in primary schools and 11.2 percent of students in secondary schools[106]. These estimates were based on household surveys but are likely to be lower bounds for two reasons. First, some of the countries with a large footprint for faith-based education tend to be populous. This is or example the case of the Democratic Republic of Congo. Therefore if estimates were weighted by population size, the market shares of faith-based education would probably be higher. Second, in household surveys some faith-based schools may be considered by respondents as public schools. This is because in countries where faith-based schools have a large market share, many faith-based schools are in fact public schools[107]. As a result, statistics based on household responses about the type of school attended by children may underestimate the role played by faith-based schools, both public and private.

[103] See Dia et al. (2016a) for a typology of daaras in Senegal and Banque mondiale (2021) on Niger.
[104] d'Aiglepierre and Bauer (2016).
[105] Male et al. (2021).
[106] Wodon (2014, 2015).
[107] In Uganda for example, parental responses in household surveys suggest that few children attend faith-based schools, but this may be because parents consider most faith-based schools as public schools since they benefit from state funding and follow the national curriculum.

Overall, given the large role played by Protestant and various types of Islamic schools (including Koranic schools) in some sub-Saharan countries, and the fact that Catholic schools alone account for 11.0 percent of all students enrolled in primary schools in the region (the estimate is 9.0 percent for secondary schools), it seems fair to assume that the market share of all faith-based schools combined could be of the order of perhaps one fifth. This would include faith-based schools that are considered as part of the public school system. In other regions of the world, the market share of faith-based schools is lower, but in South Asia as well as in sub-Saharan Africa, apart from a substantial footprint of Catholic and other Christian schools, different types of Islamic schools also have a large footprint. This is the case in particular in Bangladesh, India, and Pakistan.

Catholic Healthcare Facilities

In chapter 2, data were provided on the number of healthcare facilities managed by the Catholic Church. In order to compute tentative market shares for those facilities, data on the total number of healthcare facilities by country are needed. The World Health Organization (WHO) used to provide estimates of the number of hospitals and other health facilities by 100,000 people for most countries, but current statistics focus instead on the number of hospital beds available (this is admittedly a better statistics to assess hospital capacity). The latest available estimates of the number of hospitals and health centres from the WHO are for 2013. These are the data that can be used to assess at least tentatively the market share of the Catholic Church in national health systems.

There are however a number of potential issues with the analysis. First, there is no guarantee that what the Catholic Church considers as a hospital or a health centre in its own statistics corresponds to the way statistics are computed by the WHO for these two types of facilities. Second, the data for 2013 from the WHO is incomplete, with some large countries not included. This is the case in particular for Brazil, China, India, Mexico, Nigeria, Russia, Tanzania, and many high income countries. Assumptions would have to be made for those countries to prevent substantial bias in global estimates, but here we focus on estimates for the available countries, indicating the number of countries for which data are available. Third, while the latest data for Catholic facilities are for 2019, the latest data from the WHO are for 2013. This means that assumptions have to be made on whether the number of hospitals and health centres per 100,000 people has increased or declined since 2013. While there may have been an increase in the number of facilities in many countries, there has also been an increase in the population. It is unclear whether the number of facilities per 100,000 people increased or not.

Some insights on this issue can be gleaned from data on hospital beds. For the world as a whole, between 2013 and 2019, the number of hospital beds per 1,000 people increased from 2.79 in 2013 to 2.89 in 2017, the latest year for which statistics are available. Some of these additional beds may have been added to existing facilities, while other may have resulted from the creation of new facilities. Yet because the increase in the number of hospital beds per 1,000 people is small (a gain of 3.5 percent in four years), and because some of that gain is likely to come from existing facilities, it seems reasonable to assume that at least globally, there may not have been a substantial change in the number of hospitals (and possibly other healthcare facilities) per 100,000 people between 2013 and 2019. In that case, it seems reasonable to simply apply the number of facilities per 100,000 people in 2013 to population data for 2019 in order to compute the total number of hospitals and health centres by country in 2019.

Based on that assumption, Table 5.3 provides tentative estimates of the market share of the Catholic Church for hospitals and health centres by region and country income groups. Based on countries for which data are available, as for primary education, the market share of Catholic healthcare facilities is highest

in sub-Saharan Africa at 12.7 percent for hospitals and 5.4 percent for health centres. For North America (Canada), East Asia and the Pacific, and Latin America and the Caribbean, Catholic hospitals account for about five percent of all hospitals. Market shares in other regions and for health centres are lower.

As for education, the market share of Catholic healthcare facilities is highest in sub-Saharan Africa and in low-income countries. It is lowest in upper-middle income countries.

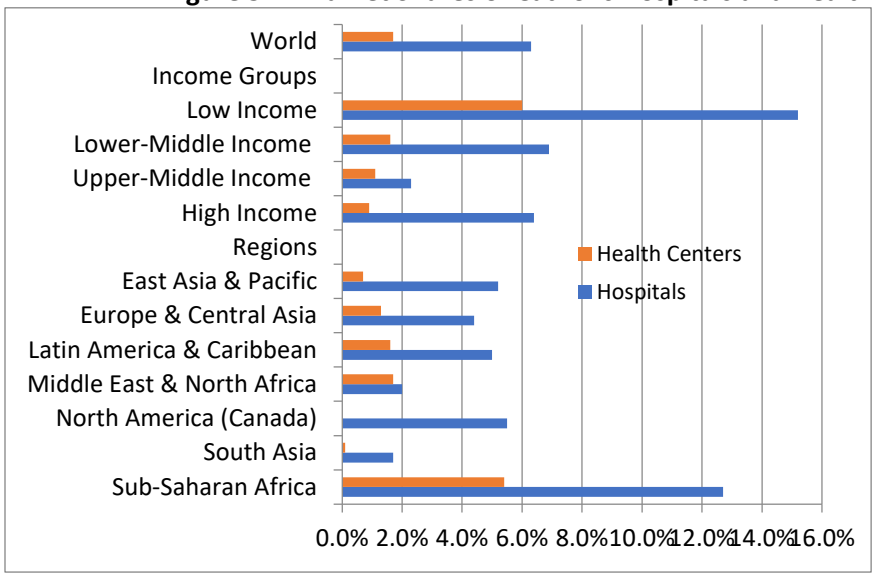
Table 5.3: Market Shares of Catholic Hospitals and Health Centers Based on WHO Data (%), 2019

Regions and Income Groups	Countries with data	Market share estimates (%)		
		Hospitals	Health Centers	Average
Regions				
East Asia & Pacific	21	5.2%	0.7%	3.0%
Europe & Central Asia	34	4.4%	1.3%	2.9%
Latin America & Caribbean	26	5.0%	1.6%	3.3%
Middle East & North Africa	11	2.0%	1.7%	1.9%
North America (Canada)	1	5.5%	-	5.5%
South Asia	7	1.7%	0.1%	0.9%
Sub-Saharan Africa	40	12.7%	5.4%	9.1%
Income Groups				
Low Income	22	15.2%	6.0%	10.6%
Lower-Middle Income	41	6.9%	1.6%	4.3%
Upper-Middle Income	41	2.3%	1.1%	1.7%
High Income	36	6.4%	0.9%	3.6%
World	140	6.3%	1.7%	4.0%

Source: Author's estimation.

Notes: As per WHO definitions, health centers or posts are either community centers or health environments with a very limited number of beds with limited curative and preventive care resources normally assisted by health workers or nurses. Hospitals from the public and private sectors include the following categories: rural and district, provincial (second level referral), regional/specialized/teaching and research hospitals (tertiary care).

Figure 5.2: Market Shares of Catholic Hospitals and Health Centers (%), 2019



Source: Author's estimation.

Globally, for the countries included in the analysis, the market share of Catholic facilities is estimated at 6.3 percent for hospitals and 1.7 percent for health centers.

Globally, for the countries included in the analysis, Catholic institutions account for 6.3 percent of all hospitals and 1.7 percent of all health centres. This is large, but as was the case for education, not as large as sometimes suggested. Note that countries such as China and Russia were included, these market shares would be reduced given none or few Catholic hospitals and health centres in those countries. On the other hand, a mentioned in chapter 2, the Catholic Church has a relatively strong healthcare presence in some of the other large developing countries not included in the analysis, including Brazil, India, Nigeria, and Tanzania. For several large high income countries as well, including Germany and the United States, the role played by Catholic healthcare is large and not factored in due to lack of data in the WHO database.

In terms of statistics by income groups, as was again the case for education, the market share of Catholic healthcare facilities is highest in sub-Saharan Africa at 15.2 percent, and lowest in upper-middle income countries (if China were included in the sample, the market share in those countries would be even lower).

All in all, despite issues in some country level estimates[108], the tentative estimates for both regions and country income groups in Table 5.3 do not seem too unreasonable. As to the fact that the Catholic Church has a stronger market share for hospitals than health centres, it makes sense as well. This is the experience of Christian Health Associations in sub-Saharan Africa that federate a larger share of hospitals nationally than is the case for health centres.

While the WHO database on the density of health facilities per 100,000 people does not include many high income countries, for many of those countries data on hospitals are available from the health statistics of the Organisation for Economic Cooperation and Development (OECD). Table 5.4 provides the data and the resulting market share of Catholic hospitals based on a comparison for the Catholic Church with data from the statistical yearbook. There may again be comparability issues if definitions used to identify hospitals are not the same, and there may be differences in how countries report estimates to the OECD[109]. Still, it is instructive that for all countries combined, Catholic hospitals account for 3.8 percent of hospitals in OECD countries. For high income OECD countries (thus excluding Colombia, Costa Rica, Mexico, and Turkey), the market share of Catholic hospitals is at 4.9 percent. This is lower than the estimate in Table 5.3 at 6.4 percent, but not of a completely different order of magnitude (note that the set of countries for both estimates is different)[110].

For high income OECD countries, the market share of the Catholic Church in terms of hospitals is estimated at 4.9 percent. For all OECD countries, it is estimated at 3.8 percent.

[108] For example, for the Democratic Republic of Congo, the estimate of the market share for Catholic hospitals is too high. This could be because the estimate in the WHO database is low (an estimate of the market share for health centers is not available due to lack of data in the WHO database).

[109] For example, Colombia has almost twice as many hospitals as the United States according to the OECD database, but the United States has more than six times the population of Colombia.

[110] The United States is one of the countries where the market share of Catholic hospitals is larger than the average. In a report that is critical of Catholic hospitals, Solomon et al. (2020) note that Catholic health systems have been growing in the country. For example, the number of Catholic-owned or affiliated short-term acute care hospitals grew by 28.5 percent over the last two decades, even as the number of non-Catholic hospitals declined by 13.6 percent. One of the report's critiques of Catholic hospitals is that according to the authors, contrary to their stated mission, they tend to serve a lower share of Medicaid-insured patients than other types of hospitals and provide slightly less charity care.

Table 5.4: Market Share of Catholic Hospitals in OECD Countries (%), 2019

	Hospitals	Catholic	Share
Australia	1,339	79	5.9%
Austria	264	27	10.2%
Belgium	164	89	54.3%
Canada	709	47	6.6%
Chile	356	12	3.4%
Colombia	10,635	82	0.8%
Costa Rica	44	0	-
Czech Republic	258	62	24.0%
Estonia	30	0	-
Finland	239	0	-
France	3,008	29	1.0%
Germany	3,026	439	14.5%
Greece	270	1	0.4%
Hungary	163	6	3.7%
Iceland	8	0	-
Ireland	86	22	25.6%
Israel	83	6	7.2%
Italy	1,056	89	8.4%
Japan	8,300	28	0.3%
Korea	4,020	42	1.0%
Latvia	61	0	-
Lithuania	94	3	3.2%
Luxembourg	10	2	20.0%
Mexico	4,707	149	3.2%
Netherlands	568	0	-
New Zealand	160	7	4.4%
Poland	1,236	58	4.7%
Portugal	238	44	18.5%
Slovak Republic	129	7	5.4%
Slovenia	29	0	0.0%
Spain	777	67	8.6%
Sweden	81	0	-
Switzerland	281	2	0.7%
Turkey	1,538	3	0.2%
United Kingdom	1,978	14	0.7%
United States	6,146	551	9.0%
All	52,091	1,967	3.8%
High income	35,167	1,733	4.9%

Source: Author's estimation.

Other Faith-based Healthcare Facilities

What do we know about the market share of other faith-based healthcare facilities? For sub-Saharan Africa, the region where the number of Catholic and probably other faith-based facilities is growing the fastest, research is available about the role played by Christian Health Associations (CHAs) that federate Catholic and other Christian facilities.[111] In particular, estimates of market share are available from a survey implemented with CHA representatives. Responses to the survey were received from 18 networks in 16 countries. The survey is a bit old: it was initiated with CHA representatives at their fourth Biennial Assembly in Kampala in 2009, with a follow-up at the fifth CHA Assembly in Accra in 2011, but this is still the source of the data mentioned by the umbrella federation - the Africa Christian Health Associations Platform (ACHAP), in its latest strategic plan for 2017-2020.

Table 5.5 provides the data on the self-declared market shares of the CHAs, as well as additional information on the number of facilities they operate. While each CHA is unique, the various CHAs may be classified according to a simple typology based on their level of development and the level of economic development of the country they operate in. This typology considers three types of countries and CHAs: fragile states (because of conflict or poor governance), low income countries, and middle income countries. The self-declared market share for CHAs in terms of the number of hospital beds they provide is at 20.7 percent on average in fragile states. It is even higher in low income countries at 35.9 percent. It is lower at 18.0 percent in middle income countries, but this last figure is based on only one observation for the market share in that group given that no estimates are available for the two other middle income countries listed. Across all countries included in the analysis, the suggested market of CHAs for hospital beds share is 32.3 percent. These estimates are only orders of magnitude not only regionally, but also at the level of individual countries[112].

[111] This section is based on Dimmock et al. (2012a, b), Olivier and Wodon (2012a), Wodon, Nguyen, and Tsimpo (2012), Olivier et al. (2015), and Dimmock et al. (2017).

[112] Twelve of the 19 country estimates are round figures, such as 10, 20, 40, or 50 percent, suggesting that the estimates are only rough approximations.

Table 5.5: Self-estimated Market Shares of hospital beds, CHAs in Selected Countries (%)

Type of countries	Unweighted average market share
Fragile (8 countries)	20.7%
Low income (11 countries)	35.9%
Middle income (1 country)	18.0%
All countries (19 countries)	32.3%

Source: Author's estimation based on CHA data.

CHAs estimate their market share of hospital beds at 32.3 percent in the countries where they have a strong presence. This does not account however for private secular hospitals, and if all African countries were included, the average market share would be smaller.

These estimates are substantially higher than the estimate of the market share of Catholic hospitals in sub-Saharan Africa mentioned in Table 5.3, at 12.7 percent. Several factors could explain the differences. In many East and Southern African countries where a majority of the CHAs with a large membership of facilities are located, other Christian denominations apart from the Catholic Church operate hospitals. One would thus expect the market share of CHAs in those countries to be higher on average than the market share obtained for Catholic facilities only.

However, there are also factors that lead the estimates in Table 5.5 to be too high. First, although this is not explicitly stated, the market shares tend to come from a comparison of the number of hospital beds owned by the facilities affiliated with the CHAs with the total number of hospital beds accounted for by both the CHAs and the public sector together. The role played by private secular hospitals (and in some countries Islamic hospitals) is not accounted for, leading to overestimating market shares. Second, the average market shares in Table 5.5 are based for the most part on Anglophone countries. The three francophone countries included are Chad, the Democratic Republic of Congo, and Mali. Two of these countries suffered from conflicts, so that Christian providers may have helped fill the void left by weak governments. By contrast, in Mali (which has been affected by conflicts, but as well, but more recently) the estimated market share of the CHA is much lower at only two percent. If all sub-Saharan African countries were included, including countries in West Africa where the footprint of CHAs is smaller as is the case in Mali, the average market share of CHAs in terms of hospital beds would be lower. CHAs would still account for a large share of hospital beds in many countries, but not as large a share as the estimate suggested in Table 5.5 (on reconciling estimates, see Box 5.1).

Box 5.1: Reconciling Estimates

For the sake of the argument, to reconcile the apparently different estimates of market shares based on hospitals in Table 5.3 and hospital beds in Table 5.5, consider a simple calculation weighting countries equally. Assume that in the 19 countries with CHA data in Table 5.5, Catholic facilities account for 60 percent of CHA hospital beds. Assume further that private secular providers account for 20 percent of all hospital beds. This would generate a market share for Catholic hospitals of 15.5 percent in those 19 countries (0.60×32.3/(1/.80)). In Table 5.3, estimates for sub-Saharan Africa are based on data for twice as many countries. Assume that in the other countries, Catholic hospitals have on average a smaller market share of beds, say at 10 percent. This would generate a market share for Catholic hospitals in sub-Saharan Africa similar to that in Table 5.3.

Another approach to measuring the market share of faith-based healthcare consists in relying on household surveys. When doing so, it is useful to start with Demographic and Health Surveys (DHS) surveys. While DHS questionnaires do not identify separately faith-inspired healthcare facilities, they distinguish between public, private, and other service providers. The list of providers in the three broad categories changes slightly depending on the type of care being sought, but in the case of diarrhea, for example, the public sector includes

government hospitals and clinics, government health centers, government health posts, mobile clinics, fieldworkers, and other public providers. In the case of the private medical sector, the list consists of private hospitals and clinics, pharmacies, private doctors, mobile clinics, fieldworkers, other clinics, maternity homes, and other private medical care. Finally, the other category includes shops and markets (i.e., self-medication), traditional practitioners, and drug peddlers. Because most visits to health facilities are related to fever/cough and diarrhea (these are more frequent occurrences in a household than, say, a delivery), these are the illnesses for which data are reported here.

Table 5.6 provides estimates from previous work of public, private, and other service provision for fever/cough and diarrhea obtained for almost 40 different countries using DHS surveys. Public market shares are on average above 50 percent for both types of illnesses, with a high correlation between the market shares obtained for fever/cough and diarrhea. The market share of private facilities-based providers is on average at 17.4 percent for diarrhea treatment and 24.3 percent for fevers and coughs. This should include facilities-based faith-inspired providers as long as there is no misidentification of these providers by households as well as facilities-based secular private providers. In other words, the average market share of faith-inspired health facilities inferred from the DHS data for faith-inspired providers should be well below 17.4 percent[113].

Table 5.6: Market Shares Estimates from DHS and Other Surveys (% of care received)

Type of provider	DHS surveys		Multi-purpose surveys
	Diarrhea treatment	Fever or cough	
Public	56.8%	54.9%	55.2%
Faith-based	NA	NA	5.8%
Private secular	17.4%	24.3%	39.0%
Others	25.8%	20.9%	NA

Source: Wodon et al. (2014).

According to household surveys, the market share of faith-based healthcare providers is smaller, probably for two reasons: faith-based providers operate a smaller share of health centers than hospitals, and household surveys include other providers such as chemical stores, pharmacies, traditional healers, and health professionals not working in facilities.

Table 5.6 also provides market shares from multi-purpose surveys already mentioned in chapter 4 when looking at the extent to which faith-based facilities reach the poor. The analysis is for a smaller set of only 14 countries, but it suggests a much lower market share for faith-based facilities at only 5.8 percent.

Why is that market share so small? Three factors are likely to be at play. First, as already shown in Table 5.3, the market share of Catholic and probably other faith-based providers is smaller for health centers than is the case for hospitals. For example, in Table 5.3, in sub-Saharan Africa Catholic facilities account for only 5.4 percent of all health centers, versus 12.7 percent of hospitals. When an individual has a cold or when a child has diarrhea, care is likely to be sought in health centers rather than in hospitals. This would lead to a lower market share for faith-based providers than is the case for hospitals or hospital beds. In addition, non-facilities based providers such chemical stores, pharmacies, traditional healers, and private doctors, nurses or other health practitioners not operating from a facility are included in the

[113] What about other reasons to seek care? As shown in more details in Wodon et al. (2014), the private sector on average accounts for 28.0 percent of the sources of modern contraceptive methods (54.8 percent for the public sector and 17.2 percent for others), but only for 9.2 percent of family planning for non-users of modern contraception methods (86.3 percent for the public sector, and 4.5 percent for others). The market share of the private sector is at 6.8 percent for the place of birth delivery (45.8 percent for the public sector, and 47.4 percent for others, in part because of deliveries at home), and 10.6 percent for antenatal care visits (83.2 percent for the public sector, and 6.2 percent for others).

estimates for Table 5.6, reducing further the market share of faith-based providers based on hospitals only. Finally, some of the countries that are known to have high market shares for faith-based providers such as the DRC were not included in the sample of the multi-purpose surveys used to identify faith-based providers separately. If the DRC had been included, this would by itself have raised the average market share by several percentage points. Overall, as expected, the estimates of market share based on household surveys, whether DHS or multi-purpose surveys, suggest smaller market shares for faith-based healthcare providers than when considering hospitals or hospital beds.

Summing Up

This chapter has provided an analysis of the market share of faith-based schools and healthcare facilities. The results for both sectors are somewhat similar. Globally, the market share of Catholic education is estimated at 4.8 percent at the primary level, 3.2 percent at the secondary level, and 2.8 percent at the higher education level. In the case of healthcare, for the countries included in the analysis, the market share of Catholic hospitals is estimated at 6.3 percent globally, while it is estimated at 1.7 percent for health centers. Separate data for OECD countries suggest that in those countries, the market share of Catholic hospitals is at 3.8 percent (4.9 percent for high income OECD countries). Even though there are some differences, these various estimates are of a similar order of magnitude, and when the Catholic Church has a large footprint in the education sector of a country, it also often has a large footprint in its health sector.

The region in which the role of the Catholic Church is the largest is sub-Saharan Africa. In that region, Catholic schools (including schools that are considered as public schools and benefit from state funding) account for 11.0 percent of all students in primary schools, although the share is much lower for secondary schools. In addition, Catholic hospitals account for 12.7 percent of hospitals, with the share being lower for health centers. Because of its strong presence in sub-Saharan Africa, the Catholic Church also has an especially strong presence in low income countries.

When considering other faith-based providers, the estimates of market share increase. In the case of education, the market share of all Christian providers globally is likely to be about one and a half times higher than for Catholic providers only. Global data for other faiths are not available, but Koranic and Islamic schools tend to have a strong presence especially in sub-Saharan Africa and South Asia, as well as in the Middle East and North Africa.

While the market shares of faith-based schools and healthcare facilities are substantial, they are not as large as is sometimes suggested. One example of discrepancy is with estimates of the share of hospital beds accounted for CHAs in sub-Saharan Africa. The explanation for the differences comes from the fact that market share estimates for CHAs based on hospital beds may lead to overestimating the role of faith-based providers for four reasons: (1) they typically do not account for smaller facilities that do not have hospital beds; (2) they typically do not account for private secular facilities given the absence of good data on those facilities in many countries; (3) they typically do not account for non-facilities based care; and (4) they tend to be representative only of countries where CHAs have a stronger footprint, and thereby a larger market share.

Box 5.2: Protecting Faith-based Providers during Crises: The Economic Case

As noted for education in the Global Catholic Education Report 2021, faith-based providers of service make important contributions to national wealth while generating savings for state budgets. Estimates for 38 OECD and partner countries suggest that budget savings from Catholic schools alone in these countries could be valued at US$ 63 billion per year in purchasing power parity terms[114]. In those 38 countries, Catholic schools account for 35.4 percent of total budget savings from private schools at the primary level, and 19.2 percent at the secondary level. The country that accounts for the largest budget savings is the United States. Similar analysis for Catholic colleges and universities suggests that they may generate another $43 billion in savings for state budgets versus a situation in which the students in those universities were to enroll in public institutions instead[115].

Another contribution of Catholic (and other) schools is through the human capital wealth they create. Estimates suggest that human capital wealth accounts for two thirds of global wealth, a much larger proportion than natural capital and produced capital[116]. Education is a key contributor to human capital wealth. Based on the contribution of education to human capital wealth and estimates of the market share of catholic schools and universities in the provision of education, estimates suggest that Catholic schools and universities may contribute US$ 12 trillion to the changing wealth of nations[117].

The main objectives of Catholic schools and universities are not economic, but their economic contributions to development are large. This has implications for the ability of Catholic and other faith-based schools and universities (as well as healthcare and social protection facilities) to continue to provide their services to the population during crises. During recessions, public funding for schools often declines with negative impacts especially for disadvantaged students[118]. Providing relief to schools and universities, including faith-based providers, can help ensure that they remain afloat. One example in the current COVID-19 pandemic has been the Education Stabilization Fund under the CARES Act in the United States where faith-based schools and universities were also able to apply for the Paycheck Protection Program from the Small Business Administration, as was the case for public institutions. These policies make sense. The cost for governments of a collapse (and closing) of some faith-based and other private schools and universities due to economic pressures during crises is often larger for national or local government budgets than the cost of supporting them during these crises[119].

[114] The estimates are based on budget data for 2014 and enrollment data for 2016. See Wodon (2019f).
[115] Wodon (2018b).
[116] Lange et al. (2018).
[117] Wodon (2019d).
[118] Jackson et al. (2018).
[119] On shocks and potential shifts in enrollment from faith-based to public schools in West Africa, see Elmallakh and Wodon (2021).

CHAPTER 6
PREFERENCES, SATISFACTION, AND QUALITY

Introduction[120]

There is a common perception that faith-based providers of education, healthcare, and social protection services may often have a comparative advantage: they may provide services that are not provided by others (such as religious education), or they may provide special value through their services in part because of their commitment to quality as well as to serving the poor, both of which are made feasible through the dedication of their staffs.

In the case of education, much of the early evidence was based on data from Western countries and especially the United States. Studies[121] suggested that an emphasis in Catholic schools on both excellence and social justice may have led to a positive Catholic school effect on learning, especially for disadvantaged students. The idea of a Catholic school advantage was supported in subsequent studies[122]. In Latin America, assessments of the work of Fe y Alegría schools, a federation of Jesuit schools, also were mostly positive[123]. In sub-Saharan Africa, the econometric evidence base is thin, but in countries where the presence of Catholic schools is massive and most Catholic schools are government-aided, differences in the performance of students in Catholic government-aided schools and traditional public schools may not be large[124].

Data on the comparative performance of Catholic healthcare are limited, but as for education, some studies suggest that differences in performance may not necessarily be large[125]. However, systematic evidence on the comparative performance of faith-based providers overall remains thin. Still, the objective of this chapter is to share some evidence in particular for sub-Saharan Africa on (1) why households choose to rely on the services provided by faith-based providers; (2) the satisfaction of households with the services provided; (3) the quality (or lack thereof) of these services; and (4) the implication for some of these services of the current COVID-19 pandemic. This is a broad agenda and the analysis is only illustrative, but it is hopefully useful for starting to assess the quality of the services provided.

A number of limits to the analysis must be emphasized from the outset. First, while for chapters 4 and 5 at least part of the analysis could be done for a large number of countries, the analysis in this chapter is more anecdotal, based on a smaller set of countries due to data limitations. The focus is in large part on sub-Saharan Africa as the region of the world where the services provided by faith-based organizations are growing the fastest. But examples from other countries are also provided, including the United States.

Second, part of the analysis is based on satisfaction rates with services as reported by

[120] For education, this chapter is based in part on Wodon (2021a).

[121] Coleman et al. (1982), Greely (1982), Coleman and Hoffa (1987), and Bryk et al. (1993).

[122] See Evans and Schwab (1995), Sander and Krautman (1995), Sander (1996), Neal (1997), Altonji et al. (2005), Carbonaro (2006), Hallinan and Kubitschek (2013), and Freeman and Berends (2016). On studies suggesting no Catholic school advantage, see Jepsen (2003) and Elder and Jepsen (2014).

[123] See Navarro and de la Cruz (1998), Swope and Latorre (2000), Martiniello (2001), World Bank (2004), González and Arévalo (2005), Peters (2009), Alcott and Ortega (2009), Para Osorio and Wodon (2014a), Lavado et al. (2016), and Wodon (2019g).

[124] See Backiny-Yetna and Wodon (2009a, 2009b), Wodon and Ying (2009) and more recently Nayihouba and Wodon (2020) on West Africa.

[125] For example, Kutney-Lee et al. (2014) suggest that patients treated in Catholic hospitals rate their hospital experience only marginally better than patients treated in non-Catholic hospitals

heads of households in surveys. Satisfaction rates are a subjective measure of quality that may or may not be strongly correlated with objective measures of quality. As with other subjective measures, satisfaction may suffer from bias. It is measured among those who have already selected a service, presumably because they like that service. This may entail a bias through self-selection, with higher satisfaction rates than would be measured in the population as a whole. In addition, there may be other sources of bias depending on the level of expectation of households. Typically, the poor have access to services of lower quality than is the case for better off households. Yet when measuring satisfaction through household surveys, it is sometimes found that the satisfaction rates of the poor are almost as high as those of the better off. This may reflect lower expectations simply because the poor are used to benefit from low quality services. High satisfaction does not necessarily imply good performance, which is why more direct measures of performance are also used in this chapter for schools (for healthcare facilities, such measures are typically less available, at least in the developing world).

The structure of the chapter is the same as for the previous two. The next section provides the analysis. A brief conclusion follows.

Analysis

Preference for Different Types of Providers[126]

Why do households decide to rely on services provided by faith-based facilities even though, at least for education and healthcare, the cost for them of those services is higher than is the case for public facilities? This section explores this question first for schools and universities, and next for healthcare facilities.

For schools and universities, the Global Catholic Education Report 2021 emphasized the importance of education pluralism for the right to education. Education matters not only for the skills and competencies that students acquire, but also for the values that are shared from one generation to the next. Parents sending their children to faith-based schools – or the students themselves when choosing a faith-based university, often do so in part because of their values and faith. This was illustrated in the report by two case studies, one for the United States and the other for Africa. The analysis is briefly summarized here.

Consider first the United States. Data collected by the National Catholic Educational Association suggest differences in the motivation of parents sending their children to faith-based versus other types of schools. Parents were asked in a survey to choose three priority areas among nine options for what their children should learn in school. Five priorities focused on skills/competencies: (1) Preparing children for college; (2) Preparing children to successfully enter the job market; (3) Teaching children strong in-person communication skills; (4) Encouraging individual and critical thinking; and (5) Measuring and monitoring student progress consistently. The other four priorities related to values and faith: (1) Teaching children to care about their community; (2) Developing individuals with a sound moral base; (3) Deeping children's relationship with their religious faith; and (4) Teaching children to accept and embrace diversity.

In the United States, parents sending their children to Catholic schools place more emphasis on their children learning about values and faith in school than is the case for parents sending their children to other schools.

For the sample as a whole (all parents), the top five priorities were all related to skills and success in college and the job market. The four priorities related to values and faith ranked lower. For parents with their youngest child in a Catholic school, values and faith ranked much higher. Developing a sound moral base ranked first, followed by communications skills, and next by deepening one's faith, critical thinking,

[126] This section is based in part on Wodon (2021a).

and being ready for the job market. Clearly, parents have different priorities for what their children should learn in school. For parents choosing Catholic schools, the emphasis placed on the transmission of values and faith in school makes it worthwhile for them to pay tuition to enroll their children in the schools[127].

For students choosing to go to a Catholic university, values also play a role. At the international level, several studies have explored the values held by students in Catholic universities[128]. In the United States, data from the CIRP Freshman Survey[129] suggest that only 7.0 percent of freshmen in nonsectarian colleges state that they were attracted by the religious affiliation/orientation of their college. The proportion is 18.1 for those in Catholic colleges, and it reaches 35.8 percent for other religious colleges, denoting an even stronger importance granted to faith affiliation by students attending those institutions, most of which are evangelical[130]. At the same time, other factors are also important (and in fact more important) in choosing a university, such as the academic reputation of the university or the intended major at that university, whether graduates get good jobs, and whether students are provided with financial assistance.

Less than one in ten freshmen in the United States considers the religious orientation of their university as a key factor for their choice of university. But for freshmen in Catholic and other religious universities, the proportions are higher, at one in five and more than a third.

Consider next sub-Saharan Africa, and in particular data for Ghana and Burkina Faso[131], two countries with a mix of populations of different faiths. Using small scale surveys and qualitative work, substantial differences have been found in the reasons leading parents to choose various types of schools[132]. The education provided by faith-based schools was valued by parents and communities for reasons related to both perceived quality and the promotion of religious and moral values. There were also differences between Franco-Arab or Islamic schools and Christian schools.

Parents choosing Christian schools in Burkina Faso did so for their academic and teacher quality. Parents choosing Islamic schools emphasized the opportunity for their children to receive a religious education, with smaller numbers listing academic or teacher quality too. In public schools, location was a deciding factor for more than two thirds of parents, followed by academic quality and the lack of school fees. Education on moral values was listed as a reason for school choice by a third of parents choosing Islamic and Christian schools, but not by parents choosing public schools. Results for Ghana were similar. Religious knowledge mattered for the choice Islamic schools. It also mattered for Christian school but less so, while academic performance and teacher quality mattered more. For public schools, low cost and proximity were the main motivations for the choice of the schools.

Several other questions were asked to parents to better understand why they chose a specific school. One question was about the most important area of study for their children. For children in Franco-Arab and Islamic schools, religious education came first, followed by moral education and academics (literacy). For parents at Christian schools, academics came first, as it did for parents at public schools.

[127] This does not imply that some parents care more about values than others. Parents not relying on Catholic schools may rely on other mechanisms than the schools to transmit their values to their children.

[128] Aparicio Gómez and Tornos Cubillo (2014), Mabille and Alom (2021).

[129] Stolzenberg et al. (2020).

[130] In another question, students were asked about the importance of various objectives. The option 'integrating spirituality into my life' was considered a priority by 43.1 percent of freshman in the full sample versus 62.2 percent in Catholic universities.

[131] This section is adapted from Wodon (2021a). See also Gemignani et al. (2014).

[132] Gemignani et al. (2014).

In Ghana and Burkina Faso, parents relying on Islamic schools emphasize spiritual goals for their children's education. Parents relying on Christian schools do too, but they emphasize moral values and academic quality more. Religion and values at school matter less for parents enrolling children in public schools.

Parents were also asked to choose the educational goal of highest importance among social, moral, academic and spiritual goals. Many parents choosing Islamic schools selected spiritual goals and the betterment of society. Parents choosing Christian schools emphasized moral values. For parents choosing public schools, religious and moral education was mentioned less. Importantly, in Christian schools religious education was not emphasized in the curriculum. Religious education featured more prominently in the curriculum of Franco-Arab and Islamic schools[133].

It is because the transmission of values and faith through schools matters for many parents that it is important to ensure that education pluralism is protected, as called for by the Universal Declaration of Human Rights. Article 26 on the right to education includes not one, but three provisions: *"(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages […]. (2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms […]. (3) Parents have a prior right to choose the kind of education that shall be given to their children."*

As discussed in more details in the Global Catholic Education Report 2021, the third provision relates to the right of parents to choose the type of education that their children should receive (within reasonable bounds)[134].

Do values and faith matter as well for the choice of healthcare providers? Not directly according to the analysis carried in Ghana and Burkina Faso through the same small scale surveys and qualitative work. Questions were asked to households as to why they choose different types of healthcare facilities, and how they perceive the care that they received in those facilities. Patients in faith-based facilities were typically highly satisfied with the quality of the facilities' staff, their hygiene, and the relatively low cost of consultations. Satisfaction rates were lower for the availability of proper accommodation, technical equipment, and medicines, especially for clinics not participating in the national health insurance scheme (which can lead to higher out-of-pocket costs for medicine). Importantly, contrary to what was observed for schools, the issue of religion was not a major reason for choosing faith-based facilities. Patients did mention the importance of values and faith, but in general terms and not as a reason to choose a particular facility. When asked about the main advantages of faith-based healthcare, the quality of the staff and services, as well as for some the proximity of the facility and the availability of assistance programs were mentioned much more than religion.

When asked about the main advantages of faith-based healthcare, the quality of the staff and services, as well as for some the proximity of the facility and the availability of assistance programs were mentioned much more than religion by patients in Ghana and Burkina Faso.

Overall, the quality of the service, and especially the respect provided to patients by staff appeared to be key reasons why patients relied on faith-based facilities. Patients emphasized the open, trusting, and respectful

[133] The emphasis on faith and values in faith-based schools does not mean however that the schools do not accept children from all faiths. Interviews with school leaders suggested that indeed all faith-based schools accepted children who belong to a religion different from that of the school. Still, there were differences in terms of the religion of the children enrolled. While many Muslims go to Christian schools, few Christians go to Islamic schools.

[134] See Wodon (2021a, 2021j, 2021k) for an analysis of the links between education pluralism and the right to education as well as their measurement.

environment of the facilities, at times in contrast with public health facilities. Some respondents explained the difference between facilities by describing how patients could be yelled at or scolded in public facilities. Such reprimands were seen as offensive and in contrast to the patient-centered environment of faith-based healthcare. In some cases, patients emphasized that while they may have a public facility closer to their home, they still prefer to travel longer distances to go to the faith-based facility. Good communication appeared central in the patients' views about the quality of services— being able to understand the health worker and in turn, to be listened to and understood. Some patients also appreciated that staffs in faith-inspired centers often have a working knowledge of the local language, whereas this was not always the case in public health facilities, especially hospitals.

Faith-based services were also viewed as potentially contributing to improvements in community health through increased use of the facilities. These results were encouraging for faith-based facilities, but they do not mean that there were no areas for improvement. In terms of the management and capacity of the health centers, problems were mentioned by patients, including a lack of personnel and long waiting periods. These problems were likely to be encountered as well in public facilities. Another issue was the difficulty for some health centers to promote the use of family planning services.

Overall religion did not seem to play a key role in the choice of health facilities, or at least not as important a role as other factors. This does not mean that religion is absent. For example, staffs at some Protestant health centers are known to discuss aspects of faith, pray for patients, or recite verses from the Bible. But religion is not the primary focus. Patients of all religions visit the centers and health services are focused on providing care that is acceptable to this diverse clientele.

For those patients who are interested, faith-based facilities provide services ranging from religious counseling to spiritual healing. Religion is to some extent part of the services offered, but participation in religious activities is on a voluntary basis. When asked about their willingness to seek care at a clinic or hospital of a different faith than their own, most respondents said that the religious affiliation of clinics was not a major concern. The decision of where to seek healthcare is based on cost and quality, not religious affiliation.

Satisfaction with the Services Provided

In chapters 4 and 5, data from household surveys were used to assess the extent to which faith-based education and health providers reach the poor and their market share in sub-Saharan Africa. The same data are used in this section to assess the satisfaction of households with the services provided by faith-based and other providers.

Consider first the results for primary and secondary education. Table 6.1 and Figure 6.1 provide the results of the analysis. On average across seven countries for which data are available, parental satisfaction with the schools their children attend is substantially higher in faith-based than in public schools. The gaps in satisfaction are large, at 16 percentage points for primary education and just under 15 points for secondary education. Private secular schools do even better than faith-based schools, especially at the primary level (at the secondary level the difference is small).

On average across seven countries, parental satisfaction with the schools their children attend is higher in faith-based than in public schools. The gaps in satisfaction are large, at 16 percentage points for primary education and just under 15 points for secondary education. Private secular schools do even better.

What are some of the reasons for non-satisfaction? While there are differences between surveys, questionnaires typically identify the following potential reasons: lack of books/supplies, poor teaching, lack of teachers, facilities in bad condition, overcrowding, lack of

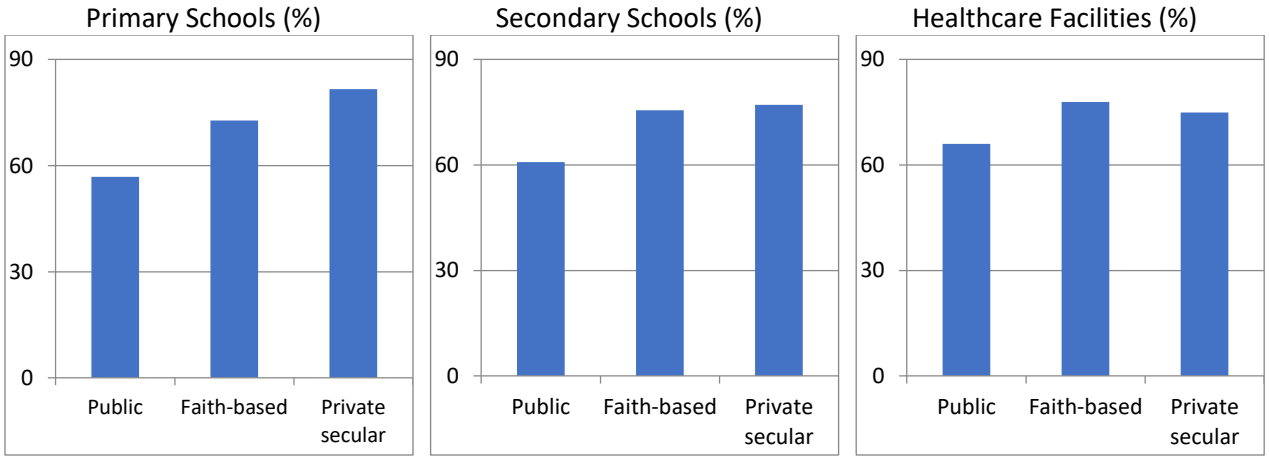
furniture, and other problems. In a few countries, cost is also included as a potential reason, but not in most. At the primary level, the lack of books and supplies is the main reason for nonsatisfaction in virtually all countries. Overcrowding and lack of teachers are also often mentioned, as well as many of the other problems. In secondary schools, the lack of books/supplies also comes first in most countries, but the lack of teachers comes up more often. It should be emphasized that the fact that the cost of schooling is not a major complaint does not mean that it is not an issue. The questions are asked only to parents who have children in school—among parents who have children of school age who are not enrolled, cost is often the main or at least a key reason for not being in school, but this is not shown here since that information cannot be disaggregated according to the type of provider given that the children are not in school.

Table 6.1: Satisfaction Rates with Education and Health Services, sub-Saharan Africa (%)

	Satisfaction rates by welfare quintile					All
	Quintile 1 (Poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Richest)	
	Primary education – Average for 7 countries					
Public	51.9	54.2	55.9	58.9	63.6	56.8
Faith-based	51.5	67.0	72.7	73.2	80.1	72.8
Private secular	67.8	66.5	72.1	80.6	87.3	81.6
All	53.3	55.7	58.8	63.2	72.0	60.9
	Secondary education – Average for 7 countries					
Public	59.6	59.9	60.4	58.8	63.4	60.8
Faith-based	47.3	61.3	75.7	72.3	79.9	75.6
Private secular	67.6	66.1	69.2	66.1	82.3	77.1
All	59.8	60.0	62.0	60.7	68.9	63.6
	Healthcare – Average for 6 countries					
Public	65.4	67.4	64.0	65.5	67.4	66.0
Faith-based	73.0	84.3	77.9	80.0	64.0	78.0
Private secular	75.2	75.1	75.3	72.2	76.0	74.9
All	70.5	70.9	68.6	69.3	71.6	70.2

Source: Estimation from household surveys. Adapted from Wodon (2014, 2015, 2019).
Note: All countries in the sample are treated equally when computing averages across countries.

Figure 6.1: Satisfaction with Services in sub-Saharan African Countries (%)



Source: Adapted from Wodon (2015, 2019).

Table 6.1 also provides estimates of average satisfaction with healthcare services, with data available for six countries. As for schools, household satisfaction with healthcare facilities is substantially higher in faith-based than public facilities by 12 percentage points on average. Private secular facilities have satisfaction rates slightly lower than faith-based facilities, but higher than public facilities.

As for schools, household satisfaction with healthcare facilities is higher in faith-based than public facilities by 12 percentage points on average. Private secular facilities have satisfaction rates slightly lower than faith-based facilities, but higher than public facilities.

In terms of the reasons for non-satisfaction, the cost of services is often mentioned, especially by households in the bottom quintiles of well-being. Faith-based facilities register less complaints regarding cost perhaps because of efforts to make care affordable for the poor. After cost, the second most important reason for nonsatisfaction is long waiting time in virtually all countries. Overall, for both faith-based schools and healthcare facilities, these results are encouraging, but at the same time, satisfaction rates are not very high, especially in the bottom quintiles, and they may not necessarily imply quality, as discussed next.

Quality of the Services: A Case Study

Even if faith-based providers receive higher satisfaction ratings from users, this does not imply that they provide a service of high quality. This is best illustrated with statistics on learning poverty in the case of education. As mentioned earlier, a child is learning poor if s/he cannot read and understand an age-appropriate text by age 10[135]. The measurement of learning poverty is based on two main data sources. The first is a large set of international student assessments that have been normalized to be comparable and provide information on the share of children aged 10 who are in school are able to read and understand a simple text. The second is the share of students of that age who are out of school, and therefore assumed to be learning poor. By combining both sources of data, estimates of learning poverty can be provided.

Even before the COVID-19 crisis, in sub-Saharan Africa and low income countries, close to nine in ten children were learning poor. In low and middle income countries together, the proportion was above half. The pandemic is likely to have led to a large increase in learning poverty as schools were closed for long periods of time. Catholic schools are not immune to those challenges. Especially in African countries where Catholic schools have a large footprint, differences in learning for students in Catholic and public schools may not be large. In fact, in those countries, most Catholic schools benefit from state funding and are part of the public education system.

Consider the case of Uganda. During the colonial period Catholic schools used to be owned and managed by the Church. One year after independence, the Education Act of 1963 placed Catholic and most other religious schools under government authority. Since then, most Catholic schools have been considered as public schools. Some schools established by the Church after independence are private, but most Catholic schools are part of the public education system. The benefit is that the state pays for teacher salaries, but the limitation is that it makes it more difficult for the schools to maintain their Catholic identity[136]. By contrast, private Catholic schools are owned and operated by the Church with autonomy and no government funding.

The fact that both public and private Catholic schools coexist in Uganda begs an interesting question: is the performance of

[135] World Bank (2019b).

[136] See Heyneman (1975) and D'Agostino (2017).

students in both sets of schools similar? Analysis based on data from a Service Delivery Indicators survey suggests this is not the case. As shown in Table 6.2, on a scale of zero to one, the average performance of students in fourth grade (P4) was at 46.2 percent for English, 43.4 percent for numeracy, 56.9 percent for non-verbal reasoning, and 46.6 percent nationally. The estimates for private schools, whether Catholic or not, are higher than those for public schools, whether Catholic or not, and differences are statistically significant. However, there are no major differences between public schools according to whether they are Catholic schools or not, and the same is true for the most part for the comparison of Catholic private schools with other private schools.

Table 6.2: Learning Performance of Students in Different Types of Primary Schools in Uganda

Values normalized between zero and one

	Public		Private		All
	NC	C	NC	C	
Language	0.431	0.421	0.655	0.753	0.462
Math	0.418	0.415	0.532	0.547	0.434
Non-verbal	0.560	0.558	0.617	0.652	0.569
Overall	0.438	0.430	0.639	0.721	0.466

Source: Wodon and Tsimpo (2021).

In Uganda, student learning performance in private primary schools, Catholic or not, is higher than in public schools, Catholic or not, and differences are statistically significant. But there are no major differences between public schools according to whether they are Catholic schools or not, and the same is true for private schools, whether they are Catholic or not.

Regression analysis suggests that after controlling for a wide range of factors affecting student performance, the same result holds: students in Catholic private schools as well as other private schools still appear to perform comparatively well, while students in public schools, Catholic or not, do less well.

The broader message is that while in some cases, Catholic schools may provide a service of better quality than public schools, this is not necessarily the case. In Catholic schools as well as many other faith-based schools, too many students are not learning (see Box 6.1 on Koranic schools).

Box 6.1: Learning in Koranic Schools

The term Koranic school is often used to describe schools that are not part of the formal education system and typically place a strong emphasis on memorizing the Koran in Arabic, as well as on knowledge of Islamic religious education and practice. Analysis for Niger[137] suggests that to a large extent, the expansion of the formal education sector has not resulted in an equivalent reduction of the number of students enrolled in Koranic schools. The schools continue to serve a segment of the population, with students from all socio-economic backgrounds enrolled in the schools. Girls are slightly less likely than boys to enroll in Koranic schools, but differences are not large. Differences are larger by location and region.

A comparative analysis of the benefits from Koranic and formal education in various areas suggests that while attending Koranic schools yields benefits, these benefits tend to be smaller than those associated with formal education. This conclusion was reached for literacy and numeracy, labor market earnings and household well-being, and infant mortality. None of these areas are the areas of focus of Koranic schools, but all these areas matter for both individuals and their families.

The analysis does not focus on policy, but it suggests that there may be benefits from better integrating Koranic schools in education systems to improve their potential positive impact on various outcomes. Government policy could enhance synergies with formal education, including by strengthening the instruction provided in the Koranic schools and facilitating a transition from Koranic schools to the formal education system [138].

[137] Male et al. (2021).

[138] On policy options, see Banque mondiale (2021).

Summing Up

This chapter was devoted to an assessment of the preferences and satisfaction of users of faith-based services in education and healthcare. Although some illustrations from the United States were provided, much of the focus was on sub-Saharan Africa. Three main findings emerge from the analysis.

First, parents sending their children to Catholic and other faith-based schools place more emphasis on learning about values and faith in schools than is the case for parents sending their children to other schools, and in particular public schools. Similarly, there is evidence that students going to faith-based colleges and universities place more emphasis on faith as a reason for choosing the university they enroll in. By contrast, faith plays less of a role in the decision to choose faith-based providers for healthcare. The perception of the quality of the care being provided is what influences patient choices.

Second, cross-country data for sub-Saharan Africa suggest that faith-based schools and healthcare facilities may have better satisfaction rates among their clientele than public facilities, and similar satisfaction rates to those observed in private secular schools and facilities. The fact that despite limited resources, faith-based providers seem to achieve comparatively higher satisfaction rate is a testament to the work done by their staff. As to high satisfaction rates in private secular schools and facilities, they are less surprising since these facilities often have more resources given higher out-of-pocket costs paid by users.

Third, high satisfaction rates need not imply that the quality of the services provided is also high. As an illustration, a case study was provided for Uganda, a country where most Catholic schools are part of the public education system. The case study suggests that student learning in private primary schools, Catholic or not, is higher than in public schools, Catholic or not, and differences are statistically significant. But there are no major differences between public schools according to whether they are Catholic or not, and the same is true for private schools, whether they are Catholic or not.

The broader message is that while in some cases Catholic schools may provide a service of better quality than other schools, this is not necessarily the case. Catholic schools as well as other schools must strive to improve learning. Similarly, Catholic healthcare and social protection facilities must strive to improve the services they provide. The need to improve quality or 'build back better' across all types of facilities has become even more urgent given the impacts of the COVID-19 pandemic (as an example, on suggestions to improve education systems, see Box 6.2).

Box 6.2: Improving Quality: The Case of Education

As noted in the Global Catholic Education Report 2021, guidance has been provided by international organizations on how to mitigate the impacts of the pandemic on education systems. The World Bank[139] suggested a dozen practical action steps for planning and implementing multi-faceted remote learning. In implementing these steps, given lack of internet connectivity, television and radio offer alternatives to online materials. [140] Catholic organizations also put together resources, including for school principals and teachers[141]. Reopening schools while preventing the spread of infections has been a priority [142]. As schools reopen, re-enrollment campaigns may be needed for some students. Ideally, such campaigns should be participatory, involving local and faith leaders[143]. Community-based early warning systems to prevent drop-outs may help and care will be needed on managing examinations, especially if they are high stake[144]. Schools will need to monitor how well students are doing and simple surveys can help in assessing whether schools are managing the crisis well.[145] Finally, education systems will need strategic frameworks to respond to the crisis, and ensure their resilience in the future[146].

Beyond the response to the pandemic, there is a need to 'build back better' to end the learning crisis that prevailed even before the pandemic. Guidance to do so is also available in a World Bank blueprint[147] whose vision is 'learning with joy, purpose, and rigor for everyone, everywhere'. Priorities are identified for five pillars: (1) Learners are prepared and motivated to learn; (2) Teachers are effective and valued; (3) Learning resources, including curricula, are diverse and high-quality; (4) Schools are safe and inclusive spaces; and (5) Education systems are well-managed. For each pillar, specific policy actions are recommended. For example, to support teachers, education systems should focus on four actions: (i) Establish the teaching profession as a meritocratic, socially valued career; (ii) Expand engagement in pre-service training; (iii) Invest in at-scale in-service professional development; and (iv) Give teachers tools and techniques for effective teaching[148]. In addition to policy actions in each of the five pillars, five core principles to guide reform efforts are also suggested: (1) Pursue systemic reform supported by political commitment to learning for all children; (2) Focus on equity and inclusion through a progressive path toward universalism; (3) Focus on results and use evidence to keep improving; (4) Ensure financial commitment commensurate with what is needed to provide basic services to all; and finally (5) Invest wisely in technology. These suggestions could apply to Catholic and other faith-based schools as well.

[139] World Bank (2020d). See also World Bank (2020l) and HundrED (2020) for a list of useful websites and tools.

[140] See Navarro-Sola (2019) and Fabregas (2019) on television, and Education Development Center (2020) on radio.

[141] For dioceses, see San Diego and Imperial Valley Catholic Schools (2020). For independent schools, see Scafidi and Wearne (2020). Even before the pandemic, many teachers were not ready for distance learning (OECD, 2018a, 2018b; Moreno and Gortazar, 2020; see also Reimers et al., 2020 on ensuring continuity in learning).

[142] Various early studies simulated the risk (Di Domenico et al., 2020). Early research suggested that children were less likely to be infected by the coronavirus, but had more contacts once schools reopen, leading to risks of spreading the virus. On reopening schools, see UNESCO et al. (2020), Center for Disease Control (2020, 2021a, 2021b), and Bailey and Hess (2020).

[143] See UNICEF (2013) for examples of campaigns. On the role of faith leaders during the Ebola pandemic in West Africa, see Christian Aid et al. (2015) and Greyling et al. (2016)

[144] See Adelman et al. (2017) on early warning systems and Liberman et al. (2020) on examinations.

[145] One example is a survey by Catholic schools in Belgium to assess school and teacher readiness to implement distance learning (Devel, 2020). The survey identified actions taken by schools and constraints faced by households to access resources, as well as the frequency of interactions between schools, teachers, and students.

[146] See World Bank (2020m) for an example of such a strategy in Benin as part of a World Bank operation.

[147] World Bank (2020k).

[148] On how to improve teaching, see also Evans and Popova (2016) and Beteille and Evans (2018). On factors affecting teacher satisfaction and thereby potentially teacher effort, see Nkenge et al. (2021).

CONCLUSION

As some of the largest non-state providers of healthcare, education, and social protection (including humanitarian assistance) in the world, faith-based organizations play a significant role in efforts to achieve the Sustainable Development Goals (SDGs) and promote integral human development. Yet with few exceptions, their contributions are rarely taken into account in global policy discussions. Similarly, global policy discussions and the lessons learned by the international community on what works to achieve the SDGs and improve human development outcomes often do not reach faith-based organizations enough.

This report is the first in a new series to be published under the Global Catholic Education project on integral human development. The report has two main aims, which are also the aims of the project: (1) to make the experiences and role of Catholic and other faith-based schools, universities, and other organizations in contributing to integral human development better known in the international community; and (2) to bring to Catholic and other faith-based educators and all those interested in integral human development the expertise and knowledge emerging from the international community.

The report is structured in two parts. The first part documents trends in service provision by faith-based organizations in education, healthcare, and social protection. Because of data constraints, the focus is on the Catholic Church. Similar data are not available for most other faith networks. Still, patterns emerge that are likely to be relevant for other faith networks as well.

In 2019, according to its latest statistical yearbook, the Catholic Church managed 221,144 pre-primary, primary, and secondary schools, 20,740 health facilities (hospitals, health centers or dispensaries, and leproseries), and 84,872 social protection facilities (this is a broad category including orphanages, nurseries, special education or reeducation centers, homes for the elderly, chronically ill, invalid, or handicapped, matrimonial advice centers, and other institutions). In addition, 6.7 million students were enrolled in Catholic higher education institutes and universities.

The range of services provided by the Church has increased over the last 40 years, although for healthcare and social protection, there has been a decline in the number of facilities managed by the Church globally over the last decade. For basic education and healthcare facilities, the role played by the Church is especially important in sub-Saharan Africa. Beyond facilities-based services, the Church also contributes to integral human development through other programs. For social protection, this includes support provided locally in cash or in kind for the less fortunate through more than 220,000 parishes. Internationally, this includes humanitarian assistance, among others through Caritas Internationalis, a confederation of over 160 organizations working at the grassroots in most countries of the world.

The second part of the report looks in more details at three questions. First, to what extent do Catholic and other faith-based service providers reach the poor, and what role may out-of-pocket costs for households play in their ability to do so? The fact that most Catholic schools and healthcare facilities are located in low and lower-middle income countries helps the Church in fulfilling its preferential option for the poor. By contrast, with the exception of orphanages and nurseries, most Catholic social protection facilities are in high (and sometimes upper-middle) income countries. As to whom benefits from faith-based services within countries, in sub-Saharan Africa public schools serve the poor slightly more than faith-based schools, but there seem to be few differences in reach to the poor between faith-based and public healthcare facilities. Private secular

facilities are by contrast titled more towards serving better off households for both education and healthcare.

Differences in benefit incidence are related in part in differences in out-of-pocket costs for households, which are themselves related to whether faith-based schools and facilities benefit or not from state funding. Yet overall, despite the fact that faith-based services are often more expensive for households to use than publicly provided services, the analysis suggests that they do reach the poor to a substantial extent.

Second, what is the market share of Catholic and other faith-based organizations in education, healthcare, and social protection? Globally, the market share of Catholic education in terms of the number of students enrolled is estimated at 4.8 percent at the primary level, 3.2 percent at the secondary level, and 2.8 percent at the higher education level. For healthcare, for 140 countries included in the analysis, the market share of the Catholic Church in terms of the facilities it operates is estimated at 6.3 percent for hospitals and 1.7 percent for health centers. The corresponding market shares are substantially higher in sub-Saharan Africa and in low-income countries. These estimates are tentative, but instructive.

Third, why do households rely on services provided by faith-based organizations, what is their satisfaction with these services, and what is the quality of the services being provided? There is an important difference between education and healthcare on the motivation for users to rely on faith-based providers. Values and faith play an important role in the motivation of parents to send their children to faith-based versus public or private secular schools, and for students to enroll in faith-based versus public or private secular universities. By contrast, faith is often not a key factor in the choice of a healthcare facility: the quality of the services is what matters.

As for satisfaction with the services received, in sub-Saharan Africa, parental satisfaction appears to be higher in faith-based than public schools. The same is observed for patient satisfaction with healthcare facilities. Gaps in satisfaction rates between faith-based and public facilities are relatively large. This does not imply however that faith-based providers are always providing services of high or better quality. In the case of education, as is the case for public schools, faith-based schools struggle with the learning crisis affecting much of the world. Too many 10-year old children are learning poor, which means that they cannot read and understand an age appropriate text. Catholic and other faith-based schools need to improve the education they provide, as is the case for other schools, public or private.

These are some of the main conclusions from the analysis. Admittedly, the report only scratches the surface of the contributions of faith networks to integral human development, as well as the challenges and opportunities they face. The focus in the report is on contributions through facilities-based services. Future reports will not only need to go deeper on this particular topic, but they will also need to consider other types of contributions to integral human development by faith-based networks, as well as some of the areas where faith networks may need to do better.

Still, the hope is that the limited analysis provided in this report will be useful to readers, and that it will encourage more work in this field. Much more needs to be done to ensure that the contributions of faith networks are better recognized in the international community, and that faith networks benefit from lessons learned by the international community on what works to achieve the SDGs and improve human development outcomes.

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STATISTICAL ANNEX

Every year, the Central Statistics Office of the Catholic Church publishes the Statistical Yearbook of the Church. At the time of writing, the latest edition was published in 2021. It provides data for 2019. Data on a wide range of Church activities are collected. For K12 education, the yearbook provides for each country and some territories the number of the schools managed by the Church and the number of students enrolled in those schools at three levels: preschools, primary schools, and secondary education. In addition, the yearbook provides statistics on tertiary education with the number of students enrolled according to three categories: students in higher institutes and students in universities, with a distinction between those engaged in ecclesiastical studies and those engaged in other types of studies.

In a separate section, the yearbook provides data on 'welfare institutions', some of which are classified in this report as healthcare facilities (hospitals, dispensaries or health centers, and leproseries), with the others are considered as social protection facilities (orphanages, nurseries, centers for special education or re-education, homes for the elderly, chronically ill or handicapped, matrimonial advise centers, and other institutions). The data for the yearbook are collected through a questionnaire sent to the chancery offices of ecclesiastical jurisdictions worldwide. The data are self-reported and may not always be fully accurate, especially in contexts where local conditions are not favorable to data collection.

In addition, not all ecclesiastical jurisdictions are able to fill the questionnaire every year. Each year a small number of the more than 3,000 jurisdictions that should fill the questionnaire are not able to do it. Typically, these jurisdictions tend to be small, so that the missing data should not affect the validity of the data substantially.

This statistical annex provides country level data for the variables included in the yearbooks that are used in the report, namely the number of schools, healthcare facilities, and social protection facilities, as well as enrollment in K12 schools and higher education. The data are for 2019 and are presented in the same way as they are made available in the latest available statistical yearbook[149].

The possibility of errors in reporting the number of schools or facilities as well as enrollment by ecclesiastical jurisdictions cannot be excluded. But overall, while estimates in the yearbooks may not always be fully accurate, especially for large and complex countries that also have comparatively weaker administrative systems, the data appear to be of sufficient quality to suggest broad stylized facts, as done in this report.

For education related statistics, country profiles with trends over time will be made available separately on the Global Catholic Education website.

[149] Secretariat of State (2021).

Annex Table 1: Country-level Data on Catholic Education from the Latest Available Statistical Yearbook of the Church

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Africa									
Algeria	-	-	7	602	1	624	-	-	3,614
Angola	80	18,489	257	307,824	158	123,910	9,222	130	8,400
Benin	119	5,625	249	50,281	117	30,593	178	249	2,115
Botswana	23	1,055	11	3,626	3	3,733	-	-	-
Burkina Faso	68	10,232	182	50,309	128	46,541	2,545	250	2,840
Burundi	231	16,816	1,001	410,014	314	68,747	181	-	1,207
Cape Verde	35	3,957	7	2,915	4	2,401	-	-	-
Cameroon	668	55,492	1,107	241,649	277	101,581	4,155	2,372	6,115
Central African Rep.	80	15,007	152	52,931	36	12,376	-	-	-
Chad	92	5,780	140	53,172	63	16,428	-	-	5,025
Comoros	1	50	1	261	4	250	-	-	-
Congo, Republic	60	5,093	133	35,143	79	14,603	7,601	46	-
Congo, Dem. Rep.	679	70,099	11,547	4,672,396	5,423	1,532,682	35,309	17,270	32,444
Cote d'Ivoire	120	8,852	397	80,577	55	45,014	316	2,997	-
Djibouti	5	505	5	1,404	2	419	-	-	-
Egypt	192	38,524	144	68,899	79	45,664	668	45	-
Eritrea	75	11,389	43	13,833	11	4,711	300	-	-
Eswatini	14	11,000	47	21,765	13	6,180	-	-	-
Ethiopia	308	50,278	178	101,988	86	27,829	3,749	185	990
Gabon	50	14,177	225	29,374	24	15,287	-	-	1,987
Gambia	52	7,396	34	25,484	37	6,960	-	-	-
Ghana	1,760	264,155	1,955	488,000	1,230	288,583	10,676	169	4,116
Guinea	38	3,666	32	16,506	21	5,297	883	61	21
Guinea-Bissau	42	4,288	71	21,075	15	7,656	533	-	-
Equatorial Guinea	73	7,833	76	19,129	58	14,057	112	-	-
Kenya	4,804	428,304	5,383	2,687,136	2,189	1,040,969	10,196	8,630	18,410
Lesotho	43	11,227	518	199,010	94	54,386	-	-	-
Liberia	40	2,545	42	9,048	40	13,270	3,625	-	-
Lybia									
Madagascar	1,953	99,330	4,076	434,979	1,074	178,908	13,032	8,950	1,014
Malawi	401	418,459	1,574	1,847,603	167	75,645	4,430	2,543	2,727
Mali	21	3,130	59	25,998	35	12,601	947	-	480
Mauritania	3	430	-	-	-	-	-	-	-

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Mauritius	2	262	51	18,311	21	13,066	-	-	-
Morocco	13	2,409	13	7,689	7	1,639	90	-	-
Mozambique	121	19,803	77	93,722	84	67,298	981	1,600	18,688
Namibia	47	2,632	17	7,951	9	3,226	22	-	-
Niger	13	1,717	16	7,402	6	3,940	-	-	-
Nigeria	1,944	194,544	2,088	498,930	1,119	359,903	9,667	1,229	11,108
Reunion	22	3,428	29	9,670	14	8,422	387	-	-
Rwanda	977	89,577	1,144	1,076,902	668	342,402	541	2,350	3,821
Sahara, Western	-	-	-	-	-	-	-	-	-
Saint Helena	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	5	1,535	1	645	1	730	-	-	-
Senegal	154	15,615	136	69,426	51	34,980	2,652	127	3,980
Seychelles	-	-	-	-	-	-	-	-	-
Sierra Leone	107	11,123	864	272,613	124	70,282	30	-	3,350
Somalia	-	-	-	-	-	-	-	-	-
South Africa	245	22,824	202	96,359	111	78,926	-	-	3,033
South Sudan	77	22,256	181	89,436	33	10,867	2,410	200	143
Sudan	93	7,875	79	35,837	16	6,089	2,370	-	-
Tanzania	908	80,172	517	297,013	389	119,536	13,455	488	49,407
Togo	210	6,869	550	112,875	97	27,811	678	320	680
Tunisia	4	386	7	5,187	1	295	-	-	-
Uganda	1,824	188,291	5,251	4,416,774	819	409,695	4,407	742	8,124
Zambia	120	11,458	140	60,470	99	37,603	2,360	-	2,925
Zimbabwe	82	10,526	108	88,444	116	53,639	2,222	288	1,123
Total Africa	**19,098**	**2,286,485**	**41,124**	**19,238,587**	**15,622**	**5,448,254**	**150,930**	**51,241**	**197,887**
North America									
Bermuda	1	46	1	128	1	221	-	-	-
Canada	730	33,924	1,471	463,281	464	281,779	9,166	6,242	7,254
Greenland	-	-	-	-	-	-	-	-	-
Saint Pierre et Miquelon	2	83	2	199	1	122			
United States	3,709	150,809	4,876	1,239,344	1,316	551,929	365,686	27,725	848,549
Total North America	**4,442**	**184,862**	**6,350**	**1,702,952**	**1,782**	**834,051**	**374,852**	**33,967**	**855,803**

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Central America									
Belize	51	1,058	115	29,422	11	2,385	1,917	-	-
Costa Rica	30	627	37	7,272	47	9,325	1,347	95	1,097
El Salvador	52	3,628	142	46,799	61	26,725	7,400	-	23,150
Guatemala	118	9,734	146	41,355	145	41,791	4,163	1,732	27,586
Honduras	62	2,095	47	7,912	74	11,304	890	7,730	15,134
Mexico	3,139	181,224	2,437	586,532	2,405	420,497	38,414	21,401	176,758
Nicaragua	134	9,937	537	51,996	121	27,015	-	190	3,922
Panama	38	3,232	45	9,463	43	14,699	-	-	-
Total Central America	**3,624**	**211,535**	**3,506**	**780,751**	**2,907**	**553,741**	**54,131**	**31,148**	**247,647**
Antilles									
Anguilla	-	-	-	-	-	-	-	-	-
Antigua and Barbuda	1	51	1	401	2	466	-	-	-
Aruba	10	1,011	14	4,093	7	3,121	-	-	-
Bahamas	-	-	6	1,670	4	1,542	-	-	-
Barbados	2	232	2	219	1	226	-	-	-
Cayman Islands	1	76	1	286	1	314	-	-	-
Cuba	11	645					400		
Dominica	8	491	5	1,765	4	1,144			
Dominican Republic	147	18,528	303	112,013	247	97,312	26,532	14,800	40,788
Grenada	20	1,058	25	5,334	7	3,987	-	-	-
Guadeloupe	14	1,332	13	3,146	8	3,449	-	-	-
Haiti	2,081	59,564	3,433	322,435	557	72,531	5,746	438	3,182
Jamaica	33	2,977	52	20,528	16	19,585	704	52	-
Martinique	6	530	7	2,329	4	2,300	-	-	-
Montserrat	-	-	1	146	-	-	-	-	-
Netherlands Antilles	26	2,191	38	11,083	16	7,085	-	-	-
Puerto Rico	46	1,057	87	21,115	52	7,359	1,060	8639	18575
Saint Kitts and Nevis	1	27	1	254	1	195	-	-	-
Saint Lucia	1	21	30	5085	2	1,302	-	-	-
St. Vincent & Grenadines	2	62	1	653	3	1295	-	-	-
Trinidad and Tobago	2	78	126	25,314	22	12,298	115	-	-
Turks and Caicos Islands	1	22	1	61	1	83	-	-	-

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Virgin Islands (GB)	-	-	-	-	-	-	-	-	-
Virgin Islands (USA)	-	-	3	285	2	112	-	-	-
Total C.A. & Antilles	**2,413**	**89,953**	**4,150**	**538,215**	**957**	**235,706**	**34,557**	**23,929**	**62,545**
South America									
Argentina	1,455	235,960	1,668	693,827	1,676	532,645	60,967	654	101,097
Bolivia	267	48,773	545	263,359	259	148,411	6,425	1,688	35,584
Brazil	1,191	182,394	1,352	620,279	830	197,442	28,603	90,867	446,355
Chile	609	66,452	867	367,038	680	183,858	91,289	323	110,971
Colombia	708	51,209	1,127	248,059	1,496	350,331	16,343	3,245	256,280
Ecuador	355	23,239	494	244,447	343	134,673	1,064	44,261	50,136
Falkland Islands	-	-	-	-	-	-	-	-	-
French Guyana	7	-	7	-	6	-	-	-	-
Guyana	2	117	2	407	2	467	-	-	-
Paraguay	211	15,953	261	54,711	200	28,241	3,254	968	13,732
Peru	474	51,391	639	202,983	557	185,147	27,564	645	86,168
Suriname	63	3,560	64	13,210	11	3,019	-	-	-
Uruguay	135	9,394	151	35084	81	26,521	340	-	1,692
Venezuela	438	73,495	533	321,274	437	135,415	2,997	518	18,706
Total South America	**5915**	**761,937**	**7,710**	**3,064,678**	**6,578**	**1,926,170**	**238,846**	**143,169**	**1,120,721**
Total Americas	**16394**	**1,248,287**	**21,716**	**6,086,596**	**12,224**	**3,549,668**	**702,386**	**232,213**	**2,286,716**
Middle East									
Afghanistan	-	-	**1**	40	-	-	-	-	-
Cyprus	5	453	5	845	4	607	-	-	-
Iran	2	43	4	291	4	485	-	-	-
Iraq	38	2,293	17	3,171	4	770	378	-	-
Israel	70	7,231	58	19,063	58	15,962	-	193	3,328
Jordan	48	3,848	56	15,760	50	9,746	-	-	1,369
Lebanon	272	38,026	447	116,279	219	62,255	19,144	847	35,866
Syria	36	2,267	18	5,282	11	2,570	124	70	
Turkey	6	341	6	637	10	4,553			
Total Middle East	**477**	**54,502**	**612**	**161,368**	**360**	**96,948**	**19,646**	**1,110**	**40,563**

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
South, East & Far East Asia									
Bahrain	-	-	-	-	-	-	-	-	-
Bangladesh	103	10,181	508	48,010	97	62,309	7,604	125	1,430
Bhutan	-	-	-	-	-	-	-	-	-
Brunei Darussalam	3	400	3	1,079	3	728	-	-	-
Cambodia	61	2,898	20	2,608	17	4,475	46	-	350
China, Mainland	-	-	-	-	-	-	-	-	-
Hong Kong	32	10,869	105	70,741	103	62,709	640	641	3,227
Macao	17	6,532	23	13,016	17	9,468	178	26	1,183
Taiwan	123	13,794	11	7,603	34	46,435	7,412	25,419	21,327
India	7,709	1,261,560	10,463	4,245,873	7,352	4,084,818	752,739	19,317	133,395
Indonesia	1,544	79,440	2,697	459,511	1,461	356,320	34,985	7,681	76,604
Japan	521	61,490	54	20,291	180	67,143	10,283	33	41,458
Kazakhstan	5	83	-	-	1	160	-	-	-
Korea, Dem. Rep.	-	-	-	-	-	-	-	-	-
Korea, Republic	222	20,506	12	3,716	68	33,466	3,646	4,104	45,906
Kuwait	-	-	-	-	-	-	-	-	-
Kyrgyzstan	-	-	-	-	-	-	-	-	-
Laos	5	436	3	574	1	46			
Malaysia	89	8,568	172	79,423	92	63,693	69		
Maldives	-	-	-	-	-	-	-	-	-
Mongolia	3	335	3	232	1	155	-	-	-
Myanmar	225	6,479	53	1,705	51	1,644	293	34	-
Nepal	23	1,380	29	11,200	25	9,030	3,016	-	166
Oman	-	-	-	-	-	-	-	-	-
Pakistan	111	12,243	126	33,205	193	100,116	9,641	1,579	-
Philippines	1215	240,173	977	503,449	1,229	893,102	340,685	50,635	162,113
Qatar	-	-	-	-	-	-	-	-	-
Russia	4	128	2	223	-	-	-	-	-
Saudi Arabia	-	-	-	-	-	-	-	-	-
Singapore	17	2,762	21	23,756	17	19,717	1,566	268	-
Sri Lanka	318	14,606	150	44,876	70	65,549	3,190	362	5,140
Tajikistan									
Thailand	211	78,766	222	182,131	175	112,108	3,795	239	11,971
East Timor	95	6,009	179	36,069	61	27,171	531	267	-

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Turkmenistan	-	-	-	-	-	-	-	-	-
United Arab Emirates	9	2,752	11	11,078	7	5,150	-	-	-
Uzbekistan	-	-	-	-	-	-	-	-	-
Vietnam	977	151,654	45	7,953	21	3,048	735	457	-
Yemen	-	-	-	-	-	-	-	-	-
Total South, East & F.E. Asia	**13,642**	**1,994,044**	**15,889**	**5,808,322**	**11,276**	**6,028,560**	**1,181,054**	**111,187**	**504,270**
Total Asia	**14,119**	**2,048,546**	**16,501**	**5,969,690**	**11,636**	**6,125,508**	**1,200,700**	**112,297**	**544,833**
Europe									
Albania	36	2,040	14	3,089	12	2,327	-	-	2,570
Andorra	3	278	3	877	3	647	-	16	-
Armenia	-	-	-	-	1	35	-	-	-
Austria	600	40,075	95	17,878	197	57,120	4,701	550	1,212
Azerbaijan	-	-	-	-	1	350	-	-	-
Belarus	-	-	-	-	-	-	81	58	-
Belgium	1099	164,832	2,090	522,391	1,051	550,739	125,842	2,731	77,940
Bosnia & Herzegovina	-	-	5	2,401	10	1,951	47	104	-
Bulgaria	1	63	1	31	-	-	-	-	-
Croatia	36	2,304	11	1,588	12	2,305	329	739	7,289
Czech Republic	30	1,453	25	6,276	32	9,214	1,248	750	-
Denmark	7	342	22	10,374	1	207	-	-	-
Estonia	1	60	1	189	1	238	-	-	-
Faeroe Islands	-	-	-	-	-	-	-	-	-
Finland	2	80	-	-	-	-	-	-	-
France	2,930	378,448	4,092	605,334	2,419	1,163,625	81,013	26,269	17,504
Georgia	2	60	-	-	-	-	-	-	1000
Germany	8,243	607,655	103	24,065	743	350,656	16,172	13,796	2,404
Gibraltar	1	64	1	358	-	-	-	-	-
Great Britain	317	10,837	1,765	437,290	361	322,627	53,550	118	181,123
Greece	9	589	10	3,685	8	3,005	-	-	-
Hungary	173	17,326	226	59,400	95	38,163	2,151	1,480	15,808
Iceland	-	-	-	-	-	-	-	-	-
Ireland	138	8,952	3,222	529,281	571	343,035	13,010	878	17,070

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Italy	4,868	310,307	1,033	127,396	945	120,845	6,227	23,984	301515
Kosovo	4	270	2	210	4	1,200	-	-	-
Latvia	3	360	4	365	3	66	61	-	-
Liechtenstein	-	-	-	-	-	-	-	-	-
Lithuania	45	8,438	13	10,583	325	83,595	318	126	-
Luxembourg	1	80	1	1,900	5	2,500	-	-	-
Macedonia	-	-	-	-	-	-	-	-	-
Malta	28	1,257	29	8,425	24	8,149	-	-	-
Moldova	4	257	-	-	-	-	-	-	-
Monaco	2	60	2	474	1	715	-	-	-
Montenegro	2	110							
Netherlands	-	-	251	-	39	-	12	7	-
Norway	-	-	5	1,193	1	244	-	-	-
Poland	534	35,825	473	76,496	391	58,714	7,878	15,957	17,842
Portugal	415	31,729	134	30,143	55	18,079	2,141	903	12,653
Romania	50	2,705	19	3,503	23	6,092	145	762	-
Russia (in Europe)	-	-	-	-	-	-	-	50	-
San Marino	-	-	-	-	-	-	-	-	-
Serbia	2	90	-	-	1	22	18	-	-
Slovakia	76	4,480	109	23,951	69	12,618	-	152	3,627
Slovenia	21	1,656	2	544	5	1,573	-	297	172
Spain	1,821	234,116	1,946	568,892	1,897	582,356	15,797	3,089	96,915
Svalbard & Jan Mayen Island	-	-	-	-	-	-	-	-	-
Sweden	7	140	3	573	3	466	-	-	-
Switzerland	8	215	11	1,230	27	5,973	200	381	80
Ukraine	48	1,850	16	786	5	690	1,377	261	35
Total Europe	**21,567**	**1,869,403**	**15,739**	**3,081,171**	**9,341**	**3,750,141**	**332,318**	**93,458**	**756,759**
Oceania									
Australia	366	20,661	1,320	390,419	460	348,553	238	6,192	40,817
Cook Islands	1	25	1	210	1	150	-	-	-
Fiji	19	591	44	11,211	19	4,222	107	-	-
Guam	11	402	11	3,576	3	1000	-	-	-
Kiribati	83	2,633	-	-	9	3,519	-	109	-

Data for 2019	Preschools		Primary schools		Secondary schools		Post-secondary (students)		
	Schools	Students	Schools	Students	Schools	Students	Higher Inst.	Ecclesiastical	Others Univ.
Marshall Islands	3	110	3	530	2	160	-	-	-
Micronesia	2	29	3	664	4	573	211	-	-
Marian Islands	2	57	2	388	1	183	-	-	-
Nauru	1	112	1	500	1	114	-	-	-
New Caledonia	15	2,417	42	10,187	23	7,511	-	-	-
New Zealand	10	467	188	36,054	48	29,947	427	13	-
Niue	-	-	-	-	-	-	-	-	-
Palau	1	7	1	214	1	121	-	-	-
Papua New Guinea	823	44,721	2,131	340,545	100	72,900	7,528	117	3000
French Polynesia	11	1,711	11	3,550	10	6,538	282	-	-
Samoa	13	720	9	2,599	6	5,700	-	-	-
Samoa, American	2	80	2	300	1	200	-	-	-
Solomon Islands	50	2,310	6	1,926	16	5,715	40	42	3000
Tokelau	1	16	1	88	1	16	-	-	-
Tonga	7	612	2	280	4	2,078	373	-	-
Tuvalu	-	-	-	-	-	-	-	-	-
Vanuatu	58	2,069	56	8,452	19	7,992	-	-	-
Wallis & Futuna Island	10	521	11	1,034	-	-	-	-	-
Total Oceania	**1,489**	**80,271**	**3,845**	**812,727**	**729**	**497,192**	**9,206**	**6,473**	**46,817**
Overall Summary									
Africa	**19,098**	**2,286,485**	**41,124**	**19,238,587**	**15,622**	**5,448,254**	**150,930**	**51,241**	**197,887**
North America	4,442	184,862	6,350	1,702,952	1,782	834,051	374,852	33,967	855,803
Central America	3,624	211,535	3,506	780,751	2,907	553,741	54,131	31,148	247,647
Antilles	1,099	164,832	2,090	522,391	1,051	550,739	125,842	2,731	77,940
South America	5,915	761,937	7,710	3,064,678	6,578	1,926,170	238,846	143,169	1,120,721
Americas	**16,394**	**1,248,287**	**21,716**	**6,086,596**	**12,224**	**3,549,668**	**702,386**	**232,213**	**2,286,716**
Asia - Middle East	477	54,502	612	161,368	360	96,948	19,646	1,110	40,563
Asia - South, East, Far East	13,642	1,994,044	15,889	5,808,322	11,276	6,028,560	1,181,054	111,187	504,270
Asia	**14,119**	**2,048,546**	**16,501**	**5,969,690**	**11,636**	**6,125,508**	**1,200,700**	**112,297**	**544,833**
Europe	**21,567**	**1,869,403**	**15,739**	**3,081,171**	**9,341**	**3,750,141**	**332,318**	**93,458**	**756,759**
Oceania	**1,489**	**80,271**	**3,845**	**812,727**	**729**	**497,192**	**9,206**	**6,473**	**46,817**
World	**72,667**	**7,532,992**	**98,925**	**35,188,771**	**49,552**	**19,370,763**	**2,395,540**	**495,682**	**3,833,012**

Source: Secretariat of State (2021).

Annex Table 2: Country-level Data on 'Welfare Institutions' from the Latest Available Statistical Yearbook of the Church

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Africa									
Algeria	-	1	-	3	5	1	1	-	6
Angola	41	229	5	7	44	30	5	5	52
Benin	28	93	5	6	56	2	5	-	26
Botswana	-	2	-	1	2	-	1	-	-
Burkina Faso	7	48	3	6	23	6	63	12	89
Burundi	18	95	-	14	28	1	25	2	6
Cape Verde	-	-	-	1	1	-	-	1	1
Cameroon	38	272	5	13	32	12	13	6	113
Central African Rep.	11	22	10	11	9	4	-	2	17
Chad	7	76	2	3	2	-	9	2	67
Comoros	4	12	-	1	1	-	-	-	-
Congo, Republic	6	26	1	7	15	9	2	-	-
Congo, Dem. Rep.	419	1,773	26	100	146	37	136	44	85
Cote d'Ivoire	9	76	3	6	16	2	-	-	13
Djibouti	-	1	-	-	1	-	-	-	5
Egypt	17	104	24	17	6	26	12	1	10
Eritrea	9	29	-	-	7	1	11	-	26
Eswatini	1	1	-	1	6	7	1	1	-
Ethiopia	17	70	10	22	21	27	10	-	21
Gabon	3	12	-	3	6	6	-	-	1
Gambia	10	2	-	-	1	-	-	-	5
Ghana	67	72	3	7	13	31	31	6	22
Guinea	2	11	-	-	12	1	-	-	-
Guinea-Bissau	5	34	1	-	1	12	3	1	8
Equatorial Guinea	-	11	1	2	6	-	-	1	11
Kenya	95	454	21	125	675	1,262	144	17	48
Lesotho	4	53	-	6	13	14	-	-	1
Liberia	6	15	2	2	-	-	-	-	15
Lybia	-	1	-	-	-	-	-	-	1
Madagascar	26	221	31	29	43	115	34	9	29
Malawi	28	62	1	7	62	69	1	1	35
Mali	7	23	-	1	3	8	4	3	13
Mauritania	-	-	-	-	-	-	-	-	-

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Mauritius	1	-	-	7	11	3	8	4	48
Morocco	1	7	-	2	4	7	-	-	8
Mozambique	20	19	-	8	39	34	4	1	53
Namibia	7	6	1	4	2	-	1	1	11
Niger	-	7	1	-	1	-	-	-	-
Nigeria	287	200	15	46	61	53	607	55	60
Reunion	-	-	-	-	-	-	-	-	-
Rwanda	9	109	1	33	7	-	61	1	11
Sahara, Western	-	-	-	-	-	-	-	-	-
Saint Helena	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	-	3	-	10	7	2	-	-	6
Senegal	2	72	-	1	18	14	1	-	22
Seychelles	-	-	-	2	3	2	2	1	-
Sierra Leone	8	9	1	1	2	-	-	-	2
Somalia	-	-	-	-	-	-	-	-	-
South Africa	2	50	-	52	64	33	15	16	71
South Sudan	14	44	9	13	7	4	7	1	5
Sudan	3	8	1	2	4	3	3	1	1
Tanzania	68	414	7	34	82	248	58	7	7
Togo	11	79	2	3	19	6	3	4	9
Tunisia	-	-	-	1	-	2	-	-	2
Uganda	33	288	1	14	26	3	103	22	98
Zambia	36	72	8	18	17	45	49	21	45
Zimbabwe	31	19	-	7	16	7	-	-	7
Total Africa	**1,418**	**5,307**	**201**	**659**	**1,646**	**2,149**	**1,433**	**249**	**1,192**
North America									
Bermuda	-	-	-	-	-	-	-	-	-
Canada	47	3	-	133	28	25	69	29	83
Greenland	-	-	-	-	-	-	-	-	-
Saint Pierre et Miquelon	-	-	-	-	-	-	-	-	-
United States	551	238	-	1,125	579	790	803	301	3,027
Total North America	**598**	**241**	**-**	**1,258**	**607**	**815**	**872**	**330**	**3,110**

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Central America									
Belize	1	-	-	1	-	1	-	-	1
Costa Rica	-	7	-	11	7	7	37	2	45
El Salvador	6	48	-	22	11	3	8	2	17
Guatemala	15	338	-	34	25	24	30	3	80
Honduras	6	87	-	18	24	30	5	2	43
Mexico	149	1,316	3	315	201	67	1,970	315	2,687
Nicaragua	4	114	-	13	12	3	27	2	8
Panama	-	4	-	5	6	2	2	1	6
Total Central America	**181**	**1,914**	**3**	**419**	**286**	**137**	**2,079**	**327**	**2,887**
Antilles									
Anguilla	-	-	-	-	-	-	-	-	-
Antigua and Barbuda	-	-	-	1	1	-	1	-	-
Aruba	1	-	-	2	1	-	-	-	-
Bahamas	-	-	-	-	1	-	1	-	-
Barbados	-	-	-	-	-	-	-	-	-
Cayman Islands	-	-	-	-	-	-	-	-	-
Cuba	-	2	1	12	-	8	-	3	13
Dominica	-	-	-	-	-	1	-	1	2
Dominican Republic	19	186	1	39	27	34	27	24	588
Grenada	-	-	-	4	-	-	-	-	-
Guadeloupe	-	-	-	-	-	-	-	-	-
Haiti	25	182	2	22	45	10	43	4	6
Jamaica	5	11	-	17	10	-	3	2	5
Martinique	-	-	-	-	-	-	-	-	-
Montserrat	-	-	-	-	-	-	-	-	-
Netherlands Antilles	6	-	-	13	3	1	4	-	-
Puerto Rico	12	11	-	23	12	13	34	15	11
Saint Kitts and Nevis	-	-	-	-	-	-	-	-	-
Saint Lucia	-	-	-	4	1	-	2	-	-
St. Vincent & Grenadines	-	-	-	1	1	-	-	-	2
Trinidad and Tobago	-	1	-	18	12	-	15	24	65
Turks and Caicos Islands	-	-	-	-	-	-	-	-	-

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Virgin Islands (GB)	-	-	-	-	-	-	-	-	-
Virgin Islands (USA)	-	-	-	-	-	-	-	-	5
Total C.A. & Antilles	**68**	**393**	**4**	**156**	**114**	**67**	**130**	**73**	**697**
South America									
Argentina	34	123	1	313	218	331	165	149	1,669
Bolivia	37	64	1	36	40	75	50	11	248
Brazil	278	704	18	690	387	874	623	578	2,825
Chile	12	28	4	85	67	74	44	18	136
Colombia	82	90	5	422	128	382	87	64	553
Ecuador	28	82	2	46	36	33	18	7	269
Falkland Islands	-	-	-	-	-	-	-	-	-
French Guyana	-	-	-	1	-	-	-	-	1
Guyana	1	1	-	10	2	3	-	-	-
Paraguay	2	21	1	25	21	25	22	14	8
Peru	23	223	2	88	108	62	96	30	532
Suriname	1	-	-	3	4	-	-	-	-
Uruguay	-	23	-	19	56	46	11	8	35
Venezuela	17	136	-	71	59	33	92	21	122
Total South America	**515**	**1,495**	**34**	**1,809**	**1,126**	**1,938**	**1,208**	**900**	**6,398**
Total Americas	**1,362**	**4,043**	**41**	**3,642**	**2,133**	**2,957**	**4,289**	**1,630**	**13,092**
Middle East									
Afghanistan	-	-	-	-	1	-	-	-	-
Cyprus	-	-	-	6	-	-	1	1	23
Iran	-	-	-	3	-	-	-	-	-
Iraq	7	6	-	5	1	9	1	1	5
Israel	6	-	-	5	10	-	1	1	9
Jordan	9	1	-	2	3	1	2	-	3
Lebanon	25	140	4	49	44	24	23	10	15
Syria	9	21	3	10	4	2	11	2	15
Turkey	3	2	-	3	-	-	-	-	5
Total Middle East	**59**	**170**	**7**	**83**	**63**	**36**	**39**	**15**	**75**

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
South, East & Far East Asia									
Bahrain	-	-	-	-	-	-	-	-	-
Bangladesh	11	82	6	18	69	34	19	8	110
Bhutan	-	-	-	-	-	-	-	-	-
Brunei Darussalam	-	-	-	1	-	-	-	-	1
Cambodia	4	25	1	3	3	-	1	1	11
China, Mainland	-	-	-	-	-	-	-	-	-
Hong Kong	6	13	-	15	22	15	49	-	90
Macao	-	-	-	10	-	7	1	3	-
Taiwan	11	2	-	99	20	12	9	10	14
India	754	2,017	216	1,195	1,990	1,581	398	288	1,797
Indonesia	103	154	9	54	87	59	27	4	65
Japan	28	10	-	279	120	120	3	23	33
Kazakhstan	-	2	-	2	1	-	2	-	33
Korea, Dem. Rep.	-	-	-	-	-	-	-	-	-
Korea, Republic	42	6	7	566	170	105	88	47	207
Kuwait	-	-	-	-	-	-	-	-	-
Kyrgyzstan	-	-	-	-	-	-	-	-	-
Laos	-	-	-	-	9	3	-	-	1
Malaysia	3	1	-	11	6	7	5	2	29
Maldives	-	-	-	-	-	-	-	-	-
Mongolia	-	1	-	5	16	2	8	-	35
Myanmar	-	43	3	10	230	250	2	37	18
Nepal	-	2	-	4	3	-	1	2	-
Oman	-	-	-	-	-	-	-	-	-
Pakistan	10	18	1	11	24	4	4	2	8
Philippines	73	89	3	90	113	65	129	24	147
Qatar	-	-	-	-	-	-	-	-	-
Russia	-	-	-	2	9	7	17	-	9
Saudi Arabia	-	-	-	-	-	-	-	-	-
Singapore	1	1	-	5	8	3	6	1	7
Sri Lanka	8	3	1	51	86	237	29	5	28
Tajikistan	-	-	-	-	-	-	-	-	-
Thailand	4	6	-	18	55	56	6	6	14
East Timor	1	27	-	1	12	1	3	1	1

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Turkmenistan	-	-	-	-	-	-	-	-	-
United Arab Emirates	-	-	-	-	-	-	1	-	-
Uzbekistan	-	-	-	-	-	-	-	-	-
Vietnam	62	103	15	140	117	369	17	10	31
Yemen	-	-	-	1	-	-	-	-	-
Total South, East & F.E. Asia	**1,121**	**2,605**	**262**	**2,591**	**3,170**	**2,937**	**825**	**475**	**2,689**
Total Asia	**1,180**	**2,775**	**269**	**2,674**	**3,233**	**2,973**	**864**	**490**	**2,764**
Europe									
Albania	8	18	-	14	5	1	4	4	8
Andorra	-	-	-	-	-	-	-	-	1
Armenia	1	20	-	-	3	-	-	-	9
Austria	27	63	-	113	8	456	77	10	363
Azerbaijan	-	-	-	1	-	-	-	-	-
Belarus	-	-	-	1	-	-	1	-	-
Belgium	89	27	8	422	100	92	52	4	95
Bosnia & Herzegovina	-	1	-	9	1	10	3	1	15
Bulgaria	-	2	-	3	4	-	2	-	-
Croatia	4	-	-	25	9	26	16	5	10
Czech Republic	62	51	-	281	62	36	118	63	230
Denmark	-	-	-	-	-	-	-	-	1
Estonia	-	-	-	-	-	-	-	-	-
Faeroe Islands	-	-	-	-	-	-	-	-	-
Finland	-	-	-	-	-	-	-	-	-
France	29	20	-	349	64	5	43	5	263
Georgia	-	11	-	1	-	3	2	-	2
Germany	439	1,477	-	2,927	892	342	2,078	152	5,585
Gibraltar	-	-	-	-	-	-	1	-	-
Great Britain	14	1	-	137	14	24	69	10	67
Greece	1	-	-	5	-	1	-	2	7
Hungary	6	7	-	59	20	9	10	4	82
Iceland	-	-	-	-	-	-	-	-	-
Ireland	22	-	-	38	3	30	54	9	5

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Italy	89	168	1	1,462	379	497	515	213	2,414
Kosovo	10	-	-	-	-	-	-	-	-
Latvia	-	-	-	1	-	-	-	2	1
Liechtenstein	-	-	-	-	-	-	-	-	-
Lithuania	3	-	-	25	24	-	46	4	18
Luxembourg	2	-	-	25	4	-	-	-	-
Macedonia	-	-	-	1	1	-	-	-	-
Malta	-	-	-	9	11	1	8	8	14
Moldova	-	4	-	-	5	-	1	2	-
Monaco	-	-	-	1	-	-	-	-	-
Montenegro	-	-	-	-	-	-	-	-	-
Netherlands	-	-	-	-	-	-	-	-	-
Norway	-	-	-	-	-	-	-	-	5
Poland	58	257	-	170	276	21	1,937	36	1,540
Portugal	44	58	-	962	84	589	126	33	870
Romania	14	33	-	34	20	13	20	6	26
Russia (in Europe)	-	-	-	-	7	6	6	-	9
San Marino	-	-	-	-	-	-	-	-	1
Serbia	-	-	-	3	3	-	-	-	-
Slovakia	7	37	-	69	9	1	16	3	133
Slovenia	-	1	-	15	-	-	11	9	5
Spain	67	55	-	827	186	308	252	129	4,631
Svalbard & Jan Mayen Island	-	-	-	-	-	-	-	-	-
Sweden	-	-	-	2	-	-	-	-	-
Switzerland	2	-	-	22	1	5	6	2	15
Ukraine	16	2	10	18	52	15	30	9	78
Total Europe	**1,014**	**2,313**	**19**	**8,031**	**2,247**	**2,491**	**5,504**	**725**	**16,503**
Oceania									
Australia	79	8	-	389	104	138	151	77	206
Cook Islands	-	-	-	-	-	-	-	-	-
Fiji	1	-	-	1	-	-	2	-	1
Guam	-	1	-	1	1	4	1	1	-
Kiribati	-	-	-	-	-	-	1	2	-

Data for 2019	Classified in this report as healthcare			Classified in this report as social protection					
	Hospitals	Dispensaries	Leproseries	Elderly	Orphanages	Nurseries	Matrimonial	Special Ed.	Other Inst.
Marshall Islands	-	-	-	-	-	-	-	-	1
Micronesia	-	-	-	-	-	-	-	-	1
Marian Islands	-	-	-	-	-	-	-	2	-
Nauru	-	-	-	-	-	-	-	-	-
New Caledonia	-	-	-	1	-	-	-	-	-
New Zealand	7	-	-	17	-	-	17	1	33
Niue	-	-	-	-	-	-	-	-	-
Palau	-	-	-	-	-	-	-	-	-
Papua New Guinea	178	506	2	5	8	11	39	17	30
French Polynesia	-	-	-	3	2	-	2	2	11
Samoa	-	-	-	1	-	-	1	1	2
Samoa, American	1	-	-	1	-	-	1	1	-
Solomon Islands	4	6	-	-	-	-	-	-	3
Tokelau	1	-	-	-	-	-	-	-	-
Tonga	-	-	-	-	-	-	1	-	-
Tuvalu	-	-	-	-	-	-	-	-	-
Vanuatu	-	4	-	3	-	-	2	-	1
Wallis & Futuna Island	-	-	-	1	-	-	-	-	-
Total Oceania	**271**	**525**	**2**	**423**	**115**	**153**	**218**	**104**	**289**
Overall Summary									
Africa	**1,418**	**5,307**	**201**	**659**	**1,646**	**2,149**	**1,433**	**249**	**1,192**
North America	598	241	-	1,258	607	815	872	330	3,110
Central America	181	1,914	3	419	286	137	2,079	327	2,887
Antilles	68	393	4	156	114	67	130	73	697
South America	515	1,495	34	1,809	1,126	1,938	1,208	900	6,398
Americas	**1,362**	**4,043**	**41**	**3,642**	**2,133**	**2,957**	**4,289**	**1,630**	**13,092**
Asia - Middle East	59	170	7	83	63	36	39	15	75
Asia - South, East, Far East	1,121	2,605	262	2,591	3,170	2,937	825	475	2,689
Asia	**1,180**	**2,775**	**269**	**2,674**	**3,233**	**2,973**	**864**	**490**	**2,764**
Europe	**1,014**	**2,313**	**19**	**8,031**	**2,247**	**2,491**	**5,504**	**725**	**16,503**
Oceania	**271**	**525**	**2**	**423**	**115**	**153**	**218**	**104**	**289**
World	**5,245**	**14,963**	**532**	**15,429**	**9,374**	**10,723**	**12,308**	**3,198**	**33,840**

Source: Secretariat of State (2021).

Measuring the Contributions of Catholic and Other Faith-based Organizations to Education, Healthcare, and Social Protection