CCIH
Christian Connections for International Health

Contribution of Faith-Based Healthcare Facilities and Organizations to Primary Health Care

Part 1: Global Landscape

Abbreviations & Acronyms

ARHAP	African Religious Health Assets Programme
ASHA	Accredited Social Health Activist
CHAMC	Christian Health Asset Mapping Consortium
CMAI	Christian Medical Association of India
CMC	Christian Medical Commission of the WCC
FBHFO	Faith-based health facilities and organizations
FBO	Faith-based organization
KI	Key Informant
KII	Key Informant Interview
LMIC	Low and middle-income countries
MCH	Maternal and Child Health
NCD	Non-communicable disease
NGO	Non-governmental organization
PHC	Primary health care
PPP	Public-private partnership
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WCC	World Council of Churches
WHO	World Health Organization

Acknowledgements

CCIH acknowledges the US Agency for International Development's MOMENTUM Country and Global Leadership project for their early support and guidance of this effort. In particular, we thank Chantelle Allen from Jhpiego for her guidance and partnership.

Citation

Ruark, A., Fountain, D., & Bormet, M. (2025). Contribution of Faith-Based Healthcare Facilities and Organizations to Primary Health Care, Part 1: Global Landscape. Christian Connections for International Health.

Executive Summary

Primary health care (PHC) is "a comprehensive approach to health that combines multi-sectoral policy and action, community empowerment, and integrated health services," [1] a definition that originated in a historic collaboration between faith-based health facilities and organizations (FBHFOs) and the WHO. FBHFOs have historically provided community- and facility-based PHC services in coordination with governments and other actors. In an era of Universal Health Coverage (UHC), there is a greater need than ever for data about the scope and location of FBHFOs so that they can be included in planning and resource allocations.

This study explored two learning questions to address gaps in existing knowledge:

1. In what ways are FBHFOs contributing to a resilient PHC system?
2. How can we improve inclusive planning and coordination with FBHFOs toward national goals of improved access to timely, high-quality PHC services?

This is the first of two reports on the global landscape of FBHFO contribution to PHC; a companion report provides an intensive case study of Uganda. A review of available research and data and interviews with key informants yielded the following key findings:

1. FBHFOs helped establish the global commitment to PHC.

FBHFOs were instrumental in the WHO's adoption of PHC as a priority in the 1970s and brought innovative community-based projects to the WHO's attention. This process culminated in the International Conference on Primary Health Care in 1978 at Alma-Ata and the Declaration on Primary Health Care. FBHFOs continue to be at the forefront of innovations in PHC globally through care group models, HIV care, and quality healthcare worker training.

2. FBHFOs historically focused on both facility- and community-based care.

FBHFOs offer a wide breadth of PHC services in health facilities and communities. They are particularly recognized for contributions in HIV and AIDS, maternal and child health (MCH), including family planning, and epidemic response. However, PHC is seen to be shifting to facility-based care, with government partnerships and insurance revenue elevating formal health services over a PHC "philosophy" rooted in affordability, community participation, leveraging of community resources, and multi-sectoral collaboration.

3. FBHFOs have a reputation for quality whole-person care and serving the underserved and geographically remote populations.

FBHFOs bring distinctive values and commitments, starting with a holistic and "people-centered" approach to caring for patients and families, and are characterized by a sense of mission and a dedication to reaching the "last mile." Along with effective treatment, FBHFOs emphasize spiritual and emotional care. In addition, FBHFOs are associated with longer-term commitment to communities than is possible with grant-dependent NGOs, including maintaining services during times of conflict and crisis.

4. FBHFOs provide a substantial proportion of healthcare in many settings, although their integration into national health systems and involvement in policy-making vary.

There are tens of thousands of FBHFOs in low- and middle-income countries (LMICs), but there are important gaps in data about their scope and scale and evidence of miscounting of FBHFOs. Further, there are gaps in understanding regarding public-private partnerships (PPPs) between FBHFOs and governments, including types of PPPs and their mechanisms. In addition, key informants reported that FBHFOs are struggling to receive support from governments, and funding is declining.

5. FBHFOs can be part of UHC systems and help expand or revitalize PHC.

The success of universal health coverage (UHC) depends on a strong PHC system, according to literature and key informants. However, some key informants believe that some features and strengths of PHC have eroded with time, including a strong community-based focus. FBHFOs could help restore a strong and comprehensive vision of PHC, one that draws on the holistic focus and integration of community- and facility-based services.

Recommendations from this global landscape study include:

1. Study the extent of government inclusion of FBHFOs in planning and resource allocation, and carry out more case studies like the Uganda intensive case study (a companion study).
2. Establish a cross-national roll-up of FBHFO data and their inclusion in national planning and resource allocations.
3. Determine the degree to which it is true and desirable that PHC has “narrowed” its focus to facility-based care and assess what is lost in the shift away from strong community-based services. Are FBHFOs prioritizing faith-based care, community-based services, or both?

Introduction

The World Health Organization (WHO) defines Primary Health Care (PHC) as "a comprehensive approach to health that combines multi-sectoral policy and action, community empowerment, and integrated health services."[1] It is a whole-person-centered approach where proactive care—health promotion, disease prevention, diagnosis, and treatment—is equitably delivered by multidisciplinary teams as close as possible to people's everyday environments, reducing morbidity and mortality across the lifespan." [2] PHC has the opportunity to serve as the foundation of global healthcare systems. When optimized, high-quality PHC could meet up to 90% of healthcare needs across the lifespan and has the potential to save 60 million lives in LMICs by 2030.[2]

FBHFOs, whose work is associated with a religion or faith, have historically played a large role in the delivery of PHC in LMICs and areas of high need. FBHFOs often consist of health facilities and community-based non-governmental organizations (NGOs) with a mission rooted in a religious foundation. They may also be associated with a religious institution. Although FBHFOs of all faiths exist in many regions of the world, Christian FBHFOs are particularly well-established and have been comparatively well-studied.

Gaps in knowledge regarding the contribution of the faith sector to PHC may hamper planning and cause assets to be overlooked in renewed strategies to expand PHC. Funders, policymakers, and health system planners need up-to-date qualitative and quantitative insights to ensure the "total" health system is considered when allocating resources. Partners, health system leaders, and researchers need information to track innovation and improve timely access to quality services.

The following key questions were raised to address these issues:

1. In what ways are FBHFOs contributing to a resilient PHC system?

    a. What are the breadth and types of PHC services provided by FBHFOs?
    b. How do FBHFOs support core PHC processes at national and subnational levels?
    c. How do FBHFOs sustain and grow their provision of PHC?

2. How can we improve inclusive planning and coordination with FBHFOs toward national goals of improved access to timely, high-quality PHC services?

    a. How (if at all) are FBHFOs' efforts connected to the public ministries of health?
    b. Imagine a future where faith-based PHC is engaged fully in national goals and strategies. What would have to change to get us to that point?

To answer these questions, the following sections summarize available data, results from a literature review, and information from key informants interviewed as part of this project.

Data on the Contribution of FBHFOs to PHC

Estimates vary regarding the proportion of health services delivered by FBHFOs, and almost no quantitative statistics exist on the specific contribution of FBHFOs to PHC. Studies from over 10 years ago estimated that faith-based health care accounts for anywhere from 20 to 70 percent of total health care globally. These statistics do not differentiate by region, population, or type of service. The 2008 WHO-commissioned African Religious Health Assets Programme (ARHAP) report estimated that FBHFOs provided approximately 40% of health services in some African countries and noted that the WHO's Health Mapping Program systematically overlooked FBHFOs.[3]

A recent analysis of over 98,000 health facilities in the WHO's Sub-Saharan Africa Health Facility Database identified only 3,680 faith-based organization (FBO)-owned facilities in 22 of the 50 African countries surveyed.[4,5]

However, data make it appear that there are none in 28 countries, including Uganda, Cameroon, and Liberia, where FBO-owned health facilities are widely known. This may result from how data are coded (e.g., as private non-profit or public if they receive any government funding). Networks of FBHFOs make it easier to describe the faith-based landscape. Another recent analysis surveyed Christian health networks and found that 22 networks coordinate 7,934 health facilities across only 17 countries in Sub-Saharan Africa (Table 1).[5] Of those, 20% are hospitals that could be assumed to offer outpatient PHC services, and the other 80% are outpatient or community-based services. While 156 community-based programs were identified, that represents only a fraction of the total investment by governments and private actors in community-based services.

Table 1: Analysis of Counts of Christian-owned Health Facilities in Sub-Saharan Africa[5]

	Total	National Hospitals	District Hospitals	Health Centers	Dispensaries, Clinics, Health Posts	Community-Based Programs
Burkina Faso	**82**	5	20	31	19	7
Cameroon	**393**	1	277	34	52	15
Chad	**132**	0	7	124	0	0
DR Congo	**3187**	258	201	2103	454	0
Ghana	**374**	13	94	83	161	2
Guinea	**47**	0	3	8	20	16
Kenya	**998**	13	95	174	618	73
Lesotho	**53**	0	8	41	0	0
Liberia	**85**	7	7	11	55	2
Malawi	**198**	0	49	111	27	0
Nigeria	**690**	15	194	206	225	4
Rwanda	**153**	0	17	136	0	0
Sierra Leone	**53**	0	12	34	1	6
Tanzania	**968**	12	91	102	696	0
Uganda	**626**	21	41	323	207	0
Zambia	**142**	16	18	77	0	31
Zimbabwe	**174**	15	78	57	0	0
Total	**7934**	**376**	**1212**	**3655**	**2535**	**156**

PPPs between governments and private actors such as FBHFOs have existed for decades. Still, a recent review provided limited data about these vehicles, which governments use to meet population health needs.[6] PPPs generally involve exchanges between governments and private actors for funding, access to medicines, access to facilities, project implementation, and staffing, among other things.

More information is needed on the scope and scale of these PPPs, such as by focusing on:

- *mechanisms of partnerships* (e.g., training, funding, procurement, staffing, designation of facilities, inclusion in planning); and
- *scope of services* (e.g., geographic, populations, conditions of interest, and specialized services).

Finally, national-level estimates are needed, but often are not made publicly available. An intensive case study of Uganda carried out under a related activity explored the data, and the results are presented in a separate report.

Uganda Protestant Medical Bureau

Literature Review

Approach

The USAID MOMENTUM Knowledge Accelerator's MAKLab (run by Ariadne Labs) initiative identified and reviewed peer-reviewed literature for primary studies, actions, or reviews on the role or impact of FBHFOs in PHC and service delivery. They focused on articles published in 2015 or later and based on LMIC. They included 27 articles; the full review is available in Appendix 1, and key findings are summarized below. The study team also identified additional "gray literature" to provide context for changes facing PHC.

The literature review conducted by MAKLab generated three conclusions.

- FBOs contributed to establishing the WHO's Primary Health Care program.
- FBHFOs offer a breadth of services with documentation and research on their impact, primarily in the areas of HIV and AIDS, MCH, and family planning, and epidemic response.
- FBOs support core PHC processes at national and subnational levels.

Results from Literature Review

1. FBHFO's Historic Role in PHC

FBHFOs have historically had strong engagement in health service delivery across LMICs. Their relationship and collaboration with the WHO became central to establishing global PHC delivery and quality standards.

The Christian Medical Commission (CMC), established in 1968 under the World Council of Churches (WCC), concluded that church-related medical programs were overwhelmingly focused on curative services offered through hospitals and had limited impact on meeting basic population health needs and called for lay people and those with medical training to engage in the work of "healing."[7] The CMC called for church-funded services to move beyond curative services to prioritize prevention, for equity in the distribution of healthcare resources, and for "comprehensive health care," meaning a "planned effort" to meet as many healthcare needs as possible.[8]

In the early 1970s, the WHO began to acknowledge the importance of community involvement in meeting basic health needs worldwide.[8] The CMC helped bring to the attention of the WHO innovative community-based projects focused on primary healthcare, such as the Comprehensive Rural Development Program in Jamkhed, India. Together with the CMC, the WHO reoriented from prioritizing "top-down" national health systems to emphasizing "bottom-up" approaches based on community involvement, culminating in the formation of the WHO's Primary Health Care program area in 1975 and the Alma-Ata Declaration on Primary Health Care in 1978.[9] This Declaration called for a global commitment to strengthening PHC.

In the ensuing years, momentum waned. Communication between the WHO, WCC, and CMC diminished. It was reinvigorated in the 1980s with the HIV and AIDS pandemic[10] when the WHO encouraged a multi-sectoral approach, including leveraging FBHFOs to deliver person-centered, community-oriented approaches to care delivery and population outreach.[11]

Despite the WHO's encouragement, collaboration between FBHFOs, national governments, and non-government partners remains variable. The contribution of FBHFOs remains poorly defined. The degree to which PHC should be located in health facilities or communities remains a debate. Sacks and colleagues acknowledge the necessity of integrating community-based and facility-based services but argue that much of PHC takes place outside health facilities and that community involvement should be the "cornerstone" of integrated PHC.[12]

FBHFOs also historically reach isolated and vulnerable populations (e.g., reaching the "last mile"), making them effective in improving healthcare access as part of modern approaches to expanding PHC through UHC systems.[13]

Christian Health Association of Malawi (CHAM)
Malaria Surveillance

2. FBHFOs Provide a Breadth of PHC Services

In facilities and communities, FBHFOs provide a wide breadth of PHC services.

Basic Services	FBHFOs provide basic PHC services. For example, the Salvation Army in East Africa provides basic disease treatment, disease surveillance, immunizations, health promotion and education, and community health interventions, including livelihood and savings programs.[14]
NCD Services	FBHFOs also support non-communicable disease (NCD) prevention and mitigation. For example, church leaders in Ghana agreed that FBHFOs should promote health education for the prevention of cardiovascular disease, and a majority of the FBHFOs analyzed were already providing various health screenings, including blood pressure monitoring, to congregants and community members.[15]
HIV and AIDS	FBHFOs helped co-develop the WHO's HIV and AIDS care strategies, including engaging local religious institutions, developing community support groups, providing counseling and social networking, supporting supply logistics, engaging with regional health organizations, and collaborating with international faith agencies.[11] FBHFOs help access hard-to-reach populations, are highly motivated to provide care as a result of their faith, are deeply integrated into local community cultures and well-trusted, and can improve the self-efficacy of patients receiving treatment.[7] In 2008, one in five organizations providing community-based HIV treatment in Sub-Saharan Africa were FBHFOs.[4] They provided health education and destigmatized HIV and AIDS through the utilization of places of worship, school engagements, and community gatherings. However, there is less evidence of FBHFOs' engagement in HIV prevention with sex workers and men who have sex with men.[7,11]
MCH and Family Planning	FBHFOs are well-perceived by their communities, although often underfunded to deliver "state-of-the-art" care.[16] FBHFOs provide healthcare worker training, health education, immunization, antenatal care, HIV testing, and PHC services.[13,17] In addition, some interventions have effectively engaged faith leaders to increase family planning uptake.[18]
Epidemic Response	FBHFOs respond to epidemic outbreaks such as Ebola and COVID-19.[19,20] In responding to Ebola, some FBHFOs provided streamlined and community-trusted health communications, which helped mitigate community fears; others further ignited fear.[19,21] In the face of the COVID-19 pandemic, FBHFOs were recognized as playing a role in alleviating vaccine concerns and increasing uptake, particularly among marginalized communities.[20] In Indonesia, Muslim FBHFOs created practical guidelines for worshipers that promoted physical distancing and limited large gatherings while finding alternate mechanisms to engage in religious activities.[22]

3. FBHFOs Support Core PHC Processes at National and Subnational Levels

FBHFOs offer similar services to government counterparts[16] but have often been recognized for distinctives, including:

- a holistic, person-centered approach to care;[13,14,16,18,23]
- a commitment to reaching geographically remote and other vulnerable populations; and
- sustaining services through times of political and economic volatility.

FBHFOs provide a substantial proportion of healthcare in many LMICs; quantitative data were described earlier in this report. Examples of successful collaboration include:

Ghana	FBHFOs receive partial government support for salaries and operations.[24,25]
Tanzania	FBHFOs are integrated into government goals through some hospitals being designated as referral hospitals and receiving funding for operating costs.[26]
India	A 2015 report estimated that 60% of inpatient care was provided by private healthcare facilities (including FBHFOs), and Christian healthcare institutions numbered more than 4,000.[10] Christian medical colleges also support India's healthcare system, serving in disproportionately rural and hard-to-reach areas as well as providing cutting-edge research and innovation.[10] Hospitals also provide community-based PHC, with one venerable hospital (Christian Medical College Vellore) providing community health programs to 150,000 people annually.[27]
Bangladesh	An Islamic bank established in the 1980s has established medical centers, dispensaries, and eleven hospitals with a mandate of serving the poor and marginalized. The bank also invests in health through community-based initiatives such as building latrines and training midwives.[28]

In some countries, successful government-FBHFO relationships have been reciprocal and include FBHFO support of health sector goals while the government provides financial support and compensation.[29] However, relationships can be strained if human management and financial systems do not work well together because of delayed payment or a lack of staff.[29] Other barriers to FBHFO and government collaboration include the fact that FBHFOs are sometimes not centrally organized or that FBHFOs and governments do not always partner well.[30]

Key Informant Interviews

Approach

Key informants were selected to provide qualitative insight into the study questions. In total, 11 key informants (KIs) participated in 10 separate interviews. KIs were purposely sampled from global experts with knowledge of FBHFOs and primary health care, with consideration to sampling KIs with expertise in various regions and LMICs, as well as professional experience in diverse settings and institutions. The KIs were:

- evenly divided by gender (five women, six men) and geography (five from the United States or Europe, six from LMICs);
- mostly medical doctors;
- experienced in sub-Saharan Africa, India/Southeast Asia, and Latin America;
- experienced with NGOs or FBHFOs, including several representing associations of Christian or Muslim hospitals and health facilities;
- experienced with universities and with multilateral institutions;
- experienced with Christian, Muslim, and Jewish FBHFOs.

KIs were invited through email to participate in Key Informant Interviews (KIIs), which were held virtually over Skype and lasted approximately an hour. The interviewer obtained consent from the KI before the interview using a verbal consent script. KIIs were semi-structured interviews conducted in English, audio recorded, and transcribed verbatim. The transcripts were coded thematically, using NVivo 11, according to a list of *a priori* themes and themes that emerged in this data.

Results of the Key Informant Interviews

Key informants discussed many of the same themes that emerged in the literature review, including FBHFOs:

- instrumental role in WHO's articulation and adoption of PHC in the 1970s;
- commitment to reaching remote and marginalized populations and
- variable and sometimes less than satisfactory integration into national health systems.

KIs highlighted two additional issues:

- Differing and unresolved views about the appropriate placement of PHC in facilities or communities.
- Concerns about integrating FBHFO services into payment structures generally and in national health insurance systems (or UHC) specifically.

Specific results are presented on the following page.

1. FBHFOs have a long history of pioneering innovation in health care, including PHC, and continue to have an outsized impact on training and innovation in many contexts.

KIs noted that Christians and Christian institutions were instrumental in shaping PHC starting in the 1970s. FBHFOs continue to contribute to PHC health systems through pioneering innovations, which are then adopted more broadly. They described Christian organizations as particularly instrumental in defining and championing PHC in the years before the Alma-Ata declaration in 1978. KIs also noted that the CMC of the WCC initially proposed the definition of PHC adopted by the WHO.

One KI asserted that FBHFOs tend to "attract very competent, dedicated people who have new ideas about how to do things," and multiple KIs gave examples. These include:

Community Health Workers in India	The Comprehensive Rural Development Program in Jamkhed, a primary healthcare program in southern India, was started by Christians, but it is not explicitly faith-based. According to a KI, Jamkhed served as an important model for the Indian government as it established the largest cadre of community health workers in the world, the Accredited Social Health Activists (ASHAs).
Care Group Model	The Care Group model of community health promotion in Africa started in FBHFOs.
Community Health Insurance in Ghana	The Christian Health Association of Ghana pioneered health insurance in the early 2000s, and this model was later adopted by the government, resulting in a national health insurance program that currently covers 90% of the population.
HIV and AIDS Care	Multiple KIs mentioned that FBHFOs were among the first to engage in care for people living with HIV.
Neglected Areas of Healthcare	FBHFOs continue to lead innovation in areas such as mental health, palliative care, and geriatric care.

FBHFOs are also known for providing training to healthcare workers in many countries. In India, where only 2% of the population is Christian, FBHFOs train a much higher proportion of clinicians and allied professionals, such as lab technicians, counselors, and chaplains. In various parts of the country, state governments have contracted Christian FBHFOs to carry out training. For example, the state government of Bihar, India, contracted with the Christian Health Association of India to train all the staff of primary healthcare centers. Another KI mentioned initiatives in Africa in which Christian Health Associations were involved in joint training with Ministries of Health.

2. PHC is now most often characterized as offered by health facilities; FBHFOs run hospitals, and many of these also engage in PHC.

All KIs were aware of the definition of PHC but generally asserted that PHC is primarily offered through health facilities and that community-based PHC is often secondary. PHC was sometimes used interchangeably with primary care delivered within health facilities, conflating the concepts of PHC with facility-based care.

For example, the place of PHC in India's FBHFOs reflects that FBHFOs tend to be hospitals, not lower-level centers. One KI shared from unpublished data that, in a 2016 study of 276 hospitals in the Christian Medical Association of India (CMAI), approximately 40% of facilities were involved in PHC, 60% had outreach activities to the community, and 70% had maternal and child health programs. The Indian government has established a tiered system of health facilities and community health workers (ASHAs) that aims to make primary health care accessible to the entire population. Still, CMAI only includes hospitals, not lower-level facilities. Community-based PHC activities in India include community-based health education and disease screening, which might involve "outreach camps" to detect disease cases and bring them to the hospital for treatment.

Definitions of community and primary health care vary across countries and contexts. In Uganda, for example, the first level of health care is the community health worker, and the second level is the lowest-level health facility. In other countries, the first level of care is the lowest-level health facility. Alternatively, PHC could be defined according to the type of service, regardless of where the service was delivered. Thus, core primary health care services such as health promotion and immunizations can be carried out at higher-level health facilities.

PHC represents more than just service types and locations. Some KIs believe that PHC should be rooted in community-based work, not in health facilities. One KI concluded PHC was often erroneously defined as primary care (i.e., the lowest level of care offered within health facilities). In contrast, PHC is a philosophy that emphasizes affordability, community participation, leveraging of community resources, and multi-sectoral collaboration, which involves far more than just the healthcare system. In other contexts, community is foundational to PHC. One KI commented that Bolivia has adopted a model of community health volunteers carrying out home visits and education through care groups, and that doctors and nurses make home visits when necessary.

FBHFOs may be a vital part of PHC in fragile health contexts. One KI noted that when government health systems are largely non-functional, private-sector facilities (including FBHFOs) could lean on outside funding to remain open. FBHFOs often receive funds from private outside donors (such as churches) in response to disasters and are established in more accessible areas of the country. Sometimes, even those services are abandoned when "the money runs out, or it doesn't work, or it's too hard."

KIs did not see a strong connection between PHC and congregational-level health promotion and care advocated by some faith-based or religious organizations. One KI stated, “In Africa, many church hospitals prioritize curative services rather than prevention and community engagement and don’t have linkages with congregations; therefore, more churches need to become involved in health promotion and community work.” KIs did mention how India’s government has worked with religious leaders and FBHFOs to promote polio vaccination. This partnership added a “lot of momentum” to engaging with FBHFOs in India, but at least one KI felt the government does not universally see the value of FBHFO partnerships. Another KI described that FBHFOs are typically active in maternal health, but added that their organization also works through faith leaders and community health volunteers. They try to build the capacity of faith leaders to become health advocates “because they are opinion shapers.”

3. FBHFOs are differentiated by providing quality whole-person care and in their commitment to serving underserved and geographically remote populations.

FBHFOs are perceived to bring distinctive values and commitments, starting with a holistic and “people-centered” approach to caring for patients and families. FBHFOs are characterized by a sense of mission and a dedication to reaching the “last mile.” Historically, Christian hospitals were often established in remote regions. To this day, health providers at these institutions may personally share a similar commitment to working in difficult or remote contexts. One KI differentiated between infrastructure and services, meaning that government facilities might exist but lack staff and medicine, creating a gap that FBHFOs could attempt to fill. Holistic health care encompasses not only effective treatment but also spiritual and emotional care when curative care is not possible. Key informants identified several ways in which this happens.

- Religious chaplains provide holistic care to patients and families at the end of life.
- FBHFOs support holistic needs, e.g., providing access to clean water and vocational training.
- Longer time horizons than project-dependent NGOs allow FBHFOs to make long-term investments in social determinants of health.
- FBHFOs promote “harmony” among people, with God and society, and through economics, politics, and care for the environment.

In addition, FBHFOs are known for maintaining activities during conflict and crisis when other private institutions close their doors. This was seen during the COVID-19 pandemic.

- In India, while private for-profit sector providers shut down, FBHFOs remained “standing strong and tall with the government.” The government utilized FBHFO staff and hospital wards, including those at government hospitals.
- Around the world, many houses of worship were repurposed during the COVID-19 pandemic to serve as feeding centers for healthcare workers, vaccination sites, or treatment or isolation centers.
- Faith leaders “came to see their place in health” due to COVID-19 in Africa when their churches were shut down.
- Post-pandemic, one KI’s organization encouraged faith leaders to promote disease screening, using the Bible or Qur’an as a resource.

4. FBHFOs are sometimes seen as indistinct from other NGOs or healthcare providers in the private sector.

Religion and faith-based organizations should be seen as a "complex system operating in politics, the private sector, and the health sector," as one KI articulated. However, there is a fear that some leaders or funders view faith and religion as problematic and think they should be minimized or "hidden under civil society" and engaged only as a "last resort." Sometimes, faith actors are grouped with private for-profit actors, who seem to respond to motives outside the government's goals. In addition, stereotypes may be shaped by interactions with a few actors who do not represent the entirety of faith-based views and may interfere with collaboration and planning.

Some governments are more comfortable than others with partners having a "faith-based" identity.

- In India, FBHFOs are classified as non-governmental organizations that both serve and employ (in most positions) people of all faiths, but typically do not present themselves as faith-based except to donors who understand the meaning of this designation.
- In Indonesia, a large network of Muslim health facilities is well integrated into the government health care system (including reimbursements through government insurance), but also operates according to Islamic values such as serving halal food, offering prayers and reading from the Qur'an, and the separation of women and men.

5. FBHFOs provide a large proportion of healthcare in many but not all settings, and the level of integration into national health systems and involvement in policy-making varies.

In India, Christian hospitals are second only to the government in the number of hospital beds provided.

- Christian hospitals partner with government programs on a grant or reimbursement basis, although reimbursement levels could in some cases be seen as insufficient for the amount of work expected.
- Many Christian hospitals are also invited to participate in policy-making bodies at the state or district level in India.
- FBHFO engagement with the government varied from state to state, with states having different policies and priorities. There is a desire to see regular forums for FBHFO and government interaction across states, including advocacy to inform government entities of the scope of FBHFOs in terms of population served, services provided, and overall contribution to the "wellness index of the state."
- FBHFOs could benefit from government help to mitigate the challenges they face. They could also help support the government's goal of UHC by "providing access to healthcare [where] the government systems are not functioning well." At a national level, Christian hospitals have successfully advocated for higher reimbursement rates for facilities under the new government insurance scheme.

In Africa, a KI noted that Ministries of Health are often "overwhelmed and do not have resources to offer, so do not work with FBHFOs or include them in the accounting of health care within the country." Still, governments are willing to engage with FBHFOs even if they do not have resources to offer. They are also receptive to FBHFOs having "a seat at the table" through participating in technical working groups and advocacy, and reporting data in ways that are integrated into national systems. FBHFO staff were described as also "thinly spread" and often lacking time to engage in policy and advocacy, and consistently make the case to governments for their work.

6. FBHFOs engage with PHC within a global context of increasing momentum for UHC, but PHC is perceived as de-prioritized.

Multiple KIs referenced PHC's origins in the Alma-Ata conference of 1978, but believe that its strong community focus had narrowed or been lost in the decades since. One KI felt that a policy of "selective" primary health care, adopted by UNICEF, World Bank, and other major donors beginning in 1980, had discouraged countries from implementing more comprehensive PHC and "derailed" PHC. One KI shared that there is a common perception that donors care about a person's health "only if he or she had an infectious disease, was under 5 years, or could have a baby." KIs noted that global donors' emphasis on vertical programming for specific diseases and relatively short 3- to 5-year funding cycles had attenuated investment in PHC programs. Such criticisms suggest that current programs are not fully aligned with the origins of PHC.

KIs in India reflected how their personal medical training 20 years ago focused on community work. One stated this was "during the golden years of the Millennium Development Goals" and that, more recently, this focus has "slipped." Today, the advent of UHC as the predominant way to expand PHC emphasizes paying for services in facilities, not communities.

Notably, only three KIs explicitly mentioned UHC. All three acknowledged that robust PHC was fundamental to achieving UHC, but none seemed optimistic that PHC was receiving adequate investment in the movement towards UHC. One KI stated that FBHFOs needed to be more proactive in supporting UHC through communicating with governments, "This is where we [FBHFOs] are present, and this is how we can contribute to… providing access to healthcare wherever government systems are not functioning well." Another KI commented, in the context of achieving UHC, that "our investment in primary healthcare needs to be much more."

A KI called for community health volunteers to be included in paid positions within African health systems to address the "failure of the primary health care system." This KI concluded, "There's still a lot of discussion of primary health care in the conference rooms, and there's very little on the policy side." Another KI similarly noted "lip service" and "grand talk about PHC," but little evidence of renewed investment in PHC or precise evaluation of what had gone wrong in implementing PHC after the Alma-Ata declaration.

Another critical assessment was offered by a KI who observed that there is often high-level political support for hospitals, which are seen as prestigious and provide jobs to doctors and nurses who wield power in health systems. Less support is given to programs to provide services such as clean water, nutrition, and housing to the poor. Further, funding many community health workers, even at small salaries, is a significant expense for governments, which are reluctant to make this investment despite evidence that it would pay large dividends in increasing the population's health.

7. FBHFOs access funding from various sources, including international churches and FBHFO networks and national and sub-national governments, but this funding can be fragile.

The share of FBHFO-provided healthcare that governments fund varies considerably across country contexts, and faith-based facilities also fund services through user fees and donations from local and international partners. The degree to which FBHFOs relied on donations in the past versus what they expected in the future is poorly understood. In India, Christian hospitals are primarily funded by patient fees and secondarily by foreign agencies or other donors, with the smallest amount coming from the government through specific partnership agreements. The Indian government has also initiated an insurance scheme that reimburses private health facilities for services, but only if the service is not provided through government facilities. Delayed payment of these reimbursements has caused problems for some hospitals that do not have sufficient financial reserves. In addition, Christian hospitals' reliance on patient fees strongly incentivizes them to focus on curative care for paying patients rather than outreach and community-based PHC work, which does not provide revenue. In the words of one KI, resources are not being used in a "rationally effective way to achieve the most impact." In Indonesia, patients can use government health insurance at an extensive network of Muslim health facilities, including the lowest level of health facilities responsible for PHC, thus significantly removing financial barriers to this care.

One KI mentioned recently observing three faith-based health facilities in a West African country that operated with different relationships to the government and funding models. In one case, the government took over a faith-based institution, which subsequently experienced shortages of medical supplies. In another case, the government partially contracted with a facility and provided staff support, medical supplies, and in-kind services; it was "functioning better than the first facility." At a third facility, the government did nothing apart from direct referrals, and the facility developed a reputation for comparatively high quality. This KI concluded that no single entity or institution can meet the healthcare needs of a population and that, in multiple countries, joint ventures between FBHFOs and the government allow faith-based health facilities to function as extensions of the government healthcare system.

Another KI also cited Ghana as an example, noting that health workers in church-owned health facilities had their salaries partially met by the government, making healthcare more affordable and improving the retention of healthcare workers. Governments support at least some healthcare workers' salaries in several other African countries. Some countries have also introduced national health insurance schemes that pay reimbursements to faith-based facilities, although implementation has been challenging. FBHFOs are often hindered in securing grant funding as they don't have dedicated grant writers or business development personnel, as do many international NGOs.

Conclusion & Recommendations

There is no question of the historic and continuing role of FBHFOs in PHC. The findings of this global landscape study are summarized in **Table 2** and include FBHFOs' contributions to holistic care, PHC services for geographically remote and underserved populations, and effective work in MCH, HIV and AIDS, and epidemic response. To confront emerging national and local health priorities, governments need a full and accurate understanding of the *current* comparative strengths of their national health system assets, including private non-profit and faith-based services. Gaps in data on FBHFOs undermine that effort, which could potentially lead to inaccurate conclusions or unbalanced allocations of resources. A renewed effort at PHC must double down on data about the scope and scale of faith-based health services.

This study highlighted key areas where FBHFOs play a vital role in health systems.

Key recommendations from this study include:

1. Study the extent of government inclusion of FBHFOs in planning and resource allocation, and carry out more case studies like the Uganda intensive case study (a companion study).
2. Establish a cross-national roll-up of FBHFO data and their inclusion in national planning and resource allocations.
3. Determine the degree to which it is true and desirable that PHC has "narrowed" its focus on facility-based care and assess what is lost in the shift away from strong community-based services.

Table 2: Summary of Study Questions and Findings

1. In what ways are FBHFOs contributing to a resilient PHC system?	
What are the breadth and types of PHC services provided by FBHFOs?	• FBHFOs played a historic role and helped define PHC as a combination of facility- and community-based care. • FBHFOs demonstrated their commitment to reaching underserved populations and remaining with them beyond project grant cycles. • FBHFOs provide holistic care, extending beyond physical to emotional and spiritual. • FBHFOs have played a particular role in HIV and AIDS, MCH, and epidemic response, and provide basic services in networks reaching thousands of facilities.
How do FBHFOs support core PHC processes at national and subnational levels?	• FBHFOs are often among the few providers serving remote or underserved populations. • Some governments support FBHFOs through forms of PPP, offsetting operating costs in exchange for continuing services.
How do FBHFOs sustain and grow their provision of PHC?	• In many cases, FBHFOs raise their own income from patient fees or private support.
2. How can we improve inclusive planning and coordination with FBHFOs toward national goals of improved access to timely, high-quality PHC services?	
How (if at all) are FBHFOs' efforts connected to the public ministries of health?	• FBHFOs can contribute more to describing the population they serve, their distinctive services, and the comparative quality and efficiency of their services. Some FBHFOs have not invested in or had the opportunity to develop strong systems of accountability for public funds and analysis of work and impact. • FBHFOs have varying degrees of success in forging PPPs with governments.
Imagine a future where faith-based PHC is engaged fully in national goals and strategies. What would have to change to get us to that point?	• The original concept of PHC that integrates facility- and community-based health programs and services needs to be revisited. The original concept had advantages that may be lost in the push to accelerate insurance-style reimbursement of primary health services in facilities.

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