

Understanding the Enablers, Constraints, and Sustainability of State-Church Health Partnerships in Ghana: A Sustainability of Innovation Framework embedded Qualitative Study

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Research Article

Keywords: State-church partnership, faith-based organisations, health system strengthening, sustainability, Universal Health Coverage, Ghana, qualitative research

Posted Date: July 2nd, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-9830056/v1>

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Additional Declarations: No competing interests reported.

Version of Record: A version of this preprint was published at BMC Health Services Research on September 28th, 2026. See the published version at <https://doi.org/10.1186/s12913-026-15696-4>.

Abstract

Background

State–church partnerships play a critical role in healthcare delivery across sub-Saharan Africa, yet limited empirical evidence explains how these collaborations are sustained in practice. This study examines stakeholder perspectives on the enablers, constraints, and sustainability of such partnerships in Ghana, focusing on the Christian Health Association of Ghana (CHAG).

Methods

Drawing on the Sustainability of Innovation Framework, this qualitative study examines how state-church partnerships function within Ghana's public healthcare sector. Participants were purposively selected from CHAG-affiliated facilities across four regions of Ghana (Ashanti, Volta, Bono East, and North East). Ten semi-structured interviews were conducted with hospital administrators and health service managers. Policy-relevant documents from 2013 to 2021, including CHAG annual reports and strategic frameworks, were reviewed to supplement and triangulate the findings.

Results

Based on the framework's five domains involving political, organizational, financial, workforce, and innovation factors, the analysis identifies several factors influencing partnership sustainability: structural dependence on government workforce and financing; financial vulnerability and coping mechanisms; institutional legitimacy through political alignment; organizational embeddedness in underserved communities; systemic inequities and fragmented integration; and faith-based adaptive capacity as a cross-cutting mechanism. One additional theme, faith-based adaptive capacity, emerged as an important dimension shaping the perceived value and limitations of the partnership model. The findings suggest that sustainability is shaped not only by formal policy frameworks or contractual arrangements but also by the extent to which partnerships are socially embedded, locally responsive, and supported by adaptive practices at the facility level.

Conclusion

State–church partnerships in Ghana are sustained not primarily through formal policy frameworks, but through adaptive practices at the facility level. Strengthening these partnerships requires addressing systemic inequities, enhancing integration, and supporting the adaptive capacities that enable resilience. These findings contribute to broader debates on health system strengthening and Universal Health Coverage in resource-constrained settings.

Introduction

Universal Health Coverage (UHC) remains a central global health priority, with the World Health Organization (WHO) advocating for all individuals to access quality health services without experiencing financial hardship [1]. In sub-Saharan Africa (SSA), where health systems are characterized by resource constraints, workforce shortages, and infrastructure gaps, achieving UHC requires innovative approaches that leverage existing resources and partnerships [2, 3]. One such approach is the collaboration between the state and faith-based organisations (FBOs), often referred to as state-church partnerships (SCPs), which have historically played a significant role in healthcare delivery across the region [4, 5].

Faith-based health providers have been recognized for their extensive networks, deep community roots, and commitment to serving marginalized populations [6]. In many SSA countries, FBOs contribute between 30% and 70% of health services, particularly in rural and hard-to-reach areas where government presence is limited [7]. In Ghana, the Christian Health Association of Ghana (CHAG) represents the largest network of faith-based health providers, accounting for approximately 30 to 40% of national health services [8, 9]. CHAG operates through a formal partnership with the Ministry of Health (MOH) and the Ghana Health Service (GHS), governed by a Memorandum of Understanding (MOU) that outlines roles, responsibilities, and expectations.

Despite their systemic importance, state–church partnerships operate within a structural paradox: they are simultaneously indispensable to service delivery and institutionally marginalized within national health systems. Yet, empirical evidence explaining how these partnerships are sustained in practice remains limited [10]. In particular, there is a scarcity of qualitative evidence exploring how stakeholders, including hospital administrators and health service managers etc perceive the enablers, challenges, and sustainability strategies of these partnerships. Understanding this perspective is essential as these actors are positioned at the interface of policy implementation and service delivery, and their insights can illuminate the mechanisms that sustain or undermine collaboration [11].

This study aims to explore stakeholder perspectives on state-church health partnerships in Ghana, addressing two research questions guided by the Sustainability of Innovation Framework [12]: 1) What do stakeholders perceive as the key enablers and constraints shaping state–church health partnerships in Ghana? and 2) How are these partnerships sustained in practice, and what strategies are employed to ensure long-term viability? In this study, "sustainability" is understood in a qualitative and contextual sense, referring to the extent to which partnership arrangements operate within and adapt to the local health system, including their ability to maintain services, build resilience, and integrate with existing healthcare structures over the long term. The findings are intended to inform policy and practice by providing actionable insights for strengthening these critical partnerships in the pursuit of UHC.

Methods

Study Design

This study employed an exploratory descriptive qualitative design using semi-structured key informant interviews. This design is appropriate for understanding stakeholder perspectives on complex partnership dynamics, as it allows for in-depth exploration of experiences, perceptions, and strategies. The design and reporting of the study adhered to the Standards for Reporting Qualitative Research (SRQR) [13].

Guiding Framework

The Sustainability of Innovation Framework was adapted to guide the research process (see Fig. 1). Originally developed by Fox et al. to support research on health service innovation, the framework offers a structured tool for examining the multiple dimensions that influence sustainability across diverse healthcare settings [12]. It comprises five interrelated domains: 1) political factors, including policy alignment, stakeholder engagement, and governance structures; 2) organizational factors, encompassing institutional culture, coordination mechanisms, and contextual adaptation; 3) financial factors, referring to funding sources, revenue diversification, and fiscal sustainability; 4) workforce factors, including recruitment, training, retention, and staff motivation; and 5) innovation factors, covering the safety, support for, and barriers to innovative practices.

The framework has been applied to evaluate sustainability in various health system contexts. For the purposes of this study, we adapted the five domains to examine state-church partnerships in Ghana, with each domain operationalized to capture partnership-specific dynamics at the interface of public sector governance and faith-based service delivery. This adaptation allowed for a systematic exploration of the enablers, constraints, and sustainability strategies shaping CHAG-state collaborations.

Figure 1: Analytical framework (adapted from the Sustainability of Innovation Framework) for assessing the sustainability of state-church partnerships in Ghana

Study Setting

The study was conducted in four administrative regions of Ghana: Ashanti, Volta, Bono East, and North East. These regions were purposively selected to capture geographical diversity within southern, middle, and northern belts and a high concentration of CHAG-affiliated health facilities. CHAG facilities in these regions serve diverse populations, including urban, peri-urban, and rural communities, and vary in size from small health centers to large mission hospitals.

Participant Selection

A purposive sampling strategy was employed to select participants with direct knowledge and experience of the state-church partnership. Inclusion criteria were: 1) holding a managerial or leadership position at a CHAG-affiliated facility; 2) having at least three (3) years of experience in the role; and 3) providing written informed consent. A total of 10 key informants were recruited, comprising hospital administrators and health service managers from facilities across the four regions. This sample size was considered sufficient to achieve thematic saturation, given the exploratory nature of the study, the depth of information obtained from each interview, and the homogeneity of participant roles across facilities [14]. However, we acknowledge that larger samples may reveal additional perspectives not captured here.

Data Collection

Informant interviews

A semi-structured interview guide developed in alignment with the Sustainability of Innovation Framework was used to maintain consistency across interviews while allowing flexibility to probe emerging themes (see Supplementary Material-Table S1). To uphold methodological rigor, one author completed training workshops on qualitative data collection, covering face-to-face interviewing techniques, with particular emphasis on mitigating bias.

Data collection was conducted between October and December 2024, consisting of 10 face-to-face interviews at participants' facilities across the four regions. All interviews took place in private settings, with each lasting between 45 and 90 minutes. With participant consent, sessions were audio-recorded; in instances where recording was declined, detailed notes were taken and later reviewed by participants to ensure accuracy.

To minimize social desirability bias and uphold ethical standards [15], the following measures were implemented prior to data collection: All participants received detailed information about the study and provided informed consent. They were assured of confidentiality, the voluntary nature of their participation, and their right to withdraw at any time without penalty. During the study, participants were reminded of their anonymity and encouraged to express their views openly to further reduce potential response bias. Following the interviews, all recordings were transcribed verbatim by an independent third party to avoid interpretive bias. Consistent with ethical research protocols, no financial incentives were offered to participants.

Document review

To triangulate and enrich the interview data, a structured review of policy and institutional documents was undertaken. Materials reviewed included CHAG annual reports (2013–2021), strategic frameworks (2017–2021), baseline assessment reports on Organizational Performance Assessment Tool (OPAT),

and administrative records related to CHAG operations. These documents were assessed using Scott's four criteria for documentary analysis: authenticity, credibility, representativeness, and meaning. The review provided historical and institutional context for interpreting implementation processes, actor relationships, and shifts in programme delivery over time.

Data Analysis

Data were analyzed using a directed content analysis approach [14, 16], which integrates deductive categorization based on predefined domains with inductive identification of emerging themes. The initial coding framework was structured around the Sustainability of Innovation Framework, specifically its five core domains (political, organizational, financial, workforce, and innovation factors), while remaining open to unanticipated patterns and insights. This hybrid strategy allowed the research team to capture both theory-informed and context-specific findings.

Following established qualitative analysis methods [17], all transcripts were manually coded, with NVivo 11 qualitative data analysis software (QSR International) used to facilitate coding, theme development, and data management. The coding matrix included columns for assigned domains, inductively derived themes, and illustrative participant quotations. Coding was conducted collaboratively by three authors, who held regular discussions to address discrepancies and reach consensus on interpretive decisions [18]. To enhance the rigor and validity of the findings, interview data were triangulated with documentary sources, including CHAG annual reports, strategic frameworks, and OPAT baseline reports. Inconsistencies or gaps were addressed through weekly team consultations, which supported reflexive interpretation and contextual alignment [17].

Descriptive statistics were used to summarize participant demographics. All identifiers were anonymized using coded initials such as participant - P01, P02, etc. This is in accordance with ethical research protocols [19]. The final analysis produced a synthesis of thematic domains, supported by representative quotes and corroborating documentary evidence. Particular attention was given to insights from participants whose narratives introduced novel dynamics not captured within the original framework. Confidentiality and data security were maintained throughout the research process.

Ethical Considerations

Ethical approval

was obtained from the CHAG-Research Department/Institutional Review Board (CHAG-IRB-3072024). All participants provided written informed consent after receiving detailed information about the study purpose, procedures, risks, and benefits. Participants were informed of their right to withdraw at any time without consequence. Confidentiality was maintained through anonymization of participants (coded as P01-P10) and facilities. All data were stored on password-protected computers accessible only to the research team, and audio recordings were deleted following transcription. No financial incentives were offered to participants.

Results

Characteristics of study participants

A total of 10 participants were included in the final sample. The characteristics of this group are summarized in Table 1. The sample represented diverse stakeholder groups, including hospital administrators (n = 8) and health service managers (n = 2). Participants had between 4 and 20 years of managerial experience and were drawn from mission hospitals serving urban, peri-urban, and rural populations across four regions of Ghana. This participant composition enabled a multi-level exploration of state-church partnership dynamics, integrating management, frontline implementation, and strategic perspectives. Data triangulation across interviews and institutional documents (2013–2021) traced the historical trajectory of CHAG partnerships, revealing systemic challenges, operational adaptations, and sustainability strategies over nearly a decade.

Table 1
Characteristics of study participants (N = 10)

Participant Code	Role	Region	Years in Role	Facility Type
P01	Hospital Administrator	Ashanti	12	Mission Hospital
P02	Hospital Manager	Volta	8	Mission Hospital
P03	Senior Administrator	Bono East	15	Mission Hospital
P04	Hospital Administrator	North East	6	Mission Hospital
P05	Deputy Administrator	Ashanti	4	Mission Hospital
P06	Health Service Administrator	Bono East	20	Mission Hospital
P07	Hospital Administrator	Volta	10	Mission Hospital
P08	Hospital Administrator	North East	7	Mission Hospital
P09	Senior Administrator	Ashanti	9	Mission Hospital
P10	Hospital Administrator	Volta	11	Mission Hospital (District level)

Thematic Domains

The analysis identified six thematic domains shaping the sustainability of state-church partnerships in Ghana. All five constructs from the Sustainability of Innovation Framework (political, organizational, financial, workforce, and innovation factors) emerged clearly through deductive analysis, confirming the framework's applicability to this context. In addition, one inductively derived domain surfaced from

participant narratives: faith-based adaptive capacity, which captured concerns regarding mission-driven values, organizational flexibility, and locally developed strategies for navigating systemic constraints. Together, these six domains offer a comprehensive perspective on the operational and relational dynamics influencing state-church partnership sustainability in Ghana. A summary of these domains and their associated factors is presented in Table 2.

Table 2
Factors shaping the sustainability of state-church partnerships in Ghana

Domain	Factors	Strengths	Challenges
Workforce Factors	<ul style="list-style-type: none"> • Government recruitment and posting of staff • CHAG-affiliated training institutions • Clinical training sites for resident doctors 	<ul style="list-style-type: none"> • Government pays staff salaries • CHAG institutions train national workforce • Recent inclusion in GHS training 	<ul style="list-style-type: none"> • Fewer government-posted staff compared to GHS facilities • Historical exclusion from GHS training program • Uneven staff distribution
Financial Factors	<ul style="list-style-type: none"> • Government salary support • NHIS reimbursements • IGF from non-insured clients 	<ul style="list-style-type: none"> • Heavy reliance on government funding • IGF from top-up payments • > 85% of clients insured 	<ul style="list-style-type: none"> • Perceived insecurity about funding withdrawal • NHIS payment delays (3–11 months) • 84.6% staff on government payroll creates vulnerability
Political Factors	<ul style="list-style-type: none"> • MOH-CHAG MOU • CHAG-MOH Bargaining Agreement • Abstention from industrial strikes 	<ul style="list-style-type: none"> • Formal partnership framework • CHAG secretariat manages state relations • Maintains government trust 	<ul style="list-style-type: none"> • Facilities lack direct government access • Limited facility-level advocacy • Reliance on centralized negotiation
Organizational Factors	<ul style="list-style-type: none"> • Sole providers in deprived areas • Specialist service provision • Community embeddedness 	<ul style="list-style-type: none"> • Institutional indispensability • Referral center function • Fills government service gaps 	<ul style="list-style-type: none"> • GHS facilities bypass CHAG referrals • Fragmented integration due to different reporting lines • Missed opportunities for efficient resource use
Innovation Factors	<ul style="list-style-type: none"> • Centralized drug pooled procurement program (PPP) • Revenue-generating innovations (laundry, 	<ul style="list-style-type: none"> • Reduced costs and ensured availability • Church governance support 	<ul style="list-style-type: none"> • Disparities in access to medical stores • Equipment supplies inequities
CHAG: Christian Health Association of Ghana; DOT: Directly Observed Treatment; GHS: Ghana Health Service; IGF: Internally Generated Fund; MOH: Ministry of Health; MOU: Memorandum of Understanding; NHIS: National Health Insurance Scheme; PPP: Pooled Procurement Program; TB: Tuberculosis			

Domain	Factors	Strengths	Challenges
	water) • Manager summits and training	• Collective approach to procurement	• Minimal percentage of government equipment
Faith-Based Adaptive Capacity Factors	• Patient-centered care beyond clinical treatment • Religious Sensitivity • Adaptive Downsizing • Strategic Financial Management (17% allocation system)	• Nutrition Rehabilitation Centre • TB Village for DOT • Pro-poor fund for vulnerable patients • Contingency funds (6 months coverage)	
CHAG: Christian Health Association of Ghana; DOT: Directly Observed Treatment; GHS: Ghana Health Service; IGF: Internally Generated Fund; MOH: Ministry of Health; MOU: Memorandum of Understanding; NHIS: National Health Insurance Scheme; PPP: Pooled Procurement Program; TB: Tuberculosis			

Workforce Factors

Staff Recruitment Processes

Participants reported that the government plays a dominant role in staff recruitment, with the Ministry of Health posting trained personnel to CHAG facilities. This arrangement mirrors the recruitment process for GHS facilities, with government providing both the staff and their salaries. However, participants noted significant disparities, with CHAG facilities receiving fewer government-posted staff compared to GHS facilities.

“Government will train Nurses, recruit them and post them to you.” (P03)

“Well, for my 10 years being with the Church of Christ, all that I know is the government supports us with staff. After providing us with staff, he also pays them their salaries.” (P07)

Recruitment for Internal Generated Fund (IGF) positions are handled locally, often through church networks when government-posted staff are insufficient.

Education and Staff Training

Participants highlighted the extensive network of CHAG-affiliated health training institutions across the country, which train nurses, midwives, and other health professionals. These institutions serve as a critical pipeline for the national health workforce. Some participants noted that their hospitals serve as training grounds for resident doctors and house officers on behalf of the Ministry of Health.

“We have quite a number. If we talk of nursing training, we have Duayankwanta Nursing Training, the Nursing and Midwifery Training School here, Beguro Laboratory Technicians Training School, and Dormaa

Training Nursing, among others." (P02)

"In terms of training, CHAG usually does training on behalf of the Ministry of Health for its facilities. Here is also a center for resident doctors and house officers." (P09)

Participants observed that GHS had historically excluded CHAG staff from their training programs but had recently begun to include them, representing a positive but recent shift in collaboration.

Financial Factors

Funding Sources Identified

Participants identified heavy reliance on government funding for staff salaries, supplemented by National Health Insurance Scheme (NHIS) reimbursements and IGF from top-up payments and non-insured clients. Top-up payments for medications outside the NHIS benefit basket were noted as an important source of IGF, reflecting a pragmatic approach to ensuring medication availability without sending patients to external pharmacies.

"Government pays the workforce that we work with, majority of them. We generate our IGF from the insurance, and because the attendance is high, we have to submit more claims to NHIS." (P04)

"Health insurance and we have a small top-up for medicines that are outside the insurance list. Because of the nature of where we find ourselves, we don't like giving prescriptions to patients to go out and buy medicine." (P07)

More than 85% of clients across facilities were reported to be insured, with non-insured clients paying full cost but constituting a minority of patients.

Perceived Insecurity about Funding Sources

Participants expressed significant concern about the sustainability of government funding. The heavy reliance on government salary support was viewed as a critical vulnerability, with participants describing potential withdrawal as an existential threat to their facilities.

"I just mentioned that about 66.1% of workforce are on GoG. If that is withdrawn, the system will collapse. Why? Because we can't pay the staff." (P01)

"CHAG will suffer, we cannot even survive if government stops supporting CHAG facilities... Do we know how to recruit staff and pay their salaries every month?" (P08)

This perceived insecurity drove many of the adaptive strategies described in later themes, as facilities proactively developed contingency plans.

Political Factors

Government and Local Policy Alignment

Participants viewed sustainability as dependent on strict adherence to government policies, mediated by CHAG through the MOU. Abstention from industrial strikes was highlighted as a key strategy to maintain government trust and ensure continued partnership support.

"The government is supporting the CHAG facilities with the idea that, in moments of crises or emergencies, they can rely absolutely on CHAG facilities. But you come to work here and you join them to go on strike, that is not fair to the government." (P06)

"We have something called CHAG-MOH Bargaining Agreement which we use as a working manual. The things we're supposed to do have been spelled out over there. There's an MOU between the Ministry of Health and CHAG." (P05)

Participants acknowledged the existence of formal agreements between the government and CHAG, which guided service provision and outlined mutual expectations.

Staff Involvement in Implementation and Decision Making

Participants viewed sustainability through the lens of national-level agreements made by CHAG, with individual facilities relying on the CHAG secretariat to manage state relations. Individual facilities do not have direct access to government negotiations.

"CHAG is our mother body and they sign all the MOUs and everything. They will let us know that this is what we have done with the government." (P03)

"The individual facilities don't have that direct access to the government. Everything passes through the CHAG secretariat." (P07)

This centralized arrangement ensures consistent messaging and negotiation but may limit facility-level advocacy for context-specific needs.

Organizational Factors

Adaptation to Local Context and Perceived Need

Participants emphasized that CHAG facilities often serve as the sole providers in deprived and remote areas, solidifying their organizational necessity. Larger mission hospitals filled service gaps that state-owned facilities could not, offering specialist services that positioned them as referral centers.

"The ministry is saying that CHAG facilities have found themselves in some deprived communities, areas where government facilities are not. So, based on this, they know that they can't do away with the CHAG institutions." (P04)

"If not for the partnership, the majority will be marginalized-those who are less privileged, who didn't have access to healthcare now do. Majority of CHAG facilities are in the hinterlands where sometimes they don't

have any GHS facility." (P08)

Participants described a wide range of specialist services including ENT, ophthalmology, pediatrics, internal medicine, surgery, and obstetrics and gynecology, often with consultants in multiple specialties. (P09)

Interdepartmental and Intradepartmental Communications

Referrals were highlighted as a key component of interfacility communication. However, participants described instances where GHS facilities bypassed CHAG facilities despite their specialist capacity, reflecting a lack of coordination and what participants termed "partiality" based on different reporting lines.

"Instead of the GHS facilities around us to refer to us, they rather refer those cases to the regional hospital. I think it is because we are not under the same agency even though we are all in the industry of health. While they are reporting to Ghana Health Services, we are reporting to CHAG." (P06)

"As a primary health facility, my facility does most of the things, with exception to a few things which we refer. Most of the cases that we can't handle, we just refer to Tamale, Kumasi, or Accra." (P03)

This fragmented integration represents a missed opportunity for efficient use of specialist resources across the health system.

Innovation Factors

Safety of the Innovation

Participants described centralized procurement systems, such as the Catholic Church's pooled drug purchasing, which reduced costs and ensured medication availability. This collective approach to procurement was seen as both safe and sustainable.

"We have something called PPP. It's one of our ways of purchasing drugs. We have pool procurement plan where all drugs are kept at a particular place for national purposes. Drugs are purchased in large quantities, so we have drugs always at store. When you purchase in large quantities, the price becomes cheaper." (P01)

This innovation was perceived as reducing the risk of stockouts and lowering per-unit costs for member facilities.

Support for the Innovation

Participants described business-centered innovations to generate additional revenue, including commercial laundries and water projects. Churches provided infrastructural support, training, and governance through boards and trustees, with regular management summits and training programmes.

"We have put up a modern laundry which we are going to extend to external people. We just commissioned it about two weeks ago. We are going to do for health, clinical care and external people also. At a fee! To raise money." (P04)

"We have trustees and board members. Recently, in the Catholic system, we call it 'Manager Summit'. Every year, we meet. Every management member is supposed to go for about one week training." (P09)

These revenue-generating innovations complemented core clinical services and were supported by church governance structures.

Barriers to Innovation

Participants identified disparities in support between CHAG and GHS facilities, including access to medical stores, equipment, training opportunities, and recruitment processes. These systemic inequities created barriers to innovation and placed CHAG facilities at a competitive disadvantage.

"It's not equal. Ghana Health facilities have access to medical stores. Our facility here, we don't have access to any medical stores. We pay for our own supplies, drugs, and everything. When it comes to equipment, most equipment at Ghana Health Service are supplied by government. But we purchase our own equipment or receive donations." (P05)

"At times, when they get equipment and release them, they do give us, but it's not like as they give to Ghana Health Service. The percentage is minimal. In terms of recruitment, they always get upper hand over us." (P06)

These barriers were consistently reported across regions and denominations, suggesting systemic rather than localized issues.

Faith-Based Adaptive Capacity Factors

Patient-Centered Care

Participants described services extending beyond clinical treatment to address social and emotional needs through counselling units, spiritual support, and community-based initiatives. The Nutrition Rehabilitation Centre admitted malnourished children and trained mothers in preparing nutritious foods at home. The TB Village provided six months of directly observed treatment in a dedicated community setting.

"We have a service called Nutrition Rehabilitation Center. We admit children and take their parents through training on preparing nutritious foods at home. When we admit the child, they spend the first month here. Once mothers have been trained, we are rest assured they will go into the community and implement what they have learnt." (P09)

"In our quest to reduce TB prevalence, we have a TB Village. When you present with TB, you are taken there to go through six months of treatment. Over there, a health worker administers medication morning and evening. Multiple TB cases are referred to us from Accra." (P02)

Additional patient-centered initiatives included the "people assembly" for patient feedback and a pro-poor fund that covered bills, food, and clothing for vulnerable patients.

Religious Sensitivity

Participants framed service provision as a fulfilment of their spiritual mandate, with the mission to "heal the sick" and "win souls through treatment" underpinning their commitment. This religious orientation discourages industrial strikes and encourages service beyond financial incentives.

"Our main aim is to win souls through treatment or through health care. So, if we have the vision that we are to do this, free of charge, we will." (P05)

"When Jesus Christ came, He was using the gospel and also healing to win more souls. So, while the church had accepted to go by the footsteps of Jesus Christ, we will go by the gospel and we will do the healing." (P07)

This spiritual framing was not merely rhetorical but translated into concrete operational decisions, including abstention from strikes and provision of uncompensated care.

Adaptive Downsizing

Participants identified downsizing as a potential sustainability strategy should government support be withdrawn, given the heavy reliance on government-paid staff. This contingency planning reflected pragmatic recognition of financial vulnerabilities.

"The other thing is for us to do downsizing. For example, in this hospital, if I am the one in charge, I can use 200 people to manage this facility. We will do the downsizing just to also cover some cost." (P01)

"What we can do maybe, we lay off some workers. We will still continue to render the services that we are providing until it gets to the point where we can't manage the numbers. We can reduce so that we can sustain the service." (P06)

While downsizing was presented as a last resort, its identification as a potential strategy indicates the seriousness with which participants viewed the threat of funding withdrawal by the government.

Strategic Financial Management

Some facilities had implemented proactive financial management strategies, including a 17% allocation system that distributed IGF across health investment, staff motivation, drugs, general procurement, and utilities. Others had established contingency funds to sustain operations for up to six months.

"We have a policy called 17, 17, 17, 17, six times, where whatever we get is divided into 17; 17% for health investment, 17% to motivate staff, 17% for drugs, 17% for general procurement, and 17% for regulatory services and utilities." (P09)

"We have put aside some funds. If the government decides not to pay staff, we can sustain the current staff for six months. But after that, maybe some will be laid off until we get the numbers we can manage." (P02)

These strategic financial management practices demonstrate sophisticated planning capacity that challenges assumptions about the financial management capabilities of mission hospitals.

Supplementary insights from documentary evidence

To complement interview findings and trace the institutional trajectory of CHAG partnerships in Ghana, we reviewed nearly a decade of programme-related documents, including annual reports (2013-2021), strategic frameworks (2017-2021), and OPAT baseline assessment reports. These sources were analysed to corroborate interview themes, such as governance arrangements, reported outcomes, and shifts in partnership focus, and to provide historical context for stakeholder perceptions. Table 3 summarizes key developments chronologically, highlighting how partnership emphasis evolved from infrastructure and service expansion in earlier years toward sustainability and systemic integration in later periods.

Table 3: Key developments in CHAG partnerships based on documentary analysis (2013-2021)

Year	Reviewed Instrument	Institutions Involved	Reported Outcomes & Thematic Focus
2013	Annual Report	CHAG	• Formalisation of MOU with GHS
		MOH	• 183 facilities across 21 denominations
		GHS	• 85% IGF from NHIS with 3–6-month payment delays
			• 19% staff increase but doctor: client ratio 1:18,845
			• Emphasis on infrastructure and service expansion
2015	Annual Report	CHAG	• Membership grew to 291 facilities (58% growth)
		MOH	• New constitution adopted; maiden Annual General Meeting
		GHS	• 12,584 staff on GOG payroll (42% growth since 2011)
			• NHIS payment delays extended to 8 months
			• MAF program for maternal mortality; mental health scale-up
2016	Annual Report	CHAG	• 300 member institutions; 19 training institutions
		MOH	• 11-month NHIS payment delays
		GHS	• 15,927 staff on GOG payroll
			• Secretariat restructured with Deputy ED position
			• Focus on service scale-up and coordination
2016	Baseline Assessment Report on OPAT	CHAG / Consultant Alex Nazzar	• 77 facilities assessed; overall score 2.9/5 (satisfactory)
			• Technology score 3.9/5 (highest); Leadership 1.6/5 (unsatisfactory); Research 1.3/5 (lowest)
			• Wide variation across denominations
			• Baseline for capacity strengthening
2017-2021	Strategic Framework	CHAG	• SDG alignment; decentralization policy response
			• Goal of financial sustainability by 2020

Year	Reviewed Instrument	Institutions Involved	Reported Outcomes & Thematic Focus
			<ul style="list-style-type: none"> • Diversified revenue sources; alternative energy/water • HR retention survey; equitable distribution mechanisms • NCD screening centers; e-medicine programme; centers of excellence
2021	Annual Report	CHAG FCDO GIZ	<ul style="list-style-type: none"> • 349 member institutions; 22 training institutions • 41,285 total staff; 34,915 on GOG payroll (84.6%) • GOG salary support GHC 1.13 billion • CRIB project (24,828 COVID-19 tests, 6,664 HCWs trained) • Safe Care (264 facilities assessed, 4 achieved level 4) • Growing emphasis on sustainability and local capacity

ED: Executive Director; FCDO: Foreign, Commonwealth and Development Office; GIZ: Deutsche Gesellschaft für Internationale Zusammenarbeit; GOG: Government of Ghana; HCW: Healthcare worker; IGF: Internally Generated Fund; MAF: Maternal and Adolescent Health; NCD: Non-communicable disease

Discussion

Factors influencing the sustainability of state-church partnerships

This study examined the sustainability of state-church health partnerships in Ghana through a health systems lens, guided by the Sustainability of Innovation Framework [12], revealing a multidimensional interplay of service delivery, institutional arrangements, and adaptive capacity. To contextualize these findings, the study considers the health system landscape into which CHAG facilities are integrated. Ghana's health system, while demonstrating resilience, contends with well-documented structural challenges: a maldistribution of the health workforce favoring urban centers, persistent resource constraints, a double burden of communicable and non-communicable diseases, and gaps in specialist care, particularly in rural areas [3, 8]. Within this context, and aligned with Ghana's decentralized health governance structure, the positioning of CHAG facilities primarily in underserved rural areas both addresses equity gaps and creates unique sustainability challenges.

In line with the adapted framework, the analysis confirms that state-church partnerships in Ghana demonstrate both strategic relevance and operational complexity. Their presence helps address key health system gaps, notably in rural service provision, human resource reinforcement, and areas where government capacity is limited, findings that echo previous research in SSA and beyond [6, 20, 21]. However, unlike traditional assessments that focus narrowly on service outputs, this study foregrounds relational factors such as faith-based adaptive capacity, patient trust, and organizational flexibility as central to the sustainability of these partnerships.

Importantly, the analysis adds one inductively derived domain, faith-based adaptive capacity, to the existing framework. This domain captured concerns regarding mission-driven values, organizational flexibility, and locally developed strategies for navigating systemic constraints. While partnerships demonstrated formal structures and policy alignment, limitations in equitable resource allocation and fragmented integration hindered systemic coordination and institutional equity. Similar critiques have been raised in other low- and middle-income countries (LMICs) contexts where faith-state partnerships struggle to achieve full integration into national health systems [11, 22, 23]. Additionally, vertical funding mechanisms further highlight the risks of fragmented approaches, which often prioritize short-term outputs over systemic integration [24, 25].

Implications

At the governance level, findings illustrate both opportunities and fragilities. Although bilateral agreements and MOUs have fostered structured collaboration, their translation into equitable resource distribution, particularly for CHAG facilities compared to GHS facilities, remains uneven. The reliance on government salary support for CHAG operations may inadvertently create dependency and vulnerability, despite policy intentions of partnership. To address Ghana's top health priorities, such as reducing mortality, combating infectious diseases, and managing the growing burden of non-communicable diseases, state-church integration must be strategically aligned. This requires moving beyond ad-hoc resource allocation to a needs-based partnership model that recognizes CHAG's unique contributions and constraints.

From a sustainability perspective, the state-church partnership model demonstrates both promise and risk. On one hand, it supports service delivery, community embeddedness, and reduced health disparities in underserved areas. On the other hand, these benefits are often dependent on consistent government salary support, equitable access to medical supplies, and supportive infrastructure. Without robust local investment and systemic integration, there is a risk of stagnation or service disruption if government support is withdrawn. These dynamics align with wider critiques of partnerships that lack embeddedness within host systems [26–28].

Furthermore, the findings align with sustainability science by illustrating the importance of institutional co-evolution and resilience in health partnerships [5, 9]. Sustainable health interventions must go beyond temporary fixes to support adaptive learning, mutual accountability, and resource continuity [29, 30]. This

study advocates a shift from transactional partnership arrangements to co-constructed collaborations, where relational sustainability is more important than mere outputs. This involves treating partnerships as learning ecosystems, where mutual adaptation, not just resource transfers, builds long-term resilience. The faith-based adaptive capacity documented here, encompassing patient-centered care, religious sensitivity, adaptive downsizing, and strategic financial management, represents a form of institutional resilience that merits recognition and support.

Strengths and limitations

A key strength of this study lies in the diverse, multidisciplinary composition of the research team, which included hospital administrators, health service managers, and public health academics from both faith-based and public health institutions. This diversity enabled balanced analysis and contextual sensitivity, particularly in interpreting partnership dynamics and stakeholder experiences. Additionally, the study employed methodological triangulation by combining in-depth interviews with a structured review of institutional documents, enhancing the validity and historical depth of the findings.

Despite these strengths, several limitations should be noted. Social desirability bias may have influenced participant responses, especially given the partnership nature of CHAG-state relations [15]. The limited geographic coverage focused primarily on four regions, which may constrain generalizability to other regions with different denominational compositions or service profiles. Ten participants, while achieving thematic saturation, may not capture the full diversity of perspectives across all CHAG facilities, particularly smaller health centers and clinics. Finally, the cross-sectional design captures perceptions at a single time point; longitudinal research would illuminate how adaptive strategies evolve in response to changing fiscal and policy environments.

Conclusions

State-church health partnerships in Ghana offer tangible contributions to clinical service delivery and health system coverage. Yet, their sustainability hinges not only on formal agreements and resource flows but on trust-building, adaptive capacity, and local system engagement. By adapting the Sustainability of Innovation Framework and integrating a faith-based adaptive capacity dimension, this study contributes a more nuanced lens for evaluating health partnerships. Strengthening these collaborations will require moving beyond short-term transactional arrangements toward shared ownership and institutional embedding, ensuring that state-church partnerships genuinely contribute to resilient and equitable health systems.

Abbreviations

List of Abbreviations	
CHAG	Christian Health Association of Ghana
DOT	Directly Observed Treatment
ED	Executive Director
FBO	Faith-Based Organization
FCDO	Foreign, Commonwealth and Development Office
GHS	Ghana Health Service
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GOG	Government of Ghana
HCW	Healthcare Worker
IGF	Internally Generated Fund
IRB	Institutional Review Board
KNUST	Kwame Nkrumah University of Science and Technology
LMICs	Low- and Middle-Income Countries
MAF	Maternal and Adolescent Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NHIS	National Health Insurance Scheme
OPAT	Organizational Performance Assessment Tool
PPP	Pooled Procurement Program
SCP	State-Church Partnership
SDG	Sustainable Development Goals
SRQR	Standards for Reporting Qualitative Research
SSA	Sub-Saharan Africa
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization

Declarations

Reflexivity Statement

The authors bring diverse academic, professional, and geographical perspectives to this research. The authors (JAA, FKE, PAB, KMA and JTMN) are affiliated with Kwame Nkrumah University of Science and Technology (KNUST), Ghana, specializing in health management and economics in public health. The authors include five health professionals (JAA, RKS, ENK, FEY and EKA, also a researcher) from a Church-based facility and a teaching hospital, informed by direct engagement with Ghanaian healthcare contexts. The team's diverse academic and professional backgrounds provide a balanced perspective on the study project.

Competing interests

The authors declare that they have no competing interests.

Ethics approval and consent to participate

Ethical approval was obtained from the CHAG-Research Department/Institutional Review Board (CHAG-IRB-3072024). All participants provided written informed consent, with participation being voluntary, anonymous, and confidential.

Funding

No sources of funding

Author Contribution

Author Contributions 1. Conception or design of the work - JAA, PAB, and KMA 2. Data collection - JAA, EKA, FKE and JTMN 3. Data analysis and interpretation - JAA, EKA, and FKE 4. Drafting the article - JAA and EKA 5. Critical revision of the article - JAA, EKA, FKE JTMN, RKS, ENK, FEY, KMA and PAB 6. Final approval of the version to be submitted - All authors reviewed and approved the final version of the article.

Acknowledgement

We sincerely thank all individuals who contributed to this study, including hospital administrators and health service managers, for their time, insights, and willingness to share their experiences. We also

acknowledge the support of the CHAG and the participating facilities for facilitating access to participants and documentary sources.

Data Availability

The dataset for this study is available from the corresponding author upon reasonable request.

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Figures

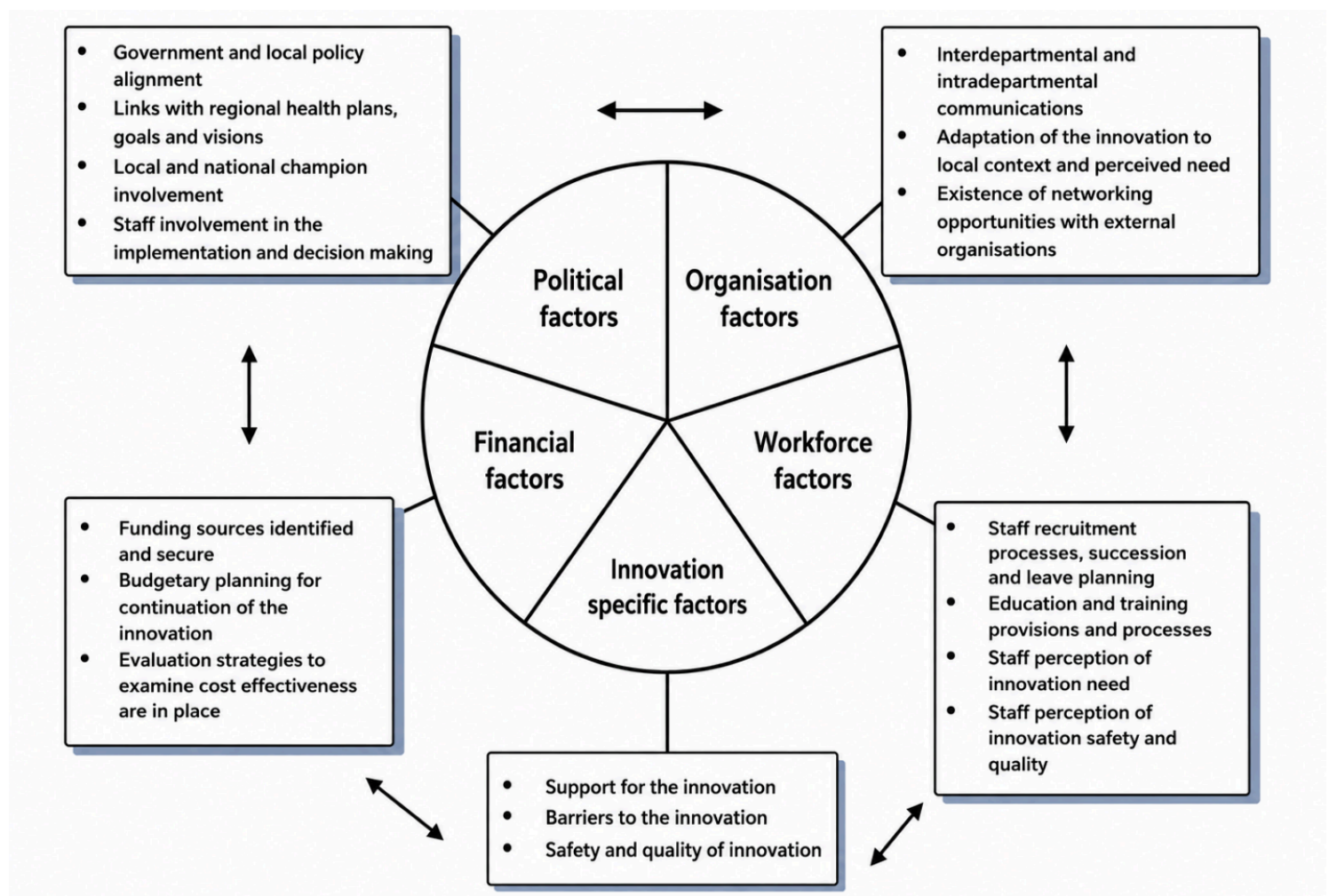


Figure 1

Analytical framework (adapted from the Sustainability of Innovation Framework) for assessing the sustainability of state-church partnerships in Ghana

Supplementary Files

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