

# Medicus Mundi International

## Newsletter No. 65, Summer 2000

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### **Introductory**

The World Health Assembly 2000 in Geneva, in which Medicus Mundi participate having the status of "Official Relation with WHO ", is already a few months behind us this introduction. For MMI the Assembly promised to be of special impact, because Health of Chad was prepared presenting a Resolution on "improving PHC at district contracting NGO health institutions". Chad took this initiative after realizing the its statement on contracting made by MMI during the World Health Assembly 1999. However too rapidly for the officers of WHO, they could not shape the resolution into the proper to pass the Assembly. Therefore they decided to postpone the Resolution until next this endeavors the subject "improving PHC by way of contracting" got already now a the members of WHO.

In the last Newsletter meantime we gave a summary report of the 1999 Dar consultation meeting of national NGOs of anglophone Africa partners, made by Marie was the person who facilitated and supervised the meeting. She has now completed the report can be acquainted on request at the MMI office. We can offer you in these presentations of the Dar report, the one of Medicus Mundi member Cuamm, Dr Gius Memisa Medicus Mundi Dr Jaap Koot.

Around the same time in November 1999, a likewise consultation meeting was held Africa partners in Conakry. WHO's Dr Berckmans and Dr Perrot have reported on the last Newsletter We have now the Memisa report available, the main organizer of the with MMI. The aim of both meetings was first to consult the national NGO partners on the MMI statement "improving PHC at district level by way of contracting". Secondly together how to improve and strengthen the representation of national NGOs at Regional Office. We are happy to give you now as a completion of the last MMI Newsletter missing reports.

MMI hopes in the coming years to develop strategies for ways of contracting and to support (local) governments in elaborating their contracts.

Speaking about contracting, WHO organized recently in Dakar, with the support of MMI contracting of NGOs and governments? Francophone partners and government MMI-member AMCES (Benin) Dr Frank de Paepe attended the meeting and gives his World Bank occupied herself with NGOs and contracting (why have WHO and WB no

on this matter? That saves time and confusion). AMCES was present there and reporting.

It should be clear for the reader that MMI is not propagating or making her international level as an international NGO. Although it looks like big business on co on at supranational level with international NGOs, this not the way MMI is direct focussed on her partners at district level; in order to improve PHC at those level b between themselves and the District Health Team by way of contracting.

Although MMI is not related to any official church, her members cooperate in the field related health institutions. The relations of MMI with the Vatican are friendly, w ourselves completely with the sometimes-rigid moral issues. Dr Peter Kok of Memis participated in the Vatican conference "the Catholic Church and the Challenge of December 1999. Interesting is to read in Peter's report how concerned many pa leaders were. He concludes that one could not speak of a unanimous fixed moral st: prevention.

MMI was also invited in the person of Dr Edgar Widmer, former president of MMI, to meeting of AISAC in Rome; the Confederation of Catholic Health Care Associa 26-28th may 2000. He was in a position to stress the role of church health institutio integrated basic health system at local level, which could be improved for inst contracting.

Malpractice of drug supply and producing fake drugs are great problems. How can yo medicines you get in your hospital are not counterfeit? Several technical and cons were held during the Geneva World Health Assembly. One of them was of special im namely the briefing on counterfeit drugs. Quality control of locally manufactured or sometimes weak and illegal smuggling is not easy to fight in many countries. So ever are imposed on illegal negotiators, the quality standard of drugs is not guaranteed. which means that all kind of drugs appears on the local market, invites for misuse ir As prices are very high and not affordable for the majority of the people, they go to and by their medicines cheaper, not aware that these are many times counterfeit market is big business and therefor very attractive for deceivers among drug provider: this malpractice international action against the high prices of medicines and long last manufacturer of essential drugs is necessary. On the other hand our partners in solution for today. In Germany they took the initiative.

It was Medeor, the MMI member in Germany, that developed with the Würzburg Troj the GPHF, German Pharma Health Fund, the so-called MINILAB used for local qt variety of drugs. The MINILAB can analyze if your tablet or solution contains the ind the given quantity is really present. Medical stores local drug stores and hospitals can quality control, under the condition that you can handle it professionally and properly not just for sale, they are only supplied when good handling is guaranteed and guided special training course of two weeks in order how to handle this Minilab. She als responsibility for the follow-up. This follow-up is of great importance to keep up your " network is ready to support and guide the Minilab introduction and strategy. The first s of the partners.

Two fascinating challenges for MMI: supporting of local contracting at district level use of counterfeit drugs. Two spearheads for the coming years?

Sake Rypkema

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## **Consequences of the new roles of Government for the NGO providers from the National co-ordinating body**

Paper for the MMI Consultation Workshop, Dar Es Salaam, 5-7 November 1999.  
Daniele Giusti, Executive Secretary, UCMB

### 1. Introduction

When a Government re-defines its roles and functions, a major change takes place in relationships between different levels of Government. This is basically what the implementation of administrative decentralization policy has brought about in Uganda, within the framework of structural adjustments many countries of the world have gone through and are still going through. This has been (and still is) one of the consequences/problems (and their analysis) caused by these changes in relationships between different levels of Government (in Uganda central, district, sub-county and respective administrations). What is often not adequately perceived, or at least not fully studied, are the consequences/problems/challenges that these changes have brought about for the organizations of civil society (associations, non-government organizations, institutions).

This presentation wants to address exactly this point, without the claim of being a final analysis. It must be looked at simply as a first attempt of outline of a set of questions that need to be addressed from all parts involved. These questions are drawn from direct experience and the analysis arising from a defined context: in the first instance we are addressing questions pertinent to the health sector in Uganda. In second instance, we are addressing questions pertinent for the health care institutions and their organizations. Without excluding that the issues are also pertinent for a wider context (indeed sometimes they are), it is necessary to maintain a broader perspective.

## 2. The changing environment

### *2.1. The new roles of Government in the Health Sector*

The recent Policy of the Ministry of Health defines the following roles for Ministry (Chapter 5)

- Policy Formulation, setting standards and quality assurance
- Resource mobilization
- Capacity development and technical support
- Provision of nationally co-ordinated services (such as epidemic control)
- Co-ordination of health research
- Monitoring and evaluation of the overall sector performance.

The implementation of the National Policy is reserved for the District. Within this framework an objective that the private sector (composed by different actors) is to be a major part of national health development. A series of 8 objectives of the policy are stated in this document, the most important of this is the first: "Institute effective means of promoting private sector health with full understanding of the nature, scope and scale of its contribution to the National Health System." (2. Health Policy chapter 9).

Two important issues emerge: decentralization and partnership. The policy does not specify how this will be achieved. The Strategic Plan has the task of outlining how this will be achieved. It is anyway already possible to make some remarks.

### *2.2. An incomplete decentralization: a "centralistic" decentralized government?*

One of the major remarks to make at this stage is that the entire rationale of decentralization has not been well absorbed at central level, and the policy witnesses to it. There is enough evidence that the context where there is need of documenting this evidence. It appears that the governments (the Districts) are lagging behind in grasping this rationale. Evidence of the uncertain status of the District Health Management Team (a broader team than the District Health Team). In several district health planning does not take into consideration the environment present in the district, but is limited to the planning of the government health sector. Even when health planning is considered, it hardly involves the various providers as stakeholders, but is limited to the provision of selected interventions (mainly related to the existing national health strategy). Partnership is emerging as feature at central level, with some inconsistency though, but not at district level. What seems to be missing here is a systemic view of health care. In second instance, the need to arrive as far as possible at an integrated systemic view of health care provision. District health teams often take up an implementing role, while, in line with the policy environment, their proper role would be that of identifying the priorities, planning, setting the agenda, mobilizing resources, securing training, monitoring the performances and evaluation.

In recent times a major policy change has been the introduction of the concept of the sub-county (a kind of smaller district the size of an administrative county (an almost self contained

entrusted to a major health unit -hospital or up-graded health centre - selected on a level, regardless of its being government, non-government or private. Even in this case, the technical criteria used by the ministry of health have often been ignored by the local government (council) is judged unsuitable to play a major role in the district health

It must also be stated that, though remarkable good examples exist, in general the health sub-district should have been handled with more attention. Partnership is not developed overnight. Each of the partners has to go through a learning process that is the expected end result. It is the nitty gritty of things that deserves attention. The following will dwell on some considerations about the partnership with non-government actors.

### 2.3. Vertical decentralization -horizontal decentralization.

The decentralization policy has clearly outlined how the powers of the state have to be transferred from the central level to the district level and to the sub-county level. We could call this (using adequate terminology) a decentralization along the vertical axis (along the axis of the state and administration of the state). It may take time to bring the policy to its full accomplishment, but the process is now firmly established.

Yet, another trend is emerging at central level, that has little or no correspondent in the past. It is the process through which the state and its organized expressions and evaluates how and when the implementation of public goals better be entrusted to other actors, without losing sight of the public goal that needs to be pursued. An extreme of this process would correspond to privatization. But we are not advocating privatization. We would rather argue that public goals can (and indeed are) pursued through the government apparatus/institutions. When, and if, so, then the process through which the state is able to recognize and support as part of the public system - at openly negotiated and agreed conditions - actors that institutionally do not belong to the state, would be qualified as "horizontal decentralization". The Catholic Church has defined the principle underlying this process as "subsidiarity".

### 2.4. The partner "church based private not-for-profit health sector"

Considering only the change of government roles is not enough. The changes occurring in the interface with a partner that has also changed. Much could be said about the past glory of the church in health care delivery. The vestige of the past is witnessed by the remarkable increase in health care delivery. It represents an all but marginal quota of the health infrastructure of the Country. I wish to dwell, rather, on the changes that have taken place in the church health services. These changes often appear as increasingly evident problems. These problems, though they can be analyzed in a summarily analytical way, need to be considered in the historic, social, political and ecclesiastic context. If any of these problems had occurred one at a time, they would have been more manageable. It is the fact that they occur together that makes their management difficult.

- The withdrawal of the founding bodies: during the eighties many of the founding bodies of health institutions in the process of "handing over" of the health institutions to the local church. At present the majority of lower level units and the great majority of Hospitals are in the hands of the local church (dioceses, religious congregation)
- The wear and tear of the socio-political upheaval: for fifteen years (mid-seventies to mid-eighties) these services have operated in the virtual absence of the state from health care regulation and provision. In other words, the church health services have borne the responsibility for health care provision for the people almost alone. They have managed to do so because independent from the administration of the state. But they have also suffered. They are like a body that has sustained a prolonged stress without support.
- Stewardship not substituted by professionally adequate management: the founding bodies and in many instances lacked adequate professional qualifications but had an established sense of stewardship. The decadence of the cultural environment is increasing difficulty with which even qualified managers behave as stewards. It is a datum that affects the entire society, hence, to a certain degree, also the church.

- The speed of change: the era of reforms that started in the late eighties has changed the external environment at unprecedented speed, that has not been matched by the process of adaptation, particularly in rural Uganda. We have a two-speed society. Rooted in the rural environment, church health services, with their management behind with that (sizeable) part of society that "is not able to make it".

### 3. A reformulated title

In the light of the summary description of the major changes occurring in the role of title of this viewpoint would better be formulated as follows:

*What is the perception and understanding that a national umbrella organization (representing based non-profit health institutions) has of the consequences of the new roles of government of the prevailing problems in the sector) for*

1. *itself and*

2. *for its affiliated institutions?*

The following paragraphs will first make some clarifications and subsequently enter into the exposition of the first point. Another presentation will take care of the second perspective.

### 4. Some necessary clarification

#### 4.1. Central co-ordination?

The national umbrella organization of the RCC health services is the Uganda Catholic Medical Bureau. The Bureau was established in 1956. It is difficult to trace now the original aim of the Bureau from the earlier descriptions of the roles and functions of the Catholic Medical Bureau. The Bureau's co-ordinating role. If one has to stick to the strictest sense of the meaning of words, the Bureau's co-ordination does not adequately apply to the national umbrella organization. The Bureau is (wrongly) considered as a highly centralized institution. This is at least the impression of a superficial observer. As a matter of fact, it is exactly the opposite. The RCC, with its canonical-juridical structure, is highly decentralized. The Health Commission Conference (of which the UCMB is the technical arm and secretariat), can suggest, coordinate, liaise on behalf etc., but hardly ever order. It simply lacks the juridical authority for a closer/comparative examination, the authority of the national umbrella is inferior to that of the co-ordination. At diocesan level, at least the co-ordinator operates with a delegated authority from the Bishop. The delegated authority of the Conference at central level is far weaker than that at peripheral level. So much for a juridical consideration. In the past, this "weak" position was corrected by the channelling of Government funds to the voluntary sector (Grant in aid). This required a good degree of co-ordination. With decentralization, this corrective mechanism (now government support takes the form of "delegated funds" to the district health sector): the central level is by-passed in the process of resource channelling.

#### 4.2. The need of balance (opposite dynamics of Government and civil society)

Extrapolating the dynamics that could be observed, one could argue that, while Government with a highly centralized organization whose weaknesses need to be corrected by decentralization, for the Church, as well as for civil society, probably there is a need for opposite dynamics. It is important not to perceive this statement under a juridical perspective but in the direction of a dynamic. The state needs to delegate part of its powers to the local level. From a highly fragmented starting point, it has to find ways and means to create aggregates that could meaningfully interact with comparable strength with the various levels of government (and not exclusively government). The dictionary here would suggest the term "co-ordinate". It is not very important to find the right word as much as identifying a process. The same applies to the RCC health services. The aggregated levels have to receive authority from the grass-roots empowered to, if that is the case, "co-ordinate".

### 5. Consequences or challenges?

In the light of the above explanations, it is possible now to expose what could be the "consequences" or, better, challenges for the national co-ordinating body. As said in the previous presentation, the challenges posed by the changes to the local co-ordinating bodies and to the implementation of the reforms are covered by another presentation.

A question here guides the answer: in the specific context presented above, what cannot be done by the local level? In other words: how is subsidiarity respected so that each level exercises its proper function?

To understand the challenges for the bureau I will distinguish between the different environments to establish and manage. Namely, the "external" environment at central level (international/national fora and professional associations, donor agencies), an "internal" environment (diocesan co-ordinations and institutions' needs). It is clear that a dichotomy forces reality into a rigid scheme and that this grid is used only for the sake of clarity.

## 6. The external environment

The main task of the Bureau vis-à-vis the external environment is that of being the actor in the sector, and its linkage with the macro level. This can be further explained by specifying the main tasks as

- Advocacy.
- Trend monitoring (of policy, of resource allocation, of legislation etc.)
- Information/communication

Though few words suffice to detail this task, it is nonetheless a daunting task in an environment that is becoming increasingly demanding and complex. The demand for progressively more detailed information, data and data analysis, documentation.

### *6.1. A place in the public health system.*

The major challenge emerging is that of securing a place in the health system driven by opposing conceptual frameworks: that of the welfare state (increasingly questioned) and the market (far from operating with concerns for equity). Beyond good intentions, there is no space in the mind of the policy makers, for a private sector that has unilaterally taken over a function and is determined to maintain it. There is disregard of professional bodies and their staunch supporters of the private sector - for those who are trying to come out from the shadows they are relegated (often spontaneously and probably inadvertently) themselves and claim to be a sector of a peculiar type. This disregard is sometimes turning into a silent albeit perceived

### *6.2. Increasing costs of service production*

The increased spending of Government for health out of taxpayers' money (now a significant amount of bilateral and multilateral funds in the Sector Wide Approach) has caused a significant increase in the cost of service production, all across the board. For a sector that has to depend on its funding from users' fees, any increased cost means a further parting from the goal of equity and accessibility for the weaker sectors of society. This dilemma is particularly acute in hospitals, a great problem for a Country where 42 of 98 Hospitals belong to the Church. It also marked geographical differences that complicate this matter further. Certain increased costs are due to loss of efficiency due to inadequate management in certain institutions. The phenomenon is nonetheless observable also in some of the best managed and therefore has a major cause in the changes of the external environment.

### *6.3. A privileged observatory.*

A constant and qualified, pro-active presence in policy making fora in this era of change for the Bureau, a challenge that cannot remain unmet.

On the other hand, the Bureau is a privileged observatory of the trends developing. It is a source of timely information for the implementing level, concerning the developments in the sector. Provision to the implementing level of information about and advice on how to adapt to a changing environment is often the only way through which the implementing level is not overtaken by events. The reverse process - learning from the experience of the implementing level and conveying this information to the central level to correct threatening policies and regulate the aspect of the linkage function.

### *6.4. Beyond the national level.*

A new aspect of the interaction with the external environment is the increasing role of the regional/international fora that could influence international policy making: also this

double flow of information, communication and documentation. This trans-national external function of a national co-ordinating body like the Bureau is a new aspect that needs more attention in a future where globalization is an established fact.

#### 6.5. *The relationship with church donors.*

One last aspect is the relationship with the traditional supporters (the church related sector). There is an increasing demand for sense of direction and guarantee of traditional donors that can come only from the central level. How best can this demand be met is an open challenge.

### 7. The internal environment

The relationship with the internal environment (the diocesan co-ordination and the Episcopal Conference) is a mix of functions with a common denominator: provision of services.

#### 7.1. *Provision of services.*

The national "co-ordinating" body can be such only when it is perceived as useful and provides tangible services. Without belittling the service dimension of the function in the external environment, it cannot but - somewhat sadly - be noted that the internal environment shows a shallow awareness of its importance. On the other hand, some services can only be provided at an organised professional level. Hence the development of a variety of services ranging from:

- procurement of drugs and equipment (for this reason UCMB and UPMB established Medical Stores) provision of consultations (financial, managerial, legal etc.)
- facilitation of training (scholarships, involvement of the Catholic University in the health related curricula)
- negotiation of package of financial support by Government (the recent release of about 2 M USD to the PNFP hospitals and lower level units, is one of the major joint Bureaux effort in these last years).
- Processing of licence for operation.

#### 7.2. *The relationship with the diocesan health co-ordinators.*

A special service is the supervision/training of and privileged link with the diocesan co-ordinator. A figure that was created ten years ago is still very weak. The apparent failure of diocesan co-ordination to exercise a relevant role in most cases is legitimately posing a question as to whether it is useful to maintain a local co-ordinating function of health services. Many factors can explain this failure but two seem to be prevailing: the poverty of human and material resources allocated to a function that, once identified as critical, should have deserved a much greater attention from the dioceses and health services. The purpose of this presentation is not anyway to blame the reasons of a failure. The diocesan co-ordination is probably a critical function in the future, when the contractual approach that is now taking place at central level will move to the district level. The new policies emerging both at national and international level (the Comprehensive Development Framework etc.) require the development of contractual relationships not at present existing. They do not even exist at local government level, and this function is even more critical: it is not only a matter of managing a process, but, rather, to accompany the government partner into a process.

It is difficult now to project the need of the co-ordinator function to the far future. It is clear, however, that this function will have a parable of usefulness in the next five to ten years.

#### 7.3. *The formulation of the Mission Statement: an introduction of self-regulating capacities.*

A major service rendered by the central level has been, in recent time, the formulation of the Health Policy. This policy now needs to be implemented and the Bureau looks to the diocesan co-ordination as the pivotal function for the policy implementation. This is not the only function of the local co-ordination. Others will be elucidated in another presentation, from a local perspective it is sufficient to say that the faithfulness of health care institution to the process of policy implementation will need to become the litmus paper for an accreditation to the Bureau that will open the way to services perceived as useful by the implementing level. The diocesan co-ordination is the engine for a request of accreditation that will give the Bureau a leverage on the implementation that it now does not have. The Mission Statement already foresees that a blanket affiliation of health services, granted in virtue of the ownership of the capital asset by the Church,

the case. The belonging to the Mission of the Church in the healing ministry need through functional criteria. This is also the only way through which non-compliance will be corrected. It is also the only way through which the Bureau can be recognised, despite the regulatory capacity of the sector that gives it title to negotiate at central level on behalf of itself. One of the critical aspects of the credibility of civil society at macro level, is capacity. The Bureau needs to assert this capacity with vigour if it has to speak for the affiliated units.

#### *7.4. Support to the discernment of the Episcopal Conference.*

One last, important service provided by the national co-ordinating body, is the informing of the stakeholders (the Episcopal Conference and the Bishops) with the developments. This is not only a matter of information, but also of consensus building around the decisions the co-ordinating body deems necessary to take in the light of the changes taking place. In this regard, the correction (*cum-regere, shared responsibility*): the ultimate responsibility of discernment related matters, lies on the Pastors. Giving the Pastors a correct, thorough, understated view of technically complex matters, often falling beyond the immediate grasp of the privileged service to the Church and to its health care institutions. This service was less frequent in the past times: it has become a major issue for the Bureau, that institutionally represents the stakeholders (Bishops and their College) and the external environment for health related matters.

### 8. Conclusion

As said elsewhere, the task is daunting. The challenges are many and the road is long. Resources (human and material) are limited. An optimistic outlook would seem out of place in the complex and confused end of the millennium. The space available for those who want to do healing ministry as work of charity (why not using Christian words?) is narrowing. If, in the future, charity takes an organized form (health institutions), things become even more difficult. The space available is narrower. Yet, the word challenge can be substituted with the word opportunity. The perspective of the central co-ordinating body is that of the useless servant who is asked to do a task with all its intelligence, creativity and dedication, knowing that the ultimate result will be determined by God. The Catholic health services are a work of God: if He wants them they will come. If He does not want them, we do not want them, too.

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## **New Roles of the Government in Health Care. A new place for NGOs in the health sector.**

Summary for the MMI Partner Consultation, Dar Es Salaam, 5-7 November 1999  
Jaap Koot, MD MBA, Public Health Consultant

### **Introduction**

During the last fifteen years, in many countries in the world a kind of public service reform has been initiated, with the aim to create a "lean and mean" public service. There are two reasons for these reforms. In the first place a kind of ideological reason: the belief in the effectiveness of free market mechanisms. In the second place a purely financial reason: cost reduction.

The ideological motivation is interesting to explore. After World War II in most European countries a state-controlled rehabilitation programme guided the building of a new economy. But it was felt to be inefficient. The fall of the Berlin wall and the fall of most Communist countries in East-Europe added to the idea that state-controlled economies could not work. According to the new ideology, the state had to withdraw its control and had to stop providing services. It was left to the market to find its most efficient ways of operation.

In most third world countries, the state-controlled economies were inherited from colonial governments and were hardly changed after independence. Bankrupt countries in Eastern Africa had to accept the consequences of the free market economy under the structural adjustment programmes imposed by the International Monetary Fund in the 1980s and 1990s. These governments were not very willing to embrace the new ideology, but simply had to accept it in order to get support from the IMF and the World Bank. Everywhere in the world is now seen (and still see) privatisation of former government services and parastatals, like telecommunications, transport companies and mining companies.

The purely financial reason for civil service reforms does not need much explanation: in many countries the government was the main service provider (if we include parastatals). A top-heavy bureaucracy consumed a large portion of the government budgets. In East Africa several civil servants' retrenchment programmes have taken place, many have been privatised and parastatals have been sold. However, the goal of a "lean and mean" civil service has not yet been reached.

Looking at the way governments in Africa handle the civil service reforms, one could ask to what extent governments really embrace the free market ideology. Are they really willing to relinquish the controlling powers of the central government?

### **Health reforms**

Though in some countries people in the health sector see the health reforms as an autonomous process, they are just part of the public service reforms. Though, in some countries like Zambia and Tanzania the health reforms have a bigger momentum than other public service reforms.

Health reforms are taking place world wide, though sometimes not as openly discussed as in Western and Southern Africa. Examples of health reforms can be found in the United Kingdom, the Netherlands, but also in Latin America, in countries like Peru and Bolivia. In Eastern Europe go through a very extensive reform process. The elements of the health reforms are more or less the same as those of the public service reforms: introduction of market competition, reduction of the role of the (central) government in service provision and not to forget at least cost-control.

A unique element in the health reforms in comparison to the general public service reforms is the discussion on the contents of the services. (Often called health care package.) The health reforms were strongly promoted by the World Bank, with publications like "Investing in Health" and "Better Health in Africa". Though there was much criticism on the way it was presented (especially the DALYS calculation), it was an important discussion. It acknowledged that the government is responsible for guaranteeing some minimum package of health care for its people and also acknowledges the limitations of the free market mechanisms in social services.

In many countries – at least in theory – the National Ministry of Health is withdrawing from direct service provision and is redefining its role as "regulator of markets". The government is decentralising management to lower levels (district or provincial levels). In Eastern and Southern Africa approaches to separating market regulation from service provision. The Zambian approach is the introduction of autonomous Health Management Boards while in Malawi and Tanzania it is the handing over of health institutions to local government.

At the same time private health service provision is allowed, which is leading to the birth of private dispensaries, especially in urban areas.

As part of the structural adjustment programmes in most countries "cost sharing" has been introduced for government health services (in general in the form of patient fees). In general, health institutions were already applying systems of patient contributions and did not suffer from an ideological breakpoint.

### **History of the NGOs in the health sector**

Before discussing the consequences of the health reforms for service providers, it is important to look at the history of NGO health services in Eastern and Southern Africa. This history is closely related to that of Roman Catholic and Protestant missions in Africa. The services were evenly spread over countries, but concentrated on areas where most missions were active. There was no planning, apart from the rule that mission facilities had to be outside the BOMA. Most health services were purely curative and often in relatively big hospitals.

The relations between the government health services and church health services can be characterised by "mutual tolerance". Churches were allowed very much to go on with their existing health services, while government planned its own programme. When

between the two was opportune, it was there. But sometimes government and church operated completely parallel to each other.

In most countries the Ministry of Health contributed something to the running institutions through bed grants or secondment of staff. But the bulk of the costs was church health organisations (mostly supported by overseas donors). On the one hand health organisations were seen as private, autonomous institutions. On the other hand as belonging to the public health system. Their voluntary agency status did set private-for-profit providers.

During the last 15 years most church health facilities have been handed over from missionaries to local church organisations. We have to acknowledge here that for many organisations, these health institutions constitute a heavy burden, both in financial and managerial terms.

### **Consequences of the health reforms**

As mentioned before, the liberalisation of the markets is part of the health sector reforms. The entrepreneurial risks of running health services are pushed from the government to private providers. Instead of a guaranteed payment of costs, contracts and competition are introduced for health institutions. For example: health institutions become employers instead of being staff on secondment. Because of cash budget systems (imposed by the IMF) the church often does not comply with the budget allocations, but leave the problems of health care to power cuts and telephone disconnections to the local health service providers.

Introduction of competition and free markets leads to the increase of private for-profit providers. They enter the most profitable segment of the market (i.e. outpatient care in urban areas). Governmental and non-for-profit private providers are left with the hospital function and primary health care. Especially in Tanzania this effect can be felt even in the rural areas.

The church health institutions are faced with a specific problem. They were very proud of their status of being autonomous and at the same time being part of the public health system. In the district health office, there was a collaboration in health programmes like TB or EPI but mostly from a distance.

Now, with the health reforms the church health institutions are forced to choose: either become part of the public health system. Being private guarantees further autonomy, but deprives them of financial contributions from local government or health board.

If the church health institutions want to become part of the public health system, they have to accept "interference" in for example the service provision, in the number of beds or in the pricing (family planning!). They have to become part of the District Health Management Committee and enter into negotiations and have to put their cards on the table (e.g. financial transparency).

The theory of health reforms is simpler than the reality. Where in theory the church is stepping back from service provision and leaving it to local government or health board, in reality there is still a direct line of command between district health services and central government. This is called a problem of the transition period.

It is no surprise that the church health institutions feel tricked; they see the referee as belonging to the other team! The one, who pretends to be a "regulator" of the market, is a market player.

Leaving the health reforms too long in a transition period creates opportunities for corruption and mistrust between the parties.

The churches, as owners of the health facilities, are faced with an even more complex situation. They have "inherited" the health facilities from expatriate missionaries and feel responsible for the continuation of the services. At the same time they see the external support drying up and the limited managerial capacity in the health institutions. They see the overwhelming changes brought by the health reforms, which they experience as threats. Sometimes in a kind of panic they shut down, most unfortunately the primary level facilities and outreach activities.

In general, the national co-ordinating bodies of church health institutions, the boards:

face a dilemma. On the one hand they have a limited mandate by their member owners of the facilities want to define their own policies. On the other hand in the process, the National Ministry of Health considers them as the negotiating partner church institutions.

### **The way forward**

The present situation calls for not less than a strategic repositioning for the church health institutions.

Most owners of church health institutions (Dioceses, Parishes) have inherited the missionaries and have never formulated for themselves what is their mission in health when the rural areas were neglected, the choice for starting health services was made. When governments have built a health service infrastructure, what is the comparative advantage of church health institutions?

What is the task of the church in the light of its Christian ministry of healing? What is the balance between pastoral work, social work and health services? The Catholic Secretariat of Health Care rightfully put this question on the agenda. Isn't it time to go back to the roots of Christianity and concentrate on home based care for AIDS patients, nutrition education for children, etc.?

Churches are faced with huge managerial and financial problems in the health sector. They already see now that the health reforms will not solve these problems, certainly not in the long run. Overseas donors are no longer a reliable source for filling deficits. Why endure and become a part of a public health system, where the only distinction between church and other institutions is the name of the owner?

The "Contracting NGOs for Health" document presented by MMI skips that question. It is a mistake. It is essential to answer the fundamental question first: "What is our service provision?" If churches come to a clear choice, they make an end to the muddling through and can come to a more pro-active role in the health reforms at the local level.

The second step church health institutions should make is the "right" seizing of the market. Right seizing first of all depends on the demand by the population, especially the poor and the vulnerable. Right seizing also depends on the "market", on what other health service providers offer. Right seizing also depends on the ability of the owner of the institution to sustain the service in the long run.

Thirdly, church health institutions should come out with a clearer profile, which underlines their competence. What makes them different, even better, than other health service providers? People consider it not done to talk about, but church health services are in competition with private-for-profit providers. The church health institutions need good marketing to the local, district and regional level, church health institutions have to improve their networking, their specific capacity, even between institutions from different denominations.

Lastly, the national boards or associations of church institutions should get a clear mandate to operate as negotiating partner with the national government, not only in issues of financing but also in issues of contents of services.

In several countries, the Ministry of Health is dragging its feet with health reforms. It does so with half-hearted measures, which do harm to the not-for-profit private providers.

More intensive contacts between the national organisation and its member institutions are needed to identify common problems earlier in the open and allow for a quicker response at national level.

Potentially the national church health organisations can become the motor of health reform in the process in a direction that does justice to the mission of the churches in health care. For this the church organisations have to put the health services in the perspective of human rights. They should indicate clearly the limited regulatory capacity of free markets. Every person should receive an essential package of health services and governments should pay more for this right.

## Conclusion

Before the church related NGOs could enter into a dialogue with the government on need to strengthen themselves and define their vision, goals and objectives for church. They need to revisit their mutual working relations and strengthen their national negotiating partner for governments.

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## Troisième rencontre des Organismes privés confessionnels de coordination sanitaire en Afrique de l'Ouest et Centrale francophone

Conakry, du 8 au 10 novembre 1999

### Généralités :

Les organisations partenaires participantes étaient les suivantes :

#### Pour l'Afrique de l'Ouest :

SENEGAL : APSPCS -MALI: Commission Santé -GUINEE : OCPH + AEMEG I  
-TOGO: OC DI +APROMESTO -COTE D'IVOIRE: MAP -IPASC

#### Pour l'Afrique Centrale :

TCHAD: UNAD + BELACD Moundou -CAMEROUN : SCS Bureau National + Diocèse  
-RD Congo: SPH-CENC + BDOM Kinshasa -BURUNDI: Service Promotion  
CED-CARIT AS -RWANDA : BUFMAR/CARITAS + Eglise Presbytérienne au Rwanda  
Médicale -RCA : ASSOMESCA

Au total il y a eu 48 participants à cette rencontre dont :

- 31 représentants d'organismes privés confessionnels de 12 pays de l'Afrique Centrale,
- 12 représentants des Ministères de la Santé des pays de l'Afrique de l'Ouest (Guinée, Benin, Sénégal, Mali, RCA, Burundi, Rwanda, Tchad, Togo);
- 3 représentants de l'OMS (1 de Conakry et 2 de Genève);
- 2 représentants de Medicus Mundi International.

## Conclusions - Pistes d'Action et Résolutions

### En rapport avec la Question identitaire :

1. Il est indispensable que les services de santé confessionnels se regroupent en une coordination nationale
2. Les coordinations nationales confessionnelles sont tenues de mettre tout en œuvre pour obtenir le statut d'institution d'utilité publique afin de mieux négocier leurs droits et les moyens nécessaires pour accomplir leurs fonctions ;
3. Les autorités ecclésiales devraient accorder une délégation des pouvoirs sanitaires nationales en tenant compte des compétences sans toutefois se désolidariser de leurs responsabilités.
4. Il est recommandé aux coordinations sanitaires nationales d'assumer leurs responsabilités en tenant compte de l'éthique confessionnelle et de la politique sanitaire nationale ;

5. Les professionnels de santé du secteur confessionnel doivent trouver la pédagogie un dialogue permanent avec les autorités ecclésiastiques.
6. Les participants ont examiné les potentialités de l'approche contractuelle de collaboration avec le secteur public pour la mise en œuvre des soins de santé primaire au niveau du district sanitaire. Dans ce cadre, l'OMS a indiqué sa disponibilité pour l'appui de cette approche. Un projet de résolution de l'Assemblée Mondiale de la Santé est à l'étude.
7. Les coordinations sanitaires nationales sont tenues à élaborer leurs plans d'action dans le cadre de la politique sanitaire nationale, l'approche contractuelle favorisant l'intégration.
8. Il est recommandé aux coordinations sanitaires dans leur mise en œuvre de la politique nationale, de tenir compte de l'éthique confessionnelle notamment dans les dimensions de l'écologie et de l'humanisme.

#### En rapport avec l'autonomie et l'autofinancement

1. Les participants reconnaissent que l'autonomie absolue n'existe pas et qu'elle doit être comprise comme un certain degré de liberté accordé à une structure ou une coordination sanitaire partielle est liée à la liberté accordée par les autorités ecclésiastiques, sur une base de compétences, et aux moyens mis à la disposition pour la réalisation des objectifs.
2. Une meilleure prise en charge des structures de santé devrait reposer sur une gestion efficace et rationnelle des ressources et sur les initiatives dynamiques visant à développer la solidarité de justice sociale (mutuelles, activités génératrices de revenu, subventions partenariales. ...) tout en évitant les dérives éventuelles.

#### En rapport avec la création d'un réseau

1. Les participants sont unanimes sur la nécessité d'avoir un réseau francophone de professionnels médicaux confessionnels en privilégiant l'approche de la responsabilité pour l'hébergement du secrétariat par les diverses coordinations soit garanti par une structure souple afin de rassembler les forces, les ressources et les compétences et de trouver des solutions pertinentes aux problèmes communs ;
2. Il est recommandé de renforcer et d'utiliser le réseau créé à Abidjan en tant qu'entité à personnalité juridique doit encore être établie le plus rapidement possible.
3. A court terme, le réseau doit favoriser les échanges entre les membres que sont les coordinations confessionnelles nationales (informations, expériences, appui technique mutuel...)
4. A moyen terme, le réseau devrait étudier les modalités pour devenir un interlocuteur auprès des instances internationales ;
5. La première étape sera de divulguer aux membres toutes les informations concernant le projet des statuts.
6. La deuxième étape devra être d'organiser une assemblée générale constitutive des statuts définitifs du réseau, un règlement intérieur et un premier plan de travail. La recommandation la participation effective de tous est primordiale sans oublier l'appui des acteurs habituels potentiels.
7. Le MAP (Medical Assistance Programme) pour l'Afrique Centrale et Francophone à Cote d'Ivoire a été chargé de ventiler les informations et de coordonner la préparation de l'Assemblée Générale constituante qui se tiendra dans 12 mois en République du Bénin. L'OMS est l'organisateur.

## "L'approche contractuelle dans les services de santé décentralisés en Afrique."

Réunion Inter-pays Dakar, du 19 au 22 juin 2000, *Dr Frank de Paepe, D/AMCES, rep*

### Introduction

L'OMS a déjà organisé deux réunions sur le thème du partenariat basé sur l'approche

- en février 1998 à Genève, la réunion intitulée "vers de nouveaux partenariats pour le développement de la santé dans les pays en développement: l'approche contractuelle comme outil politique";
- en octobre 1998 à Dakar, en collaboration avec la Banque Mondiale, la rencontre intitulée "l'approche contractuelle comme outil de mise en œuvre des politiques nationales de santé dans les pays africains".

Ces réunions ont permis de révéler l'émergence de cette approche dans de nombreux pays et d'engager une concertation entre partenaires au développement. Plusieurs pays ont développé des expériences dans des domaines différents: partenariats pour la gestion des services sanitaires, relations entre des formations sanitaires et des mutuelles de santé, impliquées dans la lutte contre certains fléaux.

Si l'offre publique et directe de soins n'a pas permis aux populations des pays en développement d'atteindre un état de santé qui leur permet d'être des agents actifs du développement, ces services par le secteur privé, y compris non-lucratif, n'est pas non plus exempte de la réalité d'un monde où secteur public et secteur privé vivent en vase clos correspondant moins à la réalité: la mise en œuvre des politiques nationales de santé en général, et des services de santé en particulier, se complexifie et l'interdépendance entre les acteurs et les fonctions qu'ils occupent, s'impose.

L'approche contractuelle est un outil qui peut s'appliquer à une grande variété de situations et contribuer à la solution de nombreux problèmes qui se posent lors de la mise en œuvre de la santé. Cette voie est sans doute prometteuse. Cependant, parce qu'elle implique un changement culturel dans le fonctionnement des administrations classiques mais aussi des partenariats, il convient que les acteurs de la santé qui souhaitent entrer dans ce domaine connaissent les potentialités mais aussi les limites et soient en mesure de garantir le professionnalisme de façon à ce que les populations en soient bénéficiaires.

La réunion de Dakar (juin 2000), à l'intention des pays francophones d'Afrique, a permis d'évaluer l'éventail des potentialités de l'approche contractuelle et de discuter les expériences significatives. Etaient invités: les secrétaires généraux des ministères de la santé et des ministères en charge de la décentralisation, les représentants de l'OMS et des partenaires au développement, dont MMI. MMI a souhaité être représenté au niveau de l'appui des projets. Des représentants des coordinations nationales du secteur sanitaire non-lucratif (confessionnel et associatif) de la Guinée, du Sénégal, du Tchad et du Mali ont participé à cette rencontre. MMI-même était représenté par l'AMCES.

Il est actuellement un domaine où l'approche contractuelle peut s'avérer un outil efficace, celui de la décentralisation. En effet, de nombreux pays ont récemment engagé des processus de décentralisation: de nouveaux pouvoirs locaux sont institués avec la pleine capacité de fournir des services sociaux périphériques (santé, éducation) sont transférés à ces instances décentralisées.

Avec la décentralisation, la logique administrative est modifiée puisque les acteurs deviennent des partenaires à part entière dans l'organisation des services de santé. La vision commune et systémique du district sanitaire passe alors par la négociation et l'entente, donc par des arrangements contractuels.

La rencontre de Dakar a répondu aux appels de plusieurs pays à l'OMS pour des appuis techniques. L'objectif général de cette réunion était de renforcer les capacités des ministères de la santé à initier, impulser et accompagner des expériences d'approche contractuelle dans tous les pays où l'analyse de la situation aura démontré sa pertinence.

Les objectifs spécifiques de cette réunion technique étaient les suivants:

- mieux connaître les potentialités de l'approche contractuelle, mais aussi ses lim pré-requis de son utilisation;
- permettre l'échange d'expériences en cours dans les pays africains;
- présenter et discuter un programme inter-pays d'accompagnement.

### Déroulement de la rencontre

La rencontre a eu lieu au CESAG (Centre Africain d'Etudes Supérieures en d'enseignement supérieur lié à la Banque Centrale des Etats de l'Afrique de l'Ouest) 23 juin 2000.

Programme de la rencontre:

- 1er jour: présentation du sujet par l'OMS et de plusieurs expériences de parten: l'approche contractuelle (dont l'expérience d'accord-cadre entre l'Etat et l'Eglise Burundi);
- 2e jour: l'implication de la décentralisation sur l'organisation des services de sai de l'expérience des pays invités;
- 3e jour: comment l'approche contractuelle peut-elle être un outil dans le cadre c décentralisation: exposés et travaux de groupe;
- 4e jour: perspectives: implication des partenaires (tour de table, voir interventio proposition de thèmes d'un programme de formation sur l'approche contractuel conclusion.

### Résultats de la rencontre

- l'intérêt manifesté par les pays pour l'utilisation de l'approche contractuelle;
- la mise à niveau des participants sur le contenu et les approches à partir des ex rapportées;
- une mise en synergie de l'ensemble des acteurs du système de santé;
- la préparation des participants pour une mise en œuvre de l'approche;
- meilleure perception des limites de l'approche contractuelle.

### Recommandations de la rencontre

- utiliser l'approche contractuelle comme outil pour renforcer les réformes en cou finalité de relever le défi de l'amélioration de la santé des populations;
- favoriser et renforcer le dialogue entre les ministères de la santé publique, les c impliqués dans le processus de réformes, les partenaires et les représentants c civile, pour assurer le succès de l'approche contractuelle, notamment à travers de cadres de concertation appropriés;

renforcer les capacités nationales pour conduire les réformes et la réussite de l'apprc par:

- la mise en place de plans de formation,
- les échanges d'expériences et autres mesures d'accompagnement,
- la réorganisation, au besoin, des cadres institutionnels,
- la création de bases factuelles.
- favoriser le renforcement des échanges inter-pays à travers la mise en place d' d'échanges et de réunions de suivi.

Dakar, le 23 juin 2000.

### Intervention de MMI (lors du tour de table des partenaires)

Medicus Mundi International (MMI) veut remercier l'OMS d'avoir pris l'initiative de c d'avoir invité les différents partenaires. MMI est une organisation internationale de cc santé, fondée en 1962, en relation officielle avec l'OMS depuis 1974. MMI est en rela 250 partenaires (Eglises, ONG, associations) sur le continent africain. Elle cherche à encourager le dialogue et la démocratisation à tous les niveaux.

MMI a perçu les potentialités de l'approche contractuelle et a fait une déclaration à c

52e Assemblée Mondiale de la Santé (AMS) à Genève en mai 1999 portant une devrait être incluse dans une résolution officielle de l'OMS) intitulée: "un contrat pour des contrats Etat-ONG: une stratégie proposée par MMI pour améliorer les soins rencontre technique à ce sujet a été organisé par MMI durant cette même AMS. personnes provenant de 35 pays y ont participé, dont plusieurs présents dans cette de la proposition de MMI a été distribuée à tous les participants.)

MMI encourage activement la concertation et stimule les échanges entre ses partenaires agences de coordination nationale du secteur sanitaire privé social (à but non-lu Dernièrement, des rencontres à Dar-es-Salam (de nos partenaires anglophones) et à partenaires francophones) en novembre 1999 ont permis un approfondissement et sujet de la contractualisation.

Il est apparu la nécessité de la création ou du renforcement des plates-formes concertation et de négociation comprenant le secteur sanitaire privé social, et le réseau international des coordinations nationales africaines du secteur sanitaire (professionnel et associatif). Ces dernières ont exprimé le souhait d'être mieux représentés de la région AFRO de l'OMS.

MMI continuera à faciliter les processus de contractualisation par la recherche et l'appui par la stimulation des échanges entre nos partenaires.

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### Report AIDS conference: "the Catholic Church and the Challenge of HIV/AIDS"

The conference was held at the Vatican from 9-11 December 1999 and was hosted by the Pontifical Council for the Health Pastorate (Pontificio Consiglio per la Pastorale Della Salute).

The conference facilities were excellent at the Nova Domus Sanctae Marthae with simultaneous translation in English, French, Italian and Spanish.

The objectives of the conference were:

- To promote assistance to the HIV / AIDS patients;
- To orient the approach to the HIV/AIDS problem in line with the teaching of the Church. Co-ordinate groups and movements of the Catholic Church working in the HIV/AIDS field.

The conference was a follow-up of a similar preliminary meeting in the spring of 1998. A local, mainly Italian Study Group, was constituted to advise the Pontifical Council and followed up with a further consultation in the year 2000.

The programme started with general introductions by the President of the Council for Pastoral Care-Vatican State, the **Most. Rev. Javier Lozano Barragan, Prof. Peter Piot, UN Secretary-General Kofi Annan, and Prof. Jose L. Redrado**, secretary of the Council for health, presenting the results of the workshop. Also a contribution from **Dr. Fiorenza Deriu Bagnato**, presenting the findings of the questionnaire sent to 112 bishops conferences, of which 56 were returned.

The afternoon was spent on "Prevention" which continued the next morning with expert presentations from the field (Uganda, India, Spain, Caritas Internationalis and Côte d'Ivoire) and group work. Programme interventions and care followed in the afternoon, with conclusions from the afternoon sessions on pastoral care.

In his introduction, **Mgr. Barragan**, president of the Pontifical Council for Pastoral Care, mentioned the aims of the meeting in promoting the church's and NGO's involvement in providing direction for the Ministry of Health and to co-ordinate the work of groups active in the field of HIV/AIDS. Also urging the members to take part in National programmes and to promote the use of condom use in national programmes.

The church may have kept silence but this is certainly not the case where it concerns efforts made in the field of care and socio-economic assistance to those affected by HIV/AIDS. He mentioned the contribution by Catholic Institutions (24,6%) in the struggle against HIV/AIDS, representing 20,6% of the funding. He urged a renewal for pastoral commitment with a clear approach

the Christian vision, chastity, secular dimensions and against prejudice. In view of the overwhelming mortality it seems a "swim against the tide". He denounces the anthrop sex and stressed chastity in celibate life and before marriage and faithfulness the objection to condom use looks absurd if the above considerations are not taken into a

He mentioned the Pope's initiative on orphans for the 28th of December with pray assistance.

### **Peter Piot.** Director UNAIDS

As world AIDS day just passed he referred to it as an occasion to re-energize our: tragedy to look for something positive. The focus on orphans is significant, as it is su what is happening to the adults. Recently Secretary-General Kofi Anan privately leaders in N.Y., to discuss what to do. He offered his convening power to African important support to end local and regional wars. HIV / AIDS is just not only statistics, of our friends and neighbours. The UN-system lost already 2600 of its members.

UNAIDS seeks to widen the number of actors, including the churches. However so rather an obstacle to prevention instead of an ally. 33.6 million people are living wi 50% under the age of 25 years. 6 million in SE and E-Asia.

The Caribbeans are showing some of the highest prevalence rates.

In Africa more people died of Aids than of malaria in the last year. In Eastern Eur states, drug-users are causing an unprecedented rapid growth in HIV prevalence.

The average life expectancy has come down to levels of 40 years ago and the ec severely felt. Child mortality has increased 4-5 times, from 30 to 150/1000 in Zimbabwe are an estimated 11.2 million orphans. 2-5 children are left for every adult dying. O went up from 2-10%. In some areas even higher, reaching the limits of the commi power. It forms a major challenge to organisations. Most important is that children their community and continue their schooling.

European models like orphanages are expensive and take funds away from better cul methods of childcare.

30-70% of the health budget is spent on HIV / AIDS.

Some success stories are emerging; Thailand and possibly Nsambya in Uganda are in HIV -prevalence rates from resp. 12 to 2,2 in recruits and 35-17%. Consistent prev by state, religious and social organisations on "protected sex only" have led to this de an HIV-group launched a meeting in the Cathedral.

Education is effective in increasing the age at first intercourse.

Response of donors towards HIV has been insufficient; governments in Africa cc million US\$. The church has contributed much to care. Ethical imperatives are: acce AR V s; reduction of mother to child transmission, interventions, counsellir discrimination and stigmatisation; prevention with its controversies in which positive a for. There is the believer's view and the social reality, which forms a social dilemm and risk approach is needed for effective prevention.

For those who cannot abstain or maintain fidelity, the condom should be used as maximum ethical consideration legitimating the lesser of two evils as it concerns the c

Attention should be given to develop "skills for life" in young people.

UN-AIDS is appreciative of the work done by the church strengthening of the relat work, although sometimes different priorities, by the MOU with Caritas International organisations.

He mentioned the emerging Interfaith network in Africa and hopes to work more toget

Emphasis should be on complementary and not on conflicting approaches.

**Mgr. Lozana** acknowledged the serious figures of **Prof. Piot** and said there is no set the Abstinence and Be faithful approaches but differ on the Condom approach.

The audience asked what the church is doing about this? This question was referred to the team.

**Mgr. Jose Redorado** , secretary of the Health Ministry.

HIV / AIDS is a fashionable disease and it shows how fragile the value of life is. The concern has been raised to the issue at the meeting of churches in Geneva, the study of the issue is of the various bishops' conferences and institutions of the church. The Pope has issued an encyclical on HIV/AIDS.

A working group was formed to study HIV / AIDS in all its aspects and the role of the church. 3 representatives from the pontifical councils of vocation, family and laity were included in the work. 9 bishops were asked to set up an extended working group and met in December.

**Dr. Fiorenza Bagnato** (social researcher) reported on the " Inquiry conducted by the church for pastoral Health Care". (See report in Italian).

Objectives of the enquiry:

- present state of the art
- what is going on
- what activities for prevention of HIV especially for youth
- what training given
- inventory of emerging problems

112 episcopal conferences received the questionnaire and 56 returned them completely.

It therefore does not represent the whole church. Some results on perceived causative factors:

- 82% of the ECs found poverty the overriding cause;
- 80% found joblessness important;
- 76% mentioned unstable families;
- 64% urbanisation as well as rural poverty;
- 53% analphabetism/illiteracy;
- 82% alcoholism;
- 82% prostitution;
- 46% political instability.

The role of the church is that of a main actor. 25% of the social institutions are seeing improvements, 34% perceive the HIV / AIDS situation worsening. The church is an integral part of the population and therefore also of HIV/AIDS.

Social stigmatisation is seen especially at the workplace, the school and in the family. HIV infection and cultural factors are important in this respect. The church and the NC can overcome this by providing correct information.

Initiatives are also taken at the vast number of Catholic schools; teachers are open and ready for a well-prepared curriculum with teacher training on prevention, emphasis on the formation of anti aids clubs has been shown successful.

Health institutions: some discrimination is seen, refusal to prescribe treatment for HIV. A majority of respondents do not like to experiment with new drugs, including those for the transmission, notwithstanding scientific results showing a 50% reduction in transmission with preventive treatment.

Information and support is given. In discordant couples counselling advice on condom use is given to over 50% of the respondents.

80% of the bishops' conferences do not have a specific HIV /AIDS co-ordination body

Training of Health workers, volunteers, peer educators, religious persons in HIV/AIDS Prevention awareness raising in young people and adults with focussing on self-respect for own body is mentioned.

Counselling services and home care are well developed and stand as model for many. In this regard the contributions of a large number of NGOs was mentioned including Memis Misereor and other members of the Caritas International taskforce.

Under the various headings of education, prevention, medical care and pastoral care activities were given.

Better communication between church and state is seen as important, even if there is a discrepancy in content of the message.

In the prevention of HIV /AIDS also other methods than condom use should be included.

Family values should be enhanced. Law reforms to protect women and children and their rights are important.

In the following discussion the question was raised as to whose views were expressed at the Bishops' conferences. In some countries working groups were formed, with widely differing views of religious and non-religious pastoral, social and health workers. It is not clear to what extent the findings reflect the thinking of the church leadership or the pastoral workers and health workers in social and health fields.

The question of orphan care and education of youth was raised as this has led to a split of responsibility in some countries between lay people, the state, international organisations and the Church. The Church feels a direct and different responsibility towards its target group.

Support for Eastern Europe was called for.

Orphans should as much as possible be cared for in the home and the community. The primary system instead of institutionalisation, appears the best practice policy.

Some members still held the view that condoms could promote HIV transmissions and that there is no evidence to the contrary.

The Interfaith meeting of churches in Botswana was mentioned as a new starting point. Churches coming together in action against HIV /AIDS, searching for solutions and targets for action. HIV/AIDS should be included in the development agenda.

TB was seen as important everywhere, the fight against it is possible, only a little more. Treatment is enhancing quality of life with about 2 years.

The lack of values was perceived as one of the problems in the fight against AIDS in some states.

In interventions for prevention, the combination of strategies was emphasised, not just the lifeboat model (Fr. Joinet) which aims at choosing Abstinence, Be faithful and Condom use. All options were stressed again.

The role of the media is important as they provide positive but also negative information. The role of the press should be one of the strategies.

Piot said that he always makes it an issue of visiting church leaders when he meets the government. Ethical commissions of the UNAIDS guard against the "cowboys of medicine". A new HIV vaccine is expected before 5-10 years to come.

The Vatican Council will continue its work regarding HIV / AIDS .

The representative of Congo Brazzaville regrets the introduction of prevention (condom (it has holes) into Africa as it is against culture and customs. Pastors feel different messages they get.

The discrepancies between funding levels for HIV / AIDS in Africa with 33 million people / AIDS and the \$1 billion for Kosovo, was seen as discriminating against Africa. There essentials like basic drugs, HIV -tests for safe blood, (Catholic ) hospital lacking essential medical services for the poor.

With the epidemic in Europe under control (mainly due to condom use by CSWs) lower priority for HIV /AIDS in developing countries.

### **Prevention session 9-12-99**

"Life as basic value" by MSG. **Riccardo Selejdak**, official of the Congregation for Cat

Supporting the Pro-life movement with emphasis on the defence of (the evangelical culture of death, which can not be questioned. The quality of life is "not instrumental" as a sacred absolute value.

**Carlo Casini**, president of the Italian pro-life movement elaborates his activist vision -day of birth a "dark day". He compared the value attached to life by those outside the evangelical vision as those " who value the life of a new born less than the handicapped child for that sake". "Big bang" is the creation of each new person. He sees in the value of life, man has autonomous value.

**Prof. Stranislaw Grygiel**, philosophical anthropology, council for studies on marriage education for a function as too technical, education is also seen as "education for function as "education to turn people into useful beings". The state wants people to be easily not independent thinking. Education should in his view be for conversion-where do where do 1 go to. Education for sexual differences is essential for understanding the life. Secular life has little meaning. The mountain sermon can be taken as the basis for

The crisis of values is not only the Immuno-deficiency but also a value deficiency.

Aids is linked to families, it can destroy families and solidarity, the family is the place values should be communicated to sons and daughters. The family is seen as the sphere where education for chaste and conjugal love is passed on.

Victims of their own addiction are presented in the world as role models. Drug addiction problems can be seen not as medical problems but family problems. Families can not help themselves and need assistance.

**Pio Cardinal Lahi**, 77,5 years old, Prefect emeritus Congregation for Catholic education on the value of education, being more than instruction for the management of functions Education not for " freedom from but freedom for" is its aspiration.

Sexual education is difficult and most teachers are not at ease. The development of a female person is more than teaching on anatomy, physiology and hygiene. Scientific education hand in hand with guidance. Education is not neutral (although science is).

He questions the right to sexual pleasure and the use of sterile syringes and condoms

Nevertheless education should be complete education.

**Msg. John Patrick Foley**, President Pontifical Council for Social Communication discuss the media and how they can assist in arresting the transmission of HIV .

Why not promotion of condom use? Because it is an "invitation to promiscuous behavior", "recreational sex", and "instrumentalisation of sex".

Abstinence is the anti-dote for sale of sex as there is no money in it. He emphasized catchword: "Fight AIDS with a new life style".

The media can promote abstinence to be the norm like no smoking, comparing the sex smoking urge.

The moral norm for sex is the moral norm for health and should lead to a drive to promote and against promiscuous life. It should become fashionable to abstain before marriage and against drinking before driving. Role models for healthy sexual lives should be promoted. Education for sex should be progressive according to age.

He is against the use of "illicit" means of protection.

### **Round table Prevention. 10-12-99. Voices from the field.**

**Dr. Ntari** from the Congo The community response to HIV /AIDS is inadequate. Abstinence makes one an object of ridicule. He compares the use of condoms with drinking without brakes as condoms carries a risk of infection as the "virus could pass through the condom" a false sense of security.

Solidarity amongst HIV /AIDS affected families should be promoted.

**Dr Giovanni Putoto.** CUAMM.

Worked as a physician for 8 years in Uganda/Rwanda in rural hospitals. The real picture with 2 million people dead in Uganda and many millions infected. 1, 7 million asking for help. 1 million are HIV-infected young people. It overwhelms the health services to deal with the sheer number of ill people.

Various effective approaches have been pursued like the work of TASO with the LUT school education. A comprehensive approach to sexual education including the use of role playing seeing some success in behavioural change, showing changes in age of first sexual intercourse, age of marriage is coming down. The HIV prevalence rate is coming down (half in Karamoja not in all areas. The AIDS death rate is still increasing.

**Sr. Meriarn Duggan** is active with a gospel club.

He stressed the need for objective information including knowledge on condom use and counselling is offered and the church is actively involved. He sees however many obstacles due to lack of funds, economic and social factors, the role and exposure of women to cultural obstruction to applying rational means of prevention, decisions by one (male) without information on spouse HIV status is not given to partner, young people do not come for fear of solitude for counselling for HIV and pregnancy prevention, lack of dialogue on initiation being able to speak more openly about sex, HIV /AIDS and how to protect oneself.

HIV/AIDS is mainly a problem of the poor. Personal ethics should also be in line with the Gospel.

**Dr. Gracious Thomas** from Gandhi Memorial University New Delhi for Caritas India. He quoted lack of attention and finance for education as one of the causes of the spread of AIDS in India. On behalf of the Bishops conference he wrote a book for HIV / AIDS awareness for schools (the book contains a lot of valuable information on diseases and social factors) however a certain amount of biased information and lacks specificity in the definition of AIDS for the readership-ed).

**Dr. Mullol** Spain. Fundacion Dimensio SIDA

Provided a picture of the activities undertaken by his organisation, its links with INCAE and the role of the church.

other European organisations and link with Medicus Mundi Spain (Barcelona).

He urged to take courage to speak openly and for the church to enter the dialogue scientific facts in appropriate behaviour. The church should learn from Galileo.

The comprehensive approach of the ABC\* (boat picture) or else vanish in the flc should be taken as both scientific in its approach in what has proven to be eff promoting the ideals of the church (AB).

The concern of the Holy Father for HIV/AIDS is appreciated. Reflection on religious is rights issues is called for. Examples are mentioned of several bishops consider STD/HIV protective devise (condom) in case of AIDS emergence. The gap betwee about HIV / AIDS and what is condoned by the church should be closed by dialogue AIDS. "If we don't talk with each other on these scientific and spiritual issues than AID

\* A= Abstinence, B= Be faithful, C= Condom use

**Rev. Fouad El Hague** (secretary-general C.I.).

Wondered about the issue to use of a vaccine with that of the use of a condom. E should be directed to diminish vulnerability to infection with HIV.

The issues of Human Rights and the Silence of stigma should be dealt with.

It is essential to explore community needs, ensure their participation and ownership use a holistic approach, consider inputs for behaviour changes for men and wome reduction, assist those living with HIV / AIDS, consider especially the vulnerability c positive side one sees some reduction of the proportion of young people with HI volunteers taking part in the fight against AIDS; and the many valuable experience other NGOs in the field. Where is God in all this suffering and death? God is present i

### **Group workshop.**

(Schwarer/ Putoto/Mullol).

Bishops and priests are unhappy that AIDS is such a problem to discuss. They lack th the problems. This is especially important, as there exists a significant amount of clergy. In Uganda (**Sr. Ursula Sharpe**) an formation programme for the religious h; they refused to go and care for patients with HIV /AIDS, thinking they were all prostitu

"The body of Christ has AIDS" (**Julien Filochowski**) which reinforces us to be non-ju approach. How to reach the male in his role as husband and migratory industrial w; the medical person is to preserve human life using all accepted scientific means avail purpose. Prevention of HIV transmission by education about all facts, by STD-preven use of condoms for those at risk in a comprehensive way are instruments availa professionals.

Programmes should be from the people and not being imposed. In Uganda committe there is still co-operation. The lack of trust between the government and the chur serious and leads to a lack of common approach necessary to contain the onslaught t

A special concern for the church in Africa should be the 50% of women, waiting i home for their husband to bring home an HIV -infection or other STD. Their only ri faithfully married to a husband forced to work for long periods far from home, which p contracting HIV. This group of migrant labour men, about 25-40% of adult males, small group of highly active females, the core of which are formed by commercial se and bar girls (2-3%). Preventive actions should therefore focus on banning unprote limited groups with high-risk behaviour. The effectiveness of condom is very high as scientifically. Even at 80% effective use by high-risk females and males, HIV transi reduced by 95%! The main reason that HIV has not become an significant epic Europe and is coming down considerably, has been the widespread use of condoms i community and their clients, even prior to the advent of HIV/AIDS. This preventi infection to spread to the rest of the population. What has been shown to be effe

Europe can that be denied to Africa on account of culture, customs, and religion? (Pet

### Estimated reduction in HIV transmission

<b>By condom use</b>	<b>50%</b>	<b>80%</b>
By high risk males only	57%	75%
By high risk females only	48%	62%
By all males and females	73%	95%

In the plenary discussions emphasis was given to:

- the importance of an array of all available preventive measures;
- the poverty and social effects caused by the epidemic;
- access to blood testing;
- to strengthen the family;
- formation of the religious;
- language of responsible love;
- quality dialogue with the church;
- the need for demystification of the issues of sex;
- sexual education and personal training;
- need for global strategy;
- improve communication between church and NGOs working in the field;
- culture is not static and can adapt to new challenges; culture can not be used :  
to apply new scientific methods to control the HIV / AIDS epidemic;
- human rights issues also include rights for children and youth, access to educ  
includes live skills to survive in a society with HIV / AIDS;
- the Pontifical Commission is asked to continue its co-ordinating role and incr  
to fight HIV/AIDS;
- to show more openness about sexuality;
- provide correct information on condoms in balance with the moral responsibi  
others by unprotected sex;
- to discourage orphanages, but aim at community and family care including fc  
groups in the community;
- develop good information and education materials for schools; start with the :  
schools;
- training for the religious;
- prevent death among the large group of vulnerable women at risk of infection  
labour husbands by all available means, including the use of condoms for tho

### Care

Care systems by the church and affiliated NGOs have been developed to a high exte

The responsibility towards human rights, counteracting stigmatisation, has been felt

Ethical problems do exist where church hospitals have refused patients or where  
workers have refused to give care. Principles of justice are at stake.

Ethical problems arise as an increase is seen in suicides and euthanasia in  
overwhelming HIV / AIDS epidemic affecting the person, the family and whole cor

The duty to privacy is being challenged in safeguarding others from being infected.

Also ethical concerns in research have been coming up.

In Europe part of the problem of HIV /AIDS concerns drug users, especially in Eastern Russian states. In the USA AIDS is the second cause of death in adults.

Pastoral letters to call for responsibility in care have been issued. Catholic emphasising A and B has been developed for schools, as well as a training manual. Resources are needed for ethnic minorities who are more affected than the average. Brazil has a huge economic (68% < poverty) and political problem affecting the health and is partially responsible for a very serious HIV / AIDS epidemic.

Brazil has made \$500 million available for treatment (ARVs) of persons with HIV/AIDS of all infections (500.000) of the Latin American Continent.

43.000 patients were treated with access to HAART. Improved facilities are made available.

This set up is far beyond the capabilities of most developing countries, financially wise, as treatment modalities take a heavy burden on staff, facilities and patients (due to side-effects).

A special concern of Brazil is the care for street kids; a multidisciplinary approach is needed.

#### *Thailand.*

Education at all Catholic schools and for premarital youth is taking place and programs for CSW s and rehabilitation of drug users are carried out. Community centres for orphans (200.000 orphans in the country) and PLWHIV/AIDS are functional and contribute to prevention.

Thailand is one of the few countries which has shown a great success in cutting HIV/AIDS. The government, the religious and the social institutions adopted a comprehensive strategy counteracting the HIV/AIDS epidemic. A strong emphasis on banning unprotected sex, a high level of protected sexual practices (85%) and halving of the number of condoms used, which resulted in a more than 70% reduction in the HIV transmission rate. This clearly shows that promoting condoms in a responsible and comprehensive prevention program can diminish promiscuity.

The Democratic Republic of Congo has a forum against HIV /AIDS and deals with increasing institutional capacity, access to care, counselling and community activities, child care and the problem of treatment for STDs. Although religious sects and quacks are often misleading the public, traditional practices can make some contribution as well.

The political instability makes it difficult to tackle the problem effectively.

#### **Some points from the plenary on care:**

- Rich countries can afford ARVs while poor countries can not even cope with opportunistic infection;
- Doctors are not prepared to talk about HIV/AIDS (India and elsewhere), prevention, counselling and feed-back towards prevention; (the example of a newspaper article)

showing the death and funeral announcement of numerous young people, and death only from car accidents and not from AIDS which can be assumed to be common cause-ed).

- Different countries have different needs, although many problems can be shared common.
- Some areas are so poor that when TB patients are treated there is no food available to satisfy the increased appetite that comes with TB-treatment;
- In Uganda the president stopped orphanages as the funds can better be used to support community care for children in their own environment; setting up networks to solve the problem and create a supportive environment is seen as a priority in dealing with a large number of orphaned children. -Foster care and other experiences are present.
- Encourage income-generating projects for PLHIV/AIDS, live positively.
- Link with traditional healers to provide optimal care.
- Due to the overwhelming number of people needing care, health institutions, dispensaries at community level, are not able anymore to pay for their drug bills and can hardly afford to pay a share of the costs.
- It is important to care for the mother as you care for her children as well.
- Although a lot of spiritual support by the church ministries is given, there are some people who were not allowed to be buried because of their inability to pay for the funeral.
- Suicide among young people has increased sharply, especially amongst young women (India); -Concept of care and death is different in the various religions (India);
- Children are afraid to leave the village as they face the danger of a HIV infection; there is hardly any defence (Burkina Faso);/
- Persons living with HIV/AIDS can be a valuable asset in the fight against AIDS; they can be trained as educators and counsellors.
- It was reported from one country that the Bishop's conference on instruction prohibited Catholic organisations from soliciting support from UNAIDS/UNICEF. In view of the Memorandum of Understanding between Caritas Internationalis and UNAIDS, this issue has shown to be able to be resolved. It should be clear that each organisation has its own mandate and responsibilities which, in itself, can never fulfil the aspiration of every religious group on the planet. This does not preclude recognising the contribution each organisation can make for the common fight against HIV / AIDS within its own ability and its own ideals.
- Church hospitals in developing countries are challenged under the District Health Sector reforms to provide comprehensive services as designated district hospitals. When seen to in that role, political pressure may lead to building new district hospitals which threatens to marginalise or even to close down of church hospitals.

### **Enlightenment. 11-12-99**

#### **Msg. Jean Marie Mpendawatu and Bro. José Carlos Bermejo.**

There is a need for a "New Word" a new salvation to the suffering world and its people.

Jesus cures and has forgiven, healing the body and the moral wounds. The world is full of suffering and with the church ideals and different approaches are seen between UN organisation and the church. The church has its ideals and values, which are difficult to apply fully in the complex field experiences.

In the pastoral reflection on HIV / AIDS one notices the ambiguity: I am not any sufferer, homosexual, drug addict, mother with an HIV infection etc.), I am born as a human being, I am lost, cried. ...I am a human drama. Look at me and you see yourself.

The pastoral approach calls for walking with the individual, the family and the community by HIV / AIDS. Social death often predates the physical death from HIV / AIDS.

It is difficult to be the Samaritan for those who have not overcome their superior attitudes.

Care and counselling is provided not only from the perspective of intellectual challenge but also include salvation, liberation and even a messianic approach.

If we are to defend the poor, the voiceless, then the church can not deny the challenges imposed on her. Are we to defend the poor who are exposed to the risks of HIV sequels well beyond the will of the individual, which leads to death and not to life?

Too much emphasis is given to sexual morality and too little to social morality, which are the realities of the poor.

Endorsement of moral issues were related to: the position of women, race and class, poverty, access to care and prevention: dramatic injustices are seen all over the world. We must visit the sick, establish a dialogue, visit homes, come as Jesus the saviour.

Help the suffering person to rebuild his life and come in peace with one's own history when possible the PLWHA into a pastoral worker, an apostle to the community.

Special attention in care and prevention should be given to those especially discriminated and observing confidentiality. Unconditional love makes it possible and meaningful to people with an other sexual orientation, drug users and prostitutes.

It includes also those in the religious communities who are affected themselves.

Social euthanasia leads to isolation and avoidance of relationships, which is harmful to the individual as well as for the community.

" More heart in your hands and in your mind". Speak out towards social injustices.

### ***Conclusions and guidelines.***

What can the council do?

1. A messianic approach of unconditional love towards all people should be followed as an "insistent voice".
2. Bishops and bishops' conferences are urged to see HIV/AIDS as a national priority and ensure, at national and local level, the functioning of a council that is actively involved in studying and supporting broad based approaches to fight the epidemic. Bishops should be aware of the serious consequences, positive or negative pronouncements. There is a need for guidelines, including statements on factual information besides value issues.
3. Address the issues of candidates to the priesthood and congregations: mandate must be proper. Training of the religious in sexual and reproductive health and promotion of skills may contribute to their own and to the community's capacity to deal with health and HIV / AIDS specifically.
4. In a special concern for women, mothers without any risk behaviour themselves should receive special attention in education for sexual and reproductive health, empowering by addressing men in their often-dominant roles and risk behaviour situations.
5. Encouraging the church to address especially the issue of protecting young girls through messages, educational support and means, including sexual and reproductive health education.

- and services commensurate to their age.
6. The church has to deal with the scientific facts of research where it concerns of prevention, not avoiding the truth, but tell the truth, recognising the place within a comprehensive approach of abstinence and the promotion of faithful
  7. To promote sexual and reproductive health by timely sexual health education and institutions, and to contribute positively to national programmes, without its vision on the ideals of the church. Such education and access to services h diminish the HIV -transmission, to diminish promiscuity, to diminish teenage to lower the abortion rate considerably.
  8. To take action in prevention of (father to) mother to child transmission and to orphanages but promote community care for orphans instead;
  9. The council and the bishops should address also the issue of drug users.
  10. To involve the community and the families, especially the " Small Christian ( and the persons living with HIV / AIDS in all activities of the church, recogn contribution each can make. Tapping resources from inside the country and tl important.
  11. Address the lack of health personnel and funding for health care.
  12. International NGOs are requested to make access to funding less of a "torture local capabilities and constraints into account.
  13. Funds provided to governments in bilateral contracts should also be made av
  14. Interaction with other religious denominations is recommended.
  15. Mandatory HIV-testing is not ethically acceptable.
  16. Confidentiality should be maintained at high levels. The church should includ within its activities.
  17. Examine the issue of drugs to be made available to resource poor countries, i issues concerning availability of drugs and possible future vaccines or other f research.
  18. The commission is urged to continue its work on advocacy and interaction wi national and others organisations, including networking and sharing reports a prayer with other churches to promote the right to proper and unbiased inform to social justice, the right to care, love and protection from stigmatisation.

*Peter Kok*, January 2000.

Health adviser, Cordaid

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### **AISAC Meeting in Rome, May 26th-28th 2000. Associazione Internazionale Istituzioni Cattoliche International Association of Catholic Health Care Institutions**

*Report by Edgar Widmer*

The meeting was organised by the Pontifical Council for Health Pastoral Care as consultation held one year ago The intention is to reactivate the international cohe many world wide existing Catholic Health Care Institutions: 5200 hospitals, 12200 health centres. AISAC has to contribute to the global network of health care I actively present where international policy decisions are made...

The meeting was presided by Archbishop Javier Lozano Barragan and Bishop J Continental Delegates were Rev. Michael Place, Catholic Health Association of t Mr. Francis Sullivan, Australian Catholic Health Care Association, Rev.P.José / from Colombia President SELARE of CELAM.for South America, Rev. P.L Vienna together with Dr.Salvador Rofes, Spain, Delegates for Europe, Dr.Douglas Africa together with Rev. F Edward Phillips from Nairobi as Delegates from Afric:

Culas from India representing Asia.

These continental delegates were all elected as AISAC Board Members. Bro Pio, former Prior General of the Fatebenefratelli, was confirmed as Director of AISAC.

Rev. Mons. Osvaldo Neves de Almeida took part in the name of the Secretary of State for other councilors. Medicus Mundi was the only non-church-bound observer at this its engagement for HFA, as the letter of invitation specified.

The Aims of AISAC had been drawn up in a paper given by Bro Marchesi. Summary following:

By the fact of growing interdependence and the increasing speed of change paradigm-shift after Alma Ata and due to consequences in the field of health Globalization, there is a felt need within the Catholic World to share responsibilities and challenges. Health promotion and engagement for sustainable development are in well as codes of conduct based on human rights and ethical values.

While recognizing Government's responsibility for formulating health policies and health services the civil society with the increasing move towards democracy has an ever-important role in its realization.

NGOs, and among them Church-bound Institutions, will continue to contribute to health services. More important still will be their engagement for solidarity and ethical values. Encyclica "Sollicitudo socialis", Pope John Paul II defined solidarity not as a compassion, but as a firm determination to commit oneself to the common good because we are responsible for all.

AISAC encourages Catholic Health Care Institutions to identify their juridical identity and to guarantee their future accreditation within given political and professional facts.

In co-operation with Governments the mixed public/private and non-profit health care should be clarified. Especially for Developing Countries the Pontifical Council and the proposal of Medicus Mundi concerning "Contracting".

I literally quote: "The proposal of Medicus Mundi Internationalis consists in improving health care through contracts with non-profit NGOs that accomplish mission of public service and are recognized as constitutive in health care sector.

The proposal presented at the WHA is officially supported by the Holy See through the Pontifical Council for Health Pastoral Care and contains the following recommendations (summary):

- to classify the health care institutions according to their capacity and not to their size;
- to base the operational definition of services offered on the possibility of access to health care for the population of a given zone without discrimination of sex, race, religion and social status;
- to define precisely the terms of collaboration between the local national health care institutions and NGOs of public utility;
- to include in the contract between the partners an agreement on the criteria for the evaluation concerning quality and efficiency of the care given.

(end of the quotation)

The delegates of Africa giving their report to the meeting could not give an overview of the health care institutions of their continent. I therefore distributed the list of address of Co-ordinating Agencies of Church-related Health Services as collected by MMI. These agencies should co-operate with these bodies although, or just because, they work in an ecumenical

I also explained that hospitals at peripheral level should no longer work within the be part of the so called District Health System and that "Contracting" is an ir reaching this goal.

A further plan of activities of AISAC will be elaborated. The secretariat is already Pontifical Council and has its proper staff.

Thalwil, 03.06.2000

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## COUNTERFEIT DRUGS

### Fact sheet

1. Up until April 1999, of the 771 cases of counterfeit drugs reported to WHO, about the quality of the active ingredients contained were supplied only for 3. these, about 59% contained no active ingredients, 7% contained the correct active ingredients, 17% contained the incorrect amount of active ingredients and 16% contained different active ingredients.
  - *The consumption of a paracetamol syrup prepared using glycerol which is contaminated with diethylene glycol (a toxic chemical used as anti-freeze) resulted in the death of 100 people in Haiti in 1995.*
  - *Around 2500 people are believed to have died in Niger in 1995 after they received a fake meningitis vaccine.*
2. A counterfeit medicine is one which is deliberately and fraudulently mislabelled with respect to its identity and / or source.
3. Both branded medicines and generic medicines are subject to counterfeiting.
4. Counterfeiting of pharmaceuticals is a criminal activity often undertaken by people and organizations involved in other types of crime.
5. Trade in counterfeit drugs is widespread and affects both developing and developed countries.
6. The supply of counterfeit drugs is more pronounced in countries where the manufacture, importation, distribution, supply and sale of medicines are less regulated and enforcement is weak.
7. The majority of counterfeit cases involve tablets and capsules. Antibiotics account for about 50% of the reported cases of counterfeit drugs.
8. Counterfeit drugs are dangerous and can even result in death.
9. Counterfeit drugs are always a waste of public or private money.
10. Counterfeiters abuse the opportunities resulting from new global trade arrangements to increase the decrease traceability of pharmaceutical products and increase the chances for counterfeit drugs to reach the market.

The terms 'drug', 'medicine', and 'pharmaceutical product' are used interchangeably in this fact sheet.

### WORKING TOGETHER FOR SAFE DRUGS:

- World Health Organization (WHO), [www.who.int](http://www.who.int)
- International Federation of Pharmaceutical Manufacturers Associations (IFPMA)
- International Generic Pharmaceutical Alliance (IGPA), <http://www.egagenerics.com/igpa/igpa.htm>
- World Self-Medication Industry (WSMI), [www.wsmi.org](http://www.wsmi.org)
- Pharmaciens Sans Frontières (PSF/CHMP), [www.chmp.org](http://www.chmp.org)

## COUNTERFEIT DRUGS

### Action sheet

1. National laws should ensure that the manufacture, trade, distribution and sale of drugs are effectively regulated.
2. Governments should establish and/or strengthen their Drug Regulatory Authority's responsibility for the registration and inspection of locally manufactured and imported drugs.
3. Drug regulatory authorities should develop standard operating procedures and strengthen the inspection of suspected counterfeits.
4. Adequate training and powers of enforcement against counterfeits should be given to drug regulatory authorities, the judiciary, customs and police. Drug regulatory authorities should initiate widespread use of screening tests for the detection of counterfeit drugs.
5. Severe penalties should be introduced and applied for criminals caught manufacturing or selling counterfeit drugs.
6. Partnerships should be established between health professionals, importers, industry and regulatory authorities to combat counterfeit drugs.
7. Countries should systematically use the *WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce*.
8. Countries in the same region should work towards the harmonization of their marketing authorization procedures.
9. Countries with experience in combating counterfeit drugs should provide assistance and training in areas related to quality control, drug detection and enforcement.

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### **Drug counterfeiting in developing countries - possible ways of providing help in quality assurance**

*by Ralf Rest, action medeor, March 2000*

#### The drug counterfeiting problem

In a letter circulated to members in May 1998, the Federal Association of German Pharmaceutical Manufacturers (BAH) in Bonn wrote: "According to information from our members, the problem of counterfeit drugs appears to have increased recently, even in the home market". If one adds to this the lack of a comprehensive network of licensing and supervisory measures and the drug analysis possibilities in Germany, it is easy to imagine the scale of the drug falsification problem in developing countries, where the regulatory network is, at best, incomplete.

The World Health Organization (WHO) confirms this assessment. Between 1982 and 1997, about 750 cases of counterfeit drugs and half of them occurred in the period after 1990. In developing countries, especially those in the African continent, were affected in approximately 1000 cases. Some 50 per cent of counterfeit drugs contained no active ingredient, 20 per cent contained an active ingredient and 10 per cent the wrong quantity of active ingredient. One third of the cases involved antibiotics.

Drugs are supposed to cure, alleviate or prevent diseases and suffering through their effectiveness and harmlessness. If drugs are falsified, these functions cannot be fulfilled, i.e. disease may get better or may even get worse, pain is not relieved, and death can result. A few examples:

- Republic of the Niger 1995: approx. 60,000 patients were injected with an ineffective vaccine. Several hundred died or suffered irreversible brain damage from subsequently contracting meningitis
- Haiti 1996: 88 children died after ingesting a counterfeit antipyretic syrup containing an antifreeze agent
- Argentina 1997: the national drug regulatory authorities received a report of an underdosed antiparkinsonian drug which had been used to treat a 10 year old boy. Investigations later uncovered a series of drug falsifications.
- Brazil 1998: several cases of unwanted pregnancy are known to have occurred after the ingestion of contraceptive pills without any active ingredient.

These examples demonstrate various types of drug falsification, such as the imitation of a drug with an underdosed or qualitatively inferior active ingredient, the counterfeit drug with no active ingredient and the selling of products containing substances damaging to health or poisonous substances. A medicinal product can be completely imitated i.e. with the identical active ingredient

packaging, or a new expiry date can be printed on products whose true shelf-life has e

Developing countries are particularly prone to counterfeit drugs because it is often imp adequate quality assurance due to deficiencies in the licensing of medicinal pro supervision of pharmaceutical production. This is compounded by difficulties in contr the lack of analytical laboratories.

#### *Combating counterfeit drugs: GPHF- Minilab<sup>®</sup>*

Developing countries are greatly affected by drug falsification due to inadequate mon market by the state. Any improvement in the situation in the short term is unlikely i due to the high costs involved. Therefore action medeor and its partners are worki drug analysis (offering training on the GPHF-Minilab<sup>®</sup>) to enable developing countri basic check on medicinal products and so stop the sometimes devastating cons falsification.

The GPHF-Minilab<sup>®</sup> provides simple testing methods for the quality control of tablets as to enable underdosed or falsified drugs to be detected. It is specifically des developing countries. The seminar covers the theory and practice of visual chei products, disintegration tests, colour reactions to test identity and also the u chromatography to determine the identity and content (semi-quantitative) of c substances.

The seminar is aimed at members of the health authorities in developing countr pharmaceutical technicians, dispensing assistants and persons with basic pharmace acquired from other sources) as well as persons who, after instruction, will wo developing countries.

The seminar is designed for a maximum of 6 participants and lasts for 8 working proper support, 2 instructors/supervisors are needed.

A charge of 180.00 DM will be made per participant per day of the seminar to c instructors, seminar documents and chemicals. In addition, travelling costs will be ab participant and food and accommodation charges are approximately 80 DM per pa The total cost, for the maximum number of participants, is about 25,000 DM per cours

(Training programme GPHF-Minilab<sup>®</sup> and fact sheet GPHF-Minilab<sup>®</sup> are available on