Market Share of Faith-inspired Health Care Providers in Africa: Comparing Facilities and Multi-purpose Integrated Household Survey Data

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MARKET SHARE OF FAITH-INSPIRED HEALTH CARE PROVIDERS IN AFRICA: COMPARING FACILITIES AND MULTI-PURPOSE INTEGRATED HOUSEHOLD SURVEY DATA

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This paper relies on facilities and household survey data to estimate the 'market share' of faith-inspired institutions (FIIs) in the provision of health care services in Africa. While estimates based on facilities data, especially for hospitals, often suggest that the market share of FIIs is at 30 percent to 40 percent, estimates from household surveys are typically at less than ten percent. A number of potential explanations for these large differences are provided. Both types of estimates suffer from limits, but observing the two types of estimates alongside one other provides a more balanced view of the market share of FIIs in health care systems as a whole than is the case for any single type of measure.

INTRODUCTION

Market share estimates - typically in the 30 percent to 40 percent range - are frequently wielded as the most concrete evidence of faith-inspired activity and impact in the area of health care provision in sub-Saharan Africa. In fact, there are few speeches, reports or articles which do not make some mention of market share, attaching some percentage to the significance of faith-inspired healthcare provision in the continent as a whole, or in specific countries. 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 resources from governments and donors. A systematic review of this literature (Olivier and Wodon 2012a) reveals that these statements have currently reached the point of becoming almost indisputable 'truth', as they are now frequently made without any referencing.

There is of course an empirical basis for these statements, but it is not as strong as commonly believed. Several attempts have been made at synthesizing the data on market share of faith-inspired health provision in Africa – usually resulting in a table listing country estimates (see for example De Jong 1991, Dimmock 2005 and 2007, Chand and Patterson 2007, Gilson et al 1994, Green et al 2002, Grills 2009, Hanson and Berman 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 however that most of these authors provide caveats to this data, naming the unevenness of the data and the inherent challenges to synthesizing mismatching measures. Indeed, any generalized statement of faith-inspired market share is immediately undermined by the fact that barely any of the evidence is measured utilizing the same indicator or measure (if such is at all apparent), and becomes more a case of 'comparing oranges, apples, and elephants'.

There are several reasons why it is difficult to obtain reliable, robust, and comparable market share estimates. Firstly, the data on faith-inspired health service provision is embedded within different evidence clusters. In different countries (and often in different studies of the same country), FIIs get differently counted as part of: private, public, non-state, voluntary, private-not-for-profit (PNFP), traditional, government-assisted health facilities, non-governmental (NGO), or civil society sectors (see Batley 2010, Schmid et al 2008). None of these classifications are without their own problems – for example, the WHO (2006) notes that the definition of public and private providers is increasingly blurred *"…as medical goods and services flow between public, commercial, philanthropic traditional and informal providers."* However, FIIs have a particular tendency to fall into the grey areas.

For example in some countries a hospital owned by a faith-inspired group can also be classified as a public (or district) health facility; or a government-owned parastatal hospital can be operated by a faith-inspired governing body (see CSSC 2007, DeRoeck 1998, Gilson et al 1994, Munishi et al 1995). In many countries, health facilities are co-owned between faith-inspired and government providers, and cross-subsidization and the co-sponsoring of staff wages and costs have created a complex environment for assessment (see Schmid et al 2008, Batley 2009). In fact, many FIIs consider their character and internal philosophy to be more 'public' than 'private'.[1] FIIs, who are usually non-profit and often profess a central intention to work with the rural poor, find little comfort in being counted as part of a private for-profit sector serving an urban elite. Further murkiness comes from the fact that some FIIs do pursue profits (see Gilson et al 1994). There is also some grey area as to which FIIs are private-non-profits and which are part of the 'traditional' health sectors – with multi-modal religious practices making a clear distinction difficult in some places, especially when looking at informal community levels. In Zambia, for example, traditional healers often run local 'healing hospital facilities' and are becoming more integrated with biomedical health systems through referral practices (see ARHAP 2006).

In addition, evidence on FIIs is also embedded in different types of studies, among others on private-public partnerships, HIV/AIDS responses, community development, and other disease-specific surveys, making cross-analysis difficult. A similar complexity has developed around the nomenclature of FIIs – with no clarity or consensus on how FIIs should most appropriately be named or classified. In this way, some FIIs are mapped and remapped again, and others remain invisible, lost between the cracks of research agendas and frameworks.

It is also often difficult to know what exactly most market share estimates refer to. Many estimates are stated as percentage of 'health care' or percentage of the 'national health system/service' (NHS) – with only a few estimates being precise and showing specific indicators such as number of hospital beds, number of doctors or nurses, number of

[1] There are implications for these classifications. It has been noted, for example, that the classification of the religious non-profit services as 'private' has encouraged an atmosphere of competition, rather than collaboration, with the public sector (see Schmid et al 2008).

training schools, number of health centers, or percentage population served, in-patient days and out-patient attendances, number of congregations, orphans and vulnerable children reached, or health and education services provided. Different measures also represent a number of different interests and 'levels' – a common characteristic of literature addressing FII's engagement in health and development, which takes a transverse slice across a number of different interests and fields. For example, studies of the faith-inspired response to HIV/AIDS in Africa commonly address response of formal health facilities, primary health care programs, networks and non-governmental and community institutions, congregations, as well as informal community initiatives within the same piece of research.

The most common measure is based on the number of hospital beds or number of health facilities which, as Hanson and Berman (1998) argue, has been so far the most readily available data. However, such data are typically used to make broader statements about faith-inspired market share – despite the fact that the evidence is primarily based on a cluster of inventories of health facilities and hospital beds owned or operated by members of the national faith-based health networks (NFBHNs)[2] in a few key countries. There is significantly less known about the non-facility-based, informal and community level of healthcare provision. All this speaks to a complex evidential landscape, in which the little data there is on market share – fits poorly together, making cross-country or regional comparison difficult – and results unavoidably in specific pieces of evidence being utilized for broader claims than for which they are usually designated.

In this context, the objective of this paper is to take one (partial) step towards a more comprehensive assessment of the role of FIIs in health care provision in Africa by comparing and interpreting the market share estimates obtained with facilities data (and especially hospital beds) with alternative estimates obtained from nationally representative households surveys that tend to take into account health systems as a whole. The results are striking: while estimates based on facilities data suggest that the market share of FIIs in Africa is at 30 percent to 40 percent, estimates from household surveys are typically at less than ten percent. Beyond providing both sets of estimates, we discuss several of the factors that help in understanding why the estimates vary so much between the two data sources (for work comparing market share estimates for private providers of health care, both faith-inspired and private secular, in sub-Saharan Africa using different types of household surveys, see Wodon et al. 2012, and Wodon, 2013).

[2] The term '*national faith-based health networks' (NFBHNs)* has gained some traction so we will leave it as is. NFBHNs are country-level providers of health services, or networks of health service providers. Apart from a few outliers, most are Christian Health Associations (CHAs). The core functions of NFBHNs are to support health services provided by their members through their activities in advocacy, technical assistance and training, capacity building, resource mobilisation, research, M&E, joint procurement and equipment maintenance, and communication. Although the NFBHNs and their members face various challenges such as financing and workforce concerns, they are generally considered to be exemplars of the positive impact of collaboration (Schmid et al 2008, CHAK 2006, CSSC 2007, Dimmock 2007 – see also www.africachap.org).

We realize that the issue of market share is a potentially inflammatory topic, with different parties having vested interests in such estimates which are perceived to have a significant impact on collaborative engagement. We must therefore be clear that this article does not set out to lambast any current estimates – the majority of which are self-admittedly based on inadequate evidence. We also do not conclude with a newly synthesized estimate of faith-inspired market share for health provision in Africa as a whole, or in any of the specific countries we are looking at. Rather, we simply suggest that there is a lot to gain in looking at different sources of data to assess the role of FIIs in national health systems, and also actually in moving beyond arguments or advocacy based on market share, which are of limited value, to start looking at some of the more important policy questions about the role of FIIs.

The rest of the paper is structured as follows. In section two, we review some of the existing estimates of the market share of FIIs that have been provided in the literature on the basis of facilities data. In section three, we provide new evidence on alternative market share estimates obtained from nationally representative household surveys. In both sections, we also discuss some of the assumptions that lie beneath the estimates, and some of the factors that may help explain the large difference in market share estimates between facilities data and household surveys. In concluding, we suggest how moving beyond the debate or advocacy around market shares may be beneficial for research aiming to assess the respective roles and complementariness of the public, private non-religious, and faith-inspired sectors.

ESTIMATES BASED ON FACILITIES DATA

Africa-wide estimates of the market share of faith-inspired health care providers are plagued by comparability issues, and estimates based on particular indicators are typically used for much broader claims (Olivier and Wodon 2012a). For example, an estimate for hospital beds provided by one faith-inspired network may be used by others as an estimate of all faith-inspired health-relevant activity in that country or the entire region. By contrast, estimates obtained at the country level are at least potentially more useful for informing policy.

Ideally, for any given country, one would like to have a comprehensive assessment of the scope and scale of all health-related services provided not only by government facilities and FIIs, but also by private-for-profit providers as well as other (non-religious) not-for-profits (NGOs), community-based organizations and initiatives - including in areas such as the response to HIV/AIDs. This is however not feasible in practice. The evidence to-date is for the most part based on estimates of the role of FIIs, and especially Christian Health Associations, in national health services, and based primarily on the share of hospital beds located in facilities owned or operated by Christian Health Associations, as compared to beds located in facilities owned by then public sector, typically through Ministries of Health.

Table 1 provides examples of such estimates. The implied market share of FIIs ranges from 10-20 percent in Chad to 50-70 percent in the DRC, with most estimates falling in

the 30-40 percent range (this is the case for Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Rwanda, Sierra Leone, Tanzania, Uganda, and Zambia). There thus seems to be substantial convergence in existing estimates on the market share of FIIs, with again most estimates reflecting the share of hospital beds or out-patient care provided by FIIs as compared to public facilities. The question is whether these estimates capture a large enough share of the total delivery of health care in the respective countries. We would argue that interpreting the data in table 1 as valid estimates of the share of services provided by faith-inspired facilities within national health systems is problematic for at least three reasons.

First, within formal care delivery mechanisms, a large share of health services are provided by other types of facilities than hospitals, such as clinics and health centers, as well as maternity homes and facilities from government-run community-based health planning and services which are primary health care focused services (sometimes with mobile units). Estimates of the market share of FIIs based solely or principally on hospital beds may lead to overestimating the role of FIIs to the extent that the share of hospital-based care among all services provided is often higher among FFIs such as the Christian Health Associations than is the case for public facilities. Indeed, when one looks at the share of total facilities operated by FIIs, one often gets a lower estimate than when referring to hospital beds only.

Second, in part because the private non-religious sector often operates independently of Ministries of Health in many countries, data on the role of private non-religious facilities are often missing, even if one restricts the analysis to measures such as hospital beds. That is, most of the estimates of the share of FIIs are based on comparing FIIs with public sector facilities, without factoring in the existence of similar facilities operated by private non-religious providers (and for that matter also without factoring in some religious providers that are not part of large federations such as the Christian Health Associations – this is often the case for Islamic clinics and hospitals.)

A third issue with the reliance on statistics on hospital beds, pharmaceuticals, outpatient care and for that matter also the number of formal facilities operated by different networks is that a large share of health care is provided by other types of providers that are not included in such statistics. At least two different groups must be mentioned here. First, many countries have a significant traditional sector that often operates alongside orthodox biomedical care, for example with patients mixing plural health-seeking modalities. While studies on religion and health-related behaviors recognize the role of traditional practices, this is rarely addressed in the literature on the market share of FIIs. Second, self-medication has also been noted to be a significant practice in many countries – given the limited availability of doctors. Some studies have shown that self-medication with privately purchased drugs may in some countries represent the most common treatment after home remedies. As noted by Bennet et al (1997), *"household surveys indicate that drugs purchased from local drug sellers or pharmacies are used to treat approximately 53 percent of illness episodes in Burkina Faso … studies on general and low-income populations in Kenya, Nepal, Rwanda, Thailand and elsewhere show similar high rates of medication with drugs acquired in the private sector."*

Table 1: Examples of national health service (NHS) market share estimates based on facilities data

Country		Share (%) of NHS	Reference
Chad	Faith-based care	~20% national health coverage	Boulenger et al 2009
	NFBHN [UNAD]	10% national health coverage	
DRC	Church related institutions	70% health services	ECC 2007
	FBOs	~50 % health services provided and facilities owned	Kintaudi 2006
Ghana	All FBOs (Christian & Muslim)	40% national health services	EPN 2005
	CHAG	35-40% national health care	CHAG 2006
Kenya	NFBHN [CHAK and KEC]	40% national health services	Mwenda 2007
Lesotho	NFBHN [CHAL]	40% national health service	Green et al 2002, MOH-Lesotho 2007
Liberia	Christian Health Networks	~46% national health sector	Chand and Patterson 2007
Malawi	Church	40% services	Robinson and White 1998
	NFBHN [CHAM]	37% health services	Mhango 2006
	NFBHN [CHAM]	20% national health infrastructure	MOH-Malawi 2001
Nigeria	CHAN	40% national health services	CHAN 2007
Rwanda	Church-affiliated facilities	45% hospitals and 35% primary care facilities	CCIH 2005
Sierra Leone	NFBHN [CHASL]	30% national health services	Dimmock 2007
Tanzania	NFBHN [CSSC]	48% national health service	Green et al 2002
	NFBHN [CSSC]	~26% all health facilities, 40% hospitals, and 50% health services in rural areas	Todd et al 2009
Uganda	NFBHNs [Christian and Muslim: UPMB, UCMB and UMMB]	50% beds, 60% hospital services, 42.3% hospitals, 22% lower level health facilities, 70.7% nursing/midwifery schools	HERA 2005
	NFBHN [UPMB & UCMB]	50% national health service	Green et al 2002
	Diocese and parishes	70% all PNFP (lower-level units & hospitals)	MOH-Uganda 2001
Zambia	NFBHN [CHAZ]	50% rural health care provision 30% total health care provision	Nussbaum et al 2005
	NFBHN [CHAZ]	30% all health services	MOH-Zambia 2002
Zimbabwe	NFBHN [ZACH]	45% national health service	Green et al 2002
	Christian Hospitals	68% total bed capacity	Benn 2003

Source: Compiled by the authors.

These three factors are likely to lead to substantial overestimation of the market share of FIIs in national health systems when the main data source being used refers to hospital beds and formal facilities. At the same time, one should also note that other factors may go in the other direction and leading to higher market shares for FIIs. As noted early on by Hanson and Berman (1994), estimates of health service provision, measured by the number of providers (beds or facilities) may be misleading if utilization levels differ significantly between different sectors and contexts. To the extent that faith-inspired facilities have higher (or lower) utilization rate (say because of a higher or lower quality of services, at least as perceived by patients), they may provide a higher (or lower) share of hospital-based care than suggested by statistics on hospital beds. There are however only a few localized studies – mostly dated, which address utilization of these services, and it is difficult to generalize from the limited evidence available. For example Mwabu (1986) reported findings from a household survey looking at provider choice in Kenya which suggest that after the initial visit, mission clinics dominated other facilities as a treatment source. In Burundi, there is dated evidence that mission facilities are twice as heavily-utilized by outpatients as government facilities (World Bank 1983). But Banda and Simukonda (1994) suggests a lower utilization of religious facilities in Malawi (based on hospital bed data from the MoH).[3]

In addition, it has also been noted that FIIs tend to be engaged in a range of activities that stretch beyond formal health services because of their 'holistic' focus on health. But data on those community-based efforts are rarely available. And overall, the factors that would lead to higher market shares for FIIs in national health systems are likely to be overridden by the above three main reasons why the market share of FIIs is likely to be overestimated when relying solely on facilities data. In order to assess to what extent this may be the case, we turn in the next section to alternative estimates of market share based on household surveys.

ESTIMATES BASED ON HOUSEHOLD SURVEYS

To date, nationally representative household survey data in which households are asked about the type of health care facility that they use when seeking care have not been drawn much into the discussion about the market share of FIIs in Africa. This may be in part because the surveys most frequently used for work on health and development, the Demographic and Health Surveys (DHS) implemented in similar ways in most African countries at regular intervals. DHS simply do not distinguish between faith-inspired and non-religious providers of care; they only distinguish between public and private providers, often suggesting that private providers provide a large share of all care in Africa, but this does not help us very much here.

For this paper, instead of using DHS data, we rely on the main multi-purpose and nationally representative household surveys implemented in approximately 30 African countries. These are the surveys that are used for poverty measurement, or for analyzing

[3] See Olivier and Wodon (2012b) in volume 2 of this collection for some further studies on utilization in relation to patient satisfaction.

the links between education and employment. But these surveys also have detailed health modules that provide information among others on whether household members have been sick, ill, or injured in the recent past (typically over the last two or four weeks), whether they did seek care, and if so, where they went for care. As shown in table 2, in about half of the surveys that we looked at, there is enough information on the type of provider consulted by households to identify public, private non-religious, and private faith-inspired providers[4].

Table 2: Identification of FIIs in the health modules of selected household surveys

Country	Identification	Country	Identification
Benin (QUIBB 2003)	No	Liberia (QUIBB 2007)	No
Burkina Faso (QUIBB 2003)	No	Malawi (HIS-2 2004)	Yes
Burundi (QUIBB 2006)	Yes	Mali (QUIBB 2006)	Yes
Cameroon (ECAM 2007)	Yes	Niger (ENBC 2007)	Yes
Cape Verde (QUIBB 2007)	No	Nigeria (LMS 2003/2004)	Yes
Chad (ECOSIT2 2003/04)	Yes	ROC (QUIBB 2005)	Yes
Cote d'Ivoire (ENV 2002)	No	Rwanda (EICV 2001)	No
DRC (123 survey 2004/05)	No	Senegal (ESPS 2005)	Yes
Gabon (QUIBB 2005)	No	Sierra Leone (SLIHS 2003)	Yes
Ghana (GLSS5 2005/2006)	Yes	Swaziland (SHIES 2009)	Yes
Guinea (QUIBB 2007)	No	Togo (QUIBB 2006)	No
Kenya (KIHBS 2005)	Yes	Zambia (LCMS IV 2004)	Yes

Source: Compiled by the authors

Table 3 provides our estimates of the market share of public, private faith-inspired, and private non-religious providers in the fourteen countries where the questionnaire provides the necessary information to do so. This table displays significantly lower estimations for faith-inspired market than those base on hospital beds or health facilities mentioned earlier. The estimates range from a market share of 1.5 percent in Niger to 15.1 percent in Cameroon. In addition, it appears that the market share of the private non-religious sectors, which includes here not only private non-religious formal facilities, private chemical stores, and pharmacies, but also traditional healers and private doctors, may be much larger than that of FIIs. On average, across the 14 countries, the market share of faith-inspired providers is below 6.0 percent. This is likely to be too low, because some of the countries that are known to have a very large faith-inspired health care sector, such as the Democratic Republic of Congo, are not included in the sample (simply adding the Democratic Republic of Congo would raise the average market share of faith-inspired providers by several percentage points). Still, the market shares based on multi-purpose integrated household surveys do suggest substantially smaller market shares than those provided based on facilities data such as the share of beds owned by the CHAs.

[4] More details on how this is done in each of the survey where the information is available given the way questions are asked in survey questionnaires are provided in Wodon et al (2012) in this volume, where the market share estimates obtained from multi-purpose integrated household surveys are compared to private market share estimates for private providers as a whole in Demographic and Health Surveys.

What could explain such different results? Obviously, much of the difference is likely to result from differences in the universe of health care being considered. In Ghana for example, hospitals account for less than a third (31.6 percent) of all consultations in the survey. Assuming that hospital beds or outpatient care are good proxies for the overall supply of care of hospitals (which itself would be a strong assumption, given that a large share of hospital care does not necessarily require hospital beds), a hospital bed market share for FIIs of a third might be diluted into a market share of about 10 percent for health care as a whole when a broader universe of care is taken into account, as is done in the surveys. The market share could be lower when accounting for the role of private sector facilities which are often not accounted for when estimating the market share of FIIs based on facilities data. This suggests that the household survey-based estimates of market share may not be completely out of sync with the reality on the ground. Still, even then the survey-based estimates look small against the current wisdom of those working on the ground – for example those in the Ministries of Health or Christian Health Associations.

Another explanation might then be that the identification of faith-inspired providers by households in the surveys is partial, with some households considering faith-inspired facilities as either private non-religious facilities, or with more likelihood as public facilities, especially when mission hospitals are considered as district or regional hospitals by Ministries of Health and accordingly funded by the government. That could very well be the case, and in that case, efforts to better identify facilities would be required in household surveys in order to obtain more reliable data. At the same time, it is unclear how large this problem might be, and the extent of the problem is likely to depend on the specific country and survey questionnaire. Although this does not fully address this question, results in Wodon et al (2012) obtained from a comparison of market share estimates for private providers of healthcare in Demographic and Health Surveys and in Multi-purpose integrated household surveys suggest that broadly, there is coherence between the various surveys even though the questionnaires tend to differ.

Another factor explaining differences between facilities and household survey-based estimates of market shares may be the fact that in table 1, most of the countries listed belong to Anglophone Africa, and the two countries that are Francophone (Chad and the Democratic Republic of Congo) are both conflict-affected countries where FIIs have helped fill the void in service delivery left by weak governments. By contrast, in table 3, we have a more balanced sample with six Francophone countries and eight Anglophone countries (if Cameroon is included in that second group). Many (although not all) Francophone countries have lower FII market share – and it is a well-established fact that colonial administrative policy had an important role in facilitating the growth of FIIs in Anglophone countries. Most of the strongly established Christian Health Associations are thus also located in Anglophone Africa. The fact that much of the literature has so far focused on Anglophone Africa may thereby have led to a bias upward in the assessment of the role or market share of FIIs in Africa as a whole.

Table 3: Estimates of Market Shares from Household Surveys

	Survey Population	Period in questionnaire	Number of Consultations	Consultations per person	Public Market Share (%)	Faith-inspired Market Share (%)	Private Non-religious Market Share (%)
Burundi, 2006	8,237,232	Last 4 weeks	1,778,654	0.216	69.3	11.5	19.2
Cameroon, 2007	18,083,282	12 months	7,318,156	0.405	44.9	15.1	40.0
Chad, 2003/04	7,393,259	Last 4 weeks	795,874	0.108	53.1	10.7	36.2
Ghana, 2005/06	22,216,866	Last 2 weeks	1,615,726	0.073	44.4	6.6	49.0
Kenya, 2005	35,494,317	Last 4 weeks	6,666,834	0.188	49.0	4.2	46.8
Malawi, 2004	12,329,494	Last 2 weeks	2,745,456	0.223	36.9	3.9	59.2
Mali, 2006	12,317,562	Last 4 weeks	1,267,931	0.103	68.5	1.0	30.5
Niger, 2007	13,427,990	Last 4 weeks	1,583,052	0.118	77.6	1.5	20.9
Nigeria 2003/04	126,482,035	Last 2 weeks	8,380,632	0.066	50.2	1.9	47.9
Republic of Congo, 2005	3,551,500	Last 4 weeks	946,993	0.267	44.0	4.0	52.0
Senegal, 2005	12,012,657	Last 4 weeks	1,417,784	0.118	-	2.3	-
Sierra Leone, 2003/04	4,825,118	Last 2 weeks	546,559	0.113	60.1	2.0	37.9
Swaziland, 2009/10	1,018,358	Last 4 weeks	138,562	0.136	-	13.2	-
Zambia, 2004	10,987,778	Last 2 weeks	922,788	0.084	55.0	6.1	38.9
Average	-	-	-	-	55.2	5.8	39.0

Source: Authors' estimations

Note: For Swaziland, the population is obtained from the World Bank Development Database Platform.

Comment: the fact that the consultation rates per person are of a similar order of magnitude for the different countries is reassuring on the validity of the data. Data on the choice of provider of health services are based on the last consultation in a given period of time; one thus expects a higher 'last' consultation rate over a one year period as in Cameroon (because it is more likely that a person was sick at least once over a one year period) than over a period of two weeks, as in Nigeria or Sierra Leone.

CONCLUSION

This paper was meant to contrast estimates of the market share of FIIs in Africa based on facilities data and household surveys. A number of explanations for why the estimates are so different have also been provided. We are certainly not claiming here that estimates from nationally representative household surveys are somehow better than those based on facilities data. Both types of estimates have strengths and weaknesses. The 'real' estimates of market share probably lie somewhere in between these estimates.

It is because so far the facilities-based estimates were virtually the only ones used in the broader advocacy and policy circles that we felt it was important to also provide estimates based on household surveys. What we find problematic is the over-reliance on one kind of estimates, especially when facilities-based market share estimates for a very specific cluster of health providers are utilized to make broad claims related to the role of all FIIs in national health systems and development more broadly. Utilization-oriented market share estimates based on household surveys were not shown here in order to undermine the significance of FIIs, or the estimates of their role based on the number of facilities or beds operated. These estimates remain important. But consideration of both types of estimates should challenge how existing market share estimates have been used for advocacy purposes, and we believe that more caution is needed in interpreting these data. Any generalized or basic estimation of market share can be easily challenged. What is necessary is to derive more complex estimates of market share that integrate different measures and data sources.

Faith-inspired market share is unfortunately a volatile topic - especially when wielded in fragile and resource-constrained collaborative contexts. The historical lack of alignment between government and FII services has led to such estimates being used as blunt instruments for advocating for or against a stronger role for FIIs. For some FII advocates, a higher estimate of the FII market share has been thought to be beneficial in order to increase funding and policy influence, or to foster greater independence for FIIs. Conversely, it could be that some government agencies might have seen benefits in lower estimates of FII market share, for example to limit requests for financing and staffing costs. Such tendencies on both sides are however not helpful, as they get in the way of establishing systematic and rigorous service delivery assessment systems where the contribution of both public, FII facilities is fully recognized, as is that of other non-public and non-religious service providers.

More rigorous data collection is necessary, as are standardized and systematic approaches. But beyond debates on market share, what is even more important is to measure the quality of services provided, the cost of services for users, and the extent to which different types of service providers reach the poor who still often lack access to services and have difficulties in affording such services. What is also needed is a detailed assessment of the extent to which policy reforms affect public and faith-inspired providers differently. For example, changes in cost recovery policies may have very different impacts on different types of providers depending on how they are funded. A number of efforts have recently been launched to better document the role of FIIs – some

are led by multilateral agencies such as WHO and the World Bank; others are led by FIIs; still others are country-led. One can hope that a few years from now, the evidence base on which policy in this area can draw will be stronger.

The main conclusion from our analysis is that that the presentation of generalized market share estimates without caveats are problematic – whether this comes from facilities or household survey data. In our opinion, broad statements on market share currently do more damage than good. The distortion and malleability of these estimates is less a result of faulty research than an indicator of powerful agendas. Market share discourse and confrontation might be acting as a barrier to the uncovering of other evidence of significance – such as performance, quality of services, or impact on those most vulnerable. Beyond the issue of market share, 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 estimation of faith-inspired market share remains a valid research endeavor, but there are other important research agendas to pursue.

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