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HOW DO HOUSEHOLDS CHOOSE BETWEEN HEALTH PROVIDERS? RESULTS FROM QUALITATIVE FIELDWORK IN BURKINA FASO

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This paper provides results from qualitative fieldwork conducted in 2010 in Burkina Faso to understand the factors that lead households to rely on traditional as opposed to modern health providers, and within modern providers, on faith-inspired as opposed to public facilities. While there is an overall preference for modern care, households still rely on traditional healers for specific health issues that they encounter. As to the choice between modern providers, faith-inspired clinics and hospitals are perceived as being characterized by lower costs and higher quality of service than public facilities. Faith-inspired facilities are well regarded in their surrounding communities and patients are willing to travel significant distances to receive care from the facilities. Although these providers vary in size and religious affiliation, they share a similar goal of offering affordable services to the poor and doing so in a way that fosters closer relationships between individuals, communities and the healthcare system. Their approach and services thus helps in expanding options for care, especially for those who for feel marginalized in the public health system.

INTRODUCTION

Significant progress has been made in Burkina Faso in the area of health service provision. The government's 10 year health sector program initiated in 2001 has led to improvements including the construction of health facilities, expanded services including vaccinations, the reduction or elimination of fees for many maternal and children's health services, and the distribution system for essential drugs (World Bank 2009). These actions are likely to have contributed to a better health status of the population. For example, between 2002 and 2008, the rate of assisted childbirth rose from 27 percent to 49 percent, the overall utilization rate for health services increased from 27 percent to 49 percent, and significant gains were made in the areas of vaccination and infant mortality (WHO 2009, USAID 2009).

Yet despite substantial gains, the country still faces many health challenges. There are still high rates of unassisted deliveries and high maternal mortality. Malnutrition rates have apparently increased over the last decade, and the capacities of district health teams

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are seen as insufficient to adequately address pressing health needs. In describing problems on both the demand and supply sides of health services, WHO (2009) states: *"The utilization rate of health services remains low due to the weak quality of care and the persistence of financial and cultural barriers…Current capacities…(do) not permit them to fully implement priority health interventions in order to attain the Millennium Development Goals in health."*

In this context, all efforts that contribute to improving access to health care for the population are crucial, including those of faith-inspired institutions (FIIs). In many countries, FIIs play a significant role in overall health service delivery, often accounting for 30 percent to 40 percent of hospital beds. In the case of Burkina Faso, their role is less imposing in terms of market share. A study by the Ecumenical Pharmaceutical Network (EPN 2005) noted that *"…the church health sector is extremely small…(with only) 44 registered church-related health structures in Burkina Faso in 2003 (only an estimated 2.3 percent of all healthcare structures were run by faith-inspired organizations). The majority of these are thought to be small health posts."* The EPN (2005) also noted the need *"…to develop a cross-denominational overview of the Burkina Faso church health service provision and its role in the supply of health care in Burkina Faso."* Nevertheless, even if small, the role of FIIs is still significant for the communities they serve.

According to WHO (2009), there are currently 272 for-profit private health providers in Burkina Faso and a smaller number of non-profit providers. Of the non-profit institutions, approximately 60 are faith-inspired (a slightly higher number than reported by the EPN study), including 35 Catholic, 18 Protestant and seven Muslim facilities. While the faith-inspired facilities operate in most cases independently from the government, they are integrated within the national health system and receive various forms of support, in material resources (e.g. vaccines, mosquito nets) as well as human resources (e.g. training of personnel and salaries for a limited number of government health workers). They are also subject to quarterly inspections from district health officials. Some faith-inspired facilities are large as is the case for Christian hospitals in the capital city of Ouagadougou. But the majority of facilities tend to be smaller clinics and hospitals often serving rural populations or populations in unincorporated urban areas. These facilities may have the status of a CSPS (*Centre de Santé et de Promotion Sociale*), the first-line health facilities responsible for providing basic outpatient, maternity and pharmacy services, or a medical center with operating capability (CMA, *Centre Médical avec Antenne Chirurgicale*).

The objective of this paper is to assess the factors that lead households to rely on faith-inspired providers in Burkina Faso, and how they see the performance of those providers (see also Wodon, 2013, on the context for the study). The paper is structured in three sections. In section 2, we discuss how households chose between traditional as opposed to modern health providers. The analysis suggests an overall preference for modern care among households, but many still rely on traditional healers for specific health issues. Next, in section 3, we look at how households choose among modern providers between faith-inspired as opposed to public health facilities. The results show that faith-inspired

facilities are perceived as providing higher quality services at a lower cost than public facilities. Finally, in section 4, we discuss briefly how the users of facilities see the issues of proselytism and family planning.

The analysis is based for the most part on qualitative data collected in 2010 in two areas in Burkina Faso (one rural, one urban). A semi-structured questionnaire was used to interview 48 patients in three rural and three urban faith-inspired facilities (eight client interviews in each facility)[2]. Two of the clinics were Catholic, two Protestant, and two Islamic, and the selection of patients for the interview was made to also ensure diversity of faith affiliations. The questions focused on patients' views and motivations concerning healthcare, their evaluation of the faith-inspired health centers and the comparison with their experiences in public centers. Interviews were conducted by a Burkina Faso based research team in French and local languages. Semi-structured interviews were also conducted with clinic leaders, and in addition 24 focus groups were held in both rural and urban areas. Finally, to set the stage, Section 2 also includes a brief analysis of part of the health module of the nationally representative 2007 QUIBB (in French: 'Questionnaire Unifié des Indicateurs de Base du Bien-être') survey.

SEEKING CARE AND CHOOSING BETWEEN MODERN AND TRADITIONAL PROVIDERS

Any discussion of health care provider choices in Burkina Faso must mention the coexistence of multiple care modalities that characterize health seeking in this country as in many other parts of sub-Saharan Africa (Schmid et al 2008, Korling 2005). Traditional medicine remains an important alternative mode of care in Burkina Faso and a pluralistic approach to health prevails, with several different types of care existing side by side, and patients often relying on multiple sources of care. Household decision making in health is shaped by religious and cultural beliefs as well as social and circumstantial factors related to the illness. A particular modality may be used alone or in combination with other approaches. Many of the respondents in our fieldwork described this eclectic approach. For example, one leader in a Catholic clinic stated: *"What one notices more and more is not a rejection of modern care but its association with other types of traditional care."* In order to discuss the decision by individuals and households to seek care and the choice made between modern and traditional providers, we start in this section by providing context through basic statistics about the type of care that patients rely on based on the nationally representative 2007 QUIBB survey. Thereafter, findings from the qualitative fieldwork are presented to better explain what drives patients to rely on modern or traditional care providers.

[2] This is admittedly a small sample size, but we were more interested in in-depth analysis than statistical representativeness. Because assessments of facilities by respondents were converging to a very large extent, we are confident in the findings obtained from the interviews.

Basic statistics from the national QUIBB survey

The health module of the 2007 QUIBB survey asks for each household member whether the person was sick or injured in the last 15 days, and what sort of sickness/injury the person suffered from. Ten types of illnesses and injuries are identified: Fever/malaria; Diarrhea; Accident; Dental problem; Skin problem; Eye problem; Stomach pain; Coughing; Ear/nose/throat problem; and others. It can be shown that fever/malaria is the most common type of illness, affecting close to half of the population, but eye problems appear to be very frequent as well, which is a bit surprising. Other illnesses or injuries frequently reported include stomach pain and coughing. Diarrhea has a smaller incidence among the population as a whole, but it affects small children substantially. The data also suggests that there are few differences in reported incidence of illnesses between urban and rural areas, as well as between quintiles of well-being based on an index of asset wealth, but it must be kept in mind that this is self-reported, and it could be that the threshold to report an incident may be higher for the poor.

What is more important for the purpose of this paper is whether individuals seek care when ill or injured. Table 1 shows the extent to which this is the case. Slightly less than two thirds of those ill or injured (62.4 percent) consulted with a health service provider of any type. Economic status was an important factor in the decision to seek care, since only 53.1 percent of those in the lowest quintile had a consultation, compared to 70.7 percent in the top quintile. Low utilization of health sector services is thus a widespread problem that has received a significant amount of attention in Burkina Faso. For example, De Allegri et al (2010) analyze women's utilization of prenatal and childbirth services after the implementation of policies to reduce user fees for these services. They show improvements in utilization rates but also considerable variability across religion and ethnicity. The authors suggest the need for further research to understand the reasons for continued avoidance of formal healthcare services. They state that the quality of maternal care services *"may shape women's decision to use ANC and to seek skilled attendance at birth... Beyond the equipment and the staff available, important differences in quality of care persist depending on the motivation and attitude of the single providers."* In other research, Mugisha et al (2004) looked at the problem of initiation and retention in the area of formal health services in Burkina Faso. They found that while many commonly cited factors influence initiation of the demand for services (these factors include income level, education, urban residence, etc.), the only predictor of retention is the perceived quality of care. Nikiema et al (2010) examined the low utilization rate of antenatal care in Burkina Faso and found that low quality of care may be the main reason for this problem.[3] As will be discussed in the next section, it is probably because of the perceived quality of care that they provide that faith-inspired facilities are found to be preferred by households when seeking care.

[3] The quality of care concerns discussed by these researchers are similar to those discussed in this paper and include communication issues, time available for consultations, and quality of information provided to patients during consultations, among others (see also work by Korling 2005 on public health services in Niger.)

Table 1: Decision to seek care and place of consultation in last 15 days, 2007 (%)

	Sex		Residence		Well-being – Quintiles					All
	Male	Female	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Decision to seek care										
Whole population	5.9	6.6	9.3	5.6	4.4	5.1	6.1	6.6	9.1	6.2
Population sick/injured	62.9	62.0	65.4	61.4	53.1	56.6	61.2	65.9	70.7	62.4
Type of provider										
Traditional/Marabout	14.8	11.7	4.8	16.1	18.8	21.5	18.0	7.8	6.3	13.1
Private doctor/pharm.	3.5	3.8	11.3	0.9	0.7	1.3	1.6	2.5	8.5	3.6
Nurse, 'sage-femme'	1.7	3.6	4.4	2.2	2.4	0.6	1.7	3.3	4.3	2.7
National hospital	2.7	1.9	6.9	0.6	0.6	0.0	0.6	1.9	5.7	2.3
Regional hospital	3.8	3.6	8.9	1.9	2.5	1.8	3.7	2.9	5.9	3.7
CMA/CM	14.0	15.2	25.6	10.8	10.1	8.9	10.8	18.4	20.1	14.7
CSPS	56.0	56.1	28.2	65.9	63.5	64.1	62.6	59.9	40.9	56.1
Private Cabinet/NGO	3.2	3.6	9.2	1.4	0.9	1.3	0.7	3.3	7.7	3.4
Traditional 'matronne'	0.1	0.2	0.1	0.2	0.0	0.5	0.1	0.0	0.2	0.1
Other	0.2	0.3	0.6	0.1	0.5	0.0	0.1	0.0	0.5	0.2
All	100	100	100	100	100	100	100	100	100	100

Source: Authors' estimates using 2007 QUIBB survey.

While the QUIBB survey questionnaire does not identify separately faith-inspired health care providers, information on the type of facility used for consultation is available. Table 1 shows that 56.1 percent of those who had a consultation in the past 15 days visited a CSPS, 14.7 percent went to a CMA and 13.1 percent visited a traditional healer or marabout. Formal healthcare options are thus more popular than traditional forms of care. We will discuss in much more detail the factors that lead to the choice of care between Western-style medicine and traditional healers in the next section using our qualitative fieldwork data.

What about the satisfaction with the services received? Table 2 suggests that satisfaction with private doctors and pharmacies, as well as nurses and sage-femmes tends to be very high, but is lower with (mostly public) national and regional hospitals, CMAs/CMs, and CPSPs, and indeed also private cabinets and NGOs. The lowest satisfaction rate is that for regional hospitals, at 68.8 percent. Importantly, satisfaction tends to be lower among the poor than among better off individuals. Although in some cases the sample sizes are small, this suggests that there may be issues with the quality of the services provided in many public facilities, both large and small.

Table 2: Satisfaction with the services received for formal providers, 2007 (%)

	Sex		Residence		Well-being - Quintiles					All
	Male	Female	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Private doctor/pharm.	96.1	90.4	91.3	100.0	100.0	84.1	81.7	95.8	94.2	92.9
Nurse, sage-femme	83.7	100.0	98.2	93.3	100.0	100.0	100.0	84.6	98.4	95.3
National hospital	69.9	88.0	78.6	75.0	-	-	100.0	73.6	81.2	77.9
Regional hospital	64.7	72.5	69.4	67.8	58.1	80.3	71.7	69.6	67.6	68.8
CMA/CM	77.3	76.9	78.6	75.8	72.4	73.5	78.1	71.3	82.6	77.1
CSPS	79.9	81.2	72.3	81.9	74.2	84.0	79.2	77.8	86.9	80.6
Private Cabinet/NGO	89.0	75.9	79.9	85.4	22.7	100.0	78.3	83.7	82.8	81.6

Source: Authors' estimates using 2007 QUIBB survey.

To sum up, three main conclusions emerge from this brief analysis of the QUIBB survey. First, cost seems to be an important barrier to care, given that the probability of seeking care when injured is significantly lower among the poor. Second, individuals tend to choose formal providers of care for treatment, although traditional forms of care remain present. Third satisfaction with the main public facilities such as regional hospitals, CMAs and CSPS tends to be lower than with other formal care providers. In what follows, we explore these issues in more detail using results from the qualitative fieldwork conducted in 2010. We start in the rest of this section with the decision to seek care and the choice between formal and traditional providers, and continue in the next section with the comparison of faith-inspired and public facilities.

Results from fieldwork

The plurality of options for care appears clearly in our qualitative fieldwork. The sample may suffer from a slight bias toward formal health care since the study was clinic-based. But even then, the role of traditional providers emerges clearly. When asked about their choice of providers, respondents suggested that formal providers were most popular with all respondents (100 percent) ranking nurses as one of the top three health practitioners they most often consult when ill. But this was then followed by traditional healers/marabouts (52.1 percent), herbalists (37.5 percent) and doctors (35.4 percent). A second question asked respondents to list the type of care that they would pursue if treatment in faith-inspired facilities was not successful. Almost all (95.8 percent) said that they would pursue treatment in a secular clinic/hospital (the vast majority of providers in Burkina Faso) while 68.8 percent said that they would visit a traditional healer. Other common answers were informal drug merchant (39.6 percent), another faith-inspired provider (39.6 percent), herbalist (35.4 percent), and pharmacist (29.2 percent).

What about perceptions of quality or efficacy? When we asked respondents how they would evaluate the efficacy of different types of care, modern care was viewed as the most effective, followed by botanical medicine, traditional healers and spiritual healing practices (table 3). While Western health care approaches are seen as the most effective, the respondents have a high regard for botanical medicine and traditional healers. There was little difference here between urban and rural respondents and urban respondents were only slightly less likely to view traditional healers as very or somewhat effective (66.7 percent compared to 79.2 percent).

Table 3: Perceived effectiveness of different healthcare approaches (%)

	Very effective	Somewhat effective	Neutral	Not very effective	Not at all effective
Modern medicine	85.4	14.6	0	0	0
Botanical medicine	62.5	37.5	0	0	0
Traditional healer	33.3	39.6	20.8	6.3	0
Spiritual healing (e.g. prayer)	35.4	22.9	37.5	4.2	0

Question: What is the degree of efficacy of the following approaches in improving a patients' health?
Source: Authors.

A more notable divergence between urban and rural areas was however found when respondents were asked whose opinion they most trusted – a doctor or a healer. Here, all of the urban respondents said they would be more likely to trust the opinion of a doctor,

compared to slightly more than half of rural respondents. Rural respondents said that they were 'unsure' whose opinion they would be more likely to trust (table 4).

Table 4: Choice of Advice to Follow between Western and Traditional Medicine (%)

	Urban	Rural	Total
Traditional healer	0	4.2	2.1
Doctor	100.0	54.2	77.1
Don't know	0	41.7	20.8
Total	100	100	100

Question: If a doctor and a traditional healer gave you contradictory advice for the same health problem, whose advice would you choose to follow?
Source: Authors.

Table 5 digs a bit deeper in the perceptions about Western and traditional medicine and shows the level of agreement with various statements relating to health care choices. Again, while there is a preference for Western medicine, few respondents see traditional healers as ineffective (only 16.7 percent overall), and over 90 percent state that there are some problems that can only be treated by a healer. Perceptions are similar for urban and rural respondents and for Muslim and Christian respondents as well. Rural respondents were slightly more wary of health problems caused by Western medical treatments and a third (versus 12.5 percent in urban areas) agreed with the statement that modern medicine endangers community health. In addition, about one fifth of respondents had a fatalistic view toward illness, stating that medical advice is not helpful.

In the in-depth interviews, when we asked respondents whether the use of traditional medicine varies by factors such as ethnicity, gender or religion, they emphasized instead a pluralistic approach that is widespread among the population and involves a large degree of consensus and conscious decision making. The following three quotations (by Christian respondents) illustrate this approach: *"Those who consult a traditional healer are not a particular social group. It is everyone – even myself. We go there for those diseases which, through experience, we've learned cannot be treated at the hospital. We know our diseases and for which ones we should go to the hospital. For example, malaria, diarrhea, treatment of wounds, cholera, meningitis, vomiting, coughs, and colds – the hospital can treat all of those"* (patient, Protestant clinic); *"This CSPS has existed for decades… Its utility is known, and its services are useful in saving lives and improving our health. However, it is better to look at health problems on a case-by-case basis. There are those for which modern drugs are effective and those which are best treated by traditional healers. We have come to use all the various services, modern and traditional, because God gave a little of his science to each and, according to the illness, it is necessary to try the different possibilities. We say that someone who is ill doesn't know 'to which saint they should devote themselves' (in French: 'à quel saint se vouer')"* (patient, Protestant clinic); *"For issues concerning health, all types of approaches are accepted in order to resolve the problem. You can see that even on television and radio, they speak about traditional healers. The healers have their own knowledge and their drugs are effective"* (patient, Catholic religion).

Table 5: Perceptions about Western and Traditional Medicine

Respondent category	Totally agree or agree	Neutral	Disagree or totally disagree
	Treatment in this hospital/clinic is better than that of traditional healers		
Urban	87.5	0	12.5
Rural	75.0	6.3	18.8
Christian	80.8	3.9	15.4
Muslim	73.7	10.5	15.8
Total	75.0	6.5	18.8
	Traditional healing has no effect		
Urban	12.5	12.5	75.0
Rural	20.8	4.2	70.8
Christian	26.8	7.7	61.5
Muslim	5.3	10.5	84.2
Total	16.7	8.3	72.9
	There are some health problems that only traditional healers can cure		
Urban	87.5	0	12.5
Rural	95.8	0	4.2
Christian	92.3	0	7.7
Muslim	94.7	0	5.3
Total	91.7	0	8.3
	Modern medicine endangers the health of the community		
Urban	12.5	4.2	83.3
Rural	33.3	4.2	62.5
Christian	26.9	0	73.1
Muslim	21.1	10.5	68.4
Total	22.9	4.2	72.9
	The advice of health professionals cannot help prevent disease because health/illness are not under human control		
Urban	20.8	8.3	70.8
Rural	25.0	4.2	70.8
Christian	26.9	3.9	69.2
Muslim	33.3	0	66.7
Total	22.9	6.3	70.8

Source: Authors.

Certain illnesses were listed by respondents as particularly suited to treatment by healers such as marabouts, diviners (‘*feticheurs’*), and herbalists rather than through Western medicine. These included mental health problems, sexual dysfunction and infertility, skin problems, genital infections, fractures, hernia, hemorrhoids, jaundice, and poisonings. As suggested by Shaikh and Hatcher (2004), health seeking behavior is often complex, and *“traditional beliefs tend to be intertwined with peculiarities of the illness itself and a variety of circumstantial and social factors.”* We found ample evidence of this complexity as respondents described the varied health care choices they make. Several Christian health center administrators also described working with healers in order to streamline care for their patients, in recognition of the significant role of traditional medicine. Most often the collaborators are herbalists or those traditional healers who are well known and respected: *“There are healers with whom we collaborate. They refer patients to us and we also refer patients to them. We complement each other. But as for the healers who perform evil acts of sorcery…we don’t work with them and we advise patients not to consult them”* (administrator, Protestant clinic). *“I believe that they often do good work. Although we are medical professionals, we sometimes also go there to*

consult them. One example is the health issues of the children – diarrhea is not well treated through modern drugs, but with herbal teas and decoctions, they can quickly be cured" (nurse, Muslim clinic).

Although the religious leaders, including Muslim, Christian and Protestant do not promote belief in the healing power of ancestors and spirits, there did not seem to be a lot of controversy around these practices in the centers we visited. The healers have strong support from the communities and have a widely accepted approach to healthcare. Rather than co-opt the idea of 'traditional healing' and define it in biomedical terms as is sometimes the case, health center personnel expressed a tentative acceptance of healers and their practices, though as shown in the first quote above, there are limits to this tolerance. The patients who we interviewed did not make such distinctions between types of healers; the only healers which are avoided are those known to be 'swindlers' with high prices for services. The respondents often distinguish between traditional healers who are 'charlatans' or 'swindlers' and influenced mainly by material gain and 'true healers' who perform their services for free or for small fees. Herbalists are also very popular.

When we asked respondents about Christian and Muslim religious leaders' views concerning traditional healers, as well as about the spiritual nature of religious healers, we were given the following responses that suggest a somewhat harmonious cohabitation with few problems: *"The true healers are religious and believe in God who has given them the power of healing. They are in service for the good of the community"* (patient, Protestant religion). *"Their role is much appreciated. Since long ago, we have owed our health and well-being to them. However, the religious leaders advise us to go only to the good healers because some are only involved in a business activity. Whereas the true healers are like the personnel of this CSPS - they are not running a business, they want just to save lives"* (patient, Muslim religion). *"Most of the religious leaders get along with and appreciate [the traditional healers]. But there are certain religious leaders among the Christians and Moslems who prohibit their followers from visiting them…But overall, the populations visit them without the interference of the religious leaders"* (administrator, Muslim religion). *"Generally the traditional healers are our customary leaders, therefore they are very influential in our village. The religious leaders do not have a problem with this and they often benefit from the care. We are a community, we have our traditions and religion does not divide us"* (patient, Catholic religion). *"Unlike the new wave of swindler-healers, the true healers are very respected in the community. We know their importance, their utility, and the religious leaders are among their patients"* (patient, Catholic religion).

Still, healers treat illnesses in ways that for some in the medical profession are less effective than Western approaches. One example is that of bonesetting, where health center administrators are concerned with potentially harmful infections and express a preference for those healers who 'negotiate' with Western medicine, for example by enabling staff to take and look at x-rays. As one nurse explained it: *"For anything related to a fracture, people do not attend the clinic…. What is better is when the healers go to [the CMA] where they negotiate by having an x-ray. They combine both. When the x-ray*

is made, they will look at it, treat it traditionally, and then come back two months later for a follow-up x-ray" (nurse, Protestant clinic). However, in some cases, the popularity of traditional approaches to health care can be problematic as some individuals simply avoid being treated at health centers - even when they offer high quality and affordable care.

Some of the factors affecting health center attendance more generally in Burkina Faso, such as education, economic status, and distance also matter. Our qualitative research suggests that one group with lower rates of attendance is that of men. Many men explained that the faith-inspired centers are *"for women and children."* The following comment from a male respondents illustrates this attitude: *"The majority of the modern treatments help the women and children. We, the men, have our own practices using traditional medicine – plants. We find it more effective. This is especially true for a farmer. These are essential medicines for him that can reinvigorate him quickly and for a long period. If he becomes accustomed to the tablets and injections, he will be hospitalized all the time, his storehouse will always be empty, and he will meet with famine."* At the same time, other men are aware that such attitudes are problematic: "*It is when the disease forces you to lie down that you start to take precautions…Here we like to say that a true man can't be hospitalized. The man must be able to endure disease and hunger. He must overcome them or die. One likes to say of a man who is morbid that he did not receive anything from his ancestors – he is without protection…He can consult a healer discreetly and follow the treatment without the village being alerted. But as soon as you frequent the health center, everyone knows that so-and-so is sick…[However] the men should be made more aware of this clinic and encouraged to have consultations.*" The reluctance of some men to access services at these health centers is important in the care and prevention of disease for half of the population and may not be evident due to the greater focus on the more well-known barriers affecting women's care. In the case of faith-inspired clinics where more women are now attending, some of the inherent gender biases affecting men's health become more obvious.[4]

Another example of lower attendance at the faith-inspired centers is that of conservative Muslim men and women. Several individuals stated that men belonging to the Wahhabi movement may sometimes prevent their wives from attending Christian health centers, even if they have few other affordable options. One woman attending a Catholic clinic stated: "*Often our husbands do not like us to come to this center if they are Wahhabi. They don't like to see the sisters living like that, without marrying and they think that they will speak to us about their religion…It is said that life came before the religion. If my religious values could provide my care, I would not come to this center, but it is the center which provides relief. I am allowed to pray here. When I'm in the center and it is time for prayer, I make ablutions and pray without a problem. I already explained that to my husband, but there are certain men who still oppose that their wives attend the center although they do not have the means to go to [CMA]."*

[4] For a fuller understanding of the gender boundaries that prevent men from accessing health services, queuing up with women for these services, and accompanying wives on reproductive health visits, see work by Bila and Egrot et al (2009).

Respondents pointed out that some Muslim women are required to be accompanied by their husbands when they visit health facilities (but this depends on the man's willingness to go and availability). There are also problems in regard to prenatal care and childbirth, since many obstetricians and gynecologists are male and there are proscriptions against women receiving this type of care from men. This is illustrated by the following quotes from Muslim women: *"In our area, the CSPS has sent a man to provide maternity services, and after that the center was no longer well attended. We prefer to give birth in the village. Maternity services are the work of women; it is not good for a man to deliver a woman"; "It is mainly the Wahhabi women who cannot remove their clothes except in front of their husband or if they are being consulted by a birth attendant/midwife"; "The problem is mainly at the CMA, because in the maternity wards at the hospitals, we must deal mainly with men. It is not part of our practices for a man who is not your husband to ask you to remove your clothes."* This avoidance of childbirth services did not occur at the faith-inspired health centers we visited, since all have women personnel in maternity wards. But this does not mean that some do not avoid the centers due to religious beliefs and values.

Another issue is the low utilization of certain services. One of our respondents declared, *"Whites cannot treat certain illnesses"* and many held the view that certain Western approaches are inferior to traditional care. We already gave the example of bone setting, but another commonly mentioned example was the treatment for jaundice. Similar issues were reported at the various centers although the particular illnesses varied, depending on local context. Personnel at all of the centers described cases where they felt effective services were avoided. One key issue was the avoidance of vaccines. The following two quotations illustrate two opposing views on this topic: *"There are people who do not believe in the effectiveness of certain drugs. Let us take the case of vaccination…We always have low levels of realization in tetanus vaccinations because there are people who tell women that it will make them sterile. There is a need to sensitize people about the advantages of modern care and especially vaccinations"* (clinic administrator); *"It is the utility of a preventative medication which we don't understand – why it is necessary to search everywhere for someone who is healthy in order to administer a vaccine… But what causes the most controversy is the fact that the preventative care brings illness. That is what happens to our children. When the health workers visit to give them strange medicines, the children start to vomit and to have a fever"* (male patient).

Religious and cultural beliefs about health and disease were often mentioned here, especially regarding the idea that vaccination can weaken natural immunities and make a person more rather than less vulnerable to future illness. Some said that vaccination is also thought to weaken the strength of traditional medicines against disease. There are taboos around vaccination as well. For example, clinic personnel in one village described how their vaccination campaigns had to account for the fact that those women living to the west of the vaccination site would not bring their children for vaccination. These beliefs with linkages to traditional religion are intertwined with rumors about sterilization campaigns surreptitiously carried out through the vaccination of children. One Muslim respondent stated: *"Among Muslims, some like to hide our children so that they do not*

receive their drugs against polio because it is said that the Whites want to decrease our capacity to procreate. By taking these products, one will not be able to make many children." Polio vaccinations were said to be the most controversial, because of the side effects experienced by some children who are vaccinated. However, all vaccination campaigns were seen by health center administrators to be a difficult and time consuming process.

CHOICE BETWEEN PUBLIC AND FAITH-INSPIRED PROVIDERS

In the previous section, we looked at attitudes towards modern and traditional care providers, as well as some of the concerns that remain about Western medicine. In this section, we focus on the choice of modern care provider for those who choose to rely on such services. That is, once households have decided to seek care in formal Western-type facilities, we ask: what are the reasons for using faith-inspired services and the perception of those services as compared to public health care options? Several questions in the qualitative fieldwork aimed at understanding the perceived advantages of faith-inspired health centers at both the individual and community level, and the ways in which faith-inspired care stood apart from care provided by the public sector. We consider first the perceived advantages of faith-inspired providers at the individual level, and next the advantages that the presence of a faith-inspired facility may bring to a community.

Advantages of faith-inspired providers for individuals

Table 6 suggests that the most important advantage of faith-inspired health providers for those who use them is the lower treatment cost (mentioned by 87.5 percent of respondents), followed by the good relationships between personnel and patients (60.4 percent), and the overall quality of care (31.3 percent). Smaller proportions of respondents identified other advantages including the religious affiliation of the center (14.6 percent), the inclusion of spiritual healing practices (12.5 percent), the availability of infant and children's health and nutrition programs (10.4 percent), convenient location (10.4 percent), and the superior skills of personnel (8.3 percent). When asked to make a comparison with public health centers, respondents again focused on cost and quality with 54.2 percent saying that a major difference between the two types of providers is cost, 72.9 percent noting the good relationships with personnel, and 27.1 percent mentioning the overall quality of care. Another 18.8 percent of respondents noted the accountability of personnel in faith-inspired centers, especially regarding fair pricing practices.

Table 6: Advantages of faith-inspired healthcare for the patient (%)

	Faith-inspired healthcare – advantages for individuals	Faith-inspired healthcare – comparison with public sector
Lower costs of treatment	87.5	54.2
Good relationship between personnel and patients	60.4	72.9
Quality of treatment – general	31.3	27.1
Religion – general	14.6	14.6
Religion – spiritual healing	12.5	8.3
Location	10.4	4.2
Infant/child health programs	10.4	6.2
Personnel skilled	8.3	10.4
Accountability	8.3	18.8

Note: Multiple answers allowed. First question: What are the advantages of faith-inspired clinics/hospitals for patients, when compared to public clinics/hospitals? Second question: How would you compare your experience in this clinic/hospital with your experience in public clinics/hospitals in this area?
Source: Authors.

The issue of cost is both very important for the population, and complex to understand because faith-inspired facilities typically benefit less than public facilities from funding from the Ministry of Health. What enables faith-inspired facilities to be low cost must therefore be related to additional funding or support that the facilities receive from other sources. The advantage of being low cost, and what makes this financially sustainable are discussed in a companion paper by the authors (Gemignani and Wodon 2012). In what follows, we focus on the apparently higher quality of services provided by faith-inspired facilities, as compared to public facilities.

In making comparisons with public facilities, respondents referred to both public hospitals (CMA) and clinics (CSPS). Respondents emphasized that while they may have a CSPS closer to their home, they still prefer to travel longer distances to the faith-inspired provider. This was due to both cost and quality, as table 6 attests. Two respondents stated, *"We have a CSPS in [town], but we travel 17 km to come here because we know that we will have better information about our illness and we won't need to pay for expensive medications."*; *"We have a CSPS in [town] but the head nurse is never there since he's always in displacement to the city. When I learned about this religious center, I brought all my family members here because I have the guarantee that we will be well accommodated and our means will enable us to look after ourselves."*

Patients were highly satisfied with the services offered at the faith-inspired health centers. They made heartfelt statements about the care at the centers and the benefits to their well-being. One man visiting a Catholic clinic stated: *"It is said that when you take shelter in the shade of a tree after a long walk under the sun, you realize the utility of the tree and the fact that God sustains you by providing you with such conveniences. It is similar when you are sick and meet somebody who can really care for you. You see them like a savior. For us, this center is an invaluable treasure."* One of the aspects of care most often mentioned and appreciated was the worker-patient relationship. Communication is seen as central to the respondents' views of quality services – being able to understand the health worker and in turn, to be listened to and understood, came up many times. Patients appreciate that staff at faith-inspired facilities do spend the time needed for

patients to be seen and listened to. The style of communication is a large part of this as is the issue of language. Respondents appreciated the fact that personnel in the faith-inspired centers often have at least a working knowledge of the local language, whereas this was sometimes absent from the public health facilities, especially the larger hospitals. *"[At the CMA]…time for the consultation is very short. From the first words, the health worker believes they understand the problem and writes an ordinance. Here, one is welcomed, has time to explain the reason for the visit, and is listened to closely"* (male patient, Catholic clinic).

Communication matters in general in terms of setting the tone in the health center: "*When you attend this health center, what you notice immediately is a certain aspect which reminds you of the village. You see people moving about, entering and leaving, greeting and exchanging news. The director for example when not in his office is always surrounded by people conversing with him. There is really a community life where everyone knows one another"* (male patient, Protestant clinic). But it also matters at a very practical level, for example through the ability of personnel to communicate in local languages: *"These private clinics are closer to the communities and more accessible because they are generally located inside the communities and the personnel are very motivated and friendly…The religious aspect of these private clinics attracts the community and creates trust because people feel great confidence in all that is attached to God and religion. The fact that the personnel are welcoming and speak the local language creates bonds of friendship and fraternity and fosters good communication between the patients and the workers"* (female patient, Muslim clinic).

The fact that the facilities are run at the community level, and that trust exists with the population, is also important, *"Since the time of my first childbirth, I've come here for the weighing and the care of my children. The hospital is very close and I know most of the midwives and nurses who work here. There is familiarity and a good atmosphere…I trust the midwife who is kind and experienced. I believe this woman can help me and can look after me when I suffer from health problems"* (female patient, Muslim clinic). Staffs at faith-inspired facilities are seen as more dedicated, for example in terms of a higher likelihood of actually be present in the facility, even late at night: *"At [CSPS], to which I have easy access, I've noticed a regular absence of the nurses in their stations, in addition to their indifference toward the suffering of a patient, even if it is a child. On the other hand, here… the reception is already proof that the worker who receives you is completely prepared to treat you. Also, the diagnosis is explained simply so that you are able to understand your illness. They explain everything to you, whereas at [CSPS], they can give you an ordinance without saying one word about your illness"* (male patient, Protestant clinic); *"Even late at night, a member of the community has access to this center for care in the event of disease; the personnel are available 24 hours a day. I often have the impression that it is our village which set up the center and those which work there are members of our community. There are no barriers*" (male patient, Catholic clinic).

The literature on faith-inspired services often makes reference to the compassion and holistic nature of the care provided, as well as the respect with which patients are

attended to. In all the centers, respondents emphasized the open, trusting, and respectful environment, at times in contrast with public health facilities. A number of respondents explained the difference by describing how patients may be yelled at or scolded in public clinics and hospitals. The frequency and severity of these reprimands were seen as offensive and in stark contrast to the more patient-centered environment of faith-inspired care. *"There is compassion and pity for patients, especially for those patients who have no resources to pay for this care. Medicine is provided, but also counseling about the illness. This allows us to sleep better at night, because we feel reassured."* (male patient, Protestant clinic); *"I have attended this center for more than 30 years and I have never heard of a case of death related to the negligence of the personnel. I have never seen a worker at this center shouting at a patient. Even if the worker is tired, they make themselves available to the patient. All of those who work here are notable for their singular desire to serve, help, and relieve the patients"* (male patient, Protestant clinic); *"When you are received, you are listened to closely, informed about your illness, and advised about your treatment, and you remember this person who consulted you, her seriousness and interest for the work that she does and the effect of her actions on the recipient. One feels in this sister the will to overcome illness when it is found in the body of another... Human warmth is very present in this center. There is a true closeness between the patients and the sister and her colleagues. One is spoken to, touched and accepted. This human warmth does not exist at [CMA], only distance and rejection…"* (male patient, Catholic patient); "*In the sisters' center, one is accommodated well and treated respectfully…A patient has the opportunity to converse with the health worker, describing the illness, and when s/he is mistaken or does not understand well, s/he is not threatened. The health personnel helps us to locate the pain and explains everything about the disease and how to treat it. When one is timid, they encourage us to speak and they try to give us confidence"* (male patient, Catholic clinic).

Some respondents went further to describe the marginalization of the poor that may take place in some public health centers, and related this to the lack of ability of the poor to pay the costs of care. Recounting prior experiences, respondents felt that those without resources are likely to be neglected in some public institutions and unable to receive quality care. *"Elsewhere, especially at [CMA], I often see the personnel shouting at the patients and ridiculing them"* (male patient, Muslim clinic); *"At the CMA, they do not have patience. Even with adults, they are not obstructed from threatening and shouting"* (female patient, Catholic clinic); *"In [CMA], when someone is not agreement with something they say it openly and often in an excessive way"* (male patient, Catholic clinic); *"I have four children… I had to give birth in a secular CSPS and there I suffered a lot… I have a bad memory of these places not only because of my suffering, but the midwives also shouted at me. Since that experience, I decided to leave that place and I discovered this medical center"* (female patient, Muslim clinic); *"Here the midwife chats with everyone and there is no barrier between the patients and the nurses.... It is not the case in certain secular hospitals such as [CMA], where the personnel are unpleasant and always have a stern expression. The midwives insult and shout at the expectant mother. Even those who need to give birth are abused and insulted. When I was pregnant with my second child, I was insulted by a midwife. That day I waited 3 hours and the midwife didn't want to receive me and, when I entered her office, she told me that she did not*

authorize me to enter and began to insult me. The personnel of these hospitals are not at all welcoming with the patients" (female patient, Muslim clinic); *"When I come here I feel more at ease because the nurses are kind. They are also Muslims and they fear God….Whereas elsewhere, especially in the CSPS, the patients are neglected and sometimes maltreated. If you are poor and have no money you don't count; you are marginalized and scorned"* (female patient, Muslim clinic); *"If you are poor, it is necessary to know someone to be well accommodated and to have a consultation. If not, you are completely ignored. People pass and pass by again. No one is concerned about your problem… For this reason, we thank God all the time for having given us this center, Before this center, one could easily die of a small disease for lack of care since one must have means to receive care at the CMA"* (female patient, Catholic clinic).

For health center administrators, fostering a positive relationship with patients is a priority in the provision of services. For some, like religious sisters, empathy, understanding and consideration is part of their own personal approach that they bring to their position. Others describe learning this approach on the job: *"Compared to my experience in the other CSPS, I can say that here the patient is king because time that one grants to him for the consultation is relatively long…There is a gift of oneself, an availability of the personnel. I will admit that when I came to this center, I was reformed in regard to my level of conscientiousness. The sister always reminds us that we are here to save lives. It is necessary to try our best, because it is not our fault if we fail but it is our fault and it is even a crime if we don't try our best… It is here at this clinic that another kind of training took place in my young career. Instead of just managing a patient's care, it is necessary to show compassion, love, and tenderness. This is 50 percent of the cure"* (male nurse in Catholic clinic). This special relationship and attention may also help to influence in a positive way the health behaviors and choices made by the patients themselves: *"All of the people who work in this center are much appreciated. That is why it why the sisters can influence us; it is because we have respect for them and not fear"* (male patient, Catholic clinic).

Advantages of faith-inspired providers for the community

Respondents were also asked questions as to whether faith-inspired facilities provided any special benefits for their community. As expected, some of the same answers as those observed when looking at benefits for faith-inspired individuals came up again. For example, as shown in table 7 the lower cost of treatment came up first in terms of the gains for the community of having a faith-inspired facility (mentioned by 62 percent of respondents). But other advantages identified for communities were new, such as general improvements in community health due to greater attendance (41.7 percent), improved antenatal and postnatal care (22.9 percent), availability of nutritional programs (22.9 percent) and a stronger attention by faith-inspired health care providers to social and economic issues (20.8 percent).

Table 7: Advantages of faith-inspired healthcare for the wider community (%)

Advantages	Share or respondents citing an advantage
Lower costs of treatment	62.5
Improvements in community health – general	41.7
Improved care for women and infants (antenatal and postnatal care)	22.9
Nutritional programs	22.9
Attention to socioeconomic problems	20.8

Note: Multiple answers allowed. Question: What are the advantages of faith-inspired clinics/hospitals for the local community, when compared to public clinics/hospitals?
Source: Authors.

Although many faith-inspired facilities are small, they offer a broad approach to care, providing not only outpatient services, but also follow-up care, counseling, as well as food and material aid on occasion. Many facilities are involved in community services focusing on preventative care, often working with community members to build support and reach more families in order to inform them about good health practices. At one rural Catholic clinic, these activities were described as follows: *"Today health is not just about looking after patients but also about prevention, in order to reduce the demands on the health system. We have developed advanced mobile strategies which consist in being off-site in the communities discussing health issues such as how to prevent malaria and dehydration, diseases due to lack of hygiene, and identifying children who are slipping toward severe malnutrition"* (administrator, Catholic clinic); Or, as a nurse explained it: *"To my knowledge, this is the first center in our zone to integrate social and medical care. We make home visits to follow up with the patients and to detect social cases. Some of these we refer to Action Sociale [social services]"* (nurse, Catholic clinic).

Faith-inspired services are also viewed as contributing to improvements in community health through increased use of the facilities. Even in the less remote study sites where other health care options are available, the work of the faith-inspired clinics was said to have caused a significant increase in clinic attendance: *"Previously, one was satisfied with [herbal medicine]. If the illness became very serious, that is when people sold their chickens or cereals to mobilize funds for their care. There were many cases of death during the periods of meningitis, cholera, and malaria. But now, since the center came, the health of the poor has improved. Our children receive immunizations because we regularly attend the center and the sisters show us how to take care of our children. And the men are the happiest, since they no longer have to spend money on the health care of their wives and children"* (female patient, Catholic clinic).

In their discussions of community advantages, respondents highlighted the special programs offered at faith-inspired centers for women's and children's health, especially maternity services and child nutrition. Such programs were said to be well-attended and seen as being of great benefit to the community: *"Most of the women in our village who have small children spend the day at the center. In the morning, the sister gives us the ingredients to make porridge, and at midday we prepare rice. We help the sisters with all their work. We sweep the courtyard and the buildings of the center, we wash the uniforms of the personnel, and in the evening we retire to the village. We train our families with the help of the sisters and their colleagues…I can say that among the women who attend*

this health clinic, no one can say today that she doesn't know the utility of breast-feeding until 6 months, or the utility of the mosquito net, or the importance of hygiene. Come to our village. If you visit the household of a woman who attends this clinic, you will see that she prepares her drinking water well, that the meals are prepared safely, there is a well-attached mosquito net, and clean children" (patient at Catholic clinic); *"The real problem for our children is hunger. This is the entryway for disease… We women have noticed that since the sisters began receiving us at the center and giving milk, porridge, and rice to the children, they no longer fall ill. For me, the true vaccine is food"* (patient at Catholic clinic).

In addition to facility-based care provided to women and children, it was common for respondents to mention non-facility based programs addressing issues such as reproductive health, child nutrition, hygiene, HIV/AIDS prevention, malaria prevention, and immunization. Community workshops, home visits, and other off-site activities were found in four of the six facilities visited. Again, women respondents had a very positive view of these efforts: *"I know of villages where the women are trained to help their sisters with their pregnancies. Some are even trained as midwives. They lead small workshops with groups of women to give them advice on their pregnancy, the health of the expectant mother, and the health issues of children. The center trained these women and in return, they help their sisters in the village"* (Protestant clinic); "*Today I know a lot about how to care for myself when I'm expecting, how to take care of a newborn, and which healthy foods a mother should prepare for her children's good physical growth. This is because the nurses explained it to me and I listened well*" (Protestant clinic); "*The sisters have had to work a lot on women's mentalities and we've seen that it's very beneficial, especially as it is a question of being able to give birth without dying or seeing the baby die. Before one would lose a pregnancy and link that to sorcery. But now, thanks to the work of the sisters, the pregnancy takes place without a problem, one gives birth without a problem, and the baby is healthy*" (Catholic clinic); *"The center distributes food provisions for the community during periods of famine, and organizes community education for the women. The sisters show us simple techniques for the care of the children for example how to prepare the pulp of mijola, how to put shea butter in the nostrils of the children during the period of meningitis, how to wet a piece of cloth and cover the child in order to lower a fever, how to use mosquito nets when putting the children to sleep…The benefits of this center for our community are priceless"* (Catholic clinic); *"Today everyone in the village understands that if one wants to keep their health and to be able to have the energy to farm, transport crops, and go to the market, it is necessary to sleep under a mosquito net because malaria kills many people…It is also necessary to be immunized against meningitis and to accommodate those who protect our children against polio. Nobody in our village is opposed. From this, we have our health and longevity. All of that is thanks to the activities of the sisters' health center"* (Catholic clinic).

The work of faith-inspired centers helps to reduce barriers faced by women in accessing care. Not only are costs reduced, but women are also provided with a caring and supportive environment. Special programs aimed at the specific health needs of woman and their young children are emphasized and the efforts are paying off in the large

numbers of women who rely on the centers for treatment and for ongoing guidance on preventative care. Here are two more examples of positive feelings for the services received: "*I saw children returned to life thanks to the center's actions. It was not easy to save them because there was no flesh left on their bones…breathing was difficult. I can say that it is a rebirth for these children. The religious leaders say that it is a resurrection, and it is indeed miraculous to see today these children who walk and play. If it was at the CMA, we would have already mourned them*" (Catholic clinic); *"The maternity services here have restored to women the pleasure of giving life without suffering. There is also a center for child nutrition which has made it possible for some women to keep their children, whereas before these children died of malnutrition."* (Protestant clinic); *"There are no women in our village who give birth without medical help… Now, all the women go to the center to give birth and there are no longer complications and deaths. Also, children who lose weight and become very thin are identified by teams of women from the center and then referred to the center to be nourished"* (Catholic clinic).

Areas of potential concern

The analysis so far suggests a higher level of performance in faith-inspired facilities than in public facilities. This does not mean however that all is well, and that there are no areas for improvement. For example, in terms of the management and capacity of the health centers, several problems were mentioned by respondents, including a lack of personnel and consequent long waiting periods. The percentages of respondents reporting various problems were as follows: long wait for treatment (54.2 percent), insufficient staff (54.2 percent), problems with facilities and equipment (20.8 percent), and lack of certain services (e.g. x-rays, blood transfusions) (31.3 percent). The problem of limited staff seemed especially acute in the Muslim centers where over 90 percent of patients complained about this problem, as compared to about a third in the Protestant and Catholic centers. Still, these problems are likely to be encountered as well in public facilities, even though we do not have data here to make this case.

Another issue is the difficulty for health centers to promote the use of family planning services. This is perhaps less due on the ground to the theological orientation of specific facilities or their affiliation to a specific faith, than to cultural and religious opposition to family planning in much the population, and especially among men (so that the difficulties in promoting family planning are also likely to be encountered in public facilities, but it is nevertheless useful to document them here). Still another issue that is much more specific to faith-inspired centers is the risk of proselytism, and how such activities, to the extent that they take place, are viewed by patients. We briefly discuss both the issue of proselytism and that of family planning in this section.

Proselytism

Is proselytism a major issue at faith-inspired facilities? Religion is to some extent part of the services offered at faith-inspired clinics and hospitals. But for the most part in the facilities surveyed, participation in religious activities is on a voluntary basis, and seen positively: *"Since the center is run by people of faith, prayer is integrated with health care. However, it is not an obligation for the patients to take part in these practices.*

Because of the testimony of certain patients who link the success of their treatment to the pastor's prayers, there are many patients who visit the pastor and this is normal because people are willing to try everything when they are ill. In our birthplace, we are taught that all types of prayer are welcome because 'it is not known in whose mouth will be found the good blessing'" (Muslim respondent, Protestant clinic).

Workers 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 of primary focus and is limited to what one leader describes as the sharing of basic 'small amounts of religious information.' Patients of all religions visit the centers and health services are focused on providing care that will be acceptable to this diverse clientele. For those patients who are interested, the faith-inspired facilities do provide a range of services from religious counseling to spiritual healing practices. As a leader at a Protestant clinic explained it: *"In each center we have a pastor who shares the word of God with groups of patients. The health workers also share their faith with the patients and we pray for the patient. Often times when a patient is cured, s/he will return to visit the pastor. We do not hide our faith from our patients but we do this only with their agreement"* (administrator, Catholic clinic). Patients' views of this approach are mostly positive. As a respondent explained: "*For 50 years I have attended this CSPS… In the time of the first missionaries, evangelization was more common. They spoke to the patient about the Lord and wanting to save his soul…but one was not obliged to accept in order have the care. It doesn't disturb me that somebody speaks to me about his religion as long as the decision rests with me. I understand the evangelization as educating men and women to have love for others"* (Muslim respondent, Protestant clinic).

Within any particular faith-inspired health center, both Muslims and Christian respondents expressed positive views about the quality of the care received. When we asked about their willingness to seek care at a clinic or hospital of a different faith than their own, almost all respondents said that the religious affiliation of the clinic was not a major concern. The decision of where to seek health care was based on issues of cost and quality, rather than religious affiliation. Many respondents also confirmed that the health centers are attended by people of all faiths and that different religious groups are made to feel welcome. As one patient at a Protestant clinic stated, *"It is health which we seek. Religious conflicts are for those who are not in the hospital, those who do not have health problems."* Similar comments were expressed by many others: "*They accommodate us like their brothers and their sisters; they are full of kindness. The center functions like a place of worship and there is no place for spite and bad intentions"* (Muslim respondent, Catholic clinic); "*The center is known and appreciated by everyone. Muslims, animists, everyone speaks about this center and the work of the sisters"* (Catholic respondent, Catholic clinic); "*At the beginning, the Muslim patients avoided this center because they thought that only the Christians were entitled to care, but now there is a great multitude. Everyone comes to be looked after here"* (Catholic respondent, Catholic clinic); *"It is true that I am a Muslim, but when I am ill, or someone in my family is ill, I do everything to get to a clinic, without taking religious affiliation into account"* (Muslim respondent, Protestant clinic); "*When I am sick I don't choose where to go as a function of my religion. I choose to go anywhere where there is healthcare and especially modern*

healthcare…" (Catholic respondent, Protestant clinic); "*I don't even realize there is this aspect of the center [religious affiliation]. Except for the presence of a pastor, nothing suggests that this center is run by Protestants. Even the Imams are authorized to come and pray for patients if they wish"* (Catholic respondent, Protestant clinic).

The question as to whether religion and spirituality should be a part of the care provided at the health centers elicits mixed responses. While 61.5 percent of Christians and 21.4 percent of Muslims were in favor of this, 30.8 percent of Christians and 42.1 percent of Muslims said that they would prefer not to see religion integrated with care (7.7 and 36.8 percent were undecided). In Protestant centers, where more religious activities are offered as part of care being provided, respondents were mostly tolerant but emphasized that participation should be voluntary. For example, one Muslim patient who had a positive experience in the Protestant clinic said that he saw religious proselytizing as a "minor defect" of the care offered: *"I don't approve of having prayer in the rooms of those who are hospitalized. This is a minor defect that can be corrected, because we know that Muslims, Catholics, Protestants, Animists, everyone - can attend the medical centre for a health issue. I notice that the Protestants always have had this propensity to want involve others in their religious family."* Furthermore, even if Muslim respondents had many good things to say about the Christian centers, we were also told that some Muslims with more conservative beliefs or views did not attend the center due to religious differences.

Family planning

A second area where concerns arise as to the ability of health centers to perform a useful function relates to family planning services. All the centers visited were engaged in family planning counseling to some extent. Catholic centers, whose focus on child malnutrition has prompted their attention to family planning, mainly promoted the rhythm method, while others offered broader options (condoms, pills, injections, implants). Some Protestant and Muslim facilities also offered counseling and workshops related to HIV/AIDS prevention and treatment. These programs were said to be controversial from the point of view of the local population however. This was especially a problem in rural areas. In the following quotations, the leaders of the three rural clinics describe the problems they are facing in providing these services: *"We are in a rural environment and birth control messages are difficult to impart. We opened [a nutritional health center] in order to help the mothers of children, not to see their children dying. Just imagine, when an infant should still be nursing, their mother is already carrying another pregnancy. Early weaning plunges the child into a state of acute malnutrition with a high risk of death"* (leader, Catholic clinic); *"Family planning messages are not listened to at all…Men do not use condoms and women are not authorized to adopt contraceptive methods. The problem of malnutrition will persist as long as planning does not become a reality. However, the subject is very delicate because it relates to intimacy among couples"* (leader, Catholic clinic); *"According to the women patients, when they return with the [birth control] pills to the house, their husbands find the pills and throw them away. The women are interested in planning because they are conscious of their sufferings, but it is the men who are opposed"* (leader, Protestant clinic).

The patients who we interviewed discussed in detail the preference for large families. Both Muslims and Catholics also described the substantive ways in which religious beliefs and practices influence opposition to family planning. During interviews and focus group sessions, men of both groups provided similar arguments that planning goes against the will of God and that to practice birth control is to challenge or deny the existence of God. Members of both of groups also described the widespread belief that promoting birth control encourages immoral sexual behavior among youth and in the broader society. Among Muslim respondents there was also strong opposition to family planning discussions initiated from outside of the community. A Muslim religious leader stated: *"One can plan according to the interests of the family. Islam does not prohibit planning if it is decided together and is in the interest of the family. But now if somebody comes from outside and comes to impose it on you, to tell you to stop the births, this is prohibited by Islam."* In sum, the fact that family planning continues to be a very sensitive topic poses difficulties for the faith-based health centers. While the clinic and hospital personnel see it as a crucial step in achieving improved community heath, there are many conflicts with social, cultural and religious realities including men's role as decision-maker, women's opportunities to negotiate power and prestige through childbearing, and perceptions of autonomy and self-determination.

CONCLUSION

The objective of this paper was to answer three questions. First, what are the factors that lead households to rely on traditional as opposed to modern health providers? Second, within modern providers, how do households assess the performance of faith-inspired and public facilities? Third, are there specific areas of concerns with the work of faith-inspired facilities regarding especially proselytism and family planning? The analysis suggests an overall preference for modern care even though households still rely on traditional healers. In addition, faith-inspired facilities are perceived as being of significantly higher quality (especially in the patient-health worker relationship) and cheaper than public facilities. Finally, potential concerns related to proselytism and family planning service appear not to be too serious, in that proselytism is limited, and the opposition to family planning seems much stronger in the population than in the personnel of the facilities, even if various denominations differ in their approach to the issue.

As is often the case with qualitative work, our sample for the analysis presented in this paper was small, and we could suffer from a selection bias in favor of faith-inspired facilities given that we interviewed only patients attending these facilities. Nevertheless, it appears that in the facilities that we visited, cost and cultural barriers to the use of formal health care are being addressed through efforts to create a welcoming and supportive care environment. Ways of speaking to patients, the ability to work within the local cultural context, and attention not just to disease but to a patient's sense of wellbeing all appear to play a central role in shaping what patients ultimately view as higher quality services in faith-inspired facilities than in public facilities. Leaders across the different faith groups described this aspect of their work as a "strength" which they bring to the health care sector and recognized it as something which is valued by the

public, including the poorest members of society, and which draws patients to their services. A user of one of the facilities summarizes well these perceptions: "*I am widowed and it is thanks to this center that my children and I have access to health care. The sisters here accommodate us well. They listen to you closely, and seek to understand your health and social issues…Illness is not something you wish for, but I can say that the illnesses of my children no longer make me worry since their treatment is not a concern. It is written that the Lord never abandons the widow and the orphan. It is the sister who reminded me of this"* (female patient, Catholic clinic).

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