

**WHO - Faith-Based Organization  
Consultation**  
*Towards Primary Health Care:  
Renewing Partnerships with Faith-  
Based Communities and Services*

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*Report*  
17-18 December 2007  
WHO-HQ Geneva



## WHO Programme on Partnerships and UN Reform

### **WHO Consultation with Faith-Based Organizations (FBOs) *Towards Primary Health Care: Renewing Partnerships with Faith-Based Communities and Services***

#### I. Background

On 17-18 December 2007, WHO hosted a two-day planning consultation to explore renewing partnership activity with faith-based communities, faith-based development agencies and health services providers. Participants came from 14 faith-based organizations representing different faiths and regions of the world, as well as staff from different WHO departments who have been collaborating with this community. The meeting, hosted at WHO headquarters centred on engaging communities involved in primary health care. The emphasis on encountering this constituency was consistent with the findings of two WHO-sponsored studies documenting that faith-based organizations (FBOs) provide at least 40% of health services offered in sub-Saharan Africa.<sup>1</sup>

Different faith communities, their associated structures, health service assets, and non-governmental organizations have demonstrated longstanding contributions to, and hold continued potential for, the delivery of primary health care, an array of disease control programs, and health promotion and advocacy. WHO is moving forward with its responsibility to enhance its capacity to partner with different sectors and actors in the health field.

As 2008 marks the 30<sup>th</sup> anniversary of the Alma Ata Declaration, it was noted that faith-based organizations were involved in contributing to the work and conceptualization of Alma Ata in the decade prior to its adoption with the creation of the Christian Medical Commission.

The majority of the world's population (73%) has been identified as adherent and practitioners of the four biggest religions (Hinduism, Buddhism, Islam, Christianity) according to a report published in the Economist in November 2007. Given this fact and the breadth of services offered by faith-related institutions and providers therefore presents another means by which WHO can influence and support the development of health services at regional and country levels in a manner that maximizes coverage for populations, and supports national authorities in their planning efforts.

WHO's work with FBOs has existed for many years (at country and regional levels, especially in the African Region, Region of the Americas and the Eastern Mediterranean Region, and within different HQ departments as evidenced by presentations provided during the meetings from the Departments of Polio, Making Pregnancy Safer, Stop TB Partnership, and HIV), but it has lacked an integrated and coherent approach across the Organization. The WHO-FBO relationship is nevertheless hampered by lack of mutual understanding of one another's mission and method of work. Thus one of the purposes of this consultation was to explore and identify areas of common understanding and work in order to move the global health agenda in a more coherent way.

<sup>1</sup> The results were reported by two independent studies commissioned by WHO to assess and verify who is doing the work of health service delivery and what those services look like.

Critical to a more creative and productive WHO-FBO relationship for attaining MDGs and furthering the public's health, is an understanding that the motivations and organization of FBO religious health assets or religious entities are different from that of WHO. Whereas the delivery of health services is a joint goal, how and why they are attained differ for the organizations. Mutual understanding of each others' drivers and methods are key to advancing potential for our joint work.

## II. The extensive range of FBOs

The term FBO refers to a wide variety of faiths, their affiliated health institutions, and the manner in which they work.

FBOs are not necessarily churches or houses of worship (in the multi-faith sense) providing health services. Many are:

- a) faith institutions which hold religious health assets such as hospitals/clinics/dispensaries or related social service centres within hospitals (e.g. Health Ministries of the General Conference of the Seventh Day Adventists, Christian Health Association of Kenya, Hope Center-Coptic Church);
- b) development NGOs that have at their core religious values and norms, but operate with a more direct health sector or development mandate (e.g., Islamic Relief, World Vision International, Caritas Internationalis, American Jewish World Service, Adventist Development and Relief Agency, etc), and
- c) religious institutions, such as mosques, temples, churches or parishes that organize large numbers of activities and volunteers engaged in various aspects of health care, including: preventive, treatment, home-based care and palliative care services (e.g. Buddhist temples in Thailand, Saddleback Church offering health services, Islamic Medical Association of Uganda, and South Africa Council of Churches).

Moreover, it is evident that faith institutions engage in advocacy for health across faith boundaries and experiences.

The mix and pattern of faith communities' engagement in health, which and how services are provided, range extensively throughout the world.

Whereas this initial planning meeting had limited participation from several world faiths, it was noted that additional insights were required from the Hindu, Buddhist faiths, as well as other faiths. Nevertheless, there was considerable agreement among the faiths present on the importance of health, its potential for being a unifying force within communities, and the overall value of the contribution of faith communities to health and to respective health goals.

### III. Consultation Objectives

The principal objectives of the consultation were to:

1. Gain mutual understanding as the basis for greater FBOs and WHO collaboration.
  - a. How we each work, what drives us, what hampers us?
  - b. Clarity on diversity of faith communities and their affiliated institutions.
  - c. Clarity on WHO and how it works.
2. Contribute to discussions on primary health care approaches to strengthening health systems: the next 30 years.

### IV. Desired Outcomes

1. Options for one or more meetings in 2008 to broaden the faith community discussion on health issues including, primary health care.
2. Discern and describe the basis for development of a WHO strategy for collaborating with faith communities-HQ, regional and country levels.
3. Identify and define specific concrete next steps for collaboration.

### V. Critical Observations

During the meeting, participants presented a number of insights and observations concerning the role of faith communities and potential collaboration with WHO:

- Broad agreement and desire to renew and revitalize partnership between WHO and FBOs and to promote primary health care within faith-based communities.
- There is considerable on the ground ecumenical and interfaith sharing, support, technology transfer going on, yet is under the radar and out of the spotlight.
- Some faith-based development agencies are regularly engaged in technology transfer and technical support to faith communities on the ground, e.g. Islamic Relief trains imams on AIDS.
- Power of culture may be more difficult than dealing with religion, per se. Cultural diversity can and does impede implementation of needed interventions.
- WHO, and the UN system, have unique roles in developing and articulating a uniform health basis for guidelines and technical interventions, regardless of culture, faith and tradition.
- Besides service delivery, FBOs bring community cohesion, social support and solidarity in the face of personal and health challenges.
- FBOs are providing interstitial connections between people and health care and public health providers.

- FBOs have potential to provide greater share of health care, but are fragile due to lack of support and funding from governments and donors-needing funding in proportion to service delivery.
- Health worker shortages are critical in FBOs, and in some cases recent public sector human resource reforms have attracted health workers from the FBO sector, exacerbating the situation for the latter. It was noted that, in many instances, FBOs provide training for large numbers of health workers.
- WHO provides an important neutral space for critical technical, scientific and ethical foundations for interfaith and ecumenical communication and dialogue on humanitarian issues, such as health.
- FBOs have huge potential capacity on the ground but lack reasonable support and recognition. They also require training on a vast scale, especially in using WHO guidelines and protocols.
- There are 1.3 billion people lacking health care worldwide--given the historic and current reach of FBOs, there is room for FBOs to make their contribution alongside and in tandem with government and private sectors.
- The experience of the polio intervention and immunization programme engagement with faith communities since 2003 offer interesting and provocative approaches for achieving results that transcend government where needed.
- There is a real desire to figure out how FBOs and WHO can work together.
- The notion of "respectful engagement" cited in the WHO report on FBOs and primary health care is impressive and needed to inform the dialogue and implementation.
- The "3 by 5" initiative provided an example of the power of a health initiative to raise hope, gave faith and moved people from expectation of death to expectation for life.
- There is a need to rollout tools to assist the government in mapping FBOs and the role of the FBOs in national plan of health care.
- WHO can help FBO systematize and plan more effective strategies and health interventions
- There is a barrier between FBOs and civil society as real as the one between government and FBOs, trust is always an issue.
- FBOs should reach out to WHO at country and regional levels, as well as to other parts of the UN system for support and technical skills development.

## VI. Participants Recommendations for the way forward

- WHO requires a clear process and method to engage wider group of stakeholders in the formulation of thinking on primary health care over the next 12 to 18 months. The FBOs are willing and eager to provide comment but need to understand how best to do so.
- FBOs should be encouraged by WHO to engage more effectively with civil society and governmental structures to ensure long-term sustainability and support.
- WHO should market the concept of FBO engagement/partnerships/collaborations at regional and country levels, and create structures where needed that will support it.
- Burden of evidence shouldn't be on FBOs, alone. WHO should be engaging in a feedback process between countries and WHO ( this would involve FBO in developing National Health Plan).

## VII. Participants' suggestions for WHO structures to support FBO engagement

- WHO should draft a concept paper for partnership with FBOs, which could be shared within planning group of FBOs.
- Establish a platform or database to share FBOs' capacities.
- Establish some structure within WHO: office/focal point/clearinghouse for coordination between WHO HQ-person must be adept in WHO policies and FBO structures.
- Establish code of conduct/principles for partnership for FBO to be recognized as member, because the process for Official Relations does not immediately engage FBOs and is limited in its scope for collaboration.
- Create a health council, reference group or similar body to manage WHO-FBO relations, standards and communication, with an annual meeting.
- FBOs have responsibilities in their own organizations to make people aware of this collaboration, to facilitate collaboration on all levels; stimulate interaction on regional and country levels between governments, WHO and FBOs.
- Publicize and share models for FBO/country-driven initiatives.
- Looking at existing networks: there are some at regional/country level.
- WHO needs to have a clear message as to what are its objectives for working with FBOs. Commitment and agreement to be able for FBOs to speak across FBOs' boundaries.
- Clarification on the nature of the role of Senior Management of WHO in this process.
- Quietly and substantially engage at WHO at regional/country level.

## VIII. Practical examples of engagement

1. The Director-General could invite FBOs to participate in high-level official and unofficial conversations, the EB and WHA, or as focus groups on primary health care activities.
2. FBOs should be involved in WHO guidelines development and systematic review processes of programme and publications.
3. WHO-FBO concept strategy paper could be developed by August 2008 as a macro plan.
4. WHO HQ in collaboration with FBOs and WHO regional and country-level offices should stimulate outreach to regions and countries to develop strategic model and approach to reaching, mapping and collaborating with FBOs.
5. Document re-vitalisation of FBO linkages with health issues, especially primary health care.

***For corrections, updates, and more information please contact:***

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**Annex I**  
**List of Participants**

# WORLD HEALTH ORGANIZATION

Office of the Representative of the Director-General for Partnerships and UN Reform

## CONSULTATION ON PARTNERSHIPS WITH FAITH-BASED COMMUNITIES

WHO Headquarters, Geneva  
17-18 December 2007

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**Annex II**  
**Final Agenda**

# WORLD HEALTH ORGANIZATION

Office of the Representative of the Director-General for Partnerships and UN Reform

## CONSULTATION ON PARTNERSHIPS WITH FAITH-BASED COMMUNITIES

WHO Headquarters, Geneva  
17-18 December 2007

### AGENDA

**DAY 1 MEETING IN THE UNAIDS-WHO D BUILDING 4<sup>TH</sup> FLOOR-46025**

**Chairpersons:** Ms Karuna Roy, Church of North India (a.m.)  
Bishop Paul Yowakim, Hope Center-Coptic Hospital (p.m.)

#### **Morning session**

- 09h15           **Welcome**  
**Opening remarks:**  
  
Dr Anarfi Asamoah-Baah, Deputy Director-General, WHO  
Dr Manoj Kurian, World Council of Churches  
  
**Objectives of the Meeting:**  
  
Mr Alex Ross, Director, Programme on Partnerships and UN Reform, WHO
- 09h.45           **Introductions and experience of FBO Primary Health Care**
- 10h.30           **Break**
- 10h.50           **Plenary: Gaining mutual understanding - What is the diversity of FBOs?**  
  
a) faith health services institutions - CHAK  
b) faith-based development NGOs - Islamic Relief Worldwide  
  
*Discussion: What are Faith-Based Organizations and services (FBO), and what do they do? What opportunities and challenges do FBOs face? What are WHO impressions of FBOs?*
- 12h.45           **Lunch**

**Afternoon session**

- 13h.45            **Plenary: Gaining mutual understanding - WHO's approaches**
- a) What are WHO's views of primary health care?  
 WHO and Primary Health Care - Dr Kumanan Rasanathan, WHO  
 Discussion after presentation
- Response from the FBOs:  
 A perspective on Primary Health Care -  
 Dr Ted Lankester, Community Health Global Network and InterHealth  
 Worldwide  
 Discussion after presentation
- b) WHO experience of collaboration with FBOs?  
 Panel of persons from WHO:  
 TB experience - Dr M Raviglione/Dr G. Gargioni  
 AMRO/PAHO regional perspective - Mr James Hill
- 15h.45            **Break**
- 16h.00            WHO experience in collaboration with FBOs? *(contd)*  
 Safe motherhood - Dr Viviana Mangiaterra  
 Polio - Mr Anand Balachandran
- Discussion: How does WHO work? What are the constraints, opportunities?  
 How do FBO's and their health care providers view WHO, and what do  
 they expect from WHO? How can WHO facilitate engagement with FBOs,  
 national authorities, other stakeholders?*
- 17h.15            **Discussion: Building together - the basis for collaboration**
- 18h.00            **Close**

**DAY 2 MEETING IN THE UNAIDS-WHO D BUILDING 4<sup>TH</sup> FLOOR-46025**

**Chairpersons:** Mr Ibrahim Mohamed Ibrahim, Islamic Relief Worldwide (a.m.)  
Mr Alex Ross, WHO (p.m.)

**Morning session**

- 09h.10      **Report back** on work of previous day  
  
Powerpoint summary - Mr Alex Ross, WHO  
  
Response from participants:  
Ms Margaret Hempel, American Jewish World Service  
Dr Peter Landless, Health Ministries, General Conference, Seventh Day Adventist Church
- 09h.30      **Group conversation on Primary Health Care and FBO engagement**
- 10h.30      **Response:**  
  
Dr Anarfi Asamoah-Baah, WHO
- 10h.40      **Break**
- 10h.55      **Small group discussions: working together**  
  
What strategies, activities, event(s) or meeting(s) would recognize the contribution of FBOs and establish a way forward for greater WHO-FBO collaboration in health?  
How shall we engage with one another?  
On what shall we engage together?  
Where shall we create a shared space and purpose?
- 12h.45      **Lunch**

**MEETING MOVES TO THE WHO MAIN BUILDING - ROOM A FOR CONCLUSION****Afternoon session**

- 14h.00      **Plenary: a) Report back; b) Discussion on planning for primary health care dialogue and future of FBO partnerships**
- What are the ideas for next steps on engaging the broader community of FBOs and related institutions?  
Towards joint activities on Primary Health Care  
Development of Programme of engagement and programme activities planning
- 15h.45      **Break**
- 16h.05      **Plenary: Taking it from here?**
- Report back from previous session  
Next steps and review of programme
- 16h.40      **Summary wrap-up from each participant and response from WHO**
- 17h.15      **MEETING ENDS**