FBO Health Networks and Renewing Primary Health Care

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Summary:

FBO health networks are a special type of FBO association, usually at the national level, that is organizationally committed to the coordination of health and healing through the network of its members. That network, sometimes tightly and often loosely structured, usually includes facility-based, congregational-based and community-based health services.

FBOs health networks, and individuals working through them, have played an important role in the development of the concepts of primary health care. Today in sub-Saharan Africa, national FBO health networks often provide 25-50% of health services. This paper draws primarily from the experience of FBO networks in DR Congo where they currently not only provide 50% of health services, but also co-manage around 40% of Congo's 515 health zones. Their work is examined with respect to three conceptual frameworks:

- Alma Ata and the principles of Primary Health Care;

- Framework for building an integrated PHC Health System; and

- Korten's Four Generations of NGO Developmental Strategies.

Concluding recommendations for strengthening National FBO health networks, and to build on their experience for renewing primary health care, are that:

1) National Faith-Based Health Networks should be treated as a not-for-profit public sector partner to the Ministry of Health, rather than as a private sector competitor.

2) The role of national FBO health networks in health systems co-management as part of a decentralized health system should be recognized and developed.

3) Health system assessments and planning should always examine the potential of roles of National FBO Health Networks.

4) Partnering and funding agencies should broaden their vision, and funding to include capacity-building of National Faith-Based Health Networks.

5) Donor agencies should consider opportunities for capacity building of National Faith-Based Health Networks to strengthen collaboration with MOHs.

6) National Faith-Based Health Networks should develop their capacity to manage umbrella projects on behalf of their members and the national health system.

1.   Introduction

The term FBO (Faith-Based Organization) has been popularized in recent years but without a clear definition. To many people health-related FBOs have become synonymous with and limited to the work of churches in HIV/AIDS. FBOs, however, encompass a much wider group of "faith" organizations that have played (and still are playing) a key role in the provision of health services and the management of health systems around the world. Christian, Muslim, Hindu or Buddhist health service providers may all be categorized as health FBOs that provide health services or health programs through a foundation of faith.

FBO health networks are a special type of FBO association, usually at the national level, that is organizationally committed to the coordination of health and healing through the network of its members. That network, sometimes tightly and often loosely structured, usually includes facility-based, congregational-based and community-based health services.

FBOs health networks, and individuals working with/through them, played an important role in the development of the concepts of primary health care, and were instrumental in organizing the 1978 Alma Ata conference. Today, in many countries, and especially in sub-Saharan Africa, national FBO health networks provide 25-50% of primary health care services.

Given the upcoming 30th anniversary of Alma Ata, it is fitting, therefore, to examine how the work of national FBO health networks match with several classical paradigms that helped shape the development of integrated PHC systems. The conceptual frameworks included in this review include:

- **Alma Ata and Primary Health Care:** from *Declaration of Alma-Ata. International Conference on Primary Health Care*.

- **Building an integrated PHC Health System:** from an article by D. Smith and J. Bryant, *Building the infrastructure for primary health care: an overview of vertical and integrated approaches*.

- **NGO Developmental Strategies**: from David Korten's book "*Getting to the 21st Century: Voluntary Action and the Global Agenda*.

This paper draws primarily from the experience of an FBO network in DR Congo where I lived and worked for almost 20 years. There are certainly many examples of FBO health networks from other African countries as well as from South America and Asia that could, and should, be similarly examined and documented.

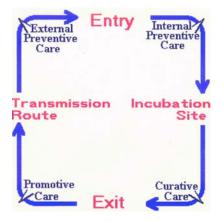## 2. "A" is for Alma Ata and Primary Health Care:

ALMA-ATA was a 1978 international conference in Alma-Ata, the capital of the Kazak Republic of USSR attended by delegations from 134 governments and 67 UN agencies.

The "Ten Declarations of Alma-Ata[1] (see box) have remained the cornerstone and gold standard for the development of primary health care programs since that time.

The four "As" of Alma Ata (availability, accessibility, acceptability and affordability) are just as applicable today as 30 years ago.
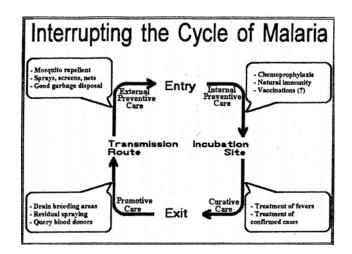
Alma-Ata established an amazingly broad and durable consensus for the conceptual framework of primary health care to include three aspects – curative, preventive and promotive health care. Those can be very useful tools for health planning and prioritization.

For example, the figures below illustrate how curative, preventive and promotive care interventions can effectively intervene in four different areas of the life cycle of malaria to reduce the transmission of this disease.[2] This can be a powerful tool for developing an promoting more integrated approaches for health improvement.

The Ten Declarations of Alma-Ata
1) Health, which is a state of physical, mental and social wellbeing, is a fundamental human right.
2) The existing inequality of health status is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
3) The promotion of health is essential to sustained economic and social development and contributes to better quality of life and to world peace.
4) People have the right and duty to participate in the planning and implementation of their health care.
5) Governments are responsible for the health of their people and should aim for acceptable levels of health by the year 2000.
6) Primary health care is essential health care made available, accessible, acceptable and affordable to people where they live and work.
7) Primary health care (PHC) should address the main health problems while promoting maximum community involvement. PHC includes maternal child health, immunizations, nutrition, local endemic disease control, water and sanitation, health education, essential medicines and basic curative care.
8) All governments should formulate national PHC policies to mobilize internal and external resources rationally.
9) All countries should cooperate to promote PHC since the health in one country concerns and benefits every other country.
10) Health for all by the year 2000 can be attained by better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.

The pioneering work of many missions, missionaries and health professionals working with FBOs contributed to developing these foundational concepts for Alma Ata. In DR Congo this history goes back more than one hundred years. A few of the key events from that history include:

- **1882:** Arrival in Congo of Dr. Aaron Sims, the first in a long list of medical doctors to work in Congo for Protestant missions.

- **1889:** Appointment of Dr. Adrien Atiman, the first in a long list of medical doctors to work in Congo for Catholic missions.

- **1928:** Forty protestant missionary societies from twelve countries create the Protestant Council of the Congo

- **1931:** Launching, by FOREAMI, of the Health District Approach in the Lower Congo

- **1971:** The Protestant Church of Zaire (ECZ) is formed with around sixty member communities, and a medical office to interface with the Ministry of Health. ECZ manages approximately 50 hospitals and several hundred dispensaries.

- **1974:** Adoption, under the leadership of Professor Ngwete, of the concept of CEBEC (Center for Community Welfare)

- **1975:** The national "Alma Ata" Conference at Mayidi establishing the mandate for integrated medicine and decentralized health zone.

- **1975-1982:** Launching of Congo's first Health Zones at Vanga, Kisantu, Kimpese, Karawa, Kasongo, Bwamanda on a revised model of the FOREAMI health districts

- **1982:** The National Health Plan puts forward the vision and plan to create 300 decentralized health zones based on comprehensive integrated approach to PHC.

- **1983- 1985:** Subdivision of the Congo territory into 306 Health Zones

- **1987:** Adoption of the Mbanza Ngungu Chart outlining public private collaboration for the health sector. [3]

The Mayidi conference in particular was organized in 1975 in collaboration between the MOH and church health services. That conference discussed and adopted the principles of "integrated medicine" and "decentralized health zones" three years before Alma-Ata.

FBO and NGOs were, in fact, among the first groups to decentralize curative care from hospitals to community health centers promoting curative, preventive and promotive services. Unfortunately these efforts and contributions have not been well documented. One article that notes the contributions states the following:
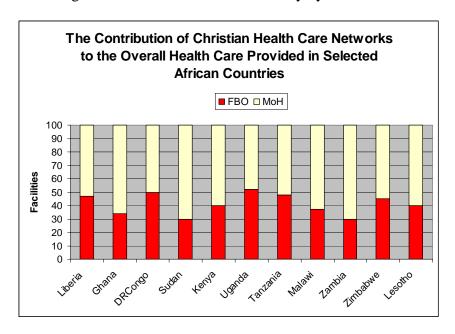
> *For well over a century, missionary organizations have played a significant role in the development and provision of health care in many African countries. Although church health services may be overlooked by health policy makers and indeed often may seem to fit uncomfortably within broader NGO systems and structures, they are probably the type of NGO most widely involved in health care, and especially hospital care, in Africa today.*

> *Missionary organizations grew significantly during the early part of the twentieth century*

and by the time of independence were a significant part of the health care services in many African countries.

Matomora notes that, in 1971, Protestant churches alone operated medical programmes in 81 countries, including over 1200 hospitals; in sub-Saharan Africa church hospitals provide a substantial part of the service: 43% of medical work in Tanzania, 35% in Malawi and 34% in Ghana.[4]

The contributions by FBOs providing primary health care services are also aptly illustrated in the chart below summarizing the level of health service delivery by FBOs in Sub-Saharan Africa.[5]
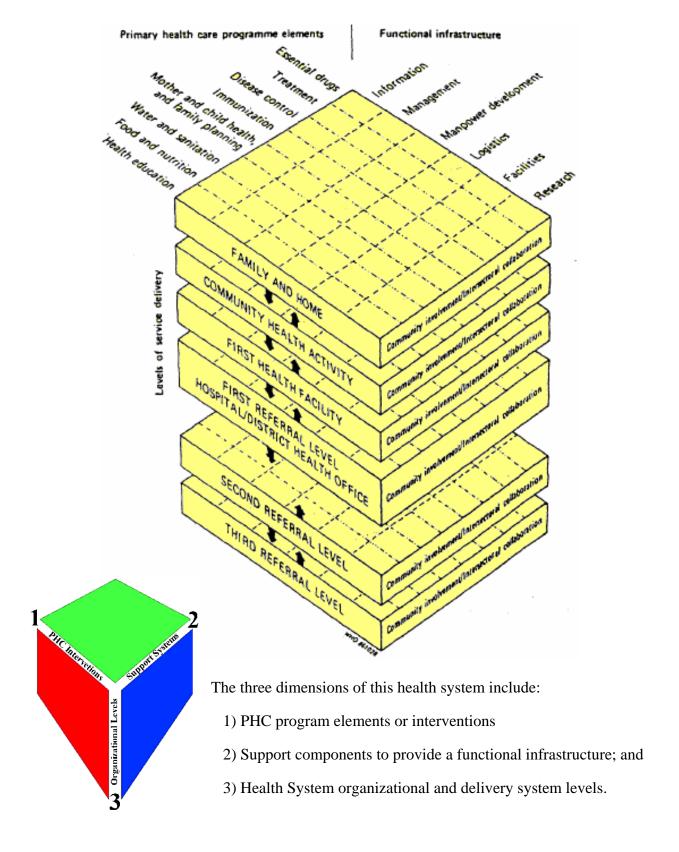
The Contribution of Christian Health Care Networks to the Overall Health Care Provided in Selected African Countries

Legend: FBO, MoH

Y-axis (Facilities): 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100

Countries: Liberia, Ghana, DRCongo, Sudan, Kenya, Uganda, Tanzania, Malawi, Zambia, Zimbabwe, Lesotho

3.   **Building an Infrastructure for PHC**:

Someone has compared having "Good Health" to listening to "Good Music." Enjoying music requires good records (or CDs or mp3s) and a system to play them on. Similarly, "Good Health" requires good health interventions and a health system to play them on. However, too often the health system record player is broken. Meanwhile more attention (and funding) is concentrated on the intervention "CDs" rather than on repairing/maintaining the health system.

A conceptual framework for the development of an integrated and comprehensive health system described by Smith and Bryant in an article entitled "Building the Infrastructure for Primary Health Care: an Overview of Vertical and Integrated Approaches." The authors concluded that:

District health systems based on primary health care provide an excellent practical model for health development, including an appropriate health system infrastructure. Within this model the concerns with accelerating the application of known and effective technologies and the concerns with strengthening of community involvement and intersectoral action for health are both accommodated. The district health system provides a realistic setting for dialogue and planning involving both professionals and non-professionals concerned with health and social development.[6]

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A conceptual framework for the integrated health system proposed in the same article is shown in Figure 1 as from a World Health Organization (WHO) technical report.[7]

The three dimensions of this health system include:

1) PHC program elements or interventions

2) Support components to provide a functional infrastructure; and

3) Health System organizational and delivery system levels.

The first dimension of program interventions are health activities selected in consultation with the community. Program interventions are represented in the model by, but not limited to, the eight essential components of primary health care as established at Alma-Ata:

- water & sanitation
- nutrition
- essential medicines
- curative care

- immunizations
- maternal child health & family planning
- health education
- disease control

The second dimension of support components are subsystems which facilitate and support the delivery of program interventions. Examples of major support components include:

- planning & management
- financial sustainability
- health education
- health infrastructure & equipment

- logistics and facilities
- information systems
- community development
- training and supervision

The third dimension of health system levels involves the capacity building of interventions and support systems at each level of the health system, including community, PHC facility, referral facilities and health system administration.

Health systems strengthening refers to strengthening the components and three dimensions of this framework. This includes a matrix of program interventions, support components and community participation at several system levels.
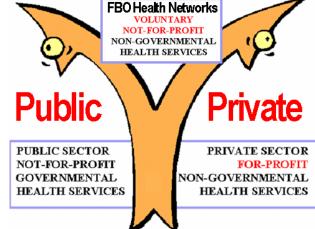
The role of FBOs within this framework is traditionally viewed as one of providing service delivery at the community, health facility and hospital referral levels. This is an essential function of FBOs. The health infrastructure built by missionary efforts a hundred years ago in many countries makes them the most important health service delivery partner of the Ministry of Health.

However, the role of FBOs as a development partner goes beyond the first dimension of service delivery to include the second dimension of developing and managing support systems, including, in some countries, the co-management of a particular health systems level, e.g., the co-management of health zones by FBOs in DR Congo.

It is important to note in this respect that FBO-managed health facilities are more public than private sector. The medical work of FBOs health networks has for many years been considered part of the "private sector." This has encouraged an atmosphere of competition, rather than collaboration, with the public sector. In fact, the not-for-profit philosophy of most FBOs and NGOs is links them much more to the public sector. And not just for the provision of health services, but also for the management of the support system.[8]
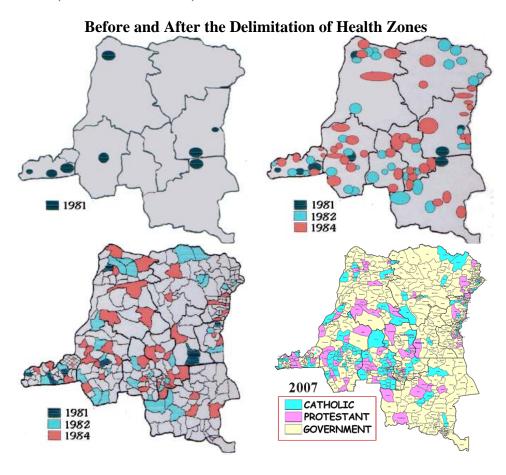

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In Congo 50% of hospitals and are owned and managed by local churches. The Ministry of Health in consultation with the churches and other NGOs opted to build on, rather than to compete with, the health infrastructure of churches. A national "Alma Ata" conference, organized jointly in 1975 with the churches, discussed and adopted the concept of a decentralized health zone. During the next five years a few pilot health zones were allowed to develop as local initiatives.

In 1982, these pilot health zones became the basis of a national health plan to create 300

Year	Functional Health Zones		FBO/NGO managed or co-managed	
	Number	Percent (out of 306 total HZs)	Number	Percent of Functional HZ
1981	8	3%	6	75%
1982	41	13%	32	78%
1983	64	21%	44	69%
1984	87	28%	61	70%
1985	112	37%	74	66%
1987	220*	72%	130*	59%
1990	179	58%	117	65%
2000	100*	33%	60*	60%

geographically defined health zones to cover the whole country. FBOs and NGOs were the developmental catalysts for this process. By 1984 FBOs/NGOs were developing and co-managing 70% of Congo's 87 functional health zones (see table).[9]

This bottom-up development of self-defining and evolving health zones (as shown in the figures below) was catalyzed in large part by FBOs. This eventually resulted in the creation of a critical mass or "People's Movement" to use the language of Korten (see next section.) The two year process for the official delimitation of health zones was truly a remarkable historical event. Today FBOs and NGOs continue their key role in the co-management of one-third of Congo's 515 health zones (re-delimited in 2001).

Before and After the Delimitation of Health Zones

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The work of FBOS in DR Congo in the development and co-management of health zones have demonstrated that:

1) FBO hospitals provide a good infrastructure for the management of a health district: The presence of a functional referral hospital, office space and equipment, a garage and maintenance facilities, housing and gardens, electricity and fuel, supply line for medicines, and schools attract and retain competent staff even in isolated rural areas. This infrastructure helped these health zones to develop at a relatively rapid rate.

2) Most FBOs are willing to adopt the health district concept: When given the opportunity, most FBOs were quite willing to concentrate their efforts in serving the entire population of a geographically defined population, rather than working in scattered and isolated pockets of church members. Making a clear distinction between administrative/financial supervision and technical supervision was a element in coordination between partners.

3) FBOs owned/managed health facilities are a permanent and sustainable resource: The medical work of these groups will continue long after other international health projects and agencies are withdrawn. FBOs contribute, therefore, to creating a sustainable health system.[10]

The role of FBOs in helping to develop the decentralized health system of DR Congo is exceptional, and does not match the experience of FBOs in other countries where their role has been more limited to service delivery. The situation in each country is unique, and the co-management model of DRCongo can not automatically be replicated in other places. However, this potential is too often simply overlooked or ignored. Their potential needs to be assessed and developed on a country by country basis as part of the national health plan. Possible models for these working relationships are summarized in the table below:

Possible Models for FBO and Governmental Relationships[11]
➢ Independence of church services with no formal relationship other than NGO registration with government
➢ Independence but with a grant-in-aid from Government, either central or local
➢ Collaboration between Government services and church services on the lines of Health Delivery areas with shared supervision, shared responsibility for service delivery and quality
➢ Collaboration in a formal partnership to provide comprehensive coverage across the district
➢ A contractual relationship, either competitive or (more probably) negotiated, with funding provided by Government for specific services and even specific levels of service to be delivered by church health services
➢ Merger between government and church health services to integrate services for a district population
➢ Nationalization by government of non-government hospitals (as in Nigeria in 1975).

4.   FBO and NGO Health Developmental Strategies

The development of an integrated and comprehensive PHC system as described above requires a special set of developmental and management skills. While the MHO must define the framework and provide the leadership for this process, other developmental partners, including NGOs and FBOs, have much to contribute tot the process. A conceptual framework for the development and management of health systems by NGOs and FBOs can be found in *Getting to the 21st Century* by David Korten.[12] As shown in the table below the potential "generational" roles of the NGOs/FBOs includes:

➢ First Generation as "doers" in the "Relief and Welfare."

➢ Second Generations as "mobilizers" for Community Development.

➢ Third Generation as "catalysts" for "Sustainable Systems Development"

➢ Fourth Generation as "Activists and Educators" for People's Movements.

Four Generations of NGO Development Strategies

	FIRST Relief & Welfare	SECOND Community Development	THIRD Sustainable Systems Development	FOURTH People's Movements
Scope	Individual & Family	Neighborhood & Village	District, Region & Nation	National or Global
Chief Actors	NGO	NGO plus community	Public & Private Institutions	Loosely Defined Networks
NGO Role	Doer	Mobilizer	Catalyst	Activist & Educator
Management Orientation	Logistics Management	Project Management	Strategic [systems] Management	Coalescing & Emerging Self-Managing Networks
Examples	Feeding centers Hospital care	Mobile teams Integrated Community-based develp.	Integrated Health System Health Districts	literacy movements IPPF network

These "Generations" would seem to imply that there is some sort of logical progression over time from one strategy to another. There is evidence for this, especially with regards to NGOs who were created in response to a crisis situation (often following a war) to provide "Relief & Welfare" during a crisis period, and later opted to continue their work along more developmental lines. The history and work of OXFAM, Mennonite Central Committee, and Save the Children follow this pattern.

However, the term "generations" would also seem to imply that a one-way evolution in the work of NGOs. This is not the case, as there is an appropriate time and conditions for all four approaches of these developmental strategies

NGOs and FBOs are probably best known for the work in "Relief and Welfare" and in "Community Development." The potential for "third generation" NGOs to assist in sustainable systems development in building a health system (or rebuilding it during a post-conflict

situation) is now being explored in a number of countries, e.g., DR Congo, South Sudan and Liberia. In this capacity, an NGO or FBO serves as a catalyst and strategic systems manager to facilitate collaboration between public and private institutions in the management of services for a geographically defined area.

There is often an assumption that NGOs who effectively provide either "Relief and Welfare" or "Community Development," could also provide "Sustainable Systems Development." This is not the case. Each developmental strategy requires a different set of technical, logistical, and management skills. There is a learning curve for "third generational" development strategies that a few NGOs are now beginning to explore. Some FBOs, on the other hand, have been doing sustainable systems development consciously or unconsciously for many years.

The evolution of FBOs work in moving across these developmental "generations" work has been captured in some vignettes by Dr. Sambe Duale, a Congolese doctor who personally experienced this transition. His recollections include the following:

> ➤ *Hospital-based curative care: Mission or church related hospitals were developed all over Zaire by various denominations. In 1960 about 50% of Congo's 400 hospitals were church-owned and managed.*

> ➤ *Hospital, dispensaries and mobile teams: Some religious groups moved closer to the community with selected curative and preventive care services such as immunizations and nutrition supplementation through dispensaries and advanced mobile teams. Children would wait anxiously and with joy for that once a year mobile clinic.*

> ➤ *Hospital and satellite health centers: In recognizing the limitations of curative care and the high cost and non-continuity of mobile clinics, pioneering groups moved to developing satellite health centers offering integrated medicine, i.e., providing facility-based and community-based curative, preventive, and promotive health care services.*

> ➤ *Decentralized integrated health zones: As part of the national health policy for "health for all" FBOs began organizing decentralized health zones to serve a co-manage all health services in a well defined geographic area.[13]*

The sustainable system development and co-management of health zones in DR Congo by FBOs as part of a National Faith-Based Health Network have demonstrated that:

1) FBOs (especially national FBO health networks) can be effective "third generational" sustainable systems development partners.

2) FBO-managed programs have access to funding not available to governments: FBOs can receive funding from international partners who do not normally provide assistance through Ministries of Health. This can provide a supplemental and complementary assistance to the development of a health district.

3) National FBOs health networks can play a key role in the management of umbrella health systems building projects: FBO networks, e.g., Christian Health Associations, can play a key role in the coordination of their diverse members with the Ministry of Health. In some cases (DRCongo, Zambia) they are also serving as effective channels for the management of umbrella health systems building projects:

5.   Recommendations

Based on the above observations, the role and work of National Faith-Based Health Networks might be examined and improved through the following actions:

1) The role of National Faith-Based Health Networks needs to be defined, recognized and promoted as a not-for-profit public sector partner to Ministries of Health, rather than as a private sector competitor. This is a perspective that all development partners need to work on, i.e., donors, MOHs, NGOs and FBOs.

2) The role of national FBO health networks in health system management or co-management (through delegation by the Ministry of Health) as part of a decentralized health system should be recognized and developed.

3) Health system assessments and planning at a country, regional, district or local level should always examine the potential of FBOs, especially the role of National FBO Health Networks. The paradigms discussed above could provide a guide for conducting such an assessment.

4) North American and European partnering agencies should broaden their vision, objectives and funding to include capacity-building of National Faith-Based Health Networks. A number of FBO networking agencies, e.g. IMA World Health and Christian Connections for International Health (CCIH) are well positioned to manage and provide this type of development assistance to National Faith-Based Health Networks.

5) Donor agencies should examine opportunities for capacity building of National Faith-Based Health Networks, e.g., Christian Health Associations, to strengthen collaboration between them and Ministries of Health in the co-development and co-management of an integrated health system should be explored.

6) National Faith-Based Health Networks should explore their capacity to manage umbrella projects on behalf of their member agencies and as part of the national health system. This may require establishing connections with partnering agencies to handle, at least initially, financial management procedures to receive funding from large donors.

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