EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

Title *Global Religious Health Assets Initiative*

Participants Franklin Baer, Jim Cochrane, Frank Dimmock, Sambe Duale, Emma Ferreira, Niels French, Gary Gunderson, David Hilton, Lucy Keough, Nduge Kiiti, Manoj Kurian, Meredith Long, Ray Martin, Deborah McFarland, Yolanta Melamed, Jacqui Patterson, Munro Proctor, David Sauer, Robert Sprinkle, Ruth Walkup

Date April 29-30, 2002

Location The Carter Center, Atlanta, GA

Background IHP convened this meeting to bring together global leaders from religious and public health organizations "to talk about religious health assets globally, especially in Africa." The meeting was convened with the goal of determining the most effective methods for mapping religious health assets and creating partnerships among religious agencies, religious scholars, schools of public health, and public health researchers.

This meeting laid the foundation for the creation of the African Religious Health Assets Programme (ARHAP) and its groundbreaking work in religious health asset mapping.

GLOBAL RELIGIOUS HEALTH ASSETS INITIATIVES

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TABLE OF CONTENTS

I. Global Religious Health Assets Initiative

The Carter Center,

April 29-20, 2002

Meeting Summary

Last month 18 people gathered at The Carter Center to talk about religious health assets globally, especially in Africa. This meeting was designed as a step toward mapping of religious health assets and toward creating a working relationship among key religious agencies and researchers in schools of public health, relevant academic settings and religious structures. All but two of the 18 participants are from religious agencies, with the two exceptions being Lucy Keogh from the World Bank Dialogue on Development and Ruth Walker from the HHS office of international health, both of which are actively trying to engage faith groups.

A condensed narrative follows, which includes a bit of update on things following the meeting. Attached along with this report is a set of notes from the two day meeting, contact information of attendees and other information.

We envisioned four tasks for our gathering, all of which we engaged.

1. Mapping the Assets

First, we sought clarity on how close we may be to putting together a comprehensive map of the major religious health assets in Africa. We did not think that anyone currently has even a large-grain quantitative map of the hundreds of hospitals, much less of the less quantifiable programs. We did not know how consistent the various lists are with each other in terms of what they count and describe. We are still not sure exactly how many existing lists there are and who has them, but we are confident now that the number may be less than a dozen and that all of the holders will likely participate in the task of assembling a web-based map. We recognized the urgent value of getting a full, broad snapshot of the current scope and scale of religious health assets, especially in Africa. We recognized that critical decision making is done at country level or lower, but some basic policy guidance is done at higher levels and that clarity about the scale and scope of religious health assets could affect how the larger intergovernmental bodies see opportunities. However, the map does not need to be kept in realtime, all the time. But every few years it needs to be real. At the very least, we felt it needs to be comprehensive and real once-- and soon.

Critical Role for Christian Health Associations

The Carter Center meeting was informed by the discussions and work in two regional meetings of Christian Health Associations in Malawi and Nairobi in which Frank Dimmock of PCUSA participated. We envision a role for CHA's in designing the data framework for the broad map to go beyond "contact information" so that the map would be useful to them. We also envision a key role for the CHA's in the "green box" work, which will be key to going beyond the old health paradigms toward new opportunities grounded in reality and hope emerging in their practice. This will require some funding for convening and communication regionally.

We had a good bit of discussion on the geographical domain of concern. Although many of us have responsibilities that are global in nature, we recognized there was good reason to focus on Africa at this

time. We often noted the relevance of the work for issues that go beyond Africa, but agreed to maintain a focus on Africa for now.

Christian Connections for International Health (CCIH), working with the Christian Health Associations (CHA) is willing to accept responsibility for assembling the Christian pieces of the map and, with Frank Baer, to get it up on the web in some logical way. The Catholic Medical Mission Board has tentatively agreed to share their data, as have the Adventists and Samaritan's Purse. Dr. Ausherman's initial research is a foundational piece of work and he has indicated that he is more than willing to help in any way possible.

The Christian data will be done in such a way that it will eventually be one component of an interfaith map, which IHP will accept responsibility for assembling. We began to explore some of the relationships necessary and noted that the World Council for Religion and Peace, United Religions Initiative, World Parliament of Religions and several Islamic networks are critical players. The interfaith dimensions will take some time, so we do not want to delay the Christian map in any way. The meeting specifically agreed to give support to CCIH as the leader. We (IHP) agreed to help them seek financial support as needed for their effort and notes some religious donors who may be open to that request.

2. Understanding the Assets

Second, we hoped to agree on a short list of things that would be valuable to know consistently across all the component lists. Especially with the catastrophe of AIDS in mind, we wanted to make visible the community-wide impact, not just the inside-the-walls services. Dr. McFarland reminded us that even as AIDS grows in priority, these religious assets are still dealing with all the "usual" problems at the same time including everything from dysentery to poverty. The more we thought about these issues, the less it seemed possible or even worthwhile to move toward a *short* list. Rather, we began sketching more and more issues that demanded careful, thoughtful analysis and a longer and longer list of people beside North Americans who could/should do the thinking. We started drawing green boxes on our flip charts around these issues, so they became known as our "green box issues." (*Right*)

"Green Box" Knowledge
-Changing from biomedical to holistic health.
-Best (good enough) practices
-Local structures/Indigenous Associations
-Movements (social)
-Media resources
-Policy Initiatives (best policy documents)
-Narratives
-Research Needed
-Theological Resources
-Faith and health framing documents/articles

Types of Data/ Sources of Evidence
-Case studies
-Policy statements
-Sermons
-Moles in strategic places/Kingdom of God Builders
-Internal reports/evaluation
-Strategies of hope
-Lessons learned/Realities
-Self-assessment of strengths and weaknesses
-Mission statements
-How are communities transforming health

Who knows and who *teaches* it is as important as *what* is known.

It became very clear that this is messy, complex, hard-to-fit and even contentious knowledge. It is also the heart of what might be powerful and transformative. We talked about who is qualified to learn and teach these kind of things raising issues of power and privilege in many ways. Some of these "green box" issues are critical for understanding the role and strategic possibilities of the hard assets being mapped, although it might also de-center some of those assets in the process. Indeed, there is a subversive potential here that may lower the status and value of the very assets that have called us to convene. So be it. We did make some important decisions about how to approach this body of work. Specifically, we began to image a network of scholars and thoughtful leaders primarily in Africa that would be a version of the Faith Health Consortium that IHP has convened in the U.S. (And Cape Town and Norway). The idea is for IHP to approach a larger donor for funding to be channeled mainly through the FHC site in Cape Town to

identify and convene a series of case studies and papers by African scholars (again, broadly conceived). There are a number of scholars, schools and agencies that are and could be involved. A concrete example: there are many MPH and PhD students who must produce a reasonable thesis anyway. Many of them are in schools with faculty and programs relevant to this body of learning. We want to capture that research energy. The new dimension provided by the creation of an FHC-Africa could be very valuable. IHP agreed to approach The Templeton Foundation, which had provided seed funding for the initial five consortium sites.

3. Engage other learning networks

Third, we wanted to sketch the existing learning efforts already underway that could be brought into relationship with each other. Some of these are internal reviews, others are conferences. Almost none of it has found its way into peer-reviewed journals of any discipline, at least in English. We see an ongoing research project that could be loosely coordinated to great effect.

Some Parallel and Convergent Efforts
-World Dialogue on Development
(World Bank- Archbishop of Canterbury)
- World Conference for Religion and Peace
(Mapping AIDS resources in Africa)
-World Bank
(developing map of religious resources in several countries)
- Ministry of Culture – France
(*Interested in Francophone religious presence*)
- Samaritan's Purse
(hundreds of models emerged in their recent international AIDS conference)
- APHA Caucus of Public Health and Faith
(Public health-faith professional meeting)
- International Association for the History of Religion
(ongoing study of religion and globalization)
-Global Fund for AIDS, Tuberculosis and Malaria
(no research capacity, but clearly needs help)
- United Religions Initiative
(Developing many "cooperating circles" related to health and development.)
- World Parliament of Religions
- U.S. Faith Initiative and Compassion Fund
(broad dialogue about religious role)

And many of the meeting participants' organizations are working actively all along.

The non-U.S. participants noted gently that just because Americans were ignorant, did not mean that everyone was in the same state. There are logical reason why so little about African religious health assets is in the English professional journals. American scholars have generally not cared very much at any point. And, at least since the Thatcher government, British African scholarship has been radically de-funded. Other European centers have been much less affected. From an African perspective, the overall effort needed to be more-than-U.S.-driven to be credible. We decided that it would be very important to convene a meeting similar to the Carter Center event in Europe in the near future. Manoj Kurian of the World Council of Churches offered to help and indicated several other key partners, including our emerging Norwegian Faith Health Consortium.

The World Bank/Archbishop of Canterbury World Dialogue on Development is another critical forum that is highly relevant to the discussion on religious health assets. Several participants felt it was important to see the discussion about health (and health assets) as a subset of the broader discussion about poverty, debt and development. The multi-billion dollar focus on AIDS, TB and malaria is not entirely helpful at this point because it may tend to drag the discussion toward short term goals and away from fundamental justice issues. The GRHAI should be grounded in both long term strategic wisdom and urgent challenges – just like the assets themselves.

4. Ongoing work

Fourth, we saw this body of work as the possibility for an ongoing relationship, not just an event, although we have been reluctant to create a formal structure. We did not and do not have any ambition to coordinate all the religious health service providers, even "just" in Africa. Our meeting made clear again that religious networks are classically chaotic, self-organizing systems and will remain so. It is still awkward for some religious networks to closely collaborate with each other visibly, although nearly all do quite well at local levels. We think there is great power in clarifying what assets religious networks have to work with, what they could do with it and how their partners could be in the process. But this is best done through open transparent dialogue with multiple leaders and venues, rather than in a tightly coordinated umbrella.

We talked about whether the word "assets" is helpful in the title of effort and decided it was, partly because it *needed* to be explained. The more obvious word– "resources"–often comes to mean those things we do *not* have. "Assets" turns us toward what we *do* have and the decisions we must make about them.

Beyond this meeting we expect an ongoing body of learning to emerge. One track is simply to find clarity about the scale of the present array of religious health assets. The second track is to develop a sense of what those assets could be doing and how they might be strengthened in that work. This is the raw fodder for the dialogue of ethics, but intentionally stops just short of the "should." We want to create a safe space in which they/we can learn together. We think the learning can change behavior and make us much smarter about how to help each other. We know that many millions of people depend on these systems for their lives and will do so for decades to come.

Finally, we should close the notes with a word of thanks to Wheat Ridge Foundation, the Lutheran Charities Foundation and The Carter Center Mental Health Program for their financial support and hosting of this seminal meeting. We are grateful for the many special efforts that were made by the participants in order to be present in such a creative, hopeful spirit.

Submitted,

Gary R. Gunderson, MDiv, DMin

Director, Interfaith Health Program

Rollins School of Public Health

Emory University

STATEMENT OF HOPE

We will live together, or not at all. We will build hope and wholeness, or watch our children grow small, surrounded by ineffective barriers against their fears. We know that acts of compassion, nobility, faithful caring for the earth and her people are all that we can do. It was once thought that acts of virtue, conservation and care were only of personal consequence. But surely it is the most fundamental adult responsibility to build and nurture systems that carry our hopes forward. There has been a slowly growing movement among people of faith and the many involved in health, as subtle as two streams converging in a forest. From convergence, comes power. Amos, a Mideastern prophet, once dreamed of justice rolling down like mighty waters—so do we.

GRG

GLOBAL RELIGIOUS HEALTH ASSETS INITIATIVE
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Participant List

Franklin Baer
Health Consultant
Baretracks
326 7th Street
Harrisonburg, VA 22802
(P) 540-433-8652
(F) 413)23506666
fcbaer@bemorecreative.com

Jim Cochrane
Professor
University of Cape Town
c/o Walker Center
144 Hancock St.
Newton, MA 02466
(P) 617-358-1858
cochrane@humanities.uct.zc.za

Frank Dimmock
Health Consultant
Presbyterian Church (USA)
167 Inman Dr.
Decatur, GA 30030
(P) 404-370-9875
fdimmock@earthlink.net

Sambe Duale
Sr. Research Manager & Infectious Diseases Advisor
Support for Analysis/Research in Africa Project
1875 Connecticut Ave NW 9th FL
Washington, DC 20012
(P) 202-884-8809
sduale@aed.org

Emma Ferreira
Graduate Student
Rollins School of Public Health
Emory University
750 Commerce Drive, Suite 301
Decatur, Georgia 30030
(P) 404-592-1464
(F) 404-592-1462
queenemma00@hotmail.com

Niels French
Program Coordinator
Interfaith Health Program/Emory University
750 Commerce Dr., Ste 301
Decatur, GA 30030
(P) 404-592-1463
(F) 404-592-1462
nfrench@emory.edu

Gary Gunderson
Director
Interfaith Health Program
Emory University
750 Commerce Dr., Ste. 301
Decatur, GA 30030
(P) 404-592-1465
(F) 404-592-1465
ggunder@emory.edu

David Hilton
Health Consultant
Ecumenical Health Ministries
4162 Cimarron Dr.
Clarkston, GA 30021
(P) 404-727-4070
(F) 404-727-0738
dhilton@emory.edu

Lucy Keough
Senior Operations Officer
World Bank/WFDD
1818 H St., NW
Washington, DC 20433
(P) 202-473-4956
(F) 292-522-5724
lkeough@worldbank.org

Nduge Kiiti
MAP International
The Healey Building
57 Forsyth St. NW, Ste 240G
Atlanta, GA 30303
(P) 404-880-0540
(F) 404-880-9411
nkiiti@map.org

Manoj Kurian
Executive Secretary
World Council of Churches
150 route de Ferney, Box 2100
Geneva 2 CH-1211
Switzerland
(P) 41 22 791 6323
(F) 41 22 791 6122
mku@wcc-coe.org

Meredith Long
World Relief
P.O. Box 868
Baltimore, MD 21203-0868
(P) 630-668-0440 ext. 230
(F) 630-668-0498
mlong@wr.org

Ray Martin
Executive Director
Christian Connections for International Health
1817 Rupert St.
McLean, VA 22101
(P) 703-556-0123
(F) 703-917-4251
MartinRS@aol.com

Deborah McFarland
Professor
School of Public Health
Emory University
1518 Clifton Rd, Rm 714
Atlanta, GA 30322
(P) 404-727-7849
(F) 404-7274590
dmcfarl@sph.emory.edu

Yolanta Melamed
Director of Programs
Global Health Action
2250 N. Druid Hills Rd., Ste 130
Atlanta, GA 30333
(P) 404-634-5748
(F) 404-634-9685
ymelamed@globalhealthaction.org

Jacqui Patterson
Infectious Disease Coordinator
Interchurch Medical Assistance
Blueridge & College Ave.
P O Box 429
New Windsor, MD 21776
(P) 410-635-8746
(F) 410-635-8726
jacquipatterson@interchurch.org

Munro H. Proctor
Boston University School of Medicine
Preventive Medecine, Medical Center B-612
715 Albany At.
Boston, MA 02118
(P) 617-638-8074
(F) 617-638-8076
munroproc@cs.com;mproctor@bu.edu

David Sauer
Catholic Medical Mission Board
16635 Burleigh Pl.
Brookfield, WI 53005
(P) 262-790-5228
Dsauer@CMMB.org

Robert Sprinkle
Consultant
4510 Derby Lane
Smyrna, GA 30082-4017
(P) 770-431-0145
(F) 770-431-0361
sprinknk@gate.net

Ruth Walkup
Department of Health & Human Services
3002 Rodman St NW #304
Washington, DC 20008
(P) 301-443-7243
(F) 304-443-6288
rwalkup@osophs.dhhs.gov

III.

Global Religious Health Assets Initiative
April 29-30, 2002 – The Carter Center

Meeting Minutes

April 29 9:00AM

Welcome

Introduction: Gary Gunderson, Director, Interfaith Health Program, Rollins School of Public Health
Welcome: Greg Fricchione, Director, Mental Health Program, The Carter Center

Introductions

Deb McFarland (DM)
Franklin Baer (FB)
Yolanta Melamed (YM)
Jacqui Patterson (JP)
Nduge Kilti (NK)
Frank Dimmock (FD)
Manoj Kurian (MK)
Meredith Long (ML)
Jim Cochrane (JC)
Bob Sprinkle (BS)
Ray Martin (RM)
David Sauer (DS)
David Hilton (DH)
Ruth Walkup (RW)
Munro Proctor (MP)
Sambe Duale (SD)
Mia Ferreira (MF)
Neils French (NF)
Gary Gunderson (GG)
Lucy Keough (LK)
Patricia Patrick
Mimi Kiser

Background and context

GG: This is not a beginning. This is about planning for the future. This is about building relationships and leadership. This is about Religious assets – in the most distressed areas of world. How can we hold them accountable to the most mature faith and most relevant science? Aligning faith and health science assets for the whole community

This group is incomplete – it is responsibility of all present to think of those absent and speak on their behalf.

This meeting owes a lot to Chuck Ausherman – IDT, grant from the Packard Foundation to develop an enumeration of religious health networks (3,732), primarily hospitals....last assessment done in the '60's....religious/health assets..... integration of government and religious domains....has become a priority of large organizations to point to religious organizations to promote health and wholeness of community (e.g., HIV/AIDS, TB, malaria)....***this meeting will be to figure out what the religious health component of this relationship could become.***

Two critical tasks/honest question: (1) DATABASE OF RELIGIOUS-HEALTH ASSETS – finish what Chuck Ausherman began with enumeration of religious-health assets – what's worth knowing without focusing on immediate crisis; need to know scale and scope of these assets and (2) ALIGN THESE ASSETS FOR REFLECTION AND FUTURE – think of what scholars have not considered....there are few peer-review articles in the English language about religious-health assets....need careful, analytical reflection on these assets, what we have been doing, what we could be doing...what we would like to happen.

Thanks: We have received funds from the Wheat Ridge Foundation and from the Lutheran Foundation for the hosting of this immediate meeting. But we haven't raised money beyond this and are open to moving forward from here.

DM: How do we engage the health systems of world as they experience crisis after crisis?
From a public health economist perspective:
Public health is about the community whereas economy is about the individual - very different disciplines with different languages.
Commonality between these is the ethics required to frame questions about resource allocation, analysis of what goes on with health care delivery systems around the world as burden of disease has become greater and greater. The institutions delivering services that thrive, or at least survive are RELIGIOUS-HEALTH NETWORKS...***can we do a systematic review of these religious-health assets?*** Have we done analysis of comparison of assets, patterns of delivery, integration with ministries of health? Could we develop an evidence-base to inform those NEW PARTNERS about religious-health assets and how to respond on a global level with a tangible agenda? Where is the empirical data. We need to see the evidence

RM: Are we talking about just Africa?

GG: Africa focus is artificial to an extent because all of us have larger interests; yes, Africa is a focus, but not necessarily.

ML: Health systems: How are we defining this? In Cambodia – measure how behaviors change; AIDS programs are congregation based...health messages...is this kind of thing included here? How do they come part of the same map?

GG: Institutional and Human Capital – how do we deal with money already invested....selling fixed hospital assets....how do we describe that stuff so it's on the same map, because it is all integrated....question is whether we count this as part of this database.

DM: What is the domain? Defining this domain is the initial question. We come from an institutional perspective, but it doesn't need to be this way.

Expectations and perspectives of others

RM: Goal to get assets map on Internet by this Christmas – DATABASE of ¾ world's developing countries.
SD: How to use and list this information on assets – hospital, nursing & training schools, pharmaceutical depots?
BS: How do you keep the database current – it will get old after 2 years (once you're done with it).
DH: Having deja vu – focus is always on institutions and never what are we doing – what is our goal and objective? What is the health/state of well-being? What are we trying to achieve and how do we get there?
MK: Regional/local ownership of process and data; apart from quantifying it, make a qualitative assessment as well and what it means....creating a database that is quite full and linked to a local level...Pentacostals and indigenous groups, not just mainline churches.
RW: At national policy level: Government institutions have not asked question about INTERNATIONAL faith-based health links; looking for baseline information about institutional resources. Faith groups need to be able to answer the government's questions or to be able to prompt the questions.
DS: We need to know what's there, because we don't know what is there. Get a handle on it.
DH: Nepal example....great health work is not in medical department, but literacy classes for women, dams for water, empowering....we can make a list of hospitals, but what else is out there that is the real health program?
DS: We need to footnote in a significant way how we can possibly take on everything we are talking about.
MP: Have problem that needs to be addressed soon: doing an impact evaluation of micro-finance in Cameroon....we need IMMEDIATE GOALS.
RM: We commit to getting this to work in the next three years, reconvene in 2005 to look at issues broader than hospital things.
DM: Rather than just an enumeration....what EVIDENCE do we have that these "things" work? If evidence is there, then let's tease it out and integrate/promote it as a PUBLIC HEALTH AGENDA. Influence the global agenda.
ML: An outcome could be for CCIH, for example, to create a database, quantitative and qualitative.
BS: Address poverty, development and peace.
RW: How do we get there? What are the baby steps? What is it that we are going to count? What is the skeleton of the framework?
JC: What is vital and how is this going to make a difference? Expectations are (1) beyond religious-health networks: How will this help us deal with problems of poverty and development on the ground in South Africa? (2) deepen understanding on how development actually works, how to facilitate/coordinate health in un-institutionalized environments (e.g., indigenous resources, traditional medicine). (3) Cannot be separated from JUSTICE and equality. (4) Plans should be incorporable beyond Christianity. Include Islam and other faiths.
FB: We may want an institutional database, as well as programmatic database. Have a directory of three or four databases. Interested in institutional database of not only hospitals, but also hospitals' associated infrastructures. Garages are essential infrastructure that go along with hospitals.

More Background

RM: What is known already about religious-health assets (defined narrowly): Attitudes of World Bank is changing: Health-project managers try to develop programs that public want, rather than what they think is most effective based on experiences elsewhere...emphasis on strengthening public health system.... ½ World Bank projects have NGO components, including Christian-based organizations...if local public health official is unable to communicate effectively and knowledgeably with World Bank, then community is at a disadvantage. The urgency is documenting numbers and names of (for example) Christian hospitals in Tanzania because information is either unavailable or inaccessible. Key stakeholders do not have information they need. NGO's locally can't get a seat at the table.
Hand-out RESOURCES FOR DOCUMENTING RELIGIOUS HEALTH NETWORKS
Chuck Ausherman's work shows we need numbers and names. Pull it together, make it available, get it exposed.
Short-term Missions is NOT currently a religious-health asset, yet 10's of thousands mission groups go from U.S. each year.
There are European agencies who would be fruitful partners in this effort – we should spend time figuring out how to incorporate them.
CCIH meeting a couple years ago: dedicated to international health in a Christian framework...tried assessing Christian-based hospitals, challenging them to think in larger terms than just surviving as hospitals.
Meeting last week – Global Fund Meeting; Christoph Benn was there; assessed degree of faith-based organizations aware of global fund.
AIDS, malaria, TB conference – 125 people from 25 countries, many from Africa...this seems to be evidence that collaboration/communication is worthwhile...Bring cohesion and identity to Christian health.
How can we build productive partnerships in order to advance public health and Kingdom?

BS: Funders?

RM: Ann Peterson – USAID, Katherine Marshall – World Bank, INTERNET (#1), Christoph Benn – Global Fund, Gates, Foege, Helene Gail

JC: People from "north" giving money to those in the "south" and deciding how it is to be used is worrisome.

RM: Looking for a practical way to get information to people who will use it.

JC: There are people in South Africa and elsewhere who can help. How do we begin in this context/paradigm? Our state has spent a lot of time "sidelining" NGOs. Structure of process, who controls it, under whose agenda and for what purposes, what the question relates to.

DS: Example of structure of Catholic Church – are there connecting links/counterparts in other countries analogous to structure of Catholic dioceses/Episcopal conference/conference of bishops?

MK: Involvement of locals and focus on them is essential. Not just for allocation of resources, but personal investment and knowing what local capacities exist. Be sure of local ownership.

MP: Regarding funders, folks in DC, senators had no idea faith-based work was going on.

ML: "Country of Africa." Feed back information "they" already have. What can we do to centralize this for "their" use. The answer has to come from "them." What do CHA's want from their perspective.

FB: Presentation on Churches and Health Care in Congo

FB: List began by Belgians, then started on Apple computer, government/NGO vision statement.

DS: Who maintains the database?

FB: Ministry of Health maintains official database; FB is webmaster.

DS: What is the use of the database?

FB: This would give you information on who to contact for services. (Demonstration of search within database.)

LK: Who uses it and what do they use it for?

FB: Using it to see who is working in what health zone doing what; used to coordinate implementation of new services.

MP: Can a donor coming in use it? Answer: Yes, see www.sanru.net or use an E-book.

NK: How sustainable is the infrastructure via social assets?

FB: Survey done in 1986 of 10 health zones....90%+ costs recovered...USAID stopped funding in 1991 and health zones were still intact, although delivery was not as good, e.g. vaccination rates.

GG: How does this model apply to our dialogue here?

FB: Applicable to hospital or health center or program based interventions.

SD: Mapping of resources available is useful to the people.

LUNCH

More Background on databases

FD: Issues of lack of data, identifying information, sustainability and relationship with government.

Personal interest to quantify comparative advantage of church/religious health communities...what is the advantage of church with healthcare?

Church is a community/indigenous foundation to build capacity; located is strategic local, rural and urban locations; also the vital spiritual component; and mission to serve the poor vs. abandoning this in exchange for financial viability. The government is acknowledging church's role. Database will be tool for advocacy, not just publicity. "Show us the evidence."

In December, 7 countries met about church-related health care: training nurses working with HIV....database would be helpful for groups like this. CHAs need to link to each other; they frequently feel that they are alone and working alone. They need to be part of a greater network. There are lots of contacts out there with information to create database with. But we must start with each country at the local level.

MK: Works with Frank and is glad he is here at this meeting. From the funding point of view, not much support from U.S. for networking...Ecumenical emphasis is poor. We need sufficient interaction in order to share information people need. WHO ARE THE STAKEHOLDERS? KEEP THE FOCUS ON THE COMMUNITY – THEY SHOULD BENEFIT AT THE END OF THE DAY. Local group should be key stakeholder. HIV/AIDS: 1999 Botswana – regional HIV/AIDS leaders met and it was apparent they did now know what each other were doing – demonstrates need for sharing local information. Doesn't like idea of questionnaires and meetings. Need summary of meetings. What is practical? Keep the community at the forefront. Government support in other countries cut. Even when the information is there, people don't know about it.

DS: It would be a great doctoral dissertation to examine Catholic Church's role in HIV/AIDS.

LK: World Faith Development Dialogue: World Bank and major faith organizations around world met...faith communities have been most vocal critiques of World Bank → damage control aspect.

Poverty alleviation/social services deliveries: church has been frontline. World Bank Board of Directors were against this initiative. It is important to have conversations with people engaged at community level, whether they are religious-based or not. Religion is important for development (as demonstrated with 9/11).

HOW DO PEOPLE MAKE PROJECTS SUSTAINABLE? It's not about funding – it's about a learning dialogue. HIV/AIDS is a priority now. WFDD – not a gatekeeper. RAISE THE AWARENESS OF THE WORLD BANK TO SEEK OUT FAITH BASED COMMUNITIES. They/we do not know what social service deliveries are out there, even though they/we know they're out there.

Due in September, the World Bank is in the process of organizing an INVENTORY of experience between the World Bank in Latin America, Asia and Africa and faith-based communities.

World Conference on Peace is having a meeting about HIV/AIDS? In faith-based African communities. Tanzanian inventory – social services provided by faith-based groups focused on health more than education. Need to know what questions you will address before you make the inventory.

DM: What does the World Bank want to have the information for?

LK: (1) Poverty Reduction Strategy Papers: Government's development policies under poverty focus...International Monetary Fund...PRSP meant to be product of government policy but also product of the country...necessary to engage faith-based communities. (2) HIV/AIDS – $1.2B – 50% to go engage community, including faith-based groups, in HIV/AIDS interventions. (3) Good to have concrete information....case-studies e.g. Columbia – government, oil company, alliance of churches doing community development in conflict areas.

MP: March, 2000 Conference on Poverty in Kenya – book on faith-based development, Faith In Development. Newspaper article stating World Bank giving money to churches rather than corrupt governments. Wilkinson – microfinance; CGAP...

LK: Need to tailor $$ programs so they are easily accessible for communities, especially in the case of HIV/AIDS. The WB has decentralized more than they used to and finance very small projects (social fund projects)...but don't have "field presence" to fund small projects. Don't have the critical mass to be present for small projects.

DS: How do you define a faith-based organization and who do you invite to these meetings? Are the "right" people being talked with?

LK: Relationships with "major faith groups." Depends....

RM: Challenge for all of us: need to create intermediaries.

LK: The WV is working at international and country levels, following formation of interfaith groups.

DS: Why isn't the WB talking to a guy like Munro?

MP: Has talked with WB reps in Cameroon; WB didn't mess it up – the government did.

LK: Why can't we fund faith-based organizations or NGO's directly is a whole other question.

SD: Need to put more effort into dialogue at country level. Somebody needs to inform government or NGO's about money available, etc. (speaking from recent experience in West Africa), and also to encourage people to seek out NGO for support.

FB: Identify partners at different levels. Three of 8 partners in Congo faith-based; used database in finding this out.

MF: **SUMMARY OF EXPECTATIONS**

PURPOSE
- Evidence based database
- Research Agenda
- Utilize for current issues

CONTENT
- May need different databases, e.g., institutional vs. programmatic
- Quantitative vs. Qualitative
- Broad vs. Specific
- Information to collect: Capacity, literacy, poverty, development
- Domain: (1) Geographic (2) Health systems, e.g., auxiliary vs. hospital
- Beyond Christian framework

PROCESS
- How to collect information
- Keeping information current
- Sustainability through social assets
- Local ownership
- Goals & Timeline: Short-term, long-term
- Commitment to project – who
- Funding

DISSEMINATION OF INFORMATION
- Internet
- Promotion of Public Health Agenda
- Policy & Government → International public health

PRE-GROUP WORK

ML: Need to be clear on purpose of database before we map out data points.

RM: Would be "easier" to gather quantitative data – how many hospitals, clinics, beds, outcomes, etc. Inventories will help us understand more deeply our progress....

JC: WCRP

LK: Is there an effort to inventory the inventories?

DM: Yes, no need to duplicate efforts.

GG: WCRP is HIV/AIDS focused. We have looked for inventories out there and don't seem to find one. One clear body of work that could come from here is identifying networks, identifying what they need...may start with sub-Saharan Africa.

ML: Three themes: (1) To demonstrate more specifically the database of faith-based communities, (2) Use this database for planning, (3) Important to facilitate people to network regionally or even locally.

GG: God's work for healthy people.

LK: Purpose is to learn.

SD: Need to show impact of contribution to donors, MDH, advocacy groups, continuing dialogue.

BS: Have answers to questions for people to tap into (for validation).
FB: Someone's project could be to inventory people's movements.
DM: What is the domain? Then what do we want to know about each component?
JC: Where are we on domain?
DM: One group could focus on the institution and one on a community; can also have domain like HIV/AIDS in sub-Saharan Africa.
ML: Can identify geographic-specific programs
DH: Can include other groups into database like advocacy groups.

GROUP WORK

TUESDAY APRIL 30, 2002

8:30AM

PRE-GROUP DISCUSSION, BASED ON PREVIOUS DAY'S GROUP WORK

GG: Data collection – doesn't need to be constantly updated or even a complete database, but snapshots of certain data. This group needs to flesh out which kind of information they want to collect, from who and when.
DM: Narratives of transforming communities – collating the stories together for others to see.
GG: Narrative group seems to be more of a Templeton Foundation thing. The group needs to describe as much as possible what that would look like – who to gather narratives from.
FB: Webmaster in thought: Geography, program, institution, search – can even have case study links to web site. Can browse too.
JC: Critical question: Important to use language that captures all sorts of categories – geography, program, etc. doesn't capture what (JC) wants.
MF: Who is the target audience – maybe there are some people who cannot access the internet.
DS: Are we talking sub-Saharan Africa or more or less?
MK: We should focus on Africa but leave it open.
GG: For this morning's purpose we should keep our mind on Africa – a helpful framework.
RW: Reminder of what we are doing here: demonstrate contributions of faith-based communities, advocacy, etc.

GROUP WORK

GROUP 2

DM: List of categories of things we would like to collect. Sources (who), whether it's even possible to get this information
BS: Case studies – virtual repository
DM: ELDIS is a search engine that include also sorts of development (www.lds.ac.uk) may be a good model and secondarily as a source of information....debt relief, transformation, case studies.
MK: Policy statements – maybe a letter, a sermon.
MF: What are the sermons, for example, addressing? Social equality, poverty, health, what?
MK: Can further categorize.
ML: Can categorize thematically....also can do BEST (GOOD ENOUGH) PRACTICES.
DM: Moles in strategic places.
YM: Evidence –
NK: Internal evaluations - they're out there so the question is how to tap this information; how to locate the information.
RW: Voice snips – doesn't have to be written information.
ML: Identifying approaches that respect the community the information comes from – and then this is translated into something others can understand.
MK: Inclusive of all religions, and then linking to the secular community....strategies of hope.
ML: Wants Jim's take on these links.
JC: Fifty to sixty students at University of Natal – theological studies for students interested in these kinds of things.
DM: What is our purpose? To create another website is important if the information can be used by decision makers, but we may lose something we are attempting to do. Evidence base....assembling information for decision makers that goes along with the global health agenda.
JC: Other categories: MOVEMENTS (sub categories of EQUITY, GENDER, JUSTICE, ECOLOGY); BEST PRACTICE CASE STUDIES; MEDIA RESOURCES (sub categories of HIV/AIDS, etc.); want to not exclude non-institutionalized health care practices, including indigenous health practices; POLICY INITIATIVES where religion and health come together and embody ecological.
MK: Want to include cultural aspects – how religion is an asset or liability
NK: Media – countering negative media with the positive; also talking case studies through on radio – these are examples of decentralizing government structures, which do not disseminate information enough.
BS: Evaluation – studies done among faith-based organizations that evaluate their practices (related to best practices).
JC: Difficult to collect private, privileged, possibly threatening information.
MF: Finding theses which may disclose alternative studies, that sit in the libraries unread.
DH: Paradigm shift from biomedical approach to holistic approach to health.

JC: A main concern – what is the specific contribution of this group; the value. Maybe the entire initiative should sit under collecting and disseminating information demonstrating shift from biomedical paradigm....comes back to a domain question.

DH: Plight of these institutions – these organizations are desperate – overworked, overwhelmed, under-funded – how do we deal with this? What is the data on this?

DM: Assets in the broadest sense – some of them are being destroyed, so what are you going to do with the remaining assets...merge them, invest them, divest them...papers need to be written that talk about experiences in all these different countries and the different variables.

DH: What is the mission statement of these institutions...most hospitals around the world don't have a mission statement...

DM: Crises.

DH: This is not a crisis – it is a pandemic – nothing has changed since the 60's in Nigeria.

NK: Category – why have programs failed? "REALITIES"

MF: Define best practice; define failure.

DH: Purpose of the hospital for some is to employ people.

ML: Identify "common challenges" e.g. income flow for hospital, rather than categorizing it as a failure.

JC: Failed systems that don't exist anymore – need closing documents, or ask for self-assessment of those organizations.

RW: How does one link articles/information?

JC: That's the webmaster's job to create key words that perform these linkages.

DH: There are lots of stories that need to be told that won't necessarily become part of a "database."

JC: Wants to collect narratives Dave is telling; story telling is very powerful when working with HIV/AIDS, for example.

DM: Stories can be powerful, but can also be short-lived (½ an hour) – the World Bank's Voices of Poverty may work.

DH: IHP could start a journal collecting these stories.

NK: Faith-based communities visiting other faith-based communities – promoting a learning exchange; encourage policy makers to get out there (visitations).

MK: Example – death and dying women talking about their experiences.

Mkiser – Movement....window of change...Barry Kimball an evaluative mystic – focus on CHANGE, not on delivery system; gets us out of a Western problem→fix it paradigm.

RECONVENING

GROUP 2 – ***What value is this exercise – how is it contributing to the greater health?

Defining domain – changing paradigm from biomedical to holistic health frames

Information dissemination – IHP do a journal

Additional Categories for Internet site

- Best (good enough) practices
- Local structures/Indigenous Associations
- Movements (social)
- Media resources
- Policy Initiatives (best policy documents)
- Narratives
- Research Needed
- Theological Resources
- Faith and health framing documents/articles

Types of Data/ Sources of Evidence

- Case studies
- Policy statements
- Sermons
- Moles in strategic places/Kingdom of God Builders
- Internal reports/evaluation
- Strategies of hope
- Lessons learned/Realities
- Self-assessment of strengths and weaknesses
- Mission statements
- How communities transform health

GROUP 1

GG: Christian identity vs. other religious identities and interfaith principles

DS: Can we get what we want out there; build a case statement; delivery of healthcare is vital/fundamental/life and death reality; strong theological component which can cut across all faiths – needs to be interfaith at the outset.

FD: Ownership/participatory nature for information collected – involve stakeholders like Christian workers at the outset so they can value it from the beginning, maintain the database and make use of the information; get their perspective on what the most important information to collect for them.

FB: Agrees with adding categories; somebody needs to do keywords but once this is done it will be easy to put into database as an active link. MULTIPLE DATABASES eg CCIH, Aga Khan. The vision is to be able to do a search and link to documents.

RW: Written documents are not the only kinds of way to get information across eg radio, story telling.
FB: Creative primary healthcare website.
NK: Access is one issue, dissemination is another issue in order to make an impact at community level.
DH: Publication CONTACT does different languages; part of the linkages could include resources like this.
MK: Domain – important in Africa to cover all religions eg. Islam; should be clear about our interfaith focus/mission.
ML: Core values homogenizing different faiths – this database should give the opportunity for information to be expressed in respective richness. Emic perspective, rather than from outside.
FB: Master database will be interfaith; its objective is to hold information e.g. ASK SAM database, which indexes this kind of information.
BS: Needs to be a roundtable for folks from each of these (different religious) perspectives.
JC: Supports interfaith notion – one reason is that the South African government makes a point of not giving privileges to Christians.
DH: Different reasons for doing what we are doing e.g. medical institutions being used to evangelize, others to cure sick people, others to create jobs; these motivations need to be recognized.
JP: More leadership from CHA in terms of they why's, who's, process of collecting information, dissemination, etc; the role of this group could be to catalyze the process of leadership among CHA's.
MK: Christian organizations vary from country to country, place to place. Get a group of people to be involved.
DH: Most of the CHA's are underfunded, overworked, understaffed, frantically trying to get work done....giving them more to do may be (not good).
JC: Critical to solicit people (students) in Africa (not here) – they are desperate for funding.
FB: Seeking funding – ensure we seek money for data collection and then beyond for dissemination, etc.
RW: If the focus is interfaith, then the front page should not have a Christian organization's name.
GG: CCIH should go ahead, but at the same time see bigger picture of interfaith.
DH: What about World Bank and USAID?
LK: Difficulty going ahead and starting at all. Link to bank – happy to discuss with them but hesitant to commit. Would have to be interfaith, could not be only Christian. Will explore collaborations.
ML: If it's going to be interfaith, need IHP or an academic institution to front project. Won't work for CCIH to approach Islamic leaders....
GG: IHP at Emory gets CDC funding.
DM: At Emory, there are very large religious studies departments that IHP is connected to; Emory is an interfaith community itself.

CRITICAL PARTNERS

Wheat Ridge
Lutheran Church in St. Louis
U.S. conference of catholic bishops
Father Bob Patillo – campaign for human development but works for bishops conference
Church World Service
European links
- UK: Tear Fund, Christian Aid, CAFOD, Frontier
- Germany: Difham, Christoff
- France: Daughters of Charity, Ministry of Culture (Yolanta)
- Holland
- MCS – health related body
- WCC – funded by Swedish/U.S. churches

Doctors Without Borders
WEBSITE company to do pro bono work
Academic sites: Universities in East, West, Central, South (Africa)
Student to student collaborators/partnerships (Foege, link to Gates Foundation?)
IHP: Templeton Foundation
Faith-Health Coalition – Explore expanding this in Africa
International Association for History of Religions

SOURCES OF FUNDING IHP/Emory; Templeton; Foege; CCIH

MOVING FORWARD

GG: ***What would a faith health consortium look like in Africa, eg. Capetown? Will contact Templeton Foundation about funding...getting academic assets on same page as other health assets.***
FB: Green boxes will be filled by others outside of academia, like World Relief, etc.
NK: Tap into African-American issues that parallel African communities with commonalities in health issues
ITC, Morehouse; Other African groups in Atlanta and Washington DC
MKiser: ***Roundtable at IHP that could intentionally bring in people of other faith traditions through APHA.***
RM: Wants Mimi to write a proposal for this because he's the chair of the IH program.
JC: International Association for History of Religions – intentionally international, broadly focused organization.
GG: ***IHP will do minutes of meeting and distribute this to the entire group.***
MK: World Council on Churches focus is very clear – programmatically he has a lot of freedom and can work with IHP. Only concern is that information should come from broad spectrum of sources – not just mainstream churches.
DM: ***IHP could set up a LISTSERVE***

IV. CURSORY RESOURCES FOR DOCUMENTING RELIGIOUS HEALTH NETWORKS

Compiled by Ray Martin, CCIH, April 29, 2002

Chuck Ausherman's work on Religious Health Networks (RHN). August, 1998, Report to David & Lucille Packard Foundation *Religious Health Networks Survey Report.*

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, (PCUSA) Polling of Christian Health Associations in southern and eastern 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 a 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.

The World Bank has inventoried religious health assets in several countries. The World Bank staff managing projects in many other countries will likely have, or could obtain, data on religious health assets.

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

Samaritan's Purse has inventoried Christian AIDS activities (may have a couple thousand entries by now). Contact: Barry Hall, Bhall@samaritan.org. They also have an extensive database of individuals involved in AIDS, about 1700 in developing countries.

Christian Connections for International Health has a 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@difiaem.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.rog.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, templebrown@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,* R. K. Asante, 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 Counseling Ministries headquartered in Jamaica. Chairman Tony Allen, tonlit@kasnet.com,

Compiled by Ray Martin, CCIH, April 27, 2002

V.

THE CONTRIBUTION OF RELIGIOUS INSTITUTIONS TO 20TH CENTURY PROGRESS IN INTERNATIONAL HEALTH

By Ray Martin, Christian Connections for International Health

Presentation at APHA conference Session #2049, "The Multi-nature of Contributions to International Health Work," November 9, 1999, 8:30 – 10:00 am, Sheraton Ontario room

Care of the sick has been a traditional undertaking of religious institutions and people of faith. The word "heal" appears 66 times in the four New Testament gospels. Most religious traditions, e.g. Christian, Muslim, Jewish, Buddhist, Hindu, African, are concerned with the sick. I will focus mostly on Christian because of the extraordinary influence of Christian churches and missions on 20th century developments in international health.

Recently, WHO, in its official definition of health, added the word "spiritual". It now reads: Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity. It was largely the influences of churches that brought this change.

Another related intriguing subject, but not the focus of this presentation, is the relationship between faith and membership in faith community and health and healing. For research on impact of faith/prayer on health and healing, do a search on "religion" at the website http://www.heartmath.org/. Also see the webpage of the National Institute for Healthcare Research at http://www.nihr.org/resrouces/books.html.

COMMON FEATURES OF FAITH COMMUNITY INVOLVEMENT IN HEALTH

- COVERAGE – reaching rural village, urban slums, refugees, i.e. most underserved
- SUSTAINABILITY – faith communities have local roots and management and are often linked to global religious networks
- HISTORY AND CREDIBILITY IN HEALTH – tradition of compassionate care of suffering, pioneering in community and institutional health programs, and reputation for quality of services and integrity in management
- HOLSIM – focusing on every aspect of human life (physical, mental, spiritual and social), addressing human concerns that transcend scientific medicine and public health. Tie in found between medico-pastoral approach to healing and psychoneuroimmunology.
- ETHICS, JUISTICE ANDADVOCACY – addressing core values derived from beliefs rather than empirical inquiry

STORY OF 20TH CENTURY EVOLUTION OF INTERNATIONAL HEALTH AND ROLE OF CHURCHES, INCLUDING THE CHRISTIAN MEDICAL COMMISSION OF THE WORLD COUNCIL OF CHURCHES

- establishment of mission hospitals in early 1900s
- 40% of hospital beds were church/mission in Africa; 20% in Asia
- international conference in Tubingen in early 1960s noted limited impact of hospitals
- mid-1960s conference ion healing role of Christian community resulted in Christian Medical Commission
- national coordinating commissions formed by Christian groups
- various projects, many church-based, conceptualized primary health care in 1960s and 1970s
- close relationship, geographic and philosophical, between CMC and WHO
- WHO/UNICEF study in 1974 led by Newell with all three examples of community health innovations (Guatemala, Jamkhed, Java) church programs
- adoption of health for all through primary health care approach in 1977