Newsletter

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Introductory

This Newsletter brings you to three events.
Memisa celebrated her 75th anniversary by a jubilee congress on the theme “How popular is health care?” questioning why do people prefer certain kinds of health care facilities. This is a reflection that can lead to improve the strategies in order to bring health care facilities closer to the people. It can result in a better-integrated social development and primary health care. There is where we Medicus Mundi stand for, strengthening the work of our NGO partners at district and village level. Tom Puls, Jos Dusseljee and Jolanda Dekker wrote a comprehensive article on behalf of the congress. Health reforms and decentralization have resulted in more responsibilities for the district health authorities and in a better cooperation with the NGO institutions at that level. Intensifying of this cooperation needs our support. Just now when WHO and World Bank move to a centralized system the SWAp movement. The congress marked also the change. Memisa Medicus Mundi left her office and name behind in Rotterdam, the city of enterprise, trade, renewals, having the whole world in her bosom. Now Memisa’s name is Cordaid, having the residence in The Hague, a stately town of distinguished people, ministers, parliamentarians and ambassadors. Will Memisa Medicus Mundi change her dress of the dock-laborer by the dinner jacket of the diplomat?

CUAMM, our Italian MMI member, celebrated her 50th anniversary on the 25th of November in Padova with the theme “Africa 2000: salute per tuti? CUAMM medici con l’Africa”. Also in Italy you can feel the tension between the NGO partnership with local NGOs at community and district level and the western governments, lead by WB and WHO, who centralize and mechanize development aid without any appreciation of all the fruits of decentralized health reforms backed and vitalized by the community. For CUAMM (and MMI is of the same opinion) is partnership, working together on an equal base, the basis of trust and so for development. I quote: ”Can the process of globalization involve all aspects of the social life of human beings, but not solidarity?" And: ”when health for all is no longer just a hope, we believe that two permanent values of our experience will remain: the participation of individuals and groups in facing common problems, and dialogue between different countries and cultures, in which the cooperation will become an exchange among equals."

Participation and dialogue.
The discussion started in Padova, but will continue with the MMI members and her partners.
An important presentation came from Nobel Price winner professor Amartya Sen on poverty, freedom and liberty. We are happy that we can present you his speech in this Newsletter.

Sector Wide Approach is a new move in the developing world. For some a challenge and others a slogan; the first belong to the oligarchy of big spenders, the latter to the sober fieldworkers. It is important to inform yourself before to judge. We attended a two days conference in Amsterdam on SWAps. A rather comprehensive introduction of the conference, edited by the Royal Tropical Institute, the organizer, was permitted to reprint in this Newsletter.
SWAps are definitely at stage, so you can’t avoid. Make up your mind, become an epigonist or an antagonist.

Sake Rypkema

Health and human freedom
Message to CUAMM: Doctors with Africa
From Professor Amartya Sen

I am very sorry that I cannot come to the 50th anniversary ceremony of CUAMM. My work duties here prevent me from joining the celebrations. However, I take this opportunity of sending CUAMM, and Father Luigi Mazzucato, my warmest greetings. CUAMM has a record of dedicated work which deserves great praise and tremendous admiration. I congratulate CUAMM on that and send my very best wishes for its future success in this extremely important field.

I take this opportunity of sending some small ideas on viewing the subject of health in the light of the importance of human freedom. I have tried to argue that freedom is not only the most important end, but also the most effective means, of bettering the lives of human beings. It is natural to think that health care and health achievement can also be viewed in this general perspective. This would be an important connection to establish. How should this be done?

An adequate understanding of the connections between health and freedom demands critical scrutiny. Health is a complicated enough subject, and to bring in the idea of freedom into all this may seem like adding complexity to complexity, especially since the concept of freedom has quite a record of having confused and confounded many people over the centuries. To try to link the two in this close way (to attempt to resolve the perplexities of health assessment by the use of the difficult notion of freedom) might appear to be too hard an exercise to try. I would, however, argue that this is not the case, and the idea of freedom can substantially enrich our understanding of the importance of health and the role that the caring of health plays in society.[1]

Motivational Issues

Freedom is not, in fact, such a complicated subject, particularly at basic and foundational level. Nor is it hard to see why freedom is valued. Freedom may be like oxygen in that we consciously value it only when we are short of it. But being short of freedom is a persistent state in which most human beings live. We have no great difficulty in seeing that people's lives could be fuller and more adequate with more freedom – the freedom to do this or do that which we would like to have but don't. CUAMM's own experience in Africa would have included very many cases of human frustration at the lack of freedom to live long and well. We do value freedom for fairly obvious reasons.

There is an important distinction hare about which we have to be clear, namely that between (1) having more freedom to do things that we may value doing, and (2) having more pleasure (or avoiding pain) which may be associated with an expansion of opportunity. The perspective of freedom is fundamentally different from that of utility. This is not to deny that being happy is among the things that we would like to be free to have. Utility, in this sense, can be one of the most important fields of our freedom. But it is not the same thing as freedom, which has a much broader domain of coverage.

Nor should we deny that having freedom may also be joyful and pleasant. However, the value of freedom is not conditional on that pleasantness, nor confined only to the extent that pleasure accompanies freedom. As Seneca wrote to Lucilius nearly two millennia ago: "the real evil is to surrender ... our freedom, in defiance of which we ought to face any suffering."

I must, however, note here that freedom is not only among the most valued ideas in the world, it is also among the most feared of human conditions. With freedom comes both opportunity and responsibility, and while the former may be prized, the latter can be a cause for anxiety and concern. This conflict has engaged many distinguished psychologists. I would nevertheless venture to suggest that in the purely individual context, it is not typically the case that people fear freedom in their own lives. Those who are afraid of freedom tend mostly to be afraid of freedom of others – the discontented lower classes, the aggrieved rural masses, the disgruntled women grumbling about their assigned 'place', the rebellious youth refusing to be compliant and obedient, and the determined dissidents protesting about the existing order. It is other people's freedom that have worried many commentators (and also authoritarian rulers) leading to sharp and severe pronouncements against freedom. The critics of freedom have not, however, offered to give up their own freedom.

Contrast with Utilitarianism

The general claim of freedom to receive our attention is indeed very strong. The importance of freedom is, however, sometimes neglected in moral and political discourse because of competing claims of utilitarianism. In fact, two centuries of utilitarian dominance seems to have persuaded many

[1] In the discussion that follows, I draw on my Rivers Lecture at the Harvard Medical School in April 2000, entitled 'Health in the Perspective of Freedom'.

observers to favor the presumption that the measure of everything must be pleasure -and pleasure alone. And yet the defense of that very special (and rather odd) claim has tended to be rather declaratory, arbitrary and unconvincing.

Consider, for example, a hopelessly underprivileged and deeply deprived person who is forced by circumstances to cut down her ambitions and desires to make them. "realistic" at the face of adversity. She may even be induced to take pleasure in whatever small mercies come her way. Now suppose she were to succeed in being happy, in constructing some pleasure in her otherwise bleak life. Would it not be unjust - indeed absurd - to decide on this ground that her real deprivations and her lack of freedom have been obliterated by her utility-creating success? And yet it is exactly her pleasure -not the basis of it -on which the utility-based calculus of deprivation and achievement would concentrate. That surely is a mistake. The person who manages to remain happy despite illness and deprivations of other kinds is still deprived. The utility calculations would give us the wrong signal here.

I have discussed these issues elsewhere, and I shall not go more into this evaluative discussion here and now. My claim here is only that it is not so hard to see the importance of the real freedom to do things that we may value doing. To this we must also add the freedom to decide what we would value doing. Both the freedoms -of action and of evaluation -are central to our lives. Given the magnitude of the problem of health deprivation in the world, it is especially important to approach the challenges with as much conceptual clarity as we can achieve.

The Importance of Health

I begin with the elementary question: why is health important?

A part of the answer as to why health is important must lie in the obvious recognition that it is an integral part of human well-being. On that there is as complete an agreement as we can expect to find (especially among self-respecting intellectuals afraid of agreeing "too much" with each other!).

We can agree on a kind of minimalist proposition that wellbeing is at least one reason for us to be interested in health. However, this does not take us very far since there is a good deal of ambiguity on how to interpret well-being. There are at least two problems: (1) Is well-being to be judged only by pleasure and the avoidance of suffering and pain (as classical utilitarians have tended to do)? (2) How do we take note of those things which we value doing (or achieving) that do not directly - at least not primarily - relate to our own well-being?

Let me take a somewhat different track instead, and try to identify some specific attributes associated with good health which we have reason to value. There is, of course, the understanding that being healthy makes life pleasanter, nicer and more desirable. This is undoubtedly so, and this recognition takes us some distance - rightly so - towards the classical utilitarian perspective. This cannot be (as I have already discussed) the whole story, but it can hardly not be one part of it.

Health, Capabilitv and Others

Health is, in general, capability enhancing This is the crucial starting point. If, for example, being healthy allows a person to take' better care of others (for example, our own children or those of others, or our neighbors, or simply other people whose predicaments appear to us to be unjust or unfair), then this can be seen as one of the advantages of good health, irrespective of the pleasure we get from these deeds. I don't know what Woodrow Wilson really meant when he said, in his acceptance speech in 1912, "No man can be just who is not free." But it is possible to interpret the remark as drawing our attention to the fact that in order to do things that we may believe justice demands, we have to be able to do those things. The enhancement of capability, which is important for us, is not merely the capability to have more personal pleasure, but the capability to do anything which we have reason to value.

Capability or freedom is best seen as a freedom of some kind (or kinds). It is not, of course, how "libertarian" philosophers see freedom, since it is not a purely "procedural" view. In the purely procedural view, your freedom does not depend on what you can actually do, but whether you are not prevented, illegitimately, from doing what you should be free to do (if you could). No matter what special importance may be attached to the libertarian view of freedom, the older - much older - Aristotelian view that freedom is concerned with capability (with being able actually to do the things that we value doing) cannot be dismissed. The effective freedom to do the things that we value, and to achieve the results to which we attach importance; can hardly fail to be significant.

The Importance of Longevity

To these two ways of judging the favorable effects of good health (in terms, respectively, of increasing pleasure and happiness, and enhancing capability and freedom), let me now add a point that in common discussion often figures as a central reason for health care, to wit to avoid death,

especially premature mortality, and to go on living. Good health may certainly help a person to live longer, and one has to be slightly crazy not to be able to see why this is valued. Living long is indeed a much shared aspiration, especially so in regions in which people tend to die early. Even though it is clearly not the only thing we seek, a long life is inter alia widely valued - and valued very strongly. So what should we make of this more "earthy" perspective, much in line with the common-sense understanding that surrounds our interest in health as a source of longevity?

The fact that longevity may be valued for all sorts of reasons is clear enough, but among these reasons, we must also include the significant recognition that it is valued -at least partly because of its close association with capability and freedom. I refer not only to the absolutely obvious fact that the capability to live on without being cut off in one's prime -or prematurely in one way or another - must be an important substantive freedom in itself. That point is well taken and has received wide empirical recognition in such publications as the United Nations' Human Development Reports, which have been prepared every year by the United Nations Development Programme since 1990.

But we have to go beyond that, since part of the reason for valuing longevity must be indirect, to wit, the fact that being alive is a necessary requirement for carrying out the plans and projects that we have reason to value. Living is not only a source of pleasure, but it also gives us an ability to do things that may be hard for us to guarantee' when we are not here. :In general, we value life because of the things we can do, if alive. The value of living must reflect the importance of those valued capabilities for which living is a necessary requirement. When dedicated help saves another life, that is what the world gains.

A Concluding Remark

It would, thus, appear that even the common-sense linking of good health with longevity has a close connection with the importance of freedom and capability. We can live longer not only for our sake, but also for being able to help others. I may, thus, conclude this discussion by noting that among the more obvious reasons for valuing good health, we must include not only happiness and pleasure, but also freedom in the form of capabilities in general. The value of health and longevity cannot be fully grasped within a value system that is quintessentially separatist and isolated.

We live in societies, and just as the delivery of help is a social commitment, the outputs that it generates - health and longevity - are also social results, full of potential for further use, further benefit. In a world devastated by epidemics such as AIDS, it is easy to see why the death of a person is not only a tragedy for herself, but also for others whom she could have helped (such as her children and the children of others). The problems of AIDS-related orphans may have made the force of this consideration more obvious than it would have otherwise been, but it is ultimately a very general connection of which we cannot lose sight, whether or not there is an epidemic of the kind that we are currently seeing. Indeed, the number of orphans and other dependants in the world was large even before the AIDS epidemic hit. Also, the ability to assist others is not confined only to parents helping their children.

This is a celebratory occasion, and I should not go on too long in developing theories and exploring foundational ideas. But when we celebrate the intense dedication and practical success of an organisation like CUAMM, it is very good for us to try to understand why their efforts and achievements are so important and so deserving of celebration. These works reduce suffering and increase happiness - that is clear enough - and this is certainly worth celebrating. But happiness is not the only basis of judging social success. The perspective of freedom provides a wider basis for celebration. That perspective takes note of the freedom to live and enjoy life that dedicated work (like CUAMM's) helps to generate, but the achievement is even more than that. Selfless work of this kind is ultimately best judged by its overall contribution to freedom. This includes increasing our freedom to help each other. The value of human freedom embraces that connection, and that in turn is crucial to understand the value of good health and the importance of work of the kind that CUAMM does.

Prof. Amartya Sen
November 2000

CUAMM – Considerations during her 50th anniversary, Padua 25-11-2000

Health in Africa

- Fifty years of work have not been in vain and health indicators show progress. However the gap between the rich and the poor is increasing (world-wide and in each single country). The year 2000 has given a signal of alarm in Africa: infant mortality has increased and the historical scourges, malnutrition, maternal mortality infectious and parasitical diseases are still present.
- All of this goes hand in hand with the HIV epidemic. There are more than 23 mil/ion people infected in the African continent (of which one million are children) and in 1999 there were 5.6 million new infections and 2.2 million deaths (85% of the world total). Orphans exceed 5%. Life expectancy in many countries will decrease by more than 10 years.
- Improvement of the quality of life (not only of life expectancy) requires more and diversified aid contributions, from food to housing, schooling and increased earnings. Access to health services is only one determinant for health, but it is however a human right.
- Unfortunately we are witnessing the progressive deterioration of Africa's health systems. The trifling resources given to health (on average less than USD 5 per capita per year), the introduction of user fees in public services, the reduction of international aid and the rapid spread of market systems and privatisation are creating situations of grave injustice with an ever increasing number of people with no access to services. Many families are forced to break into their "capital funds" (cattle, savings, etc.) or to deprive themselves of basic essentials (food, schooling, etc.) just to have one of their members treated for a health problem, exacerbating the vicious circle of poverty--illness-poverty.

What are the answers?

- There have been two main slogans circulating in the literature in recent years: "eradication of poverty" (main objective of the European Unity and of Italian Co-operation) and "globalization of solidarity" (the Pope himself has taken this expression for his own).
- One of the practical consequences is to acknowledge that the provision of minimal social services, which are indispensable in guaranteeing respect of human dignity and of possible development, depend on international solidarity. When a country's resources are not sufficient to sustain health and education, the international community cannot be satisfied with demanding the transferal of costs to single users as this means exclusion of the majority who cannot afford them.
- The international community must come together with African governments in order to reach the standard indicated by the World Bank, that is to invest USD 12 (at present prices USD 14.3) per capita in a package of essential preventive and clinical services available to the population as a whole. African governments must do their part, first of all by reducing military expenditure.
- Health co-operation must always address support of the health protection system in its entirety. Thus the Sector Wide Approach (SWAP) strategy is justified as it tends to return the full responsibility of programming and prioritisation in the field of health to governments and stimulates and co-ordinates aid according to local choices. It is a difficult and complex process which requires that all partners, local governments and donors alike, overcome inefficiency and distortion; an evolutionary and promotional process therefore, in which everyone is called upon to test themselves and to experiment the most suitable solutions for local realities acknowledging the fad there are no obvious and universal solutions to this type of problem.

Co-operation - Times and methods.

- International solidarity is often called upon to respond to emergency situations, a necessity and an obligation. However, the limits of this type of intervention must be recognized above all when emergencies become "chronic" as occurs in many parts of Africa. Emotion distracts attention from underlying problems, mechanisms of corruption are magnified and the solutions found are fortuitous and lead to the risk of imbalancing existing social and health systems instead of strengthening them.
- Health co-operation must have medium to long term prospects. Sustainability cannot be gained in just a few years when it is known that local resources are not sufficient and that the general context does not change.
- The integration of public and private interventions and resources is important in ensuring accessible services to all. The tutelage of health must remain a collective interest. It is hoped that each and every country will find suitable solutions for their own context in order to enhance, promote and co-ordinate the private sector, above all the non-profit sector, according to the degree in which it contributes to reaching common goals.
- One of the main objectives and criteria in co-operation is making the most of local resources and of human resources in particular. Increased professional competence and enhanced management abilities are two of the essential ingredients in strengthening health systems and making them sustainable.
- The Pope reminds us that "entire populations do not even have the possibility of utilising drugs of basic and immediate necessity" (11/2/2000). In reality this limit goes even further: because of poverty entire populations are cut off from access to new technologies and research is not interested in facing problems which do not entail an adequate economic return. Less than 10% of expenditure is dedicated to diseases which represent 90% of the total burden of disease. Pneumonia, diarrhea, tuberculosis and malaria receive less than 1 %.
- In the case of AIDS, international attention goes no further than the lack of efficacious instruments at accessible cost. Africa cannot benefit from the curative and preventive instruments already available due to the high cost of drugs and to the protective mechanisms (patents) which pharmaceutical industries impose. It is the first time in the history of mankind that medical progress cannot benefit the vast majority of its possible beneficiaries: it did not happen with the discovery of antibiotics and vaccines.
- Paradoxically, this challenge (increasing the access of the poor to the resources of science) may have a positive outcome for rich countries if it provides the opportunity to come out of the spiral of increased health costs. Understanding that resources are limited for everybody and accepting equal sharing of the same: this could be a result of "globalisation of solidarity".

Use of Health Care facilities.
Some considerations on contributing factors to health care seeking behaviour

By Tom Puls, Jos Dusseljee and Jolande Dekker, Cordaid.

When looking at the theme of the Memisa congress: "How popular is health care", a relevant question comes up: Why do people prefer certain kinds of health care facilities? This question has been looked into by researchers of several disciplines.. People working in health care development should consider this question as well. **(See box 1**).
Also as one of the most important considerations for decisions on programme support during Its 75 years history, Memisa has always tried to assess actual or potential utilisation of health care facilities in relation to the estimated or projected target population and this of course In combination with available data on the local morbidity and mortality situation.
So: which factors play a role in determining if, when and where people choose to seek professional help to find a solution to their health problems.

Box 1

Some years ago a catholic hospital in Kenya got hold of information that the Red Crescent Society planned to open an out-patient clinic in the small town in where the hospital was situated. This came as a large surprise. The hospital actually had a high attendance, it was comparatively successful with mobile clinic programmes, a CBHC programme, etc. The general impression was that the relationship with the surrounding communities was good.
Nevertheless, looking deeper into the matter, it became evident that the local Muslim community, roughly 25% of the population, under-utilised the hospital services, thereby apparently undermining the public health responsibility of the hospital. The hospital management team there upon took action, met with local Muslim leaders at the mosque, and listened to what they had to say. As it appeared there were essential, but rather uncomplicated reasons for the under-utilisation, like e.g. absence of facilities for the Friday prayers, absence of facilities for certain rites at the mortuary, recruitment policies for the local nurse training which apparently disfavoured Muslim candidates, etc. Within a short time, the necessary arrangements were made, and as a result the attendance increased and the additional out-patient clinic was never heard of again.

First of all it should be noted that, especially for acute and severe conditions, it is more likely that professional help is invoked by the victim and by the relatives, whereas for minor conditions, especially of less acute onset just as well as for chronic problems treatment is often applied without invoking professional help, through a combination of dietary measures, home remedies (e.g. herbal products) religious ceremonies, allopathic products bought on the open market (self-medication), etc.

Indeed in many developing countries just as well as in industrialised ones there is a variety of professional health care providers in addition to those who practice modern (mainly Western) medical science. The alternatives are ranging from Ayurvedic, acupuncture, iriscopy, herbalist, fetishist, to homeopathic-, etc- practitioners.
Indigenous and modern medical systems frequently co-exist (medical pluralism). People may use these systems in a complementary way, either from a pragmatic or from an ideological consideration. Then there is the transitional health care as already referred to above: This system includes elements of both modern and the traditional health care and is embodied by persons, often with only limited technical background themselves, who make a living by supplying mainly for self-care purposes a variety of modern or traditional medicines to the population on a commercial basis.
All these alternatives are being used and consequently they have an influence on the utilisation of modern primary health care, although it clearly differs per country and even per region within countries whether such alternative facilities affect the utilisation of modern health care.

Apart from the choices between different systems, there are different other aspects to be considered:
When looking at the utilisation of modern health care facilities more in particular one cannot ignore that

in making their choice people have indeed to overcome certain barriers to actually reach those facilities in order to benefit from the services offered. These barriers of access are the combined result of geographical, economic and social-cultural factors. In the context of the Primary Health Care strategy these important determinants for practical utilisation were summarised as the 4 A's i.e.: 1 Availability, 2 Accessibility, 3 Affordability, and 4 Acceptability of these facilities.

In developing countries distance is a more critical determinant of medical care-utilisation especially if people, in the absence of a dense public transport system and without private means for transport, have to walk great distances to reach (scanty) health care facilities. From various studies it appears that patients who live further from the available health care facilities make less use of these facilities than people who live close by (distance-decay effect). Indeed, apart from the effort it takes to cover the distance or the price for the transport, it takes time in which the person cannot pursue normal economic activities. In other words: constraints in accessibility due to geographical circumstances are to be viewed in practice just like economical constraints: Even before considering the fee possibly charged for the actual treatment the question arises only too often: whether people can afford the time and/or the transport-fee to reach the available service.

In theory the balance between total price paid (transport, time and treatment fee) and average income-level of the target-population would represent the sum total of the economic barrier as a factor determining health care utilisation. In practice however, even when total cost and average income levels can be estimated or measured rather accurately the question, how accessible services are or how affordable people would consider them, cannot be answered consistently. Much influence is also to be attributed to the perceived quality of the available care. Many examples are known of not just a few people, but even a large percentage of a the targeted community, rather using a more distant and more expensive hospital than a cheaper, nearby facility, particularly so, in case of perceived, serious conditions. In many cases people will be prepared to travel further for better care.

Memisa intends to devote more attention to bringing health services closer to the people.

Since it was observed, that even in the presence of a dense rather well equipped and relatively cheap network of modern healthcare facilities utilisation in some developing countries remained below 50 consultations per 100 people per year, one cannot but conclude, that vital influence is also to be attributed to other factors than economic barriers or variety of choice. The socio-cultural factors as determinants for healthcare utilisation were certainly mentioned in the context of Primary Health Care, but deserve far more attention.
Some examples of socio-cultural barriers limiting access are:

- the target group's negative past experience with the health institution concerned;
- the attitude of medical personnel;
- people or certain categories of people avoiding a health institution as a result of differences in world view, religion, language, ethnicity, attitude towards diversity, or degree of modernisation between them and the health service personnel;
- particular ideas that may be held by the target group as to when, where and in case of what kind of illness action should be taken;
- the strength of the attraction of other available medical systems for particular groups;
- organisation of the medical service (e.g. opening times and waiting times);
- availability of medical equipment and supply of medicines; and
- perceived quality of care in relation to relevant expectations in the target community.

In more general terms one could ask in this respect the question, to what extent people must be able to identify themselves sufficiently with the institution or with the service, before they can share with it the responsibility for their own health or for curing their illness. In practice numerous examples can be found in which a technically spoken proper facility, charging relatively affordable fees, remains yet underutilised temporarily after the replacement of some key-members of the medical staff like the senior midwife or the doctor of the OPO. In some Islamic states it is obvious, that appointing male staff or even a single male gynecologist would be tantamount to closing the maternity department concerned. It is obvious from such examples, that utilisation of services can be strongly influenced by socio-cultural factors. Yet, in the administration of health systems or in the administration of individual

institutes like hospitals, one will only rarely find systematic attention being paid to this issue. Mechanisms to identify the nature and the extent of related problems hardly exist and strategies to solve them are devised in an ad hoc fashion case by case. In this way effective integration of health care in peoples life will take a long time. Of course several authors have advocated, that health should be brought closer to the community and that listening to the community is a crucial starting point for any health care professional. Yet in practice the health services remain only too often isolated and preoccupied with epidemiological data, technical performance and budgetary considerations.
In this context and in view of the theme of the present congress, we ought to consider especially the matter of identity of the provider of health services, the matter of ownership of health institutions and the participation of the local community therein. This is particularly relevant for organisations like Memisa (Cordaid) in view of their selective approach towards health system development, by their preferential support for private not-for-profit church related health care.[2]

Over the years Church-related institutions, partially benefiting from external support from donor organisations like Memisa, have gained a good reputation as far as offering services in established institutions is concerned. But is the utilisation of these services in line with the actual needs?
If indeed the Alma Ata Conference stressed the need for self reliance and self determination, it is of crucial interest for us to consider how a healthcare provider accommodates a participatory approach so as to make the surrounding community partly responsible for the kind of services offered and their required quality. (**see box 2**)

Box 2

Due to many years of civil strife the health care system in Cambodia got into a sorrow state. lack of infrastructure and of competent staff added up to a complete lack of confidence among people in Governments ability to serve their needs. This resulted in what has been described as "empty hospitals and thriving business". The population turned massively to private services, which were not regulated and were of disputable quality. Not surprisingly such private services were often rendered by staff who were also on the Governments payroll.
The complex problems needed a comprehensive answer. Some 5 years ago Memisa, in close collaboration with a local health department, started to rehabilitate health services in one of the provinces in Cambodia. Great efforts were made not only to restore infrastructure but in restoring peoples confidence in the care offered as well. One of the key strategies was to form health centre committees, which, in terms of sex-distribution, ethnic groups, social economical situation, etc., mirrored the local community. An anthropologist facilitated the tedious exercise to instate these committees. Ultimately they are meant to assume responsibility for day to day management of the health centres. This will include not only control over services offered, but also over (re)allocation of the health centres fee-income e.g. for replenishment of essential drug-stocks, for the vital, appropriate remuneration of health centre staff, etc.
It is too early yet to assess clear results of this approach. What has degraded in decades can't be restored in a few years. Nevertheless, the first outcomes seem to hold a promise for positive final results.

Who is rightfully the owner of the services offered and to whom is the provider accountable and in which way will actual utilisation vis-a-vis the actual and/or perceived need for the services be analysed and evaluated? Which checks and balances should be minimally present in a society in order to guarantee that the population has access to the health care it needs, taking into consideration all the basic values incorporated in the Alma Ata declaration?
Indeed, let us agree that there is something beyond purely administrative ownership. From a public health point of view: optimal utilisation of health services should be promoted by designing them

[2] *This preference is based on the concept that whereas responsibility for policy, quality and availability of health services lies with (local) Governments, the actual operation of health services can be dealt with by other parties* as *we", lest they meet the formal requirements. In this way civil society becomes more multiform in line with the variation in peoples preferences and needs.*

systematically in line with the needs and preferences of a population. A stewardship role for the quality of services offered is more relevant for the provider than exclusive ownership and full control perhaps. This need not be in contradiction with proper economic running and financial administration, on the contrary!

Accountability is not just for the funds received from the state of from donors but also for the funds, contributed by the users! Moreover accountability should not be seen solely in a financial way, but also apply to the functionality of services. In any case accountability is essential where the local population pays for the services, either directly out-of-pocket or indirectly through the tax system and where the populations lacks alternatives. The community should be involved in taking up responsibility for health services on which they depend. This requires representation in boards and other control bodies where decision on services are taken. Moreover, in this respect community health insurance schemes could be a balancing factor as well. (**see box 3**)

Box 3

In Rwanda around 1980, a number of initiatives to start co-operative health insurance schemes was taken, many of which inspired by hospitals, confronted as they were with increasing numbers of people, unable to meet the substantial and... unexpected bills for inevitable hospital admissions. Typically, public health staff of the hospital would mobilise community leaders and, jointly with them, mobilise the surrounding communities to enlist their participation in the establishment of a co-operative fund aiming at providing clinical treatment free of charge or against very reduced price for members. In most cases the predominantly, community based committees (notwithstanding an occasional hospital based facilitator) acting as custodians of the collected premiums, were mandated by the members not only to discuss fees, accounting and premium levels, but soon enough also to negotiate availability and quality of the hospitals services. In effect such a co-operative insurance scheme, in a number of places, became a rather powerful expression of participation of the target population in the running of the institution and its programmes and thus a factor to reckon with for the other stakeholders in determining hospital policies.

In conclusion, Memisa intends to devote more and systematic attention to bringing health services closer to the people, but not merely in the physical/geographical sense or by keeping the economic barriers as low as possible, but also by promoting the discussion and fostering the introduction of all possible mechanism which could facilitate the integration of healthcare institutes and of health services in their local communities. The ownership discussion as key element, may just be one of the starting points. Promoting closer co-operation between our private, not- for-profit partners and their respective Ministries of Health is likely to give extra momentum by enhancing the sense of public interest, accountability and community participation. It would be appropriate for Memisa in this sense to add a paragraph or even a separate social contract to each health care development project it undertakes...

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Statement by the participants of Memisa's 75 year Jubilee Working conference

From Monday 2nd to Wednesday 4th October ten Bishops responsible for health matters within the Episcopal Conferences of eleven developing countries from three continents, their health secretaries, representatives from Cordaid/ Memisa, Medicus Mundi International, Misereor, CAFOD, Porticus Stichting and various experts, attended a working conference, in the framework of the jubilee celebrations of the 75th years of Memisa.

The conference was held at the Cenacel in Soesterberg, the Netherlands. It was opened by His Eminence Adriaan J. Cardinal Simonis. The conference was entitled: *"The church and its involvement with health care: the healing ministry".*

The purpose of the conference was the need for the church to adapt its approach to health in response to the ever changing circumstances in which the healing ministry has to be exercised.
The objectives of the conference were the following:

- To increase the general understanding among representatives of Episcopal Conferences and donor agencies of the threats and opportunities related to the contribution by the church towards health promotion and health care provision for disadvantaged persons, groups and communities in developing countries so that they can make well balanced choices for future direction of health policy.
- To increase the understanding among representatives of Episcopal Conferences of optional roles the church may play at policy and implementation level, complementary to other stakeholders and/or health care providers, with a distinguished identity, competence and ability to reach the less-advantaged in society.
- To increase the understanding among representatives of Episcopal Conferences and donor agencies of the requirements of owning and managing of health care institutions and programmes, which includes matters related to planning, financing, staffing, transparency and accountability, etc.
- To improve the co-operation between Episcopal Conferences and donor agencies in general, and between the donor agencies and church health institutions, programmes and co-ordinating bodies, for mutual support and fruitful co-operation in achieving the overall objective of improving the health situation of the less advantaged in the world.

Three themes were examined in depth through presentations, experiences, group work and plenary discussions about:
1. the healing ministry of the church;
2. current policies and practice of church health promotion and health care development in developing countries, and the perceived need for change;
3. strategic options available to the church in promoting health and/or in implementing health care.

At the end of the conference, the participants decided to issue a statement on their position in relation to health care.

Statement

I. The healing ministry of the church is part and parcel of the church's mission to healing and wholeness in accordance with Christ's mandate: *The spirit of the Lord has been given to me, for He has anointed me. He has sent me to bring the good news to the poor, to proclaim liberty to captives, and to the blind new sight, to set the downtrodden free to proclaim the Lord's year of favour This text is being fulfilled today even as you listen.* (Luke 4: 18,22)

II. The church is a complex reality made up of persons, organisations and institutions, both hierarchical and social, with different and complementary functions. It expresses this ministry in different ways and forms, ranging from direct provision of health care in institutions (hospitals, health centres, health programmes), to animation and mobilisation of communities for their empowerment to achieve health for themselves. In this sense it subscribes to the philosophy of primary health care of all.

III. The action of the church as a whole aims at the liberation of the human person from the slavery of poverty, sickness, ignorance and evil, at the promotion of the dignity of the human person in a holistic perspective and therefore in all dimensions: physical, psychological, spiritual and social. Paul VI's encyclical, "The Development of People," (1967) describes development as: *"the growth* of *each person and the whole person."*

IV. In her fight against poverty and sickness, the church has developed and continues developing organised forms of action in different fields, which includes health institutions and programmes. This is one of the ways the Church shows her solidarity with the poor and the suffering.

V. Health care is affected by poverty, sometimes by traditional cultural values and practices, by ignoring the human rights of women, by the neglect of children and orphans, by ignoring the problem of international debt.

VI. Direct provision of health care, though an important aspect of her healing ministry, is not the only way through which this healing ministry is exercised. Advocacy with and on behalf of the weakest groups in society, for the poor, for women, for marginalised persons and communities and active lobbying for the defence of their rights are complementary options for the exercise of the healing ministry.

VII. In different geographical, social, environmental contexts, within the same understanding of the healing ministry, the same mission and vision, the church's approach to health is diverse.

VIII. Aware that the she is the largest actor in health besides governments, the church knows that this is not the time to sit back contemplating past achievements. More than a billion people are still struggling in abject poverty. Although health care is a basic human right, health services are scarce, often not available, nor appropriate or affordable. When looking at basic statistics of life expectancy, child mortality, maternal mortality, the need for great efforts to further improve health is patent. Investing in health care as well as in social economic advancement have to proceed together. Moreover, the HIV/AIDS epidemic exacerbates the situation and threatens past achievements. Evidently, there is still a lot of work to do and the church is determined to continue to be active.

IX. The church is still at the forefront of health care development, but not without major difficulties. Over the years many developments in the configuration of health care have occurred, changing the environment in which church health services are implemented.

X. Church health care is evidently an intrinsic part and parcel of society, and she is rapidly losing its former, comparatively independent position. New paradigms on health care development, lead to new conditions as far as the work of church in health is concerned.

XI. Sometimes, the church finds it hard to adapt to these new circumstances. Interaction with governments is often strained. Health institutions endure financial and personnel hardships. A clear, well worked out and distinguished path for further development of the church health activities is often lacking. Among other issues this implies that the capacity and professional profile of personnel needs to be adequate to the demands posed by the new circumstances.

XII. As a member of civil society, the church advocates for a correct understanding and application of the principle of subsidiarity in the relationships between different levels of organisation of the state and of civil society itself. Convinced that in the increasingly complex environment, all actors in civil society have their contribution to give and a right place to occupy, the church knows that it is no longer time to pursue initiatives in splendid isolation but to join hands in a bond of partnership: partnership between the church and the communities, between donors and churches, between different health care providers, between health care providers and communities, between church and state.

XIII. The church believes that co-operation and partnership should not merely consist of the

transfer of goods from the developed world to developing countries. It should rather be a real solidarity among peoples. It should be a relationship that seeks the good of the other through a sharing in a humane way and in a dialogue among peoples, of personnel and funding.

XIV. The special partnership existing between church in developing countries and church donor organisations in the north requires a well-structured dialogue. Church donor organisations are accountable to the public for the use of the funds provided to target the poor. On the other hand, church organisations in health in the south own the programmes and institutions implementing interventions that contribute to the reduction of poverty. This shared vision needs a new form of co-operation that is tangible and well defined with shared objectives, leading to documented results.

XV. No fruitful relationship among partners is possible without transparency and reciprocal accountability. Transparency is needed in any declaration of intent, in the process of decision making, in financial management, in the management of human resources and in the documentation of quality and results. What is needed to make any partnerships effective and valuable is that it should be based on general understanding of on what partnership is all about. Constitutions, mission statements, charters, contracts are essential elements in this, as means to make each partner's role and function explicit.

On the ground of the common understanding reached, the participants wish to express also the commitments they are ready to jointly undertake.

Commitments

To:

Healing Ministry

1. Different aspects and forms of the healing ministry have to be pursued concomitantly, without omission, in our respective contexts, organisations and programs and we are determined to do so.
2. We consider it necessary to occupy ourselves with an appropriate and affordable health care, available to those who are most in need.
3. We commit to playing a prophetic role through an active advocacy with and on behalf of the weakest groups in society, for the poor, for women, for marginalised persons and communities, so that their rights are promoted and respected by governments and in society.
4. We commit ourselves to approach health care in a holistic way. We commit to place with the whole of civil society to remove obstacles (political, social, economic) which oppress people and affect health care.
5. In view of the tragic consequences of the AIDS pandemic and the particular challenges it poses to the exercise of the church healing ministry, we commit to bring the issue of HIV/AIDS in the agenda of our Episcopal Conferences in order to foster an active role by the church in the struggle against the spread of the disease and to mitigate its impact on the life of people, families and communities.

Change

6. We regard it necessary to start and sustain a process of change within our institutions and programmes, and commit ourselves to animate and empower people in our institutions and programs to be pro-active in this direction.
7. We recognise that it is indispensable that we should develop charters, guidelines, mission statements, policy statements, constitutions of health institutions and programmes to ensure that we achieve our common vision and aims in a transparent way.
8. We recognise the need to clarify the relationships between ownership and management of health institutions and programmes, according to local circumstance and legal environment, in order to promote stewardship as an added value at all levels.

Professional practice

9. In order to run health institutions and programmes effectively, we see a dire need for professional staff, professional co-ordinating bodies, professional service units and training institutions. We commit ourselves to promoting professional practice at all levels, with a particular attention for religious who assume managerial roles.
10. Professionals should be allowed to manage church health services and programs with clear terms of reference and with maximum professional integrity. We commit to creating those conditions which professionalise the management function.
11. We find it necessary that different initiatives and institutions of the church providing training of health managers complement their efforts within the geographical context in which they operate in.

Transparency

12. We commit our institutions and programs to a transparent management and accountability in terms of financial and medical performance. We aim at ensuring efficiency, effectiveness and quality in a way that it is harmonious with different understandings of these concepts in different cultures.

Partnership

13. We also need to ensure the participation of communities' representatives and other stakeholders in the governing structures of our health institutions and programs. In the understanding that women are a key actor in the promotion of health, we shall pay particular attention to a balanced participation of women and men in the governing structures of our health institutions and programs to secure the formulation of gender sensitive policies.
14. We support "contracting out" as a way to enhance and formalise co-operation and integration between the various stakeholders, including (local) government and other providers, and church health institutions in order to offer essential health services of sufficient quality at an affordable cost to a population in well-defined geographical areas.
15. We commit to actively participate in health reforms in order to contribute our understanding and experience to health development.
16. We will engage in contracts with donor agencies which support the capacity of the church to foster health development within a shared framework for mutual co-operation with well-formulated objectives and specified results.

Follow up

As part of this process of change:

17. the representatives of the Episcopal Conferences commit to disseminating the above understanding and commitments by organising appropriate for a of dialogue among stakeholders in the church and other stakeholders in our respective countries. Furthermore we see the need to involve other Episcopal Conferences at regional level and to take initiatives to strengthen the links with the Pontifical Council for the Pastoral Care of Health Workers;
18. the representatives of the donor agencies undertake to provide the technical, financial and moral support for the implementation of the initiatives aforementioned.

As agreed by the participants
Rotterdam, The Netherlands, 6th October 2000

Sector Wide Approaches in Health: Moving from theory to practice

KIT Conference, November 27-28, 2000

Grant Rhodes, Bert Schreuder, Jurrien Toonen, Anna Vassall

Introduction

In the mid 1990's sector wide approaches to development cooperation were proposed in response to a growing acceptance of the limitations of assistance programs and projects. Fundamental was a recognition that the effectiveness and sustainability of individual projects is often constrained by the political, institutional and economic environment in which they are implemented. The role of government generally (World Bank 1998) and within specific sectors of the economy, had come increasingly into focus. In the health sector, a group of multi-and bilateral donors, formulated a set of concepts, issues and working arrangements on Sector Wide Approaches (SWAp) (Cassels 1997). SWAp has drawn increasing interest from donors and recipient countries alike.

SWAps are currently at different stages of development in a number of low-income countries and several development agencies are embarking on SWAPs as a guiding principle in health sector development. In this conference, it is taken as given that SWAp as a broad approach is generally accepted. The objective is to provide a forum for addressing a variety of issues and constraints at the implementation of SWAp, as experienced by both national authorities and their development partners.

This conference will focus on identifying successful strategies, knowledge gaps and the need for research and technical tools. It focuses on the Southern perspective of SWAp and will promote the South-South exchanges of experience. Sessions will be held in French and English.

Background

As an 'Approach' rather than a series of elements or steps, precise definitions of SWAp are difficult. Earlier authors talked of SWAp 'criteria' (Harrold 1995). Many of these criteria are echoed in Foster et al (2000), for whom the defining characteristics of a SWAp are that:

"All significant funding for the sector supports a *single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector; and progressing towards relying on Government".*

This conference takes as its starting point, issues raised during the first important international effort on SWAp in the health sector (Cassels 1997). "At the heart of the sector-wide approach is a medium-term collaborative program of work concerned with the development of sectoral policies and strategies;

- projections of resource availability and expenditure plans;
- the establishment of management systems by governments *and* donors, to facilitate the phased introduction of common management arrangements;
- institutional reform and capacity building, in line with agreed policies."

Such issues point to many changes, both for recipient and donor countries. A change strategy demands that we pay attention to not only the destination, but also, the point of departure. The starting point in terms of foreign assistance to health sectors in low income countries has been a multitude of small(er) projects and programs. Their performance has been varied, but it is clear that such a fundamental change in the philosophy of assistance will affect both the good; and the not so good. A recent evaluation of 10 years of health sector support by Danida, a donor which has been at the forefront of SWAp in the health sector, points to many of the issues involved (Danida 2000).

This conference is timely as it aims to build on and complement existing efforts by providing a forum for the interested, and the more and less experienced, to meet, network and develop a clearer vision of what SWAp might mean in the context of their own country by seeing what it means in others. This at a time when an increasing number of both recipient and donor countries consider embarking on a SWAp (Foster 2000, Irish Aid 2000, Dubbeldam 1999). The conference recognizes the key role of particularly the WHO interagency group on SWAp, in terms of conceptual developments.

Against this background, the conference proceeds by building around three central themes, each with a special session:

- Accountability and visibility
- Is SWAp 'Sector Wide' or 'Sector Narrow'?
- Institutional consequences

The session on *Sector-Wide or Sector-Narrow* is aimed at discussing issues around the changes flowing from moves from self contained projects to sector wide national health policies and priorities. The objective is to enable participants to form a clear vision in their own setting of how successes in priority policy areas can be carried forward under a national government control (as articulated by a national Ministry of Health).

The session on *Institutional Consequences* is aimed at discussing issues around the change that SWAp demands of national governments, particularly Ministries of Health, and donors in an institutional and organizational sense. The objective is to enable participants to form a clear vision in their own setting on how changes from a 'rowing' to a 'steering' culture will affect the main actors and interaction between them.

The session on *Accountability and visibility* is aimed at discussing issues around the demands for transparency with respect to what is going into the health sector (domestic and foreign resources and money) and what is coming out (a well defined and well performing set of health services and health promoting activities). The objective is to enable participants to form a clear vision in their own setting on the principal technical steps necessary to starting these continuous processes towards a cycle of: monitoring, evaluating, and improving health and health care services.

Accountability and visibility

Developments in monitoring, evaluation and research are important elements in raising accountability and visibility. In turn, accountability and visibility are necessary to developing trust. Trust, both between parties within the sector and between foreign and domestic partners, is the key to the future success of SWAps. The issues involved are however, highly complex as SWAp closely links the performance of development cooperation assistance, to the performance of an entire health sector. The working group session will examine the monitoring and evaluating of a number of distinct but often related activities in SWAps to date:

1) Managing and regulating pooled foreign assistance funds to health sectors;
2) Managing and regulating an entire health sector, that is:
    a) parts of the health sector the public sector controls directly (the public health care system);
    b) parts of the health sector that may (can only) be regulated by the public sector and/or from which the public sector buys health related services (the private and independent health sector).
    c) changes to elements of both or either 2a. or 2b. (i.e. reforms to the sector)

Such a distinction has a number of advantages. First, it helps to emphasize what must be the primary objective of SWAp, namely success in the second group of activities will gradually reduce the need for the first, and ultimately it must be hoped, the funding behind it. Secondly, the first group of activities is primarily (although not uniquely) technical, focusing as it does on accounting, auditing and open financial reporting procedures and requirements. Finally, the second group of activities requires the collection, analysis and interpretation of data relating to fundamental choices in (public) health policy in a sovereign state. The requirements for participation and accountability in this area are far more complex and not purely technical.

On the basis of a number of case studies, this working group will focus on and discuss, the following issues:

- *Accounting procedures for basket funding*
  In implementation, particularly in highly donor dependent health sectors, accounting systems for basket funding from donors can be (or aimed to be) integrated within (adopted by) general financial accounting systems for the public sector health system a SWAp typically supports. Are there preferred arrangement and what are the issues at stake? Can there be a role for 'readiness criteria'?
- *Management Accounting in health services*

Concerns about institutional, organizational and managerial capacities with respect to financial and sound budget planning have become an important part of implementing many SWAps. Shortcomings in this area are often seen as a major obstacle to improving services. The central dilemma is clear, without resources to manage, it is unlikely that the capacity to manage resources will develop. How can the need for strengthened health services management be assessed and achieved?

- *SectorStewardship*
  Throughout the world health policy is a headache. While there is almost universal acceptance of equity, access to basic/essential health services, efficiency, and financial sustainability as the broad goals of health sectors, the means to reach these goals, and the choices involved, are the subject of much discussion. In countries with extreme resource constraints, stark choices make such discussions all the more difficult. Does SWAp provide new answers, or does it simply imply new means to address old questions? How can the performance of an entire sector be feasibly tracked?
- *Indicators*
  Having differentiated SWAp from the sector it supports, and particularly policy initiatives or reforms within that sector, it remains the case that the two are closely linked. How can and should this be reflected in measurable and meaningful indicators against which the success of SWAp can be measured? What are the institutional requirements, and relevant levels of participation, for the collection, interpretation and dissemination and use of such information?

Sector-wide or Sector-narrow

Over the last thirty years, a number of health issue such as TB, Malaria, Nutrition, HIV/AIDS have been recognized as global priorities. This is reflected in the establishment of international agencies and programs, such as UNAIDS, Roll Back Malaria, Stop TB, and key policy documents by international organizations such as the WHO, World Bank and bilateral donors. National governments supported by these agencies have implemented a multitude of projects and programs focused on these priorities. SWAp implies fundamental challenges to the way this support is given. This working group will examine the threats and opportunities of this change for these global priorities.

Many projects/programs have achieved considerable success in delivering high quality services. There is now considerable concern, particularly from those agencies supporting global priorities, on how to maintain these gains as support goes *sector wide.* The concerns center around two issues: how to maintain the level of priority and financing and, how to maintain (or develop) the level of domestic capacity to deliver high quality services? For some global priorities such as HIV/AIDS and Nutrition, an additional concern is that the *sector wide* approach may in fact be *sector narrow.* SWAp concentrates on support to the Ministry of Health, whereas these area may require an inter-sectoral approach.

Despite the concerns, SWAp can also be seen as an opportunity to consolidate, and make sustainable, the gains previously made. Through the development of a collaborative national program, resource projections, management systems and institutional reform, SWAp can provide an opportunity to fully integrate global priorities in national health systems.

There is significant country experience of the transition from project and programs to SWAp and a variety of models exist. In some countries donor support to these areas is now incorporated in national plans and channeled through joint financing mechanisms. Other countries have adopted a more phased approach and have been experimenting with earmarking and joint support for programs.

On the basis of a number of case studies, this working group will focus on and discuss, the following issues:

- *National Programs and Priority Setting*
  At the heart of SWAp lies a medium term program, developed by the national government, which provides the framework for donor support. Global priorities may differ from national priorities as expressed in national policy documents or plans. What should be the technical basis for prioritization, and what should be the process? In particular, regarding the process, which stakeholders should be involved and how?
- *Maintaining the capacity to provide quality services*
  An essential part of project and program support has been capacity building. Projects could achieve success by funding staff, training, technical assistance and essential supplies. Is it

possible, and/or necessary, to offer the same secured support under SWAp, and; how can governments prevent the decline of service quality during the transition to SWAp?

- *Channeling support to multi-sectoral institutions and institutions outside the MOH*
  The sector, in regard of SWAp, has been defined as everything under the remit of the MOH (Cassels 1997). Sector width, is then dependent on important factors: the breadth of MOH policies, and the breadth of institution structures which fall under it. Some health issues do not fall exclusively under the MOH, for example, in several countries HIV/AIDS falls under independent executives. What institutional structures offer the best opportunities to provide inter-sectoral approaches? How can these institutions be supported in a way that is consistent with SWAp? Support can be provided to NGOs in several ways, through the MOH, through international NGOs or directly. Support through the MOH may be consistent with SWAp, but may be unacceptable to some NGOs. What are the advantages and disadvantages of alternative models that governments and donors could adopt? And, how can different models be integrated in a way that is consistent with the SWAp approach.
- *The role of single issue agencies*
  When a donor has a mandate for a single issue, it may be impossible for it to provide support for broad programs. Pooled funding mechanisms may mean that these donors cannot directly link support to the issue for which they have a .mandate. Here, there are several issues at stake: how to involve these agencies in donor co-ordination, how to involve them in the medium term programs of work and ultimately perhaps, how to involve them in basket funding?

Institutional Consequences

Probably the most fundamental change of SWAps will be "that some donors will give up the right to select which projects to finance, in exchange for having a voice in the process of developing sectoral strategy and allocating resources" (Cassels 1997). Donors are making a trade. They become a recognized stakeholder in negotiating the objectives of the sector and in which direction resources are spent. The price for donors is giving up the right to formulate, for example the type, scale, duration and/or location of specific interventions through projects. But recipient countries are also making trade-offs. In exchange for increased, guaranteed and concentrated funding, donors will demand *administrative transparency* in terms of, for example: financial administration and management procedures; and *policy transparency,* in terms of, for example: sector objectives and priority setting.

While the theory and principles of such trade-offs are conceptually clear, subscribing to them in practice is wrought with difficulties. In practice, implementation will often require enormous institutional change. Crucially, by changing the procedures and type of work, institutional changes, affect the work of the people within those institutions.

For their part, while donor agencies may be keen on becoming a partner in voicing health policy issues, institutional factors may make it difficult to move away from a
project or program approach, and associated internal management procedures. This has been the experience in a number of countries (Danida 2000). Similarly, while recipient countries may be keen to concentrate resources and decision making, institutional factors may make it difficult to change working practices and procedures.

The establishment of common management procedures is one of the cornerstones of a SWAp. Although the acceptance of common procedures should in principle diminish the fragmentation that characterized project approaches, there is perhaps a tension between extending ownership and control in recipient countries while satisfying often stringent accountability rules and expectations in donor countries.

On the basis of a number of case studies, this working group will focus on and discuss, the following issues:

- *Actors, their roles, and their skills*
  Many roles can be played by the different partners at country level: financier, visionary, implementer, negotiator, team-builder, facilitator or controller. Many partners play different roles at the same time. Many and varied technical and personal skills are also needed to fulfil these roles. Do required skills change under SWAp? What are the personnel challenges for those on both sides of the negotiation table, that is within donor organizations and recipient governments?
- *Institutional requirements*

Dramatic changes in the objectives of co-operation policy may also demand changes in the management culture and systems of the organizations involved. Organizational and policy developments have not always evolved at the same speed. Do required organizational procedures and management culture change under SWAp? What are the demands on both sides?

- *Weighing risks and ensuring flexibility*
  While the principle of SWAp would seem to imply a move away from micro-management by donors, in reaction to the risks emerging from the channeling of large amounts of funding to a single authority. control mechanisms have in fact frequently been tightened. What mechanisms are needed to guarantee on the one hand sufficient flexibility and on the other hand sufficient capacity of national government institutions to meet administrative requirements. How can these be developed?
- *Developing trust and consultation*
  Mutual trust is at the heart of a SWAp partnership. However trust is not automatic and must gradually be built up. National governments can sometimes fail to meet the expectations of partners due to, for example, a lack of the institutional capacity, or un-transparent policy making or administrative procedures. Equally, donor demands and policy expectations can be divorced from domestic political processes and realities. SWAp can also be undermined by direct bilateral arrangements, even at Ministerial department level. Donors must therefore also prove that they are committed, long-term and reliable partners. How can trust be built up? Codes of conduct? And, what happens with non-SWApers?

Conclusion

The concept of sector wide approaches would seem to be gathering momentum. As it does so, it is perhaps natural to get caught up in the many complex objectives, rules, procedures, measurement methods and indicators that have and are being developed both internationally and within specific countries. Indeed, in this conference, it is hoped that many such issues will be discussed and shared amongst participants. At the same time however, it is hoped that this conference will afford those involved a moment to reflect on what is perhaps the fundamental challenge at the heart of sector wide approaches:

SWAp represents a clear move towards accepting that even in highly donor dependent countries, a national government is the appropriate authority to accept the primary responsibility for the health and welfare of persons within that country's borders. For donors and governments while there may be pressing and immediate needs to alleviate suffering and improve people's health, it is a recognition there are longer-term development issues at stake. The immediate challenge for both governments and donors in the early stage of SWAp is to how to address these longer term developmental aims at the same time as addressing the more immediate ones.

Whether our emphasis lies in the short or the long-term, it is clear that health policy in a country is not subject to an easily agreed number of tidy goals and/ or technical solutions. Looking at health systems around the world we can see that national health policy ships chart different courses, to different objectives; that social, political and economic conditions determine that most have to navigate turbulent seas, in often small and vulnerable vessels. Having agreed on the captain and assessed the risks, SWAp is not so much an end in itself, as the beginning of a longer venture.

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Personal comments on SWAps

SWAp, Sector Wide Approach, is the new slogan of cooperation. The idea to regulate so many different programs by the central government is simply good, this cannot be denied: it can save money, manpower and goods. Central government with donor partners decide and make their priorities. The intention is to create a balanced and integrated development in the health and other sectors. Who could be against it?
But is this new? Integrated programs have started since Alma Ata. Since 1976 health development has been approached as part of an integrated development. Sanitation, water supply, nutrition and education are part of PHC. To have better control on this process and to have the community involved in the decisions and implementations, decentralization to district level was started in most countries, called Health Reforms, coached and guided by WHO. NGOs, usually small and nearby the community, became partners in this process at this level. Evaluation and control of the proceedings were at least possible. Indeed a difficult process, asking time and capacity of the scarce human resources.
Now SWAp makes a move of 180° by complete centralization of the development process. Donors (read: the big multilateral ones) participate as stakeholders at central level, competition will start to please the final decision-makers. Bureaucracy is growing; corruption, exclusion of 'smaller' donors like NGOs are very likely. And where is the participation of the community, including NGOs, in this top-down decision making?
The big international vertical programs, like UNAIDS, MAP, PAVI, have already stated "cooperation: yes, integration will be difficult, our funds are earmarked and cannot be put in the big basket".
NGOs should therefore be careful not to lose what is built up at district and community level. There is a danger that SWAps are just braking the decentralized health development, keeping the bureaucracy, including the usual bribery, in the capital. Who is losing? I think the community, far from the central political power, and with them the NGOs, our partners. And was and is PHC, since Alma Ata, not the equivalent of SWAp, but at decentralized level?

Sake Rypkema

SWApS AND HEALTH

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MMI STATEMENT MINILAB -DRAFT

Ways of combating counterfeit and substandard drugs

Pharmaceuticals cure, relieve or prevent disease and suffering by virtue of their quality, efficacy and safety. If drugs are counterfeited these functions often cannot be fulfilled, i.e. diseases are not cured, they get worse, pain is not relieved, and death can occur. For instance in Nigeria in 1990 a cough mixture diluted with poisonous solvent caused the death of over 100 children.

The most effective way to prevent counterfeiting is the establishment of adequate and vigorous national regulatory systems, including licensing/authorisation of products and manufacturing sites, and inspection. However, for developing countries it is often impossible to ensure adequate regulatory and inspecting systems due to lack of financial means and manpower.

In these circumstances it is crucial for health care institutions to establish their own rigorous system of supplier qualification to minimize the risk of obtaining counterfeited or substandard drugs. The German MMI member organisation *action medeor* has supplied various regions of the World with reasonably priced, high quality medication and medical equipment for 36 years and developed a thorough knowledge of assessing its suppliers. *action medeor* offers support in the establishment of supplier qualification systems.

Even after comprehensive supplier qualification and purchase planning health care institutions may have to buy pharmaceuticals through uncontrolled providers, e. g. after an unexpected high incidence of malaria cases. For this situations it is very useful for the health care institutions to be able to detect substandard or fake drugs. The GPHF-Minilab provides necessary simple testing methods. It is specifically designed for use in developing countries. *action medeor* promotes the GPHF-Minilab.

The easy-to-use test methods are designed to protect the people in developing countries against the, frequently fatal, consequences of taking counterfeit or substandard drugs. As described by GPHF and experienced by users, the Minilab test methods are inexpensive, transferable, versatile and used reliably even by less experienced local personnel in developing countries. In the contract of the purchase of drugs the confirmation of an acceptable standard by the Minilab could be stipulated as a condition for validity of the contract. For evident reasons, MMI strongly recommends that the use of the Minilab in a specific country is notified to the national drug control authorities and that cases of counterfeit and substandard drugs are reported to them.

Within the GPHF-Minilab's quality management package the training of the personnel organised by *action medeor* is an important element. The seminar covers the theory and practice of visual checks on medicinal products, disintegration tests, color reactions to test identity and also the use of thin layer chromatography to determine the identity and content (semi-quantitative) of currently 20 drug substances in tablets or capsules. It is aimed at members of the health sector in developing countries (pharmacists, pharmaceutical technicians, dispensing assistants and persons with basis pharmaceutical knowledge acquired from other sources) and to persons who after instruction will work as trainers in developing countries.

MMI welcomes *action medeor's* involvement in the promotion of the Minilab, hoping that joint international and national efforts {o improve quality control of medicines will make the use of the Minilab one day unnecessary.