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This paper relies on household survey data as well as qualitative fieldwork to answer two questions about the services provided by faith-inspired health care providers in Ghana: how satisfied are patients with the services received?; and why are patients choosing faith-inspired providers for care? The quantitative survey data suggests that the level of satisfaction with the services provided by faith-inspired facilities is similar to that for public facilities, but lower than for private non-religious facilities. The qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit. Indirectly this suggests that the satisfaction with and quality of services provided by faith-inspired providers may be higher than suggested by survey data. At the same time, patients mention some areas for improvement including in terms of availability of medicines and equipment.

INTRODUCTION

Faith-inspired providers of health services, many of which are affiliated with the Christian Health Association of Ghana (CHAG), play an important role in Ghana (e.g., Boateng 2006, CHAG 2008, Dieleman and Hilhorst 2009, Ghana-MoH and CHAG 2006, Olivier et al 2012, Rasheed 2009, Salisu and Prinz 2009, Makinen et al 2011, Miralles et al 2003). Anecdotal evidence suggests that the quality of faith-inspired health service providers is often higher than that encountered in government led facilities. This may be one of the reasons why the occupancy rates of faith-inspired facilities are also often higher than those of public facilities, and this is indeed the case in Ghana with the facilities federated by CHAG. Yet solid evidence is often lacking to confirm that the quality of fait-inspired services, or at least its perception among users, is indeed better.

In this paper, we use both household survey and qualitative in-depth interview data to first assess the extent to which patients are satisfied with the services provided by faith-inspired providers, and second the reasons that are invoked by patients for choosing faith-inspired providers of health services as compared to other providers. While CHAG plays an important role among faith-inspired providers,

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clinics and hospitals are also associated with Islamic organizations such as the Ahmadiyya Movement. Both Christian and Muslim facilities will be considered.

The limited existing research in Ghana on satisfaction rates with the health services received and the reasons for choosing specific providers suggests relatively few differences between various types of providers. Based on an exit poll carried at different types of facilities, Makinen et al (2011) find that the main reason for choosing public, private-for-profit, and CHAG facilities is the same: all the facilities are perceived as providing good quality care, although the proportion of patients mentioning that reason is lowest for CHAG at 41 percent, and highest for public facilities at 45 percent. The second main reason is the fact that the facility is nearest to the patient's home - this ranges from 18 percent of patients for CHAG to 26 percent for public facilities. Among other reasons, the low cost of some facilities is mentioned more often for CHAG than it is for other providers. The study also finds high and similar rates of satisfaction for the various types of providers. Yet when inquiring about the distinguishing features of various providers, low cost tends to be cited most for public facilities, while courteous service is associated with CHAG, and shorter waiting times is mentioned as an advantage of private providers.

Following up on Makinen et al (2011), this paper relies on household survey data and qualitative fieldwork to answer two questions about the services provided by faith-inspired health providers in Ghana: how satisfied are patients with the services received?; and why are patients choosing faith-inspired providers for care? Section 2 presents our data and methodology. Sections 3 and 4 provide the key results in terms both of the satisfaction with the services provided, as well as the reasons for choosing a specific facility, with a focus on Christian and Muslim clinics. The quantitative survey data suggests that the level of satisfaction with the services provided by faith-inspired facilities is similar to that for public facilities, but lower than for private non-religious facilities. The qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit. Indirectly this suggests that the satisfaction with and quality of services provided by faith-inspired providers may be higher than suggested by survey data. At the same time, patients mention some areas for improvement including in terms of availability of medicines and equipment. A brief conclusion follows.

DATA AND METHODOLOGY

This paper relies on both quantitative and qualitative data for assessing the role of faith-inspired health providers in Ghana. The quantitative evidence was obtained from the analysis of two nationally representative household surveys. The first survey is the Ghana Living Standards Survey (GLSS5) implemented in 2005-06. The GLSS is a multi-purpose household survey covering demography, health, education, employment, migration, housing, agriculture activities, non-farm self-employment, household expenditures, durable goods and, remittances and other incomes. The 2005-06 round was administrated to around 36,500 individuals grouped into 8700 households. This nationwide sample is deemed representative at the level of the ten regions. The second survey is the large sample (50,000 households) 2003 Core Welfare Indicator Questionnaire (CWIQ) survey. Both surveys distinguish between faith-inspired and other types of providers when asking about care sought by individuals. The data from both surveys may appear to be a bit dated given that substantial progress has been achieved in health care provision in Ghana since the surveys were implemented, but they are still instructive in assessing the satisfaction with faith-inspired providers as well as what leads households to choose them at an aggregate level, but acknowledging the limits of multi-purpose household surveys for such work.

Given that this paper relies in part on household survey data, it is legitimate to ask whether the identification of faith-inspired providers by households in the surveys is reliable. One way to do this is to look at the market share of faith-inspired providers in the surveys, and compare it to administrative data. As discussed by Olivier and Wodon (2012), the market share of faith-inspired providers in the two surveys is fairly similar, but lower than is commonly assumed in Ghana on the basis of administrative data on the share of hospital beds or facility survey data on the consumption of pharmaceuticals that is accounted for by faith-inspired organizations. But a large part of the difference in market shares can be explained by the fact that the surveys cover virtually all of health care provision in Ghana, while data on hospital beds and pharmaceuticals are related only or principally to the services provided by hospitals, which themselves account for only a third of the total number of consultations according to the surveys. Thus, while it could be that the market share in the surveys is underestimated, this may not be as serious a problem as one might think, and Olivier and Wodon (2012) also discuss why even if there were a bias, this need necessarily not affect comparative work using these surveys on the characteristics of faith-inspired, other private and public providers.

In addition to the analysis of the CWIQ and GSLL5 surveys, qualitative research was conducted between April and June 2010 through interviews with patients (four male and four female patients at each clinic/hospital), the directors of the clinic/hospital and doctors. The providers were selected with district health officials on the basis of their being located in areas where both public and faith-inspired providers were available in order to allow patients to discuss the advantages and disadvantages of different types of providers and explain the reasons why they chose specific providers. The faith-inspired providers contacted

for the qualitative field work can themselves be categorized in two groups: Christian and Islamic. Due to limited resources, only patients and staffs from faith-inspired clinics/hospitals were interviewed. Table 1 provides basic data on the six clinics/hospitals selected for the qualitative study. The clinics/hospitals A-1 to A-4 are managed by Christian organizations; those labeled B-1 and B-2 are managed by Islamic organizations. Of the four Christian clinics/hospitals, three belong to CHAG. In Islamic clinics, while the B-1 clinic does not belong to any broader association of providers, the B-2 clinic receives support from a foreign faith-inspired organization. As the table shows, there is substantial variation in the areas of care provision in which each clinic/hospital works, as well as in the number of staff in each facility, which is useful to assess whether common tendencies can be uncovered across providers that differ in size and coverage of services provided.

The core data from the qualitative work comes from in-depth interviews carried for each of the six faith-inspired providers. A semi-structured questionnaire was used to interview parents using the facilities (eight patients per facility, four women and four men). Each interview took from one hour to one hour and a half, and focused in large part on the perceptions of the providers by parents and the reasons that led them to choose one provider versus another. Quantitative statistics will be presented in percentage terms from those interviews, but it must be emphasized that the sample is small (a total of 48 parents were interviewed). A separate semi-structured questionnaire was also administered to managers of the faith-inspired care providers (or owners in the case of a private faith-inspired school) as well as to the doctors. Additional interviews were conducted with key informants, such as officials from the Ministry of Health.

Table 1: Characteristics of Sampled Clinics/Hospitals for the Qualitative Field Work, 2010

Health Facilities		Partnership	Religious organization	Areas in which clinic/hospital works								Number of staff				
				General health	Reproductive health	Pre- and postnatal care	Children's health	Disability	Care of the elderly	Mental health	HIV/ AIDS	Doctor/Specialist	Nurse/ Mid wife	Health Assistant	Other	Total
A-1	Christian	CHAG	Catholic Church	○	○	○	○		○		○	4	13	11	15	43
A-2	Christian	None	Rural for Christ Internatioanl Ministries	○			○					1	1	1	0	3
A-3	Christian	CHAG	Catholic Church	○	○	○	○					0	4	2	8	14
A-4	Christian	CHAG	Church of Pentecost	○	○	○	○				○	8	3	3	8	22
B-1	Islamic	None	Islam	○	○	○	○		○		○	1	5	0	9	15
B-2	Islamic	Kwait IC clinic	Islam	○	○	○	○		○		○	1	3	1	4	9

Source: Authors based on qualitative fieldwork data.

A few basic statistics on the characteristics of the patients that were interviewed are given in Table 2. Among patients in Islamic clinic/hospitals, slightly more than half had registered with or were covered by a health insurance scheme, while the proportion in Christian clinics/hospitals was higher, at two thirds. The most common reasons for not being registered with NHIS mentioned by patients were that such registration was perceived as "not useful" or the patients had "no knowledge of any scheme" or the "premium is too high". The share of patients unemployed at the time of the interviews was similar in both Islamic and Christian clinic/hospitals at about 10 percent. Data on monthly income suggest that on average patients in Christian clinics/hospitals were slightly better off than patients at Islamic clinic/hospitals, and those data are consistent with the levels of schooling registered, as well as with the higher insurance coverage among patients at Christian hospitals. About a fourth of patients in Islamic clinics/hospitals were not Muslim and the proportion of patients in Christian clinics/hospitals that were not Christian was a bit smaller, but of a similar order of magnitude. Again, those data are not representative of the characteristics of patients using various types of faith-inspired facilities nationally; they simply provide some pointers as to the characteristics of the patients interviewed in our qualitative field work.

Table 2: Patient Characteristics in Faith-Inspired Facilities, 2010

Occupation	Patients in Islamic clinics/hospitals	Patients in Christian clinics/hospitals
NHIS		
Registered	56.2%	68.8%
Occupation		
No job	12.5%	9.4%
Wage earner	6.3%	18.8%
Monthly income		
No income	6.3%	9.4%
Mean income	113.6 GHC	118.2 GHC
Final education		
No education	18.8%	12.5%
JSS +	40.0%	65.6%
Religion		
Muslim	75.0%	18.8%
Christian	18.8%	78.1%
Other	6.3%	3.1%

Source: Authors' calculations based on qualitative fieldwork data.

One of the parameters that may affect the choice of a specific provider is the cost of that provider. As we will see, cost indeed appears to be one of the main complaints observed in the 2003 CWIQ survey, but that survey was implemented before the major reform of the healthy system in Ghana that led to the creation of the National Health Insurance Scheme (NHIS) in 2004. The NHIS was introduced precisely as an effort to increase the access to and affordability of health care, especially for the poor. The scheme has led to smaller out of pocket payments at the time of our qualitative work in 2010 than was the case at the time of the implementation of the CWIQ survey, at least to the extent that individuals are

covered by the scheme. Looking at each clinic/hospital in our sample in table 3, it appears for example that all sampled patients of A-1 Christian hospital were registered with the NHIS, while 50 percent of sampled patients in B-1 Islamic clinic were covered. Data on consultation fees, travel cost, travel time, and time spend at the clinic/hospital were obtained and vary according to the clinic/hospital with some charging higher fees, but for most of the facilities the fees are relatively low, probably in large part thanks to the introduction of the NHIS. This suggests that cost would be a smaller issue in 2010. Other useful background data are provided in table 3. Mean monthly income varies by clinic/hospital. While it is at 155.0 GHC in A-2 Christian clinic, it is at 78.1 GHC for A-4 Christian hospital. As for the travel time to the facilities and the cost of such travel, differences are also observed. For example patients of B-1 Islamic school live relatively closer while patients in A-1 Christian hospital live much further away.

Table 3: Basic Statistics by Clinics/Hospitals, Qualitative Field Work, 2010

	Health facilities	Partner-ship	Monthly income	Health insurance holder	Consul-tation fee	Cost to travel to the clinic or hospital and return	Time to travel to and from the clinic or hospital	Time spend at the clinic or hospital
A-1	Catholic	CHAG	108.3 GHC	100%	2 GHC	2.2 GHC	63.1 mins	296.3 mins
A-2	Catholic	None	155.0 GHC	25%	5 GHC once	0.05 GHC	31.8 mins	43.8 mins
A-3	Catholic	CHAG	128.8 GHC	75%	1 GHC	1.1 GHC	21.7 mins	90.0 mins
A-4	Pente-costal	CHAG	78.1 GHC	75%	6 GHC	2.6 GHC	29.8 mins	185.0 mins
B-1	Islamic	None	111.3 GHC	50%	5 GHC	0.4 GHC	15.0 mins	52.5 mins
B-2	Islamic	Kuwait clinic	116.7 GHC	63%	1 GHC	0.5 GHC	16.5 mins	98.1 mins

Source: Authors' calculations based on qualitative fieldwork data.

SATISFACTION WITH SERVICES

The data from the household surveys used here cannot be used to measure the quality of the care provided by various providers. But it is feasible with the 2003 CWIQ survey to measure subjective levels of satisfaction with the care received (similar data are not available in the GLSS5). The survey asks whether individuals had any type of dissatisfaction with the care received, as well as the reasons for dissatisfaction, and it can be assumed that households who said that they did not have any problems with the care received were satisfied. As shown in Figure 1 and table 4, nationally the satisfaction rate is at 73 percent for both faith-inspired and public facilities, versus 83.5 percent in non-religious private facilities (which also tend to be more expensive). There are few differences between public and faith-inspired facilities in terms of the reasons for non-satisfaction, although there is a slightly higher proportion of patients using faith-inspired providers that consider care as too expensive, while there is a higher proportion of patients using public

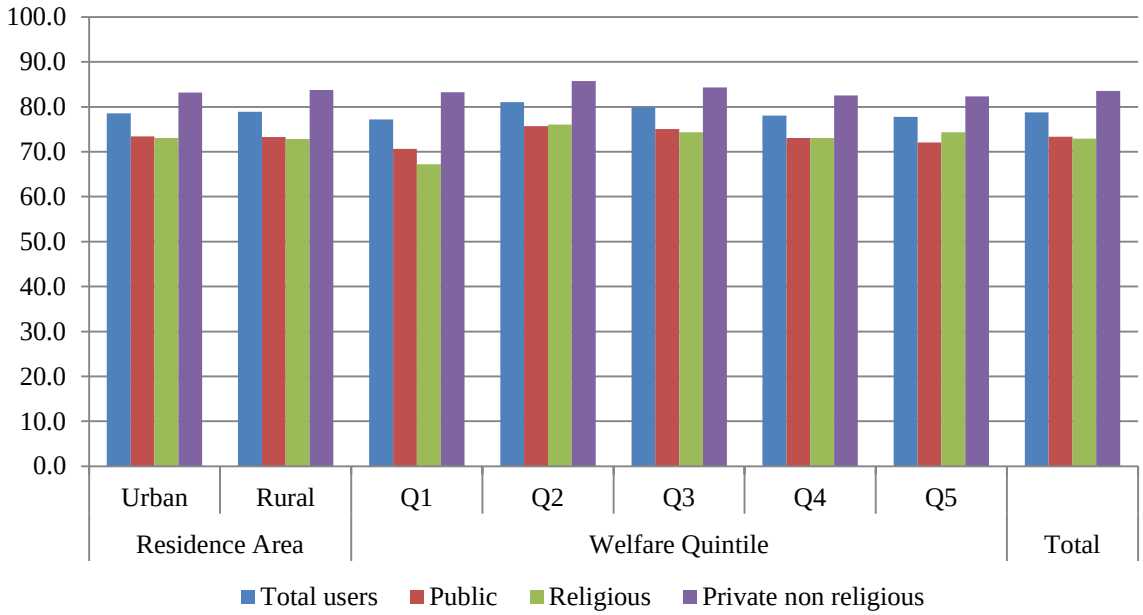
facilities who complain about a lack of medicines. Still, overall, even if it must be emphasized that subjective perceptions on satisfaction with the care received have limits for assessing the quality of care (especially if different facilities tend to reach different types of households in terms of their levels of well-being, but this tends not to be the case too much for public and faith-inspired facilities), the quantitative evidence suggests similar levels of satisfaction among faith-inspired and public providers.

Table 4: Satisfaction and Problems Encountered, 2003 CWIQ (%)

	Residence Area		Welfare Quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
	All facilities							
No problems (satisfied)	78.5	78.9	77.2	81.0	79.9	78.0	77.8	78.7
Facilities were not clean	0.6	0.5	0.5	0.7	0.5	0.4	0.5	0.5
Long waiting time	4.9	3.1	3.2	3.1	3.4	4.4	4.8	3.9
No trained professionals	0.7	0.7	0.8	0.7	0.6	0.8	0.7	0.7
Too expensive	12.9	10.3	10.4	9.8	10.5	12.5	12.9	11.4
No drugs available	5.1	3.9	4.5	3.4	3.9	4.8	5.2	4.4
Treatment unsuccessful	4.3	7.7	9.2	6.3	5.9	5.3	5.6	6.3
Poor staffing attitude	1.4	1.3	1.4	1.1	1.1	1.5	1.6	1.4
Other problems	0.2	0.3	0.3	0.2	0.3	0.3	0.2	0.3
	Public facilities							
No problems (satisfied)	73.4	73.2	70.6	75.7	75.0	73.0	72.1	73.3
Facilities were not clean	1.0	0.8	0.8	1.2	0.8	0.5	1.0	0.9
Long waiting time	8.3	5.7	5.8	5.6	6.2	7.9	8.0	6.8
No trained professionals	1.1	1.2	1.6	1.3	1.0	1.0	1.0	1.1
Too expensive	13.8	12.8	13.1	12.4	11.8	13.7	14.6	13.2
No drugs available	7.0	5.7	7.1	5.3	5.6	5.9	7.3	6.3
Treatment unsuccessful	5.6	8.5	10.1	6.8	6.7	5.9	7.3	7.2
Poor staffing attitude	2.5	1.9	2.0	1.8	1.7	2.3	2.7	2.2
Other problems	0.2	0.4	0.4	0.3	0.4	0.3	0.2	0.3
	Faith-inspired facilities							
No problems (satisfied)	73.1	72.9	67.2	76.0	74.3	73.0	74.4	72.9
Facilities were not clean	0.1	0.4	0.0	0.8	0.3	0.1	0.4	0.3
Long waiting time	6.1	6.0	8.1	3.6	5.3	3.6	9.0	6.0
No trained professionals	1.3	1.6	0.7	2.1	1.2	2.9	0.7	1.5
Too expensive	17.6	13.1	17.3	12.0	14.9	14.0	13.4	14.4
No drugs available	3.9	3.9	4.3	2.5	3.0	4.6	4.9	3.9
Treatment unsuccessful	6.3	8.4	10.6	8.5	7.1	9.2	4.0	7.9
Poor staffing attitude	1.2	2.2	2.0	2.5	3.1	1.0	1.4	1.9
Other problems	0.6	0.4	1.0	0.2	0.9	0.0	0.3	0.5
	Private non-religious facilities							
No problems (satisfied)	83.2	83.8	83.2	85.7	84.3	82.5	82.3	83.5
Facilities were not clean	0.3	0.2	0.3	0.2	0.3	0.3	0.2	0.2
Long waiting time	2.0	0.9	0.7	1.0	1.0	1.6	2.1	1.3
No trained professionals	0.4	0.3	0.3	0.2	0.2	0.5	0.4	0.3
Too expensive	11.9	8.1	7.6	7.5	9.1	11.4	11.6	9.7
No drugs available	3.6	2.6	2.5	2.0	2.6	3.9	3.6	3.0
Treatment unsuccessful	3.2	7.0	8.3	5.7	5.1	4.6	4.4	5.4
Poor staffing attitude	0.5	0.8	0.8	0.5	0.5	0.8	0.8	0.7
Other problems	0.2	0.2	0.2	0.1	0.1	0.3	0.3	0.2

Source: Authors' estimation using CWIQ 2003 survey.

Figure 1: Satisfaction of Users by Provider Type, CWIQ 2003



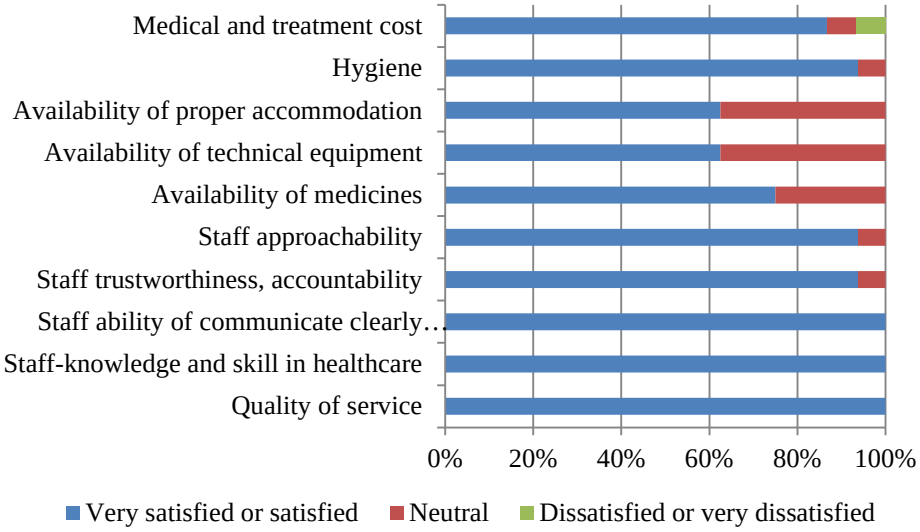
Source: Authors' estimation using CWIQ 2003 survey.

As mentioned in the previous section, the creation of the National Health Insurance Scheme (NHIS) in 2004 and its implementation as of 2005 has reduced significantly the out of pocket costs of care for households, since many procedures are now paid for by the scheme directly to the health facilities. It is thus likely that cost is less of an issue today than it was at the time of the CWIQ survey, at least for the estimated two thirds of the population that is registered today in the scheme. This is a positive development, but some issues remain. All directors of CHAG facilities interviewed for this study cited delays in receiving funds from the scheme as well as insufficient amounts received as issues which affect their cash flow as well as their ability to deliver their services smoothly. As the Director of a Christian hospital explained, *"the idea of the NHIS is perfect. It is good for the poor and brings clinic to certain standard. But delivery has some problem. Our workload increased. It put stress on our finance because payment does not come regularly. I have doubt of the long-term viability of the NHIS. Many complained that the NHIS delay the reimbursements for more than two months."*

Returning to the analysis of the satisfaction of households with the services received at faith-inspired facilities, as was the case for the survey data from the 2003 CWIQ, the data from the qualitative fieldwork suggests relatively high satisfaction rates with the services received, albeit with some caveats. Figures 2 and 3 suggest that patients were highly satisfied with the quality of the staffs, the hygiene in the facilities, and their cost (again, this is explained in large part by the introduction of the NHIS), with rates of satisfaction near 100 percent. However, satisfaction rates were lower regarding the availability of proper accommodation, technical equipment, and medicines, with the situation apparently being more

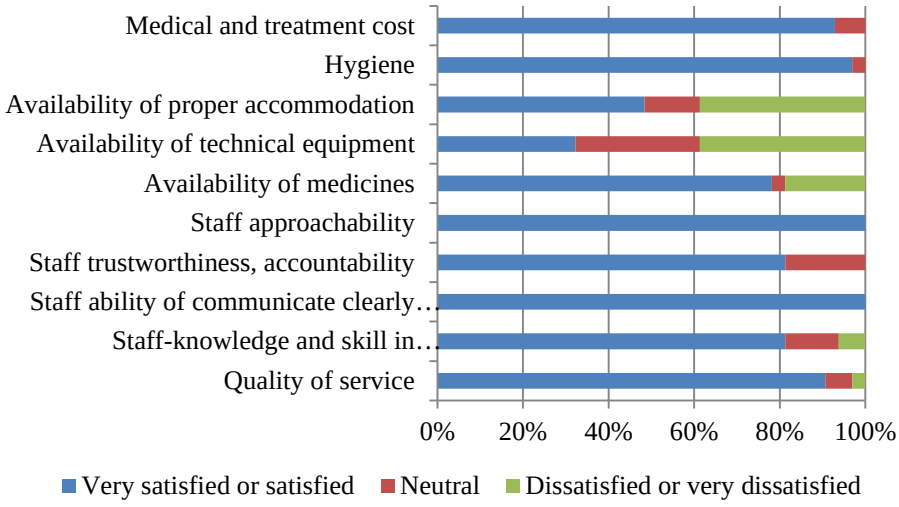
difficult for the three clinics and hospitals not yet accredited with the NHIS. Patients using Christian clinics/hospitals were also found to be less likely to be satisfied with the level of availability of various resources than patients using Islamic clinics/hospitals, but given the very small sample size, one should not try to infer too much from the differences between the two types of faith-inspired providers.

Figure 2: Satisfaction of the Interviewed Patients in Islamic Clinics/Hospitals



Source: Authors' calculations based on qualitative fieldwork data.

Figure 3: Satisfaction of the Interviewed Patients in Christian Clinics/Hospitals



Source: Authors' calculations based on qualitative fieldwork data.

REASONS FOR CHOOSING FAITH-INSPIRED PROVIDERS

We now turn to the reasons for choosing health care providers in Ghana, starting again briefly with the survey evidence, and then using the more detailed and nuanced results from the qualitative field work. Because of the way in which questions are asked in the survey questionnaire, data from the GLSS5 tend to better identify faith-inspired facilities than the data from the 2003 CWIQ. Looking at the basic statistics presented in table 5, differences are relatively small in terms of the market shares of public, private religious, and private non-religious providers among the various religious groups, and it is likely that some of the differences observed are related simply to the location of the facilities, rather than to specific choices made by households. Regression analysis on the drivers of the choice of provider confirms that neighborhood effects are much more important than faith affiliation for choosing one or another provider.

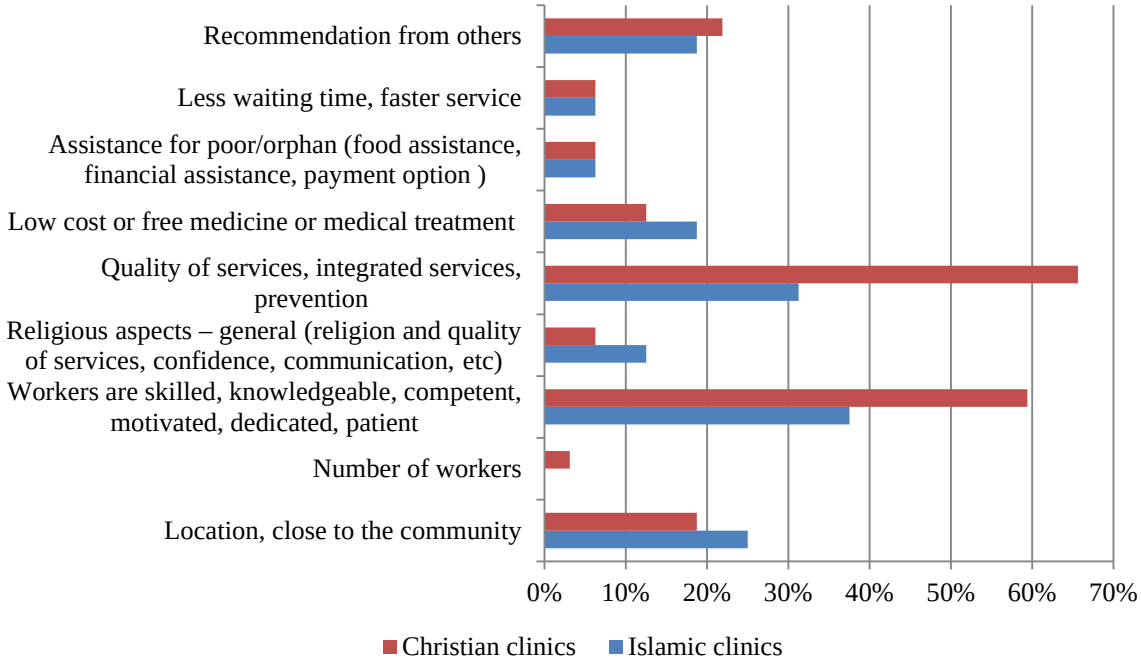
Table 5: Market Share of Alternative Providers by Religious Group, 2005-06

	Catholic	Protestant	Evangelical	Muslim	Other religion	Total
Public	72.9	71.4	67.1	76.2	72.1	70.7
Private religious	6.1	7.5	9.0	6.6	3.1	7.5
Private non-religious	20.9	21.1	23.9	17.2	24.9	21.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Authors' estimation using GLSS5 2005-2006.
Note: Consultations at hospitals, clinics, and maternity houses only.

The qualitative work also confirms that faith affiliation is not a major reason for choosing faith-inspired care providers. Questions were specifically asked to the patients as to why they chose the faith-inspired providers they used (multiple motivations were allowed). As shown in Figure 6, among patients in Christian clinics/hospitals, two thirds (65.6 percent) responded that quality of service was the main reason for choosing the clinic/hospital; 59.4 percent mentioned that workers are skilled, knowledgeable, competent, dedicated, and patient; in short they appreciated the quality of the staff. A third common answer (21.9 percent) was "recommendation from others". For the patients in Islamic clinics/hospitals, the most common answer (37.5 percent) was "quality of workers" followed by "quality of service" (31.3 percent). Twenty-five percent mentioned "location" (25.0 percent). Overall, quality service, and especially the respect provided to patients appears to be a key reason why patients rely on faith-inspired hospitals, as a few quotations help illustrate: *"I get a lot of relief at religious clinic since nurses are very kind and treat patients with dignity. I think staff here are working by faith. Their services are done for mankind because they are God-fearing"* (Male Christian patient, Christian hospital); *"Here we are treated with respect. They listen to us well and understand all of our problems. They take their time to talk to us in a polite way. You don't regret spending your money at this hospital. Even if they don't have all the equipment, the way they handle makes me feel comfortable"* (Female Muslim patient, Islamic clinic); *"I have heard that they are a top quality hospital and they are very serious with their work and they treat patients with care and respect"* (Male Christian patient, Christian hospital).

Figure 4: Main Reasons for Choosing the Clinic/Hospital



Source: Authors' calculations based on qualitative fieldwork data.
Note: Multiple answers allowed.

While quality and respect are important for choosing faith-inspired hospitals, religion itself is much less important, with only 6.3 percent of patients in Christian clinics/hospitals and 12.5 percent of patients in Islamic clinics/hospitals respectively mentioning that religion was a key reason for their choice. When asked whether their religious beliefs and values affect their choices regarding healthcare for themselves and their family, nine in ten patients respond that this is not the case in terms of choosing health care providers. This emerged clearly from the interviews: *"I am Christian but came to this Islamic clinic not because of my religious beliefs but because the clinic works well"* (Female Christian patient, Islamic clinic); *"I will seek health care from even a Christian health facility if that is of high quality but not go to a traditional priest"* (Male Muslim patient, Christian clinic); *"My religious beliefs do not affect my choice of health care for me and my family. I am Moslem and I have been attending a Catholic clinic in the past, so religion doesn't matter to me. Any clinic where I can receive effective medical care, I will go"* (Male Muslim patient, Islamic clinic).

We also asked patients if they would be willing to use health care services at a clinic grounded in a faith different from their own. As shown in Table 9, again nine in ten patients would not mind using services at a clinic grounded in a faith different than their own, as illustrated through the following quotes: *"If they will take good care of me to get well, I don't care what faith is behind them"* (Male Christian patient, Christian hospital); *"I use Islamic clinic here even though I am Christian because I believe that it is providing gravity health care and not about changing me to Moslem"* (Male Christian patient, Islamic clinic).

Table 6: Patients' Values and Choice of Health Care Service

Questions	Patients who use a clinic that belongs to a different religion	Patients who use a clinic that belongs to the same religion
Do your religious beliefs and values affect your choices regarding healthcare?	Yes: 0 %	Yes: 10.8%
Are you willing to use health care services at a clinic which is grounded in a faith different from your own?	Yes: 100%	Yes: 89.1%
Do you think that the health clinic/hospital should provide spiritual guidance and counseling to the patients?	Yes: 18.1%	Yes: 33.3%

Source: Authors' calculations based on qualitative fieldwork data.

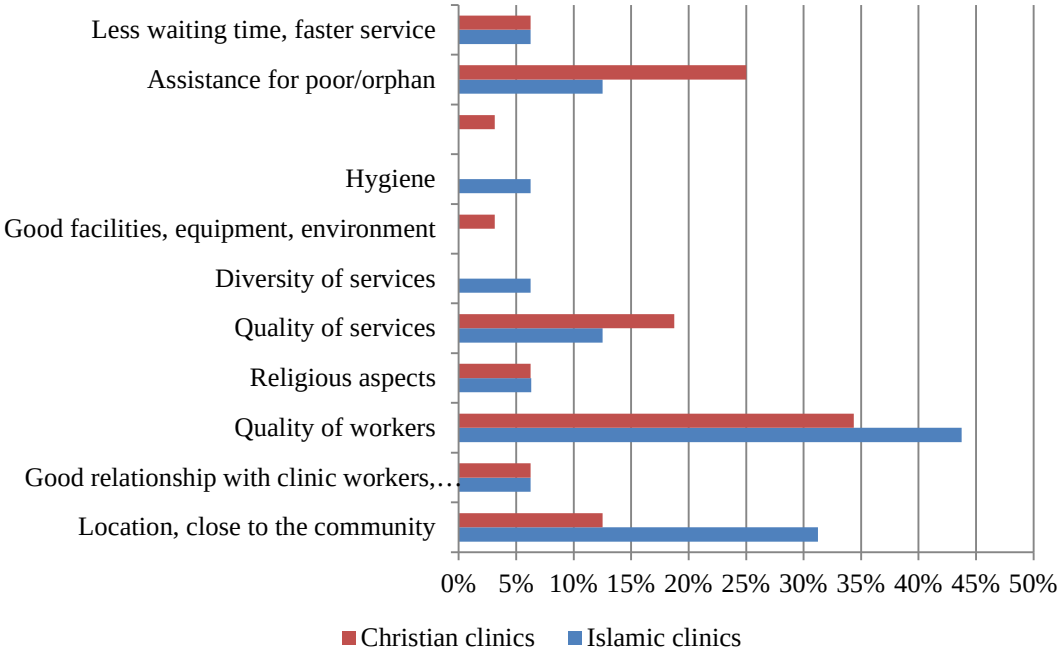
The desire to serve communities as a whole also emerges clearly from the interviews conducted with the Directors and staff of the clinics and hospitals. As the Director of a Christian hospital explained it, *"First a maternity clinic was established in 1946 by the bishop of Accra. Then in 1977, the hospital registered to the government. We serve all mankind. We accept patients who belong to different religion. The vision of the national catholic health services is to provide high quality health care in the most effective, efficient and innovative manner, specific to the needs of the communities we serve and at all times acknowledging the dignity of the patient."* Or as a doctor at an Islamic clinic shared *"there was no clinic around here before. We established this clinic to assist poor community in this area. Most of the people in this area are Moslem, but our target population is entire community. We accept everyone…Personally I am Christian, but I am working at Islamic clinic as a doctor. I don't care the patients' religion. Whatever they believe, we are fighting for our own goal to support the people's health*" (Doctor at an Islamic clinic).

Finally, to get at the question of the role of faith in the choice of facility still in a different way, we asked patients to share the advantages that they see in using faith-inspired clinics or hospitals. As shown in Figure 7, in Christian facilities a third of patients cited "quality of workers" as the main advantage of the facilities, followed by "assistance for the poor" (25 percent of respondents) and "quality of service" (19 percent). Among patients in Islamic facilities, the most common answer was "worker's skills and quality" (44 percent) followed by "location" (31 percent). Two other reasons were mentioned: "Assistance for the poor/orphans" and "quality of service" by 12.5 percent of respondents. The availability of assistance for the poor, while not a leading criterion for the choice of provider, was also mentioned by facility staff. As a Director at an Islamic clinic explained, *"What is the target population of this clinic? It is not by us, it is not by religion. Elders come, youth come, children come, and pregnant women come… any kind of category. Majority of people who come to this clinic are Moslem, but we have non-Moslem too. They are Christian or believe traditional religion. Also we have both poor and somehow middle income group. Majority of the patients are actually poor. That is one of main reason of establishment of this clinic. People are facing financial problems, unemployment and deprivation. Their monthly income is low.*

We try as much as possible to subsidize our services." But as far as religion is concerned, in most cases respondents mentioned that it was not in itself a key reason for their choice of health care provider, and the fact that no discrimination takes place on the basis of religious affiliation was in fact appreciated by patients: *"Members of the local community can come here anytime because there is always a doctor available and there is no discrimination"* (Female traditional religion patient, Christian clinic).

The data also shows that all of the sampled clinics and hospitals in the qualitative fieldwork do accept patients who belong to different religious denominations, and as mentioned earlier some doctors or health staffs actually belong to a different religious denomination than the one to which their clinic or hospital is affiliated. As to the patients, when they did mention the importance of values, faith, or religion, this was done typically in general terms as a good influence overall, rather than in partisan terms: *"As an Islamic community this clinic is seen as a good model of what Islam can do for Moslems. It is providing health care as well as spiritual care for the people"* (Male Muslim patient, Islamic clinic); *"They try to increase the faith of patients who come to this clinic, so it is good. It boosts the moral of patients and increases their faith. Even though I am Moslem, I like it so much"* (Male Muslim patient, Christian clinic).

Figure 5: Advantages of the Faith-inspired Clinic/Hospital You Selected



Source: Authors' calculations based on qualitative fieldwork data.
Note: Multiple answers allowed.

CONCLUSION

This paper has explored the role of faith-inspired health service providers in Ghana, with a focus on two questions: what is the level of satisfaction of patients with the services received? And what is the motivation of patients for choosing faith-inspired providers? Quantitative survey data suggest that satisfaction rates with the services of faith-inspired and public providers are similar, and lower than those observed for private non-religious facilities, which may be related in part to the higher cost of the services that they provide.

The picture that emerges on satisfaction from the qualitative work is slightly different. First the issue of cost, which came out strongly in the 2003 CWIQ survey as a problem in all types of facilities, does not appear to be as important in the qualitative fieldwork, and this may be due in part to the introduction of the NHIS which has reduced out of pocket payments. Second, even though we do not have comparative qualitative data on public providers, the qualitative data suggests that the satisfaction with the services received in faith-inspired facilities is high, including in areas such as respect paid to patients. Subjective satisfaction does not measure quality per se, but it is an important indicator and it appears indirectly from the qualitative data that faith-inspired facilities may have a comparative advantage at least in terms of the attention paid to patients. More data would be needed to confirm this, but it is encouraging for faith-inspired facilities. It also appears that faith-inspired facilities try to help the poor afford the cost of care. Finally, and this is also related to the question of quality, religion itself does not seem to be a key factor for the choice of faith-inspired facilities. Many patients use services from clinics and hospitals that are affiliated with a different faith from their own, and the main reason for the choice of facility is precisely the perception that they provide services of quality.

This study has been exploratory and descriptive in nature, and it was not meant to generate specific policy recommendations. But it is clear that as a staff from the Ministry of Health put it, *"non-state service providers are our partners. They play an important role in delivering health care services to the Ghanaian. Thanks to their great effort, we, Ghanaian are trying to improve our quality of the health services. We still need more collaboration."* One of the objectives of Ghana's national health policy is to foster closer collaboration and partnership between the health sector and communities, other sectors and private providers of care, including not only organizations such as CHAG but also traditional healers. As mentioned in the introduction, CHAG signed a memorandum of understanding with the government. As a Director at a Christian hospital explained it, by acting as an umbrella body for Christian facilities, CHAG gives a voice to these facilities not only for negotiating with the government, but also for sharing ideas and experiences.

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