

## **Playing Broken Telephone: assessing faith-inspired health care provision in Africa**

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### **Abstract**

*In the literature on the religious contribution to health and development, it is commonly stated that faith-inspired institutions (FIIs) provide from 30 to 70 per cent of all health care provision in Africa. This article tracks the sources of such statements back to the 1960s, highlighting a process of 'broken telephone' whereby estimates are passed on and frequently distorted by policy- and advocacy-oriented influences at both the national and international levels. This demonstrates how estimates are being wielded bluntly, often resulting in poorly substantiated claims to the detriment of more careful research, thereby weakening the empirical knowledge-base and improved practice.*

**Key words:** Social sector – health; Methods; Sub-Saharan Africa

### **Introduction**

There is a trend in the literature addressing the religious contribution to health and development in Africa. Commonly, in the opening stages of presentations, articles, and reports, a percentage is provided for the share of provision of care accounted by faith-inspired initiatives (FIIs)(1) in Africa – often stated as 30 to 70 per cent. Such statements do not only emerge from within the so-called 'faith sector', but are also widely seen in agency and policy-level texts. These estimates are utilised as the evidential basis for arguments that the 'faith sector' is significant to improved health and development, and therefore requires more attention and resources. These estimates are also usually followed by a corollary that FIIs have characteristic comparative values, for example that they are better targeted to the poor, or enjoy greater access or trust in the local communities they serve. Any of these assertions, if correct, should have a major impact on policy, since donors and possibly governments might then be more inclined to support FIIs in their service delivery activities. Unfortunately, the evidence base and data on the role of FIIs in Africa is fragmented, so that the basis for policy and public-private partnership remains weak, with a limited impact on practice.

Questioning these estimates of the 'market share' of FIIs is a potentially inflammatory task, as different parties have vested interests in these estimates which are perceived to be essential for collaborative engagement (as discussed below). We must therefore be clear that this article does not set out to lambast any particular estimates or parties, nor do we conclude with a newly synthesised estimate of faith-inspired market share for health and development in Africa. Rather, we seek to understand the context in which such estimates are wielded by tracking historical trends through the literature and assessing their potentially conflicting assumptions – with a view to guiding future research agendas and policy engagement. To this purpose, a systematic review of

literature addressing health services, care and delivery in Africa was conducted, searching within that literature for specific mention of faith-inspired care and service provision over a twenty-year period. We identify some of the main historical estimates of market share, tracking the sources of these as far back as possible. We also introduce some new analysis of FII market share from nationally representative household surveys based on reports of health service utilisation directly expressed by households, in order to provide some contrast to the more frequently cited estimates.

This paper thus explores the development of market share estimates of faith-inspired health provision in Africa – and how this impacts on the broader health and development discussions at a policy level. By tracking such estimates from the 1960s to today, what emerges is a process of ‘broken telephone’, whereby estimates are commonly distorted by policy- and advocacy-oriented influences at both the national and international levels. This is a clear case of statistics taking on a life of their own, especially in an informational vacuum, and it demonstrates how estimates are wielded as blunt instruments, often resulting in poorly substantiated claims to the detriment of more careful research, thereby weakening the empirical knowledge-base and improved practice. Thus our study concludes that greater caution should be utilised if genuine policy-level engagement is to occur.

### **The ‘significance’ of FIIs in health and development in Africa**

It is safe to say that the health services and care provided by FIIs and communities are ‘significant’ in Africa. In the colonial period, mission-based hospitals and primary health care (PHC) were a dominant source of healthcare provision in many African countries, although different patterns of provision can be seen, dependent on the particular colonial strategy employed. Since independence, different national strategies were adopted as governments dealt with the legacies of their respective colonial administrations. In some countries FIIs established in colonial times have remained dominant despite attempts at imposed controls of the ‘voluntary sector’ (such as in Tanzania, Zambia, Kenya and Malawi), while in other countries FIIs have been nationalised into public systems (such as South Africa, see Robinson and White 1997, Schmid *et al.* 2008). New FIIs were established post-independence as well, as many African governments, struggling to overcome health crises, have not been in a position to provide universal access through public systems. There has also been a rapid growth of the private health sector and civil society actors, often supported by international partners – thereby creating a complex landscape of non-state, private for-profit (PFP) or non-profit (PNFP) health provision. Furthermore, at least in sub-Saharan Africa, HIV/AIDS response has also had a significant impact, resulting in a rapid growth of FIIs (of the NGO variety) being formed around the year 2000 (see ARHAP 2006, Haddad *et al.* 2008). As a result, the involvement of faith-inspired civic institutions in health and service provision remains significant in Africa, particularly in sub-Saharan Africa, and perhaps more so than in any other region of the world.

While it may be safe to describe faith-inspired healthcare as ‘significant’, putting a number to that significance is more challenging. One difficulty is that FIIs are rarely

properly aligned with national health systems, with faith-inspired, other private and public health sectors operating in parallel to each other in many countries. The idea that FIIIs own a large portion of the health infrastructure, added to the concept of FIIIs having a strong grassroots presence, has resulted in talk of there being a 'faith sector' which is a 'hidden giant' in Africa – but stated with the caveat that this giant is hidden both because it is poorly integrated and because there is little systematic information available to make it more visible (see Asante 1998, Schmid *et al.* 2008).

In the last two decades, there has been a resurgence of interest in non-state and in particular faith-inspired health service provision. This came as a result of several factors, such as growing recognition of the importance of religion to African communities, an increased focus on community-oriented development and health engagement, reforms of national health sectors, an awareness of the need for public-private partnerships (PPP) in health services, and health sectors looking to better harmonise activities and strengthen increasingly fragile and resource-constrained health systems (see Hanson and Berman 1994, Schmid *et al.* 2008). Governments and international agencies have also begun to ask how FIIIs could be more clearly mapped, so that they might become stronger allies in the delivery of health services and the accomplishment of global targets, such as those of the Millennium Development Goals. This has generally resulted in increased collaboration, or at least in calls for such collaboration (see Marshall and Keough 2005, Olivier and Paterson 2011).

This increased interest has also highlighted substantial gaps in the evidential landscape, not only in relation to non-state service delivery in general, but especially the subset of faith-inspired (usually) non-profit health services which remain frustratingly elusive. As a result of a complex history of secularisation and modernisation theories and academic tendencies, the 'faith sector' had become largely invisible, so that while the work of FIIIs continued, these activities were either hidden from view, or in a few cases, subsumed as part of private, non-state or civil society sectors (see Schmid *et al.* 2008, Batley and Mcloughlin 2010). As a result, data is frequently absent, incomplete or stored in protected nodes, for example, with different institutions conducting separate inventories that are often not made publicly available. The evidence is also slanted heavily towards formal and organised FIIIs with an international or national footprint; towards 'mainstream' denominations (with less coordinated faith-inspired groups such as the Pentecostals or 'traditional' groupings getting significantly less attention); and towards Anglophone countries (the bulk of the literature being in English). The diversity of the so-called 'faith-sector' has presented many challenges for evidence gathering – with a wild diversity of religious profile across regions, of types of FIIIs and services differently engaged in health and development work. As many have noted, this diversity makes any broad regional generalisations dangerous. There is no complete international inventory or map of faith-inspired health services or facilities, and national and international mapping projects often do not include FIIIs who have flown 'under the radar' for decades, and remain invisible to national and international views, as well as unaligned with national health systems (see ARHAP 2006, Schmid *et al.* 2008). As World Bank President James Wolfensohn (now famously) said in 2002, "*half the work in education and health in sub-Saharan Africa is done by the church ... but they don't talk*

*to each other, and they don't talk to us" (in Kitchen 2002:1).*

In this context, market share estimates frequently are wielded as the most concrete evidence of faith-inspired activity and impact. Some of the most frequently seen statements include the claims that that 40 per cent, or from 30 per cent to 70 per cent of all healthcare is provided by FIIs in Africa; that FIIs provide 50 per cent of all health and educational services; or that 25 per cent of all healthcare and HIV/AIDS services are provided by the Catholic Church – with many variations on these statements. In fact, there are few speeches, reports or articles addressing the intersection of religion with development and health which do not make some mention of FII market share. Such statements usually appear in the early stages of a text, and are the basis on which a further argument is made, for example that this sector therefore requires further attention or resourcing. Today, these statements have for all practical purposes reached the point of becoming indisputable ‘truth’, as they can now commonly be made without any referencing. Table 1 provides just a few examples of such statements.

**Table 1:** Examples of common market share estimates for faith-inspired contribution

Across Africa, for example, faith-based organisations provide up to 50% of health and education services, especially in poor, remote areas (Marshall and Marsh 2003:29)
Religious entities in many African countries provide between 30 and 50% of institutional health care (Benn 2003:6)
(FBOs) account for around 20% of the total number of agencies working to combat HIV/AIDS (WHO 2004:46)
Faith-based groups are priority local partners . . . In certain nations, upwards of 50% of health services are provided through faith-based institutions (PEPFAR 2005:2)
(FBOs) provide some 50% of health care services in many developing countries. The Vatican’s Pontifical Council on Health Care estimates, in fact, that at least 25% of all HIV/AIDS-related services are sponsored by the Catholic Church (Vitillo 2005:3)
Faith groups provide on average 40% of the healthcare in many African countries (Tearfund 2006:4)
FBOs are major health providers in developing countries, providing an average of about 40% of services in sub-Saharan Africa (Bandy et al. 2008:5)
Faith-based universe 30–60% of health care and educational services (UNFPA 2009:1)
In many African countries, you provide 30 to 70% of the health services, and in post-conflict countries, the majority of primary education services (World Bank - Wheeler 2010:2)

Source: Compiled by the authors.

### **Tracking market share estimates: a game of broken telephone**

Tracking market share estimates of FIIs engaged in health care in Africa through the available literature is an equally difficult activity – one that can be equated to the children’s game ‘broken telephone’ where a message is subtly changed as it is passed on. We began reviewing this material with the intention of providing a graph showing

how such estimates had changed over time, hoping to relate estimates of how the FII service landscape had changed over time to new conditions and policies in each country. However, it became quickly clear that this could not be done, given evidential 'holes' and mismatching measures, as well as (most worryingly) the not too subtle ways in which estimates have been adapted and passed on from one study to the next. It became clear that what was needed was less a quantitative account of trends in market share estimates, but rather a discursive analysis of how market share estimates appeared and were used in the literature. We will try to show how the main market share estimates became 'common knowledge' by looking at three of the most common estimates.

#### *About 40 per cent of health care in Africa*

A common estimate provided for total faith-inspired healthcare provision in Africa is 40 per cent (see Banda *et al.* 2006, Bandy *et al.* 2008, Deneulin and Rakodi 2011, Grills 2009, Kawasaki and Patten 2002, Rookes 2009, Tearfund 2006, Turshen 1999, Vitillo 2006, WHO 2004, Woldehanna *et al.* 2005). Although there is some variation on this theme (sometimes also 30-40 per cent or 30-50 per cent, and sometimes addressing 'developing countries' and other times 'Africa'), the 40 per cent estimate is strongly present, and mainly addresses faith-inspired *health facilities*. The 40 per cent estimate provides a good example of just how difficult it is to track the historical roots of what has become a 'discourse' or accepted fact. A common trend is for authors to cross-reference back and forth between studies, until the origins of the estimate are obscured, or you reach a text which provides no reference at all. For example, a World Health Organisation (WHO) report on primary health care notes "40% of health services being provided by religious organizations in some poorer African countries" (Bandy *et al.* 2008:18), and references a Global Health Council (GHC) report from 2005. This GHC report states that "in a number of poorer countries private religious organizations provide 40% of all healthcare" (Woldehanna *et al.* 2005:14), and references a WHO newsletter from 2004 as the source. The WHO newsletter, in turn, notes that "In Africa, for example, up to 40% of medical care is delivered by FBO and faith-based communities" (WHO 2004:3), but does not provide any source – and note how the locality, Africa or just generally, shifts over time.

Another worrying trend, is that while many of the recent 40 per cent estimates reference a contemporary source, making it seem topical to the rapid reader, these are in fact usually 'references of references of references'. If you track backwards, seeking the original source, most references eventually lead to a particular set of studies on the public-private mix (see Kawasaki and Patten 2002, Turshen 1999), which in turn, have two main sources: the work of McGilvray (1981) reporting on surveys conducted by the Christian Medical Commission (CMC) in 1963-64; and some early reports from the World Bank (primarily: De Jong 1991 and the 1993 World Development Report). This demonstrates how dated and persistent this 40 per cent figure is, with the estimate first noted in the 1960s and still quoted today, albeit through a filter of more recent references. Considering the dramatic health sector reforms and natural evolution of healthcare provision that has occurred in Africa over this fifty-year period, the dated 40 per cent estimate must be viewed with caution.

### *About 30-70 per cent of health care in Africa*

Another, more recent estimate, is usually stated as a range of 30-70 per cent of health services provided or owned by FIs in Africa – although again there are some variations of this range (see Abuom 2001, Asante 1998, Hafner 2009, Grills 2009, Samuels *et al.* 2010, Pearl *et al.* 2009). This ranged estimate has appeared in the literature since the 1990s, for example, in a World Bank collection, Abuom (2001:125) estimates that “... up to 70 per cent of modern health care is now managed by churches in some African countries.” The ranged estimate appears to be an attempt to move away from 40 per cent, and show some of the diversity in Africa – the higher end mainly tied to figures provided for the Democratic Republic of Congo (DRC) and Southern Sudan. In the DRC, the government handed over responsibility for almost half of the nations’ health zones to a coalition of mostly faith-inspired health institutions in 1999, and as a result a coalition of FIs and partners are said to provide between 50-70 per cent of care (see Dimmock *et al.* 2011). Similarly, Hipple and Duff (2010:47) note: “approximately 75 per cent of South Sudan’s health services are provided by faith-based institutions.”

However, the 30-70 per cent estimate suffers from the same broken telephone effect as above. For example, in the most recent literature the 30-70 per cent estimate is commonly referenced to a mapping study by the African Religious Health Programme (ARHAP) for the WHO in 2006. If you return to that study (which is a localised ‘deep-dive’ mapping study of seven communities in Zambia and Lesotho, and not a national or regional survey), the only place where such an estimate is mentioned is in the introductory literature review, saying:

There are a handful of studies which seek to assess (FBOs) such as hospitals and clinics ... These studies estimate that 30% and 70% of medical infrastructure is owned (or health services provided) by religious organisations. What these studies demonstrate is that while the religious-health infrastructure in Africa appears to be significant, there is still a critical lack of systematic research or information that can ultimately guide policy. The full scope of the religious health system is unknown, and what information there is, remains disparate and often conflicting (ARHAP 2006:20).

Unfortunately this 30-70% has since taken on a life of its own, bolstered by other statements, and translated into (for example): “According to the African Religious Health Assets Program (ARHAP), in sub-Saharan Africa faith-based facilities provide 30%-70% of the region’s health care services” (Pearl *et al.* 2009, see Grills 2009). Or Samuels *et al.* (2010), referencing the same ARHAP study, who say: “faith based communities...provide 40% to 50% of healthcare in developing countries.”

### *About 25 per cent of all health care provided by the Catholic Church*

The final example of broken telephone that we provide is the estimate that the Catholic Church provides 25 per cent of all health care facilities and services globally (see Benn 2003, Grills 2009, Vitillo 2005 and 2010). This is a particularly challenging estimate to dispute, as the Catholic Church indeed provides a massive amount of healthcare and

services around the world, and it feels almost mean-spirited to hold this to scrutiny. However, the main concern with this estimate, as with the others, is that there is no clarity as to how it was reached. It is entirely possible that the Catholic Church conducted some internal inventory about which we are ignorant. All that seems publicly available is that Cardinal Barragán, President of the Pontifical Council for Health Pastoral Care, made a statement at a United National General Assembly Special Session that “26.7% of the centers that treat people with HIV/AIDS in the world are Catholic based” (Barragán 2006:1). It is not clear how the 26.7% estimate was reached, but the preciseness suggests there was some specific measure. What is interesting is how widely this figure is now used, with small alterations, sometimes rounded down to 25 per cent, or changed, for example, to “*The Catholic Church alone claims to provide a massive 24 per cent of health care worldwide*” (Grills 2009:506). CAFOD, in turn, estimates that “*around 40% of HIV/AIDS initiatives across Africa are supported by the Catholic Church*” (2006:6). These small shifts in fact, figure and estimation may seem insignificant. However, they are difficult to reconcile with the other market share estimates inclusive of other religious traditions. The WHO, for example, estimated in the World Health Report of 2004 that FIs represented 20 per cent of the total agencies working to combat HIV/AIDS. This is difficult to reconcile with 26.7 per cent or 40 per cent provision by the Catholic Church alone. Again, although these estimates appear to be focused on the same thing, attempting to integrate such estimates is a fairly pointless exercise given the obscured or mismatching measures on which they appear to be based.

### **The main sources of market share estimates**

Many of the historical origins of market share estimates are obscured or provided without any discernible origins (or reference) in the first place – especially those prior to 1990. Based on literature analysis and tracking, we have been able to identify six key sources of prevailing estimates:

1. A set of surveys conducted by the Christian Medical Commission (CMC) and partners around 1964 (references often leading to McGilvray 1981).
2. A cluster of texts addressing pharmaceutical provision, often linked to work by the WHO (see Banda *et al.* 2006, Kawasaki 2001, Vogel and Stephens 1989).
3. World Bank health sector reviews: in various archived reports but frequently referenced to a working paper by De Jong 1991 or the World Development Report of 1993 and its background papers (see also World Bank 1986).
4. A set of meetings held in 1993 and 1994 on the public-private mix and subsequent national surveys (most frequently referenced to Gilson *et al.* 1994).
5. A more recent synthesis of percentages of national faith-based health networks (NFBHNs) provision of national health services (frequently referenced to Green *et al.* 2002 or Dimmock 2005 and 2007).
6. Current estimates provided by NFBHNs vis-à-vis government provision found in the annual reports, presentations and websites of NFBHNs such as the Christian health associations (CHAs).

It is rather startling to observe just how many current estimates are based on observations from the 1960s and 1980s, given the significant health system reforms that

have taken place since then, and the development of public health services over the last fifty years. This is both the case for estimates which reference from one text to another (obscuring for the reader just how dated the estimates are), and also for newly calculated estimates which are uncomfortably close to those estimated in the 1960s. For example, McGilvray and CMC's 1963-64 surveys estimated that church health providers accounted for 43 per cent of health services in Tanzania, 40 per cent in Malawi, 34 per cent in Cameroon, and 27 per cent in Ghana – and importantly, immediately after these estimates, McGilvray then adds, “*however, one should not read too much into the above ratios...*” (McGilvray 1981:39). It is likely that in the absence of robust data since then, the original estimates obtained in the 1960s continue to inform today's perceptions, including those of staff working in CHAs. For example, in a survey of CHAs conducted in 2010, Dimmock *et al.* (2011) report market share estimates by CHAs staff of 42 per cent for Tanzania, 37 per cent for Malawi, 38 per cent for Cameroon and 42 per cent for Ghana. It is difficult to understand how half a century could have had such a small impact on most of these estimates, especially given the wide range of new public and secular private providers now involved in these national health systems (NHS) – apart from Ghana, whose estimate has gone higher.

### **The problems with existing market share estimates**

At least three problems plague existing market share estimates. Firstly, the estimates rarely correspond to measures that are sufficiently comparable – they tend to compare ‘apples, oranges, and elephants’; secondly, most estimates are based on a narrow view of health care provision that emphasises facilities-based care (and with insufficient attention paid to secular facilities-based private providers); and thirdly, evidence on a select group of CHAs in a select collection of African countries is used to derive broader estimates for the region as a whole.

#### *Comparing apples, oranges and elephants*

It is difficult to know just what the underlying measure of most market share estimates are. Most estimates are simply stated as percentage of ‘health care’ or percentage of the NHS, and most *appear* to be based on the number of hospital beds or number of health facilities owned by faith-inspired actors, which, as Hanson and Berman (1998) say, is by far the most readily available data. Significantly fewer estimates integrate other indicators such as utilisation, number of staff, percentage of population served, in-patient days, out-patient attendances, or health-education services provided. Indeed, what becomes glaringly apparent is how reliant *all* FII market share estimates are on a small sub-set of data, namely, the percentage of health facilities operated by the members of CHAs, usually counted by number of hospital beds or health facilities owned or managed *relative to government provision* – rather than relative to the NHS as a whole, including other private (sometimes for profit) provision.

For example, it is widely noted that the Christian Health Association of Ghana (CHAG) caters to between 35-40 per cent of the national Ghanaian population (see CHAG 2006). This estimation is usually based on the relative ownership of facilities or availability of hospital beds. However, while there has been a greatly improved tracking of government and CHAG figures, in the current Ghana Health Service (GHS)

estimations, a table is provided of hospital beds by ownership and region. While GHS and CHAG figures are present, most of the Islamic, quasi-government and private providers are blank (GHS 2009:19). It is, in fact, currently unknown just how many hospital beds are available in the Ghanaian private sector – making a nationally valid market share estimate difficult. There are many other such examples, where even the most basic measures of relative provision of the NHS is compromised by the fact that much of the ‘other’ provider information is missing. And, as noted during a recent CHAs conference in Ghana, even estimates based on hospital beds are often confounded by the common utilisation of ‘floor beds’ which are not generally counted (ACHAP 2011), especially in the rural contexts in which FIs are often operating.

Nevertheless, several attempts have been made at synthesising the data on market share of FIs in Africa – usually resulting in a table listing country estimates (see De Jong 1991, Dimmock 2005 and 2007, Chand and Patterson 2007, Gilson *et al.* 1994, Green *et al.* 2002, Grills 2009, Hanson 1994, Hecht and Tanzi 1993, Kawasaki and Patten 2002, Robinson and White 1997, Rookes 2009, Schmid *et al.* 2008, Turshen 1999). It should be noted that, like McGilvray above, most of these authors provide strong caveats to this data, naming the unevenness of the data and the inherent challenges to synthesising mismatching measures. However, these caveats never travel forward in the literature – and it is common for these troubled estimates to be quoted as ‘fact’ in the next text in which they are referenced.

The main difficulty encountered by the authors attempting to synthesise these estimates is that any generalised statement of faith-inspired market share is immediately undermined by the fact that barely any of the evidence utilises the same indicator or measure (if such is at all apparent), and becomes more a case of ‘comparing oranges, apples, and elephants’(see Schmid *et al.* 2008:47). The data on faith-inspired health service provision is also embedded within different evidence clusters, as in each country, FIs are either counted as part of private, public, non-state, voluntary, PFP, PNFP, traditional, government-assisted health facilities, non-governmental (NGO), or civil society sectors (see Batley and Mcloughlin 2010, Schmid *et al.* 2008). Many of these classifications are blurred – but FIs have a particular tendency to fall into the grey areas. For example, in many countries in Africa, FIs are co-owned or co-operated between faith communities and government, and through complex cross-subsidisation arrangements, they are often partially part of the public system. Furthermore, some FIs do pursue profits (see Gilson *et al.* 1994). Evidence on FIs is also embedded in studies on private-public partnership, on HIV/AIDS response, community development, and other disease-specific surveys, making cross-analysis difficult. In this way, some FIs are mapped and remapped again, and others remain invisible, lost between the cracks of imposed research agendas and frameworks.

#### *Reliance on facilities-based care with weak data on secular private providers*

Most of these estimates also come from CHAs’ or governments’ perspectives, and there is very little data on the relative *utilisation* of care from the health-seeker’s perspective. In another paper (Olivier and Wodon 2011), we have attempted to calculate market share using nationally representative household surveys, for those countries in which a

distinction is made in survey questionnaires as to whether the health provider utilised was faith-inspired or not. Based on this data, the estimates tend to drop dramatically (for example, most countries which were estimated at around 40 per cent of CHAs relative to government, come in at around 5-10 per cent FII provision, relative to all providers.) Of course, when you are counting more than the CHA facilities relative to government facilities – the pie gets bigger, so the slices gets smaller. By taking into account non-traditional service delivery (traditional healers, pharmacies, chemical stores, and the like) the surveys expand the universe of health-seeking behaviour and thereby reduce the market share of *both* public and faith-inspired providers, but the reduction in market share is typically much more dramatic for FIIs than for public facilities essentially because private secular facilities are better taken into account. Thus, even pulling out only the facilities data, the estimates tend to be significantly lower than 30-70 per cent often claimed. What this does is remind us that there is often a low utilisation of formal curative health facilities in Africa, so that making claims for provision of ‘health care’ to the entire population by counting (mainly curative) medical facilities data is increasingly problematic.

#### *Applying CHA estimates to all of the ‘faith sector’ in Africa*

Considering that this basic evidence (of relative provision by CHAs) is fragile, it is therefore concerning when such evidence is commonly used as the basis for much broader conclusions about the contribution of the ‘faith sector’ to health in Africa. Estimates for Africa (as in table 1) are being based on evidence from a particular handful of countries which have ‘significant’ number of FIIs engaged in healthcare delivery (indicated in the first place by the presence of a CHA there), namely: Cameroon, Chad, DRC, Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe. In other words, the common 40 per cent estimate for Africa, or estimates of ‘up to 70 per cent’ of care provided by FIIs is derived as valid for Africa – but is based on a smattering of evidence from these specific countries and then extrapolated for the whole of Africa. Other African countries are greatly under-represented, particularly those in regions which have historically lower levels of faith-inspired health service provision (such as Mali, where faith communities’ engagement in health rarely manifests itself through formal healthcare facilities; see Schmid *et al.* 2008). Current generalisations for Africa, based as they are on this particular set of countries, unavoidably drive estimates for Africa as a whole to much higher levels than seems warranted, and result in immediate pushback at a policy level. In short estimates of a 30-70 per cent market share for FIIs simply do not ring true for many countries in the region.

The CHA-facilities data is also frequently used to estimate the entire national and continental contribution of all FIIs to health and development. This is problematic in two ways: firstly, CHAs are not representative of *all* FIIs engaged in health in their country, as many FIIs remain (sometimes intentionally) out of network. Therefore, national estimates which are only based on CHAs-facilities data might in a few cases actually *underestimate* the market share of the ‘faith sector’ more broadly. Secondly, CHA-facilities-based estimates might well underestimate the extent to which the CHAs and the broader ‘faith sector’ in that country might be engaged in health-promoting activities

at the community level. Indeed, one of the main comparative advantages often stated in the literature is that FIIIs have an abiding connection to community (see Gilson *et al.* 1994). But here again, due to lack of other evidence, mismatches of data are common. For example, an assessment of community initiatives in HIV/AIDS says:

Religion is an integral feature - often the most important feature - of a community's life. It is central to all of the critical milestones in most individuals' lives, including birth, marriage, and death. According to UNAIDS, quoted in F. Dimmock, Christian associations in Africa provide about 48% of health services in Tanzania, 47% in Liberia, 45% in Zimbabwe, 40% in Kenya and in Lesotho, and 30% in Zambia. FBOs have credible leadership, existing structures, and effective channels of communication within communities (Ninan and Delion 2009).

Note how the CHA-facilities data is utilised here to support the argument about the broader engagement of religion and FIIIs at a community and interpersonal level. This is a common practice, as the market share estimates based on the percentage of NHS provided by CHAs remains the main 'hard evidence' available. The extent to which FIIIs (or the 'sleeping giant' that is the 'faith sector') are engaging and impact at community and often informal levels is largely unmapped. Much of the literature has also emphasised the characteristic way FIIIs tend to offer a range of holistic health and development activities (see ARHAP 2006, Haddad *et al.* 2008). A count of health facilities is therefore a rather imperfect measure, for example, for a religious hospital which acts as the hub for a range of community activities from support groups to safe water and sanitation, from fertilizer to financial schemes (see Green *et al.* 2002); or a network which combines health and educational activities (often in the same facility). Estimates which do try to take this broader range of activities into account tend to be higher (see Bandy *et al.* 2008).

### **The politics of percentages**

We cannot point fingers at any of the estimates detailed above (indeed, we have both previously used such estimates in the past). We highlight these problems relating to 'market share' of FIII engagement in healthcare provision in order to demonstrate how fractured the field of inquiry is. Some of the 'broken telephone' effect is the result of a high burden of policy- and practitioner-level inquiry faced with a grossly neglected field of interest and evidence base. Some of lack of evidence can be explained by the complex and varied position of FIIIs in modern health systems in development contexts. However, the way that certain estimates have become accepted as 'truth' (such as the 40 per cent in Africa), so that they no longer even require referencing, is also reflective of the way these estimates are connected to different powerful institutions and agendas. Said differently, these estimates have become quasi-political.

These estimates now appear to serve as the foundational proof on which other arguments are based. A useful example is how strongly these estimates are present in the emerging memoranda of agreement (MOUs) between the CHAs and their national governments – shaping the basis of those relationships (see Dimmock *et al.* 2011). The

logic goes: if FIs are providing a certain percentage of health care, then they should rightly be receiving a roughly equivalent percentage of the available resources. For example, the CHAG annual report (2006:9) states “*about 2% of the total health fund (Donor Pooled Fund) is allocated to CHAG facilities. It is important to note however that when we put this against the proportion of health services delivered by CHAG health institutions it will be easy to state that there is high level of inequity here.*”

Unsurprisingly then, there is also a great deal of dissent and negotiation evident over what the ‘correct’ market share estimate is. For example, in 2002, the Central Board of Health in Zambia estimated that 77 per cent of health facilities in Zambia were owned by the government, 16 per cent by the private sector, and only 7 per cent by Christian missions (CBoH 2002). This compared to the 40 per cent that the Christian Health Association of Zambia (CHAZ) usually estimates (see Dimmock *et al.* 2011). At a recent CHA meeting, a representative noted how frustrating it was when the government asked them for their assessment of these estimates, and then published a much lower figure without explanation or consultation (personal correspondence, see ACHAP 2011).

These anecdotes point to how important these estimates have become, especially in collaborative spaces such as these where there is an evidential vacuum, and partners are coming together and assessing each other’s strengths and potentials. These collaborative contexts are also often filled with both historical and current tensions and in some cases a lingering reluctance on the part of some FIs to lose autonomy or become fully aligned with government (Green *et al.* 2002, see Haddad *et al.* 2008). In such contexts market share estimates often form the basis on which power relations are organised. As it can be imagined, for some advocating for or from a faith-inspired platform, a higher estimate of the market share can be perceived to be beneficial in order to increase recognition, funding and policy influence, to foster greater independence from governing structures, or establish better standing in collaborative (and sometimes interfaith) relations. Conversely, it could be that some government agencies might perceive benefits in lower estimates of FI market share, for example to limit requests for financing and staffing costs, or to have more power to integrate ‘wild card’ FIs into national systems. These are substantial decisions to be made upon a flimsy evidence-base. It is no wonder that market share estimates are wildly conflicting and often appear more advocacy-oriented than evidence-based. The malleability of these estimates therefore appears to be less a result of faulty research work, and more an indicator of the powerful agendas and politicking happening in the background, and any policy work that could lead to improved alignment and harmonisation would have to take this into account.

## **Conclusion**

Most FIs are facing difficult times in Africa, working in increasingly constrained resource environments and within weak health systems. It is thus not surprising that many FIs feel the need to defensively advocate for fair and equal treatment by their governments and the international community – for which a declaration of their percentage of healthcare ownership or provision is a critical first step. It is not for us to say whether such defensive advocacy is still necessary or not (and indeed, in many African

countries, it would appear that it is may well still be a valuable tool). FIIIs are supported in this by a large group of international policy-level actors and commentators who are convinced about the significance of FIIIs in Africa, and who similarly use these market share estimates to advocate for more attention to be paid to FIIIs. Nevertheless, it is our contention that generalised advocacy-oriented market share estimates are now doing more harm than good, especially when extrapolated for much broader conclusions about the faith sector in Africa. As we have suggested, such estimates are easily challenged.

What concerns us is the way that the market share discourse and confrontation might be acting as a barrier to the uncovering of other evidence of significance – such as performance, quality and cost of services, or impact on those most vulnerable. Almost two decades ago, Hanson and Berman asked (1994:5):

Which parts of the private sector in Africa are the most important from a public policy point of view? First we need to identify how importance is measured: by the level of expenditure; by numerical importance; by level of utilization; by public health impact? ... Assuming that the essential goal of public policy is to improve the access of the poor to a basic package of preventive and curative services, it is likely that the most important non-government players in the African context will be mission and other religious services, informal modern services including drug sellers, and traditional healers. It is these providers which are predominantly located in rural areas serving relatively poor populations and/or providing basic health services ... (Unfortunately) information about private providers tends to be available in inverse relation to their anticipated importance.

Yet today there is still a worrying lack of basic evidence on facility-based faith-inspired healthcare, never mind the more complex range of informal and community level activities. The proper estimation of faith-inspired market share remains a valid and urgent research endeavour, given that the significance of FIIIs remains clear, if not the exact tools for demonstrating this significance.

More rigorous data collection is certainly necessary, as are standardised and systematic approaches. We need to focus on comparative quality and efficiency of services provided, access, cost, equity, and utilisation. We urgently need to know more about the sustainability of FIIIs – which are anecdotally more resilient, with a different operational timescale – but with few longitudinal studies to support this. With static market share estimates holding sway in the policy discourse, it is difficult to assess faith-inspired health provision relative to other providers over time or in reaction to contextual events. It is also urgent that we know whether care is provided differently by FIIIs in rural or hardship areas, and whether FIIIs indeed target the poor better than other providers.

All of these needs demonstrate the importance of moving away from simplistic estimates of faith-inspired market share, especially those speaking of Africa as a whole. These are now only getting in the way of more complex, contextualised, systematic and rigorous assessments of where the real contribution of public, faith-inspired and other

private services can be fully recognised, and have a more profound impact at a policy level.

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### **Notes**

1. It should be noted that there are ongoing difficulties with nomenclature in this field of interest. Terms such as 'faith sector' or 'faith based organisation' (FBO) have been widely used for advocacy purposes, but the actual definitions or typologies remain hugely problematic and unresolved (see Olivier 2011). Although not ideal, for the sake of brevity, we utilise the term faith-inspired institution/initiative (FII) here as the generic term inclusive of all faith-inspired, faith-based, mission, 'church', or religious non-profit private health institutions, facilities, organisations and initiatives.

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