The World Health Organization Engaging with Civil Society Networks to Promote Primary Health Care: A Case Study

Claire Dickerson, Nathan Grills, Nick Henwood, Susannah Jeffreys, and Ted Lankester

Engagement between the World Health Organization (WHO) and civil society organizations (CSOs), gains importance as CSOs increase their contribution to public health; particularly to primary health care. To better engage civil society in revitalizing primary health care the WHO collaborated with the Community Health Global Network (CHGN), a civil society network. This article uses the WHO-CHGN relationship to demonstrate how this collaboration enabled the WHO to inform and to learn from those with current primary health care experience. Learning from a systematic documentation of the collaboration provides insight into the WHO and CHGN perspectives concerning the relationship; informs future WHO-CSO collaborations and contributes to the understanding of the ways in which the WHO accesses and hears those actively engaged in health care programs.

INTRODUCTION

The World Health Organization and Civil Society

The constitution of the WHO encourages engagement with nongovernmental organizations (NGOs) as part of the wider engagement of civil society.[1] Such interactions reflect a UN wide pattern of engagement.[2] "Civil society" is a term used "to refer to the wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore refer to a wide of array of organizations: community groups, non-governmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations."[3]

Civil Society Organizations have become more visible as they form national and global networks, supported by greater access to information and opportunities for communication through the Internet.[4] Based on set criteria, Fidler[5] suggests that NGOs are among the actors involved at the 'global governance' level and Lee[6] reports that the potential role of CSOs has been considered in relation to discussions about the strengthening of global health governance.

In 2001, the Director-General of the WHO established the Civil Society Initiative to support relations between civil society and the WHO.[7,8] This reflected growing recognition by governments and multilateral organizations of the importance of civil society for improving public health. At the national level, CSOs make a particular contribution to providing services for marginalized peoples and "strengthening primary health care and community based health care."[9] Primary health care is one area where CSOs have intervened in global health policy.[10]

In 2002, the Civil Society Initiative concluded that "[t]he increasing role of civil society in public health has not only placed new demands upon WHO but has also opened up fresh opportunities for expanding the mutual benefits involved in partnerships. Integrating civil society into its work will be vital to the Organization's future development and bring much needed vitality and energy to meet the public health challenges of the 21st century."[11] Interactions between the WHO and CSOs bring benefits and challenges for the organizations involved. One of the challenges for the WHO is assessing the suitability of CSOs for engagement.[12]

Recently, there has been greater recognition of the contribution made to public health and primary health care by faith-based organizations (FBOs)[13] and "religious entities."[14] The role of FBOs in public health and international development is one factor that

has led to increasing engagement between the WHO and FBOs.[15]

Primary Health Care

The primary health care model was launched by the WHO through the Alma Ata Declaration in 1978, when there was agreement to tackle the "politically, socially and economically unacceptable" health inequalities worldwide.[16] Although initially taken up, much of the primary health care work from the 1990's onwards has been carried out through vertical rather than horizontal programs, which focus more on program delivery around specific issues than on community level empowerment.[17]

In 2008, thirty years after the Alma Ata Declaration, the WHO relaunched primary health care as an important component in its global health strategy and the focus of The World Health Report 2008.[18] Such an approach is supported by evidence of the effectiveness of community-based participatory intervention,[19] community health workers and primary health care.[20,21,22,23,24] However, the renewed interest in primary health care[25] and also in global health[26] comes at a time of shortage of trained health workers,[27] increasing health inequalities,[28] and a change in the nature of health problems due to factors such as urbanization, globalization,[29] and climate change.[30]

Collaboration Between the WHO and a Civil Society Network

In preparation for The World Health Report 2008, the WHO hosted a consultation with FBOs to explore renewing partnerships with faith-based communities and agencies.[31] This was followed by a consultation with NGOs the following year.

Prior to the consultation with FBOs, the WHO started to engage with the Community Health Global Network (CHGN), a network of over 2,500 organizations and individuals.[32] The vision of CHGN is to see high quality, community and faith-based health development raising health standards in the world's poorest areas. CHGN operates through fostering networks of practitioners, both internationally through newsletters and a website, and locally, through geographically-based clusters of programs.[33]

In this article, the WHO-CHGN engagement is used as a case study of collaboration between the WHO and a faith-based civil society network. In a discussion paper, the WHO defined collaboration as "the agreement of two or more parties to work together; it may entail nothing more than an understanding regarding mutual communication or it may extend to formal agreements to share various aspects of support so as to obtain a common goal."[34]

The purpose of the study reported in this article was to identify and document the learning arising from the WHO-CHGN collaborative process. A systematic documentation of the collaboration, completed in real-time, was utilized to elicit the learning of five key participants in this complex process. This learning is presented using a thematic analysis. This adds to the learning previously recorded from engagements between UN Organizations and CSOs, including FBOs.[35,36] Learning from a range of sources has been used to devise guidelines for multilateral organizations engaging with NGOs.[37,38]

METHODS

Nature of the Collaboration

The main foci of the WHO-CHGN collaboration were three primary health care consultations (2007-2009) and a NGO briefing held prior to the World Health Assembly in 2009. Table 1 summarizes these events and the nature of the involvement by members of the CHGN team. These team members liaised with, informed, and consulted with WHO staff, principally the WHO designated technical officer, and with staff and colleagues from a variety of NGOs during the preparation, conduct and follow-up of the events. There were

also a number of informal collaborative activities. For example, the WHO Partnership Office invited the director of CHGN for input on a document setting out parameters for the WHO's engagement with various strategic and operational partners.

Table 1   WHO-CHGN collaborative events and role of CHGN

Date	Event and Role of CHGN
December 2007	WHO Primary Health Care Planning Consultation with FBOs: *Towards Primary Health Care: Renewing Partnerships with the Faith-Based Communities and Services* Co-sponsor: World Council of Churches CHGN role: delegate and speaker (co-founder and director of CHGN)
September 2008	WHO Primary Health Care Consultation with NGOs: *Renewing and Enhancing Collaboration with NGOs Towards a Shared Agenda* Co-sponsor: CHGN CHGN role: co-chair (co-founder and director of CHGN); facilitator; participant; rapporteur (four CHGN team members including co-founder and project manager)
April 2009	World Health Assembly – Pre-Assembly Briefing for NGOs CHGN role: delegate (co-founder and director of CHGN)
November 2009	WHO-Center for Interfaith Action on Global Poverty (CIFA) Consultation on mapping FBO involvement in Primary Health Care worldwide Co-sponsor: CIFA CHGN role: delegate (co-founder and project manager of CHGN)

Documentation Method

A structured documentation method was used to record and learn from the WHO-CHGN collaboration during the period 2007 to 2010. An established field based method was adapted for this purpose.[39] This method is a documentation process used to organize information arising from activities and provide an opportunity to reflect on and learn from those activities in order to support future practice and facilitate sharing. Reflection and shared learning are seen as important aspects of the process, where learning is viewed as a social, collective process, based on practice and involving questioning current knowledge and building new knowledge together.

In the approach described in this article, a detailed record of the context and events relevant to the WHO-CHGN collaboration was used to facilitate informants' reflections of their experience of the relationship. Their reflections were documented and content analysed to formulate "learning points." The term content analysis is often "used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings."[40]

General framework

The general framework of the documentation was established by recording background information about CHGN including its vision, mission, focus and structure; its audience and beneficiaries; and the relationship of CHGN with other organizations and stakeholders.

Participants

Five participants were selected to act as informants for the documentation process based on their knowledge and experience of the collaboration between the WHO and CHGN. These five participants were: the WHO technical officer; the co-founder and director of CHGN; the co-founder and project manager of CHGN; and two other key members of the CHGN team. Purposive or systematic sampling, rather than statistical sampling, was used to identify those informants who could enable in-depth exploration of the collaborative relationship.[41,42]

The documentation process was coordinated by a researcher with experience of qualitative and quantitative research methods who has a volunteer role with CHGN. The researcher attended CHGN team meetings at which the collaborative activities were discussed but did not attend any of the four events that formed the foci of the documentation.

Data Collection and Collation

Phase 1. During the first phase of the documentation process, the researcher compiled the record of the context and events into a series of tables, or logframes. Relevant data and information from meeting notes and minutes, correspondence, other written records and online resources were extracted, added to the tables and referenced. The resulting "context and event" tables summarized the setting in which the collaboration operated in terms of developments in primary health care; current global health challenges; and the role of FBOs/NGOs in healthcare provision. Importantly, they also included a detailed record of each of the four events that formed the foci of the collaboration (Table 1). Each event was considered in three stages: preparation, consultation (or briefing) and follow up, and each stage was sub-divided into a series of activities providing a detailed "reconstruction" of the event to support the informants' reflections. This phase was conducted in consultation with three of the CHGN informants who also suggested outcomes and indicators for assessing the success of the collaboration, which were added to the tables.

Phase 2. During the second phase of the data collection each informant contributed their reflections of the collaborative process, providing insights from different perspectives. These reflections were collected independently from both parties; the CHGN informants first, followed by the WHO informant, using the context and event tables as a framework to aid recall. The informants were invited to identify their views of the main achievements, challenges and unexpected results for each event; and to reflect on the suggested outcomes and indicators, and to consider any enablers, challenges and unknown aspects for each outcome.

Three members of the CHGN team took part in the reflective process through face-to-face discussions in team meetings, when their insights were noted, and/or by providing independent feedback via email. The fourth CHGN informant, who was unable to attend the team meetings, submitted his reflections independently via email.

The WHO designated technical officer (henceforth referred to as the WHO-key informant) took part in an informal, in-depth telephone interview led by a CHGN informant with extensive experience of working with the WHO. The researcher took detailed notes during the interview and transcribed them afterwards.

Data Analysis and Interpretation

The reflections provided by the three CHGN informants were analysed first. The final tables, including the reflections, provided an organized and detailed text for content analysis. Using these tables as one "field text" the researcher prepared a research text,[43] composed of extracts or "learning segments" identified from the data, emergent themes, notes and comments, based on the field text. During the next stage of the analysis some of the

segments were collated within themes derived from the data to form a set of "learning points" or observations, which were reviewed by one of the three CHGN informants. This process was repeated using the tables which included the reflections of the fourth informant as a second field text. The researcher then integrated the two sets of learning points to form a composite set of CHGN learning points. A separate set of learning points was derived by repeating this analysis process using the transcript of the interview with the WHO-key informant as the field text. The emerging learning points were cross-checked against the field texts during the analysis process. Finally, the five informants were invited to comment on the learning points prepared for public sharing.

The following learning segments recorded in the research text illustrate the process of "decontextualization"[44] in which extracts from the data, which referred to "individuals" were excerpted and used to derive a single learning point, which is included in the main findings below:

1. *Learning Segments*
   a) Success of individual invites in getting involvement in the process (reference: data Table 2 Part 1)
   b) Forward movement seemed to be focused around individual relationships forming (inter-FBOs and with WHO) (reference: data Table 2 Part 2)
2. *Learning Point*
   a) Personal invitations were successful in involving participants in the consultations, and forward movement seemed to focus on the formation of individual relationships (with the WHO and between FBOs)

MAIN FINDINGS

Learning Points and Observations

The learning points and observations formulated by analysing the completed documentation are presented using four themes: the collaborative relationship (theme A); specific collaborative events (themes B and C); and the documentation method (theme D). Some learning points are relevant to more than one theme.

The perspectives of the WHO-key informant (denoted "The WHO perspective") and the CHGN informants (CHGN perspective) are shown separately. Some extracts from the transcript of the interview with the WHO-key informant are shown in quotation marks.

A. The Collaborative Relationship
   The Relational Framework
   The WHO Perspective
   - The WHO-CHGN collaboration developed through personal links between members of the WHO and CHGN. This relational background assisted in promoting an equal partnership in this endeavour.
   - All change is relational and has "everything to do with the ability of people to work together."

   CHGN Perspective
   - Personal relationships were key to the collaboration. The relationships between the members of the WHO and CHGN who initiated and led the process were more than professional; they were characterized by friendship, trust and mutual respect. This relational framework was important in the process of communicating ideas to the WHO.
   - Personal invitations were successful in involving participants in the consultations, and forward movement seemed to focus on the formation of individual relationships (with the WHO and between FBOs).

Procedures, Approach and Culture
The WHO Perspective
- The WHO needs neutral partners with expertise.
- The involvement of CHGN in contributing to WHO technical programs and guidelines is important in linking with WHO.
- CHGN was not seen as a global player by some in the WHO. However, after linking with WHO it has become "part of the global conversation – up front rather than behind."
- CHGN has a focussed identity as "a community health network." Networks can be more inclusive.

CHGN Perspective
- The WHO needs key spokespeople to be channels to and from the NGO/FBO community.
- Learning to understand how the WHO operates ("getting to know the system") and having the confidence to work with WHO were important. For example, understanding the WHO vernacular and how to collaborate so to influence the agenda.
- The ongoing process of WHO-FBO engagement at a central and policy level requires a change in WHO culture. Normalizing FBO engagement would be the most important long-term gain.
- The neutral network role and function of CHGN enabled it to act as a channel for an exchange of information and expertise; passing from the WHO via CHGN to the members of the network across the world and vice versa. CHGN was seen to be representing "community health", providing links to community health programs "on the ground" and enabling members to have a voice in a global arena.
- CHGN's open and inclusive approach to other religions was an important aspect of the collaboration.

Benefits of Collaboration
The WHO Perspective
- The WHO has been able to garner more players indirectly out of the collaboration with CHGN. ("CHGN did its job exceedingly well in terms of bringing players into view.")

CHGN Perspective
- Working collaboratively with the WHO enhanced the ability of CHGN to be a credible network; encouraged new members to join; raised awareness of CHGN in the US and provided opportunities for CHGN team building.

B. The WHO Primary Health Care Consultations with FBOs and NGOs
The WHO Perspective
- The consultations opened communications between the WHO and people in primary health care.
- There were differences in the terminology used by the WHO, CHGN and other players. During the meeting the WHO was talking about primary health care whereas CHGN and other participants had moved to terms such as community health and development.
- Indirectly, working with FBOs gave permission "in-house" for WHO staff interested in faith-based health services to dialogue around FBOs.

CHGN Perspective
- It was important for an insider at WHO to manage the WHO stakeholders to

ensure the consultation met their expectations and adhered to WHO protocol. This role was taken by the WHO-key informant whose coordination was largely responsible for the perceived success of the program.

- When working with the WHO, an FBO requires confidence to pursue and help lead the agenda.
- The consultations provided opportunities for building trust and confidence; collaboration; developing partnership and greater mutual understanding; learning from each other; respectful engagement; sharing beliefs; having an open conversation (speaking and listening); and for FBOs and NGOs to be recognized and valued.
- Greater clarity of the purpose and intended outcomes of the consultations was needed, together with a clear, empowering process for participants to move the common agenda forward.
- There were difficulties in measuring the extent of achievement, impact and influence of the consultations.
- For the FBO consultation with the WHO there was simplicity in coming to a shared agenda on primary health care without the need for detailed theological discussions about values.
- Using email to engage NGOs (including CHGN contacts) in the collaboration increased the understanding amongst NGOs of the WHO and of WHO's acceptance and interest in FBOs. More people came to know about the WHO report on primary health care and the importance of FBOs.
- There were challenges in managing the different approaches and different types of NGOs. For example, theoretical, philosophical, political, academic and practical approaches; and advocacy and service-delivery focused types of NGOs. However, working together in this way was valuable as there was a need for members of different types of organizations to learn from each other.
- It was difficult to include smaller NGOs. Even those who attended the consultations tended to be dominated by larger NGOs. The WHO meeting protocols and systems can be quite intimidating and might even marginalize smaller NGOs.
- The richness of the consultation and the credibility of the documentation were encouraging. For example, the value of the group discussions; the range and relevance of the ideas shared; and the degree of cooperation between participants.

C. The WHO-CIFA Consultation

The WHO Perspective

- Rather than building primary health care the momentum behind FBOs/NGOs has gone into an agreement on the WHO-Center for Interfaith Action on Global Poverty (CIFA) Global Mapping Standards to describe Religious Health Assets. This is a major advance for FBOs as it allows CIFA to document and quantitatively measure the contribution of FBOs to alleviating health problems world-wide. Civil society and FBOs need to capitalize because "If you're not on the map you don't exist."
- Through the CIFA mapping, the WHO is now working with global civil societies. CHGN was "an inspiration for all of that."
- CIFA has been able to develop a WHO linkage based on the model used with CHGN and the World Council of Churches. They have been able to contribute and assist the technical team in the WHO, which is important.
- In terms of the mapping "visibility draws attention to you and may raise questions of transparency."

D.   The Documentation Process
   CHGN Perspective
   - The documentation process encouraged CHGN team members to reflect on and discuss their activities and experience of working with the WHO and identify some of the learning. This learning can be shared with others and used by CHGN to improve future planning and practice.

DISCUSSION

Civil society, including NGOs, FBOs and global and national health networks, has made a significant contribution to the development, implementation and renewal of primary health care.[45,46,47] In the 1970s, for example, collaboration between the WHO and a global health network established by the World Council of Churches, the Christian Medical Commission, played an important part in the formulation of the primary health care model. [48,49]

This study took place at a time of revitalization of primary health care[50,51,52] and demonstrates that ongoing collaboration with the WHO using intermediary groups is still possible. The case study demonstrates how collaboration with CHGN, a civil society network, enabled the WHO to inform and to learn from those with current, practical experience of primary health care and community based health care.

A rigorous documentation-based method was used to formulate learning from the WHO and CHGN perspectives of the collaboration. Documentation methods are typically used to learn from the experiences of members of project teams at the end of a project, seen as the end of "collective learning."[53] These individual insights can contribute to organizational learning, the process by which organizations collect and use knowledge to change their practice.[54] Bloch and Borges, drawing on the work of Argyris, argue that an organizational learning approach is relevant to NGOs, with its emphasis on learning, continuous improvement, reflection on practice and on the values that underlie it. [55]

Adaptation of this technique in this case study facilitated learnings that will inform future WHO-CSO collaborations within primary health care and more widely. It also informs the discussion around the challenges faced by multilateral organizations, such as the WHO, when they engage with FBOs.[56] Some of the learning supports findings from previous interactions between the WHO and NGOs.[57,58]

A study of collaboration between NGOs, Ministries of Health and the WHO reported that mutual confidence and having a specific contact individual within the WHO were important, suggesting that 'people are more important than formal structures'.[59] In this case study, both parties viewed aspects of the relational framework as fundamental to the success of the collaboration. Developed and maintained through personal and professional links, this relational background helped to establish an equal partnership. It is this "partnership between equal partners" that suggests collaboration.[60] In 1998, Jareg and Kaseje reported a view that the WHO would benefit from treating NGOs and communities as "equal partners" in the context of renewed commitment to the health for all strategy.[61]

The extent to which beneficiaries see an NGO as representative of their interests is considered an important selection criterion when identifying an NGO partner.[62] In this case study, CHGN, as a network, was considered to represent "community health" and provide a means for the "exchange of information and expertise." The collaboration itself was thought to have developed from a need for the WHO to engage with "neutral partners with expertise" and "key spokespeople." The WHO-key informant suggested those seeking to work with the WHO might engage through involvement in WHO technical programs, thus contributing to the WHO's role as a technical agency.[63]

Both parties identified benefits from the relationship. The collaboration produced a type of reciprocal legitimacy where the WHO gained legitimacy through being able to engage with NGOs "on the ground" whereas CHGN gained credibility and recognition as part of the "global conversation" in primary health care. Therefore, the collaboration was an opportunity for both parties to effect greater outreach and influence.[64] Additional benefits

for the WHO included gaining access to public opinion. Challenges were associated with the practicalities of managing the individual consultation events. Differences in terminology and language between the WHO and CHGN and the wider primary health care community were acknowledged and members of CHGN identified a need to learn more about the culture and way of working of the WHO. For example, one important way of working for WHO is to create an enabling environment, in this case a normalizing of engagement with FBOs. However, such intangible outcomes were insufficient for the NGO partners who sought more concrete and practical outcomes. Such differences highlight the importance in such consultations of clarifying objectives, what represents progress, and methods of measuring of impact.

Members of CHGN acknowledged the value of using a structured documentation method to capture the learning. This approach had strengths and limitations. Schindler and Eppler identified four reasons: time, motivation, discipline and skills, for not identifying and recording project learning.[65] An essential component for the success of this documentation was the continued commitment of the contributors despite the time consuming nature of the process. A personalized approach was taken to collecting the reflections, enabling all the main contributors to take part. This was consistent with the value placed on individual views. Insights from the WHO perspective were provided by one key contributor, whereas four team members provided the CHGN viewpoint. Different contributors emphasized different events; CHGN participants identified more learning points from the NGO consultation in which they all took part, whereas the WHO-key informant focussed on insights from the WHO-CIFA consultation.[66]

CONCLUSION

The publication *Building from Common Foundations*, *The World Health Organization and Faith-Based Organizations in Primary Healthcare* states "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."[67] This article shares some learning to inform future collaborations between the WHO and CSOs and contributes to the understanding of the ways in which the WHO accesses and hears the "voices" of those actively engaged in health care programs. One of the challenges for the WHO and CSOs working in primary health care and community based health care is to maintain a commitment to working and learning together and ensuring that their interactions achieve maximum benefit for those living in the poorest communities for whom primary health care is not working.

Claire Dickerson *is a research fellow in the School of Education at the University of Hertfordshire, UK, with research experience in health and education.*

Nathan Grills *is working as a public health physician in North India. He completed his DPhil in Public Health at Oxford University exploring the relationships between civil society, government and multinationals in the field of HIV. He also undertook research for WHO on this same topic. He is currently employed at the Nossal Institute of Global Health, (Melbourne University) as a public health physician and post doctoral fellow.*

Nick Henwood *worked for community health and development in Nepal for 9 years from 1995 to 2004. Presently he is a general practitioner in a deprived urban area of Leicester, UK. He was a co-founder of Community Health Global Network.*

Susannah Jeffreys *is the Operations Manager for Community Health Global Network. She previously worked for the relief and development organization Tearfund, both in the*

UK-based Advocacy Group and overseas with the Disaster Management Team.

Ted Lankester *is the Clinical Director of InterHealth, an international health centre in London, and Community Health Global Network, a worldwide grouping of those committed to locally-driven empowerment responses to health needs. He is an international speaker, and the author of the widely used book Setting up Community Health Programmes; a practical manual for use in developing countries.*

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