



**Medicus Mundi Internationalis. Primary Health Care,
a main Challenge**

Barcelona, June 2013

by Edgar Widmer

CONTENT

I. The beginning of Medicus Mundi in the post colonial context

II. Health care in the context of poverty requires new visions

III. Primary Health Care (PHC) and Health for all, the official strategy

IV. Restriction of PHC to Selective PHC

V. MMI establishes dialogue with WHO, politicians and church leaders.

VI. MMI Promotes tools for implementing PHC

VII. MMI promotes the recognition of NGO's role for PHC

VIII. MMI's role in training

IX. MMI and the new challenges in a globalised world

X. Operational change within MMI

50 years Medicus Mundi Internationalis. Primary Health Care, a main Challenge

I. The beginning of Medicus Mundi in the post colonial context

In 1957 several Dutch doctors who worked as post-colonial technical assistants in Indonesia came together in order to talk about their experiences and about their future. All reached the same conclusion; the few NGO- or missionary hospitals scattered across the islands have had little influence on the health conditions of surrounding populations. They proposed that from now on, the emphasis should shift from curative and charitable actions to prevention, training auxiliaries, mother and child health-

This was in 1957, only two years after the **Bandung conference** in which 29 non aligned countries denounced colonialism and soon afterwards rushed to independence and established new relationships between foreign assistants and local professionals.. Within the context of this new historical era Medicus Mundi had its origin.

II Health care in the context of poverty requires new visions

In July 1962 when the International Federation of Catholic Doctors¹ was discussing in London about: *The Catholic Physician in societies in evolution* Misereor's medical consultant,² Dr. Jentgens, spoke about the **role expatriate doctors should fulfil in developing countries**. Professor Janssens from Antwerp and Professor Oomen from Amsterdam, both directors of the Institute of Tropical Medicine in their respective cities, submitted a **report concerning hospitals in third world countries**. Out of the meeting was born the idea to found an organisation for international medical cooperation.

The idea led to the first international meeting of the organisation-to-be, hosted by *Misereor* in Aachen on 8 December 1962, A few months later, in 1963, the founders³ of the organisation formally registered Medicus Mundi International (MMI) as corporate body according to German law.

The **vision** as an organisation for international medical cooperation was mainly aiming at **professional assistance, rather than financial and material assistance**. The main target

¹ F.I.A.M.C. "Fédération Internationale des Associations Médicales Catholiques.

² *Misereor* created in 1986 by the German Bishops Conference as an organisation for assistance to the third world.

³ In alphabetical order: Mgr. A. Cauwe / Belgium; Dr. Gerhold / Austria; Prof. H. Jentgens / Germany; Prof Oomen / The Netherlands; Dr. Puig Massana / Spain; Dr. V Sheehan / Ireland; Dr. Signoud / France.

were the **most needy populations** in the developing countries. As the colonial health system concentrated its engagement mainly on establishing health institutions in the capital or in other urban settlements where the majority of the expatriates lived, it was up to the churches to take over the subsidiary engagement in poorer rural areas. That is why MMI, even not being-denominational, offered its help mainly to grass-root rural church hospitals which in absence of governmental institutions usually functioned as district health centers. It is not surprising that the identification of Medicus Mundi doctors with the need to serve the poor populations became the background for Medicus Mundi's orientation.

While in better off places medical services were rather in line with European standards, in the poor regions the question was more pertinent, whether hospital concentrated work had any influence on the health status of the population. Medicus Mundi came to the conclusion that hospitals not only had to deal with diseases, but to promote and maintain health. The community had to be considered as much as single patients. Medicus Mundi, apart its personnel assistance, started more and more reflecting alternative strategies based on grass root experience and defined its development-vision and strategy in a series of own publications.⁴

Later at the occasion of MMIs 25th Jubilee, Dr. Halfan Mahler , the Director General of the WHO, confirmed that: *“MMI's new approaches were a stimulus to the evolution of primary health care, thought and practised as part of concerns within the organisation.”*⁵

As a matter of fact, in the **Halifax Conference**.⁶, half a year before Alma Ata, MMI was able to contribute, together with some other international NGOs, in the preparation of an **NGO-position paper** for the announced International Conference on PHC. to be held in **Alma Ata**.

III.Primary Health Care (PHC) and Health for all, finally confirmed as the official Strategy

⁴ *Concepts 1* (1971) and *Concepts 2*. (1975) *Un Nouveau Combat Pour la Santé et Medicus Mundi*, Editions Cana, Paris 1980, *Novos Caminhos Na Promoçao da Saude et Medicus Mundi* Edições Paulinas, Sao Paulo, Brasilia 1981.

⁵ Mahler H. *Foreword*, North South Dialogue and Health, éditions Karthals, Paris 1985, p. 6.

⁶ *Non-Governmental Organisations and Primary health Care*. World Federation of Public Health Associations, Washington, June 1979.

In September 1978 the Alma Ata Declaration expressed the need for urgent action by all governments, all health and development workers, and the world community as a whole to protect and promote the **health of all people**, based on the human right for health.⁷

As participants we were determined to spread the Alma Ata conclusions within our organisation and to induce MMI's member organisations to change their way of work, trying at the same time to convince our partners in the South about the necessity to reorient their strategies accordingly.⁸

One year later, in **1979**, MMI was offered **official relationship with WHO** and ever since we have been sharing discussions within this United Nations Institution. This enabled us to keep up with main stream strategies and to anticipate and influence new policies.

At the same time MMI together with those NGOs who participated in the Alma Ata Conference joined in the *NGOs Group on PHC* contributing in 1981 to a position paper on: *The Role of NGOs in Formulating Strategies for Health for All by the Year 2000*.⁹

IV. Initiative to restrict PHC to Selective Primary Health Care?

The Bellagio Conference in 1979, organised by the Rockefeller Foundation at its Conference Center in Italy, with the participation of World Bank, USAID and UNICEF on: "Health and Population in Development" proposed to reduce the PHC-concept to a **Selective Primary Health Care Approach**, a strategy aiming at saving **as many lives as possible at a low cost** by ranking the "major infectious diseases of the South" according to prevalence, mortality, morbidity and the effectiveness and cost of available cures.¹⁰

MMI adhered to such an approach in 1982, when **UNICEF declared the GOBI-slogan** for the survival of young children. through **Growth control, Oral dehydration, Breastfeeding and Immunization**.¹¹

As for breastfeeding MMI took an active role in 1981 in the promotion of the **International Code of Marketing Breast-milk Substitutes**

⁷ human rights charta 1948.

⁸ Widmer E. *Statement given at the International Conference on PHC in Alma Ata*, North South Dialogue and Health, éditions Karthals, Paris 1985, p. 32.

⁹ published in English, French, Spanish, Portuguese and Arabic by the Christian Medical Commission of the World Council of Churches, Geneva.

¹⁰ Walsh JA, Warren KS, N.Engl.J.Med, 1979, Nov 1, *Selective primary care, an interim strategy for disease control in developing countries*.

¹¹ cf. Widmer E. *Joint Efforts in Bolivia* Newsletter Nr. 46, 1992.

V.MMI was aware that the promotion of PHC needs dialogue with decision-makers not only with WHO as mentioned above, but also with governments and with church leaders.

- creating a forum for dialogue with ministers of health. From 1974 to 1984 for 10 years, MMI organised weekend-meetings at the occasion of the World Health Assembly (WHA) inviting ministers of health from countries in which MM doctors were active. The outcome of this *North-South Dialogue has been* summarised in 1985 in a booklet, published in Paris.¹²

MMI further concentrated its dialogue by

- addressing bishops who were owners of those private not for profit hospitals in which MM personnel was engaged, because many of the bishops rarely were aware of the revolutionary paradigm-change after Alma Ata.¹³

Our aim in the dialogue with the church was

- **to promote PHC-Leadership. and Stewardship**¹⁴

A further aim in the dialogue with the church was

- to **improve collaboration with church leaders** by replacing blind obedience with a Free Dialogue, a dialogue bottom up and top down, enabling in such a way to reach consensus. We were convinced that team dynamics would ensure creativity. participatory methods would optimise motivation and improve efficiency.¹⁵

Another aim in the dialogue with the church was

- to promote **Coordination** *within the Catholic Health Care Sector*. because the need for contact and cooperation in form of a church's own network was not fully recognised. Our slogan was:: *unite for more efficiency*

Finally our aim in the dialogue with the church was

¹² *North-South Dialogue and health, Medicus Mundi 25 years in the field, KARTHALA , Paris, 1985.*

¹³ In the 80ties MMI counted about 1200 MMI-doctors cooperating with more than 250 Church Hospitals.

¹⁴ B.Marchal & G.Kegels, *Current critical issues in Human Resources for Health in developing countries* MMI-publication 2003.

¹⁵ Widmer E. *Health and Power, Practical Actions to be promoted in Relation to Hospitals*, XVI International Conference, Pontifical Council for Health, Dolentium Hominum No 49, November 2001.

- to better integrate Church health Institutions into the District Health System (DHS)¹⁶

Important was the **dialogue with the churches in the field, when in 1981** together with its 35 Medicus Mundi doctors working in the **Cameroons**, MMI organised the **First Seminar on PHC on African soil**. Participants were the Catholic Medical Bureau of Cameroon, the Federation of the Protestant Churches in Cameroon and the Foundation Ad Lucem. 240 health workers from about 100 private health centers gathered for 5 days of work in the Center John XXIII. in the capital Yaounde. The Alma Ata PHC-concept and its importance was explained, so that the participants were convinced that reorientation was necessary. One of our outstanding participants was doctor Christian Auranche, a Jesuit linked with MM France. In the years to come his hospital in Tokombere became a pilot project for PHC, for which some years later during a World Health Assembly he was awarded with an honorary price.

Another important occasion for dialogue with the church was the **Dodoma Church's Consultation on PHC in 1985**. 24 MMI doctors working in Tanzania took part. All church hospitals had been represented by their Doctors in charge, by their administrators, by many church leaders and by government representatives..¹⁷

In **1983**, MMI had the opportunity to **collaborate with the church at its highest level** when the Pontifical Council Cor Unum¹⁸ had invited some personalities to discuss the question, whether there exists a **Pastoral for Health**. MMI was part of the workshop. The way the question was formulated, indicated that the organisers were aware that after Alma Ata an important paradigm-shift had taken place. Not the sick or the disease was at the centre of interest, but health, the promotion of health and the human right for health. This workshop proposed the creation of a specific Health Dicasterium, which finally came into being in the year **1985** by the Motu Proprio "Dolentium Hominum" of Pope John Paul II. Right from its beginning, representatives of MMI were able to collaborate with this **Pontifical Council for Health**. We were convinced that by the fact that so many of our

¹⁶ *Harare Declaraton*, 1987 WHO/SHS/DHS. establishing the *District Health System* as a reference strategy for the implementation of PHC.

¹⁷ *Tanzania churches consultation on primary health care*, African Medical and Research Foundation, Nairobi, 1985.

¹⁸ Cor Unum, Vatican Dicasterium for Development, founded 1971 by Pope Paul V.

own doctors worked in faith based health institutions, it was useful to have **a voice as medical professionals at this top level.**¹⁹

VI. MMI promoted tools for implementing PHC

Such a tool was the WHO Model List of Essential Drugs²⁰

In 1977 MMI got involved in the definition and introduction of the WHO Model List of Essential Drugs. Doctors in developing countries felt the need to have a limited list of drugs that would cover the majority of health needs and achieve the widest possible coverage of the population. Generic or non-proprietary names instead of brand names should describe the active substance of a medicine and replace the bewildering multitude of drug information.

In 1977 the First WHO Expert Committee on Essential Drugs annotated a list of about 200 active substances. The work had strong backing from World Health Assembly resolutions and notably from Dr Mahler, the WHO Director-General, and **Dr Fattorusso**, the Director of the Division of Prophylactic, Diagnostic and Therapeutic Substances. Experts from teaching, research and clinical institutions offered their knowhow.. But the Committee still needed expertise from someone who would know about the African drug situation at grass root level. It was Dr. Fattorusso who commissioned MMI to check among its many doctors in the field the usefulness of his list. Thanks to MMI's inquiry some necessary amendments could be added to the essential drug list

- In 1988 MMI adhered to the **Guidelines for donors and recipients of pharmaceutical donations**²¹

Another tool was “Contracting”

When in **1999** under the the presidency of Miguel Angel Argal, MMI promoted a side event at the 52nd WHA, the idea of a **resolution on “Contracting NGOs for Health”** the observer of the Holy See immediately endorsed our proposal and bishops conferences around the world received the pertinent informations.published by MMI.²²

¹⁹ **Pontifical Council for Health**, press release in Sao Paolo, Brazil Feb 10, 2010 announced at its **25th anniversary** that the Catholic Church manages 26 percent of health care facilities in the world. and that the Church has “117,000 health care facilities, including hospitals, clinics, orphanages,” as well as “18,000 pharmacies and 512 centers” for the care of those with leprosy.

²⁰ *La sélection des médicaments essentiels, Papport d'un comité d'experts de l'OMS*, Série de Rapports techniques 615, OMS 1977.

²¹ published by Christian Medical Commission of the World Council of Churches, 1988.

²² Extra issue of MMI Newsletter 1999 in which MMI advocates contracting as an efficient method for the integration of NGO (Church)-health services into the District Health System.

Pursuing the **Contracting issue**, MMI organised in **1999 Consultations in Africa** among Health ministers and Church leaders; in Conakry for the francophones and in Dar es Salaam among anglophones in view of a draft for a WHO Resolution on the importance of public/private-partnership through Contracting.

It took MMI four years of diplomatic lobbying until May **2003** when the representatives of about 190 nations adopted the **WHA resolution 56.25** with the title *“The role of contractual arrangements in improving health systems’ performance”*

Even though the Holy See had given its support for the promotion of the resolution, MMI found it necessary to organise during the years between **2004** and **2010** a series of **Working Conferences among African Associations of Bishops Conferences**. The aim was awareness-building for the Public/Private Partnership modality. At the same time, we intended to stress the **strategic reorientation of church health institutions**.

As an example, I would like to mention the Uganda working conference whereto in March **2004**, nine Anglophone African Episcopal Conferences sent their delegates. The conference discussed the viability and sustainability of catholic health services and took due notice of the rapid changing circumstances in which they have to be provided. The **Kampala Statement** contains a number of resolutions that have been adopted by the delegates of the participating Episcopal Conferences. To mention but a few, namely:²³

- to foster stewardship
- to install professional coordinating bodies
- to develop institutional capacity
- to engage into partnerships particularly with Government,
- to seek participation in debates on health policies at national and international level.

A very important possibility to advocate the contracting modality was MMIs participation in **2010** in **preparing a paper** of the International Federation of Catholic Health Institutions (AISAC) with the title: *A contribution of Catholic Health Care Institutions to reconciliation through health care*, to be presented to the **Second Synod of African Bishops**. The Synod accepted AISACs proposal saying that the improvement of the

²³ <http://www.medicusmundi.org/en/topics/church-based/milestones>

church's collaboration with governments in the field of health was important. The Synod's decisions were **confirmed**, by Pope Benedict XVI in 2011.²⁴

Already in **1984** the MMI-Rome-conference spoke about ***Strengthening Coordination of Health Activities by local NGOs towards health for All.***²⁵ Its final statement expressed the: *desirability of cooperation between NGOs and governments, and that one should move from simple collaboration and exchange of information to true agreements on common actions.*

As you can see, nearly 30 years passed by until these Rome recommendations were heard by the African Synod of Bishops.

VII. MMI promotes the recognition of NGO's role for PHC within WHO

After the 1984 Rome Conference, our MMI Secretary Sleijffers together with the Christian Medical Commission (CMC) of the World Council of Churches (WCC) launched the idea that it would be desirable to put the discussion on: ***the importance of International not for profit NGOs for health.*** on the agenda of the next technical meeting during the **38th WHA 1985**. The WHO not only took up this proposal, but MMI together with CMC and the International Red Cross had been given the chair for these Technical Discussions. 150 NGOs were present. Dr Halfdan Mahler, with regards to the contribution made by NGOs, spoke about their prime importance as a subsidiary assistance. He said: *many governments would like to unload their responsibilities, and no longer having to provide resources. But NGOs prime importance is a subsidiary one and governments ought to be partners joined in a marriage which the WHO would like to bless.*

VIII. MMI's role in training

MMI-Experts, some of them in charge of Tropical Institutes²⁶, added to the classical lessons on tropical diseases, **complementary modules** such as public health, epidemiology, environmental health and sanitation, mother and child health, health service

²⁴ Post.Synodal Apostolic Exhortation *Africae munu*, 2011.

²⁵ MMI-Newslette No16, *Fifteen National Christian Health Associations and their corresponding ministers of health were present.*

²⁶ Such as the ones in Basel, Tübingen, Amsterdam, Antwerp, Brescia, Heidelberg, Tübingen and Barcelona.

management and district-health care development, health education, PHC teaching and teaching methods.²⁷

These were the kind of preparatory courses our future expatriates had to go through and later MMI was able to sponsor for future local staff responsible within national coordinating offices.

IX. MMI and the new challenges in a globalised world

In view of the Jubilee 2000, an analysis of the world health situation showed that poverty, inequality, violence and injustice were still at the root of ill health in many low income countries, because economic restructuring had led to reduced public spending on health care and international market mechanisms were not geared to promote global, equal access to essential drugs and health-promoting commodities.

The 2000 Millennium Summit of the United Nations agreed in its Millennium Declaration to achieve, by the year 2015, eight goals in order to overcome poverty and hunger.

1. Eradicating extreme poverty and hunger,
2. Achieving universal primary education,
3. Promoting gender equality and empowering women,
4. Reducing child mortality rates,
5. Improving maternal health,
6. Combating HIV/AIDS, malaria, and other diseases,
7. Ensuring environmental sustainability, and
8. Developing a global partnership for development.

In order to fight the dramatic situation as defined in the Millennium Summit important funds became available, such as:

- Bill and Melinda Gates Foundation (1999).
- GAVI (Global Alliance for Vaccines and Immunisation) (2000)
- GFATM (Global Funds to fight Aids, Tuberculosis and Malaria) (2002)

In the year **2001** when the Belgian government held the EU presidency, together with the Antwerp Institute of Tropical Medicine, it tried to give a response to the critical health situation as described above. **“Health and Care for All”**. was the new slogan. Adding the

²⁷ See J.J.Gilberts' *Guide Pédagogique pour les personnes de Santé*, OMS Publication No 35, 1977) (*Teaching experiences*, Bulletin MM Schweiz Nr. 41, 1989.

word **care** meant that **care is a basic human right**. Be it a more intense fight against Aids, Tbc and Malaria, be it the implementation of the Millennium-goals: more human resources are needed.

Therefore **MMI** insisted in its **comments on the Antwerp meeting that the human resources factor** being the main pillar within the health system, **needs more attention**.²⁸

30 years after Alma Ata the **World Health Report 2008** preaches as a remedy against the increasing health disaster: *Primary health Care, Now More Than Ever*. The author of this publication is Wim van Lerberghe, from the WHO Department for Health System Governance and Service Delivery. He had been sponsored by MMI in 1988 for his publication on: *Health for All, methodological tools*, when he was still working at the Tropical Institute of Antwerp.

X. Operational Change within MMI

Up to this point, the Board members were the executives of MMI's programs. From now on a strong secretariate would try to more involve member Organisations into MMIs policy plans.

- **MMI changed from being an umbrella-organisation to becoming a strong network-**
- **MMI started formulating multiannual policy plans**
- **MMI established working groups**
- **MMI organised joint network meetings**
- **MMI created a platform for civil society**

The first multiannual policy plan 2007-2010, a plan that had carefully been developed during the years before, was finally endorsed by the MMI-General Assembly **2007**;

The MMI secretariat and its president engaged itself for the **Network Development**, Cordaid headed the working group on **Human Resources in Health (HRH)**, and two board members of MM Switzerland engaged in **Strategic repositioning of church-based health care facilities**. In **2009** the executive secretariat had to be relocated, from Brussels, where it was housed at the premises of Medicus Mundi Belgium for over 20

²⁸ Widmer E. *The Antwerp Declaration on "Health and Care for all"*, MMI Newsletter Nr. 68, 2002.

years, to Basel, where the secretariat found a new basis within the offices of Medicus Mundi Switzerland.

Strengthening the Network

In order to strengthen contacts with the Network the board started to hold its meetings in the offices of its member organisations. So:

- in October 2009 at the generalate of the Hospitaller Brothers of St John of God (Fatebenefratelli).in Rome.
- in October 2010 in the offices of Misereor in Aachen, combined with a **workshop** under the title ***“Redefining our Role in Global Health.”***
- in September 2011 in the office of MM Italy in Brescia with focus on ***mother and child health.***
- In November **2012 a network-meeting** was held in **Amsterdam**.dealing with ***Health systems’ strengthening in fragile state.,***

These events are inspiring models for future similar Network-meetings.

The **Second Working plan 2011-15**, concentrated on the following three programs:

- Human Resources for Health,
- Health Systems Research and
- Global Health Policy.

The Human Resources for Health (HRH) issue remained a priority also in the second working plan: In the frame of the Global Health Workforce Alliance the HRH working group contributed to the implementation of the ***WHO code of practice on the international recruitment of health personnel.***”

Wemos, being the coordinator of the working group for HRH,- has been selected by the Global Health Workforce Alliance to host the secretariat of the Health Workforce Advocacy Initiative (HWAI)²⁹ and submitted to the European Community an Agenda for Global Action called **“Health Workers for all and all for Health Workers”** because acute shortages of health workers in most countries, rich and poor, are undermining advances already made in improving health.

²⁹ Global Health Workforce Alliance – is a partnership of over 350 organizations !!! working on the global health workforce crisis.

As concerns Health Systems Research: “MMI decided to foster mutually beneficial partnerships between NGOs and research institutions.”

On September 2012, the **Amsterdam Symposium** was an opportunity for talks about NGO-research partnerships. It has been decided to establish a **MMI-Project of a marketplace for NGOs “in search of research and young researchers”**.

On November 19th 2012 the eight Medical Faculties of Catholic Universities in Africa., at an informal meeting at the Pontifical Council for Health in the Vatican, have been informed by MMI about the planned marketplace for research.³⁰

MMI Network creates a civil society platform.

Global health policy has become a key issue of the MMI-Network. However, it is difficult to define the concrete “demand” by the Network members, as some topics of our activities, such as the **reform of the WHO**, seem to be far from the day-to-day business of health care and health systems support. Nevertheless, since 2010 the MMI Network has become visible in the **WHO reform process**. The importance of **civil society’s say** in this process, seems to be recognized by the WHO leadership. In accordance with our network strategy, the MMI Network has been strongly involved in setting up a **civil society coalition** dealing with the WHO reform, called: **MMI “global health governance team”**. Its activity is based on a clear mandate by the Network members, which says: “*Advocacy in the field of public health is a core activity of the MMI Network. Joint advocacy adds a layer of value to the Network’s activities. Supporting our members’ efforts to achieve the shared vision of health for all, our advocacy aims at influencing the policy landscape in which our members’ and their partners’ activities take place.*”³¹

A Midterm review of MMI Network Strategy 2011-15 will have to analyse: the latest new engagements. Do they achieve the shared vision of Health for All, are they contributing to the development of capacities of its members and are they providing a platform for joint activities ?. Everyone working within the MMI network is invited to determine the future and to contribute to the future of the organisation. United we will have the chance to continue our work for a more healthy and more just world.

³⁰ Université Catholique Bukavu and Butembo RDC / Martyr-University Kampala, Uganda // Bugando-University, Mwanza, Tanzania / Université Saint Thomas d’Acquino, Ouagadougou, Burkina Faso / Universidade Catolica de Moçambique / Université Le Bon Samaritain, N’Djamena, Chad.

³¹ MMI-advocacy policy, 2009.