Shaping service delivery through faith-based service inclusion: the case of the Salvation Army in Zambia

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Abstract

Purpose – While service inclusion principles raise the awareness of scholars to service that improves holistic well-being, little research explicitly investigates the spiritual dimensions of service inclusion. This study, therefore, aims to explore faith-based service inclusion in sub-Saharan Africa.

Design/methodology/approach – A qualitative case study of the Salvation Army's Chikankata Services in Zambia was undertaken. Semi-structured interviews with the organization's leaders and professionals were analyzed thematically.

Findings – Service inclusion pillars evince contextualized meaning and priority. In resource-constrained, vulnerable communities, faith-based service inclusion prioritizes two additional pillars – "fostering eudaimonic well-being" and "giving hope," where existence is precarious, fostering (hedonic) happiness is of low priority. Findings reveal that pillars and processes are mutually reinforcing, harnessed by the individual and collective agency to realize transformative outcomes from service inclusion.

Research limitations/implications – This paper provides unique insight into faith-based service inclusion but acknowledges limitations and areas warranting further research.

Practical implications – The study yields important managerial implications. Service providers can use the framework to identify the contextual priority and/or meaning of service inclusion pillars and relevant reciprocal processes. The framework emphasizes the harnessing potential of individual agency and capability development for transformative well-being.

Social implications – Faith-based service inclusion, predicated on inclusion, human dignity and holistic well-being, has important implications for reducing the burden on scarce resources while building resilience in communities.

Originality/value – By examining a faith-based service in sub-Saharan Africa, this paper provides a holistic framework conceptualizing pillars, processes, agency and outcomes to extend Fisk *et al.*'s (2018) service inclusion pillars and to better understand the shaping of service delivery for service inclusion.

Keywords Co-creation, Well-being, Service inclusion, Faith-based organizations, Sub-Saharan Africa, Transformative service research, Salvation army, Chikankata

Paper type Research paper

1. Introduction

Despite service scholars recognizing the centrality of service to transformative human experience and well-being (Alkire *et al.*, 2019; Fisk *et al.*, 2020; Rosenbaum *et al.*, 2011), service research has typically overlooked the spiritual aspects of well-being, favoring the physical and psychosocial aspects. The "significant and sustained interest within the health sciences on the topic of religion/spirituality and health" (Koenig *et al.*, 2012, p. 5) and the considerable work revealing faith as an integral factor in the health and well-being of people (Ivtzan *et al.*, 2013), challenge service researchers to consider spiritual and religious dimensions in service inclusion. Service inclusion research and the ServCollab initiatives (Fisk *et al.*, 2020) are responding to this challenge by "rais[ing] the aspirations of service researchers[...]and build[ing] mutually collaborative service research approaches that transform human lives" (Fisk *et al.*, 2020, p. 2). Fisk *et al.* (2018) argue that service inclusion principles can facilitate transformative well-being through enabling opportunities, offering choice, relieving suffering and fostering happiness. Thus, appreciating the transformative value of service, there is "great power and potential in this new

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understanding of the central role of service in human life" (Fisk *et al.*, 2020, p. 2).

However, development scholarship recognizes that secular approaches to service can fail to deliver the required transformations in peoples' lives, putting "faith under the spotlight" (James, 2011, p. 111). Faith-based organizations (FBOs) are organizations with the religiously-informed and inspired professions and practices that deliver and support community services and maintain a religious identity through their activities, decision-making and staffing (Leurs, 2012; Tagai *et al.*, 2018). Although the FBO term lacks conceptual and definitional clarity (Tomalin, 2012; Yasmin *et al.*, 2014), faith is pivotal to the purpose and mission of FBOs guiding how they engage with communities differentiating them from secular organizations (Smith and Sosin, 2001). Notwithstanding some skepticism regarding the role of FBOs (Olivier *et al.*, 2015), their positive impact on service delivery is unquestionable (Duff and Buckingham, 2015; Magezi, 2012). Although assessing the magnitude of FBOs' contribution to education and health services in sub-Saharan Africa is problematic (Olivier *et al.*, 2015), FBO services have nevertheless been called "the hidden giant in African health care" (Olivier and Wodon, 2012, p. 821) and considered critical in the drive to achieve the Millennium Development Goals (Olivier *et al.*, 2015).

Human development challenges in sub-Saharan Africa (e.g. unequal access to education and negative health outcomes emanating from cholera, malaria, Ebola and HIV/AIDS) are in stark contrast to the recent documented economic growth (Africa Development Bank Group, 2016). In sub-Saharan Africa, much of the population lives below the poverty line (Okojie and Shimeles, 2006) and there are massive infrastructure gaps (Nel, 2018). Over four decades, sub-Saharan Africa has been grappling with HIV/AIDS, the effects of which have been devastating. Mortality from AIDS has left a legacy of loss, depriving communities of many of their socially and financially productive adults and a generation where large numbers of children are currently living or have grown to adulthood, as orphans and vulnerable children (Doku, 2009). However, the total collapse of the health delivery system has been averted, in part, by the active engagement of FBOs (Duff and Buckingham, 2015; Magezi, 2012). Thus, the faith/development interface is crucial in addressing the complex health service challenges in countries whose resource-constrained health systems are increasingly fragile.

The parallels between emerging service scholarship initiatives and FBOs' core foundations, namely, the holistic view of individual well-being – physical, psychosocial and spiritual – and "commitment to the dignity of every human being" (Duff and Buckingham, 2015, p. 1786), are central to this research. FBOs' focus is on mobilizing resources for the poor, vulnerable and marginalized people to provide both individual and community well-being outcomes (Bielefeld and Cleveland, 2013; Duff and Buckingham, 2015). However, to date, the relationship between service inclusion, well-being outcomes and FBOs has been under-researched. Therefore, our research purpose is to understand faith-based service inclusion and how FBOs' service logic shapes collective and personal transformative value. To address this purpose, we pose two research questions:

RQ1. What are the foundations of faith-based service inclusion?

RQ2. How do faith-based service inclusion shape service processes and potential collective and individual transformative outcomes?

We provide several contributions. The first theoretical contribution of this study is the extension of service inclusion pillars (Fisk *et al.*, 2018) to include pillars reflecting contextualized meaning and priority. Moreover, we suggest that in resource-constrained contexts the pillar of fostering happiness and the experience of hedonic well-being from services is a variant that deserves further exploration. The second theoretical contribution is a holistic framework that builds on Fisk *et al.*'s (2018) service inclusion work conceptualizing pillars, processes, agency and outcomes to better understand the shaping of service delivery for service inclusion. This conceptualization is elaborated in four propositions. We argue that effective service inclusion requires congruent processes and principles, exemplified in faith-based service inclusion, to achieve transformative outcomes and that these factors are mutually reinforcing. Further, we demonstrate that community capability harnesses both service inclusion and inclusion-congruent processes, allowing individuals to flourish in their daily lives and strengthening their capacity for improved well-being. Thus, transformative outcomes are a negotiated practice against a complex backdrop of social, cultural, economic, political, historic and even geographic forces. Examining the under-researched area of FBOs' health care service delivery in sub-Saharan Africa supports the understanding of transformative services and the impact of service inclusion on value co-creation.

This paper is structured as follows. First, the key concepts relevant to our study are discussed in Section 2. The method is then outlined including the justification for our case study context, the Salvation Army (TSA) in Zambia, specifically Chikankata Health Services (CHS) at the Chikankata Mission are discussed in Section 3. The findings are presented in Section 4 and discussed leading to the faith-based service inclusion framework in Section 5. Finally, the theoretical, managerial and societal contributions conclude the paper in Section 6.

2. Service inclusion

2.1 Service inclusion and outcomes

Fisk *et al.* (2018, p. 835) define the concept of service inclusion as "an egalitarian system that provides customers (consumers, clients, patrons, citizens, patients and guests) with fair access to a service, fair treatment during a service and fair opportunity to exit a service."

By adhering to principles of service inclusion, service providers can make good on promises to create value without discrimination, disadvantage or exclusion, thereby promoting well-being via service design and delivery (Fisk *et al.*, 2018; Grönroos, 2008). Service inclusion practices are the means by which individuals can participate in society and where service providers (and service systems) help to enhance people's well-being. As services operate within socio-cultural systems, service inclusion must also evolve and respond to social trends and pressures if the inclusive practices are to be egalitarian into the future. This evolution must be complemented by service design and delivery that acknowledges fairness as individually

perceived and interpreted, yet also influenced by social and organizational contexts.

Service inclusion is built on four broad, yet interrelated concepts. Using a bridge metaphor Fisk *et al.* (2018) call these pillars: enabling opportunities through the access to services and the ability to receive and co-create valued services; offering choice between different service offerings and service provision free of coercion; relieving suffering through fulfilling basic human needs; and fostering happiness and the hedonic well-being from service experiences. Each pillar is necessary for connecting service providers and consumers and achieving service inclusion; moreover, service inclusion practices must be delivered in an environment that fosters human dignity and happiness. The outcomes of service inclusion occur at multiple levels (micro, meso and macro) although the mechanisms through which well-being leads to transformative change are not yet well understood (Previte and Robertson, 2019).

Service exclusion occurs when "services (service providers or service systems) deliberately or unintentionally fail to include or to adequately serve customers in a fair manner" (Fisk *et al.*, 2018, p. 835). While many factors impact inclusion and perceived fairness, service inclusion challenges marketers to respond to diversity and intersectionality structures of discrimination when designing and providing fair access to resources and services. In sub-Saharan Africa, with multiple contexts of service exclusion: race, class, gender, poverty, illness, sexuality, the applicability of service inclusion models to FBOs is yet to be fully explored. The contexts of hardship, scarce resources and health access disparities in sub-Saharan Africa further highlight the relevance of service inclusion.

The link between service inclusion and transformative outcomes is complex but it can be generally agreed that when improvements to wellbeing are "enduring[. . .]they are transformative" (Dean and Indrianti, 2020, p. 11). The multi-dimensional construct of well-being encompasses both hedonic and eudaimonic dimensions (Ryan and Deci, 2001). Equally important, well-being is both personal and subjective, within an individual's world view, psychological attributes and socio-cultural context (Blocker and Barrios, 2015; Reynoso *et al.*, 2015). Service organizations and service inclusion principles and actions can, at best, be facilitators of transformative outcomes shaping the opportunities for well-being and long-term change in people's lives.

While value co-creating resources reside in the relationships and social contexts of a service ecosystem (Edvardsson *et al.*, 2011), consumers may lack the resources or access to resources, that lead to them often facing service inclusion issues (Hill and Sharma, 2020; Shultz and Holbrook, 2009). Organizations and institutional arrangements are also influential in consumers' experiences of vulnerability as service structures and processes may enhance or hinder these consumers' resource integration (Baker *et al.*, 2005). As lack of resources (or lack of control of these resources) can occur at individual, interpersonal and system or structural levels, experienced vulnerability can be exacerbated when these are combined. For example, the intersectionality of poverty, race, norms, gender and social capital may combine to reduce resource integrating activities (Mick *et al.*, 2012). Vulnerability is thus situational, fluid and socially constructed, not a property of a group (Baker, 2009). This experienced vulnerability may become embedded in communities leaving a legacy for future generations (for example, ongoing effects of famine and HIV/AIDS). However, Sen's (2002) capability theory emphasizes the ability and agency of individuals in transformative change and how they can realize the possibilities of their capabilities. Resilience theory also identifies the assets that individuals, communities and systems possess enabling them to rebound from adversity, strengthened and more resourceful. Resilience is considered an ecosystemic concept embedded in contextual and cultural factors whereby actors (persons, organizations or systems) secure the resources required to sustain well-being (Ungar, 2012, 2018). Service inclusion can shape these enabling environments and interactions to provide greater access to resources, provide consumers with greater control over resources and through co-creation build existing social capital within community networks and practices (Blocker and Barrios, 2015; Fisk *et al.*, 2018). Thus, service responses must address both resource assets and deficits and the adaptive capacities of consumers and contexts.

2.2 Faith-based organizations' service approach

The presence and contribution of FBOs in health, education and humanitarian services in developing countries is not new. Although linking back to the missionary era when health and healing were woven into the overall work of religious conversion (Olivier *et al.*, 2015), more recently governments and development organizations re-acknowledged the compelling evidence of FBOs as agents of transformation and added value in development (Mati, 2013). Public policy and development scholars in particular have addressed the added value and comparative advantage of FBOs in service outcomes (Clarke and Ware, 2015). FBOs participating in healthcare service delivery offer capacity and scope for improving community health outcomes and for effecting health-related behaviors and attitudes (Duff and Buckingham, 2015). They are effective in fostering relationships with communities to facilitate widespread basic treatment, disease prevention, health promotion and community health (Magezi, 2018). In particular, churches are recognized subsystems of the community (Magezi, 2012).

Acknowledging the difficulties in separating faith from secular and distinguishing faith versus religion, scholars agree that faith itself makes a difference in FBOs' participation in service. The essential principles that characterize FBOs' approach to service include: "spiritual teaching; hope, meaning and purpose; transcendental power" (James, 2011, p. 111–112). Both in the development context and elsewhere (Clarke and Ware, 2015; Cloke *et al.*, 2013; Leurs, 2012) these principles offer added value in several ways, including: reaching the poorest at the grassroots; having a long-term presence and creating long-term social capital; being highly trusted institutions; and eliciting motivation through "compassion and service; unity and interconnectedness; justice and reconciliation" (James, 2011, p. 113). These principles are operationalized into service from a position of eternal hope (Cloke *et al.*, 2013). Thus, FBOs' (and their members') concept of service works against service exclusion and discrimination, embodying much more than the same services offered by secular service organizations. It is from this

perspective that we examine the role of a FBO in health delivery in sub-Saharan Africa.

3. Method

3.1 The sub-Saharan context

The research uses the specific context of sub-Saharan Africa and a case study FBO, TSA, to extend our understanding of service inclusion. We improve the context-sensitivity of service theory by "indigenizing" the definition of a service phenomenon – service inclusion (Tsui, 2006, p. 8). Two contextual attributes of sub-Saharan Africa – task shifting and *Ubuntu* – are pivotal to our study.

3.1.1 Task shifting and health service delivery

Task shifting moves transferable activities from health worker to another health worker (e.g. doctor to nurse) and health worker to lay health worker (e.g. nurse to community/faith-based leader/peer educator) (Mdege *et al.*, 2013; Mwai *et al.*, 2013). As community health workers can reach remote areas, build caring relationships and provide dignity for patients, task shifting is a cost-effective method for improved patient outcomes (Mwai *et al.*, 2013; World Health Organization, 2008) in regions such as Zambia with limited expenditure on health and the low physician to population ratios. While task-shifting fosters an enabling environment for FBOs to participate in health service delivery, little is known about how it is orchestrated at the grassroots level as part of a broader service inclusion endeavor.

3.1.2 Ubuntu in sub-Saharan Africa

Several sub-Saharan African countries share a cultural heritage through *ubuntu*. *Ubuntu* – a word with synonyms across several Bantu and Nguni languages – literally translates to "being human" and denotes the word "humane." While, initially, *ubuntu* was viewed simply as a human quality typified by being hospitable, generous, caring, compassionate, sympathetic and empathetic (Lutz, 2009), the concept is far more nuanced and holistic and thus "very difficult to render into a Western language" (Tutu, 1999, p.34).

Increasingly, *ubuntu* is a way of being or philosophy which articulates interpersonal and community bonds. Proverbs such as *ubuntu ngumntu ngabanye abantu* (Xhosa language) or *umuntu ngumuntu ngabantu* (Zulu language) which roughly translates to "a person is a person through other people" encapsulate this worldview (Gade, 2011). This notion of "*I am because we are*" speaks to the enduring bonds of solidarity that interdependent individuals and communities share. For this reason, *ubuntu* is an enlightening context for examining service philosophy and initiatives in sub-Saharan Africa (Lutz, 2009; Mugumbate and Nyanguru, 2013). Concerning service delivery, *ubuntu*-centric philosophies emphasize respect and preservation of human dignity (Chasi and Omarjee, 2014; van Dyk and Matoane, 2010).

3.2 Setting

While Zambia faces great challenges in achieving universal health care, FBOs are acknowledged as a major contributor of health-care delivery (Zambia Ministry of Health, 2016); some data suggest FBOs account for 40% of Zambia's national health-care services (Churches Health Association of Zambia, 2018; Olivier *et al.*, 2015).

TSA, a Christian church, is one such FBO long established in health and education service delivery in Zambia. TSA is widely known for its social services and mission with the delivery of health care in 37 nations (The Salvation Army, 2019). TSA mantra of "soup, soap and salvation" underscores the very beginnings of its social services (Wolf-Branigin and Bingaman, 2017, p. 160), depicting that pressing health needs must be attended to before preaching can be effective. Continuing today, TSA adopts a covenant partner approach moving services wherever possible into the community from an institutional base as part of their community-based care philosophy (Wolf-Branigin and Bingaman, 2017).

TSA's CHS is the focus of this study, made up of a 200-bed hospital (Chikankata Mission Hospital) and a primary community health care service, together serving a geographically isolated area of over 100,000 people, predominantly cattle and subsistence farmers. The mission complex houses 3,000 people and includes: health-care training facilities, a secondary school, radio station, church and divisional headquarters. The community-based care philosophy centered on building relationships with local leaders and facilitating community counseling where all members have a platform to learn and contribute provides a compelling reason for our study context.

3.3 Design

The research design is guided by a constructivist and transformative worldview (Creswell, 2013) assigning meaning to social phenomenon yet at the same time, focusing on identifying, understanding and alleviating societal ills (Mertens, 2007). Our choice of a qualitative explanatory case study reflects methodological fit as it provides an informative way of answering the "how" and "why" questions (Yin, 1981).

3.4 Participants and data collection

Due to the challenges of fieldwork in the study context (Dean and Indrianti, 2020; Ostrom *et al.*, 2015; Reynoso *et al.*, 2015), a purposeful sampling strategy was used to select experts at the operational levels of TSA (Miles and Huberman, 1994). This recognized participants' roles as service providers enabling exploration of the application of TSA's mission and values in service inclusion. Participant selection was achieved through TSA Territorial Leadership in Zambia.

The data were generated via in-depth interviews with eight participants. Each interviewee received a semi-structured question guide prior to the interview. The interview guide focused on the respondent's role in health care or leadership, their understanding of how faith-based health care might transform communities and individuals, TSA approaches that lead to success in health care and personal experiences they believe impacted most on their belief in the influence of FBO health care implementation. Recorded interviews were conducted via skype, zoom and WhatsApp, lasting between 50 and 120 min and transcribed verbatim. Data collection occurred in early 2020 coinciding (unintentionally) with the emergence and rapid escalation of the COVID-19 pandemic. While the pandemic response was often part of interview

conversations around healthcare capacity, this was not the focus of the research.

The participants were TSA staff: involved with TSA health care service delivery in Zambia, either in a leadership, governance or managerial/coordination position (Lead, four participants); or health-care professionals or administrators at CHS (Health, four participants). Three participants were TSA Officers (pastors) who held commissions that also included health appointments (medical and nursing) with the current registration and practicing certificates. Six participants resided in Zambia (Zam); the remainder (Os) who had recent previous experience at the Chikankata Mission resided in New Zealand (n = 1) and the United Kingdom (n = 1). Three participants were native-born Zambians.

3.5 Analysis

Data analysis involved reflexive thematic analysis (Braun and Clarke, 2006) and Gioia *et al.* (2013) synthesis. Themes emerged reflexively through the researchers' thoughtful engagement and reflection with the data and analytic process (Braun and Clarke, 2019). The rigor of the research process was supported by two of the researchers participating at the reflexive stage of the analysis to help "develop a richer more nuanced reading of the data" (Braun and Clarke, 2019, p. 594). The Gioia *et al.* (2013) process guided the interpretation of informant terms illustrated by participant quotes) into themes. To answer *RQ1,* Fisk *et al.*'s (2018) service inclusion pillars provided the basis for exploration of the data-driven themes. To answer *RQ2* the themes were inductively derived from the data. Combined with creative reasoning processes (Hunt, 2020) this analysis led to a framework and propositions that explain the interconnectedness of faith-based service inclusion and transformative outcomes, providing broad signposts for future research (Cornelissen, 2017).

4. Findings and discussion

This section presents the findings that address the two research questions to achieve the purpose of the paper. The findings present the service inclusion pillars in a FBO (Section 4.1) and then how these become manifest as processes (Section 4.2), how they intersect with individual and collective agency (Section 4.3) and then the transformative outcomes of service inclusion (Section 4.4). From these findings, four propositions emerge. Section 4.1 addresses *RQ1*, concluding with the proposition.

P1. Service inclusion pillars evince contextualized meaning and priority.

In addressing *RQ2*, a further three propositions emerge in Sections 4.2, 4.3, 4.4, respectively:

P2. Service inclusion processes are shaped by the service inclusion pillars in a mutually reinforcing relationship.

P3. Individual agency and community capability harness service inclusion pillars and processes to facilitate transformative outcomes.

P4. Transformative service outcomes reaffirm service inclusion pillars, processes, individual agency and community capability.

The following section addresses *RQ1* and elaborates on *P1*.

4.1 Service inclusion pillars in a faith-based organization

Five elements emerged as pillars of faith-based service inclusion. Fisk *et al.* (2018) three pillars – enabling opportunities, offering choice and relieving suffering – were evident. Two additional dimensions emerged from the participants' responses – fostering eudaimonic well-being and giving hope. These interdependent service inclusion pillars are explained below and summarized in Table 1.

4.1.1 Enabling opportunities

Health care as a prescribed intervention without enabling opportunities for communities to identify solutions is seen by TSA participants as ineffective. Much of the dialogue focused on relationships of equivalent status, "*We need to be people with people, on a level playing field*" and "*What are we going to do together*?" (Health, Zam), setting the tone for co-created solutions. In the Chikankata community, enabling opportunities for families and communities proved critical for coping with overwhelming sickness and unrelenting death rates during the HIV/AIDS epidemic.

The participants' dedication to the relational nature of enabling opportunities rests on trust in the community's capacity to co-create solutions and effective practices:

> We go into the community and sit down now with the chief and the village headmen to say, can you come up with a way of how we can do this other than the way we are doing it now. (Health, Zam)

A key element in enabling opportunities is task shifting. The task shifting is evidenced at two levels, provisioning the extended family to supply the care:

> soon we realized that the team was burning out. They couldn't cope and we went back to the community[. . .]Care and Prevention Teams were formulated within the communities in order to mitigate and to shift some tasks from the professionals to the caregivers or community caregivers. Using the African concept, if one is sick, we are all sick so we need to help one another. (Health, Zam)

and arranging teams and training programs. Both of which empower the people to access and receive services (Fisk *et al.*, 2018) and enabling a movement away from vulnerability toward well-being (Blocker and Barrios, 2015).

4.1.2 Offering choice

The participants shared confidence in the potential of relationships to bring about service inclusion through choice, not coercion. Honoring the community is a central element in TSA offering the people choices embedded in a deep understanding of the context – social, cultural, political, economic (Edvardsson *et al.*, 2011). Acknowledging the importance of the Chieftain/Chieftainess structures and respecting the significance of their authority is key to offering the community and individuals choice to "enter or exit" a service offering.

Headsmen and the region's Chieftainess hold authority and significant influence. While traditional belief systems and rituals do not always align with Christian-based practices, they are respected. The traditional leadership collective structure

Table 1 Faith-based service inclusion pillars

Service inclusion pillars	Definition	Practices	Illustrative quotes
Enabling opportunities	Empowering people by providing access to services and the ability to receive and co-create valued services (Fisk *et al.*, 2018)	Co-creating solutions within the community	*we sit down with them, spend time "hearing the community", being people with people what comes from the people is sustainable the resources and capacity sit within the community as a solution*
		Maximizing task shifting	*we build models of service delivery on existing community structures, provisioning the extended family to supply the care* *we formulated teams and rearranged training programs within the community to shift tasks from the professionals to enable capacity*
Offering choice	Providing people with viable choices between different service offerings, along with giving people the choice to opt out of services should they desire (Fisk *et al.*, 2018)	Honoring the community	*we build relationships with key change agents to develop a health-producing relationship* *traditional leaders, headsmen and chiefs hold authority, they have the mandate for leading the way and making change*
Relieving suffering	Providing fair access to essential services that fulfill basic human needs in diverse service contexts (Fisk *et al.*, 2018)	Serving the needy without discrimination	*we operate without discrimination to help any who need it, including the marginalized, so that everyone accesses our services* *the health of a community cannot be improved if some members are excluded*
Fostering eudaimonic wellbeing	Helping people to realize their potential emotional, psychological, and social well-being by meeting their needs for autonomy, competence and relatedness (adapted from Ryan and Deci, 2001).	Helping individuals and communities to flourish	*you see what they struggle with and you speak to their context, with what they have* *it's not just about curing patients, it's about being reunited with your God and thriving as a person*
		Providing lasting commitment to service	*we were there in their suffering, we will still be here afterwards* *this too will pass, and after this the Salvation Army will still be standing here* *our commitment is unconditional, they are our people*
Giving hope	Providing assurance for improved wellbeing and encouraging people to transpose their current situation into one that provides dignity and confidence in their resilience (adapted from Blocker and Barrios, 2015)	Serving unconditionally	*we came alongside them when no one else would, to the place where we both stand* *we practice on a platform of prevenient grace*
		Expressing faith	*you cannot satisfy human needs holistically without faith* *when it was bad, we pray with the people because then they had hope beyond the grave*

can sanction a changed practice that complies with traditional norms while avoiding the danger associated with the previous behavior. Therefore, as one participant explained, offering choice relies on honoring the community:

> The headmen are key for changing culture and tradition so we have worked with them in many ways[. . .]even to change their cultural practice on HIV/AIDS and so we are really believing we will still be helped by the community to change the way people do things. (Health, Zam)

4.1.3 Relieving suffering.

Serving the needy without discrimination is fundamental to the TSA mission statement and describes this service inclusion dimension. Participants made multiple references to service without discrimination, providing service to everyone including the most marginalized,

> [. . .]the Army, when it's doing its work best, is working amongst the poorest of the poor. (Lead, Os)

For TSA, church membership is not a prerequisite to receiving health care; those not within the church are equally important service beneficiaries. To do so, one respondent described the work in breaking down the stigma around home-based care of family members with HIV whereby TSA facilitated the relief of suffering without discrimination and ameliorating the effects of social norms that reinforce stigma (Fisk *et al.*, 2018; James, 2011).

4.1.4 Fostering eudaimonic well-being

This contextualized pillar of faith-based service inclusion is defined as helping people to realize their potential emotional, psychological and social well-being by meeting their needs for autonomy, competence and relatedness (adapted from Ryan and Deci, 2001). Life in Chikankata can be harsh; the consequences of HIV are realized daily, from the number of people who carry the AIDS virus, a very significant orphan population, to the unrealized benefits through the effects of poverty and sickness. Participants spoke of helping individuals to realize their potential for emotional, psychological, and social well-being by:

> [. . .]seeing their life in all its fullness, it's not just about curing patients, it's about being reunited with your God and thriving as a person[. . .]it's this holistic salvation, body, soul, spirit, environment. That's what is transforming. (Lead, Os)

Understanding close family ties and kinship, where if "one is sick, we are all sick" is integral to helping individuals and the collective to flourish. TSA service delivery "speaks to their context" by recognizing the importance of the strong community fiber, facilitating the maintenance of *ubuntu* and sustaining authentic relationships with the community. As one participant explained,

> People prescribe what to do themselves and then we endorse them and affirm them. (Lead, Zam)

Fostering eudaimonic well-being also embodies the theme of continuity where the FBO has a long-term presence. Participants described how TSA "prepares the ground" for service inclusion and transformative outcomes, anticipates future and emerging health needs and, above all, is committed to enduring service, "we will still be here afterwards." TSA's dedication to continuity in transformative outcomes for those experiencing vulnerability applies both individually and collectively in terms of building community capabilities.

4.1.5 Giving hope

This second contextualized pillar of faith-based service inclusion is defined as providing assurance for improved well-being and encouraging people to transpose their current situation into one that provides dignity and confidence in their resilience (adapted from Blocker and Barrios, 2015). All the participants emphasized that TSA's service delivery is based on unconditional commitment "to the place where we both stand" acknowledging the region's suffering through successive epidemics (HIV), endemic disease (malaria), poor resources and environmental challenges (drought and famine). Giving hope centered on physical, emotional and spiritual wellbeing, as explained by one participant, "the Salvation Army established this mission on faith and on spiritual grounds. First of all, we believe that you cannot satisfy the human needs in a holistic manner without faith" (Health, Zam). Faith then is the stronghold for hope "when all else fails":

> [. . .]the good thing about faith is that when medicine fails, when medicine has no answers, there's always hope when you have faith[. . .]but faith in action - anchored by a practical approach, there's hope in God, number one. Number two, what can we do as a community? (Health, Zam)

By giving hope through expressions of faith TSA encourages people to transpose their current situation into one that provides dignity and confidence in their resilience (Blocker and Barrios, 2015).

4.1.6 P1

The first three pillars of faith-based service inclusion generally corroborate three of the four pillars in Fisk *et al.* (2018). Yet, the differences are noteworthy.

The pillar of fostering happiness defined as "Encouraging people to experience the pleasure that services can provide (hedonic well-being). This includes co-creating "happy" service interactions by welcoming and accommodating all consumers within a positive environment" Fisk *et al.*'s (2018, p. 844), was not a foundation of faith-based service inclusion in the sub-Saharan study context. When viewed in the context of Base of the Pyramid (BoP) markets characterized by varying degrees of precariousness and scarce resources, happiness is of lower priority as a service inclusion pillar. Rather, the foundations of "fostering eudaimonic well-being" and "giving hope" operationalize the faith-based service core values and underscore the focus on realizing human potential (Ryff, 2018) – emotional, psychological, social (collective wellbeing) and spiritual (that which transcends the individual). From the data, these were also resilience-promoting features of faith-based service inclusion. Therefore, they did not fit conceptually under the pillar of happiness/hedonic well-being (Alkire *et al.*, 2019).

The additional pillars of "fostering eudaimonic well-being" and "giving hope" although interrelated to the first three pillars (as noted by Fisk *et al.*, 2018) embody different elements and illustrate the FBO's respect for the people's experiences of hardship. We speculate that the characteristics of the combined context of sub-Saharan Africa and faith-based health care service provision distinguish it from other approaches to service inclusion that may account for this finding. The everyday reality of sub-Saharan Africa is characterized by structural disadvantage, scarce resources and related hardship (Theron *et al.*, 2020). Individuals and communities in BoP contexts tend to focus on basic needs with unique perspectives on value, thus service experience outcomes of hedonic well-being/happiness are not prioritized by many service providers. This does not deny that eudaimonic well-being may "gradually build resources that raise baseline positive affect" (Huta and Ryan, 2010, p. 758), in turn, relating to increased hedonic well-being via less fear, strain and stress (Anderson *et al.*, 2013).

Drawing on these findings, Figure 1 highlights Fisk *et al.*'s (2018) service inclusion pillars and the two additional pillars. In this regard, we contribute two additional pillars to extant service inclusion knowledge. Based on the findings we advance that:

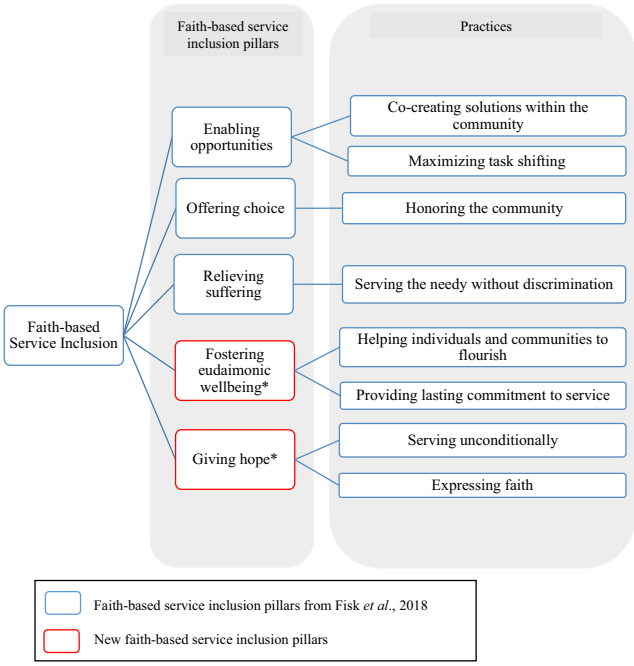
service inclusion pillars evince contextualized meaning and priority.

The following sections address *RQ2* and elaborate P2, P3 and P4.

4.2 Service inclusion processes in a faith-based organization

To understand how service inclusion pillars are implemented by FBOs, the next stage of analysis focused on inclusive processes and the more specific practices of TSA. Five faith-based service inclusion processes emerged from the data (Table 2): advocating for resources by leveraging network relationships, ministering to the whole person, learning and adjusting, using organizational assets and integrating service with the local context.

Figure 1 Faith-based service inclusion pillars



Notes: *Refer Table 4 for definitions of new faith-based service inclusion pillars

4.2.1 Advocating for resources by leveraging network relationships

As a highly trusted institution with a long-term presence, TSA works closely with Zambian Government resources and structures to improve fair access to resources and services for Chikankata people. During the early HIV/AIDS epidemic it was the advocacy of TSA that mobilized the political will of the Zambian Government to address the need for urgent action in home-based care. In addition, networks and relationships with international agencies, national health networks and authorizing bodies are leveraged to improve access to critical resources at the organizational level of partners. One participant explains,

> [. . .]our leadership has done a great job in lobbying and mobilizing resources in financial teams and material support. Through their cooperating partners, or international support agents they've mobilized resources in terms of money and will work together. (Health, Zam)

Relationships with local leaders are also leveraged to mobilize community resources and capabilities in the adoption of new ideas and change practices that improve service inclusion, "traditional leaders become vehicles for change, they make a way for us" (Health, Zam). While these processes of advocacy and the associated practices rely on strong, trustworthy relationships they are not without risks given scarce resources, the potential for ideological differences and the need to legitimize needs to stakeholders in contexts of vulnerability (Blocker and Barrios, 2015).

4.2.2 Ministering to the whole person

Underlying TSA's service inclusion processes is recognition of health as holistic – body, mind and spirit. One participant describes the TSA's duality of commission as "feeding one's spirit while restoring physical health as an extra bonus" of faith-based service. Ministering to the whole person, "helps patients get better quickly mentally because their psychological aspect, psychosocial aspect is taken care of by the spiritual care." (Health, Zam)

Participants demonstrate the embodiment of holistic caring where pastoral care and health care are administered simultaneously:

Table 2 Faith-based service inclusion processes

Service inclusion processes	Practices	Illustrative quotes
Advocating for resources by leveraging network relationships	Working with government resources and structures	*we work closely with national health networks and government to mobilize resources* *we collaborate and supplement other organizations services and vice versa*
	Connecting with local leaders	*the Chieftainess uses her resources, and says "I'm the Chieftainess, I can do it"*
Ministering to the whole person	Implementing the duality of commission	*we feed the spirit and restore health* *salvation is the transformation of the whole individual in every aspect of their life - body, soul, spirit and environment*
Learning and adjusting	Restructuring services	*we had to do something different since change requires sustained support* *experiencing life with the people enables a shift in our practice and thinking*
	Improving and improvising services	*we became innovators of home-based care for HIV/AIDS in mobilizing the community*
Using organizational assets	Making assets available to co-create value	*the building is a church on Sunday, a clinic during the week* *we have the benefit of an international brand- leadership and expertise in other areas*
Integrating service with the local context	Understanding the lived experience	*life can be harsh here, there can be struggles with food supply, water sanitation, electricity, transport* *we meet people where they are, we listen to the local story* *we [TSA] need to be 'in sync' with the community experience*
	Using champions to create change	*women are the most "churched"* *they [the women] share messages about health practices*

> [. . .]one of the most valuable things you can do if you're a Pastor and you're visiting a family where people are sick- they always ask you to pray so there is spiritual healing and physical healing and then better sanitation. (Lead, Os)

Through its faith-based approach to ministering to the whole person, TSA is an enabler of transformation within the individual and their subjective sense of well-being.

4.2.3 Learning and adjusting

Reflecting, learning and restructuring services to improve health care and well-being underpin TSA's commitment to "learning from the people." Looking back is an important factor in gaining information, recognizing the meaning of emerging patterns and using institutional knowledge to address new problems of access to resources and services. Participants acknowledged innovation, based on the ability to improve or improvise services, as a strength of TSA's organization structures and processes. When the region was flooded with orphans through the loss of both parents to AIDS, a conventional response would have been to institutionalize the children, yet TSA worked with the community to establish a process where children could be raised within their community as part of an extended care system. One participant recalled that:

> [. . .]it takes a listening and learning approach to the local story. We had to go beyond being a provider of healthcare. (Health, Os).

TSA also constructs international organizational responses based on their learning in the field, thus facilitating collective understanding and evolving service inclusion approaches in other contexts and services. For example, "we institutionalize the learnings we make (of the facilitation process) and call for a sustained global response" (Health, Os). This adaptive capacity of TSA echoes the co-learning of value co-creation (Blocker and Barrios, 2015; McColl-Kennedy *et al.*, 2012).

4.2.4 Using organizational assets

TSA's infrastructure assets such as church buildings provide flexible and readily available service delivery sites. Further, with a large volunteer base and generosity of church membership, TSA accesses repositories of institutional knowledge and service support structures from its international brand; for example, one participant describes going "to the international headquarters and [I] said that there needed to be a sustained facilitated response" (Health, Os). Complementing the structural, personnel and financial assets of TSA that are part of the service inclusion processes, is the less tangible asset of the church. The eternal church that is embedded in the culture of the community becomes a resource that, in turn, shapes transformative change, for example,

> And the church is there long-term, so people belong to the church. It's this eternal nature of the church[. . .]stuff goes into a women's group. It becomes part of the culture of that women's group. (Lead, Os).

The TSA practice of making tangible and intangible assets available is a vital part of service inclusion processes, co-creating value in ways that are important to the individuals, the community, service provider and the service organization.

4.2.5 Integrating service with the local context

Understanding the lived experience of the people leads to TSA's contextualized service responses that not only efficiently use available resources but also are creative practices for service inclusion, "experiencing life with the people enables a shift in our practice and thinking" *(*Health, Os). Another participant noted, "we leave no one behind, ensuring they access services right in their own setting" (Health, Zam). For example, acknowledging transport difficulties and to reduce risk from non-attended birth, a shelter has been erected adjacent to the hospital; women can travel to Chikankata in the late stage of pregnancy and await the onset of labor on the hospital grounds. Also, within the local context, women are the "most churched" and are influential agents of change as they are engaged through attendance at church groups and responsive to information about family health. Therefore, involving the women as champions for improved health-care behaviors is a further practice for integrating service with the local context and improved service inclusion.

4.2.6 P2

Consistent with TSA's mission to meet the needs of the under-served and its communitarian concern for the health and well-being of all, our findings demonstrate service inclusion processes of advocacy. This was revealed in working with donor agencies and building partnerships within the government, local community context and international development agencies. Next, by ministering to the whole person and addressing the holistic development of an individual, TSA connects with communities at a profound level. Dialogue that is part of the faith-based mission strengthens service inclusion processes, integrating services into the moral and social underpinnings of the community's life. The combined focus on faith and [health-care] service fosters improved health outcomes and serves to influence norms and behaviors. Although the embeddedness of the TSA in the local communities provides a high level of trust it also adds accountability and transparency to their activities. What happens when traditional practices compromise or conflict with religious principles? Learning not to marginalize the beliefs of others but to deliver services that resonate with local needs and traditions is an important service inclusion process. Using organizational assets (including physical assets) is another key service inclusion process. These are the resources of people, organizational systems, infrastructure and technical expertise that provide stability and continuity, mutually reinforcing the service inclusion foundations that guide the FBO's health care service activities. Training, technical assistance and task shifting further contribute to strengthening the effectiveness of these processes. Additionally, making use of an organized pool of community workers and volunteers helps community ownership and inclusiveness of health-care services. Finally, central to TSA's service processes is the embeddedness within the local community fostering joint learning while delivering health care to the disenfranchised. This close relationship enables the FBO to be responsive to needs, adapt services to local knowledge and traditions and to build social capital and community capability. The long-standing history strengthens the respect and trust of these relationships. Integrating service with the local context reinforces service inclusion through the value and resources mobilized by these relationships.

We, therefore, advance a bidirectional, mutually reinforcing relationship between processes and pillars. The processes operationalize the pillars, the guiding principles of faith-based service inclusion. For example, the processes of advocating for

resources, ministering to the whole person and integrating service with the local context are shaped by the pillar of "giving hope." The findings demonstrate how the FBO's service inclusion processes reciprocally reinforce the pillars. Thus, we propose that:

Service inclusion processes are shaped by service inclusion pillars in a mutually reinforcing relationship.

4.3 The role of individual agency and community capability in service inclusion

Within the study context, strong agency exists to ensure ideas and desired actions are disseminated and service benefits are realized. These are spread from village to village through the power of agency and ownership of solutions. Communities are not just passive recipients of health-care services but have a strong collective voice demonstrating resilience and belief in their resources. The people are entrepreneurial and use their resourcefulness to ensure a needed change occurs as summed up by one participant, "their shared voice is strong, where the idea itself may have originated in a person it very quickly became a collective purpose" (Lead, Zam). In this way, traditional structures and intact fibers of *Ubuntu* harness the transformative potential of service inclusion pillars and processes within established networks, traditions and relationships. The emerging perspective, endorsed here, is that BoP consumers in Africa are active co-creators of service value and service solutions, despite the complex and unique characteristics of the services context in Africa. One participant described this as:

> [. . .]the strengths of the people for caring, for being community as belonging, for wanting change to happen - if not actually making change happen - but that's a strength to want change to happen and to understand what hope consists of and what it feels like. If those things are in place, the fundamentals of local programme design could spring out of that because the people themselves could say what they would do together in the presence of a facilitated conversation. (Health, Zam)

4.3.1 P3

From our findings, individual and community agencies are forces to perpetuate transformative change. It is not solely what faith-based service inclusion offers to individuals but what the individuals and communities do with service inclusion (Sen, 1985). Thus, the gaining of agency – when people realize they have the strength, hope and access to resources – is required for transformation (Dean and Indrianti, 2020). While faith-based service inclusion enables a movement away from vulnerability by recognizing the adaptive capabilities and resilience capacity of individuals and the community, it is the strengths of the people that harness these practices for enduring service inclusion and transformative change.

Individual agency and community capability "enables actors to act upon resources to create value" (Davey and Grönroos, 2019, p. 689), in turn, allowing individuals and communities to flourish (eudaimonic well-being) and their lives to be enhanced. Drawing on service logic, the service provider's role is one of value facilitation where consumers' value co-creating processes are influenced by a wider ecosystem of actors, resources and capabilities (Grönroos and Voima, 2013). Based on our findings, we conclude that:

individual agency and community capability harness service inclusion pillars and processes to facilitate transformative outcomes.

4.4 Transformative outcomes from faith-based service inclusion

The final aim of *RQ2* was to explore the service provider's perspective of transformative outcomes of faith-based service inclusion. Four outcomes emerged (Table 3) – improved health and well-being, changed norms and practices, progress toward prosperity and resilience and capacity to withstand risks.

4.4.1 Improved health and well-being

Improved health outcomes have been achieved through the continued presence and service inclusion efforts of TSA in the region. However, the work of TSA to ensure service inclusion affirms both pillars and contextually appropriate processes along with the community's efforts to achieve transformative change:

> [. . .] the best part of faith-based health services is actually not about curing sick people but about making healthy communities. And the corps officer [pastor] with his and the women's groups who are doing mother and childcare and doing better gardens with better nutrition and wash programmes and all of that. That is a hell of a lot better than a hospital that cures sick people. (Lead, Os).

Health and well-being outcomes, demonstrating the progress toward national goals in line with the Zambian Government's agenda, have also brought about change in expectations and confidence within the Chikankata community on the reality of improved health.

4.4.2 Changed norms and practices

An important first step toward transformative change occurs at the community level through citizens being informed. One participant explained:

> [. . .]we keep on emphasizing education, changing of attitude is another aspect to health to really change in the communities, [is] their traditional way of living, mourning. (Health, Zam.)

For example, to increase the exposure to COVID-19 health messaging, the Chikankata radio station broadcasts Government public service announcements. Seen as an important medium by health information-seeking residents, radio transmission reaches audiences that are normally hard to reach due to remote localities.

4.4.3 Progress toward prosperity

In a region where life can be harsh, long-term investment in improved community resources more than just bricks and mortar moves the well-being of its people forward and strengthens a belief in a better future. This directly contributes toward the Millennium Development Goals such as zero famine, water and sanitation and education. By recognizing health and well-being as contingent on service inclusion, participants described both measurable and intangible outcomes of continuous progress toward prosperity:

> [. . .]the impact of the Salvation Army is in reducing poverty, goal number one. Number two, zero hunger and number three, good health and wellbeing. Goal number four, quality education and another one, sustainable development. (Health, Zam)

4.4.4 Resilience and capacity to withstand risks

Although this region continues to struggle with many issues that impact health, participants were confident in the will of the people and their capacity to withstand future stress and adversity. Personal and relational resources are the most prominently reported resources in accounting for the

Table 3 Potential transformative outcomes from faith-based service inclusion

Potential transformative outcomes	Practices	Illustrative quotes
Improved health and wellbeing	Attaining health goals	*being in touch with the community improves children's nutrition, lifts living standards, reduces poverty, teaches skills* *lifechanging experiences by improving health of the people* *we uphold human rights through holistic healthcare* *our outcomes measure up to the Zambian National Health Strategic Plan and National Health Agenda.* *the church has played a major role in ensuring communities have clean and safe water provision*
Changed norms and practices	Reducing stigma Informing citizens	*we asked, "what is your concern" and by asking and sharing stories, stigma is reduced* *we use the radio station to share messages about COVID-19* *we make sure the communities have health knowledge to prevent the epidemic from spreading*
Progress toward prosperity	Improving community resources	*we establish institutions for health and education* *we empower individuals with life skills for sustainable livelihoods and income* *TSA contributes to decent work, economic growth, reduced inequalities*
	Inspiring belief in a better future	*we choose a better future and we choose to love one another* *we are moving towards achieving the UN health and sustainability goals*
Resilience and capacity to withstand risks	Affirming community capabilities	*you have to affirm and work with the community generated decisions* *we need to provide the community with support to react positively to health threats*
	Creating collective strength	*it's really based in the community actually doing stuff for themselves.* *the church community becomes that new survival group and they look after one another.*
	Strengthening capacity	*they [the people] are a resilient people, saying "we will get through this", "we are strong"* *TSA came alongside them when no one else would and they got back on their feet*

extraordinary resilience among sub-Saharan African communities (Theron, 2020), explained by one participant as, "they have a resilience that far exceeds anything you will see in the west" (Lead, Zam).

Resilience, the capacity to develop or function successfully despite exposure to adversity (Masten, 2014), is strengthened by TSA's service inclusion: affirming choices the community makes, hearing their voice and integrating these with health-care services policies. Evaluation to improve existing programs and structure new ones, flexibility to change, response mobilization earlier rather than later and continuous learning through experience provide important resilience-enabling resources that are culturally situated (Theron, 2020). Thus, TSA's faith-based service inclusion – the inclusiveness of multiple actors, community-centric value (Reynoso *et al.*, 2015) and embeddedness within the socio-cultural systems – can co-create opportunities for the dynamic processes of adaptation and adjustment to stress, risk and adversity that is central to resilience (Baker, 2009; Rutter, 2012). Resilience as a transformative outcome secures the resources required for sustained successful functioning and human well-being (Ungar, 2018).

4.4.5 P4

Transformative outcomes validate the appropriateness of the faith-based service inclusion pillars and contextually apt processes. From the findings, the nature and extent of transformative service outcomes enabled by faith-based service inclusion provide TSA with a dialectical mirror for the adequacy and efficacy of their processes and practices. It is largely through transformative service outcomes that a service provider can ascertain if they are mobilizing/using the right assets, learning and adjusting or sufficiently integrating service inclusion with the local context as they operationalize their service principles. Consequently, transformative service outcomes dynamically shape the elements or concepts associated with service inclusion pillars, processes and agency. For example, the excerpt below illustrates how the transformative outcome of reduced stigma reaffirms the pillar of relieving suffering (helping each other to live positively with HIV and AIDS) and reaffirms the processes of ministering to the whole person and using organizational assets:

> Chikankata went through a process that we call community counselling and community confidentiality where all villages would come to have a test and be open. It's no longer a secret, they support one another when they are taking the medication and they encourage each other and support each other. So now at least the stigma in that particular area is very much reduced and everybody's helping each other to live positively with HIV and AIDS. (Health, Zam)

The relationships between transformative outcomes and service inclusion (pillars and processes) make the development of individual agency and community capability logical and plausible. Transformative change that strengthens individual agency and community capability development is of particular interest in communities experiencing vulnerability, limited access to resources and service exclusion. Blocker and Barrios (2015) argue that moral agency is impacted by service inclusion over time where, consequently, individuals demonstrate confidence in their capabilities, opportunities and future. Consistent with the depiction of "form and flow of transformative value creation" (Blocker and Barrios, 2015, p. 276–277), we, therefore, propose that:

transformative service outcomes reaffirm service inclusion pillars, processes, individual agency and community capability.

5. Faith-based service inclusion framework

The research findings and propositions provide a comprehensive depiction of faith-based service inclusion.

Table 4 summarizes these elements illustrating the linkage between the service inclusion pillars, the operationalization of these pillars through processes, illustrative examples as evidenced in our data and transformative outcomes.

We synthesize the insights from the findings with literature on value co-creation and service inclusion into a faith-based service inclusion framework (Figure 2). The left-hand side of the framework depicts five interdependent service inclusion pillars – enabling opportunities, offering choice, relieving suffering, fostering eudaimonic well-being and giving hope – that are manifest in five interlocking service inclusion processes. Next, the framework recognizes individual and collective agency in service inclusion. Next transformative outcomes complete and re-energize the work of service inclusion, while at the same time providing opportunities to identify the gaps and as yet unrealized achievements that service inclusion should strive for.

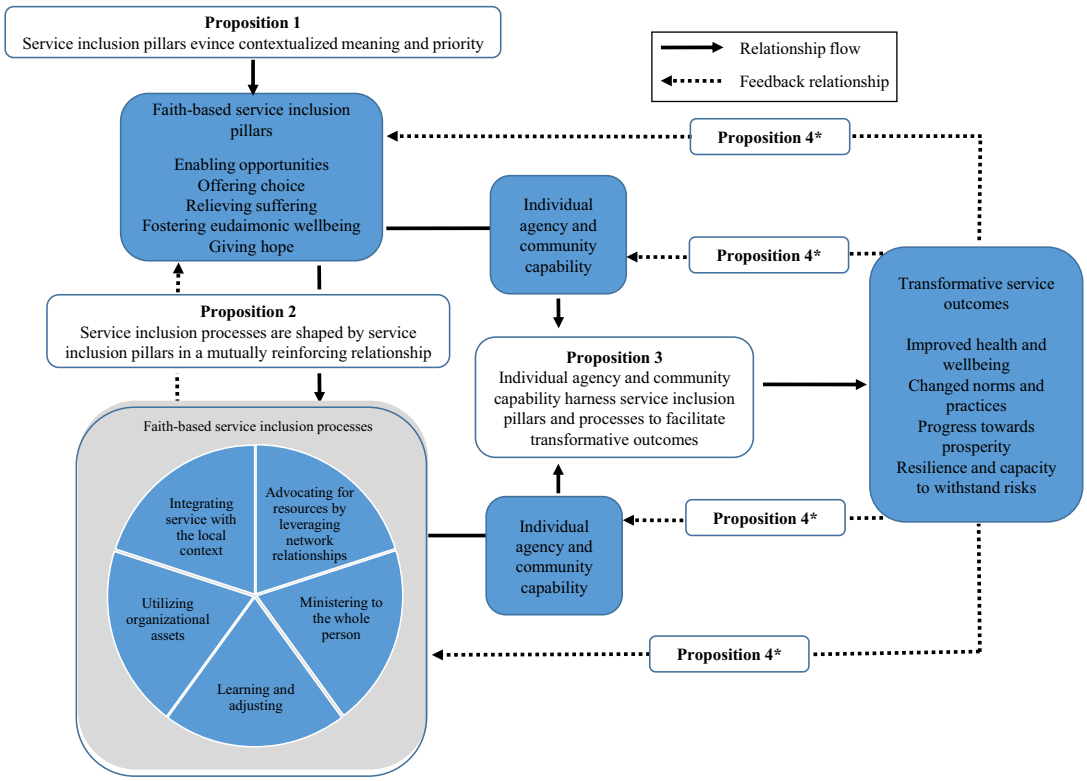
Notably, the five service inclusion pillars do not include fostering happiness/hedonic well-being. Rather fostering eudaimonic well-being and giving hope contextualize faith-based service inclusion, co-creating value for all the partners in ways that are important to each.

Despite calls for service concepts and systems that embody service inclusion, there are few that specifically address the

Table 4 Faith-based service inclusion pillars and linkages between pillars, processes and outcomes (refer Table 1 for definitions of pillars)

Faith-based service inclusion pillars	Service provider processes that operationalize and strengthen faith-based service inclusion pillars	Examples (drawn from participant interviews) of how processes (in italics) are linked to transformative outcomes (in italics)	Illustrative transformative outcomes from faith-based service inclusion
Enabling opportunities	•Advocating for resources by leveraging network relationships •Learning and adjusting	Chikankata Mission as part of the Zambian Salvation Army Territory is a member of the Churches Health Association of Zambia (CHAZ). CHAZ represents approximately 60% of the health care in Zambia. Working collectively, it is effective as a national Christian health service and highly linked to other national health bodies. TSA can *advocate for resources through its networked relationships* which improves its effectiveness in *improving community resources*	Progress toward prosperity – improving community resources Resilience and capacity to withstand risks – creating collective strength
Offering choice	•Learning and adjusting •Using organizational assets •Integrating service with the local context	CHS provides health-care services to a community of close to 100,000 people through outreach activities in hard-to-reach communities *learning and adjusting to their needs* This is possible through TSA's structure and service model that includes volunteers and participation within the local context to provide care for communities who would otherwise be unable to access formal health care. *Informed citizens* are a vital link in *improving community resources*	Changed norms and practices – informing citizens Progress toward prosperity – improving community resources
Relieving suffering	•Advocating for resources by leveraging network relationships •Ministering to the whole person •Using organizational assets	Chikankata Mission adopted a process of community counselling where all villages were offered HIV/AIDs screening. By *using organizational assets,* the process of was centered on openness and inclusion so that community members could support one another, for example, in adhering to medication regimes. This led to *significant reduction in stigma* and everybody helping each other to live positively with HIV and AIDS	Improved health and wellbeing – attaining health goals Changed norms and practices – reducing stigma
Fostering eudaimonic well-being	•Ministering to the whole person •Learning and adjusting •Integrating service with the local context	Through long-term commitment and closely working with the community TSA *integrates its service with the local context*. TSA progresses achievement of many other sustainable goals that interlink with health. Nurses, midwives and bio-medical students who graduate from education programs at Chikankata are being used by government – sustainable jobs for sustainable income. This assists economic growth and the overall well-being of the communities and families *building resilience and capacity to withstand future risks*	Resilience and capacity to withstand risks – affirming community capabilities
Giving hope	•Advocating for resources by leveraging network relationships •Ministering to the whole person •Integrating service with the local context	The TSA Zambian health model, is a comprehensive model of faith-based care that is *ministering to the whole person*. It offers the clinical facilities of a hospital through to outreach clinics and then to community development programs. As a faith-based health service it does not simply focus on curing sick people but also *helping communities to progress toward prosperity*	Progress toward prosperity – inspiring belief in a better future Resilience and capacity to withstand risks – strengthening capacity

Figure 2 Faith-based service inclusion framework



Notes: *Proposition 4 - Transformative service outcomes reaffirm service inclusion pillars, processes, individual agency and community capability

processes and relationships that foster service inclusion. Our framework is a parsimonious explanation of the complexity of value co-creation in service ecosystems, illustrated through the four propositions linking the components of service inclusion pillars, processes, agency and transformative outcomes. The first proposition is that there is a mutually reinforcing link between service inclusion pillars and processes. These pillars and processes deliver transformative health-care outcomes to the extent they are harnessed by individual agency and community-capability development. In our findings, community-capability development is made possible by the congruence between the strong grounding in faith and *ubuntu*-centric philosophies, both of which amplify the will of the people. Our case of faith-based service in sub-Saharan Africa, predicated on inclusion, human dignity and holistic well-being, is part of the socio-cultural system. Thus, the faith-based service inclusion framework explicitly acknowledges individual and collective socio-cultural situations and resourcefulness as critical for service inclusion (Edvardsson *et al.*, 2011; Fisk *et al.*, 2018).

The framework culminates in transformative service outcomes that engender feedback, modifying service inclusion pillars, processes and individual agency and community capability development. Take for instance, our first service inclusion pillar – enabling opportunities; while the pillar remains intact, the relative importance of some of the associated practices (e.g. facilitating task shifting) may change. For example, changing norms (e.g. increased interest, confidence and aptitude on the part of service beneficiaries to influence their own health outcomes) may present opportunities to dynamically modify practices of "hearing the voice of the community" to "letting the community express that voice directly and independently."

The framework offers a first step in understanding the multi-level, interactive dynamics of service inclusion within socio-cultural systems that support transformative outcomes. The framework relationships endorse the focus on transformation being a holistic, interactive process that exists within a system of interacting parts.

6. Conclusions and implications

Inspired by the transformative worldview which views research as a vehicle for confronting injustice and inequality and for alleviating suffering, we examined service inclusion in sub-Saharan Africa. The challenges faced by underfunded and overstretched centrally-planned health delivery systems, especially to remote rural areas, provided the impetus to the study. The participation of multiple actors, community-centric values (Reynoso *et al.*, 2015) and embeddedness within the socio-cultural context, justified a service inclusion and value co-creation perspective (Fisk *et al.*, 2016). Faith is an integral factor in many communities experiencing vulnerability and service exclusion (Cloke *et al.*, 2013). Thus, we contribute to the growing literature on service inclusion by integrating

concepts from value co-creation with faith-based service and development scholarship.

6.1 Theoretical implications

This research makes several important theoretical contributions. We use empirical data from a faith-based service organization, a service-provider context often overlooked in service theory development, to extend and explain service inclusion in a BoP context. We "identify the existence of new conceptual categories" (Rosenbaum and Russell-Bennett, 2019, p. 573) and abstract these new insights into a novel faith-based service inclusion framework (MacInnis, 2011) providing our first contribution.

Concerning foundations of service inclusion, five pillars emerged – enabling opportunities, offering choice, relieving suffering, fostering eudaimonic well-being and giving hope. Three of the pillars corroborate Fisk *et al.*'s (2018) description of enabling opportunities through access to services; offering choice between different service offerings; and relieving suffering through fulfilling basic human needs. Because access, choice and relieving suffering appear to transcend service exchanges, a portion of the service inclusion discourse is generalizable across dissimilar contexts. However, the other two pillars in our study diverge somewhat from extant knowledge. This is where the uniqueness of the sub-Saharan African faith-based context provides insights for service inclusion scholarship. While Fisk *et al.* (2018) depict happiness in a hedonic sense we argue that in different contexts service inclusion pillars take different forms. We advance the concept of fostering eudaimonic well-being as a contextualized pillar of service inclusion. We identify the elements of helping individuals and communities to flourish and a lasting commitment to service inclusion as practices that foster, for example, health equity, respect for human dignity and support for social networks. Developing an individual's and community's capacity for health, prosperity and economic survival are important means to realizing potential. Although acknowledging the complementary roles of eudaimonic and hedonic well-being we note the absence of fostering happiness. Thus, our second theoretical contribution is the contextualized meaning and priority of service inclusion pillars.

Our third contribution is the conceptualization of the mechanisms – processes, practices and agency – of service inclusion that explicitly adopts a strengths-based approach. Based on a faith-based service concept, the resultant service system of a "configuration of people, technologies and other resources" (Patrício *et al.*, 2011, p. 186) emphasizes advocating for resources by leveraging network relationships, ministering to the whole person, learning and adjusting, using organizational assets and integrating service with the local context. These processes and practices demonstrate the service provider's deep commitment to understanding the service context but also demand critical organizational structure and resourcing decisions to enable an inclusive service system. The faith-based service system recognizes individual agency and community capabilities as anchor points that harness the resources and opportunities made available through service inclusion. At the service organizational level, service inclusion is facilitated by attention to community processes and structures that reflect resourcefulness. We endorse Fisk *et al.*'s (2018) view that national-level government service systems should consider how interventions and service programs could incorporate such faith-based concepts and processes.

Finally, thinking about service inclusion and transformative change as a process encourages service researchers to explore how to improve the constituent parts of the process and how changes in these lead to shifts in one or more of the other interdependent parts. Therefore, the service concept of inclusion and the resultant service system and interactions can be examined as a continuous process of improved inclusion (including reduced implications of exclusion), adaptation, agency and transformative outcomes that contribute to human flourishing.

6.2 Managerial implications

Insights from the faith-based service inclusion framework can inform several strategies for health-care service providers, BoP service providers and other service providers in general to address service exclusion experienced by individuals and communities.

First, to achieve long-term improvement in the health and well-being of BoP communities and emerging economies, service organizations need to invest in service systems and organizational structures that enable a long-term presence, as opposed to those service programs that are allocated short-term project duration. Second, local networks and influence channels must be understood and respected. A service provider cannot design for inclusion nor achieve inclusion and transformative change without operating within the socio-cultural system of deeply held traditions and channels of influence. TSA learnt during the HIV/AIDS challenge that changing individual and community practices that were causing the HIV to spread rapidly could only be achieved through negotiation and working alongside local leadership. Service providers can use the framework to better understand the contextual priority and/or meaning of service inclusion pillars and relevant reciprocal processes. While the framework has been developed using a faith-based service inclusion case, the relationships and propositions are transferable to other service inclusion contexts and transformative service organizations. For example, service inclusion pillars in the context of refugee services may prioritize pillars of giving hope and offering choice. Service inclusion processes and practices in this context may emphasize respect for culturally and linguistically diverse communities strengthening different inherent capabilities.

Third, the framework emphasizes the strengths of individual agency and community capability, acknowledging the culturally nuanced resourcefulness that can be protected and strengthened by service inclusion. This strengths-based framing for service inclusion is at the core of FBOs – believing in the potential of the individual, looking for good, helping to prosper (James, 2011; Cloke *et al.*, 2013) – that is transferable to other organizations and services other than health care. The findings from this study indicate that service providers (faith-based and secular) should use the framework to co-design programs and interventions that recognize the full spectrum of resources that reside within individuals and communities. This study has shown that when a service provider is responsive to the resources that reside within individuals and communities, service inclusion is enhanced (Adkins and Ozanne, 2005;

Hutton, 2016). The by-products of this strengths-based approach to service inclusion are reduced stigmatization and promotion of successful behaviors. Service providers must also be resourceful to successfully progress service inclusion in service settings where resources are stretched and external infrastructure elements (e.g. transportation) are difficult for providers and consumers alike. CHS ensure health care reaches those in need through adaptive outreach to rural areas and TSA service provision is synonymous with health care that comes to the people.

Integrating eudaimonic well-being and giving hope into service inclusion pillars enables service providers to push back on differences (poverty, age, gender, sexuality, race, religion, ethnic and tribal affiliation) that often lead to service inclusion issues.

6.3 Societal implications

The results of this research have important societal implications. Despite some skepticism around FBOs (Olivier *et al.*, 2015), faith-based service inclusion and the notion of the enduring church as a community asset can reduce the burden on scarce resources and has the potential to meet development goals for BoP communities. The findings illustrate how faith-based service inclusion can shape the opportunities for well-being and long-term change to people's lives, underscoring the resilience-promoting features of a purposeful life, positive relational ties, and faith and confidence in the future. If the service provider understands the interconnectedness of resourcefulness, resilience and vulnerability, transformative outcomes may be facilitated in a virtuous cycle of growing individual agency and community capabilities.

6.4 Limitations and future research

We acknowledge some limitations. The research analyzed the faith-based service provider's perspectives through interviews with key informants in CHS and the wider TSA organization. Accordingly, a limitation is that we have not examined the service beneficiaries' perspectives on faith-based service inclusion and hence our faith-based service inclusion framework warrants further research with service actors. We have examined TSA's health service delivery role in sub-Saharan Africa and the representativeness of our findings is predicated on the homogeneity of FBOs. This warrants future research with other FBOs in relevant contexts as we have argued that the compatibility between faith-based and *ubuntu*-centric philosophies underpins transformative outcomes. Furthermore, our faith-based service inclusion framework and the four propositions proffer relationships that can be used in future empirical investigations refining and expanding the framework's scope. For example, while we explored the potential transformative outcomes of faith-based service inclusion, further research is needed to better understand the mechanisms for transformative outcomes. A longitudinal study of how the pillars, processes and outcomes (and their interrelationships) change over time among communities experiencing vulnerability is also warranted.

Finally, service inclusion is built on pillars that validate the community and individual life context, mobilizing and enhancing those aspects that allow humans to flourish. These pillars are vital for fostering community capability development necessary to deliver transformative outcomes. We acknowledge that the essence of faith is complex and multi-faceted residing within the service concept, the community, consumers and their interactions. The local community looks to TSA for spiritual leadership but, equally, faith that resides within the community remains a core component of holistic well-being. We have strived to do justice to this complexity in our effort to make it concrete within the articulation of the framework presented.

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