

Building From Common Foundations

The World Health Organization and
Faith-Based Organizations in Primary Healthcare



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Cover photograph

A program run by Addis Kidan Baptist Church provides safe and effective care to Ethiopians infected or affected by HIV.

Photographer: Ross McDermott

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The World Health Organization and Faith-Based Organizations in Primary Healthcare

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Executive Summary

The World Health Organization (WHO) worked with faith-based organizations (FBOs) in preparing for the Alma-Ata Declaration of 1978. Together they gained a clearer picture of healthcare in the developing world, and then established the concept of primary healthcare. This report is intended to assist in the process of rejuvenating dialogue and partnership with FBOs in the face of widespread health challenges in communities around the world, not least of which is HIV/AIDS. The revival of the primary healthcare model within WHO underscores that if this framework is to be promoted as a more sustainable system of health servicing and delivery, then the inclusion of FBOs will add greater potential for breadth and effectiveness.

Key findings

- FBOs are major health providers in developing countries, providing an average of about 40 percent of services in sub-Saharan Africa. Despite being closely aligned with community needs, FBOs often go unrecognized because they usually operate outside government planning processes.
- FBOs' core values lead them to offer compassionate care to people in need. Commitment to individual dignity and worth is consistent with best practices in providing decent care. Engaging with FBOs entails challenges, but with careful alignment, much can be gained from partnership.
- Evidence from studies of FBO responses to HIV/AIDS demonstrates that they have delivered a range of treatment, care and prevention activities in accordance with WHO strategic priorities and primary healthcare principles.
- With attention to accountability and monitoring, governments can work with FBOs on the basis that such partnerships will deliver public value and narrow gaps in national health planning systems.
- Local interest in participative planning is strong, according to exercises in community mapping. Engineering a network of FBO and other community assets could open new possibilities for comprehensive health systems.

Key observations:

- In partnership with FBOs, WHO can develop the concept of primary healthcare to provide guidance for the engagement of religious health assets..
- WHO can engage in dialogue with faith institutions to consider the interplay between their respective values of compassion and decent care, and to ascertain the relative roles and contributions of FBOs in developing healthcare systems.
- WHO can encourage national governments to consider public values created by FBOs and engage FBOs when developing national health plans.
- WHO has an opportunity to spearhead pilot programs of health system re-engineering so potentially successful models can be evaluated for widespread adoption.
- WHO can promote interaction among FBOs, governments and donors to forge constructive relationships and advocate for inclusion of civil society actors in the contexts of broader health policy, global health partnerships and financing mechanisms.
- WHO can develop relationships with faith-based development agencies (FBDAs) to identify roles that will allow them to facilitate development of religious entities in health systems.
- As a matter of urgency, FBOs and FBDAs (as part of broader civil society) and their national umbrella organizations (such as CHAs) could be supported in developing proposals on behalf of member agencies to:
 - Submit to financing mechanisms such as GFATM
 - Ensure on a broader scale the recruitment and retention of staff to support accelerated scale-up of primary healthcare and HIV/AIDS prevention, treatment and care
- Monitoring and accountability frameworks that are fit for purpose for use with a variety of FBOs could be developed by WHO and its Member States.

Introduction

“An integrated primary healthcare approach is the cornerstone of effective health systems,” WHO Director-General Dr. Margaret Chan said in 2007, as part of WHO’s renewed focus on primary healthcare. “Although the world is changing rapidly, the challenges currently facing governments as they strive to provide equitable access to effective health services are similar to those faced three decades ago – the Alma-Ata principles of primary healthcare are just as relevant now as they were at that time. Sustainable health systems require measures to address equitable access to services, retention of motivated health workers, and affordable health financing options.”⁽¹⁾

Intrinsic to a reinvigorated primary healthcare concept are strategic partnerships for health that reflect significant shifts since 1978 in global health systems, including the number, size and mandates of new stakeholders working in health. Strengthening relationships with civil society organizations, including FBOs and private sector actors, is particularly important. This will improve alignment of vision, goals and strategies in the health sector and its partnerships, as well as provide the extended reach needed to access grass-roots communities. Renewed emphasis on national health systems strengthening and achieving the United Nations’ Millennium Development Goals (MDGs) presents opportunities to consider how best to link the public sector and civil society, including FBOs, to ensure increased coverage and access to health services.

In 2007, WHO reviewed experiences and literature on the performance of FBOs in healthcare related to HIV/AIDS and to assess if these organizations could be effective in WHO’s strategic partnership framework rejuvenate primary healthcare and boost access to health services. WHO reviewed more than 100 documents (see bibliography in appendix 4). Most documents were studies focusing on HIV/AIDS in sub-Saharan Africa. FBO approaches to health assets in this region show that Christian activities are more extensively documented and analyzed than those of other faiths, resulting in a bias in the findings toward Christian organizations. But the authors of this report encourage WHO to continue reviews to verify if these findings are also relevant to non-Christian FBOs as well. In this report, the authors attempted to ascertain whether their assessments were faith-specific or faith-systemic. In most cases, assessments appear to be valid for any FBO.

This report notes the revival of the primary healthcare and health systems debate within WHO. This report also emphasizes that if WHO wants to encourage this framework as a more sustainable system of health servicing and delivery, including FBOs, although not always easy, is necessary to achieving desired coverage. As the WHO documentation show, FBOs cover about 40 percent of the healthcare and services in Africa alone. But they tend to operate outside governmental planning exercises and are therefore generally unrecognized. This has significant implications for how new initiatives – such as the International Health Partnership and others, as well as funding mechanisms – design, plan and deliver national health programs. Varied assets used by FBOs – physical, human and community support – have great potential for increased value to the benefit of their communities and nations. The report details how engaging with FBOs will bring challenges, but the authors conclude that all parties stand to gain by this new approach. Ultimately, the communities that both WHO and FBOs seek to serve will be better cared for, and chances will improve to achieve the MDGs.

Finally, the report concludes with concrete recommendations addressed to WHO and its country offices on how to better engage with FBOs and encourage their linkage to respective public sector counterparts and planning processes.

Primary healthcare: Mobilizing civil society to meet national health targets

The 1975 introduction of the concept of primary healthcare to the WHO Executive Board was a departure from the organization's previous approaches to developing and strengthening health systems. A global search for evidence for alternative approaches to improving health services was conducted through an alliance with the Christian Medical Commission (CMC) of the World Council of Churches (WCC). Data was collected from countries where innovative health systems approaches were tested through church agencies associated with WCC in partnership with governments and communities. These innovative approaches reflected the refocusing of Christian medical mission on preventive and comprehensive services, with the assessment that curative efforts in more than 1,200 hospitals operated by WCC-associated organizations were not changing basic patterns of preventable disease in the communities where they were located.⁽¹⁾ Evidence collected from these countries reinforced developing momentum in WHO leadership for the case for primary healthcare and enabled support at the 1978 International Conference on Primary Healthcare held in Alma-Ata (now Almaty, Kazakhstan) by nongovernmental organizations (NGOs), including religious communities, concerned with community health.⁽²⁾

The 1978 Alma-Ata declaration outlined essential components of primary healthcare, which were characterized as “essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination.”

The Alma-Ata conference was described as a watershed event.⁽³⁾ Supported by the international donor and NGO communities, many countries adopted the primary healthcare model. Those countries that implemented adequately resourced primary healthcare approaches were able to demonstrate reductions in infant mortality rates,⁽⁴⁾ improvements in immunization coverage levels⁽⁵⁾ and reductions in measles mortality⁽⁶⁾. Some observers, however, have noted the equivocal impact of primary healthcare approaches on the health outcomes of marginalized populations after more than two decades of implementation.⁽⁷⁾

Changes in economic and political views in the 1990s saw a shift from emphasizing primary healthcare to a more private-sector-focused health reform agenda. Principles of primary healthcare, such as community control, participation and multisectoral involvement, were replaced by concepts of user pays, cost recovery, private health insurance and public–private partnerships. Primary healthcare goals of universal access to services were replaced by more rational economic objectives framed around the benefit that improved health could deliver, and stated in terms of improvement of human capital for development.⁽⁸⁾

But in the early 2000s, WHO regional offices,^(9,10,11) learning from the lessons of health sector reform and following the release of the reports of the second consultation of the Commission for Macroeconomics and Health,⁽¹²⁾ began to advocate for a reinvigorated primary healthcare model.

The new approach would bring to primary healthcare the gains delivered by the health sector reform process, including more sustainable financing models, work-force development strategies and a comprehensive, multisectoral approach encompassing civil society (including FBOs) and private sector actors. It was argued that this approach would allow countries to: “address new challenges such as epidemiological and demographic changes, new sociocultural and economic scenarios, emerging infections and/or pandemics, the impacts of globalization on health and the increasing healthcare costs within the particular characteristics of national health systems.”⁽¹⁰⁾

An additional element to the rising popularity of rejuvenated primary healthcare arose from the 2005 evaluation of the implementation of a “three by five” initiative to accelerate the uptake of antiretroviral

therapy for HIV. The evaluation report⁽¹²⁾ noted that the global response to HIV/AIDS was shifting focus, even during the initiative, toward the ambitious goal of universal access to HIV prevention, treatment and care services. The report noted that

“Supporting national governments to get public health approach (PHA) guidelines into practice will become increasingly important.”

for WHO, “supporting national governments to get public health approach (PHA) guidelines into practice will become increasingly important as countries scale up coverage by decentralizing their HIV treatment services (which requires direct support to primary care providers in first-level facilities).”⁽¹²⁾

The report added that “WHO has missed opportunities for expanding both the coverage and quality of HIV-related PHA interventions through the non-state (private) sector in a number of these settings and has not offered technical support to national governments to exercise more effective stewardship over private providers.”⁽¹²⁾

The report strongly recommended that WHO “urgently establish the effectiveness and feasibility of sustaining integrated service delivery approaches as the ‘common platform’ for strengthening primary healthcare services through which a broader public health approach package of essential disease control interventions can also be delivered.”⁽¹²⁾

Although the mention of nongovernment actors in this context appears to be limited to private, for-profit providers, WHO has a clear opportunity to support countries in their engagement with civil society entities, including FBOs, as health service providers in achieving the universal access goal of prevention, treatment and care for people with HIV/AIDS. Attention to nongovernment health sector civil society is necessary when it provides a critically large segment of healthcare in a nation. Given the previous seminal role of the CMC in the initial development of Alma-Ata primary healthcare models, there is a precedent for engaging with multiple FBOs in the articulation of new primary care paradigms. As shown in the next chapter, the current scale of FBOs’ involvement in healthcare in sub-Saharan Africa makes a compelling case that religious entities could become significant players in the new primary healthcare approach to strengthening health systems, especially related to achieving the goal of universal access.

FBOs:

Significant healthcare providers in the developing world

In 2006, WHO commissioned South Africa-based African Religious Health Assets Programme (ARHAP) to conduct an extensive survey in two Southern African countries of FBO healthcare delivery. Considering the range of evidence gathered, the study concluded that the proportion of faith-based health service provision averages about 40 percent in many sub-Saharan African nations. Although details vary,⁽²⁾ evidence for this figure is convincing.

Methodological challenges make it difficult to determine the exact proportion of faith-based healthcare provision. With complex interweaving of ownership and resourcing of FBO health projects, many FBO coordinating bodies lack clarity on assets at their disposal. For example, a recent mapping study on the outreach of the worldwide Anglican Communion⁽³⁾ revealed a lack of coordinating capacity and information systems in central coordinating bodies. Only through field visits can the quantity and nature of Anglican health assets be ascertained. Further, many FBOs are not centrally organized; they are local faith communities responding to local needs.

Another challenge is that FBOs are often outside national ministry of health mainstreams when providing health services, even if they provide substantial proportions of services. One conclusion is that “the general invisibility of religious entities to the public health infrastructure must mean that efforts are not being properly coordinated, that differing local and public health systems are not in alignment, and that resources are thus being misdirected.”⁽¹⁾

FBO health projects are often independently funded and do not in general receive an adequate proportion of public funds distribution.⁽⁴⁾ For equitable and effective distribution of health funding, a notion of partnership is needed so funds can deliver desired outcomes. The general invisibility of FBO health activities is doubly counterproductive: It inhibits effectiveness of governments to mobilize all national resources and assets and dilutes capacity already to fulfill these outcomes, while blocking FBOs from receiving government support. National health plans' strategic aims should take into account the full potential of all health assets at their disposal, including those delivered by civil society agencies, especially FBOs.

There are, however, examples of effective partnerships. Some Christian health associations (CHAs) have negotiated contractual arrangements in countries such as Zambia, where they are responsible to the government for providing an overarching healthcare strategy in some districts where their members' hospitals are the only facilities.⁽⁵⁾ A partnership between Saddleback Church, a megachurch in the United States and a network of 1,000 church leaders in Rwanda is currently rolling out a three-year program to train 2.5 million Rwandans how to combat malaria.⁽⁶⁾

Donors also have engaged FBOs to fulfill strategic objectives. For example, the U.K. Department for International Development (DFID) has a range of relationships with FBOs. It has partnership program agreements with faith-based development agencies such as World Vision, Catholic Agency for Overseas Development (CAFOD) and U.K.-based Islamic Relief. DFID also funded the Anglican Church of Southern Africa to operate an HIV/AIDS education and prevention strategy.⁽⁵⁾

The 40 percent figure related to FBO health services is indicative rather than definitive, though this indication has yet to be challenged. Faith-based organizations can therefore be considered significant health service providers in developing countries. If health systems are to be strengthened, especially with a view to offering universal access to healthcare, many faith-based projects and assets could be used to meet this and other strategic aims of national health plans.



*Margaret Ngandwe seeks treatment at Mansa Hospital.
Photographer: Cate Thornton*

Faith and healthcare connections

One reason FBOs are ignored by some national agencies and intergovernmental organizations appears to go beyond the traditional governmental agency-NGO gap. It is related to the secular nature of most governments and intergovernmental forums that tend to keep their distance from professed religious values, even if their values overlap. But in healthcare, religious entities may have value that outweighs their perceived disadvantages. These added values are composed of:

- Values they convey in terms of a holistic conception of health and healthcare⁽¹⁾
- Quality of their roots in the communities they serve
- Potential for further primary healthcare outreach

Compassion: the universal attribute of faith

Compassion is the primary value underlying major religious systems. This is often summarized in the ethic of reciprocity:⁽²⁾ Do unto others as you would wish them to do unto you. For a person of faith to reflect on how they would feel if they were in a position of another is to elicit the compassion that drives them to act on the other's behalf. Belief in the divine origin of compassion compels believers to offer compassion to others.⁽³⁾

Many complex layers of religious practice and tradition overlie the basic principle of treating others as one would want to be treated, but each recognizes the call toward the care of others as a divine calling. Most religious belief systems underscore the value of the individual, but with an emphasis that he or she has a firm grounding within their community. For instance, foundational to the Jewish faith are the Ten Commandments and the Torah, which express a commitment to a system of social justice that aspires to a harmonious community in which each person is valued. Christians follow Jesus' summary of this law, which further establishes the duty to "love your neighbor as you love yourself." Muslims recognizing Allah as fundamentally compassionate and merciful accept this version of the golden rule. Buddhists seek to alleviate the realities of suffering; to offer help and assistance so they can live out the four sublime states of loving kindness, compassion, sympathetic joy and equanimity. Hinduism has a similar basis in compassion.⁽⁴⁾

Before the establishment of secular health systems in the 1800s, religious communities, motivated by their calling for compassion, offered remedies for sickness and care for suffering people. This was the case in many temples, mosques, monasteries or churches. This continues to express itself today in a range of health activities. Some resemble the ancient practice of refuge and care within a traditional religious community. Others have developed a level of professionalism consistent with modern medicine and include the most advanced medical facilities. The degree of explicit religious intent apparent in these activities varies considerably, but each has been inspired by the religious call to compassion for the sick, and each has its origins in the action of committed religious adherents.

In caring for others, religious communities not only act out of compassion, but also act out of an ethic of decency. This ethic of decency prescribes values and principles about how to treat others in accordance with their humanity and establishes an imperative to abolish conditions that would damage or degrade people's inherent dignity. This ethic demands that care is provided that meets people's individual needs and respects their dignity and self-worth. Out of respect for the individual's dignity and agency,

“Decent care focuses not only on the quality of care, which is crucial, but also carefully considers the input of those receiving care.”

it is imperative that healthcare systems and FBOs in particular provide individuals with decent care (comprehensive or holistic care services that address the individual's medical, physical, mental, social and spiritual well-being) and place

the individual at the center of these services. While this understanding and practice of decent care is not new – it has been a critical component of nursing and provision of care to people in community, hospital, hospice and assisted-living settings – it is critical related to HIV/AIDS. Built on the foundation of the primary healthcare movement, reinforced in Alma-Ata and subscribed to by WHO⁽⁵⁾ decent care includes treatment literacy, patient advocacy and person-centered care. Decent care focuses not only on the quality of care, which is crucial, but also carefully considers the input of those receiving care. In this process, care recipients help define and manage the care they need and receive in collaboration with healthcare providers and those providing supportive services. This is of particular importance in faith communities and FBOs that provide HIV caregiving and support services and in those that because of the enormous losses to HIV/AIDS are just now entering this critical arena. To successfully provide decent care, however, healthcare providers and recipients must overcome the damaging stigma and discrimination often associated with particular behaviors and diagnoses.

Dilemmas in faith-based healthcare

Much attention has been given to the difficulties expressed by FBOs related to HIV spread predominantly through sexual contact. The epidemiological concern for nonjudgmental protection has come into tension with religious values that discourage risky behavior. Moreover, the tension has impacted not only local strategies for distributing condoms, but has also influenced policy debates and strategic actions in the global environment. In an era when debate focuses on the growing influence of fundamentalist religions,⁽⁶⁾ secular public policy institutions are generally cautious, though this was less clear in studies keying on Asia, where there seems to be a greater degree of interdependence between faith and health. Lack of clarity on the degree to which some religious organizations seek power to reshape predominantly liberal societies according to their particular values is of concern to the secular public health policy institutions, as is the perceived proselytizing ambitions of some religious groups.

In general, public institutions cannot harness only the secular elements of faith-based healthcare.⁽⁷⁾ Religious values have deeper and indivisible purposes. They seek to promote a more humane and spiritual environment under the terms of their ethical construct with a service philosophy that encompasses a more holistic set of practices. In addition, religious values suggest a greater range of human assets than might be expressed in a secular economic development model.⁽⁸⁾ In an attempt to fulfill the physical needs of the global population, religious tradition critiques the materialist basis upon which development models are built. FBOs relieve poverty and bring health gains to vulnerable communities, but they also offer less tangible means for self-fulfillment and communal well-being.

The five ways FBOs use or deploy faith, drawn up by G. Clarke in “Faith Matters: Development and the Complex World of Faith-Based Organizations,”⁽⁹⁾ can be used to describe the range of FBO mandates and agendas:

- Peak body representation
- Charitable or developmental work
- Sociopolitical action
- Missionary endeavor
- Radicalized or militant action

Drawing on analyses from other authors,⁽¹⁰⁾ Clark also proposed a four-term gradation in the style of a Likert scale to describe the degree to which faith influences relationships with beneficiaries:

Passive

Faith is subsidiary to broader humanitarian principles as a motivation for action and in mobilizing staff and supporters. Faith plays a secondary role in identifying, helping or working with beneficiaries and partners.

Active

Faith provides an important and explicit motivation for action and in mobilizing staff and supporters. It plays a direct role in identifying, helping or working with beneficiaries and partners, although there is no discrimination against nonbelievers and the organization supports multifaith cooperation.

Persuasive

Faith provides an important and explicit motivation for action and in mobilizing staff and supporters. It plays a significant role in identifying, helping or working with beneficiaries and partners and provides the dominant basis for engagement. It also aims to bring new converts to the faith or to advance the faith at the expense of others.

Exclusive

Faith provides the principal or overriding motivation for action and in mobilizing staff and supporters. It provides the principal or sole consideration in identifying beneficiaries. Social and political engagement is rooted in the faith and is often militant or violent and directed against one or more rival faiths.

Analyses incorporating the different uses of faith and the character of the faith-beneficiary relationship can provide an approach to defining the challenges in working with particular types of FBOs, and for assessing the opportunities to include FBOs in multisectoral health development enterprises and partnerships.

Health, healing and the emergence of primary healthcare

Many religious traditions are characterized by a focus on healing: "A primary focus of religious expectations in the 21st century is the multidimensional longing for healing of body and mind, of soul and spirit, of personal and social relations, of political and ecological dimensions in this broken world."⁽¹¹⁾

ARHAP studies have identified a range of expressions of this approach to healing that characterize the wider values and purposes of religious entities. Their hospitals, clinics, care groups and educational activities encompass this broad notion of healing the individual, community and society. Within this spectrum is a commitment to a holistic approach to primary care.⁽¹²⁾

Some religious leaders may articulate the full range of these aspirations; others may focus on more limited aspects.⁽¹¹⁾ Evidence for wider interest and enthusiasm for holistic primary care is evident in church reports.⁽¹¹⁾ The concept of healing within religious entities is a patchwork of activities ranging from the purely spiritual to scientific biomedical.

It is noteworthy that the CMC, established in 1968 by the WCC, reassessed the theological basis and the manner in which church mission organizations engaged in health-related activities. Based on the outcomes of two related consultations (Tübingen I in May 1964 and Tübingen II in September 1967), CMC deliberations resulted in a reappraisal of the use of church resources for health. That work proved to be a major influence in the development of the primary healthcare model in collaboration with WHO that would later receive global endorsement through the 1978 Alma-Ata conference.

In summary, engagement of secular healthcare authorities with FBOs raises questions of power and influence on individuals and policies. But it also opens the biomedical environment to a more holistic perspective on the nature of people in communities. Religious compassionate and communal values suggest a strong public service mentality. Religious ideas also challenge materialist approaches to health and well-being and offer more holistic perspectives, bringing a qualitative contribution through religious faith for individuals and communities.

HIV/AIDS:

Demonstrating FBOs' flexible and committed response

Over the past 25 years, the HIV/AIDS pandemic has repeatedly underscored the challenges of containing a pandemic, mitigating its effects, preventing new infections and treating people affected by the disease, as well as managing the social aspects of the disease. The complexity of HIV/AIDS as a health issue provides a useful example for challenges confronting health systems strengthening more broadly, as well as the potential role of FBOs.

WHO has developed a policy framework directed at achieving universal access for all to HIV/AIDS prevention, treatment and care.⁽⁷⁾ It details five strategic directions, and within these a number of priority health sector interventions directed toward country development and strengthening of health systems:

- Knowledge of HIV status
- Comprehensive prevention measures
- Accelerated uptake of treatment and care
- Strengthening health systems
- Strategic information management

This is a useful tool for assessing concordance of the activities of FBOs providing HIV-related services with international best practices as defined by WHO. A significant engagement by FBOs can be seen across the five key strategies, including the activities of:

- Local clergy and members of churches, mosques and temples
- Community-based support groups
- Specialized counseling and social networking agencies, clinics and hospitals supported by mission organizations and faith-based development agencies
- Supply logistics agencies
- Country and regional health-related umbrella organizations (such as national CHAs)
- International faith-based development agencies (such as Caritas Internationalis, Islamic Relief, the Salvation Army, Tearfund and World Vision)

In support of a strategy for enabling knowledge of HIV status, studies show widespread involvement of FBOs in the provision of services for HIV counseling and testing.^(2, 3, 4, 5, 6, 7) Organizations are offering pre- and post-test counseling and in many places, full testing services, as well as links to care and treatment programs. This work was enhanced by the wide reach of FBOs in rural and remote areas, and facilitated by the involvement of FBOs and religious leaders in education and awareness raising, promoting openness and reducing stigma surrounding the disease and infected people.

Regarding prevention, in addition to sources already cited,^(3,4, 5, 7) the studies^(8,9) concur that FBOs are actively involved in raising awareness and providing education about HIV and its modes of transmission and working to demystify and destigmatize AIDS. This occurred in places of worship, schools, community centers, social gatherings and outreach work to the most vulnerable groups such as commercial sex workers and homosexual men. “Teaching while preaching” reportedly reached a ready audience and the extensive networks of many FBOs facilitated a wide reach of messages. Some FBOs worked with people living with HIV/AIDS (PLHIV) to deliver their message. Faith in Action by the Global Health Council ⁽²⁾ described this as “becoming missionaries of AIDS.” Others used multimedia approaches.

While prevention remains the most controversial area of involvement for FBOs addressing HIV/AIDS⁽¹⁰⁾ due to the tension between moral teachings and the sexual nature of transmission, the consensus view appears to be that FBOs’ attitudes have been changing as they work in the face of the reality and the extent of the AIDS pandemic, and that openness, acceptance and support for infected people are becoming the norm. This also includes an increasing acceptance toward the use of condoms as part of measures to reduce individual risk, together with measures to reduce vulnerability within the wider social context.⁽¹¹⁾

Such is the cultural presence of religion in many people’s lives that “educating the educators” is recognized as a crucial element of prevention in religious communities. Pathfinder⁽⁴⁾ reported on initiatives in Ghana, Kenya, Nigeria, Ethiopia and Egypt to help religious leaders understand the issues around HIV prevention, to frame their understanding in terms of religious texts and to support their spread of the messages through counseling, sermons and public meetings. ARHAP’s Masangane study⁽¹²⁾ reported the use of training programs delivered by the Treatment Action Campaign (TAC) of South Africa to train volunteers and staff. ARHAP⁽⁹⁾ called for recognition of the “need to assist in the education and training of religious leaders to mobilize effectively these important assets.” Faith in Action contributors⁽²⁾ noted that religious leaders need education not only in details related to HIV, but also in counseling and teaching skills.

Strategies to reduce vulnerability of women to HIV infection – empowerment through education, income-generating activities and other efforts to reduce gender inequity⁽¹³⁾ – have been widely reported, although Global Health Council⁽²⁾ noted the potential impediment of the patriarchal structure of many religious organizations. There is evidence of FBOs engaging with groups at particularly high risk, such as female commercial sex workers in some areas, but in others this is still seen as taboo.

Prevention of mother-to-child transmission programs by FBOs are reported by Tearfund⁽⁶⁾ in seven African nations using qualitative and quantitative analyses. It was reported that churches were present “in abundance” at all sites evaluated, that church leaders were willing to sensitize their communities once they were educated and that church groups were eager for information and keen to volunteer to work. Best results for uptake of prenatal testing was achieved in a program in Tanzania, operating with four mobile clinics in conjunction with a district hospital, where the emphasis was on a strong program of community education.

Concerning accelerated uptake of treatment and care, FBOs have been providing health services and social care in developing countries for years, often well before the HIV era. The tradition of care in the community setting has always been strong, and fits naturally with the overall mission of nearly all FBOs.

Estimates reported by the Global Health Council⁽²⁾ of 40 percent of health services being provided by religious organizations in some poorer African countries demonstrate the scale of pioneering work of FBOs in healthcare. Services such as home-based and palliative care, and support for vulnerable and orphaned children, have evolved to address the needs of communities devastated by the AIDS pandemic, but many have developed further to provide treatments including those for opportunistic infections and antiretroviral therapy (ART). WHO⁽¹⁾ estimated that one in five of all organizations involved in HIV programming are faith-based. A study funded by UNAIDS and WHO, "Expanding Access to HIV Treatment Through Community Based Organizations,"⁽⁹⁾ reported that many community-based services (not all faith-based) have evolved by necessity to fill the gaps where public health services were lacking or inadequate and that of the 274 organizations involved in HIV care that responded to a survey in African countries, 68 were already involved in prescribing ART, while 94 were at various stages of preparing to do so.

Studies reviewed also showed evidence of meeting best practices in the use of PLHIV as volunteer workers and expert patients, restoring self-respect, dignity and financial independence for affected individuals, as well as providing examples to communities of successful treatment. Training and subsequent employment of community members and PLHIV to deliver education and healthcare provides an opportunity to break the cycle of poverty, susceptibility to HIV/AIDS and its complications for those individuals and their dependents. There was evidence of collaboration with other FBOs and NGOs for clinical support and mentoring, and for training purposes. The Masangane case study demonstrated many of these attributes, and reported successful treatment, care and adherence to treatment of its clients (90 percent adherence in one section of its program). These results echoed findings in general studies that showed that adherence and response to ART can be achieved in home-based or community-based programs in resource-poor settings.^(14, 15)

The Masangane study⁽¹²⁾ also highlighted some ways in which FBOs may fall short of WHO recommendations: lack of clear standardized treatment protocols (or at least documentation of them), lack of documentation of costs and limited involvement with other local health providers or referral pathways. Information guiding use of treatments for HIV was also reported as a problem. While WHO published comprehensive guidance for treatment protocols, and encouraged countries to develop their own protocols in line with local drug supply networks, there was little indication of programs using them. But many larger FBOs and faith-based development agencies have published their own guidelines for tackling ART at the community level. Some emphasize the importance of community involvement, development of partnerships and integration with other health services to provide care, which is consistent with government guidelines. The Salvation Army⁽¹⁶⁾ is clear on this and lays out a framework for action: "what we need to know" and "what we need to do" at all levels, from the individual PLHIV through families, neighborhoods, congregations and clinics, covering specific areas of healthcare, drug management, documentation and partnerships.

In the strategic direction of strengthening health systems, the Global Health Council through its Faith in Action report⁽³⁾ surveyed participation of FBOs in national policy dialogues in its six study countries. Findings included a spectrum of involvement from minimal presence in public policy making in Thailand and India, to significant engagement over a long period in Uganda. In Uganda, FBOs were reportedly represented on various policy boards, participated in the HIV/AIDS strategic planning processes and have contributed directly to specific policies and bills. In addition, the contribution of specialist FBOs in pharmaceuticals supply logistics to strengthening health systems has been reported to have particular relevance in some national settings.



*A development project funded through Geneva Global benefited these Hondurans.
Photographer: Helen Davis*

FBOs have generally acknowledged, in the studies reviewed, limited achievements in line with the WHO strategic direction of investing in strategic information to guide a more effective response, through surveillance of HIV and sexually transmitted diseases, drug resistance and side effects reporting, and more general monitoring, evaluating and reporting on the wider health sectors' response toward universal access. However, a scan of selected FBO Web sites suggests trends toward the use of systematic record-keeping and electronic databases. Less clear is the degree to which this health information is linked with national databases and health information systems.

Conclusion

As demonstrated in the previous chapter, FBOs are providing an average of 40 percent of healthcare in many developing countries. They are currently implementing HIV-related programs and activities in general accord with WHO best-practice guidelines. Areas for improvement in FBO (and wider civil society) practices include greater emphasis on organizations using relevant WHO treatment guidelines instead of drafting their own, and more determined monitoring of effectiveness of activities across the spectrum of WHO strategic directions.

FBOs have an impressive, though underrecognized, track record in HIV/AIDS treatment. They demonstrate a close integration in their communities at a grass-roots level. They have infrastructure available and flexibility in using it so that they adapt to the new challenges. Inclusion of FBOs in a larger, government-led drive toward primary healthcare and more generalized access to health services would benefit all concerned. Despite certain shortcomings, such as less investment in investigations and research, or being somewhat outside the mainstream health planning activities, they have the potential to become an important partner in primary healthcare and health service delivery. Their inclusion in national health planning systems would allow them to narrow the gaps they currently present in their work.

Public value: A framework for healthcare partnerships

The role of religion in development currently lacks a widely accepted conceptual framework.⁽¹⁾ Governments tend to work with FBOs for pragmatic and utilitarian reasons. But in the discourse of new public management, the notion of public value could justify such a pragmatic and utilitarian approach.⁽²⁾ It takes the perspective of public managers and expresses a purpose for them to create further value from the services they deliver. Public value theory has three building blocks:

- Service quality
- Outcomes
- Trust

Each is seen as an independent source of public value. Transposed into health delivery, an improvement in health outcomes generates value even if satisfaction with doctors or hospital services remains constant. Likewise, public value is created when levels of trust in public institutions increase, even if that does not flow from improved services or outcomes. Public value also addresses wider factors than are conventionally considered in new public management, but citizens tend to value: issues such as equity, ethos and accountability, which overlap to some extent.⁽³⁾

Public sector organizations can create public value if they have strategies that cumulatively meet three broad tests. Strategies must be:

- Substantively valuable
- Legitimate and politically stable
- Operationally and administratively feasible

If managers of a public sector organization “have a substantively valuable goal that is administratively and operationally feasible, but cannot attract political support, that enterprise will fail.”^(2, p.28) These pragmatic conditions for the development of public services offer a framework for governments to consider the benefits of engaging FBOs in healthcare partnerships, because alignment of these conditions could yield important gains.

Value FBO partnerships can deliver

Evidence suggests that FBOs already offer tangible value by:

- Delivering services that supplement government offerings
- Bringing external resources from a range of donors
- Arising within religious and cultural loyalties of the local communities they serve
- Being numerous and on the whole more integrated with the communities they serve
- Connecting into associated services that are considered valuable within primary healthcare strategies

Much of the evidence for this is in evaluation reports prepared for donor organizations and others that have been summarized by ARHAP⁽⁴⁾. Health ministries have opportunities to maximize the public value of these assets in their quest for universal access to healthcare.

FBOs are well-placed to draw upon their respect within communities. But health managers should consider the relative merits of potential faith-based partners in line with Clark's typology (see *Chapter 3*) and ensure that the values of a particular FBO will increase the overall public value for the services they are responsible for. This is important because the values of any partner organizations "must be judged by how appropriate they are to the creation of value: better outcomes, services and trust. Inappropriate values may lead to the destruction of public value."^(3, p.4)

The potential of appropriate partnering to improve service delivery should yield greater public value as the interaction opens learning on both sides: "Given the way in which religion and health are intertwined

"FBOs are well-placed to draw upon their respect within communities."

in Africa, public health practitioners need to ask: 'How can we expect to understand and help people if we miss the very thing that they consider to be the most important thing in their lives, even if it may not be so in our own?' At the same time, religious leaders need to ask: 'How can we

expect to make a real difference in the health and well-being of our communities, if we do not draw on the wisdom and experience of those dedicated to and trained in these fields?"^(4, p.132)

If FBOs are harnessed creatively, public managers can "achieve greater results or reach broader communities."⁽⁵⁾ The combination of these factors and their reach into their respective communities presents an incompletely tapped resource that, if harnessed, could contribute to national healthcare outcomes and achievement of the MDGs.

Engaging FBOs in national health plans

WHO convened the Commission for Macroeconomics in Health (CMH), which produced its final report in 2001.⁽⁶⁾ The CMH's key pledge was that "low- and middle-income countries would commit additional domestic financial resources, political leadership, transparency and systems for community involvement and accountability, to ensure that adequately financed health systems can operate effectively and are dedicated to the key health problems."^(6, p.5)

Any national plan that seeks to fulfill this pledge must evaluate the most effective strategy for doing so. "All governments should want to maximize public value added; that is, the benefits of government action when weighed against the costs, including the opportunity costs of the resources involved."^(2, p.33) The question that inevitably arises for government authorities is whether medium- to long-term goals are enhanced by partnerships with FBOs. This is a particularly pertinent question where health delivery systems are seen as competitive:

- If both government and faith-based sectors are seeking funds from international donors and national budgets, what is the value to the public of a partnered approach?
- Will the government's capacity to deliver be inhibited?

It would seem unrealistic to exclude FBOs from national plans where they currently provide an average of 40 percent of healthcare delivery and infrastructure.⁽⁷⁾ Resources required to replace the assets of the faith sector would not be available for service improvement, as opposed to the service replacement it would be. The cost of nationalizing such assets would include loss of trust and the wider community assets that operate alongside the infrastructure.

To maximize value in strengthening of health systems, partnerships must be effectively animated. The healthcare provided by FBOs should be seen as complementary to the healthcare provided by the public sector. Drug supply systems are a case in point. A recent study found that across 10 sub-Saharan

“Community efforts to provide treatment represent an important opportunity to enroll more people in antiretroviral therapy.”

African countries, faith-based supply systems were covering an average of 43 percent of the population as a “necessary complement to public systems.”⁽⁸⁾

A government’s role is to ensure services are delivered, but “this does not imply that direct provision by government is the only, or even primary, route through which public value will be created. Voluntary and community associations, business and professional and citizen groups will all play a key role in achieving the goals of public policy.”^(3, p.6)

Governments are already dealing with mixed economies in health. Including the work of FBOs in national plans seems a natural step, one which is already widely recognized and in many cases practiced: “In most countries, the [close-to-client] system would involve a mix of state and non-state health service providers, with financing guaranteed by the state. The government may directly own and operate service units, or may contract for services with for-profit and not-for-profit providers. Since public health systems in poor countries have been so weak and underfinanced in recent years, a considerable nongovernmental health sector has arisen that is built upon private practice, religiously affiliated providers, and non-governmental organizations. This variety of providers is useful in order to provide competition and a safety valve in case of failure of the public system. It is also a fait accompli in almost all poor countries.”^(6, p.7)

In fact, healthcare funding from governments in some countries is a small proportion of the total funding of HIV/AIDS programs, for example. In 2006, Uganda’s government contribution was 5 percent and Mozambique’s 2 percent.⁽⁹⁾ By negotiating with FBOs about the healthcare they can realistically provide, governments can maximize this contribution and direct public funds to address priority gaps. In a study on the work of community-based organizations in 2005,⁽¹⁰⁾ UNAIDS recommended that “community efforts to provide treatment represent an important opportunity to enroll more people in antiretroviral therapy. To seize this opportunity, national governments and the international community need to quickly provide support to expand the coverage and impact of community-based treatments. ... The challenge is to find ways for community organizations to mobilize to respond to their particular HIV situation, while working closely with the public health sector, so that each reinforces the efforts of the other.”⁽¹⁰⁾

The onset of new global initiatives devoted to health system strengthening⁽¹¹⁾ and to specific diseases, as well as with expanded resources through mechanisms such as GFATM and the Global Alliance for Vaccines and Immunizations (GAVI), present important opportunities for engaging FBOs in coordinated national planning, financing and delivery of health services. Effective alignment of all actors must include all stakeholders in civil society, including FBOs.

Conversely, national health planning should better consider the impacts of public sector reforms, such as measures to retain or recruit health workers, on FBOs and their skill base, as addressed later in this report.

Pursuing public value with FBOs: challenges of accountability and monitoring

FBOs are significant recipients of donor funds for HIV/AIDS. For instance, they received 12 percent (\$999 million) of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding in 2006.⁽¹²⁾ They may also be subrecipients of country level Global Fund grants.⁽¹³⁾ Even so, FBOs report problems of sustainability for their programs. For example, 50 percent of the members of the Christian Health Association of Kenya (CHAK) report that sustainability was a challenge for them.⁽¹⁴⁾ FBOs therefore seek commitments from funders to sustain their HIV/AIDS and other healthcare programs.

But one barrier for FBOs in scaling up their HIV/AIDS operations is their lack of capacity to report their actions in the form and detail demanded by current and prospective donors, who tend to focus on management and financial processes.^(14, 15, 16) Donors want sustainable and capable FBOs so they are assured their funding reaches its target. They require recipient organizations to report mainly on their financial effectiveness, yet they are seldom willing to offer core funding to pay for this function.⁽⁴⁾ This may be short-sighted, since the nature of the data the FBOs are able to collect could yield a important information related to the social manifestations of the epidemic, and yet it is seldom required of them.⁽⁹⁾

Scaling up the financial and managerial monitoring capacities of FBOs could have benefits such as increased skills and an enhanced mutual understanding between sectors. But there are risks that the regimes for monitoring performance and accountability will strain the organizations and their leaders. A distinctive characteristics of smaller organizations and their health assets is that they involve local people in the production of health outcomes.⁽²⁾ A groundswell of enthusiasm inherent in community projects evokes a commitment from participants to improving their own health alongside that of community members. This is an important component of the public value gain that is achieved. The key challenge that governments, donors and FBOs must resolve is how to manage partnerships so that the distinctive nature of the FBO is retained.⁽⁵⁾ Enforced development of organizations, as part of a desire to build their capacity to deliver and monitor more professionally, may damage the more fragile elements, and risks stifling what made the service effective in the first place.⁽³⁾

Donors and governments should be creative about the demands they place on FBOs, especially relatively small ones. To gain a greater depth of public value, flexible and proportionate frameworks for monitoring and accountability need to be developed to capture the distinctiveness of the public value FBOs present.

Religious health assets and FBOs:

A broad-based primary healthcare system to achieve universal access

Participative health system re-engineering

ARHAP mapping studies conducted in Zambia and Lesotho⁽¹⁾ revealed a range of health assets identified by community members. Most of the health assets are not visible outside the community; most having a religious dimension that is called by ARHAP a “religious health asset” or RHA. Such “hidden” assets have potential to be used as part of a primary healthcare delivery system for the WHO policy framework⁽²⁾ for scaling up priority interventions, including HIV/AIDS. These health assets are broad-based and encompass the widest interpretation of well-being:

Religious Health Assets

Theory Matrix ▼



From Kiser, M.; Jones, D.L.; Gunderson, G.R., “Faith and Health: Leadership Aligning Assets to Transform Communities,” *International Review of Mission*, Vol. 95, Nos. 376/377, January/April 2006

ARHAP used its Participatory Inquiry into Religious Health Assets, Networks and Agencies (PIRHANA) tool to engage community participation in identifying and evaluating these assets, and assigning them relative values. This participation demonstrated a greater potential than for mere mapping: “Our PIRHANA workshops have already spawned a number of local interfaith and interdisciplinary task forces formed as a result of this study to carry forward the local action plans generated by the participants. These offer a starting point for the next level of engagement.”⁽¹⁾

It is conceivable that this tool could be adapted for a process-driven strategy which incorporates religious health assets into a broad coalition of health and well-being providers at a district level. Such a coalition could develop a locally relevant and resourced primary healthcare strategy that would be fit for purpose within what ARHAP identifies as a local “healthworld.”⁽¹⁾

“Healthworld” is a neologism for “bophelo” (Sesotho), “impilo” (isiXhosa), “ubumi” (Bemba) and other African linguistic equivalents and is expressed as a concept argued to be of general significance. It refers to peoples’ conceptions of health, as framed by the background store of inherited or socialized knowledge that defines their being in the world. A person’s healthworld expresses and guides health-seeking behavior, choices and actions. Culturally and linguistically, it addresses the condition of the whole body – understood as the ecology of the individual body in relation to the social body under particular material conditions – and thus includes the social and environmental determinants of health.

A U.N. Population Fund (UNFPA) report, “Culture Matters,”⁽³⁾ suggests that health strategies can be rendered more effective if they are shaped according to cultural and religious patterns. This notion of healthworld implies that an appropriate degree of cultural sensitivity is required if healthcare systems are to be developed effectively. This does not necessarily mean a passive acceptance of a static set of cultural and religious propositions, since cultural and religious patterns are fluid and will have a determining influence depending on what people perceive as being most suited to their needs at a given moment. “Individuals may simultaneously engage with different health systems, or may choose different remedies depending on their perception of the disease and the treatment that is offered. These health systems may be biomedical hospitals and clinics, traditional healers, or even faith healing.”⁽³⁾

Opportunities for learning through developing health systems would be of significant value. They could allow community participants to reappraise superstitious attitudes to health problems, and learn about the benefits of evidence-based treatments. It also would force science-based methods to adapt to particular religious and cultural environments to serve a broader range of needs as articulated by the people they are destined for. ARHAP describes this as respectful dialogue or engagement, which is an important element of a patient-centered primary healthcare model.

The UNFPA report⁽³⁾ describes a process by which trust assets are created so that project implementation can run smoothly. This respectful sensitivity arises from a concern not to provocatively override cultural beliefs and values. It also ensures the trust factor highlighted in the previous chapter on the public value of FBOs. Such sensitivity is pragmatic in avoiding pitfalls of disrespect and alienation that occurs from a postcolonial perception of superior learning.

This is particularly important when faced with harmful cultural traditions. The implicit interaction in a partnership model allows key cultural gatekeepers to reflect on the relative merits of traditions in the face of new information. Areas of controversy can more easily be opened for widespread discussion within communities after a period of familiarization and recognition among community leaders, as opposed to confrontation with centralized and authoritarian models.

Difficulties in managing public services under an outside system, such as a Western bureaucracy transposed into a developing world context, have been identified and documented.⁽⁴⁾ With little cultural or religious relevance, these structures may not function effectively; they may not be able to engage the respect of the people they serve. Indigenous, more culturally specific and respectful delivery and governance systems are more likely to be successful even if they require more time to germinate.

A hybrid structure of governance that connects into the strategic functions of the national and local government through a coalition of public assets, community assets and private sector service deliverers could advantageously be formed. This hybrid structure would then engage each stakeholder in agreements according to outcomes, and could monitor, evaluate and hold each part of the system accountable. This would involve religious and community leaders, as well as professionals and businesses, alongside politicians. It must encourage economic activities to harness both innovation and motivation, but it should also encourage voluntary approaches in developing social capital within the relevant cultural context.

A hybrid governance system should balance the axes of power so that a district health system can respond systematically and creatively, to national plans. Observations on the functioning of one contemporary integrated primary healthcare model suggest that long-term effectiveness and sustainability may be related to the degree of community control over the services provided (see Appendix 3, “Case Study on the Gurriny Yealamucka Aboriginal Health Service, North Queensland, Australia”).

Supportive and substantive roles of FBOs

Relational dynamics among faith-based development agencies, religious institutions and ecumenical or interfaith bodies are not explicit in studies. Evolution of mission agencies in the Christian faith from independent evangelistic enterprises into support functions for post-colonial churches has been charted.⁽⁵⁾ Development of the ecumenical movement created new agencies to work across the mainstream

“These faith-based development agencies have an accepted role in international development.”

denominational boundaries, such as Christian Aid, while evangelicals developed their own agencies (Tearfund, World Vision). The Roman Catholic

Church has over the centuries developed a number of religious orders and agencies (such as Caritas). Most of these agencies are now highly professionalized organizations that offer services in the same indiscriminate and evidence-based manner as their secular equivalents. Similarly, many Islamic relief agencies appear to provide support on a needs-alone basis.^(6,7) As noted in Chapter 3, these faith-based development agencies have an accepted role in international development and offer a faith literacy that is balanced by their professionalism.

More recently, Christian denominations have begun to articulate their interest in developing their capacity to manage their service deliveries. The Round Six Global Fund bid by the Lutheran World Federation, the Anglican Communion and the World Alliance of Reformed Churches demonstrated a new level of interest in denominational energy and capacity. Funding of HIV/AIDS programs of the Province of the Church of Southern Africa by DFID was a leading example of the commitment of denominational churches to take up responsibility for managing this area of their work. The attraction of working through such religious institutions is that they are grounded in the communities they serve and have national and regional bureaucracies with which to develop long-term relationships with donors. The importance of these previous experiences and eligibility of FBOs active in countries to sources of funding will increase as the GFATM implements a new, second track of funding specific to civil society beginning in Round Eight. Many national umbrella medical agencies represent Christian institutions and medical facilities supported by faith-based development agencies. Having arisen from an array of post-missionary arrangements, they are now organized into Christian health associations.^(8, 9) Currently, 12 African countries have functioning CHAs:⁽¹⁰⁾ Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Sierra Leone, Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

Many national CHAs have similar characteristics, reflecting a history of health networking through early association with CMC activities and carrying a significant portion of national health service provision, including training health workers. Many have formal agreements such as memoranda of understanding with national governments and specific service agreements at district levels. Most participate in national health planning and policy development and have health program management experience. Most retain affiliation with the World Council of Churches, the Ecumenical Pharmaceuticals Network and other relevant international entities.

But many CHAs find themselves at a crossroads in terms of effectiveness and sustainability. The 2007 Dar es Salaam-Bagamoyo conference⁽¹¹⁾ identified a critical recurring theme for participating CHAs: difficulties in recruiting and retaining staff. A key factor reported by several CHAs was a brain drain away from the faith-based sector into the more highly remunerated public and private sectors. In response to this and other challenges, the conference launched a CHA Platform, with a secretariat hosted by the Christian Health Association of Kenya. The secretariat will provide a coordination role among the CHAs, and add capacity to CHA advocacy efforts.⁽⁸⁾

Conclusion

Microlevel religious entities and health assets are usually interconnected with religious institutions, ecumenical networks or international faith-based development agencies. Participative healthcare system re-engineering could be strengthened by the support functions offered by these larger faith organizations. Additionally, channeling resources through these organizations to the grass-roots level could accelerate the scaleup of effective work.

If the target of universal access to healthcare is pursued with these groups as partners and participants, the resource base can be expanded and strategic action is more deeply rooted within communities. The nature of the resulting system would offer a more holistic notion of health and well-being, closer to the re-emerging principles of primary healthcare currently under consideration.

Ways forward

Observation 1

In the 1970s, the World Health Organization and certain FBOs started together on their journey to develop and implement a primary health care framework. After considerable experience of a range of initiatives, this framework still stands as a concept of proven effectiveness and value. In view of the urgency that the AIDS pandemic has created, with the need to achieve the MDGs and with the benefit of a good degree of evaluation of the widespread FBO activity in response, it is timely that renewed partnering is being considered.

In partnership with FBOs, WHO can develop the concept of primary healthcare to provide guidance for the engagement of religious health assets.

Observation 2

At the heart of ARHAP's mapping methodology was a commitment to respectful engagement. The nature of this engagement was dialogue, which implies a willingness to learn on all sides. This sort of engagement builds a relationship of trust. Interactions required for true dialogue build a common

“WHO can encourage national governments to consider public values created by FBOs.”

platform for any practical response. The PIRHANA model of participation demonstrated its potential to motivate people of faith in this way and to orient their perspective toward a local, interconnected

and responsive approach to health and well-being. The religious imperative to exercise compassion is complemented by the commitment of health professionals to deliver decent care. This practical and philosophical proximity offers common ground for partnership. If health systems are to be strengthened, there is demonstrable public value in pursuing these partnerships. WHO can act as a convening focus so faith leaders can meet with national leaders and each other to consider common causes. With respectful engagement in mind, WHO can promote this dialogue.

WHO can engage in dialogue with faith institutions to consider the interplay between their respective values of compassion and decent care, and to ascertain the relative roles and contributions of FBOs in developing healthcare systems.

Observation 3

FBOs provide a substantial proportion of healthcare in developing countries, particularly in sub-Saharan Africa. From the point of view of public governance in healthcare, it is reasonable to pursue partnerships to generate greater value for the public. FBO inclusion will bring a greater degree of community participation and empowerment. Including FBOs in national health plans will yield greater outcomes. FBOs are able to offer themselves as both implementers of strategic priorities and as assets in community planning.

WHO can encourage national governments to consider public values created by FBOs and engage FBOs when developing national health plans.

Observation 4

Primary healthcare is person-centered, values-led and locally conditioned. It addresses the needs of the whole person, and encourages people's participation in attention to their health needs. The spread of HIV, for example, had impacts on many aspects of people's personal and communal lives and has shown how much a renewed primary healthcare system is required. The desire to offer universal access to ARVs has demonstrated the absence of equity in health provision; one of the principal foundations of primary healthcare. If a truly comprehensive and effective health provision is to be achieved, WHO could create the opportunity to explore the assets that faith partners could bring to promoting renewed primary healthcare systems and facilitate bridges among these institutions and respective public sector agencies.

WHO has an opportunity to spearhead pilot programs of health system re-engineering so potentially successful models can be evaluated for widespread adoption.

Observation 5

Many FBOs' health assets are fragile and require reinvestment of human and facility resources. While recognizing their responsibilities, religious institutions lack capacity to manage development of these assets. With greater confidence in the terms and objectives of FBO health partnerships, the wider international community could work alongside national governments in channeling funds to strengthen FBO assets.

WHO can promote interaction among FBOs, governments and donors to forge constructive relationships and advocate for inclusion of civil society actors in the contexts of broader health policy, global health partnerships and financing mechanisms.

Observation 6

Few FBOs and FBDA are engaged in national policy and planning dialogues and their follow up. WHO serves a critically important role at country levels as a neutral body and advisor to the health ministries and other public institutions. WHO also interacts with many global health partnerships and initiatives. In this regard, WHO is in a unique position to facilitate and advocate for productive relationships among FBOs, FBDA and the public sector.

WHO can develop relationships with FBDA to identify roles that will allow them to facilitate development of religious entities in health systems.

Observation 7

WHO recently published various approaches to health system strengthening, including "Everybody's Business" and several similar regional office approaches. It will be useful for WHO to discuss with FBOs and FBDA how best to identify and integrate the roles, opportunities and assets of the latter institutions to achieve both alignment and coordination, and ultimately national health outcomes. Approaches such as PIRHANA mapping need to be scaled up to fully understand the breadth and depth of FBOs and FBDA efforts at country levels.



*The families of these children, who live in Likuni district, benefit from the Lilongwe Diocese's home-based care for people with HIV.
Photographer: Catherine Thornton*

As a matter of urgency, FBOs and FBDAs (as part of broader civil society) and their national umbrella organizations (such as CHAs) could be supported in developing proposals on behalf of member agencies to:

- Submit to financing mechanisms such as GFATM
- Ensure on a broader scale the recruitment and retention of staff to support accelerated scale-up of primary healthcare and HIV/AIDS prevention, treatment and care

Observation 8

FBOs' priorities are varied. Their internal coordination can be complex. Effective partnerships would involve evaluating appropriate alignments of FBOs' goals with that of the health sector. Attention is required to ensure that monitoring systems do not overwhelm FBOs, particularly the most locally based. But it is important to ensure that the value that they deliver to health systems is ultimately in the best interests of public value. This report has indicated the lack of consideration for how some public sector reforms (such as in human resources) are affecting the internal dynamics with other longstanding organizations such as FBOs and FBDAs. As opportunities arise for FBOs and FBDAs to gain access to new sources of international aid, WHO, given its experience, should advise and support FBOs and FBDAs on lessons learned in crafting proposals and ensuring that their content meets WHO-recommended technical guidelines.

Monitoring and accountability frameworks that are fit for purpose for use with a variety of FBOs could be developed by WHO and its Member States.

Conclusion

Much can be achieved in renewed interaction and cooperation between WHO and FBOs. This requires a clear, long-term commitment to dialogue and mutual learning. The next step should involve forming a road map that interested parties can commit to so that they can embark on the next stage of the journey together.

Appendix 1

Abbreviations and acronyms

ARHAP	African Religious Health Assets Programme (Cape Town, South Africa)
ARV	Antiretroviral
ART	Antiretroviral Therapy
CHA	Christian Health Association
CMC	Christian Medical Commission (part of the World Council of Churches)
DFID	U.K. Department for International Development (London, United Kingdom)
CMH	Commission for Macroeconomics in Health (convened by WHO)
FBDA	Faith-based development agency
FBO	Faith-based organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria (Geneva, Switzerland)

MDGs	U.N. Millennium Development Goals
NGO	Nongovernmental organization
PEPFAR	United States President's Emergency Plan for AIDS Relief (Washington, D.C.)
PIRHANA	Participative Inquiry into Religious Health Assets, Networks and Agency
PLHIV	People living with HIV
RHA	Religious health asset
UNAIDS	Joint U.N. Programme on HIV/AIDS (Geneva, Switzerland)
UNFPA	United Nations Population Fund (New York, N.Y.)
WCC	World Council of Churches (Geneva, Switzerland)
WHO	World Health Organization (Geneva, Switzerland)

Endnotes

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Appendix 3

Case study: Gurriny Yealamucka Aboriginal Health Service, North Queensland, Australia

Australia, typical of many industrialized economies, has a primary care model based almost exclusively on general practice. This approach, however, has been historically ineffective in addressing the primary health care needs of communities of Indigenous peoples. In response to this situation, most Australian states in which there are distinct Indigenous communities have developed and funded a community-controlled health sector, based on the core principles of the Alma-Ata Declaration.

Founded in 1997, the Gurriny Yealamucka Aboriginal Health Service (Gurriny), in the community of Yarrabah in Tropical North Queensland is an Indigenous community-controlled primary healthcare service initially established to address social and emotional wellbeing issues related to entrenched Indigenous disadvantage. While this disadvantage persists to the present time, Gurriny has made slow but steady progress in the social health agenda, including in the difficult areas of suicide and family violence. Gurriny has been very effective in mobilizing support from local church and community organizations, including the recruitment of representatives of these organizations to its board of management. Now in its 10th year, Gurriny has begun the transition to provision of a more comprehensive range of promotive, preventive and clinical services, as workforce development policies begin to mature and qualified Indigenous practitioners across the range of clinical, allied and preventive health become available to the service.

The effectiveness and durability of Gurriny programs suggests that those primary healthcare services that are adequately funded, that vest control through local boards of management in the communities they serve and that mobilize local human and community (including faith-based) resources for their function may achieve significant health gains even under extremely difficult circumstances.

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*Project beneficiaries attend school in Bangalore.
Photographer: Kevin Kovaleski*

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