CONCEPT PAPER

CHAMC
CHRISTIAN HEALTH ASSET MAPPING CONSORTIUM

MAPPING FAITH-BASED PUBLIC-PRIVATE PARTNERSHIPS WITH NATIONAL MINISTRIES OF HEALTH

Context, Gaps, & Strategies

Developed by Christian Connections for International Health and the Christian Health Asset Mapping Consortium

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Summary

Private, nonprofit, faith-based organizations (FBOs) provide a substantial share of health services in local and national health systems. Many governments engage in **public-private partnerships** (PPPs) with these actors to maintain or expand services for populations. Lags and gaps in data about PPPs contribute to misunderstandings about the scope and scale of these initiatives. Better data will reduce confusion and facilitate inclusive "whole of society" planning for responsive and accountable health systems.

Decades of research point to how PPPs are developed in accordance with the local, complex health system and markets and how certain features predict their likelihood of success. Governments form PPPs with corporate partners and local nonprofit organizations. However, there are important gaps in understanding what PPPs with FBOs provide, how they are structured, and what strategies are in place to improve their success.

Data collection and classification improvements would help accurately represent the "total" health system by including better information on PPPs, especially local, nonprofit faith-based actors. This paper provides a framework to **help private actors, governments, stakeholders, and donors understand and improve upon these PPPs** for better health system performance.

Introduction

Rapid changes in the world mean that decision-makers must understand and leverage all available resources to meet compounding challenges in health. Sudden onset emergencies, pandemics, effects of climate change, population migrations, and changes in disease patterns require national and global leaders to rethink key health strategies. The advent of universal health coverage and predicted declines in development assistance underscore the urgency of meeting care needs among the most underserved people. Private actors are long considered a source of innovation and inspiration in the design and delivery of services. New alliances and networks are forming to leverage resources. Private initiatives become potent partners for public resources.

Faith-based health services are widely known and well-regarded partners, accounting for many health services in many countries, including high-income and low- and middle-income countries (LMIC). According to one recent account, in 17 countries in Sub-Saharan Africa, **over 8,000 health assets are specifically Christian "owned."**[1] These include nonprofit hospitals, health centers, clinics, community health, health worker training, and drug supply organizations.

Private, faith-based actors provide intangible benefits. They are trusted partners due to their longevity in communities and are often focused on reaching "the last mile."

They are integral to emergency or pandemic response and sources of innovation. Because they tend to focus on whole-person care, they will engage chaplains and provide health volunteers for those in need.

Photo: Helping Children Worldwide

[1] Christian Health Asset Mapping Consortium (2023). Summary Data Report from 22 Christian Health Networks in Sub-Saharan Africa. **https://www.ccih.org/wp-content/uploads/2024/01/2024_SSA_Data_Summary.pdf.**

Private nonprofits, including faith-based organizations, are part of the complex local health systems but sometimes are excluded from government planning or underinvested compared to their actual contribution to health. For this reason, a new framework is needed that recognizes the complexity of health systems and **promotes "whole of society" health system planning.** Public Private Partnerships in health services are mechanisms by which governments can meet the population's needs and leverage non-government organizations, infrastructure, networks, and professionals. There is, however, inconsistent information and sometimes a poor understanding of the role of PPPs among governments and donors. This may be affected by assumptions about the health system or poor data on services.

Poor understanding by governments and donors is compounded when faith actors need to communicate more effectively about the scope, scale, and impact of their services. A church leader who advocates for funds or supplies for their health unit may not describe their work in the context of how those services fill important gaps in services experienced by local populations. They also need tools to explain their services, how far those services reach underserved populations, and how they contribute to better outcomes.

Here is an example of a problem based on an accumulation of experience and evidence rather than one instance in one country. A faith-based health center that can manage labor and delivery, including cesarean section deliveries, saves lives for mothers and children. If government planners outfit lower-level health centers to refer mothers to a government hospital much farther away, mothers may have to travel a considerable distance, even passing by the faith-based center, to obtain necessary services. In a related scenario, the government may refer patients to the health center but may have yet to invest in the facility or improve supplies or training. In either case, the local authorities may understand the capacity of the local health center. Still, the Ministry of Health may lack data on the capacity of that center, and global partners may need more information about them to include them in resource allocations.

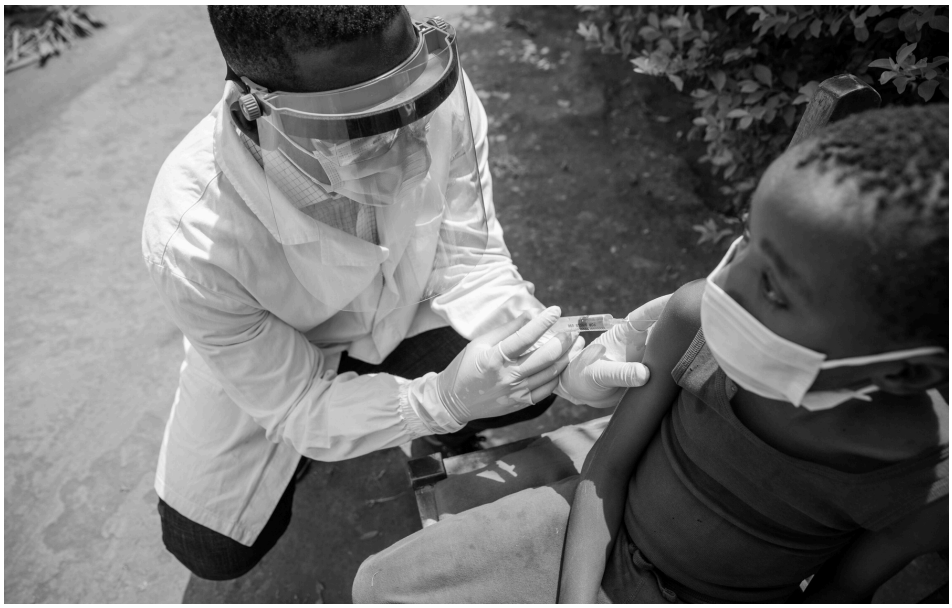
Objective and Scope

This paper provides a framework to better understand PPPs with private not-for-profit (PNFP) actors as part of the "whole of society." It proposes a **roadmap** for better data collection and dissemination that will support health system strengthening and pandemic prevention, preparedness, and response, as well as utilization of data policy and planning.

This paper should be used by:

- **Private nonprofit faith actors** who set the context of their work in terms of partnerships with governments
- **Pandemic response planners** and other health system planners concerned with understanding the contribution of the "whole of society" to health system success and accountability
- **Global donors and partners** seeking to catalyze changes in health services, which are necessary to reduce disparities in access to quality health services and improve the population's health.
- **National Ministries of Health** and their advisors who chart efficient strategies to care for their population.

This paper considers PPPs with nonprofit, faith-based health services. In some locations with a theocratic government, the government and religious structures may be one and the same. In those cases, faith-based services are, therefore, part of the public sector. That is an area for further research into the nature and delivery of services and is not part of the PPP framework considered here.



Background

For the sake of this paper, PPPs are defined as collaborative arrangements between government entities and private sector entities aimed at financing, designing, implementing, and operating projects and services that the public sector may traditionally provide. These partnerships leverage the strengths and resources of both sectors to achieve better outcomes than either could independently.

Key characteristics of PPPs include:

1. **Shared Investment:** Both the public and private sectors contribute resources—financial, technical, or operational—to the project.
2. **Risk Sharing:** Risks associated with the project, such as financial, construction, operational, and market risks, are distributed between the partners based on their ability to manage them.
3. **Long-term Relationship:** PPPs typically involve long-term contracts, often spanning many years, that outline each partner's roles, responsibilities, and expectations.
4. **Performance-based:** Payments to the private partner are often linked to performance targets, ensuring accountability and efficiency.
5. **Innovation:** The private sector can introduce innovative solutions and efficiencies due to its competitive nature and expertise.

PPPs are commonly used in infrastructure (roads, bridges, airports), healthcare, education, and utilities (water supply, waste management). They can help address public funding gaps, enhance service quality, and accelerate project completion.

Photo: Churches Health Association of Zambia (CHAZ)

Public-Private Partnerships in Health

Why do PPPs exist in health care? Governments sometimes lack sufficient facilities or staff to meet the total population's needs, so they extend services in partnerships. It may be inefficient for the government to operate its own service if a private service already exists, such as a highly specialized service center for women with fistulas or a remote hospital in a geographic area requiring only one facility. In such cases, a PPP could "de-risk" the government by sharing the financial risk and operational burden with private actors who can leverage other resources. There may be other reasons governments do not need or want to offer services and prefer to work with private actors.

Global health PPPs are widely documented to address the government's financial limitations by leveraging private sector investment and other resources; however, some struggle with implementation. There is no specific definition of PPPs, though they have served as mechanisms to address financial gaps in healthcare delivery and opened markets to private sector activity.[2] PPPs are now accepted as a promising way of **generating new opportunities** to leverage financial, human, and technological resources that will not be available if the government goes it alone.[3] A review of 61 studies of PPP found that their challenges came during start-up and implementation—usually related to education, management, human resources, financial resources, information, and technology systems.[4]

COVID-19 spurred interest in how global PPPs can leverage private investment in vaccine development while local PPPs offer ways to improve access to health services, especially given their scope and scale. COVAX, the vaccine pillar of the Access to COVID-19 Tools Accelerator (ACT-A), is seen as a "super-PPP" due to its scope of financing and global reach.[5] Some large PPPs (e.g., CEPI, GAVI, and the Global Fund) seem to benefit from their own rising level of authority and agency,[6] leading some to call for increasing transparency and any effects of this on, for example, disincentives for cooperative research.[7]

Over the past decade, the International Finance Corporation, the World Economic Forum, and the US National Academies of Sciences convened forums or conferences to review and advise on PPPs for health in LMIC contexts. Each identifies implications and recommendations that especially apply to corporate partnerships but are also important for the nonprofit and faith-based sectors.

[2]Babacan, H. (2021). Public–Private Partnerships for Global Health. In: Kickbusch, I., Ganten, D., Moeti, M. (eds) Handbook of Global Health. Springer, Cham. **https://doi.org/10.1007/978-3-030-45009-0_117.**

[3]Martina and Halachmi, 2012. Public Administration Quarterly, Vol. 36, No. 2 (SUMMER 2012), pp. 189-237. Sage Publications. **https://www.jstor.org/stable/41506769.**

[4]Joudyian, N., Doshmangir, L., Mahdavi, M. et al. Public-private partnerships in primary health care: a scoping review. BMC Health Serv Res 21, 4 (2021). **https://doi.org/10.1186/s12913-020-05979-9.**

[5]Storeng KT, de Bengy Puyvallée A, Stein F. COVAX and the rise of the 'super public private partnership' for global health. Glob Public Health. 2023 Jan;18(1):1987502. **https://doi.org/10.1080/17441692.2021.1987502.**

[6]Antoine de Bengy Puyvallée, The rising authority and agency of public–private partnerships in global health governance, Policy and Society, Volume 43, Issue 1, January 2024, Pages 25–40. **https://doi.org/10.1093/polsoc/puad032.**

[7]Nunes C, McKee M, Howard N. The role of global health partnerships in vaccine equity: A scoping review. PLOS Glob Public Health. 2024 Feb 22;4(2):e0002834. **https://doi.org/10.1371/journal.pgph.0002834.**

The International Finance Corporation[8] sees PPPs as a strategy to assist emerging markets where governments are pressured to expand health services and coverage due to aging populations and the growing burden of chronic and non-communicable diseases. "Governments have turned to PPP models to improve the operation of health services, leverage private investment, formalize arrangements with nonprofit partners, access managerial resources and health expertise, and generally identify new ways of operating" (page 2). PPPs include contracted services, health infrastructure, or combinations. They note that the scope of public and private actors must be clearly defined.

The National Academies of Sciences, Engineering, and Medicine convened several panels over a seven-year **Forum on Public-Private Partnerships for Global Health and Safety**, reflecting the growing role of private sector contributions in global health initiatives.

- One panel[9] drew from the COVID-19 experience to outline the implications of PPPs for global health security, with one contributor summarizing lessons learned this way: 1) the need to plan now, not when the next crisis hits, 2) investing in multisectoral responses, 3) working with communities to bridge the gap from plan to action, 3) prioritize timely and effective collaboration, and 4) invest in transparency, governance, and accountability mechanisms.
- A second panel[10] considered "enabling environments" for PPPs, concluding that the private sector actors must be "established" in the region and that public sector leaders prepare to accept private sector collaborations to support and advance the public good. A PPP must include an arrangement between public- and private-sector entities, provision of services by a private partner for public health benefit, private partner investment in or management of public assets, and definitions of the time period, risk sharing, and quality and performance standards.
- A third panel[11] focused on PPPs for urban health contexts, highlighting that PPPs depend on the *"government's ability and willingness to work with civil society and the private sector."* (quotes from page 87)

The World Economic Forum issued a White Paper in 2021 that outlines best practices for PPPs for health access. These practices span six categories: identifying the problem and stakeholders, navigating joint governance, aligning vested interests, financing arrangements, engaging the public as a partner, and going to scale.

Faith-based partnerships are often expansive and long-serving within local health systems, even if the nature of partnerships, populations, and risks are new.

[8]International Finance Corporation (2019). Public-Private Partnerships for Emerging Market Health: A briefing paper from the IFC public-private partnership (PPP) think tank discussion at the 2019 global private health care conference). **https://www.ifc.org/en/insights-reports/2019/eiu-briefing-paper-ppps**

[9]National Academies of Sciences, Engineering, and Medicine. 2020. Public Private Partnership Responses to COVID-19 and Future Pandemics: Proceedings of a Workshop—in Brief. Washington, DC: The National Academies Press. **https://doi.org/10.17226/25999.**

[10]National Academies of Sciences, Engineering, and Medicine. 2020. Public–Private Partnerships for Global Health at the National, Municipal, and Community Levels: Proceedings of a Workshop—in Brief. Washington, DC: The National Academies Press. **https://doi.org/10.17226/25904.**

[11]National Academies of Sciences, Engineering, and Medicine. 2020. Health-Focused Public–Private Partnerships in the Urban Context: Proceedings of a Workshop. Washington, DC: The National Academies Press. **https://doi.org/10.17226/25790.**

Faith-Based PPPs in Global Health

Studies and commentaries about strengthening relationships between the public sector and faith-based groups have existed for decades. A seminal document in 1998 on the sustainability of faith-based hospitals in 12 countries included this recommendation: that government policies be "conducive toward private providers" - and specifically, governments could strengthen "their own coverage by making provision for selected para-public institutions such as church hospitals into the national health network while leaving the churches free to make their own capital development and administrative policies."[12]

A well-regarded Lancet series from 2015 framed the modern conversation about the role of faith actors in global health development. It highlighted their contribution to health systems and outlined ways to ensure that the FBO sector meets public needs. In a framing article for the series,[13] authors concluded that multisectoral development approaches favor strong partnerships between the public sector and faith-based groups; that ideological challenges present barriers to collaboration and need careful negotiation on both sides; faith-based groups' potent influence on health-related behaviors might contribute substantially to health outcomes and could be scaled up to national or regional population level, and models of collaboration between the public sector and faith-based groups exist that could be adapted for sustainable engagement. They highlight five areas of activity to **strengthen cross-sector partnerships:**

1. Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups' work in healthcare
2. Appreciate respective objectives, capacities, differences, and limitations
3. Increase investments in faith-based groups and use an efficient business style
4. Exchange and build core competencies in health and faith in both secular and faith-based groups and inspire innovation and courageous leadership
5. Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine the effectiveness of faith-based groups' work in health

Recent studies highlight the conditions and contributions of faith actors to public sector agendas. One study in Papua New Guinea concluded that collaboration through PPP was accelerated by strong interpersonal relationships, nurtured through partner investment of time and effort, and encouraged by formal governance structures. Changes such as a partner's planned exit disrupted collaboration.[14]

[12]Rexford Kofi Odur Asane. 1998. Sustainabilty of church hospitals in developing countries: a search for criteria for success. Geneva: World Council of Churches. ISBN 2-8254-1258-6 (out of print).

[13]Strengthening of partnerships between the public sector and faith-based groups. Jean F Duff, Warren W. Buckingham (2015). Lancet 2015; 386: 1786–94. Published Online July 7, 2015, **http://dx.doi.org/10.1016/S0140-6736(15)60250-1**

[14]Collaboration in a Partnership for Primary Health Care: A Case Study From Papua New Guinea
Georgina Dove, Angela Kelly-Hanku, Jethro Usurup, Annmaree O'Keeffe, Geoff Scahill and Adam Craig
Global Health: Science and Practice February 2024, 12(1):e2300040; **https://doi.org/10.9745/GHSP-D-23-00040**

Another study in Nepal[15] identified that the public sector benefits from PPP innovations - especially when there is a clear vision and model for the PPP; federalism, role, and readiness of the government; reasonable cost of operation; leadership; trust between the partners built on the impact; and organizational and personal values of the people involved in the process. Certainly, the experience of Ghana's health insurance system is a success of the partnership with the Christian Health Association of Ghana.[16]

The nature of faith actors may change as a result of PPPs. Sundqvist (2017)[17] documented the role of religious agents in development through the prism of contractual partnerships between church organizations and the Tanzanian state in healthcare delivery, concluding that "By entering into PPP health agreements, church organizations have moved to center stage and gained more influence following the latest political and economic reforms. Their attraction as service providers follows from their existing infrastructure and previous experience and capacity in the health sector. The analysis shows that faith is a key motivator and a central factor in the running of church health services." Changes in the financial strength of faith actors could affect their continued independence.

Current Status of Data on Faith-Based PPPs

Better data and information will improve faith-based and government partnerships. A landmark work in the 2015 Lancet series[18] recommended that improved information is needed at all levels for better partnerships and for health systems to be strengthened by aligning faith-based health providers with national systems and priorities. Comparisons of basic factors (such as magnitude, reach to poor people, cost to patients, modes of financing, and satisfaction of patients with the services received) within faith-based health providers and national systems show some differences.

Two recent analyses completed in 2023, taken side by side, provide a cautionary tale about relying on available data systems. Data from 22 Christian Health Association Networks in 17 Sub-Saharan Africa gathered in 2023 identified 7,778 inpatient and outpatient facilities.[1] In contrast, an analysis in 2023[19] of the WHO's 2019 Master Facility List compiled from 50 African countries (over 98,000 facilities) found only 3,680 FBO-owned facilities in 22 countries. According to this data, there were none in 28 countries, including Uganda, Cameroon, and Liberia, where FBO-owned health facilities are widely known. This is not because they do not exist but because the data collection and reporting do not consistently gather faith-ownership data. Some facilities may be missing entirely, while others may not be classified as FBO-owned in their source data.

[15]SP Kalauneee (2022). Public Private Partnerships and adoption of innovation: A case study of Charikot Hospital in Nepal. Eastern University.

[16]Yeboah and Buckle. (2017). The evolving partnership between the Government of Ghana and national faith-based health providers: leadership perspective and experiences from the Christian Health Association of Ghana. Development in Practice, Volume 27, 2017 - Issue 5: Special Issue: Faith and health in development contexts. **https://doi.org/10.1080/09614524.2017.1332163**

[17]Sundqvist, J. 2017. Beyond an instrumental approach to religion and development. Challenges for church-based healthcare in Tanzania. Studies in Religion and Society 16. 307 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-513-0100-6.

[18]Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. Jill Olivier, Clarence Tsimpo, Regina Gemignani et al., Published:July 06, 2015 DOI: **https://doi.org/10.1016/S0140-6736(15)60251-3**

[19]How strengthening data on faith-owned health facilities supports health systems. An analysis of the World Health Organization's 2019 Sub-Saharan Africa Helath Facility Dataset by the Christian Healht Asset Mapping Consortium. (2023). Accessed at **https://www.ccih.org/wp-content/uploads/2024/01/2024-_WHO_Analysis_June_Update.pdf**

The advent of electronic health records and Health Management Information Systems (including the robust global DHIS2 system) should help collect and report data. However, that works only when the descriptive inputs into that data are accurate. Better descriptive data is not available for various reasons. Analyses of the above literature led to the following challenges, resulting in inaccurate data on private, faith-based data in national systems.

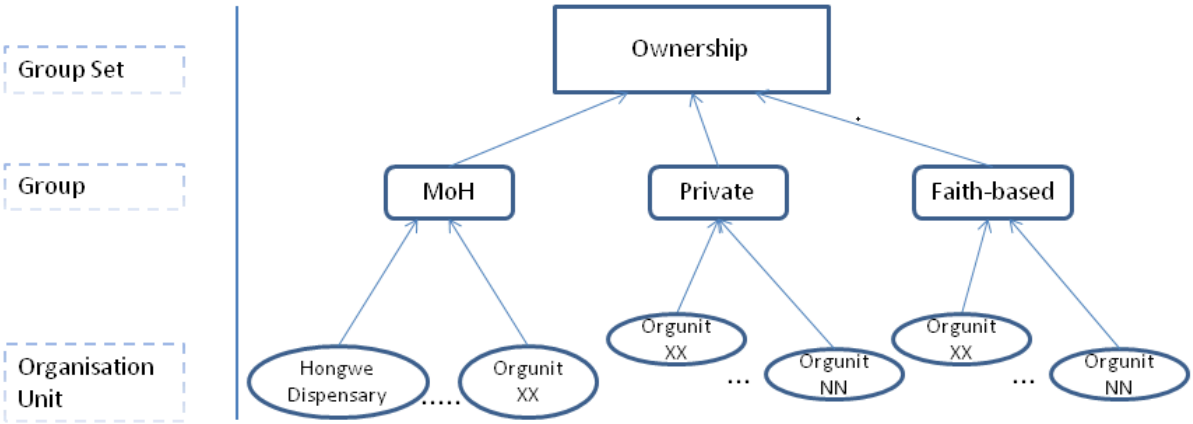
- There is no single data repository or registry that consistently represents faith partners.
- Government lists sometimes include or exclude FBOs; in either case, they may not reflect the complexity of PPPs - FBOs may 'roll up' in public data if they receive any public resources or under a broader label of "nonprofit" providers.
- Some data sources focus on populations (e.g., mapping services for HIV care).
- "Ownership" is itself complex. A religious group may own land or a facility on that land; the staff may be government employees or staff of the religious organization; the government may fund the majority of services even if the rest of the organization is "faith-owned." Or, the government may contract with a faith-based organization to operate a public-owned facility.

Precise data on FBOs and their degree of coordination with government will help ensure that planning is well done, misinformation is reduced, and resources are deployed appropriately, both generally and in times of health emergencies. The DHIS2 system (District Health Information System, version 2) is the default data architecture for capturing and reporting health service utilization in over 70 countries. This system articulates clearly that care should be taken to reflect private actors, especially nonprofit and faith-based organizations. An excerpt from the DHIS2 guidance is provided in the exhibit below.

DHIS2 Implementation Guide: Organization Units[20]

Organization Unit Hierarchy Design

The process of designing a sensible organization unit hierarchy has many aspects. Include all reporting health facilities: All health facilities that contribute to the national data collection should be included in the system. Facilities of all kinds of ownership should be incorporated, including private, public, NGO, and faith-oriented facilities. Often, private facilities constitute half of the total number of facilities in a country and have policies for data reporting imposed on them, which means that incorporating data from such facilities is necessary to get realistic, national aggregate figures.



[20]DHIS2 Implementation Guide. Accessed on 8 April 2024 at **https://docs.dhis2.org/en/full/implement/dhis2-implementation-guide.html**. Section quoted: **https://docs.dhis2.org/en/full/implement/dhis2-implementation-guide.html#organisation-units**.

Understanding the Faith-Based PPPs

Despite limitations, these studies and proceedings highlight relevant experience for helping governments plan to expand services for underserved populations or to extend economically efficient options to government-delivered health promotion and care. The limitations of these are that most commercially-driven PPPs are independently or privately financed, include new resources or actors in the health system, and could be limited to narrowly scoped products (e.g., a vaccine, a screening tool, or a new medication).

One way to summarize PPPs is to consider the "transactional," what the private sector offers and needs, and what governments offer and need.

A Transactional View of Public-Private Partnerships

	Private Nonprofit (Faith-Based) Actors (health networks, facilities, programs, supply chain partners)	**Public Sector Actors** (MOH and lower-level government offices)
Offer in Partnerships	• Access to owned facilities • Access to projects • Access to staff • Access to medical and commodity procurement and distribution networks • Access to underserved communities • Specialized treatments, medicines, or models	• Access to owned facilities • Access to projects • Access to staff • Access to medical and commodity procurement and distribution networks • Licensing
Seek in Partnerships to Obtain:	• Funding or cost recovery • Participation in government insurance programs • Access to medicines or commodities not otherwise available • License	• Special project funding from partners • Staffing and operation of health facilities, programs • Access to communities
Other Considerations	• Reputation (occasionally deserved) for doing things without coordinating with government partners, e.g., bringing foreign workers or working from a theological position that limits their ability to deliver public health services • Faith actors are committed to access for those "at the last mile" • Faith actors are committed to holistic care	

PPP allows funding on both sides to leverage the other's resources; it allows faith-based funders an opportunity to leverage government resources and vice versa. This leverage allows additional equipment purchase and infrastructure construction. These new assets funded by faith-based organizations also leverage staffing when they include coverage of staff costs for types of health workers prioritized by the government.

Describing Faith-Based Public and Private Partnerships

Good data about PPPs **improve "whole of society" planning** and are necessary for the initiatives' success. Data on PPPs should follow a common framework to support planning over time and comparisons across contexts or countries. Basic descriptive data on PPPs should clarify the types of services they cover, their scope (and reach), and the partnership mechanisms (e.g., how and why).

Following is a framework that will help classify and describe PPPs with faith-based actors in two phases: 1) ensuring an accurate health master facility record at the national level and 2) describing the PPP mechanisms, scope, and types of health assets included.

Creating an Accurate and Accessible List of Health Assets

Countries need an accurate and accessible list of all health assets with health facilities and other health assets.

Facilities: A Health Master Facility List (HMFL) that includes all facilities, including the name, type, and location of each facility in a list. This list must include public-owned and all private, nonprofit (and faith-based) facilities.

A clear plan for collecting and reporting data on these facilities would help in the analysis. For example, data in country DHIS2 instances or other electronic medical records would allow identification of all facilities in the HMFL.

Other Health Assets: Country-level Health Facility Master Lists sometimes include only licensed inpatient and outpatient health facilities. However, other types of health assets could include community-based services, health worker training programs, and supply chain organizations.

A comprehensive list of **Health Assets** would, therefore, include the following types:

1. **Inpatient care** (rural, district, tertiary, and referral hospitals)
2. **Outpatient care** (Health centers, clinics, or outposts)
3. **Community-based services** (health care and prevention services)
4. **Health Worker Training Institutions** (through private universities or colleges)
5. **Supply chain** (drug supply organizations)

Profiling Health Service Public Private Partnerships

With a clear and complete list of health assets, a profile of the mechanisms and scope of Public Private Partnerships will clarify the unique value and contribution of different partnerships for overall health systems.

Mechanisms of Partnerships. Public/Private Partnerships take on any of the following forms:

1. **Training:** Governments sometimes train health workers in private organizations.
2. **Funding:** Government funds, either prospective grants or reimbursements for services.
3. **Procurement:** Governments supply private entities with commodities or support services (e.g., access to lab testing).
4. **Staffing:** Governments may directly place health workers or subsidize them.
5. **Designation:** Governments may recognize that a private organization operates where no other government services exist and designate it as a de facto public resource for that geographic area.
6. **Inclusion in planning:** Governments include private organizations in counts of health services and incorporate them in health sector planning.

Scope of Services Covered. The scope of services covered in a partnership may be general or specific and include:

1. **General** health services and/or general population
2. Specific **geographic** coverage
3. Specific **populations** of interest (e.g., women/children, Indigenous people, key populations)
4. Specific **conditions** of interest (e.g., HIV/AIDS, non-communicable or neglected tropical diseases)
5. Specialized **services** (e.g., advanced testing, care for people with disabilities, cancer care)

A good starting point would be to list all the existing PPPs and simply check the characteristics that apply. A basic data inventory at the national level would help illustrate gaps in knowledge.

The following table could also be used to assemble data across PPPs.

Data Available on Faith-Based Public-Private Partnerships

	Inpatient	Outpatient	Community-Based	Health Worker Training	Suppliers
Mechanism					
Funding					
Procurement					
Staffing					
Designation					
Planning					
Scope					
General					
Geographic					
Populations					
Conditions					
Services					

Conclusion and Recommendations

Expanding information on PPPs would help ensure that information is available to strengthen health and community systems and plan for pandemics and other health emergencies. Faith-based health services are essential to achieving Universal Health Coverage and the Sustainable Development Goals.

Several audiences would benefit from better information about the scope, scale, and location of faith-based health assets.

1. **Public sector funders/decision-makers:** may prefer to fund government programs.
2. **Corporate or other organizations:** may need support to understand FBO scope, scale, and location or how to partner.
3. **Multilaterals (e.g., WB, WHO):** assume they are integrated with local government initiatives.
4. **Religious institutions and FBOs:** strengthen ways to demonstrate the benefits of their services to national health systems.
5. **Researchers:** seek data about access, cost, and quality of services.
6. **Journalists:** seek information about the use of policies and funding, need better context.
7. **NGOs:** seek to design and implement system-level improvements.

Specific recommendations for this work include:

1. Seek agreement on creating a common framework in data systems of faith-based partnerships and test this framework with case studies in two to three settings. Ask the WHO to convene these through the regional offices.
2. Pay attention to gaps or confusion in the framework and rectify this in version 2.0.
3. Discuss with DHIS2 system experts to see how improved codes can be integrated.
4. Use the data from this framework to analyze resource flows through PPPs, especially including training, research partnerships, and funding for vital services or highly underserved populations.
5. Use results in this data to analyze faith-based partnerships for priorities to strengthen quality, access, and equitable services.

Successful pandemic planning and strengthening of the general health system depend on the ability of planners to direct resources with precision to fill gaps in health service delivery systems. This data framework for Public-Private Partnerships with nonprofit, faith-based organizations is **one vital step forward**.

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This paper was developed by **Christian Connections for International Health (CCIH)** and the **Christian Health Asset Mapping Consortium (CHAMC)**.

CHAMC is an association of organizations addressing the urgent need for quality data and information on the Christian health asset landscape across the globe.

The mission of the CHAMC is to **increase resources, learning, and partnerships in faith-based health services** by improving understanding of the nature, scope, and location of those services.

Founding Members of CHAMC include the Africa Christian Health Associations Platform (ACHAP), the Catholic Health Association (CHAUSA), Christian Connections for International Health (CCIH), the International Christian Medical and Dental Association (ICMDA), The Dalton Foundation, and the World Council of Churches (WCC).

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