World Health Organization

CENTER FOR INTERFAITH ACTION on global poverty

Final draft for comments

WHO - CIFA CONSULTATION NGO MAPPING STANDARDS DESCRIBING RELIGIOUS HEALTH ASSETS

Report
10-12 November 2009
Château de Bossey, Bogis-Bossey, Switzerland

WHO Programme on Partnerships and UN Reform

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This publication is still in draft and does not necessarily represent the decisions or policies of the World Health Organization.

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Executive Summary

The efforts to scale up the response against major diseases and achieve the MDGs have drawn attention to the need for strong country monitoring of health service, covering the public, private and faith based sectors. Among the latter, religious health assets are major suppliers of health care services in many countries. By some measures, at least 40% of health services are provided by faith-based organizations (FBOs). However, exact figures are difficult to come by owing to a current deficiency in measurable data and inconsistencies in terms used to define religious health assets.

Standard approaches to data collection, management, use, and dissemination are needed to quantify the value added by FBOs in health services delivery. Mapping the services they provide is a valuable way to literally be put “on the map” to increase their visibility to government partners, donor agencies, and their own communities. It also allows them the opportunity to have a “seat at the table” and thereby participate in national, regional, and local government agency planning and funding negotiations.

Representatives from 39 international partners including governments, faith-based organizations (FBOs), academic partners, and international organizations, convened to discuss mapping standards for assessing, monitoring and mapping health services, including those used to describe religious health assets provided by the faith-based or faith inspired organization.

Service delivery is one of the core building blocks of health systems and a key area for health systems strengthening. However, information on key health services is still incomplete or lacking. Information about religious health assets in the health services sector is especially incomplete or difficult to access. WHO and its partners have been working to develop tools and methods to collect data on the health infrastructure, service availability and readiness. Mapping of services availability is a key mechanism for filling these gaps and for supporting monitoring of service delivery.

Based on WHO's tool and methodology for assessing and mapping health services availability and readiness("SAM"), working groups discussed standard approaches to data collection, management, use, and dissemination for mapping data that represent the value added by FBOs in health services delivery, especially those religious health assets deemed to be intangible or at least difficult to quantify. Specific modifications to the Services Availability and Readiness Assessment (“SAM”) core instrument were suggested including the addition of a module to represent specific interests of FBOS (e,g provision of free or concessional care, capacity for spiritual care providers and volunteer staff, and provision of psychosocial services, including bereavement services).

Regarding data collection and management, recommendations included emphasizing the participation of FBOs at all stages of data collection and management and

increasing capacity building. Also, better communication and partnerships among FBOs, Ministries of Health, donor agencies, and WHO were recommended to capitalize on mutual resources, as was improved planning through coordinating committees and National Mapping Task Forces.

Recommendations regarding data needs of FBOs included prioritizing assessments of service consumers, linking service availability mapping with disease mapping, identifying service gaps, and developing frameworks to better understand and increase data availability through data clearinghouses. Recommendations for data uses included improving catchment area assessment, prioritizing data consolidation at the national level to prepare for crisis readiness, and encouraging joint assessments of service performance at facilities. Improvements in accurately interpreting data could come through the development of frameworks through National Mapping Task Forces to procure data, and developing more comprehensive interdisciplinary and inter-sector maps. Recommendations for data integration included improving delays in the feedback process by identifying bottlenecks and improving capacity for analysis, encouraging alignment between FBOs and MOHs on national health plans, and balancing political issues with data sharing needs.
Data sharing and dissemination recommendations included encouraging the use and further development of standards for Memoranda of Understanding (MOUs) between public Health Ministries and the faith based community, evaluating ways to simplify the MOU process, and encouraging the use of metadata in data dissemination. The use of web-based data repositories may better establish transparency that individual stakeholders seek.

Immediate next steps included rolling out of the WHO SAM Tool with modifications as recommended at the Consultation and convening a working group to discuss standards for mapping community-based services of FBOs. Furthermore, partnerships need to be strengthened, both within the faith community, with national networks, and with international partners. This will be facilitated through increased communications among FBOs through the use of a new electronic mailing list and a web-based information clearinghouse to be developed.

Introduction

On 10 November 2009, representatives from 39 international partners including governments, faith-based organizations (FBOs), academic partners, and international organizations convened for three days at the Château de Bossy, just outside of Geneva, as part of a joint consultation between the World Health Organization (WHO) and the Center for Interfaith Action on Global Poverty (CIFA). The purpose of this consultation was to discuss mapping and monitoring standards used to describe religious health assets as they relate to facility-based primary health care provision.

Faith-based organizations have been prominent in the health sector for as many as 150 years, often serving the most marginalized and rural populations. Yet historically, many of the resources they provide have remained invisible to the outside world or been “taken for granted” as part of the normal and longstanding service structures of faith community services. Mapping the services they provide is a valuable way to literally be put “on the map” to increase their visibility to government partners, donor agencies, and their own communities. It also allows them the opportunity to have a “seat at the table” and thereby participate in national, regional, local government agency planning and funding negotiations. This is especially crucial in the current economic climate, since like other NGOs, FBOs are under increasing pressure to provide accountability to donor agencies to maintain the resources used to provide necessary services to their constituents.

This report details the events and recommendations that came out of this historic meeting. It begins with a brief section providing the background for the consultation and the reasons why collaboration between faith-based organizations and international organizations like WHO is so crucial in the development of systems to monitor health services delivery around the world.

Chapter 1 features perspectives on health services delivery from the World Bank and UN agencies and those from faith-based or faith-inspired organizations.

Chapter 2 describes current experiences and practices by faith-based organizations working in countries like United Republic of Tanzania, Bolivia, Kenya, India, and Zambia, including case studies showing the benefits and challenges of mapping. Such examples provide a flavor of the work that is currently being undertaken and the lessons learned from these projects.

Attendees assembled into working groups during the Consultation in order to better discuss and make recommendations on the standards needed for mapping facility-based health services provided by faith-based organizations. Chapter 3 focuses on summaries of the recommendations by the working groups for (1) defining a minimum core data set for health services, (2) the main technical considerations for data collection and management, (3) data analysis and use and (4) data sharing and dissemination, and also documents (5) preliminary discussions on the mapping of community-based services provided by FBOs.

Finally, Chapter 4 discusses implications of mapping religious health assets for the future and the next steps based on the recommendations made from the Consultation. The report ends with web links to key documents used as part of the Consultation. As progress is made in developing mapping standards for health services delivery, we hope that the reach of faith-based community and the value added by its services to improve the health of the most marginalized populations will be recognized by the international community.

Background to Consultation

Sound information on the supply and quality of health services is essential for health systems management, monitoring and evaluation. The efforts to scale up the response against major diseases and to achieve United Nations Millennium Development Goals (MDGs) through global health partnership have drawn attention to the need for strong country monitoring of health services, covering the public, private-for profit and the private not-for-profit sectors. Among the latter, religious health assets, also described as faith-based or faith-inspired organizations (FBOs), are major suppliers of health care services in many countries.

The World Health Organization (WHO) and partners have been working with countries to develop tools and methods to collect data on the health infrastructure, service availability and readiness. A country monitoring system should comprise four components: (1) data collection strategies to meet critical data needs; (2) interoperable databases covering key aspects of health service functioning; (3) data synthesis and analysis; and (4) dissemination, communication and use of the results.

Even though progress has been made in several countries, much more needs to be done to help countries develop systems to monitor service delivery, one of the core building blocks of health systems and a key area for health systems strengthening. Information on key health services is still incomplete or lacking. Information about these religious health assets in the health services sector is especially incomplete. Mapping of services availability is a key mechanism for filling these critical data gaps.

Mobilization of international partners, governments, non-governmental organizations (NGOs), faith-based organizations, and academic partners and WHO Centres of Excellence will be necessary to rapidly move this agenda forward, especially in the context of the International Health Partnerships at country level.

The overall objective of this workshop was to initiate an open consultation between WHO and international partners including governments, NGOs/FBOs, academic partners and international organizations, towards agreeing on a standard protocol for assessing, monitoring and mapping faith-based or faith-inspired services in the health sector.

This includes identifying:

- instruments and tools for assessment of core services availability
- technical issues and standards for conducting service availability mapping in the field
- standard protocols for archiving and synchronizing data
- best practices for data dissemination, sharing, and use of data.

Expected outputs and outcomes of the workshop were:

- outline for a standard protocol for mapping health services
- minimum standard datasets for mapping core health services
- minimum data set for religious health assets in the health sector

- standardized instruments for collecting data
- improved accessibility to datasets.

The Center for Interfaith Action on Global Poverty (CIFA) is a Washington DC based organization that supports faith institutions internationally to increase their impact on global poverty. WHO invited CIFA, as a neutral convener of inter faith-based institutions, to assemble the international representatives faith based organizations for the Consultation.

Chapter 1: Setting the Stage for the Consultation

TED KARPF, PARTNERSHIPS OFFICER, PROGRAMME ON PARTNERSHIPS AND UN REFORM, WORLD HEALTH ORGANIZATION

I. We are gathered in this international consultation with Member States, health services providers, donors and international organizations to establish a common understanding and build consensus on Mapping Standards for NGOs, which includes and better describes or captures the work by these 'faith health assets'.

Rationale:
The truth is, "If you are not on the map, then in the eyes of donors and Member States, you do not exist! If you do not exist, you are not accountable or known, thus NOT invited to the health services table with donors, communities and Member States."

Commentary:
If there is an international standard for data sets, agreed on in collaboration with those who administer these health assets, then all future collections of data can be submitted to WHO and other organizations for possible inclusion on the health maps which are used by donors and Member States. This activity will also ensure useful comparison of data sets, more effectively described, and stimulate inclusion of this "hidden" health system.

Sound information on the supply and quality of health services is essential for health systems planning, supply chain and system management, along with more useful monitoring and evaluation activities. Efforts to scale up responses against major diseases and achieve the MDGs through global health partnerships have drawn attention to the need for strong country-level monitoring of health systems and services, covering the public, private-for profit as well as the private and not-for-profit sectors. Among the latter, religious health assets, described as faith- based or faith-inspired organizations, are often the leading providers of health care services.

WHO and its many international partners have been working with countries to develop tools and methods to collect data on health infrastructure through services availability mapping and readiness. A country monitoring system should comprise four components: data collection strategies to meet critical data needs; interoperable databases covering key aspects of health service functioning; data synthesis and analysis; and dissemination, communication and use of the results. Today marks a new beginning as WHO is soliciting input from those representing these religious health assets to ensure a clear and more precise disclosure and analysis of these health systems.

II. More effective and compelling mapping, including data on value-added by religious health assets, are needed to substantiate basic health services and demonstrate advantages and quality of care among all providers.

Rationale:
International health systems leaders need data to evidence value-added and evidence of quality of care. Why? How can we expect donors and governments to invest in "unknown" or spurious services based on anecdotal evidence alone?

Commentary:
Even though there has been progress in several countries, much more needs to be done to help countries develop systems to monitor service delivery, one of the core building blocks of health systems and a key area for health systems strengthening. Information on key health services is still incomplete or lacking. Information about these religious health assets in the health services sector is especially incomplete. Mapping of services availability is a key mechanism for filling these critical data gaps. Mobilization of international partners such as governments, NGOs/FBOs and academic institutions and WHO Centres of Excellence will be necessary to rapidly move this agenda forward, especially in the context of the International Health Partnerships at country level. The result is much more honest and effective national and local health planning for all.

III. Transparency of data and sound financial accounting systems are crucial to demonstrate accountability and clear lines of ownership.

Rationale:
Government and donors will not invest with what cannot be seen and understood. For too long, some religious health assets have shielded their financial accounting systems and sources of funding, as well as the amounts from public and governmental scrutiny, fearing reprisal and reduced funding. This has led to a perception that there is something to hide and has cost fundamental trust or confidence in the very structure to be supported. On the other hand, strengthening management systems can ensure continued funding flows from governments and donors in an era of government contracting out and donor systems (e.g., just look at PEPFAR and the GFATM CCMs).

IV. Better documentation of health data and alignment with national health plans is crucial for future programming and stability over the long haul.

Rationale*:*
Governments need to see how what is being done is reported, and how programmes and services align and even harmonize with national plans and aspirations.

Why? Because it is easier and more efficient to support programmes and services that are aligned with national health policies. Religious health assets must begin to see themselves as part of the national health plan and participate in its creation, execution, and monitoring.

Conclusion

So I invite you on behalf of the international community to lend an ear, make choices and join international efforts to bring focus and credibility and evidence to those at the health table.

About this consultation

Finally, the overall objective of this event is to initiate an open consultation between WHO and international partners including governments, NGOs/FBOs, academic partners and international organizations, towards agreeing on a standard protocol for assessing, monitoring and mapping religious health assets often seen as faith-based or faith-inspired services in the health sector.

1.1. Stakeholder perspectives

1.1.1. Perspective of WHO: Monitoring and evaluation of health systems strengthening: Global and country context

Ms. Kathy O'Neill, Coordinator, Public Health Information and GIS, World Health Organization

Service delivery is one of the core building blocks of health systems and a key area for health systems strengthening. Despite its importance however, information on key health services is still incomplete or lacking. Information about these religious health assets in the health services sector is especially incomplete. Mapping of services availability is a key mechanism for filling these critical data gaps. Mobilization of international partners such as governments, NGOs/FBOs and other partners will be necessary to rapidly move this agenda forward.

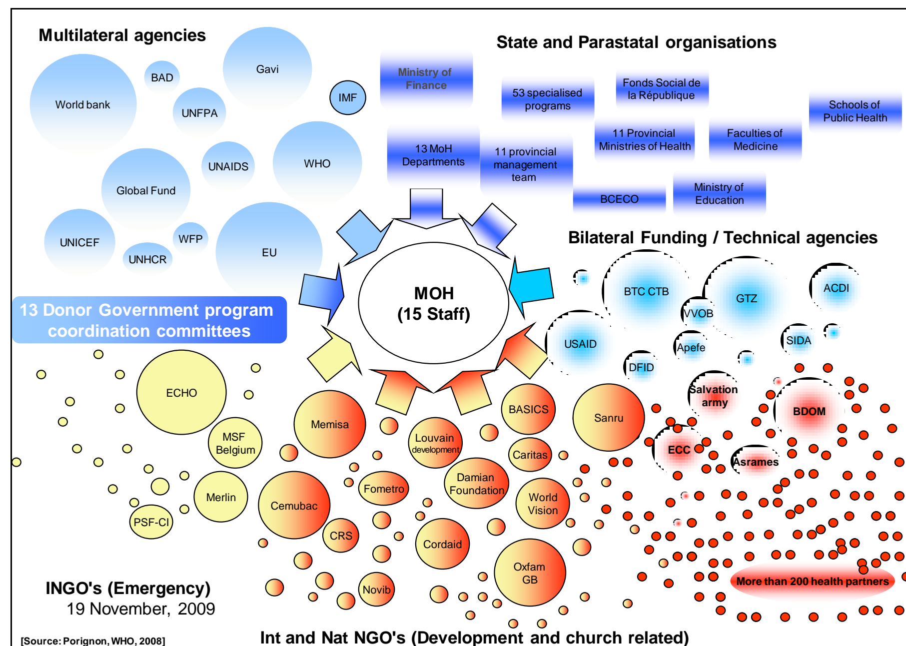
In order to frame the discussions of the Consultation on assessing, mapping and monitoring services delivery, it is important to consider the global and country contexts in terms of monitoring and evaluation of health systems strengthening efforts.

Recent increases in international funding for health have been accompanied by increased demand for data at country and global levels for better management of services, tracking progress and performance of health systems. The use of results-based financing mechanisms by major global donors has created further demand for timely and reliable data for decision-making. Such demands have often led to a fragmentation and lack of coordination of donor-driven monitoring and evaluation activities.

At country level, data generation, data analysis and synthesis, and data use can all be improved. There are usually limited data for sub-national concerns, and existing data tend to be program-specific (e.g., for TB or HIV/AIDS programs) or focusing on one particular element of the health system. Data gaps span the range of input, process, output, outcome and impact indicators. Data quality assessments and transparency are often weak. Analytical capacity of country institutions are limited and it is often

difficult to have access to those data and information that do exist. Figure 1.1 shows a schematic of the complexities that exist at the country level in integrating data and the needs of stakeholders during crisis.

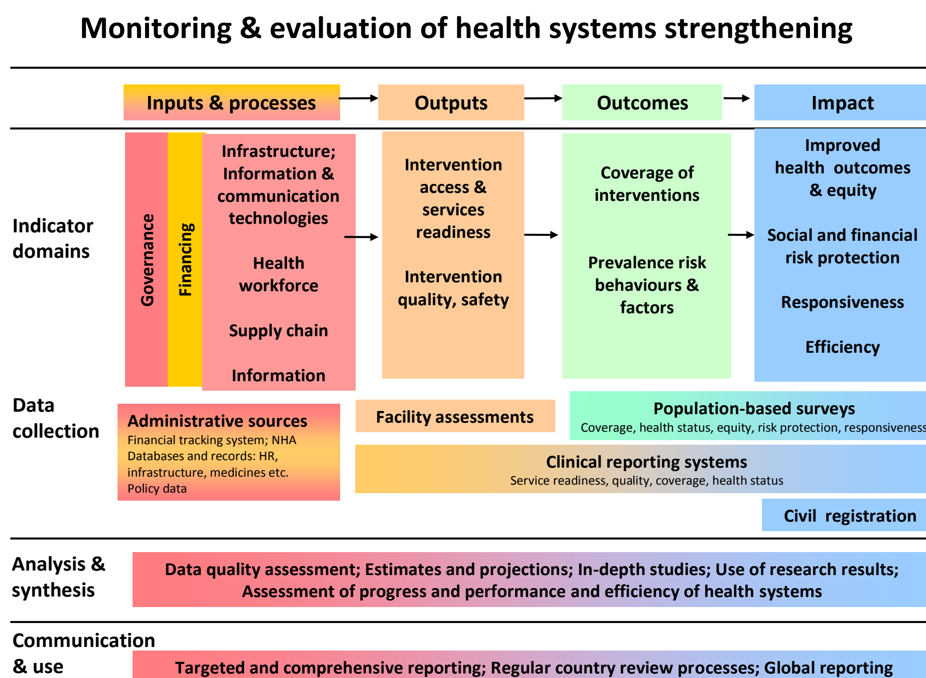
Figure 1.1. Schematic of multiplicity of players at the national level during crisis. (Source, Porignon WHO 2008)



Better harmonization of processes among partners and countries is necessary to improve decision making processes. International Health Partnership (IHP+) is a collaboration among donor agencies, sovereign states, and UN agencies that aims to harmonize donor funding to support one national health plan. A key component of IHP+ is one results framework for monitoring and evaluation of health systems strengthening. The framework is intended to be relevant for countries and for global health partnerships, donors, and agencies. It will result in better alignment of country and global monitoring systems and can be used both for monitoring HSS joint programming as well as for tracking specific programmes.

The framework (Figure 1.2) shows how health inputs are reflected in outputs, outcomes and impact. The framework addresses indicator selection, related data sources, analysis and synthesis practices (including quality assessment), and communication and use.

Figure 1.2.Framework for monitoring and evaluating health systems strengthening (IHP+)



Operationalizing this framework will be done through a global community of practice working to support "countries health systems surveillance" (CHeSS). In doing so, the availability, quality and use of the data needed to inform country planning processes.

In terms of standards for assessing and mapping services availability and readiness, it is important to consider the different elements of the M&E framework as they relate to data collected, the data sources, data synthesis and analysis and communication of use of data.

1.1.2. Perspective of UN Agencies and the World Bank: Towards a consistent approach

Ms. Sally Smith, Partnership Adviser, Civil Society Partnerships Team (CSP), United Nations Joint Programme on AIDS (UNAIDS)

UNAIDS's response to the HIV epidemic was shared with Consultation members. It was noted that data are often political, and that maps may display uncomfortable facts that governments may consequently be reluctant to publish. Various publications produced by UNAIDS have been important tools, yet have not been taken seriously by some due to these political issues. UNAIDS is interested in putting together a framework with other large organizations that includes not only a focus on health delivery systems but also a roadmap to better communicate with groups that have religious health assets. Three levels of work by FBOs were described:

1. Religious leaders (who are often gatekeepers to a community)
2. Health care delivery by FBOs

3. Grass roots community work

The first and third levels are sometimes overlooked by outsiders but they play important roles and can be crucial in reaching out to faith-based communities. The language used by FBOs also plays an important role and has sometimes generated misunderstandings in the past, for example, related to beliefs about HIV/AIDS and human sexuality. Therefore UNAIDS has been working with FBOs to enhance communication skills to be able to bridge gaps created when agencies and FBOs speak "two different languages".

Dr. Quentin T. Wodon
Adviser & Program Manager, Development Dialogue on Values and Ethics, World Bank

The World Bank's relationship with FBOs has transitioned from a specific focus on dialogue with faith leaders to more policy-relevant empirical work with FBOs and country teams. This work includes examining the role of FBOs in service delivery, the impact of faith and behavior, and ethics of development policy. To achieve the full value added by FBOs, steps are needed to (1) document the role of FBOs in health, (2) evaluate its performance, (3) help improve programs through capacity building, and (4) elevate voices of FBOs in national discussions with governments and in international forums.

Not only is collecting relevant data difficult, but analysis is also; improper data analysis can give the wrong results. Three common assumptions are prevalent with respect to faith-inspired service delivery but have not been proven:

1. FBOs address the needs of the poor more than the public sector
2. FBOs better target the poor than other providers
3. FBOs provide better services than public providers.

Documenting and evaluating the roles of FBOs is essential to assess performance. Examples from education and health in countries like Bangladesh, Venezuela, Colombia, Sierra Leone, Demographic Republic of Congo, and Cameroon were shared to demonstrate that this can be done. Proper analysis techniques were emphasized (e.g., econometric control of other characteristics likely to be associated with income) to show the true effect of FBO services on health. Also, assessing the market share of religious health assets is important for geographic targeting of services, as is the quality of the actual services being provided, though this is more difficult to measure.

The World Bank also shared additional ideas on actual outputs that may be useful for outcomes assessments, including cost-effectiveness analyses. Quality of services could be measured through report cards from service beneficiaries themselves if this data can be collected. Sampling might be a more feasible approach to collect such quality indicators than a census, due to the economies of scale saved. Consequently,

mapping could not only be used for geographic targeting of service provision, but also for the identification of higher (and lower) quality services. The World Bank is willing to collaborate with FBOs to facilitate these sorts of analyses.

Dr. Azza Karam, Senior Culture Advisor, United Nations Population Fund (UNFPA)

The new mandate of UNFPA to integrate culture (faith and religion) into the organization at the behest of the new Secretary General was described. Three areas regarding UNFPA's new direction were reviewed: why they are doing this, how they are doing this, and what are the lessons they are learned so far.

One reason why UNFPA is integrating faith and religion into the organization is the sheer reach of FBOs. UNFPA has recorded at least 75 country offices that have a partnership with at least one FBO, and this number may be an undercount because some country offices have deliberately chosen not to publicize partnerships with FBOs in the past. This may be because UNFPA has been criticized for its sexual and productive health mandate, and it also deals with other sensitive issues like migration, youth, and urbanization. Nonetheless, UNFPA plans to engage with cultural and religious communities as a component of its family and reproductive health work.

UNFPA is integrating culture into its programs through partnerships with established interfaith networks that are regionally based. It also launched a global effort in Istanbul involving 450 organizations last year. For its own colleagues, it has established guidelines for engaging with FBOs, addressing key mechanisms and modalities. Capacity building has been a key focus, to develop further knowledge and advocacy skills. UNFPA has also tried to bring together various UN colleagues so that its work is informed by their experiences as well.

Some issues moving forward include how it can partner better with FBOs to make sure that its partnerships deliver. Some challenges exist from within the UN system, such as the difficulty among some employees to adjust to the idea of working with religious entities. Furthermore, some FBOs are also political actors, which can impede progress, especially when tensions escalate to the point of violence, as has occurred in some UNFPA offices.

In the end, UNFPA's mandate is the UN Declaration of Human Rights. UNFPA hopes to achieve its goals by partnering with both FBOs and other UN agencies, and expanding its empirical, technical, and theoretical knowledge bases.

1.1.3. Perspective of Faith-Based Organizations

Religious health assets: Faith-based/faith-inspired organizations in health service delivery

Ms. Jean Duff, Executive Director, Center for Interfaith Action on Global Poverty (CIFA)

FBOs combined with congregational community services reach hundreds of millions of people in the delivery of health care. Faith-based values shape service delivery, as they put people first and provide “end of the road” care Furthermore, care is provided for the “whole person”. Much of the services provided are community-based by trusted providers.

The faith sector faces many challenges including lack of data, fragmentation and under-utilization. It also has inadequate funding and a lack of representation at decision-making and funding tables. To address these challenges, CIFA works to improve the capacity and effectiveness of the faith sector in its collective effort to reduce global poverty and disease. CIFA provides a neutral (all-faith) convening platform for use by FBOs for sectoral purposes. Four strategies are used to strengthen the faith sector:

1. Strengthening and scale-up of development effectiveness of the faith sector through the formation of large scale multi-faith coordinating mechanisms.
2. Mobilizing public and private financial resources to support an expanded development role of the religious sector
3. Building the evidence base for the faith sector as effective development partners.
4. Making the case for investment in the faith sector as partners with governments against poverty and disease.

CIFA defines an FBO as any organization from any faith tradition that self-identifies as “faith-based” or faith-inspired, among them faith-based development organizations (e.g., national and international NGOs), faith-based health facilities (e.g., hospitals, clinics), and congregational infrastructure (e.g., faith leaders, faith-based community case, faith-based home outreach). CIFA defines religious health assets (RHAs) as private, non-governmental, civil society FBOs delivering (at least) primary health care, including FBO facilities-based health services (e.g., hospitals, clinics) and FBO community-based health services (e.g., mobile health care, home health care, care delivered at house of worship and in other community settings).

The presence of and magnitude of gaps in RHA data were noted, including issues such as the proportion of health assets (and specifically of RHAs) not counted in national facilities censuses, and the proportion of all health assets that are not RHAs. Closing these gaps will strengthen FBOs’ ability to:

- Integrate into public sector national facilities census
- Study fit between actual health needs and available health services
- Scale up collaboration among FBOs and other private and public partners
- Participate in public funded community health strategies and vertical health programs
- Have a baseline database for FBO community health assets
- Have a “seat at the table” and participate in national, regional, local government agency planning and funding negotiations
- Better function as a religious sector, if desired.

Ms. Jill Olivier, Researcher, African Religious Health Assets Programme, University of Cape Town, South Africa

Issues related to terminology and translation when discussing religious entities were discussed. Scores of terms are used to describe religious entities. There is a clear need to be able to group all “religious entities” with a faith factor with some sort of generic term like “faith-based organization”. Furthermore, typologies of FBOs are also needed to capture the variation in different groups.

Certain groupings already exist in the literature but each has its own limitations. Who or what is being named, and who or what is the “faith community”, are complex and often controversial questions. FBOs are diverse – they are fluid in nature and differ in many ways including regionally and denominationally. Religious entities are not always “organizations”, and some organizations may not self-identify as “faith-based” despite having a faith component. Ultimately, collective statements attributing services to “FBOs” may only describe a subset of religious entities.

Three “cautious” questions regarding the current terminology used were posed:

1. Has the time of the term “FBO” passed?
2. Can we still make general statements about the nature of so-called FBOs?
3. Are we doing the right thing by generalizing the “faith community” in this context?

It is clear that for policy and for advocacy, some sort of generic term is still needed, along with more complex precision to capture sub-classifications of the faith community. Battling over terminology is unproductive and only perpetuates the lack of solid evidence for the contribution of FBOs to the health marketplace. Agreeing on terminology and typologies will allow for better comparative research and improve the ability to assess the actual “value-added” by such organization. Further research is urgently needed to better understand religious entities and conduct more meaningful engagement and collaboration among groups.

Mr. Frank Dimmock, Health Adviser, Christian Health Association of Lesotho (CHAL), Lesotho Consultant, African Christian Health Associations (ACHA) Platform

Religious health assets (RHA) in sub-Saharan Africa associated with Christian Health Associations (CHAs), which comprise both Protestant and Catholic churches, were described. Almost half of the 46 countries in sub-Saharan Africa have some association with ACHA. Historically involved in rural areas, they conduct a variety of health activities including facility-based, community-based, and home-based care. Some supply pharmaceuticals as well. The African continent varies with respect to the percent of health services provided by CHAs, with consistently higher percentages observed in East and southern Africa.

The breadth of health services provided by these networks necessitates their synchronization with national health systems in terms of mapping. Most have developed provider directories, and some have recorded GPS coordinates on these providers, including those in Kenya, United Republic of Tanzania, Malawi, Zambia, and Lesotho. Adapting existing data and collecting additional data on service availability are priorities so that service maps at the national level are comprehensive. Some CHAs have had success in collaborating with their Ministries of Health, such as in Kenya, but most have systems that are less mature and that will require additional capacity to get to the same level.

1.1.4 Summary of the opening presentations

Rapporteurs: Dr. Sarla Chand, Vice President, International Programs, IMA World Health & Mr. James Lattimer, Management Officer, Office of the Director-General's Representative for Partnerships and UN Reform, World Health Organization

Dr. Chand noted that the purpose of the Consultation is to make decisions on what global health standards are for mapping information on health care services. These standards will be crucial to further develop the infrastructure needed to improve the health status of those served by FBOs. Improved reporting, transparency, data sharing, and building of trust are all necessary. While national data gathering is the focus, the “action” really occurs at the district level. The challenge is how to involve and enable district teams to look at all health assets, whether public, private, or faith-based, in order to improve the health of everyone in that district.

Mr. Lattimer noticed the commonality of messages being transmitted, both by UN agencies and by individual organizations. FBOs clearly have a broad reach even though not all of the data may have been collected yet. He noted the uniqueness of the meeting’s themes and expressed hope that it will result in a willingness of FBOs to reach out and work together. More specifically, some of the same challenges in mapping also came up repeatedly, such as reliance on anecdotal evidence, fragmentation and incompleteness of data, differences in language or vernacular, overlaps of data, and difficulties in accessing data that already exist.

Consequently, the work of FBOs is not fully recognized, there is a lack of representation, and funding opportunities may be lost due to missing data. The results of this Consultation should help to move forward in addressing these problems.

Chapter 2: Gathering data on religious health assets: current experiences and practice

Six presentations offered a variety of perspectives on the challenges of FBO health services data collection, and on the application of mapping tools.

2.1. "Health facilities and human resources geographic information system for the Christian Social Services Commission of Tanzania"

Scott Todd, Senior Program Officer, HMIS/GIS, IMA World Health

A case study of a GIS for health facilities and human resources in the United Republic of Tanzania that IMA World Health developed for the Christian Social Services Commission of Tanzania (CSSC) in collaboration with five other global partners was reviewed. The project began in 2006, and by 2009 it had mapped all 932 CSSC member health facilities in the United Republic of Tanzania and collected data on approximately 85% of human resources. The database includes basic identification for health facilities and GPS coordinates and can generate maps showing human resource capacity and service availability at site locations, as well as linkages to population-based data (e.g., population density and transportation infrastructure). The GIS is currently being used by CSSC and is maintained at its headquarters in Dar es Salaam and in five zonal offices in the United Republic of Tanzania.

During the development process, various information needs had to be addressed, such as data collection, program needs, Ministries of Health (MoHs) and donor requirements, infrastructure issues (e.g., power, phone, Internet), and systems needs. A Memorandum of Understanding (MOU) was signed in 2008 between CSSC and the United Republic of Tanzania Ministry of Health and Social Welfare (MoHSW) for data sharing and development. For example, the MOU defined ownership by MoHSW and data utilization by CSSC. A further MOU is planned to document development and sharing of data collaboratively with other supporting partners. There was collaborative review of data collection tools, and a Mapping Task Team was created to coordinate, define policy and designate responsibilities. The MoHSW is currently considering ways to integrate the database information into national processes.

2.2. "Medical Assistance Programmes (MAP) International"

Ms. Luz Stella Losada, Community Health Specialist, Map International

The mission of Medical Assistance Programs International (MAP International) was described: to promote the "Total Health" of people living in the world's poorest communities by partnering to: (1) provide essential medicine, (2) promote community health development, and (3) prevent and mitigate disease, disaster, and other health threats. Total Health was defined as "the capacity of individuals, families and communities to work together to transform the conditions that

promote, in a sustainable way, their physical, emotional, economic, social, environmental and spiritual well being."

This particular MAP program is based on Bolivia but also does work in Ecuador, Honduras, Kenya, and Côte d'Ivoire. A description of the state of health in Bolivia was given, including data on child mortality and infectious disease incidence and prevalence. MAP International trains Health Promoters to increase knowledge and skills in areas such as diarrhea diagnosis, prevention, and management. By allowing clients to gain control over health determinants, they can construct healthy environments and lifestyles.

2.3. "Christian Health Association of Kenya (CHAK)"

Dr. Stanley Kiplangat, Health Services Manager, CHAK

The work of CHAK, an association of Protestant Churches' health facilities and programs in Kenya, was reviewed. It has 431 members, including 23 hospitals, 45 health centers, 310 dispensaries, and 55 churches//church health programs. It is the only FBO that has been successful in becoming fully integrated in a national health plan. This was accomplished through its Mission for Essential Drugs and Supplies (MEDS) program, which promotes access to essential drugs in Kenya.

Some issues that arose during the implementation of this program included a lack of necessary skills in-house for data collection and analysis, lack of hardware and software infrastructure (which limited access to GIS technology), data accessibility issues since there was no central repository, a lack of clarity in the beginning of what data to collect, incompleteness of data, and parallel donor systems. Ways that these issues have been addressed since then include partnering with the MoH (which has trained staff and has access to a master facility list), further capacity building for staff, investment in hardware and software for ongoing GIS technology, and solicitations for support from development partners.

Data collected by CHAK include information on outpatient and inpatient services, health outcomes, physical infrastructure and equipment, human resources, and the commodity supply chain (e.g., through the government, through MEDS). Data collection tools include MoH data registers, CHAK data registers, questionnaires, databases, and GPS data. Data are disseminated through quarterly and monthly reports, at an annual health conference, through presentations at stakeholder forums, through collaborations with other working groups, and on CHAK's web site: http://www.chak.or.ke.

To date, results have been used to plan resource allocation, advocate for governmental resource support, account for donor funds, identify training and resource gaps, and monitor trends in indicators and programs.

2.4. "Example from field: Kenya and the United Republic of Tanzania"

Mr. Andrew Inglis, GIS Specialist, MEASURE DHS, North Carolina, USA

Experiences from the work of MEASURE DHS in two countries, Kenya and the United Republic of Tanzania, were shared. For example, initiatives to map both facility-based and community-based (i.e., non-facility-based) activities by FBOs have been undertaken in Kenya. FBO mapping can be challenging because many participate in both types of activities, and different mapping techniques are appropriate for each.

One project, called the "Master Facility List Initiative", was a government-led data management activity aiming to assign a unique identifier to all government and private facilities for use in multiple databases (http://www.kenyahealthfacilities.net). Such work is important to minimize redundancy of facility data. The list is managed at the district and central office levels and updated quarterly, although there is an aim to institute real-time updating. Currently, 51% of facilities are geo-coded, with a goal of 75-80%. Standards and definitions have been developed from this project. Key activities moving forward are continued capacity building and ongoing geo-coding and other GIS-related training, including using open source GIS software at all levels. Maintaining facility lists requires strong leadership that can support coordination at different levels, create feedback loops, and encourage data sharing and exchange.

A project undertaking mapping of community-based HIV/AIDS and TB service organizations is being done by the Kenya AIDS NGOs Consortium (KANCO), in order to answer the questions, "who is doing what, where, and how?": http://www.kanco.ushahidi.com.

A project mapping community-based activities related to orphans and vulnerable children in the United Republic of Tanzania was also described. It involved building capacity within community programs to encourage them to map their own data, based on a one-day intensive GIS training (based on open source GIS software) and on-site follow-up. Training personnel in open source GIS software can allow them to become comfortable in mapping their own data.

2.5. "Ramakrishna Mission"

Dr. Sujata Mazumdar, Resident Physician, Ramakrishna Mission, Seva Pratishthan Vivekananda Institute of Medical Science, India

The Ramakrishna Mission, headquartered in Kolkata, India, aims for "harmony of the ancient and modern, spiritual fulfillment, all-around development of human faculties, social equality, and peace for all humanity, without distinction of caste, creed, race, or nationality." It is part of the core of a spiritual movement called the Ramakrishna Movement. The Mission provides medical services in its 15 hospitals, 124 dispensaries, 53 mobile medical units, and 7 nurses' training institutes. Among

the kinds of specialized services it provides are programs in TB control, leprosy eradication, blindness control, HIV/AIDS control, child nutrition, maternity and child welfare services. Other services include medical camps, educational work, work in rural and tribal areas, and disaster relief and rehabilitation.

Geographically, the Ramakrishna Mission works in 164 branches throughout India and in 42 centers outside of India, with a focus on the economically poor. While the Mission is 100 years old, it has yet to incorporate mapping into its programs.

2.6. "Health facility assessment and routine data systems: Case study of Zambia"

Dr. Jason Pickering, Consultant, World Health Organization

A case study of the implementation of WHO's Services Availability Assessment tool in Zambia, aiming to fill critical data gaps required for monitoring health systems strengthening, was provided. Steps involved in planning and conducting this assessment included convening a coordinating group at the country level, constructing a list of all public and private health facility sites to be visited, arranging site visits, reviewing and adapting the core health facility questionnaire, identifying teams and equipment (e.g., PDAs, GPS, laptops), training data collection teams, and discussing analysis and dissemination.

Data were collected using questionnaires on PDAs by district health teams, and GPS units were used to record geographic locations. The PDAs were synchronized with computers for data transfer. Finally, data were analyzed and maps and charts were produced. A variety of maps could be generated, showing diverse metrics such as locations of HIV counseling and testing sites compared with population density, and the percent of facilities in districts with electricity.

In Zambia, the routine facility reporting system has undergone major revisions in the past two years and has evolved into a comprehensive monthly reporting system in all 72 districts, which contain 1,700 primary health care facilities. However, it currently excludes many private facilities and 1st and 2nd level hospitals.

Facility surveys are a valuable part of a country's semi-permanent dataset but require significant resources to conduct. Data obtained from surveys can be "re-cut" for other purposes, such as routine data collection, and such surveys should be conducted with integration, reuse, and dissemination in mind.

2.7. Plenary session and concluding remarks

Below are comments given by Consultation attendees during the plenary session:

- Poor data quality and completeness may be related to breaks in feedback loops – therefore there may be disincentives to share data currently.
- Maybe "being on the map" is not enough of an incentive for some organizations – something more needs to be provided.

- Some organizations may not want to share their data with the government – it may be a matter of trust.
- If the benefits of data sharing can be explained to organizations (and resources are provided), then more groups may be more receptive to data sharing (unless there are political reasons not to share data).
- Donors are demanding greater accountability but without the resources needed to support this. If we are going to ask for common standards of measurement, then we will have to offer common support to those whom we are requesting the data from.
- Accreditation may or may not be an incentive to organizations for data sharing
- Local-level mapping can give people what they need or what they want, based on experiences with participatory mapping and integration. This process is very instrumental in creating feedback loops – so that the facility/organization and the community both benefit.
- Community-based services require a different sort of mapping, but because the basic information is not yet known, it is important to start with facility-based mapping.
- Duplication of efforts should be avoided when possible. This may mean making a choice as to who does the technical mapping and how. Having a central repository that contains comprehensive mapping could facilitate this.
- Once people "on the ground" are involved, they will want to be part of the data collection – this sort of work is very exciting to people at the facility level.
- Assisting organizations with their own data gets them excited about the possibilities – they get energized. It is a matter of feeling part of the system as opposed to having something extracted from you.
- Politics may play a role in how FBOs work with mapping
- It is important for all stakeholders to be at the initial planning meeting with MoHs in the process, including FBOs.
- In some countries, there needs to be authority that mapping is important – either from the Ministry of Health or directly from WHO – otherwise data collection will be a struggle.

Summary from Rapporteurs

Dr Sarla Chand and Mr James Lattimer

Dr. Chand noted that many “high-tech” tools were presented. She emphasized the need in facility assessment to include not only religious health assets but also non-religious health assets in order to provide a comprehensive picture of service availability. The importance of unique identifiers (currently missing in many programs) was also noted, as was the need for governments to work with FBOs to define them. While Christian Health Associations are the largest FBO networks in Africa, such groups also exist in Asia, but Asia is often not a focus of this work because it is often viewed as “too complex”. More work should be done to identify groups in other areas like Asia and do interfaith assessment. Finally, there will be faith-based or faith-inspired individuals or groups that will not want to share information. This will always be the case but if a goal of perhaps 80% participation is reached, this might be considered a success.

Mr. Lattimer noted the examples of real work being done using various GIS tools. These presentations were helpful to set the stage for more concrete discussions on data collection and analysis occurring later in the Consultation. Real barriers have been raised by several individuals including lack of staff, lack of trust, and lack of motivation. Creating the demand for mapping work is essential, through motivation and incentivizing, and might be facilitated through public/private partnerships. Motivational incentives can be self-generating; improved quality of care is an obvious benefit of this work. Also, seeing this as a part of broader goal of the “project management cycle management” may be useful. This type of information can feed directly into project design and generate new outputs and new activities and lead to real project delivery. Finally, there is recognition that the discussions at this Consultation are not all-encompassing but only a first step dealing with facility-based services. Challenges in defining catchment areas and mapping the inter-delivery of community services remain.

Chapter 3: Summary of Working Group Process and Recommendations

Working Group Process

During the Consultation, five Working Groups were formed to devise standard approaches to data collection, management, use, and dissemination for mapping data that represent the value added by FBOs in health services delivery. Specifically, the groups addressed the following questions:

1. What is the minimum core data set for health services?
2. What are the main technical considerations for data collection and management?
3. What are the standard approaches for data analysis and use?
4. What are the standard approaches for data sharing and dissemination?
5. How can community-based participation be incorporated?

The first two groups met concurrently on Wednesday, with the remaining three convening on Thursday. Members discussed the main questions and concerns from the perspectives of their individual organizations. Groups were given the option to subdivide into smaller groups to facilitate discussion. After a final synthesis, facilitators reported back to the plenary on key issues and recommendations made during each Working Group session as presented below:

3.1 Working Group 1: What is the minimum core data set for health services?

Working Group 1 was given the task of deciding on a minimum core dataset for assessing health services availability that meets FBO needs. The group discussed how to represent the value added by FBOs in health services delivery, especially those religious health assets deemed to be intangible or difficult to quantify. After reviewing the WHO's Core Questionnaire of its Services Availability and Readiness Assessment Tool, the group recommended that questions relating to the following areas be added to better represent FBO interests:

- self-identification of facilities as "faith-based"
- existence of places of worship at facilities
- provision of free or concessional care
- capacity for spiritual care providers and volunteer staff
- provision of psychosocial services, including bereavement services.

Other specific changes to the Questionnaire were recommended to help improve its capture of health service delivery.

3.2 Working Group 2: What are the main technical considerations for data collection and management?

Working Group 2 developed ideas on the technical considerations of data collection and management of this minimum core dataset and made the following recommendations:

Data collection strategies

- Encourage and support mapping through FBOs
  - Consider existing strategies as good entry point for some FBOs
  - Use external technical assistance for data collection to enhance neutrality
- Enhance participation of FBO network members to establish buy-in
- Recognize that donor cycles can influence data collection
- Add survey questions related to the definition of catchment areas

Improving coordination of data collection efforts

- Explain and emphasize the policy importance and implications of joint mapping to encourage Ministries of Health, FBOs, and donors to be more inclusive in mapping
- Promote a “public domain” partner-based “wiki” style repository or facility list including the basic health facility information sufficient for mapping
- Emphasize importance of a coordinating committee at the district level to use the mapping data for improved planning

Systematic processes

- Organize data collection within countries, with option to combine data or conduct searches across country databases made possible by data field standardization
- Encourage development of Memoranda of Understanding between FBO networks and Ministries of Health to initiate joint mapping and planning processes
- Encourage creation of national Mapping Task Forces with Ministries of Health and FBO joint leadership, but also including all partners doing mapping work

3.3 Working Group 3: What are the standard approaches for data analysis and use?

Working Group 3 was given the task of agreeing on standard approaches for data analysis and use with respect to mapping by FBOs. The group focused on four main issues: information needs, uses of data, tools and approaches for accurately interpreting data, and integration of data into decision-making processes. Recommendations are as follows:

Information needs

- Prioritize assessment of consumers or users of health services
- Identify gaps in services through comprehensive mapping
- Link service availability mapping with disease mapping

- Develop frameworks to better understand existing data and increase data and map availability, such as through clearinghouses created by National Mapping Task Forces

Uses of data

- Improve assessment of catchment areas
- Prioritize data consolidation at the national level as preparation for crisis readiness
- Encourage joint assessments of performance at the facility level to improve quality of services and of data collection

Tools and approaches for accurately interpreting data

- Develop frameworks through National Mapping Task Forces for data procurement to support decision making
- Develop interdisciplinary and inter-sector maps for more comprehensive information useful for decision making

Integration of data into decision-making processes

- Improve delays in the feedback process by identifying bottlenecks and improving analysis capacity at all levels
- Encourage alignment between FBOs and Ministries of Health on national health plans
- Balance political issues with data sharing needs

3.4 Working Group 4: What are the standard approaches for data analysis and use?

Working Group 4 focused on developing standard approaches for data sharing and dissemination. Group members discussed ways in which data are currently shared and used by entities outside their own organizations. Recommendations included the following:

Data sharing

- Continue to encourage data sharing between Ministries of Health and FBOs
- Use data collection (e.g., use of WHO tool) as opportunity to convey reciprocity of relationship with respect to data dissemination
- Develop standards for MOUs between Ministries of Health and FBOs
- Evaluate ways to simplify the MOU process
- Encourage provision of metadata during data dissemination

Integration into country health planning processes

- Prioritize inclusion of FBO data, including educating FBOs that on its importance
- Establish better communication between key Ministry of Health staff and FBOs to promote data sharing and ensure data are adequately fed into the national health plan

Data sharing challenges

- Prioritize data standardization early to minimize later questions about data validity
- Address data sharing concerns when developing MOU
- Encourage specificity of data requests
- Consider development of web-based data repository to establish transparency

3.5. Working Group 5: How can community-based participation be incorporated?

Working Group 5 was formed to initiate discussions on how community-based services of FBOs could be mapped to complement mapping of facility-based services. The group identified services that FBOs provide to the community, linked them with facility-based services, and began the process of categorizing them. They also proposed a module assessing community-based services that could be developed as part of the WHO’s service availability mapping tool. Two main recommendations in moving forward were made:

- Establish a technical working group to develop module on community-based services that is open to the broad community
- Develop a strategy in collaboration with the WHO

Chapter 4: Implications for the Future and Next Steps

4.1. Mapping religious health assets: Implications for the future
Dr. Phyllida Travis, International Health Partnership + Core Team, Health Systems and Services, World Health Organization

Many countries grapple with problems when trying to improve health and health services. For example, progress toward the health MDGs remains inadequate. Many health system constraints are unaddressed. Global and domestic investment in health is insufficient, while international funding is unpredictable and support to countries is inefficient. At the same time, there is a rising number of development partners at the country level, who support different providers.

To address these issues, IHP+ was created in 2007 by a group of partners, including developing countries, bilateral donors, international agencies and foundations, and civil society, who share a common interest in improving health services and health outcomes by putting Paris Principles on Aid Effectiveness into practice. Commitment is signaled by signing the "global compact."

IHP+ aims to increase support for one national health plan. The assumed benefits include (1) reduced transaction costs and therefore more time for implementation, (2) better results through better use of existing funds (and therefore more money), and (3) stronger government leadership in sector coordination.

There are opportunities for greater engagement by civil society (including FBOs) in the form of commitments made in country MOUs and global compact, entry points for dialogue, and demonstrating value (through health sector monitoring processes and in greater mutual accountability). However, known obstacles on both sides include limited mutual trust and a current lack of organizational mechanisms.

The agenda for IHP+ is difficult but worth the effort. Progress will be messy and gradual, but participants must keep a focus on results. At the heart of IHP+ is mobilizing more stakeholders like FBOs to support national health strategies. Whether IHP+ “works” depends on active engagement and some risk taking by IHP+ partners.

4.2. Next steps for WHO

Ms. Kathy O’Neill

Based on input and feedback from the participants , WHO will work to finalize and publish a standard instrument for assessing Services Availability and Readiness. A new version is slated for publication in first half of 2010 and will comprise a core health facility module as well as a set of related specialized modules for laboratories, pharmacies etc.

- In addition to the health facility assessment instruments, WHO will work on the development of a standard protocol for mapping health services, including religious health assets . A draft will be circulated for review by the group by end of first quarter of 2010. The protocol will reflect the many excellent suggestions and recommendations made by the working groups during the consultation, relating to core datasets and best practices for data collection, analysis, dissemination and use of health services availability data.

- Work is ongoing within the context of the Country Health Systems Surveillance (CHeSS) to improve the availability, quality and use of data for monitoring and evaluation of health system strengthening. As part of this WHO will continue to promote the development of national databases of health facilities and services that include the FBO services and the development of country observatories to facilitate data sharing, analysis and reporting.

At global level, WHO will work towards the establishment of a global data repository to host health services availability data and reports and make that available also to the FBO community. In addition, WHO will continue to work with CIFA in the development of interoperable databases of health services and the creation of a global map of FBO networks.

4.3. Next steps for the faith-based community

Mr. Frank Dimmock

- FBOs need to strengthen partnerships, in order to build trust and ensure transparency:
    - within the faith community
    - with networks at the national level (including interfaith networks)
    - with Ministries of Health.

- FBOs should accept the responsibility for providing and sharing factual information.
    - There is recognition of numerous weaknesses and the need to improve these to be able to strengthen these partnerships and the value of data and mapping.

- CIFA will host a web clearinghouse of information that can be shared publicly with links to websites and other resources. This will reinforce the importance of communicating broadly.

- A working group will be convened to continue the discussion on formalizing the community health module of the data collection tool.

- FBOs will share what has been learned at the Consultation with colleagues at the national level.

4.4 Next Steps for CIFA

Ms. Jean Duff

CIFA is willing to provide continued support to the Faith based sector and to WHO to address some of the key recommendations stemming from this Consultation. CIFA will Working in close collaboration with faith-based partners, CIFA will provide technical and organizational support to make progress in the following areas:

- With regard to WHO's Services Availability Tool:
  - work with WHO and FBOs to resolve the terminology question for the drop down box after one checks off "Faith-based" – should specific religions and denominations be listed, and if so, which ones?
  - support a working group to continue the discussion on a module to measure community-based services (led by World Vision International).
- participation by FBOs with national coordinating mechanisms such as the Christian Health Associations so that they may have a 'seat at the table' in negotiations with MOHs.
- expansion of national faith based coordinating mechanisms, such as the Christian Health Associations and Interfaith Action Associations to include all faith based health care delivery systems as well as congregational systems where appropriate.
- work with WHO and faith based partners to encourage composite mapping, e.g., a faith-based map of the capacities of FBOs, both in Africa and outside of Africa.
- support an Internet-based clearinghouse with information on MOU development, survey advice, monitoring and evaluation partners, advocacy, tools, and other links.
- establish an electronic mailing list to facilitate continued communication among the various faith-based organizations and partners.
- continue to make a case for the faith-based community by compiling and producing a report that FBOs can use to demonstrate the unique attributes of the faith community and what it has to offer.
  - This will be useful when communicating with government partners and most importantly with donors.
- develop a platform to showcase the work done already so far by FBOs (e.g., Zambia, Kenya).

4.5. Concluding remarks from WHO

Mr. Alex Ross, WHO

- It is rare that he sees the sort of multi-disciplinary, multi-sector work in such a small group of people like those convened at this Consultation – WHO meetings are usually more uniform.
- WHO has a responsibility to move forward this agenda as a partnering issue.
    - Partnering takes a lot of time – particularly when everyone has a day job.
    - What is done with it takes major force.
    - WHO has a responsibility to cross-fertilize this information among its partners (e.g., UN agencies, other partners, countries, etc.).
- Donors want hard information, for accountability and management of information.
    - These data are a starting point. IHP+ is trying to demonstrate that this is possible.
    - The development world is much bigger than WHO.
- This meeting is really about diversity – but there is underrepresentation of FBOs.
    - Additional challenges of the faith community exist.
    - E.g., In Thailand, groups do not consider themselves as faith-based organizations, but in a way everyone is faith-based. How does one map that?
- Regarding the Commission on Social Determinants of Health – how can we make an impact on this?
- Evidence-based care is absolutely critical for accountability. But different conflicts will emerge along the way.
- Fundamentally, data are important in the climate for institutional survival and for global health aims as well.
- Regarding partnerships, a lot of work still needs to be done, and WHO has not lost sight of that. WHO awaits the report and will link it in with other UN family members and bilateral donors and revisit it in 6 months.

Mr. Ted Karpf, WHO

The vision of WHO is that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." Thus the objective of the World Health Organization shall be the "attainment by all peoples of the highest possible level of health."

- Implicit in this is that health is not just the absence of disease or infirmity, but rather the highest attainable level of physical, mental, and social well-being.
- This is a larger vision than public health usually offers – it moves to the language of the qualitative. It raises a fundamental question: How do you know when you arrive at well-being?
- It would appear that there may be something here for the religious/faith community to consider.
- There have been attempts to add the word “spiritual” to the definition of health, and it will probably come up again in the future.

- This Consultation is coming on a tide of goodwill between programmes at WHO and between the WHO and faith communities and perhaps marks a real hope.
  - There has been a lot of discussion of similarities and not differences at this meeting. This is promising.
  - The hope is that this vision does not go away after leaving this meeting.
  - Namely, the "attainment by all people of highest possible level of health." (from the WHO Constitution)

Annexes

1: Agenda
2: List of Participants
3. Photo of Participants
4. Bibliography

Annex I
Final Agenda

WHO - CIFA Consultation: NGO on Mapping Standards
Describing Religious Health Assets
10-12 November 2009 - Château de Bossey, Switzerland
Final Agenda

<u>Tuesday, 10th November</u>

12h45	**Lunch**
14h00-15h30	Registration & Sign up for small groups Pre-meeting with Moderators, Facilitators & Rapporteurs
15h30	**Break**
16h00-18h00	**Convening**
16h00-16h15	**Welcome** *- Ms Namita Pradhan, ADG, PUN, WHO*
16h15	**Keynote: "Religious Health Assets and the necessity of Health Partnerships"** *- Mr Ted Karpf, WHO*
16h35	**Session 1: Setting the scene** **- Monitoring and evaluation of health systems strengthening: global and country context** - Ms Kathy O'Neill, WHO
17h10	**UN considerations: towards a consistent approach** *- Ms Sally Smith, UNAIDS* *- Dr Quentin Wodon, World Bank* *- Dr Azza Karam, UNFPA*
17h45	**Panel: Religious Health Assets: Faith-based/faith inspired organizations in Health service delivery/mapping challenges** *- Ms Jean Duff, CIFA* *- Ms Jill Olivier, ARHAP* *- Dr. Nawa Mukumbuta, CHAZ*
18h30-21h00	**Welcome Reception and Dinner**

Wednesday, 11th November

9h00-10h45	**Report Back and Summary - Day 1** *Rapporteurs: Mr James Lattimer / Dr Sarla Chand*
9h15	**Session 2: Gathering data about religious health assets: current experience and practice** **Case study presentations:** *- Mr Scott Todd, IMA* - Luz Stella Losada, MAP international *- Dr Stanley Kiplangat, CHAK* *- Dr Sujata Mazumdar, Ramakrishna Mission Seva Pratishthan, Vivekananda Institute of Medical Sciences* *- Mr Andrew Inglis/ Mr John Spencer,* Measure /IHFAN *- Dr Jason Pickering, WHO Consultant, Zambia* *Moderators: Ms Jean Duff / Ms Kathy O'Neill / Mr Ted Karpf*
10h45	**Break**
11h15-12h15	[Session Cont'd] Plenary Discussion: Q&A /Feedback
12h15-12h45	Report Back on Session 2 *Rapporteurs: Dr Sarla Chand / Mr James Lattimer*
12h45	**Lunch** **- Special interest groups TBD**
14h00	**Plenary - Introduce working groups** **Session 3: A) Towards a standard protocol for mapping health services, including religious health assets.** *Moderator: Ms Jean Duff* *Overview: Nate Heard, Kathy O'Neill*
14h20-16h00	**Working group 1: What is the core data set?** *Introduction of discussion points - Ms Kathy O'Neill* *Facilitator: Mr Frank Dimmock* **Working group 2: What are the main technical considerations for data collection and Management** *Introduction of discussion points: John Spencer/ Kathy O'Neill* *Facilitator: Dr Franklin Baer*
16h00	**Break**
16h30-18H30	**Session 3 [cont'd]**
16h30-17h15	Synthesis meeting - small groups in Working Groups.

17h15-18h30	**Working Groups Report Back t**o plenary on key issues and recommendations
18h30-19h30	**Dinner**
19h45-21h45	**Faith based/faith inspired organizations caucus** *Facilitator: Frank Dimmock / Richard Omasete*

Thursday, 12 November

9h00-10h45	**Report back and Summary - Day II** *Rapporteurs: Dr Sarla Chand /Mr Alex Ross / Mr James Lattimer*
9h15	**Plenary** **Session 3: B) Towards a standard protocol for mapping health services, including religious health assets**. *Introduction: Ms Kathy O'Neill* **Working Groups** (Two small groups in each to ensure discussion) **Working group 1**: **What are the standard approaches for data analysis and use?** *Introduction of discussion points: John Spencer* *Facilitator: Lily-Rose Maida Awori* **Working group 2: What are the standard approaches to sharing disseminating data**? *Introduction of discussion points: Jason Pickering* *Facilitator: Ms Mary Hennigan*
10h15-10h45	Synthesis meeting - small groups in working Groups
10h45	**Break**
11h15-12h45	**Session [cont'd]** **Working Groups Report Back** to plenary on key issues and recommendations *Moderators: Ms Kathy O'Neill / Ms Jean Duff / Mr Ted Karpf* **Meeting Evaluation**
12h45	**Lunch** **Special Interest Groups TBD**
14h00-16h30	**Report Back and Summary of the Consultation** *Rapporteurs: Mr Alex Ross /Dr Sarla Chand* **Session 4: Implications for the Future - IHP+** *- Dr Phyllida Travis, WHO* **Summary and Next Steps** *- Ms Kathy O'Neill, WHO* *- Ms Jean Duff, CIFA* *- Mr Alex Ross, WHO*
16h30-16h45	**Departure for Airports**
18h00-19h30	*Dinner for those staying over*

Annex II
Final List of Participants

WHO - CIFA Consultation: NGO on Mapping Standards
Describing Religious Health Assets

10-12 November 2009 - Château de Bossey, Switzerland
Final List of Participants

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Annex III
Photo of Participants

Annex IV
Bibliography

Data collection tools

1. Health Facility and Services Availability and Readiness Assessment Tool: Questionnaire (WHO - draft, November 2009)
2. Health Facility Assessment and Services Availability and Readiness Assessment Tool: Planning Process for Countries (WHO - draft, September 2009)
3. Profiles of Health Facility Assessment Methods (International Health Facility Assessment Network, June 2008)
4. A Comparative Analysis of Select Health Facility Survey Methods Applied in Low and Middle Income Countries (MEASURE Evaluation, July 2009)
5. Flow Chart of Steps to Conduct a Health Facility Assessment (International Health Facility Assessment Network, June 2008)
6. Field Guide to GPS Data Collection (MEASURE, Macro International, 2005)
7. Signature Domain and Geographic Coordinates: A Standardized Approach for Uniquely Identifying a Health Facility (WHO, MEASURE Evaluation, January 2007)
8. Pillars of Health Facility Assessment: An Illustrative Capacity-Building Curriculum for Mid- and Senior-Level Managers, (MEASURE Evaluation, September 2009) http://www.cpc.unc.edu/measure/networks/ihfan/health-facility-data-collection-workshop-curriculum-developed-by-ihfan
9. International Health Facility Assessment Network - IHFAN http://www.ihfan.org/home/

Data dissemination, analyses and use

10. Country Reports Services Availability Mapping http://www.who.int/healthinfo/systems/samdocs/en/index.html
11. Tanzania Service Availability Mapping 2005-2006
12. Tanzania FBO GIS - Overview
13. ARHAP – Summary of 2006 mapping research in Zambia and Lesotho (October 2009)
14. Using Health Facility Profiles as a Monitoring Tool: An Example Based on Data from Three African Countries (MEASURE Evaluation, December 2007)

Strategy and resource documents

15. WHO framework for monitoring and evaluation of health systems strengthening (draft, October 2009)
16. Toolkit on Monitoring Health Systems Strengthening, WHO (2008, 2009) http://www.who.int/healthinfo/statistics/toolkit_hss/en/
    a) Introduction to the Toolkit: Measuring Health Systems Strengthening and Trends
    b) Service Delivery
    c) Human Resources for Health
    d) Information Systems
    e) Medical Products, Vaccines and Technologies
    f) Health Systems Financing
    g) Health Systems Governance

17. Putting people and health needs on the map (WHO, 2007)
18. Building From Common Foundations, WHO and Faith-Based Organizations in Primary Healthcare (Geneva Global Performance Philanthropy, WHO, 2008)

FBO Resources

19. ARHAP Summary of 2006 mapping research in Zambia and Lesotho. Done for the World Health Organization. October 2009.
20. Terminologies and Definition Work on "Religious Health Entities" Discussion brief for WHO-CIFA mapping meeting—Geneva, Nov 2009 by Jill Olivier
21. Summary of research tools related to the mapping and assessment of religious health assets. Nov 2009. Compiled by Jill Oliver

RESOURCES FOR DOCUMENTING RELIGIOUS HEALTH NETWORKS. Bibligraphy compiled by Ray Martin, Executive Director Christian Connections for International Health

Chuck Ausherman's work on Religious Health Networks (RHN). His August 1998 report, *Religious Health Networks Survey Report* and his CD. He refers to survey in 1963. Who has it?

Mission Handbook 2001-2003, a directory of 1000 mission agencies from Mission Advanced Research & Communication (MARC), 800 E. Chestnut Ave., Monrovia, CA 91016. Tel. 1-800-777-7752. Online purchase at www.marcpublications.com/ costs $49.95. Polling many of these organizations would be fruitful.

Frank Dimmock polling Christian Health Associations in southern Africa .

H. Bruce Carr annotated directory of agencies organizing short-term missions. Email: HbruceCarr@aol.com. Go to: www.laromana.homestead.com/BruceCarrResDirectory1.html. (His mother is retired librarian at Emory Medical School and could be interested.)

World Faiths Development Dialogue, Director Michael Taylor, wfdd@btinternet.com, is considering researching the involvement of faith communities in health and education, their views on health services and how they should be paid for, and how they might be strengthened. WFDD is a collaboration of World Bank and leaders of nine major world religious faiths.

World Bank has inventoried religious health assets in several countries. Bank staff managing projects in many other countries might be able to obtain data on religious health assets.

USAID health officers in many countries will likely have, or could obtain, data on religious health assets.

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Christian Connections for International Health has database of 1500 persons in over 100 countries as potential sources of information. CCIH can probably mobilize volunteers to work on information gathering.

The U.S. Catholic Mission Association keeps a list of Catholic organizations supporting health missionaries overseas. Address: US Catholic Mission Assn., 3029 Fourth St, NE, Washington,DC 20017. Catholic Relief Services probably could help, too. Also Terry Kirch, Catholic Medical Mission Board, 10 W. 17th St., New York NY 10011, 212-242-7757, cmmb@compuserve.com

DIFAEM, the German Institute for Medical Mission in Tubingen is interested in this project and might help. Contacts: Rainward Bastian (bastian@difaem.de), Director, and Deputy Christoph Benn (benn@difaem.de). Various other European health mission leaders could be contacted, e.g. Christina de Vries, of the Medical Coordination Secretariat of the Netherlands. Email: C.de.Vries@sowkerken.nl (Vries, C.L. de). Others are (EZE and Bread for the World); Misereor, Germany;
Cordaid and Memisa, Holland; MCS, Holland (ICCO, Uniting Churches in the Netherlands); Memisa, Belgium; Christian AID, UK www.christian-aid.org.uk; Caritas Italiana, Italy; The Christian Medical Fellowship, Medical Missionary Association, and HealthServe which maintains database of UK-based mission societies, Contacts David Clegg and Steven Fouch at director@mmahealthserve.org.uk. Website: www.healthserve.org. Also www.cmf.org.uk/mma/ovac.htm; also in UK is Christians in Health Care, which networks with Christians overseas, Director, Howard Lyons (howardlyons@msn.com) website: www.christian-healthcare.org.uk/c-hc. Another in UK is ACET in England, Scotland, Wales – start with England: acet@acetuk.org, or gus@acetuk.org, Website www.acet.org.uk

International Christian Medical and Dental Association, Cambridge, England, email: icmda@compuserve.com, may be an ally, as well as the Christian Medical and Dental Association in the US, director David Stevens in Bristol, TN. Website: www.cmds.org

Interfaith Health Program with all its Atlanta contacts and networks through the listserve, newsletter and website.

WHO could be contacted. Person to start with: Nelle Temple Brown, templebrownn@whowash.org. PAHO might well be interested for Latin America. Initial contact: David Bradley Bentley, No.2 at PAHO.

Directory of *Christian Health and Medical Associations and Other Christian Health Care Providers,* published by World Council of Churches in November 1998. Contacting the various CHAs could be a prime source of data.

World Council of Churches has inventoried programs in a good number of African countries. Contact Manoj Kurian, mku@wcc-coe.org.

The NGO Forum for Health and its 500 members, loosely affiliated with the WCC, might be worth contacting. Director is Eric Ram and Manoj Kurian is Treasurer.

The Executive Director of the Harvard Institute for International Development Sara Sievers, (sara_sievers@harvard.edu), is very interested in faith-based health programs and might be interested in analyzing religious health assets.

Various coalitions could be helpful. Some examples:
- The Africa Community Action Network For Health (AFRI-CAN),
- African Regional Forum of Religious Health Organisations in Reproductive Health. Website: www.oneworld.org/IFH,
- International Alliance of Religious Organizations against HIV/AIDS, supported by UNAIDS, Contact: Calle Almedal, almedalc@unaid.org,
- Inter-Church Association of Health, Healing and Counselling Ministries headquartered in Jamaica. Chairman Tony Allen, tonlit@kasnet.com,

Compiled by Ray Martin, CCIH, April 27, 2002

KEY NOTES FOR APRIL 29-30, 2002, MEETING IN ATLANTA

Global Religious Health Assets Initiative

Chuck Ausherman
A first step is to conduct an inventory of RHNs and diagnosis of the situation. The last such survey which was done in 1963. This requires a quantification of religious health networks (RHNs) and a sharing of this information.

Foundation to build on:

Chuck Ausherman's work on Religious Health Networks (RHN). His August 1998 report, *Religious Health Networks Survey Report* and his CD. He refers to survey in 1963. Who has it?

Mission Handbook 2001-2003, a directory of 1000 mission agencies from Mission Advanced Research & Communication (MARC), 800 E. Chestnut Ave., Monrovia, CA 91016. Tel. 1-800-777-7752. Online purchase at www.marcpublications.com/ costs $49.95. Polling many of these organizations would be fruitful.

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International Christian Medical and Dental Association, Cambridge, England, email: icmda@compuserve.com, may be an ally, as well as the Christian Medical and Dental Association in the US, director David Stevens in Bristol, TN. Website: www.cmds.org

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- Inter-Church Association of Health, Healing and Counselling Ministries headquartered in Jamaica. Chairman Tony Allen, tonlit@kasnet.com,

Ray to IHP

Here is what I would propose. We would contact, mostly by email, a variety of potential information sources within our CCIH constituency, e.g. Christian Health Associations, national Christian health leaders, missionaries, sending denominations with health ministries, Christian NGOs, the World Council of Churches, donor health people, etc. At this initial stage, we would ask for information that is readily available to them. This would include Christian hospitals with name of Medical Director and/or administrator, name of hospital, number of beds if available, mailing address, phone, fax, email, website. If such information on clinics were available, we'd ask for that. We would seek information (name, responsible official, contact information, objectives, resources, etc.) on defined health programs that go beyond the walls of a hospital or clinic. We would seek information on coalitions such as Christian Health Associations. I never did see Chuck Ausherman's CD. If he had a lot of data, it would be good to access that as well.

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> We are publishers of specialized reports and directories
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> group medical practices, medical manufacturers, etc. It is available
> at an introductory price of $245. If you are interested

> in receiving this directory, please provide us with your mailing
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