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Review Article

Faith-based organisations and religious affiliation and their interactions with financial risk protection in health in Sub-Saharan Africa: A systematic review

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ABSTRACT

Objectives: Over 80 % of the world's population identifies with a religion, especially in Sub-Saharan Africa. However, little is known about how religious affiliation and beliefs influence health insurance uptake. Faith-based organisations also play a major role in healthcare delivery, yet their contribution to financial risk protection, health insurance uptake, and universal health coverage remains underexplored.
Study design: We conducted a systematic review of anglophone publications to examine the interaction between religious affiliation, faith-based organisations, and financial risk protection in health in Sub-Saharan Africa.
Methods: We systematically reviewed anglophone studies published between 2000 and 2024 that explored the themes of religious affiliation and faith-based organisations and their interaction with health insurance or financial risk protection in Sub-Saharan Africa. We searched Embase, Medline, and Global Health. Quality appraisal used JBI and CASP checklists, and data were narratively synthesised.
Results: We included 26 studies from seven Sub-Saharan African countries. Key findings are: i) Several studies reported religious affiliation as a predictor of enrolment, though findings were inconsistent across contexts. ii) Religious norms were found to often negatively influence individual insurance uptake. iii) Case studies showed faith-based organisations support enrolment through outreach and financial aid. iv) Few studies assessed their role in insurance fund pooling or purchasing.
Conclusions: Faith-based organisations are well-positioned to possibly advance universal health coverage by fostering trust in health insurance and providing financial risk protection. However, evidence remains limited. Future research should focus on qualitative insights, fragile settings, and the broader functionalities of health insurance systems to leverage the potential of faith-based organisations in addressing universal health coverage.

1. Introduction

Faith-based organisations (FBOs) encompass a broad spectrum of religiously affiliated groups, including churches, charities, and international faith-based NGOs.[1] While there are no exact data on the number of FBOs in the world, the World Bank estimates that over 80 % of the world's population is affiliated with some religion.[1]

FBOs have long played a crucial role in healthcare, particularly in low- and middle-income countries (LMICs), where they have been integral to the provision of medical services.[2–6] This is often the case in Sub-Saharan African (SSA) countries, where health systems are relatively more fragile and under-resourced in most areas.[6] FBOs are involved in healthcare in various forms, providing medical services, running health facilities, providing disaster relief, or distributing vital healthcare information.[1,6] They often serve communities in remote or underserved areas where government-led healthcare services are

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limited.[6] Worldwide, the Catholic Church has 5245 hospitals and over 14,000 healthcare centres as of 2020.[7] In Kenya, the Christian Health Association of Kenya (CHAK)[8] oversees a network of mission hospitals and dispensaries, and the Uganda Catholic Medical Bureau (UCMB) supports numerous healthcare facilities across Uganda.[9]

FBOs often experience a high level of trust from the communities they serve and are often held in high regard by their members and communities.[10,11] This position enables them to reach populations that might otherwise be overlooked, offering a vital safety net in regions with high rates of poverty and limited access to medical care.[6,10]

The ongoing global push for Universal Health Coverage (UHC) aims to ensure that all individuals and communities receive the healthcare services they need without enduring financial hardship.[12] This goal is central to the United Nations Sustainable Development Goals.[13] However, achieving UHC remains a significant challenge in many LMICs.[14] In SSA, a significant portion of healthcare costs is still paid out-of-pocket,[15] leading to a high risk of catastrophic health expenditure and medical impoverishment.[16,17]

While FBOs play a significant role in healthcare delivery, their contributions to health insurance and financial risk protection remain underexplored in the academic literature.[6,10] Similarly, a comprehensive review of the influence of religious affiliation on health insurance coverage and the ways through which religious affiliation affects individual decision-making on insurance uptake is lacking.

This review thus aims to examine the intersection of FBOs, religious affiliation, and health insurance in SSA, focusing on FBOs' role in advancing financial risk protection and UHC. The findings aim to inform policymakers, healthcare providers, and FBO leaders on strategies to enhance health coverage and achieve SDG 3.8.[13]

2. Methods

2.1. Study design

We conducted a systematic review of published studies examining the relationship between religious affiliation, faith-based organisations (FBOs), and financial risk protection in health within Sub-Saharan Africa (SSA). The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines[18] and the Synthesis Without Meta-analysis (SWiM) reporting guideline.[19] The review protocol was prospectively registered on the PROSPERO database (registration number: CRD42024598105) on December 9, 2024.

2.2. Eligibility criteria

We included peer-reviewed primary research studies that reported on the relationship between religious affiliation and health insurance enrolment or financial risk protection, as well as studies examining the role of FBOs in promoting health insurance, facilitating enrolment, risk pooling, or financing. Studies conducted in any country in SSA and published in English between January 1, 2000 and December 1, 2024 were eligible, regardless of study design. We included quantitative, qualitative, and mixed-methods studies.

We excluded studies conducted outside SSA, as well as commentaries, editorials, protocols, conference abstracts, or narrative reviews. Studies that did not report outcomes related to health insurance enrolment or financial protection were also excluded.

2.3. Information sources and search strategy

We searched three electronic databases, MEDLINE, Embase, and Global Health, all via Ovid, up to December 1, 2024. In addition, we screened the reference lists of all included articles and relevant reviews to identify additional studies.

We developed the search strategy in consultation with an experienced information specialist and combined controlled vocabulary (MeSH and Emtree terms) with keywords related to religious affiliation (e.g., "faith-based organisation," "religion," "church"), financial risk protection and health insurance (e.g., "health insurance," "financial protection," "risk pooling"), and SSA, including both regional and individual country names. Detailed search strings for each database, including Boolean operators, field tags, and applied filters, are provided in Supplementary File 1.

2.4. Selection process

All records retrieved were exported to EndNote for de-duplication. Two reviewers (MAF and NAABD) independently screened titles and abstracts using Rayyan.[20] Full texts were obtained for all potentially eligible studies and screened in duplicate. Any disagreements were resolved through discussion or adjudication by a third reviewer (ADL).

2.5. Data collection process

A standardised data extraction form was developed and pilot-tested on a subset of studies. Two reviewers (MF and ADL) independently extracted data, with discrepancies resolved through consensus.

Extracted information included study identifiers (author, year, country), study design, setting and population characteristics, descriptions of health insurance schemes, measures of religious affiliation, key outcomes such as enrolment rates, perceptions, and financial impacts, quality assessment results, and funding sources or conflicts of interest.

Specific variables of interest included exposure to religious affiliation or participation in FBO-led activities, outcomes such as health insurance enrolment, financial protection measures, or health service utilization, contextual variables (country, setting, study period), study characteristics (design, sample size, data collection methods), and implementation factors related to the use of FBOs for health insurance or financing.

2.6. Risk of Bias assessment

We assessed the methodological quality of included studies using appropriate critical appraisal tools. For cross-sectional studies, we applied the JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies.[21] Qualitative studies were assessed using the CASP Qualitative Checklist[22] while mixed-methods studies were evaluated using a combination of JBI and CASP checklists.[21,22]

Two reviewers (MF and ADL) independently appraised all studies, resolving discrepancies by consensus. Each study received an overall quality rating (low, medium-low, medium, medium-high, or high), which is included in Supplementary File 2

2.7. Synthesis methods

Given the substantial heterogeneity in study designs, populations, and outcomes, we did not conduct a meta-analysis. Instead, we conducted a narrative synthesis, in line with the framework proposed by Popay et al.[49] and structured according to the SWiM guideline.[19]

Studies were grouped according to the main topic focus; specifically, whether they examined religious affiliation as a determinant of enrolment, mechanisms through which religion influences decision-making, or the role of FBOs in promoting or financing insurance; and by study design (quantitative, qualitative, mixed-methods). Where possible, comparable measures such as odds ratios or proportions were extracted and transformed into narrative summaries; due to differences in operational definitions and measurement, standardized effect sizes were not calculated.

Within each thematic group, we described the main findings, compared similarities and differences, and explored potential reasons for heterogeneity, such as differences in study design or setting. Findings are presented as structured thematic summaries, supplemented by detailed tables of study characteristics and quality appraisal results. To assess the robustness of the synthesis, we examined the consistency of findings across studies and considered the potential impact of methodological limitations on the conclusions drawn.

2.8. Certainty of evidence

Due to the diverse nature of the included studies and the absence of meta-analysis, we did not formally apply the GRADE approach.

3. Results

3.1. Search results and eligible studies

Our database search yielded 4870 articles of which 1929 articles were excluded as duplicates. After title and abstract screening, 47 articles underwent full-text screening, with 23 being retained. Three additional studies were identified through reference screening, resulting in 26 included studies.

Fig. 1 below details the search process, and Table 1 below summarises key findings of the studies included in this review. A more detailed table summarising additional characteristics is included as supplementary file 2.

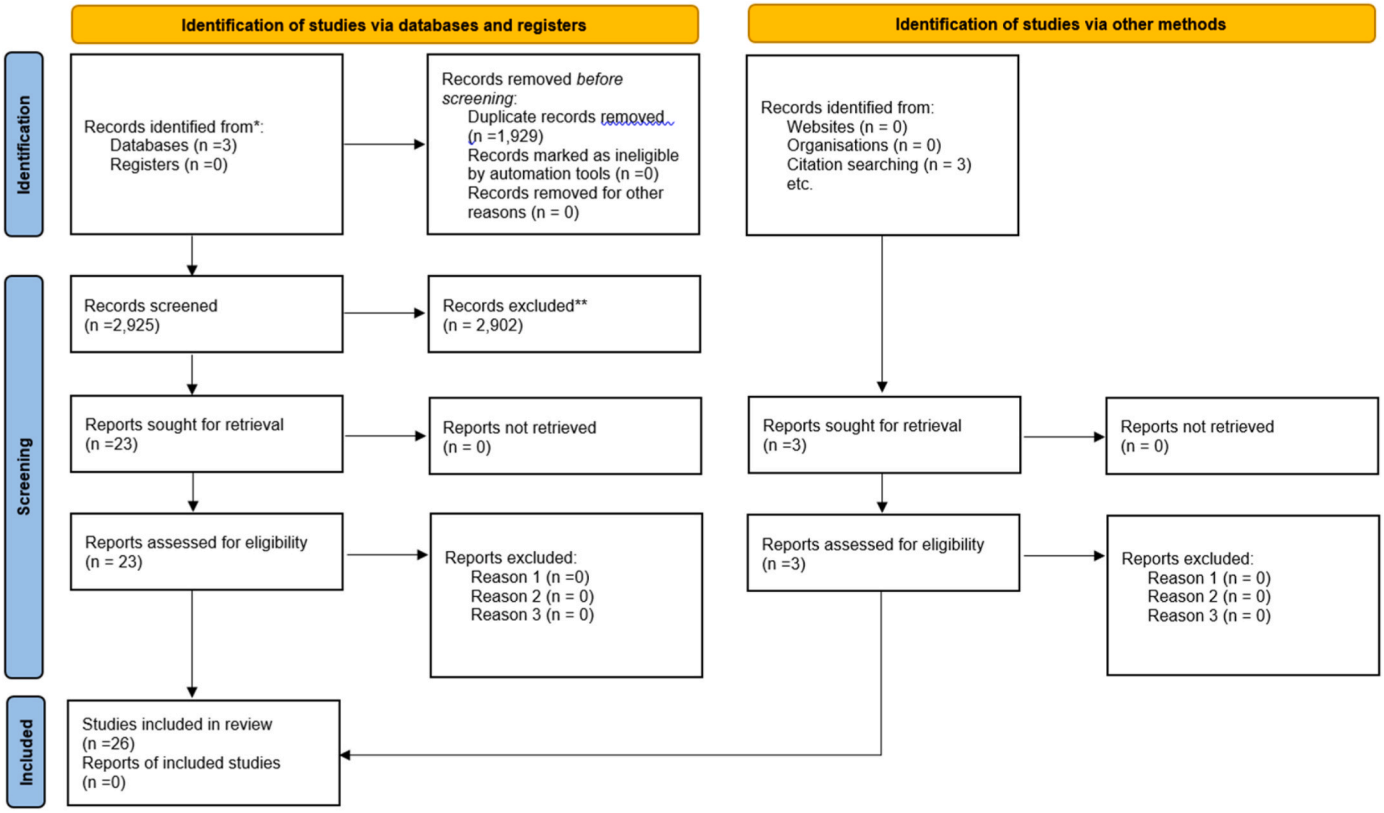

Fig. 1. PRISMA flow diagram for study screening and selection process.

Table 1
Included studies on faith-based organisations and health insurance in Sub-Saharan Africa with title, year, outcome of interest, and key findings. NHIS = National Health insurance scheme: CBHI = Community-based Health Insurance, HSB = Healthcare seeking behaviour.

Title	Year	Outcome of interest	Key Findings
Predictors of enrolment in a health protection scheme among informal sector workers in Kumasi Metropolis of Ghana[23]	2019	Enrolment in NHIS	Non-Christians significantly less likely to enrol in NHIS compared to Christians
Payment for Health Care and Perception of the National Health Insurance Scheme in a Rural Area in Southwest Nigeria[24]	2015	Perception of NHIS	Religious belief described to conflict with NHIS enrolment
Is Ghana's pro-poor health insurance scheme really for the poor? Evidence from Northern Ghana[25]	2014	Enrolment in NHIS	Well educated, prosperous, married, and Christian women more likely to be insured than other women.
Determinants of enrolment in health insurance scheme among HIV patients attending a clinic in a tertiary hospital in South-eastern Nigeria[26]	2023	Health insurance enrolment	Age, marital status, Christian religion, self-employment, urban residence, absence of comorbidities, and HIV diagnosis less than 10 years positively associated with enrolment
Health insurance subscription among women in reproductive age in Ghana: do socio-demographics matter?[27]	2016	Enrolment in NHIS	Wealth, age, religion, birth parity, marriage and ecological zone predicted health insurance enrolment
Health insurance enrolment in the Upper West Region of Ghana: Does food security matter?[28]	2019	Enrolment in NHIS	Religion, occupation, and education significant predictors of health insurance enrolment
Family Circle and Willingness to Subscribe to Community-based Health Insurance (CBHI) for the Elderly in a Rural Community in South-South Nigeria[29]	2023	Willingness to Subscribe to CBHI	Age, tertiary education, occupation, religion, marital status, place of residence and monthly income significantly associated with willingness to subscribe to CBHI
Willingness to pay for National Health Insurance Fund among public servants in Juba City, South Sudan: a contingent evaluation[30]	2017	Willingness to pay for NHIS	Willingness to pay influenced by religion, awareness, sources of individual income, household size and insurance coverage.
Health insurance in Ghana: evaluation of policy holders' perceptions and factors influencing policy renewal in the Volta region[31]	2013	Enrolment in NHIS	Religion, gender, marital status and perception of health status significantly influenced NHIS enrolment and renewal
Sources of healthcare financing among surgical patients in a rural Niger Delta practice in Nigeria[32]	2011	Payment for healthcare	Religious organisations most likely organisations to assist in the payment of hospital bills.
The National Health Insurance Scheme in Ghana's Upper West Region: a gendered perspective of insurance acquisition in a resource-poor setting[33]	2014	Enrolment in NHIS	Muslims less likely to enrol in NHIS compared to other religions
Factors contributing to low uptake and renewal of health insurance: a qualitative study in Ghana[34]	2016	Enrolment in NHIS	Cultural and religious norms discourage enrolment in and renewal of NHIS membership
The role of community-based health insurance on healthcare seeking behavior of households in Addis Ababa, Ethiopia[35]	2023	HSB	Muslim household heads more likely to display appropriate healthcare seeking behaviour than orthodox Christians
Enrolment of reproductive age women in community-based health insurance: Evidence from 2019 Mini Ethiopian Demographic and Health Survey[36]	2023	Enrolment in CBHI	Women of protestant religion were less likely to enrol in CBHI than those of orthodox religions. Women of other religions more likely enrolled in CBHI than those of orthodox religion.
Exploring the role of social representations in micro-health insurance scheme enrolment and retainment in sub-Saharan Africa: a scoping review[37]	2022	Enrolment in health insurance	Religion allegiance of household head influenced preferences of joining health insurance schemes ran by religious organisations.
Barriers and facilitators to enrolment and re-enrolment into the community health funds/ Tiba Kwa Kadi (CHF/ TIKA) in Tanzania: a cross-sectional inquiry on the effects of socio-demographic factors and social marketing strategies[38]	2017	Enrolment in CBHI	Social marketing strategies using religious leaders, traditional dances, sports, games and mainstream media important in attracting community members to enrol in CBHI
Predictors of Willingness to Participate in Health Insurance Services among the Community of Jimma Town, Southwest Ethiopia[39]	2014	Demand for health insurance	Religious beliefs, perceived health, ability to afford healthcare payment and premiums, and level of information were determinants of health insurance awareness and demand
Leveraging Innovative Financing Strategy to Increase Coverage and Resources Among Informal Sector for Social Health Insurance Within the Nigerian Context of Devolution: Evidence From Adoption Model Implementation[40]	2022	n.a., qualitative design	Religious and cultural beliefs about health insurance, distrust in the healthcare system, and health system barriers affected adoption of new healthcare financing models
Socio-demographic Factors associated with Health-Seeking Behaviour and Clinical Outcomes among Patients attending Health Insurance Facility of a Teaching Hospital in Southwestern Nigeria[41]	2023	Timeliness of healthcare seeking	As compared with Christians, more Muslims sought medical attention earlier (less than 24 h of symptoms onset)
Predictors of Community-Based Health Insurance in Ethiopia via Multilevel Mixed-Effects Modelling: Evidence from the 2019 Ethiopia Mini Demography and Health Survey[42]	2022	Enrolment in CBHI	Rural residency, male household heads, funds from safety net programs, primary education, bank accounts and wealth index, and religious affiliation associated with CBHIS coverage.
Uptake of health insurance among Muslims in Nairobi county, Kenya[43]	2017	Enrolment in NHIS	Low uptake of health insurance among Muslims partly due to perception of Sharia law prohibiting them from

(continued on next page)

Table 1 (*continued*)

Title	Year	Outcome of interest	Key Findings
			enrolling in conventional insurance
Households Sociodemographic Profile as Predictors of Health Insurance Uptake and Service Utilization: A Cross-Sectional Study in a Municipality of Ghana[44]	2018	Enrolment in NHIS	Muslims, minority ethnic groups, widows, divorced families, respondents aged 38–47 years, and 58 years and above less likely to have NHIS membership
Piloting Mutual Health Association Establishment in Enugu State, Southeast Nigeria Lessons Learned[45]	2022	Faith-based CBHI	Establishing CBHI through faith-based organisation was possible and sustainable
Drivers of Health Insurance Coverage in Low Income Settlements: A Case of Kibera Informal Settlement, Nairobi County, Kenya[46]	2023	Health Insurance enrolment	Religion, gender, age, frequency of hospital visits, cost of premium and pre-existing illness negatively impact health insurance uptake
The determinants of the willingness-to-pay for community-based prepayment scheme in rural Cameroon[47]	2011	Willingness to pay for CBHI	Catholic household heads more likely to pay than those of other religions.
Determinants of Uptake of Community-Based Health Insurance in the Bamenda Ecclesiastical Province Health Assistance[48]	2023	Enrolment in CBHI	Religion, age, marital status, and level of income positive impact on CBHI enrolment

3.2. Quality appraisal

Of the 26 studies included in the review, five were of high quality,[24,33–35,42] ten of medium-high quality,[25,27,28,31,35,38,40,44,46,47] three of medium,[23,30,39] three of medium-low,[41,43,48] and four studies of low quality.[26,29,32,45] One study[37] received no quality appraisal due to the nature of the study as a scoping review.

3.3. Characteristics of included studies

The 26 studies included in the review were conducted in seven countries: Ghana (8 studies),[23,25,27,28,31,33,34,44] Nigeria (7 studies),[24,26,29,32,40,41,45] South Sudan (1 study),[30] Ethiopia (4 studies),[35,36,39,42] Tanzania (1 study),[38] Kenya (2 studies),[43,46] and Cameroon (2 studies).[47,48] One included study was a scoping review covering all of SSA.[37]

19 of the 26 included studies used a cross-sectional design,[23–29,31,33,35,36,38,39,42–44,46–48] two studies employed a mixed-method,[30,40] and two used a qualitative design.[33,45] One study each was a longitudinal quantitative study,[32] a retrospective review of patient records,[41] and a scoping review.[37]

3.4. Religion as determinant of insurance enrolment

Most studies examined religious affiliation as a factor in health insurance uptake.[23,27–31,35,36,41,42,44,46–48] The findings of these studies are inconsistent and have limited comparability for two main reasons. Firstly, the definitions of religious affiliations, as well as the granularity in the description of different religious affiliations, differ across studies. For example, Adei et al.[23] define only two religious groups, "Christians and non-Christians", whereas Amu and Dickson[27] define nine groups (Catholic, Anglican, Methodist, Presbyterian, Pentecostal, Other Christian, Islam, Traditionalist, and no religion).

Secondly, three studies did not provide detailed descriptions of which religious groups were analysed. Basaza et al.[30] described religion as a factor for health insurance uptake but did not describe which religious groups were analysed. Similarly, Ng'ang'a and Odhiambo[46] found that being of any specific religion reduced the probability of obtaining health insurance, and Solomon et al.[41] found no association between religious affiliation and insurance uptake.

Findings on religious affiliation as a determinant of enrolment were inconsistent across the studies. Some reported higher enrolment among Christians compared with non-Christians,[44] followers of traditional African religions,[25,27,29,33] those of no religion,[25,27] or Muslims.[26,31,33,44] Conversely, other studies showed that Muslims or other religious groups were more likely to enrol in health insurance.[25,28,48]

Comparing different streams of Christianity, two studies showed Catholics to be more likely to enrol than other Christian groups.[27,47]

Two studies from Ethiopia[36,42] analysed the health insurance enrolment of Orthodox followers, with inconclusive results. Handebo et al. showed that followers of the Orthodox religion were less likely to enrol in health insurance than Muslims and other religious groups, but more likely to enrol than followers of the protestant religion.[36] This conflicts with another study from Ethiopia, which found followers of the Orthodox religion to be more likely to enrol in health insurance schemes.[42]

3.5. Mechanisms through which religious beliefs influence insurance uptake

Five studies[24,34,37,39,43] analysed the interplay between specific religious beliefs and individual decision-making processes about health insurance enrolment. Most studies revealed mechanisms through which religious beliefs negatively affect insurance uptake.

Adewole et al. revealed that among household members in rural Nigeria, 25.8 % of respondents stated that taking up health insurance would conflict with their religious beliefs.[24] Similarly, Hassan et al. revealed that for 74.8 % of respondents, religious beliefs negatively influenced their decision on insurance uptake.[43] Specifically, respondents said that many health insurance offers contradicted Sharia law and were thus unacceptable for believers.[43] For women of the Islamic faith, patriarchal religious norms hindered them from enrolling in health insurance schemes, even when they themselves were interested in enrolling.[34]

Among community members in Ethiopia, insurance uptake was equally seen to conflict with their religious beliefs.[39] Kalolo et al. revealed that people believed that saving for future episodes of ill health may invite future health problems and that health insurance schemes were not apt to local cultural and religious contexts.[37]

Only one study[37] reported mechanisms through which religious beliefs positively influenced insurance uptake, where community members were more interested in joining insurance schemes run by missionaries, religious organisations, or members from the same faith or ethnic group, expressing an increased sense of identity and trust in these systems.[37]

3.6. Faith-based organisations and leaders for outreach about insurance

Two studies examined the effect of religious leaders conducting outreach activities about insurance, showing a significant increase in insurance enrollment among community members.[38] Onyemaechi and Ezenwaka described how religious leaders advocating for insurance uptake among community members and identifying vulnerable people who would particularly benefit from health insurance increased insurance uptake.[40] They additionally analysed the role of religious leaders in identifying local philanthropists who would cover insurance enrolment costs for vulnerable community members as an innovative financing mechanism.[40]

3.7. Religious organisations helping to cover hospital bills

One study analysed the sources of financing for high hospital bills among surgical patients in Nigeria and found that approximately 31.44 % of respondents drew on local religious organisations to help cover hospital costs.[32]

3.8. Faith-based community health insurance schemes

Only one study describes a faith-based community health insurance scheme in Nigeria.[45] The study found that the scheme, building on the community standing of faith-based networks, was both feasible to implement and sustainable, and highlighted mutual solidarity among religious communities as a key success factor in setting up the insurance scheme.[45] This solidarity facilitated risk-pooling and progressive insurance premiums as part of the scheme analysed.[45] Further, the study showed that church-based structures were not only influential in conducting outreach and sensitisation about insurance uptake but also in collecting insurance premiums, a task with which priests, as trusted community members, were entrusted.[45]

4. Discussion

This review is, to our knowledge, the first to address the collective role of FBOs in financial risk protection in health in SSA.

The relationship between religious affiliation and insurance uptake was not uniform across the studies included in this review. Several studies indicated that Christian groups reported higher enrolment than Muslims, while others suggested the reverse, with Muslims or members of other religious groups showing greater participation in health insurance programs.[23,25–31,35,36,41,42,44,46–48] These inconsistencies likely reflect the different study settings, population groups, and measures of religious affiliation applied across the literature. For example, some studies defined only broad categories such as "Christians and non--Christians," while others differentiated between denominations or included traditional and unaffiliated groups, which complicates direct comparison. Despite this variability, there was consistent agreement across studies that individuals practising traditional African religions were least likely to enrol in health insurance schemes.[25,27,29,33] However, these findings may not fully capture the influence of other determinants of insurance uptake, such as socioeconomic status, education, and literacy, that are known to be important predictors of health insurance uptake in SSA[50,51] and to differ systematically between religious groups in LMICs.[52,53] Further research is needed to examine the relationship between religious affiliation, socioeconomic inequalities, and insurance enrolment.

A second group of studies examined the mechanisms at the individual level through which religious affiliation may affect decisions on insurance uptake.[24,34,37,39,43] In most studies, religious affiliation had a negative impact on insurance uptake.[24,34,39,43] Several studies reported that health insurance conflicted with religious beliefs.[24,34,39,43] One study found that religious norms reinforced gender inequalities, limiting women's financial autonomy and ability to enrol in insurance.[34] Conversely, one study highlighted a positive influence, with individuals more likely to join insurance schemes affiliated with their religious community.[37]

Beyond individual religious beliefs,the evidence on the broader role of FBOs in supporting health insurance uptake was limited and inconsistent. Two studies[38,40] found that religious leaders played a crucial role in promoting insurance enrolment through community outreach and education, suggesting that leveraging religious institutions could enhance the impact of health insurance programs. However, only one study[32] identified religious institutions as direct financial supporters for covering hospital costs, and one study[45] described a faith-based insurance system in Nigeria.

While limited, the evidence offers insights into how health systems, policymakers, and other stakeholders could engage with FBOs in financial risk protection. Studies in this review did suggest that trust in health insurance schemes was linked to religious affiliation and that outreach by religious leaders enhanced insurance enrolment in some contexts.[38,40,54,55] In countries with large informal sectors like Ghana or Kenya, where health insurance schemes depend heavily on voluntary uptake, strategic engagement with FBOs may represent one possible approach among several to facilitate insurance education and outreach.[52,53,56]

Additionally, FBOs could serve as platforms for pooled health funding in contexts where traditional health financing mechanisms are lacking or inadequate. Two studies in our review[32,45] illustrate that FBOs can offer informal financial support or establish community-driven pooling systems to ease healthcare costs for lower-income groups. Implementers could partner with FBOs to mobilise financial support for the most vulnerable populations, including those unable to afford even subsidized insurance premiums. Religious leaders also hold potential as advocates for philanthropic health insurance contributions, which could help impoverished members access healthcare, as described in one study in this review.[40]

While this review has highlighted several ways in which faith-based organisations (FBOs) show promise in supporting financial risk protection in health, implementers should approach these collaborations with caution due to several nuanced challenges. For instance, the review highlights that followers of traditional African religions are less likely to enrol in health insurance schemes, and there is no evidence that religious leaders from these communities effectively promote insurance uptake.[25,27,29,33] Therefore, aiming to build trust in health insurance among these groups may require exploring alternative advocacy and outreach strategies. Culturally tailored interventions involving respected community figures such as local elders or healthcare providers may be more effective than religious leaders in these contexts.[54,57]

Additionally, implementers should remain cautious of potential conflicts between certain religious beliefs and health insurance principles,[24,34,39,43,58] as such beliefs can pose significant barriers to health insurance enrolment and retention. Implementers must therefore consider ways to address these barriers sensitively, for example by working with religious scholars or developing insurance products that accommodate these beliefs.[59–61] This approach may prevent alienation and ensure that financial risk protection programs are inclusive.

Further, it is important to acknowledge that some FBOs may hold doctrinal positions that restrict access to particular health services, such as contraception or abortion care.[62–64] These positions may restrict medical services provided under medical schemes collaborating with FBOs, limiting patients' rights and access to essential medical services. Further, FBOs may be reluctant to cooperate with individuals who do not share the same faith or values. In such cases, there is a risk that health financing mechanisms tied to FBOs could exacerbate, rather than reduce, inequities. Policymakers and implementers therefore need to weigh the potential benefits of partnering with FBOs against these limitations, ensuring that collaborations do not compromise equity or access to comprehensive healthcare.

4.1. Strengths and limitations

Despite these important findings, this study has several limitations.

First, we only included studies published in English, which likely led to the exclusion of relevant research from Francophone African countries and studies in other languages. As many of these countries have weaker health financing systems, FBOs may play an even more significant role in healthcare provision and financial risk protection in those settings.[65–67] Additionally, most included studies focused on countries where national insurance schemes have been implemented or are being expanded. While this focus is relevant for understanding interactions between religion, FBOs, and insurance frameworks, it overlooks fragile settings where FBOs may be particularly critical.[6] The heterogeneity of included studies prevented a meta-analysis, limiting our ability to quantify overall effects. Moreover, while study quality was generally high, four studies were rated low quality. These studies were included due to their unique insights into the role of FBOs in financial risk protection, though their findings should be interpreted cautiously.

Overarchingly, these limitations of our research highlight that more research is needed to better understand the relationship between

religious affiliation and health insurance uptake in SSA. Specifically, there are not many documented studies from other African countries without national health insurance schemes, particularly those in low-resourced settings. Additionally, future research should employ more qualitative and mixed-methods approaches, such as process evaluations, to examine the specific mechanisms through which FBOs influence health insurance uptake. Finally, while this review focused on enrolment, little is known about how FBOs contribute to broader health insurance functions, such as risk pooling and purchasing. Further research is needed to explore these aspects, especially given the prominent role of FBOs in healthcare provision across underserved regions.

However, despite these limitations, this research has several important strengths.

To our knowledge, this is the first systematic review to explore the role of FBOs in financial risk protection in health across SSA. Our review provides a comprehensive synthesis of evidence not only on religious affiliation and insurance uptake but also on the contributions of FBOs in promoting enrolment and supporting informal pooling mechanisms. By including studies examining both individual-level and institutional-level influences, we offer a nuanced perspective that goes beyond prior work focused solely on household determinants of insurance enrolment. Furthermore, our findings have clear practical relevance, offering concrete recommendations for policymakers and implementers on collaborating with FBOs to strengthen health financing systems and for researchers by highlighting gaps in existing evidence.

5. Conclusions

Our review summarises the roles FBOs currently play in financial risk protection in health in SSA and potential future areas for involvement. However, the existing evidence is limited and heterogeneous, underscoring the need for further investigation into the ways FBOs may contribute to financial risk protection, and for more targeted research into how FBOs might engage in pooling, purchasing, and other strategies aimed at reducing out-of-pocket expenditures. Future studies should explore the practical and contextual factors that influence the effectiveness of FBOs in supporting UHC and financial risk protection. Policymakers, stakeholders and researchers should prioritize these areas of inquiry to better understand the potential role of FBOs in achieving the broader goals of UHC in sub-Saharan Africa.

Author statements

Ethical approval

Ethical approval was not required as this study was a systematic review of published literature.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhe.2025.106014.

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