

# Summary report of the inaugural meeting of the Anglican Health Network

Geneva, 15-16 June 2009

## Background

Following presentations at the Lambeth Conference 2008, a proposal for an Anglican Health Network began to gain widespread interest. Meeting in Houston in January 2009, a range of Episcopal and Anglican representatives explored elements of potential collaboration in the hospital systems in the United States, India and Middle East. With the support of the Anglican Communion Office, Revd Paul Holley and Mr. Lee Hogan made presentations at the Anglican Consultative Council meeting in May 2009. The Council accepted a motion to welcome the development of an Anglican Health Network. This inaugural meeting was called to organise the development of the network.

## List of participants

**Dr. Bennet Abraham** Medical Director of the Diocese of Kerala in the Church of South India.

**Revd Canon Dr Mwita Akiri** General Secretary of the Anglican Church of Tanzania and a member of the Anglican Consultative Council.

**Revd Rachel Carnegie** Archbishop's Secretary for International Development at Lambeth Palace.

**Dr. Alan Crouch** Population health consultant from Australia.

**Matthew Ellis** Executive Director of National Episcopal Health Ministries.

**Bishop Rayford High** Suffragan Bishop of Texas.

**Lee Hogan** recently retired as Executive Chair of the St. Luke's Episcopal Health System in Houston, having been a board member for 19 years.

**Revd Paul Holley** Priest-in-charge of La Côte Anglican Church and a member of the Anglican UN group in Geneva.

**Revd Dr. Robert Lee** Chair and CEO of Fresh Ministries and Be the Change International.

**Dr. Hisham Nassar** Medical director for the diocese of Jerusalem.

**Dr. Ernest Nwaigbo** Medical director of Owerri diocese in Nigeria.

**Emmanuel Olatunji** HIV/AIDS coordinator for the Council of Anglican Provinces of Africa (CAPA).

**Canon Diane Porter** Deputy for Episcopal Administration for the Episcopal Diocese of Long Island and on the board of Episcopal Health Services.

**Revd Terrie Robinson** Networks Coordinator at the Anglican Communion Office in London.

## **Monday 15 June**

### **Morning session**

The morning session took place in the World Health Organization. The meeting began at 09:00 and participants were welcomed by Revd Ted Karpf, Partnerships Officer for the Director of Partnerships and UN Reform in the Office of the Director General of WHO. Mr Karpf introduced the participants to the organizational structure of WHO and its policy- and decision-making processes. In particular, he explained the concept of primary health care and its evolution since the Declaration of Alma-Ata in 1978. WHO is today promoting the primary health care approach as a key element in strengthening health systems worldwide.

Dr Kumanan Rasanathan of the WHO Department of Ethics, Equity, Trade and Human Rights explained that WHO has done considerable work on the “social determinants” of health and the inequities in health status worldwide, and recognizes the role that nongovernmental (including faith-based) organizations have to play in achieving “universal coverage” of health care.

Asked how faith-based organizations could become effective partners with WHO, Mr Karpf explained that WHO is an “intergovernmental” organization in which governments are members. The delegates to the annual World Health Assembly are representatives of governments. It would be important, he said, for a faith-based organization to be known by the government in its own country in order for its role in health care to be recognized by WHO. He advised the AHN to collect evidence of what it does, compile data and show how it makes a difference.

Dr Badara Samb, Senior Adviser to the Assistant Director-General for Health Systems and Services, explained how efforts were being made to use the focus of tackling HIV/AIDS, tuberculosis and malaria not only to strengthen services for those diseases but also to strengthen the entire health system. He also described the need for “massive investment in health care worker training” in developing countries in order to ensure that enough doctors and nurses are trained, and stressed the need for adequate financial rewards and properly staffed and equipped health facilities so that health staff do not need to migrate in order to do their jobs properly.

Mr Alex Ross, Director Partnerships and UN Reform, described the reasons for global concern about pandemic influenza and the work of WHO and its global “alert and response network” that keeps track of disease outbreaks worldwide. He urged faith-based health organizations to give feedback to the national WHO office on any H1N1 infection that they may find in patients. In discussion it became clear that there was a lack of communication between ministries of health and Anglican health services in the countries represented (except the USA). For instance, WHO had arranged for the despatch of supplies of Tamiflu to a number of countries, but Anglican Health Network (AHN) participants were not aware whether their country was included or not.

### **Afternoon session**

The afternoon session, and the rest of the inaugural meeting, took place in the Ecumenical Centre. AHN participants were welcomed by Dr Manoj Kurian, Programme Executive for Health and Healing at the World Council of Churches (WCC). Dr Kurian explained that the WCC set up the Christian Medical Commission (now administratively the WCC Programme for Health and Healing) in the

1960s. The commission has a formal relationship with WHO as an NGO in “official relations” with that organization, which entitles it to send observers to meetings of WHO governing bodies.

Mr Lee Hogan then introduced the topic of faith-based health care which, he stressed, brings an extra dimension to health care systems. He spoke of the Anglican Communion as an enormously powerful entity with 80 million members worldwide. He pointed out that a system that was set up to distribute the gospel is also suitable for distributing mosquito nets, health care and other services.

Two basic premises were agreed regarding AHN: i) there is no intention to exclude any part of health care already being offered by Anglican churches, and ii) there is a need to measure what AHN does. AHN is intended to make a difference and there needs to be a record of whether it does so.

Two areas of focus were proposed for AHN:

1. Communication. The Anglican Communion currently has no clear overview of what it is doing in terms of health care. The communication role of AHN – initially through a website – would help it to see more clearly what is being done and whether there are gaps that need filling. On controversial issues, the site could provide a facility for open dialogue. It would also become a resource for Anglican health care workers.

2. Programmes. Unlike other networks of the Anglican Communion, AHN would initiate programmes. Two initial programmes that were proposed related to the sharing of medical equipment of all kinds (with training as required), and to micro health insurance to ensure that families do not sink deeper into poverty as a result of paying medical bills.

In discussion, there were further proposals for the inclusion of elements such as education (to help pastors understand health and to help health workers understand faith), training in advocacy, and grant facilitation.

The afternoon session closed with a stock-taking of what the various participants could bring to AHN in terms of experience, resources (of all kinds), contacts, and linkages.

## **Tuesday 16 June**

### **Morning session**

In the opening part of the session Revd Paul Holley proposed an organisational rationale for the participants of the meeting. This would provide the beginnings of a structure in which people and organisations from around the Anglican Communion could engage with the network.

1. Operational roles to develop the shape and activity of the network:

**Paul Holley** – coordinator of the associational elements of the network and project manager for the communications system.

**Lee Hogan** – coordinator of the programmatic elements of the network and project manager of the micro health insurance scheme.

**Claudine Haenni** – coordinator of the Francophone and Hispanic membership of the network and developer of the trilingual capacity of the network

**Emmanuel Olatunji** – network coordinator for the African provinces including liaison with leadership and adaptation of the HIV/AIDS network to the wider health agenda.

2. Diocesan and provincial partners in the development of their health work:

**Bennet Abraham** – Church of South India

**Hisham Nassar** – Diocese of Jerusalem and the Episcopal Church in Jerusalem & The Middle East

**Ernest Nwaigbo** – Diocese of Owerri and the Church of Nigeria

**Alan Crouch** – as a champion and consultant to the development of Anglican health collaboration in the provinces of the Far East and Oceania.

3. Organisations that can partner with the network to help develop particular elements:

**Robert Lee** of Fresh Ministries – assistance with the programmatic activity of the network

**Matthew Ellis** of National Episcopal Health Ministries – assistance with developing a wider parish health and healing element to the network

**Bishop Rayford High** – support for the development of chaplaincy and pastoral care services of Anglican hospitals.

**Terrie Robinson** – liaison with the Anglican Communion Office, the Instruments of Communion, and other networks.

4. Oversight roles on a board of directors:

**Diane Porter**

**Mwita Akiri**

**Rachel Carnegie**

The group agreed that it should maintain a continuing role in shaping the future of the network alongside other key individuals. It will plan a further meeting following the first year's programme to review progress.

The following session chaired by Mr Lee Hogan focused on the practical steps that would need to be taken in establishing AHN. These were:

- to find funding;
- to establish a legal presence and an office;
- to set up a website;
- to do the background research necessary for setting up programmes on equipment-sharing and micro-insurance.

It was agreed that funding would probably have to come from specific church sources initially, but that any announcement of the network would invite all parts of the Communion to participate, even with small amounts, as founding members. Buy-in from developing countries would not only help to generate enthusiasm and commitment but could also help in fundraising. AHN would need to seek mid-term and longer-term funding during its first year of existence.

It was agreed that Geneva was a useful location for the AHN office in view of the international reputation of the city, and the presence of church organizations in the Ecumenical Centre and the World Health Organization (and other UN agencies). An office would be available in the Ecumenical Centre (the office of the Anglican UN group) and Ms Claudine Haenni would be ready to work on establishing AHN as an “association” under Swiss law.

The creation of a website would involve specific technical work, decision about target audiences, design, selection and creation of content, and promotion. Revd Terrie Robinson said that the AHN website could be accommodated within the Anglican Communion website, managed by the Anglican Communion Office in London and it was agreed that this was appropriate, though with the proviso that the site might have to move if it grew too large or too rapidly.

On programmes, Lee Hogan provided participants with a general introduction to the issues of micro-finance and micro-insurance, and specifically health micro-insurance.

The first year’s budget for AHN was agreed at a total of US\$ 162,500

### **Afternoon session**

This session was devoted to the topic of micro-insurance, with specific contributions from Richard Leftley, the president of MicroEnsure (a company that provides micro-insurance services to developing countries), Craig Churchill, team leader of the Microinsurance Innovation Facility of the International Labour Organization, and Allison Kelley, a consultant from the Ministerial Leadership Initiative for Global Health.

Issues that were raised during the session included:

- Much health care in developing countries has to be paid for out-of-pocket. Thus paying for health care can be catastrophic for a poor family. According to Freedom from Hunger, 24% of people admitted to hospital in India leave destitute.
- Outpatient care is best funded through a savings scheme; inpatient care is best covered by insurance which enables large risks to be pooled.
- The insurance would need to specify which diseases and conditions are covered (and not follow the western policy of everything is covered unless it is specifically excluded). One idea would be to focus on the top five causes of illness in the country concerned.
- It would be difficult to design a global insurance. The micro-insurance scheme would need to be designed and costed differently for each country.

Participants agreed that AHN should test the viability and replicability of a health micro-insurance scheme through a pilot project. Such a pilot project would require:

- a large and relatively accessible group of people in one geographic area (not dispersed over long distances);
- strong local leadership;
- a willing insurer, and someone to perform the “back office” functions of paying claims and controlling fraud;
- access to hospitals and health facilities nearby;
- ability to design an appropriate insurance product, and to educate users.

Participants discussed possible locations for the pilot project, and Mr Hogan was charged with investigating the issue further and selecting a partner to provide the micro-insurance service. An issue that would need to be agreed locally would be the sales channel – via the local Anglican priest to the congregation, via the congregation to the local community, or via an agent of some kind. Signing up the entire parish at once would reduce costs but might not be viable.

### **Next Steps for AHN**

1. Establish a mission statement and a case statement that can be used to promote and fund raise for the network.
2. Constitute an association under Swiss law as the legal body that will host the network.
3. Sign a Memorandum of Understanding with MicroEnsure to further explore the potential of micro health insurance.
4. Undertake a fund raising appeal to launch the first year programme.

Report compiled by:

**David Bramley and Paul Holley**

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