

Newsletter no 73 November 2005

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1. Introductory

With pleasure we inform you about the latest activities of Medicus Mundi International.

In a former Newsletter we reported about the Kampala meeting of 2004, an anglophone African consultation of bishops responsible for church health institutions, Medicus Mundi gave the technical assistance and facilitated the conference, with assistance of the Uganda Catholic Medical Board. An extensive report you can find on the MMI website.

This was an anglophone meeting. The same kind of conference has been organised for the francophone and lusophone African countries. This took place in the month of June of this year 2005, in Cotonou. Medicus Mundi again gave technical support; the local organisation and logistics were executed by AMCESS, the MMI member organisation in Benin. The conference was officially convened by the regional bishops conference of francophone/lusophone Africa

A full report of the conference, including the ‘Cotonou Declaration’ you find in this newsletter.

Important now is the follow-up: what implementations and decisions have been applied in the period after, what are the restraints, how do the bishops deal with difficult questions and how do they communicate? MMI has been asked by the national bishop conference of the Central African Republic to give assistance to facilitate the discussion on health matters. On the other hand, continuous communication by way of a virtual network can give a proper feedback in a sustainable way. Start of a virtual network is the contribution of Marieke Verhallen.

The MMI working group on Human Resources Development is steadily active. The deskstudy Aids and the health workforce in Africa is ready now. The outline is given here. The full publication can be find on the MMI website. As a background article we draw your attention to the maiden speech of the congress of the Dutch Society of Tropical Medicine congress: Brain Drain or Brain Gain?

The third core activity of MMI, Appropriate Technology and PHC has come to a draft action plan. The Italian MMI member Cuamm takes the lead. A working group is formed. Action will start soon. The draft action plan, being still a bit premature, we nevertheless publish, in order to keep you informed.

This year a Medicus Mundi Switzerland member of the board of MMI attended the People Health Assembly in Cuenca. In fact it was the second assembly of the People Health Movement. The aims of the Movement are in the field of Primary Health Care very near to the philosophy of MMI, trying to reach a sustainable and affordable healthcare for the poor and to reveal the structures in our society that hamper the health goals. We thought it useful to publish background information on the People Health Movement and the Cuenca Declaration.

Sake Rypkema

2. The Cotonou Conference and Follow-up of Kampala and Cotonou

(Full report www.medicusmundi.org/cotonou2005.htm)

Déclaration de Cotonou

Sur recommandation du Conseil pontifical pour la pastorale des services de la santé, la Conférence épiscopale régionale de l'Afrique de l'ouest francophone (CERAO), la Conférence épiscopale du Bénin (CEB), l'Association des œuvres médicales privées confessionnelles et sociales au Bénin (AMCES) et Medicus Mundi International (MMI) ont organisé une conférence sur :

“La Pastorale de la Santé de l'Eglise catholique dans les pays africains francophones et lusophones à l'aube du troisième millénaire : les défis et les opportunités”

Cotonou, Bénin

Du 31 mai au 2 juin 2005

1. Introduction

Nous, les Evêques catholiques ayant participé à cette conférence, en cette année de l'Eucharistie, « source inépuisable d'espérance dans les épreuves de la vie », considérons le Ministère de la Santé comme une partie essentielle de notre mission évangélisatrice. A la suite de Jésus-Christ, « *Redemptor hominis* », nous affirmons notre compassion avec tous ceux qui sont éprouvés dans leur santé physique et spirituelle. Car, en effet, comme le soulignait Mgr Leonardo Sandri, Substitut de la Secrétaire d'Etat, « c'est dans le Christ, mort et ressuscité pour le salut intégral de l'homme et de tous les hommes, que se trouve l'espérance de la santé véritable et plénière, la vraie guérison de l'homme ».

Nous avons réfléchi sur la manière la plus appropriée pour assurer ce Ministère et relever les défis qui s'imposent conformément aux valeurs évangéliques propres au Ministère de la Santé et pour le bien-être total de nos frères et sœurs malades afin qu'ils « aient la vie et qu'ils l'aient en abondance » (Jn 10, 10).

La parabole du Bon Samaritain (Lc 10, 30-37) rappelle à tous les chrétiens la responsabilité qui est la leur de répondre aux besoins de nos frères malades et dont les visages reflètent celui du Christ souffrant (Matthieu 25,40).

2. Les constats et les recommandations issus de la Conférence de Cotonou

Au cours de nos travaux de réflexion, nous avons relevé un certain nombre de **constats** concernant nos institutions et que nous aimerions partager ici.

- Insuffisance de vision stratégique et de politique de santé
 - Difficultés rencontrées lors de demandes de financement de nos structures et de nos activités,
 - Insécurité de la prise en charge et la couverture des coûts,
 - Existence d'une concurrence entre nos structures sanitaires d'Eglise,
 - Coût élevé des équipements nécessaires à la fourniture de soins,
 - Déficit de partage d'information,
 - Manque d'engagement et de loyauté de certains membres du personnel,
 - Manque général de ressources et utilisation inadéquate quand elles existent.

Mais aussi

- Une ouverture de l'Etat dans le dialogue avec l'Eglise,
- Une reconnaissance du travail accompli par l'Eglise,

Ces constats sévères révèlent des **besoins** pour l'Eglise que l'on pourrait formuler de la façon suivante :

- Besoin de disposer d'une vision stratégique partagée,
- Besoin d'améliorer la disponibilité et l'accessibilité des services et des soins,
- Besoin de structurer les formations sanitaires de l'Eglise,
- Besoin d'adopter des normes et des standards professionnels,

- Besoin de développer la solidarité et le partenariat,
- Besoin d'échange et de partage,
- Besoin de disposer de personnel qualifié et loyal,
- Besoin de réaffirmer la qualité des prestations fournies,
- Besoin de gagner la crédibilité de nos partenaires,
- Besoin d'accéder aux ressources disponibles,
- Besoin de rendre davantage visible le travail de l'Eglise dans la santé,
- Besoin de réaffirmer la loyauté et le respect de la mission de l'Eglise.

En déterminant ces besoins pour nos Institutions, nous ouvrons la voie à des **recommandations** que nous voudrions formuler :

Stratégie et politique :

- S'assurer que nos efforts au niveau de la Pastorale de la Santé sont conduits selon une vision et une mission - desquelles découlent nos objectifs - et identifier les moyens par lesquels nous pourrions les atteindre,
- Inscrire toutes les démarches stratégiques dans le contexte local et national.

Plaidoyer :

- Présenter les problèmes qui affectent les pauvres et les vulnérables dans l'exercice de leur droit à la santé. A ce titre, l'Eglise cherchera à participer au débat sur la politique sanitaire au niveau national.

Coordination :

- Développer des compétences et des capacités pour garantir une supervision et un accompagnement adéquat des institutions sanitaires de l'Eglise,
- Mettre en place une coordination diocésaine,
- Mettre en place une coordination nationale,
- Mettre en place une coordination régionale,
- S'assurer que chaque Conférence nationale possède un Département ou une Commission de Santé avec du personnel qualifié et équipé d'un mandat solide,
- Assurer la complémentarité des spécialisations,
- Développer des ressources communes, comme par exemple des centrales d'achat ou des services de maintenance des équipements médicaux,
- Refléter les résultats des efforts novateurs des bureaux nationaux de coordination qui démontrent un impact manifestement positif sur la prestation des services de santé catholiques.

Partage d'information, d'expériences et de savoirs :

- Créer un service médical ayant pour fonction de réunir, filtrer et échanger des informations pertinentes,
- Partager et échanger du personnel,
- Utiliser du personnel clé dans des bureaux nationaux qui auront le rôle de personnes ressources aux assemblées plénières des Conférences épiscopales au niveau national, régional et continental,
- Entamer une communication avec et parmi des représentations gouvernementales, supranationales ainsi qu'avec la société civile,
- Faciliter la communication entre le Symposium des Conférences Episcopales d'Afrique et Madagascar (SCEAM) et les Conférences régionales, le Saint-Siège, l'Union Africaine et les bailleurs de fonds internationaux.

Prestations :

- Favoriser la disponibilité et l'accès à des services de santé de qualité abordables pour tous,
- Traduire en actes la complémentarité des centres de santé (paquet minimum d'activités) et des hôpitaux (paquet complémentaire d'activités).
- Mettre en valeur les mécanismes institutionnels de standardisation qui garantissent une qualité acceptable de soins de santé. Ceci contribuera à la promotion des services de santé catholiques auprès du public et des parties prenantes, bailleurs de fonds compris.

Formation :

- Faire un état des lieux des besoins quantitatifs et qualitatifs en personnel,
- Identifier les moyens disponibles (formations existantes, partenaires potentiels, bailleurs de

- fonds),
- Former au sein de la commission de la santé un groupe de travail épiscopal sur les besoins de compétences et de formation,
- Développer une formation au-delà du point de vue strictement médical,
- Informer largement sur les besoins des institutions de l'Eglise et sur les formations existantes,
- Améliorer et renforcer les relations avec le personnel des institutions catholiques, afin qu'il puisse préserver des valeurs chrétiennes comme l'amour, l'intégrité, la dignité, la justice, l'équité et avoir un cœur ouvert pour les pauvres et les vulnérables.

Partenariats :

- Inscrire le diocèse ou la Conférence épiscopale dans la politique sanitaire de l'Etat pour donner plus de chance à l'atteinte des objectifs communs,
- Travailler avec les parties prenantes du domaine des soins de santé qui démontrent l'utilité publique, sans compromettre les valeurs des soins de santé catholiques,
- Travailler dans un environnement oecuménique là où cela est requis et là où des opportunités se présentent,
- Signer des accords entre nos gouvernements et l'Eglise en prenant en compte l'approvisionnement et la promotion de soins de santé, sans compromettre l'identité de l'Eglise,
- Engager un dialogue continu avec nos gouvernements au nom de nos fidèles pour assurer la disponibilité de soins de santé de bonne qualité, accessibles et abordables pour tous,
- Partager l'expérience et le savoir de l'Eglise,
- Reconnaître et assumer les conséquences des formations différenciées dans la collaboration sur le terrain,
- Recourir à la collaboration d'experts ou de personnes-ressources si nécessaire.

Accès aux ressources financières :

- Identifier les sources de financement, les organismes responsables et les formalités de recours,
- Développer les compétences et les capacités nécessaires pour accéder aux financements de façon coordonnée,
- Soutenir la contractualisation comme moyen pour les institutions de l'Eglise d'accéder à davantage de ressources financières,
- Garantir une gestion professionnelle des ressources allouées,
- Mettre en place les procédures nécessaires à l'élaboration de comptes-rendus périodiques sur l'utilisation des fonds, les prestations réalisées et les résultats atteints,
- Maintenir nos efforts pour freiner l'augmentation des coûts des soins de santé pour les pauvres et les vulnérables.

Régulation :

- Ce rôle reste de la compétence de l'Etat.

Nous, les Evêques catholiques ayant participé à la Conférence de Cotonou, souhaitons insister sur la spécificité des soins de santé de l'Eglise : les institutions et les programmes catholiques de soins de santé complètent la qualité des soins par la richesse d'un héritage spirituel.

Au regard de ce qui précède, nous pouvons réaffirmer que nous sommes fortement décidés à ne pas délaissier le rôle et la situation de l'Eglise dans les soins de santé, illustrés à travers ses programmes et ses institutions. Nous souhaitons bien plus entreprendre ce qui est nécessaire pour améliorer ce rôle et plaider en faveur de la santé pour tous.

3- Engagements

Compte tenu des acquis de la Conférence de Cotonou et de la visée globale du Ministère de Guérison de Jésus, nous, Evêques francophones et lusophones d'Afrique présents, pasteur de l'Eglise famille de Dieu, voulons renouveler et préciser notre attention aux malades à travers lesquels le Christ nous offre à aimer son visage défiguré. Aussi, nous engageons-nous selon les termes suivants : pour une Pastorale de Santé proche de l'attention que le Christ a manifesté aux malades et aux souffrants:

1. Différents aspects et formes de la Pastorale de Santé doivent être poursuivis de façon conjuguée selon les contextes.

2. Nous trouvons nécessaire de nous préoccuper de l'approvisionnement en soins de santé appropriés et abordables; disponibles aux personnes dans le plus grand besoin.
3. Nous nous engageons à jouer un rôle prophétique à travers un plaidoyer actif avec et au nom des groupes les plus faibles de la société : les pauvres, les femmes, les enfants, les personnes et les communautés marginalisées, afin que leurs droits soient reconnus et respectés par les gouvernements ainsi qu'au sein de la société.
4. Nous nous engageons à comprendre les soins de santé dans une approche globale. En conséquence, nous nous engageons à travailler avec la société civile entière pour vaincre les obstacles (politiques, socio-culturels, économiques) qui oppressent les gens et affectent les soins médicaux.
5. Suite aux conséquences tragiques de la pandémie du SIDA et aux défis particuliers que cela impose à l'exercice de la Pastorale de la Santé de l'Eglise, nous nous engageons à inclure ou à maintenir dans le programme de nos Conférences épiscopales le problème du VIH/SIDA pour encourager un rôle actif de l'Eglise dans le combat contre l'épidémie de la maladie, à aider à son éradication et réussir à minimiser son impact sur la vie des personnes, des familles et des communautés.
6. Nous considérons qu'il est nécessaire d'organiser ou de réorganiser au mieux nos structures sanitaires dans le but d'une part d'y apporter des changements qualitatifs pour une meilleure prise en charge des patients dans la durée et d'autre part de développer auprès du personnel le sens de l'homme dans toute sa dignité.
7. Nous reconnaissons qu'il est indispensable pour nous de définir des chartes et des directives, de formuler des missions, des politiques, ou encore des règlements d'établissements de santé et des programmes dans le but d'une bonne gestion de nos institutions sanitaires.
8. Nous reconnaissons la nécessité de clarifier les questions de la propriété et de la gestion des institutions et des programmes de santé, conformément aux circonstances locales et à l'environnement légal, de façon à promouvoir la supervision et l'accompagnement (« Stewardship ») comme une valeur ajoutée à tous les niveaux.
9. Afin de faire fonctionner efficacement les institutions et les programmes de santé, nous voulons répondre aux besoins urgents de main d'œuvre professionnelle par la mise sur pied d'une coordination de professionnels, d'unités de service et d'institutions de formation compétentes. Nous nous engageons ainsi à promouvoir le professionnalisme à tous les niveaux, en confiant aux personnels compétents les missions qui leur sont spécifiques.
10. Des professionnels devraient être habilités à gérer les services et les programmes de santé de l'Eglise avec des « termes de référence » clairs ainsi qu'avec un maximum d'intégrité professionnelle. Nous nous engageons à créer ces conditions qui professionnalisent la fonction de gestion.
11. Nous trouvons nécessaire que les différentes initiatives et institutions de l'Eglise qui offrent une formation de gestionnaires de santé rassemblent leurs efforts en tenant compte du contexte géographique dans lequel elles opèrent.
12. Nous engageons nos institutions et nos programmes à avoir une gestion transparente et à rendre des comptes sur le plan des performances financières et de l'activité médicale. Nous visons à garantir l'efficacité et l'efficience des prestations de service.
13. Nous soutenons la contractualisation comme un moyen d'améliorer et de formaliser la coopération et l'intégration entre les différentes parties prenantes. Cependant, nous pensons qu'il serait plus bénéfique pour nos pays de commencer dans un premier temps par le système de financement des « inputs » (intrants ou facteurs de production) avant d'adopter un système « d'achat de performances ».
14. Nous nous engageons à participer activement aux réformes des structures sanitaires afin de partager nos valeurs chrétiennes et notre expérience en matière de développement sanitaire.
15. Nous nous engagerons contractuellement avec les bailleurs de fonds qui soutiennent l'Eglise dans l'amélioration et le développement de ses capacités sanitaires ; ceci dans un cadre de travail partagé pour une coopération transparente et loyale, avec des objectifs précis et des résultats spécifiés.
16. Nous nous engageons avec l'appui des organismes financiers à appliquer les engagements ici définis.
De plus, nous demandons au niveau du SCEAM que des initiatives soient prises pour impliquer toutes les conférences épiscopales régionales dans le processus de restructuration des institutions sanitaires par une organisation adéquate régionale et panafricaine.
17. Nous nous engageons avec discernement à encourager et à soutenir les recherches scientifiques et fiables ainsi que les résultats avérés dans le domaine de la phytothérapie ou de la pharmacopée, en vue d'alléger les frais sanitaires des populations et de promouvoir l'hygiène de vie.

4. Programme d'action

Un plan d'action formé de 4 éléments a été mis en place en utilisant des données provenant des Conférences épiscopales représentées à la Conférence de Cotonou.

Nous, les Evêques catholiques ayant participé à cette Conférence, nous engageons à accomplir, en nous fondant sur les spécificités propres à chacun de nos pays, ce qui est mentionné ci-dessus, à travers les quatre stratégies suivantes : la diffusion, le renforcement de la portée de nos recommandations, la mise en oeuvre et le suiviévaluation.

4.1 La diffusion

La diffusion accentuera la valeur et l'importance des résultats de la Conférence de Cotonou et pourra contribuer à la mise en œuvre du plan d'action.

Les résultats de la Conférence seront distribués par différents moyens au sein de l'Eglise au plus grand nombre possible d'institutions et de personnes.

La liste de distribution inclura :

- o Le Conseil Pontifical pour la Pastorale des Services de la Santé,
 - o Le Symposium des Conférences Episcopales d'Afrique et Madagascar (SCEAM),
 - o Les Conférences Régionales en Afrique, en particulier l'Association des Conférences épiscopales de l'Afrique centrale (ACERAC),
 - o Les Conférences Episcopales Nationales en Afrique,
 - o Les Conférences Africaines des Supérieurs Religieux Majeurs des ordres masculins et féminins,
 - o Les Institutions Africaines d'études et de hauts enseignements de l'Eglise, tels que les grands séminaires, les universités catholiques etc.

La stratégie de diffusion retenue comporte trois domaines d'action : l'information, la sensibilisation et la diffusion proprement dite.

Information :

- o Le soin est laissé aux organisateurs de la Conférence de Cotonou d'écrire des lettres informatives, d'envoyer des courriers électroniques et des copies de la présente Déclaration de la Conférence aux organisations et aux personnes concernées sous la responsabilité du Président du Comité exécutif de la Conférence de Cotonou;

Sensibilisation :

- o Présenter les résultats de la Conférence sur les forums appropriés, tels que les réunions des Conférences épiscopales nationales, régionales et continentales. Là où cela est nécessaire, nous demanderons un support technique à des personnes ressources familières avec la Déclaration et ses rapports dans différents aspects.

Diffusion :

- o Publication dans les médias nationaux, régionaux et continentaux tels que des journaux, magazines, radio, télévision lorsqu'ils sont disponibles.

4.2 Le renforcement de la portée de nos recommandations

Devant constater la faible représentation à la Conférence de Cotonou des pays francophones de l'Afrique centrale, qui sont néanmoins bien engagés dans le domaine de la santé, compte tenu de leur contexte particulier, nous les Evêques catholiques présents souhaitons poursuivre les échanges avec nos confrères et recommandons à l'ACERAC d'organiser le plus rapidement possible une séance de travail complémentaire qui viendra renforcer la portée de nos recommandations.

4.3 La mise en œuvre :

La mise en œuvre appelle un certain nombre de modalités exécutées par les différents protagonistes.

Acteurs chargés de la mise en œuvre :

- o Les coordinateurs des commissions diocésaines de santé,
 - o Le Président et Secrétaire général ainsi que le Président et Secrétaire exécutif (ou la personne désignée à ce poste) des Commissions pour la santé des Conférences épiscopales nationales (au niveau national)
 - o Le Président et Secrétaire général des Conférences régionales (au niveau régional)
 - o Le Président et Secrétaire général du SCEAM (au niveau continental).

Au cas où l'un ou l'autre de ces acteurs en terme de structure n'existait pas dans un pays, il est recommandé aux Conférences épiscopales de créer un comité temporaire ou permanent au niveau respectif. Ce comité devra être doté d'un mandat clair, précis et du soutien dont il aura besoin pour l'atteinte des objectifs.

Modalités de mise en œuvre :

- Des ateliers de planification opérationnelle seront organisés par le Président de la Commission épiscopale pour la santé dans chaque pays dans un délai maximum d'un an, avec l'appui en cas de besoin d'experts.

4.4 Le suivi et l'évaluation

Le Président de la Commission Episcopale pour la Santé de chaque pays est garant du suivi et de l'évaluation des recommandations. A ce titre, il est responsable des mécanismes de diffusion et de planification. Il pourra mettre sur pied les organes de suivi et d'accompagnement qu'il jugerait nécessaires.

Déclaration approuvée le 2 juin 2005 par : Mgr Jean

Zerbo, Bamako, Mali (CERAO) Mgr Victor Agbanou,

Lokossa, Bénin

Mgr René-Marie Ehouzou, Abomey, Bénin Mgr Antoine

Ganye, Dassa-Zoume, Bénin Mgr Nestor Assogba,

Cotonou, Bénin Mgr Fidèle Agbatchi, Parakou, Bénin

Mgr Marcel Honorat Léon Agboton, Cotonou, Bénin

Mgr Basile Tapsoba, Koudougou, Burkina Faso

Mgr Luis Gonzaga Ferreira da Silva, Lichinga, Mozambique

Mgr Joseph Koerber, Makokou, Gabon Mgr

Ambroise Djoliba, Sokodé, Togo

Mgr Armando Umberto Gianni, Bouar, RCA

Annexe – Liste complète des participants à la Conférence de Cotonou

Nom et Prénoms	Institution
Mgr Jean ZERBO	CERAO, Archevêque de Bamako, Mali
Mgr Pierre N'GUYEN VÂN TÔT	Nonce apostolique Bénin-Togo
Mgr Antoine GANYE	Evêque de Dassa-Zoumé, Bénin
Mgr Fidèle AGBATCHI	Archevêque de Parakou, Bénin
Mgr Marcel Honorat Léon AGBOTON	Archevêque de Cotonou, Bénin
Mgr Nestor ASSOGBAR	Evêque Emérite de Cotonou, Bénin
Mgr Victor AGBANOU	Evêque de Lokossa, Bénin
Mgr René-Marie EHOZOU	Evêque d'Abomey, Bénin
Mgr Paul K. VIEIRA	Evêque de Djougou, Bénin
Mgr Basile TAPSOBA	Evêque de Koudougou, Burkina Faso
Mgr Luis Gonzaga FERREIRA da SILVA	Evêque de Lichinga, Mozambique
Mgr Joseph KOERBER	Préfet Apostolique de Makokou, Gabon
Mgr Ambroise DJOLIBA	Evêque de Sokodé, Togo
Mgr Armando Umberto GIANNI	Evêque de Bouar, RCA
Mgr Joseph BALLONG	Radio Vatican pour l'Afrique, Vatican
Père Novat KPODA	CERAO
Père Ruffin MIKA MFITZSCHE	CERAO
Père Raoul André AYIOU	Ordre hospitalier des religieux Camilliens
Père Eugène HOUNDEKON	Conférence épiscopale du Bénin
Abbé Désiré ATTONDE	CSD/COTONOU, Bénin
Sr Félicité Perpétue BIO-SEKO	OCPSP, Oblates Catéchiste Petites Servante des Pauvres, Bénin
Sr Emilie SOMDA	ASIENA, Bénin
Frère Léopold GNAMI	Ordre Hospitalier St Jean de Dieu, Togo
Mme Dorothé KINDE-GAZARD	Ministre de la Santé Publique, Bénin
Dr Marcellin AYI	Ministère de la Santé, Bénin
Dr Barthélémy DOSSOU BODJRENOU	Directeur Hôpital BETHESDA, Bénin
Dr Marie Anne DOVONOU	Hôpital Saint Luc, Bénin
Dr Pierre EFFA	SCEAM, Ghana
M. Charles-Juste GUEDOU	Ministère de la Santé, Bénin
Dr Christa KITZ	Misereor, Allemagne
M. Alfred Coffi KOUSSEMOU	BEC/AMCES, Bénin
M. Lazare LOCO	OMS, Bénin
Mme Béatrice LOOIJENGA FAUCOUNEAU	Cordaid, Pays Bas
Dr Jean-Paul MUNDAMA	UCC Raben, Diocèse de Butembo, (RDC)
Dr Patricia J. NICKSON	Conseil oecuménique des églises, G.B.
M. Jean PERROT	OMS, Suisse
Dr Alain SANTOS	Président CCNS, Bénin
Dr Robert SOETERS	Consultant MMI, Pays Bas
Dr Yves SOSSOU	Directeur BEC/AMCES, Bénin
M. Matthias VAN VLIJMEN	Medicus Mundi International, Belgique
M. Thomas VOGEL	Medicus Mundi Suisse, Suisse
Prof. Ahouefa Anna VOVOR	CET, Togo
Mme Frederica WIJCKMANS	Medicus Mundi International, Belgique

Proposal to induce an understanding of the outcomes of the Kampala Conference and to promote follow-up.

1. Introduction

Health Care delivery is rapidly changing in the developing countries. This process started in the 1980'ties following the international economic crisis, but is still continuing and accelerating even. Health sector Reforms, Sector Wide Approaches, and Global Initiatives are processes that at present dominate policymaking and implementation.

In most of the East African Countries Church and secular Non Governmental Health Care facilities (Private Not for Profit providers or PNFP facilities) provide between 30 to 50% of the health care services in these countries. If only the rural area's would be considered, these percentages would be significantly higher as the highest number of PNFP facilities can be found here.

The Church health care facilities were mostly founded in colonial times by expatriate congregations in answer to the needs of the local population and as a complementary part of the church's mission. Initially these facilities heavily drew on financial support from abroad. However, since the 1980ths the perspective gradually changed. Increasingly the ownership of the health facilities was handed over by the congregations to the dioceses, and bishops became proprietors of these institutions. At the same time external funding dwindled, and contributions from the Ministry of Health (not in all countries) could not compensate for this. Hence the facilities are increasingly experiencing resource and other constraints, at the expence of quality of care offered to the patients as well as affordability to the poorest, as most facilities saw no other option than to charge fees for services provided.

At national level, co-ordination offices, or umbrella organisations, represent these facilities. In a number of countries the Catholic and Protestant co-ordination offices have joint forces to form a Christian Health Association. All these offices have the assignment to liase with government and provide technical assistance and general support to the affiliated health units and their owners.

In the context of Reforms and Sector Wide Approaches (SWAp), the Governmental Health Authorities are increasingly seeking ways to develop close co-operation with PNFP facilities and their umbrella organisations. In each country the Church umbrella organisations and the individual units need to develop new co-operation strategies and integrate new or different ways, of operating to take on public purpose responsibilities. They do aspire to these responsibilities, as these will allow them to deliver comprehensive services and be more effective. At the same time however these organisations and units do wish to retain their identity and basic autonomy, as these are required to ensure that they can continue to answer to their wider social mission.

In the Anglophone African countries the context and needs are comparable. Increasingly the Church umbrella organisations feel the need to be able to exchange experiences with their sister organisations in the neighbouring countries to learn from each other and to avoid that each has to invent own solutions to common problems.

At several inter-regional meetings the plan, to either have more regular meetings, or set-up an inter-regional co-ordination method, has been tabled, but to date no adequate approach could be found.

During the AMECEA and Medicus Mundi International hosted conference for Episcopal Conferences from Anglophone countries, held at Kampala, Uganda from 22nd – 24th March 2004, the issue of professionalizing church health care through coordinated efforts received ample attention. Reference is made to the final statement endorsed by the conference participants, as well as a narrative summary report on the presentations held. The final statement includes intentions to set up facilities at national, regional and continental level that are considered to be instrumental for supporting implementation of the resolutions and recommendations passed by the conference.

2. AIM OF THE DOCUMENT

This document aims to propose a comprehensive strategy to promote implementation of the resolutions passed at the conference. More specifically it is desired to enhance the co-operation between Public and

Private Not-for-Profit health care providers in order to improve equitable and high quality health care provision to all populations of the East Africa countries.

The comprehensive strategy includes three mutually reinforcing elements:

1. to promote understanding and follow-up among respective Episcopal Conferences
2. to promote professionalisation of health secretariats of Episcopal Conference, through networking
3. to introduce a “virtual network” that seeks to facilitate targeted exchange of information for those involved with health matters within Episcopal Conferences.

During the Kampala Conferences other options were tabled as well. A number of delegates were in favour of setting up a designated secretariat within e.g. AMECEA or any other regional Episcopal Conference (a). Others contemplated on using UCMB to champion the process of professionalisation in other Episcopal Conferences (b). Also the option of setting up a regional/continental church health network was mentioned (c).

We haven't concentrated on these options for the following reasons.

(a) This option does not necessarily require outside support: if it is the desire to do set up a secretariat complementing what is already in place, we assume that the necessary means and staff can be found. Moreover we feel that “institutionalisation” of the promotion of professionalisation can be viewed positive as well as negative. Beyond any doubt having someone well-situated and competent may be an asset. On the other hand professionalisation refers to a process for which local ownership is indispensable. Making someone from “outside” responsible may be convenient but may not take some of the most prominent characteristics of the church structure into account, i.e. the strong sense of autonomy. Whereas many church umbrella bodies already face continuous challenges due to a limited mandate, a secretariat that operates at a distance may face this even stronger.

(b) Whereas the performance of UCMB has been outstanding, as has been acknowledged by many, we think that adding another burden to this office that focuses beyond Uganda may compromise the limited capacity present. This may come at the expense of what has been started in Uganda, and may not create the right feeding ground for activities beyond Uganda. Expanding the staff at UCMB may not really resolve this fear.

(c) A network may not function, unless a secretariat is installed, regular venues are organised where members may meet each other, etc.. Needless to state that international networks are usually quite expensive to run with limited proven outcome.

3. COMPREHENSIVE STRATEGY WORKED OUT

3.1 to promote understanding and follow-up among respective Episcopal Conferences

A number of Episcopal Conferences failed, for a variety of reasons, to be represented at the Kampala Conference. Merely sending the statement and the conference report may not induce a shared understanding of the background as well as a shared appreciation of the resolution and recommendations.

The delegates of the Episcopal Conferences that did attend may face similar problems upon return to their respective country. As they have experienced a learning process, and have been able to contribute actively, they may still have to “buy-in” colleague bishops as well as the national health secretariat. Reference is made to the characteristics of a “learning organisation” as have been explained to the Conference by Dough Reeler (see Appendix 1).

It may be too optimistic to expect that the change processes desired can be left to either individual Episcopal Conferences themselves or in a regional engagement. Outside input may be essential to set a process in motion.

We suggest that an effective strategy is the following: One but preferably two facilitators are hired from outside who are given the task to organise a programme of a limited duration (one to maximum two days). The objective of the programme primarily comprises of contributing to a proper understanding of the presentations held at the Kampala Conference, as well as the final Statement. Moreover the programme can include the compilation of an action plan.

This involvement can be a one time occasion. Ownership, organisation and initiative need to lie with the respective Episcopal Conference. Where competent local facilitators are available, a local facilitator can work together with an external facilitator. Suggestions for local speakers are welcomed. Ideally, such a

programme could be “attached” to a periodic function that already draws the target group, so to limit costs and interference with individual agendas.

3.2 to promote professionalisation of health secretariats of Episcopal Conference through networking

An essential criterion for promoting sustainability of church health care is the efficacy of coordinating health secretariats at respective Episcopal Conferences. Professionalisation of the health secretariats is an essential issue.

Like the Episcopal Conferences need to undergo a learning process in order to induce change, the same may be true for the health secretariats. In order to create an effective learning ground, we feel that it is essential to invite one or two representatives of each national health secretariat to a conference that addresses the issue of professionalisation of church health secretariats. The objective is partly the same as mentioned under one, but goes beyond it as it focuses on operational aspects as well.

Facilitation from outside may be required. The meeting is preferably organised on a pan-African level. However, if the number becomes too large and in order to reduce costs, similar meetings could be organised on a regional level, using a team of facilitators. Duration would be ideally be minimal three days.

In addition we recommend initiating a pan-African network for health secretariats, that has a steering committee of a limited number of prominent partners, whereby prominence is determined by the level of professionalisation achieved. Objective is primarily to promote exchange of learning experiences as well as to do process monitoring in respect to what transpires in individual health secretariats. This steering committee may meet maximal three times, supported by outside facilitators, before it dissolves and leaves matters to the third strategy presented below.

3.3 to introduce a “virtual” network that seeks to facilitate targeted exchange of information for those involved with health matters within Episcopal Conferences.

The “virtual” network is primarily a Church (health) network that has the following objectives:

- Study and discuss regional and international health policy and system reform proposals with respect to their possible implications for the potential of church facilities to contribute to effective and equitable health provision;
- Formulate responses to plans that endanger equity and quality of services and / or endanger the possibilities of the church health care facilities to contribute effectively while preserving their operational autonomy;
- Facilitate the dialogue with governmental and international health care partners;
- Design common approaches to regional governmental health policies and implementation plans that can be adjusted per country in accordance with the realities there;
- Exchange information, best practices, and operational research results;
- Learn from each other.

The difference is that it is a **Virtual** Network, consisting of e-mail addresses, a website and a moderator. The umbrella organisations are all inter-linked by e-mail (e.g. through a so-called list-serve) and feed information and questions to each other, discuss matters, formulate (or refine) common standpoints, through this medium.

The difference with many other virtual networks is the addition of a moderator. This part-time resource person has the assignment to distil common issues, provide international information, stimulate the debate, summarise discussions and propose standpoints and reactions. In other words ensure that the network continues to operate.

The resource person can be located anywhere in Africa or Europe, primarily depending on the location where a suitable person can be found.

A virtual network is comparatively less expensive to install and maintain. It does not burden the individual church health secretariats as it is facilitated by an outsider. However, continuity and institutional memory can be realised at national and regional level and a much wider group can participate as the network can be enlarged as required.

It is superfluous to state that adequate e-mail/internet facilities are essential. However, a professionalized health secretariat is unthinkable without these facilities anyhow.

4. HOW TO APPROACH THIS MATTER?

It is essential that Episcopal Conferences and particularly their regional bodies take up the responsibility of stimulating and monitoring what has been resolved at the Kampala Conference. The Conference Statement spells out responsibilities as well as the way forward. A time frame has been indicated as well. This document can only go as far offering suggestions regarding a possible way forward. The authors in no way wish to take over the responsibility for the implementation of the Kampala Statement. This document does not carry any obligations whatsoever. It has been written out of concern as well as professional interest. The authors welcome to be involved in any follow-up exercise, but this is totally up to the respective Episcopal Conferences.

Needless to state that the processes indicated need further elaboration. This can only be done in close collaboration with the respective Episcopal Conferences, from where essential input needs to come. It is needless to state too that the process will come at an expense for which donor support need to be sought and obtained. For the sake of objectivity, the authors cannot facilitate such a process.

Appendix 1

From Kampala Conference report: par. 4.15

Doug Reeler, Community Development Resource Association

“Sustainable organisations and healthy change processes”

The Episcopal Conferences present at the Kampala Conference have convened to discuss opportunities and threats experienced by the Church while fulfilling the Healing Ministry. It is therefore helpful to identify key factors allowing for *healthy processes of change*, leading to *sustainable organisation*, and of *leading or stewarding organisational transformation*.

In order to do so, three core dimensions of the *Learning Organisation* (an organisation that consciously and continuously learns from its experience and proactively responds to its changing context) have to be explored:

- *The practice*. This focuses on understanding who we are; where we find ourselves; what do we want to achieve; which strategies do we use; which resources and skills do we apply;
- *The organisational forms that best support this practice*. This focuses on the existing (strategic) processes that are in place; on the organisational culture; and on the support systems that are required;
- *The forms of Leadership most supportive of this organisation and practice*. This focuses on visioning the future while energising the present and learning from the past; in challenging and supporting people.

Once this is done a *process of change* can be entered:

- The *first stage* basically is what this conference is about: facilitating a common understanding of the situation or crisis, exploring the current practices; testing the will to change; engineering new foundations of beliefs, values, principles and leading ideas; creating new visions or leading images; developing concrete plans of actions, while identifying those who will implement them.
- The *second stage* refers to managing the transition. This is a difficult phase, where one easily is confronted with uncertainty, fear and confusion, aggravated by loss of productivity and met by resistance to change.
- The *third stage* refers to consolidation of new change and managing ongoing change. It has to be anticipated that there are no definite answers; there is need for continuous learning (from each other) while implementing; there is need for willingness to continually re-strategise in response to changing contexts.

The second and third stages lie ahead of the Episcopal Conferences. These will immediately start once the bishops present at the Kampala Conference will have returned to their respective countries. There is evident need of leadership and endurance, which needs to be complemented with technical input and with a variety of resources.

3. Human resources and Health

Deskstudy Tropical Institute of Antwerp *Aids and the Health Workforce in Africa*

Introduction

(full report will soon be available at www.medicusmundi.org)

The health workforce has made its comeback on the agenda, as witnessed by a recent flurry of reports that deal with the crisis of the human resources for health. One stream explores the human resource bottlenecks for the new global health initiatives and the rapid scaling up of ART and the effects of the pandemic on the health workforce. Another stream focuses on the brain drain, while a third stream presents global overviews of the factors that underlie the crisis. If anything, this 'new' attention being given to the health workforce shows that both the world of research and international development has taken up the issue of human resources. It seems that a certain momentum is being created that may set in motion initiatives and changes that could have profound effects. The issues underlying the problems of the health workforce are, however, many and finely intertwined, leading to a high degree of complexity and wickedness. The two-way interaction between the health workforce and HIV/AIDS is a prime example and it is the main subject of this report, which was commissioned by Medicus Mundi International.

The choice of the subject will take us primarily to the southeastern regions of Africa. However, we would like to insist on the point that other health workforce crises are emerging in other regions of Africa, and indeed other regions in the world, of which the brain drain can be regarded as one of the symptoms. These present in many 'configurations' of deficits in training and production, distribution, management and policy. While we believe that (wo)manpower is a key issue in healthcare provision, we will discuss these dimensions only tangentially in this report.

With the dropping cost of antiretroviral drugs, the burning question in the ART scaling up debate is no longer in the first place how to finance access to drugs or indeed the scaling up of ART schemes, but rather how to ensure the implementation of the programmes. Health system performance is increasingly acknowledged as a condition for success of programmes like the *3x5 initiative* and the notion that the human resources will be one of the decisive determinants is gaining ground (Narabsimhan *et al.* 2004, Tawfiq & Kinoti 2003). However, in most south-eastern African countries, the health workforce is teetering. Chronic deficiencies regarding training capacity, distribution and skill mix, and retention in the medical and caring professions have left the health services with little margins to cope with new challenges (Aitken & Kemp 2003, Huddart *et al.* 2003). Furthermore, under current conditions in many developing countries, performance and accountability of health providers are difficult to ensure. In other words, countries in South-eastern Africa not only are facing huge problems of implementation capacity to scale up antiretroviral treatment schemes, but also to ensure the adequate performance of the health system as a whole.

If we want to find ways of dealing with this HIV problem, we will need radical shifts in thinking and these shifts will have to be paradigmatic ones. We need to question accepted models of thinking, rethink concepts (or our understanding of them) like 'health systems', 'medical communities', 'health care', 'disease', 'health production', 'public health', 'stigma', 'medical

ethics',... The crisis in southern Africa should make us rethink everything and we need especially new ways of thinking about programmes and projects with their implicit assumptions of who does what to/for whom, who is the subject of action and who is the object.

With this text, rather than bringing together a maximum of factual information, we will attempt to be interpretive and reflective, and to point to possible new accents. We will present many questions: 'What is AIDS doing to populations and society? What is AIDS doing to the health workforce? How can the health workforce cope with new financing mechanisms and the resulting increased funding? What is the health workforce's role in tackling AIDS?'

One concern runs through most chapters of this report. Given the complexity of the underlying social root issues of both AIDS and the health workforce, we believe different viewpoints and perspectives are necessary if the attempts of answers to these questions are to be relevant. Not only the analysis, but also the actions need to take account of the complexity of both the issues and the social contexts in which they are situated: *Answers will essentially need to be context-dependent*. Our ambition is then not to present a state of the art, but rather to offer some 'other' ways of looking at the dynamic interplay between the HIV/AIDS pandemic and the health workforce in the hope that this may lead to better insights in the complexity and diversity of these problems.

Action Plan for Human Resources in Health

Workplan

Introduction

This document elaborates a work plan for MMI and its members on the basis of the strategic plan 2005 – 2009. The aim of the work plan is to get a clear view of the dynamics behind the brain drain and develop strategies to counteract the development by 2006. The plan is based on the strategic plan of MMI and studies in the field of human resources implemented by Cordaid in recent times.

The Medicus Mundi Internationalis Strategic Plan 2005 – 2009

The MMI strategic plan states the following on human resources in health:

“Developmental objective II: Development and implementation of strategies to keep competent and motivated staff available for non-governmental health care providers in Sub-Saharan Africa

Since its foundation local human resource development has been among the key issues pursued by MMI and most of its MOs. In the sixties medical and paramedical personnel were recruited in Europe to assist running health care facilities at district level and to organise these activities according to locally felt needs. Appropriate training curricula were developed and implemented by a number of specialised research and training institutions in Belgium, the Netherlands, Italy, Spain and Switzerland. An important objective of the technical assistance was the transfer of knowledge and local capacity building. The provision of training, enhancement of local recruitment and systematic improvement of the working environment for local qualified staff, were strategies to promote local human resource development.

This policy has been successful in a number of countries. Missionary and voluntary staff has been phased out in most paramedical functions and have been replaced by local qualified staff. However among the higher educated medical staff, particularly when trained by medical schools in developed countries, there was and is a strong tendency not to return to the country of origin or to migrate some time afterwards. The evolution of the HIV/AIDS pandemic also has enormous impact on medical staff. The sheer numbers of patients to be confronted every day with very limited means to treat them properly, tend to affect the motivation of staff to a point where many decide to quit the profession. An above average amount of medical staff is infected themselves.

Given these developments, MMI is of the opinion that there is a need to review the approach to local human resource management in a systematic way. Accessible healthcare of acceptable quality is dependent on health care personnel, which is available, competent and motivated. In the health sector decentralisation and privatisation is in full swing. The relationship between the qualified staff and the local employer (institutional authority) is in evolution and has implications for career planning, participatory management, ongoing education, retirement benefits and other additional terms of employment. In 2003 MMI published the booklet: Which role for Medicus Mundi Internationalis in Human Resource Development?¹ This publication is a first step MMIs renewed action in the field of local human resource development.

Specific objectives

- A. Rethinking human resource management in the changing context to develop strategies to keep competent and motivated staff available for non-governmental health care providers in Sub-Saharan Africa
- B. Implementing these strategies in church based and secular non-governmental health care providers in Sub-Saharan Africa

Expected results

- A. Clear view of dynamics behind brain drain and implications of HIV/AIDS pandemic on human resource development in non-governmental basic health care providers in Sub-Saharan Africa and determination of effective strategies to counteract these developments available by 2006
- B. Implementation of strategies to keep competent and motivated staff available for church based and secular non-governmental health care providers in 5 countries in Sub-Saharan Africa by 2008.”

¹ Which role for Medicus Mundi Internationalis in Human Resource Development? Current critical issues in Human Resources for Health in developing countries, Bruno Marchal and Guy Kegels, Institute of Tropical Medicine, Antwerp, MMI August 2003

General Background on Human Resources in Health

There is overwhelming evidence from literature and from practical experiences of MMI members that there is an imbalance between demand and supply of health workers in most developing countries of the world. The MMI study provided an in-depth analysis of the human resource situation.

The human resources problem in health is not new, but recent attention in relation to the achievement of the Millennium Development Goals (MDGs) has put the issue again in the lime light. Through the High Level Forum on Health MDGs meetings, like in Abuja in December 2004 and action plans governments and multi- and bilateral agencies work on solutions. Next year's World Health Report will be devoted to the issue. The WHO will launch the human resources decade in 2006, on World Health Day.

Often in articles and debates, the Non-Governmental Organisations in Africa are described as competitors of the government services, attracting highly competent workers with high salaries. This may be the truth for NGOs with foreign support, but it does not apply to most of the partner organisations of MMI members. From several reports from partners in Africa it transpires that the human resources problems in faith-based organisations may be even worse than in government. In Uganda, Tanzania and Zambia government health services are attracting many health workers from private non-for-profit (PNFP) institutions.

At the same time, in many African countries there is a trend for upgrading health cadres (e.g. nursing aides, health assistants), affecting the private-non-for-profit institutions that often work with these cadres. There is also a trend to upgrade enrolled nurses to registered nurses, which is affecting both the nursing schools and the PNFP health facilities.

In the international debates, the discussion concentrates on the role of national governments, international organisations and multi lateral funds. In general, the role of smaller PNFP organisations, which are functioning in the public health system ("mission hospitals"), are overlooked in the debate. There is little interest in their problems and potential solutions. Exactly these organisations are the partners of MMI members.

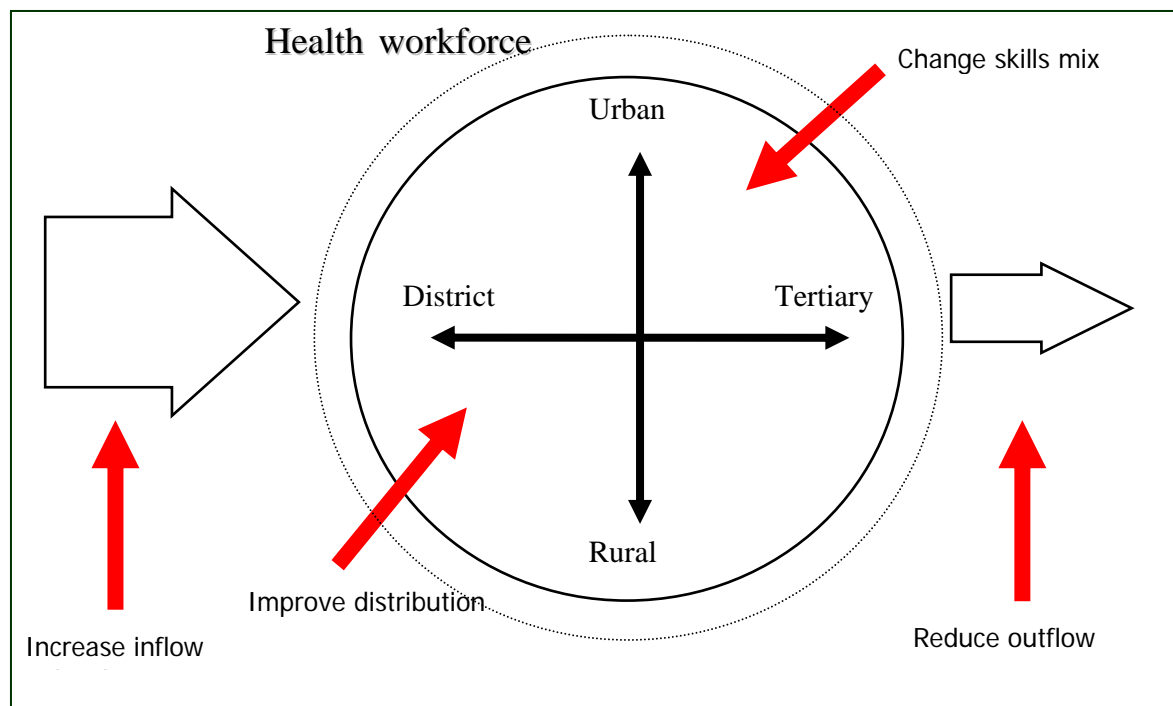
Cordaid HR analysis

Over the years Cordaid has supported organisations in various ways, trying to improve the human resources situation in health facilities. In 2004 Cordaid did an inventory of human resource issues and interventions of its partner organisations, as a follow-up on the MMI publication of 2003.² Cordaid's inventory not only looked at the problems at hand, but also at possible interventions, which partners applied.

The figure below shows a grouping of the HR problems and interventions which have been done in tackling human resource problems.

Fig.1 Mobility of health work force

² Koot et. al (2004) Human Resources for Health. International Developments and experiences of Cordaid partners in Africa.



In the figure above the arrows indicate four areas to tackle the human resource problems. The elements, issues and interventions are explained in the table below.

Table 1: elements, issues and interventions in HR by Cordaid and partners

<i>The four elements</i>	<i>Issues</i>	<i>Interventions</i>
increased inflow	Role of universities and training schools in HR	Construction of training schools, TA and financial support to universities, training schools, provision of scholarships for students
improved distribution	Role of internal markets, competition by government health services and NGOs in international aid programmes	Construction of staff houses, providing means of transport, means of communication (internet) Capacity building of management in HR issues in recruiting staff Collaboration in recruitment through umbrella organisations International recruitment (South-South)
skills mix	Redefining roles and responsibilities in health care provision, roles of regulatory bodies, councils, etc	Training of cadres in PNFP hospitals Upgrading of staff, on-the-job training, in-service training
reduction of outflow	brain drain, but also loosing on HIV-AIDS, burn-out, etc.	Retention schemes, bonding contracts Performance management systems, career development programmes, continuing professional development Provision of ARVs to workers Private practice in PNFP hospitals for additional income

Important findings of the Cordaid inventory:

- Incidental interventions in isolation give little relief. It is necessary for local health providers to tackle in a cohesive manner all four elements related to human resources (inflow, distribution, skills mix and

retention). This should be done as part of strategic planning and improved governance of health facilities (and medium level organisations, like dioceses).

- Many of Cordaid's partners do not have the size to come to an economy of scale. They are not able to establish quality human resource management structures; they cannot offer a career to health workers; they are not able to offer interesting retention packages. Investments therefore have an insufficient rate of return, to justify them.

The findings constitute the basis for proposal below. Two principles will lead the work in this area:

- interventions should cover the full range of HR elements
- smaller and medium size organisations must work together

Proposal

On the basis of the findings of the Cordaid inventory, the expected results of the MMI strategic plan are refined as follows:

- A. Clear view of dynamics behind Human Resource mobility in smaller and medium-size PNFN organisations, using the four elements as basis for analysis, and formulation of a comprehensive package of interventions, which is feasible for umbrella organisations, dioceses, or other PNFN health care providers.
- B. Implementation of strategies to keep competent and motivated staff available for church based and secular non-governmental health care providers in 5 countries in Sub-Saharan Africa by 2008, based on an innovative organisational approach, which guarantees a critical mass for effective and efficient implementation.

Activities for 2005 – 2006:

- A. Clear view of the dynamics
 - o Extending the Cordaid inventory of problems and best practices in HRM to partners of other MMI members in Sub Saharan developing countries, especially West- and Central Africa. This will increase the insight into operations of medium and small size organisations and the support provided by MMI members in francophone and lusophone Africa, where Cordaid has fewer partners in health services.
 - o Publication of the findings in a MMI publication, which is a follow up to the previous MMI publication on HR. This publication can also serve as an input into the 2006 World Health Report.
 - o An international conference where umbrella organisations and dynamic partners from five countries in Africa with experience in HR strategies exchange ideas and experiences to formulate the comprehensive strategy.
 - o Strategy for medium and small size organisations (with support from umbrella organisation) which concentrates on the comprehensive package of interventions and innovative way of collaboration between organisations to achieve an economy of scale for HRM.
- B. Piloting of strategies to keep competent and motivated staff available for church based and secular non-governmental health care providers
 - o Translate the MMI strategy into national action plans with the support of umbrella organisations (or bigger NGOs, if there are no functioning umbrella organisations in countries). At least five countries should be identified, if possible two in francophone Africa.
 - o Establish collaboration between smaller and medium size organisations to implement jointly an HRM policy. Different types of organisational models can be applied in different contexts, like associations, partnerships, franchising, contracting, etc. North-South exchange and South-South exchange has to take place. Use of modern information and communication technology is important in this exchange

- Establish a monitoring system, which will allow measuring success and failures through out the pilot programme period. An important part of the monitoring will be the cost-benefit analysis of necessary investments.

Activities 2007 – 2008:

- A. Clear view of the dynamics
 - Drawing lessons learned from pilot and develop methodology for scaling up the pilot.
- B. Piloting of strategies to keep competent and motivated staff available for church based and secular non-governmental health care providers
 - Implementation of scaling up, expanding programme to more countries and more organisations within the pilot countries.

Role of MMI members

- Provide seed money to organisations for initiating new activities, and implement good monitoring system to measure results.
- Technical assistance to development of strategies, analysis of findings, reporting
- Facilitation of exchange between partners of MMI members

2005 2006					
Activity	Product	Responsible	Contributing	When	Cost
A. Clear view of dynamics					
Extend Cordaid HRH study to partners of other MMI members	Documented strategies for solutions and best practices	MMI Belgium	Cordaid		
International conference for exchange	Partners formulate comprehensive strategy to enforce HRH, including smaller organisations	Cordaid			
Participate in consultations	Input for 2006 WHO report	MMI Belgium			
Lobby WHO for stronger inclusion of Africa in 2006 report	-do-	MMI Belgium			
B. Piloting of strategies					
Translate developed strategies into national action plans	Action plans in place in 5 countries				
Establish collaboration between smaller organisations	Economies of scale achieved. Different types of organisational models applied.				
Establish monitoring system					
2006 2008					
A. Clear view of dynamics					
Activity	Product	Responsible	Contributing	When	Cost
Draw lessons learned from pilot	Methodology for scaling up the pilot				
B. Piloting of strategies					
Expand programme to more countries					

Brain drain or Brain gain?

Keynote speech: Brain Drain in the Health Sector of Ghana

Congress of the Dutch Society of Tropical Medicine and the Royal Tropical Institute,
Amsterdam 17 October 2004

Based on the presentation of Dr. A. Nsiah-Asare, MB ChB (Ghana), FACHirg (Saar), FGCS (Ghana), Chief Executive of Komfo Anokye Teaching Hospital, Ghana / Consultant General Surgeon; edited by Esther Jurgens.

Ghana has an estimated total workforce of situation is continually worsened by lems of internal mal-distribution of the about 43,000 in the health sector. This is alarming migration of trained health health professionals remaining. The health woefully inadequate to meet health service professionals out of Ghana – the ‘Brain sector in Ghana is therefore experiencing a delivery for a population of 20 million. The Drain’ phenomenon together with prob-human resource for health crisis and if not arrested, Ghana like other sister developing countries will not be able to achieve the Millennium Development Goals.

The ‘talent drain syndrome’ is not exclusive for Ghana but appears to be a global issue. Between 1989 and 1997 more than 10,000 health professionals emigrated from South Africa. Over the past decade more than 70% trained nurses left the Philippines. And strangely enough, also in the UK the same phenomenon is happening: more than 6,000 nurses left for greener pastries. Brain gain is a serious development even more so in a situation of increasing levels of HIV/Aids, malaria and other communicable diseases.

The Ghanaian situation is demonstrating two migration patterns of health professionals: internally, from the northern regions to the South and to the cities, as well as from the public to the private for profit sector and foreign NGOs. External migration is seen mostly to the US (with more than 1,200 Ghanaian doctors working in the States), the UK, Canada, Germany, and the Arabian Gulf. Some migration also occurs to other developing countries in Africa (Nigeria, Cameroon, Gambia, and others). It is known that there are more Ghanaian doctors working abroad than in their own country. The attrition of nurses has recently reached significant proportions. Ghana is estimated to have lost 50% of its professional nurses to the US, UK and Canada. The estimated vacancy level for nurses has more than doubled over the past four years (from 25% in 1998 to 57% in 2002).

What are the underlying factors that contribute to this development? We can distinguish *push* and *pull* factors. *Push factors* include a lack of structured professional training and career development opportunities; poor health care infrastructure in the country; low levels of remuneration and compensation for (health) workers; and inefficiencies in human resources management processes. Added to these factors is family pressure and a desire for better living standards.

Pull factors, factors that lie mainly outside of the Ghanaian society, include the high levels of demand in developed countries and the available global labour market for certain categories of health workers. For example, the US State department in a report estimates that by the year 2015 there will be a need for 500,000 nurses in the US; the UK will require 35,000 nurses in 2008. Similar figures can be shown for Australia and Canada. The likelihood that poor countries like Ghana can afford to meet such demands and keep their home services staffed is extremely unlikely. It is estimated that this trend will continue, threatening to completely collapse the health services in Africa. It is very unlikely that economic improvement in Ghana advances

within the short to medium term. It is therefore unlikely that Ghana will achieve levels of revenue that can make public sector incomes compete with those in recipient countries. A doctor in the US is earning 22 times the salary in Ghana. Besides better salaries, developing countries offer better training and career opportunities and a better, modern, equipped health infrastructure. In addition to these pull factors is the existence of a proactive recruitment policy by a number of developed countries. Trade agreements made the removal of the barriers to global labour flows possible and last but not least: because the gap in educational standards has narrowed – in itself a positive development – labour flows could occur and obstacles to attract (health) workers from Ghana diminished.

Obviously, the costs of brain drain and the effect of these trends on the Ghanaian economy and infrastructure are enormous. The situation has worsened by the fact that the crisis in health intensifies with the advent of the HIV/Aids crisis. The outlook for the health sector in Ghana seems dim given the scenarios described as above. The loss of human capital is shown in the acute shortage of health professionals throughout the health care system. Poorly manned or even unmanned health facilities are on the rise. Hospitals are closing their doors because of shortages in health personnel. In effect the workload for the remaining health workers is overwhelming: 9,000 nurses are doing the work of 30,000. The workload for 3,000 doctors is done by not more than half the required number. All these factors combined are adding up to a loss of confidence in the health system and the poor quality of health care in the country. It is clear that Ghana is losing out on opportunities for sustainable development and is far from reaching the Millennium Development Goals.

Is it possible to turn brain drain into brain gain? In what lies the solution to this problem? Despite efforts undertaken by various governments, such as the expansion of training infrastructure in the health sector, employees have been leaving the system. Often because measures to retain the health workers are lacking. The key issues that need to be resolved should be aimed mainly at improving supply, attraction and retention, motivation and extending services in a cost effective a way as possible. This will mean developing, motivating and utilizing human resources for health in ways that differ from the traditional methods of the past. Effective human resource management should involve going beyond the narrow issues of salary and training to consider broader incentives and systems for encouraging and managing good performance. Solutions can be found in a variety of measures, such as decentralisation of training. Local governments should be allowed to locally manage training budgets, allocate resources and develop schemes to bond health workers for a period of time. In addition to increased training opportunities, there is a need for career development for all categories of health professionals. This can be done through reform of remuneration systems and the introduction of benefit and welfare schemes. Drain from the public health sector can be stopped, by allowing doctors to see patients in intramural private practices, while being part-time employed in public health institutions. Furthermore, good transport, housing and educational facilities have proven to be motivational factors for health workers to stay in the system. Non-fiscal and fiscal incentives can be introduced to attract people to invest in the health care system, for example through awards, tax relief and the introduction of home ownership schemes.

On the human resources management side, a number of measures form part of the solution, for example the redesign of the remuneration system. These systems need restructuring in order to improve and increase pay and allowances for health workers, while at the same time be linked to their performance and productivity. In order to solve the problem of future security the government will have to improve, and make the Welfare and Benefits Schemes transparent. A well managed and fair pension, transport and housing schemes are motivating factors. The public

sector retirement in Ghana is at 60 years. Specific efforts should be made to add another 5 years to retirees in specifically needed cadres to certain locations with added benefits. As done in some other countries, retention may be better served by recruiting older entrants into the workforce. The notion is that people already with established family links will be less inclined to leave the country. Bonding and Compulsory Service periods are to be introduced, as was recommended by the 2003 Human Resources for Health Forum. Reinstitution of bonding for health trainees needs to be insured with guarantors' collateral property or social security contributions (like University loans scheme etc). Diplomas and Certificates obtained, should also be retained by government until the bond period has been served. These and other measures will have to form part of a National Human Resources Management Plan and other Administration Plans. And after completion of the plans: ensure their implementation and endorsement.

International efforts should focus on the control, management of labour flows and to the return of migrants. The 'Dual Citizen Act' in Ghana is an instrument in the return of non-resident Ghanaians to the country. Over the past years a number of projects have been designed to use the Diaspora for strengthening the health workforce in Ghana. For example, the Migration of International Doctors Agreement Project is designed to facilitate Ghanaian doctors who work in the UK. The programme establishes the possibility for them to return to Ghana for a short period of time on condition of paid-leave. In such a way, non-resident Ghanaians can share knowledge and experience that is attained abroad with health workers back home. Additionally, there is a need for negotiations and agreements with the recipient countries. Advocacy at the international level should be geared towards the formulation of policies to reduce emigration from developing countries, e.g. the Commonwealth agreement on ethical recruitment (WHA Resolution 57.19).

The General Agreement on Trade and Services (GATS) provides the generic framework for these negotiations. The Human Capital Replenishment Assistance (HCRA) programme is geared towards the set up of education and research facilities in the developing countries to train personnel for recipient countries. This would enhance training opportunities in developing countries for a global labour market under condition that the recipient country invests in good training, education and research facilities. North-South cooperation, through twinning of hospitals for professional development should be encouraged. Ghana may well decide to become and exporter of health workers, both as a way of raising morale but also to mitigate the numbers leaving at any particular time. This would involve negotiations and agreements with the major recipient countries. This system has worked between developing countries (eg. Ghana/Jamaica/South Africa/SADC) but has not received any interest with rich industrialized countries that are the main recruiters of Ghana's professionals. A rotational system for persons, who have served their bonds, could be facilitated by the government and designed to also gain critical experience and training for staff that go out. How have we fared so far? Locally there are mixed outcomes: still doctors and nurses are leaving Ghana for greener pastures. Temporary there is a slowing rate of attrition for selected groups of professionals. Doctors are more inclined to stay but the nurses are leaving. On the international level there are very poor outcomes. Agreements have tended to be one-way conduits: agreements are mainly profitable for donor countries. There are some ethical codes of practice and resolutions, however they are not legally enforceable yet.

In conclusion: capacity building is a strong instrument in turning brain drain into brain gain. Policy makers should initiate strategies to attract and retain health professionals and mitigate the effects of the brain drain, as suggested in the above. The creation of opportunities for local training and career development is crucial in this, however is not the only component. In the international setting, governments of developing, as well as developed countries will have to

understand the dynamics and trends of the international labour market in health and act responsibly. It is time to direct 'Bilateral Transfer Programmes' towards meeting potential local and national demands, rather than 'poaching' health workers from poor, disadvantaged developing countries.

4. Appropriate Technology

New technologies and PHC

When speaking about “new” medical technologies and PHC does mean that those technologies are supporting a system that provides basic health services, affordable and sustainable for the community. This means that the services are an integrated part of the overall health services of the district, curative, preventive, sanitation, and education and home care oriented. MMI deals for a great part with church-related NGO’s. Those NGO health institutions can be a village health post, a health center or a hospital at first referral level. Sometimes those hospitals are integrated in the national health system, but usually not. So an isolated church health post, dispensary, health center or private clinic, not taking part of the overall district health system, should be stimulated to start negotiations with the district. In other words negotiations with the health authorities (by the way of contracting) at district level should have all priority. Which medical technologies are requested in a health institution is fully dependent of the role the institution plays in the setting of the district health system. Especially NGO institutions have very different roles in a district. PHC means provision of basic health services in an integrated health perspective.

The health services in the PHC setting can roughly be divided in three health care services:
The Health post and/or community health worker at village level.
The Health Center with more medical skill and facilities.
The first referral hospital.

They all should not only give clinical services, but should have an overall role in guiding the PHC elements. Which role depends on the (contracted) allocation of activities by the District Health authorities?

A hospital at first referral level plays a central role in the PHC system. It relates to other sectors of development and it is a problem-solving resource for the referring health center and health posts.

Hospitals at first Referral level may be considered as an aggregate of one or more functional modules (Montoya-Aguilar, WHO)

1. A “core module” which includes in-patient care, emergency services, maternity care and medico-legal responsibilities, together with the technological support needed according to its level of complexity (diagnosis, treatment, care, and rehabilitation).
2. A “health center unit” attached to the hospital, providing ambulatory frontline care, integrated with prevention and promotion, to the surrounding population.
3. A hostel for patients (and family members) coming from a distance and not in need for hospitalization.
4. A unit that supports front-line clinics and community health organizations.
5. A health office responsible for health administration and epidemiological and sanitation tasks in the area.

But there are critical issues in these hospital services:
Which we should recognize (Preker 2003)

- Technology: Hospitals have often a high prevalence of broken medical equipment and primitive or non-existent management information systems.

- Management: Hospitals often have poor managers that lack in decision-making skills.
- Payment: Hospitals have often poor payment structures that have weak incentives, leading to low quality and efficiency of services.
- Community orientation: Politics and the elite of the medical profession oppose changes that threaten their interests. Thus hospitals respond inadequately to the actual health need of a population, especially for the marginalized populations

When we come back to the medical technologies in the perspective of PHC, the question is, which technologies have priority to support an overall effective basic health service package.

Basic Packages in developing countries have been formulated in relation with different functions, like: clinical support functions, clinical departments, clinical services, essential drugs, etceteras.

The Ministry of Health of Zambia formulated basic packages for first referral level hospitals, health centers and health posts/community health workers in the perspective of PHC. This could serve as a framework for MMI when formulating essential and new technologies.

When concentrating on integrated basic health services, the operational field of MMI partners, the strategic plan for the coming five years concerning appropriate technology could concentrate herself on the following steps:

Postulate: Over 50% of the medical equipment in basic health services and first referral level hospitals are not used correctly, not functioning or not maintained. Which appropriate devices fit in the function of the health service is usually not questioned, especially when this concerns donations from overseas.

Objectives

- To develop effective ways of basic health care providers to access information on appropriate technologies.
- To define the role of management in the purchase and maintenance of appropriate instruments, in the provision of adequate training and repair service.

Expected results

Basic health services and hospitals at first referral level, active partners of MMI members, will improve their services tremendously through proper management, rational procurement, regular maintenance and better training facilities of appropriate technologies.

- Defining, publishing and propagating a manual on Best Practices for Appropriate Technology (AT) for basic health services.
- Defining and propagating the role of management in procurement, maintenance and training for the NGO Church leaders and national coordinating agencies.
- To assess a long term quality assurance by giving feed-back and professional advice through establishing a virtual network.

	year	lead	results	finance
Select a number of countries where MMI members are active	2005	Cuamm and working group	Defined cluster of BHS for the research approach	?
Collect information on appropriate technology (AT) at national and international (WHO) level	2006	Cuamm	Deskstudy State based or international guidelines on the right choice of AT for basic health units or first referral hospitals. Management of procurement, maintenance, access and affordability of AT. Training and quality assurance.	10.000 ?
Assessment and analysis of the constraints in reaching AT by a census. Composing a questionnaire and sending to the Health Services in the selected countries	2006	Cuamm and working group	Assembling of evidence based facts	20.000?
Best Practices Manual on AT Printing and distribution.	2007	Cuamm and working group.	Best Practices available in the health services of the selected countries Starting good practices, procurement, maintenance, well defined AT and follow-up	20.000?
Best Practices manual on the role of management to maintain a affordable and durable AT Information to the regional church leaders responsible for health (follow-up Kampala, Cotonou)	2008	Cuamm MMI	Reaching a durable, affordable and accessible AT. Maintenance, training and quality assurance initiatives. Interaction via a virtual network.	30.000?

5. People Health Assembly

About the People's Health Movement

How it all started

In the beginning, there were thousands of people across the world working very hard in big and little ways to promote the dream of a world where a healthy life is a reality for all. In the optimistic, joyous, compassionate 1970's it seemed that this would be possible. And was not the Alma Ata Declaration signed by 134 governments in 1978? Did not the declaration promise *Health For All by 2000*? When the millennium edged closer and equitable health policy was still nowhere the optimists did not give up. They knew that the Third World had been plunged into debt and health care was in danger of complete privatization. To remind the world of the commitment made in more hopeful times the optimists came together in solidarity.

The optimists meet

People's organizations, civil society organizations, NGOs, social activists, health professionals, academics and researchers came together to make a strong statement against the studied indifference in this crucial area of human life. The First People's Health Assembly was organized in Savar, Bangladesh in December 2000 to discuss the Health for All Challenge. The 5 day meet led to sharing of experiences from across the globe. The representatives discussed the adverse impact of the structural adjustment programmes on people's health and the role of the World Bank, IMF and WTO in pushing these policies. The assembly in a single voice condemned these institutions and governments which are willingly pursuing these anti-people policies. The multi-national corporations who push for policies which put profits before people and the proponents of liberalisation who recommend that governments should cut expenditure on social sector like health and education also came in for scathing criticism. In all 1453 participants from 75 countries came together to create and endorse a consensus document called the People's Charter for Health. The charter reflects the vision, goals, principles and calls for action that unite all the members of the PHM coalition. It is most widely endorsed consensus document on health since the Alma Ata Declaration.

The Movement: From Savar to Cuenca

The participants of the assembly took strength from each other and reiterated their goal to seek more compassionate and equitable health policy. The time for lonely battles was over because the threats were global and it was only a question of who went under first. Since Savar, the People's Health Assembly knit into a movement of over 80 nations across the world, sharing energy, knowledge and resources. Affirming the goals of that first meeting, the Second People's Health Assembly will meet in July 2005 in Cuenca, Ecuador.

The Cuenca Declaration

Coming from 82 countries around the world, 1492 people met at the Second People's Health Assembly in Cuenca, Ecuador from 17th to 22nd July 2005, to analyse global health problems and to develop strategies to promote Health for all.

Overwhelmingly we reaffirmed the continuing importance of the People's Charter for Health (2000) and saw it as a rallying document for the ongoing struggles of the People's Health Movement globally and within countries.

The vision endorsed at PHA2 is for a socially and economically just world in which peace prevails; a world in which all people, whatever their social and economic condition, gender, cultural identity and ability, are respected, are able to claim their right to health and celebrate life, nature, and diversity.

Solidarity with struggles in Ecuador

Here in the heart of the Andes we have learned much from the hospitality, living cultural heritage, and current struggles of our Ecuadoran sisters and brothers.

- We join them in solidarity to oppose the signing of the Free Trade Agreement imposed by the government of the United States and the international financial institutions. This agreement will increase corporate profits, impoverish the workers, campesinos and indigenous peoples of the Andes, negatively influence their living and working conditions and impede their access to health care and enjoyment of health.
- We also join our Andean partners in opposing Plan Colombia, the name for the biological warfare carried out against them by the United States, which is poisoning their land and water, and militarizing their border regions.

The global health reality

We deplore the worsening conditions of health experienced by many of the world's people and we denounce their cause – neo-liberalism. Neo-liberal policies imposed by the G8, transfer wealth from the South to the North, from the poor to the rich, and from the public to the private sector. Corporate profits increase while poor people, indigenous peoples and the victims of war and occupation, suffer.

Economically and politically generated health inequalities have increased, yet these root causes of avoidable disease and death are not effectively addressed by current policies or programs.

The spirit of Alma Ata has been betrayed by most official health systems, though it has been kept alive in the face of adversity by health activists and health workers in community projects all over the world. Comprehensive primary health care is implemented in very few places, and the provision of health services is rarely seen as a collective social responsibility. Under neo-liberalism there is no right to health, racism is nurtured, women's oppression deepens, social exclusion increases, environmental degradation becomes the norm, workers' rights are non-existent, and war serves the profit seeking of big corporations. Governments, IFIs, WHO, multilateral and bilateral agencies are strongly influenced by the agendas of these corporations.

Establish the Right to health in an era of hegemonic globalization

PHM calls on the peoples of the world to mobilize against the denial of the Right to Health. The global economic framework of neo-liberalism, privatization and "free trade," made operational through the WTO and international financial institutions, has played a determinant role in the transfer to the corporate sector of the control of the determinants of health. This leads to environmental destruction, toxic pollution, denial of rights to water, food, and life itself. The human right to health and health care must take precedence over the profits of corporations, especially the profiteering of pharmaceutical companies. The WTO operates as a de facto world government even though it is unelected, unrepresentative and unaccountable. Responsibility for international trade and development must be returned to the people through reappropriation of relevant UN bodies such as UNCTAD. Unless it is massively reformed to operate democratically, the WTO must be dismantled as it is a major source of massive human rights violations and injustice and a key mechanism of corporate control of life on earth.

The right to health will be achieved through large scale popular mobilization.

- PHM will initiate or support struggles related to the right to water, food security and food sovereignty, a healthy environment, dignified work, safe housing, universal education and gender equity, since people's health depends on the fulfillment of these basic rights.
- PHM will launch a comprehensive campaign to achieve the "Global Right to Health and Health Care" at the local, national and international levels, to defend health and social

security (including health care) systems, and to document and oppose health inequities and denial of the right to health.

- PHM will defend health workers in their opposition to the privatization of health services by building broad multi-sectoral alliances.
- PHM will campaign to end TRIPS, remove it from the WTO, and oppose bilateral Free Trade Agreements and TRIPS+.
- We call upon governments to use the Doha agreement to provide people with affordable generic drugs.
- We oppose public-private partnerships because the private sector has no place in public health policy making.
- PHM will continue to monitor and provide inputs for the WHO Commission on the Social Determinants of Health to ensure that it effectively addresses the political and socio-economic causes of poverty, ill health and health inequity and engages in meaningful dialogue with civil society as much as possible.
- PHM will work with allied movements to coordinate common international actions against privatization and inequitable trade regimes.

Defend the right to health in the face of war, militarization and violence

- PHM calls on the people of the world to oppose war and militarization as the most blatant attacks on people's health, especially the health of women and the poor. While the terror attacks in New York, Madrid and London caused unjustifiable damage, the US-led "war on terror" has generated an even more terrible, unjustifiable and endless war on defenseless populations in order to control their natural resources. At the same time, wars that have claimed millions of lives are unacknowledged as the UN system and our governments allow them to continue unabated.
- PHM will continue to participate in the global movement to end the US occupation of Iraq and Afghanistan. Foreign troops should be removed immediately and reparations paid for damage caused by the US-led war.
- PHM calls for an investigation into the use of torture by US soldiers and medical personnel at Guantanamo Bay, in Iraq and Afghanistan, and an immediate end to the detention of foreign nationals held without trial at Guantanamo Bay.
- We demand that medical personnel refuse to participate in illegal detention and torture. The US and its allies must be charged with violations of the Geneva Conventions for their attacks on civilian populations, particularly medical personnel and institutions in Iraq.
- PHM calls upon the United Nations and humanitarian agencies to intervene effectively in the "hidden wars" in the Congo, Sudan, Chechnya and many other places to foster lasting peace through political reconciliation and economic and social development programs that transform the social and economic conditions that give rise to these wars.
- PHM opposes the Israeli occupation of Palestine and the efforts to isolate and ghettoize the Palestinian people behind the illegal separation wall. Denial of Palestinian health rights on the West Bank and Gaza has reached emergency proportions.
- PHM supports the steps toward democracy and self-determination made by the indigenous people of southern Mexico, and calls for an end to the low-intensity conflict waged against them by the Mexican government.
- PHM denounces the biological warfare called Plan Colombia currently being waged against the peoples of Colombia, Ecuador and Peru under the guise of drug control. These actions contravene international conventions, and irreversibly damage environmental and human health in the region.

- PHM calls upon the United States to take responsibility for and compensate victims of Agent Orange in Vietnam, and the toxic contamination left by US military bases in the Philippines and elsewhere.

Struggle for comprehensive primary health care and sustainable, quality, local and national health systems

PHM recognises that neo-liberal policies have resulted in disinvestments in public sector health services; the promotion of a limited number of mostly curative technical interventions selected solely on the basis of a very narrow and often inappropriate application of cost effectiveness analysis, the corresponding neglect of broader environmental actions; the accelerated migration of health workers from public to private sectors and thence to wealthy countries; and the continuing spread of HIV/AIDS especially in Africa, with the collapse of public health services in many countries.

PHM calls upon governments to:

- Implement comprehensive community-based Primary Health Care initiatives that enroll or involve relevant sectors and are supported by legislation.
- Provide healthy living and working environments in order to respect and guarantee the health rights of all.
- Establish and fully implement universal health care financing mechanisms at national level in all countries (public health expenditure being at least 15% of the overall budget, especially in African countries) in order to provide protection for the whole population.
- Address the crisis of human resources for health (HRH) by: improving working conditions, training, support and supervision for health workers; implementing an International code of practice on ethical recruitment, financial compensation to exporting countries, return and reorientation of health workers in the diaspora through incentives, and establishing a global fund for HRH.
- Ensure widespread knowledge on HIV status; access to opportunities for voluntary testing; equitable, and sustainable access to ARVs with emphasis on prevention; comprehensive home-based care including health and social services.

PHM calls upon the WHO to support and promote the above as national government responsibilities and to advocate for the removal of economic and political obstacles at global, regional and national levels, that adversely affect national governments' social policies.

PHM will continue to raise awareness among communities on policies, policy-making processes and financial issues to enable them to monitor government performance, increase accountability and address health equity issues. PHM commits to gathering from within its movement, positive experiences of comprehensive PHC to build up the evidence base that supports such an approach, and to undertake concerted advocacy for its revitalization.

Finally, PHM salutes and supports the strong social justice approach to health in Venezuela and Cuba which inspires and encourages us towards Health for All.

Support the growth of PHM

The People's Health Movement is both a network and a movement that takes as its mission the strengthening of the much wider movement of individuals and organisations around the world fighting for the Right to Health. PHM is bound by a commitment to the People's Charter for Health and includes country circles, issue circles and affiliates, which are actively involved in advancing the work of the PHM. Beyond this core of PHM activists are the friends of PHM and organisational partners at all levels.

Another world is possible – these are our strategies to achieve it!

This declaration urges health activists around the world to organise, influence, advocate, analyse and educate to advance global people's health.

The People's Health Movement -

- Will pursue work on the human right to health that includes both individual and community rights.
- Will continue to struggle for improved ways of working by strengthening its regional as well as its global coordination. It will continue to develop participatory and transparent decision making so that activists at all levels know that their views are valued.
- Celebrates the inauguration of the International People's Health University, a university for health activists with courses presented in association with local PHMs and selected universities around the world.
- Will engage with formal training institutions and challenge the dominance of the biomedical paradigm of health care. It will incorporate diverse strategies for reorienting health worker education to comprehensive PHC, keeping people in communities at the centre.
- Will become a forum within which intellectuals can support local activists in their action and struggle.
- Will challenge the media to disseminate its perspectives and publicize its activities.
- Will strengthen its communications strategy to reach communities at the grassroots.
- Will translate as many of its communications as possible into two or more languages; will establish a mix of central and regional/national websites; the PHM newsletter will continue quarterly publication and will be translated into other languages.

As a summary of PHM's strategy for the next three years:

- PHM will be linking the local, the national and the global by passing on and giving guidance to its geographical circles on the issues on which to concentrate tactically.
- PHM will document, analyze and disseminate research findings on key issues pertaining to the principles in its Charter, including gathering, analyzing and disseminating key evidence for its constituency of the efficacy and sustainability of initiatives in comprehensive primary health care.
- PHM will create awareness about the burning health issues of the day and will delegitimize and demystify false claims, prescriptions and slogans used by the Establishment.
- PHM will work with grassroots organizations and communities trying to understand their issues, building partnerships and supporting their activists in their struggle.
- PHM will adopt an approach of strengthening rights, and will support initiatives to achieve the Right to Health and Health Care at the local, national and international levels
- PHM will work tirelessly to build international solidarity with the oppressed and with those affected by natural disasters and civil strife,
- PHM will confront powerful forces of oppression in the struggle for economic justice, in particular through support for cancellation of debt, the end of economic conditionalities and the establishment of a fair international tax regime.
- PHM will incorporate cultural and spiritual practices in all aspects of its work.
- PHM will advocate with national governments, UN and other national and international agencies to influence their decision-making.

The power of the People's Health Movement can change the world. Another World, which includes Health for All, is possible. We must all demand and struggle towards a world in which health is a right, and is not subject to the forces of neo-liberalism.

SUPPORT and sign on to the People's Health Charter and the Million Signature Campaign which is demanding Health for All Now, JOIN your local PHM group and support the new campaigns and activities being initiated. www.phmovement.org

Cuenca, Ecuador
22 July 2005