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Introduction

This Newsletter reports on the follow-up of the main MMI initiative of the last two years, concerning strengthening the Health for All (HFA) activities at district level through a combined approach. It is in fact a follow-up of the 49th World Health Assembly (WHA), Geneva 1997 and also of the WHO regional conference for Africa, Dakar, 16-18th February 1998. There, the opportunities were explored in achieving HFA in the tripartite partnership WHO, Government and NGO. It was suggested, in order to facilitate an effective co-operation and co-ordination, to set up a NGO liaison office at regional level in Harare. Its prime concern was a better co-ordination between northern NGOs and WHO Afro Region.

The MMI members are of the opinion that co-operation between WHO Afro Region and our NGO partners needs to be improved and intensified. A liaison office can contribute greatly to improving relationships. It will have to be combined though with structural representation/participation of our partners in the WHO regional meetings. We are aware that this liaison office has yet been set up. A request for funding had been addressed to us and other International NGOs. The MMI members, after extensive deliberations, found that funding directly from International NGOs to the WHO-Afro-liaison office would not be in the interest of the co-operation intended.

To ensure that the co-operation between the NGOs of the Afro Region and WHO can really be improved, these NGOs must be able to influence the functioning of the liaison office. To obtain that influence they need to have a say regarding the planned activities and the use of funds.

Therefore MMI spent her energy first on the way of contracting at district level and on the consultation of her local partners in the Afro region.

Two partner consultations were organised, in close co-operation with Memisa Medicus Mundi. There were 45 participants in the English speaking Dar es Salaam meeting, coming from six neighbouring countries, representing Ministries of Health, national church related co-ordinating agencies and others.

Conakry was the French consultation, with attendants of comparable gremia and countries. Reports of the Dar es Salaam meeting are given by Marieke Verhallen and Edgar Widmer Mr. Jean Perrot and Dr. Patrick Berckmans of WHO report on the Conakry meeting.

At both meetings the MMI statement on contracting (WHA 1999) was discussed. Several countries, member states of WHO, are in favour to propose during the next WHA 2000 an official WHA resolution of the contractual approach at district level, reaching a better HFA . Another approach by MMI was via the channel of the owners of NGO health care institutions, in many cases the churches. Therefore Dr. Widmer, Board member of MMI, approached the Vatican. This resulted in a letter of recommendation of the Vatican, in order to support this way of contracting. Dr. Widmer gives his report in this Newsletter.

September 1999 MMI was present in San Sebastian where Medicus Mundi Gipuzkoa celebrated its 25 years anniversary and organised a conference at the University of San Sebastian on “Health and Poverty”.

In December, our German member AGEH celebrated its 40 years by a two-day conference on personal assistance: ‘Menschen gestalten Gerechtigkeit und Frieden’. In the next Newsletter we will report more on this interesting happening.

Full reports of the Dar es Salaam and Conakry meetings will be available in due time. Readers who are interested in these reports should address themselves to the office of MMI. We hope to keep your attention in the year 2000.

Sake Rypkema.
MMI Partner Consultation Dar es Salaam.

Challenges Ahead:
First Impressions of the Partner Consultation: ‘Updating Health Care Development Co-operation’ held in Dar Es Salaam from the fifth to the seventh November 1999.

Marieke Verhallen

Introduction:
Medicus Mundi International this year planned two Partner Consultations. One in Conakry, for the Central and Western African partners and one in Dar Es Salaam for the Eastern African partners.

The reason to hold these consultations lies in the changing realities of the MMI partners and the need to adapt our support. Many of the changes represent new challenges as well as new chances to take up important new public functions, but they can also bring new risks and threats to continuity of services and maintaining identity as well as optimal autonomy. One of the important new challenges is the new relationship needed between Government, at the different levels, and the NGO providers. To construct balanced relationships renewed dialogue, more effective communication and new tools are required.

In view of finding more effective tools MMI and her members have been developing the idea of the Contractual Approach between Governments and Non Governmental Institutions. This approach can enable non governmental health care providers to be assigned responsibility for public purpose services and become a more integral part of District Health System with the aim to improve access to the poor and complete coverage. The potential advantages convinced MMI that the Contractual Approach is worth pursuing to the extent of a World Health Assembly Resolution. However we did also want the opinion of our partners on this plan and the resolution proposal.

In view of the changing relations between Governments and NGOs the relations of the latter with the WHO need to be improved. In 1998 at a meeting in Dakar, Senegal the plan for a NGO liaison office at the WHO Afro Region was proposed. MMMI thought this should be discussed further with the partners at this occasion.

In Dar Es Salaam the participants came from Ethiopia, Kenya, Malawi, Tanzania, Uganda and Zambia. Each country group consisted of five representatives from the various levels of the Christian Health network (national, intermediate and peripheral levels) and one representative from the Ministry of Health. The speakers ranged from Country Representatives, National or International Experts, WHO representative and last but certainly not least Representatives from Ghana Ministry of Health and Christian Health Association in view of their advanced experiences with contractual approach.

The program combined introductions from the speakers with group and plenary debates. The main parts of the program were:
- The new roles of Government in Health Care and the consequences for NGO providers;
- Possible approaches to ensure equal dialogue between Government and Non Governmental Institutions including the experiences with the contractual approach;
- Contracting views form various sides and the plan;
- The plan and draft text for the WHA resolution;
- The future: proposals for strategy outlines and phases approach to achieve equitable roles and/or contracts;
- The involvement of Coordinating Organizations in the WHO Afro Region NGO Liaison office.

In this brief article we want to give some impressions and highlight some aspects. A full report will be published soon.
Consultation Proceedings:

Opening:
The Consultation was opened by Bishop Sindoro and the Vice Chairman of Medicus Mundi International, Mr. Eskens. A minute silence was first taken, to remember the Father of the Nation Mwalimu Julius Kambarage Nyerere. Both speakers honored him for his incomparable contribution to social services.

For Bishop Sindoro the present socio-economic problems, resulting in resource constraints, urge us all to address partnership between Governments and Non Governmental Organizations as a rational approach. The main aim should be equity an improved access for the poor. He also urged the participants to pay attention to improving the quality of health care provision.

Mr. Eskens explained that participation of the communities and decentralization of authority and budgets prompt the need to find other ways to work together at all levels. This in turn calls for other capacities of health staff and managers. Also a whole new system of legislation, accreditation and administrative rule has to be elaborated. MMI wants to contribute to the search for and elaboration of new approaches, among others by conferences like these. Thus the MMI Members will also be able to ensure that their support remains adapted to the need ‘on the ground’.

1. The new roles of Government in Health Care and the consequences for NGO providers;
Dr. Kyabaggu, Director of Planning at the Ministry of Health Uganda, draw the picture of the present context of health care provision and the reforms in Uganda. He then explained that, in Uganda, the Government involvement will in future be found at two levels: central and district. The central level’s main functions range from policy setting, legislation, resource mobilization to system planning, standard and verification. The district level is the level actually ensuring service delivery. The central level has chosen to enhance the potential contributions of the Private Not for Profit thus the policy and legal framework reflect this approach. The central level should guide and stimulate the district level in this. He recognized that the process is temporarily stalled due to lack of institutional arrangements to foster the changes. Communication and interaction are keys to harmonizing interpretations and implementation of policies and priorities.

Dr. Daniele Giusti, Executive Director of the Uganda Medical Bureau, first completed the picture of changes in Uganda from the perspective of the Bureau and its members: incomplete decentralization and horizontal decentralization. The districts still need to be equipped and are not yet aware of the latter trend.

The church related health care institutions are experiencing particular internal problems next to the external ones ranging from withdrawal of the founding bodies, lack of own professional management development to lack of adaptation to changes.

Where the government system was highly centralized, the church structure still is highly decentralized. Decentralization of government now calls for an opposite movement from the churches: to be able to effectively promote dialogue and partnership the church structure needs bodies with adequate mandates at intermediate and central level.

Mr. Beekes, Diocesan Health Care Coordinator Kabale Diocese, colored in the effects of the external and internal problems at the level of health units in the periphery. From the first steps to developing partnerships with the district health management teams he concluded that a professional and mandated intermediate level is required to support the primary level. But also that to effectuate collaboration there is need for new definitions, new forms of partnerships, tools and negotiation skills.

Dr. Jaap Koot, independent expert, widened the picture by placing health care reforms in the context of the overall civil services reforms and the church problems in the context of the africanization of the church health services. Decentralization and privatization moves force the church related health care institutions to choose. The choice for becoming part of the public health system will probably mean, in the long term, that the distinctions between governmental and church institutions may fade away. Therefore he argued that it is important that the church leaders and health care professionals answer fundamental questions first. He questioned the benefits of the / regulatory capacity of free market mechanisms and foresees here a role for the churches to defend the right of each person to an essential
package of health services. But to obtain negotiating power at both local level and national level equality between the partners is required. To achieve that the visions and missions need to be clarified and harmonized and adequate mandates given to national co-ordinating bodies.

All four speakers showed that to realize the theories of decentralization the implementation process needs much more attention. Communication and learning are key factors that need to be complemented with new instruments.

The three latter speakers agreed on the problems the church health service are facing and that these problems are closely linked to not really being part of the system and financial and management constraints. Striking is their conclusion that the decentralization of the government calls for clarification of vision and mission as well as clearer centralization of church organizations.

The time for discussion proved much too short. Important points of discussion were: the fear of government absconding from its responsibilities and the churches having to compensate; the mistrust that has grown between government and church institutions and how to change this; keeping the positive factors of decentralization in focus; institutional health care costs versus primary health care and prevention needs and costs and thus on the definition of district health care services.

2. Possible approaches to ensure equal dialogue between Government and Non Governmental Institutions including the experiences with the contractual approach;

a. Equal dialogue:

In the invitation for the partner Consultation MMI had requested the partners to propose speakers and subjects. Particularly regarding ‘Approaches to Equal Dialogue’ we had hoped to receive suggestions. To our regret none came. It might be important to ask ourselves why. Does it confirm one of the speakers comments that the churches just continue to muddle on?

MMI then requested the Christian Relief and Development Association (CRDA) and Afri-CAN to give their views. The Christian Social Services Commission (CSSC) proposed to add their views during the consultation.

Dr. Filimona Bisrat, Health Project Officer CRDA, first painted the complicated and difficult picture of health care provision in Ethiopia. Then explained the needs for further development of the relations between governmental and non governmental health care providers. The main aims should be improving trust, completing community coverage, effective resource use and joint action. Important factors needing realization are: official recognition of the non governmental providers, involvement in policy and guideline formulation, adherence to rules and regulations and last but not least accountability. As first actions he proposed that the NGOs develop a code of conduct for themselves and then a structural platform for dialogue should be installed. On all sides and levels training in negotiation should be started.

Mrs. Alice Mudiri, staff member of Afri-CAN, using the definition of dialogue and the present health care provision context, showed that a first step is to know what you are and what you want yourself. Equality in this context can only be achieved when the differences are made apparent. In this process the churches have to remember that they claim to represent the poor as individuals and communities, who have a right to health care.

More specifically in the present health care reforms the churches will also have to determine position towards the changes, the risks to be taken in account and the boundaries to be set. On this basis own policy, strategies and tools need to be developed as point of departure for dialogue and negotiation.

She called for the installation of round table meetings between government and all actors in health care provision to improve collaboration and actual impact. The initiatives of consultative meetings of international donors support this call.

The challenge for the churches is to assist in finding ways to restructure the districts so that they can work effectively.

Dr. Kigadye, Director of CSSC: CSSC, as an ecumenical body, was started specifically to be able to better address the challenges resulting from the present changes. The most important
issues are: changing government policies and roles, democracy as well as the upsurge of new diseases while the old ones have not disappeared or pose new problems.

The main functions of CSSC, for health and education, are:
- ensure the flow of information internally and externally;
- participate effectively in formulation of policies;
- advocate for policies in accordance with church ethics from both sides: government and church bodies.

Key words in the CSSC mission statement are: equity, quality, transparency / accountability and compassion. The latter forming the important point of difference with others.

Crucial for the dialogue is the recognition of the duty of Government to ensure health service provision for all and the role of the churches to complement government efforts where they can. The Tanzanian church leaders have determined that they have a moral commitment to continue their involvement in health care and education.

Dr. Nangawe, head of the Health Department of CSSC, regretted the note of hopelessness of the first part. His message of hope comes from two directions: history and practice in Tanzania at this moment. History: the churches started health care services in many African countries and initiated the Primary Health Care approach as later formalized in the Alma Ata declaration. The presently proposed health care reforms are in fact nothing new. The same key words figure prominently: participation, decentralization, sector wide, self-reliance and sustainability. The churches started it, they have to continue and cannot leave the responsibility to other.

Regarding various issues raised in the morning the CSSC he explained the progress made and way forward. In conclusion Dr. Nangawe urged the participants to be ready to look critically at oneself and pursue openness and understanding. The churches should ensure that they are transparent and provide balanced reports. In general he deplored that there is too little attention for operational research.

Common features in these introductions regarding equal dialogue are: there is a clear need for the non governmental / church health services to strengthen themselves and to determine more clearly their own vision, goals and objectives. Such clearer profiles are prerequisites to enter into dialogue with other parties. To initiate and sustain the dialogue as well as ensure an adequate outcome the national and intermediate levels need to dispose of sufficient professional capacity and clear mandates to act in the interest of the primary level and the target population. These views coincide with the views of the speakers in part one.

New is the call of the various speakers here, for structural dialogue platforms.

b. Contracting experiences:
Mrs. Cecilia Bentsi, Head of the Private Sector Unit of the Ministry of Health of Ghana, presented the experiences from the perspective of the Government. Historically it is important to note that the Government always continued a considerable subsidy to church related health care facilities. The institutional reform and the Medium Term Health Strategy for 1997 – 2001 had among its objectives: ‘fostering closer collaboration and partnership between the public health sector, and communities, other sectors, private health care providers, both allopathic and traditional, including NGOs and other interest groups’. The contractual approach is meant to enable the Ministry to channel resources for effective utilization and to synchronize plans and budgets. The objective is to establish a system of performance linked contracts and define measures of performance against which practice will be judged.

She then enumerated the possible disadvantages and potential advantages. The contract design Ghana chose consists of a Memorandum of Understanding between the Ministry of Health and the Christian Health Association (CHAG) on which is based a standard contract format for the agreement between health institute and district health authority. Some important choices were made in the process to build on trust, ensure maximum flexibility for both parties, ensure community involvement, take religious principles into account and facilitate arbitration. Also during the negotiation process criteria for readiness were determined together.

Important aspects of the process were: consultative meetings at various levels, expert advise, joint workshops, joint working on formulations, involvement of all stakeholders and funding of the process itself.
Dr. Yao Yeboah, board member of CHAG and co-ordinator of the Presbyterian Health Services, first presented the reasons for the CHAG members to opt for the contractual approach. These are:

- security and continuity of funding as now formalized and legalized;
- confirmation of the mutual complementary roles and institutionalized co-operation;
- improved flexibility as the funds can be used as contribution to the entire budget;
- reduction of the disparity: all units will be treated equally and thus mission also have access to funds to treat the poor.

He stressed the importance of the preparation process during which the activities of the Private Sector unit and the, non political joint Government - Private Steering Committee and the CHAG internal Steering Committee were essential.

Implementation has started but the risks and challenges need to be closely monitored and addressed when necessary. As first challenge he mentions the mistrust and suspicion. During the entire preparation deliberate efforts have immensely improved understanding, but the problem has not disappeared. It is closely linked to the ownership question: church leaders the fears of losing autonomy and influence can only be dissipated when it proves to work. Other challenges are: future policy directions of churches and government, personnel issues, expectations of users and staff, and funding issues ranging from neglect of Primary Health Care to inadequate and insecurity.

Dr. Biempa, Executive Director of Churches Medical Association Zambia, explained how the process came about in Zambia. Essential to the choice for the contractual approach is the key concept of the reforms: ‘the Purchaser – Provider split’. The Ministry being the purchaser and the Central Board of Health the provider. In its turn the CHO H can subcontract to district boards and hospital boards, including mission hospitals. District Boards can subcontract in their turn. Within the CBOH has a unit for contracting ‘Health Services Commissioning’ and the contracts have been elaborated in a consultative process.

Now well into implementation it is felt that the government seemed to base her expectations on two erroneous assumptions: the churches have sufficient capacity and access to financial support. Some of the important lessons learnt so far: the issues of sustainability, access and equity must be addressed more explicitly in the process and allocation, the de-linkage of personnel needs to be solved soon; the contractual arrangement changes the relationships between government and church health services deliberate communication and efforts are needed to integrate the different ways of working, the mutual trust is growing, there is a need for a clearer operational framework and code of conduct and last but not least transparency together with accountability are indispensable for the success of the contractual process. A key problem at the moment, which the contracting approach cannot address but which is crucial to its success, is the difference between budget agreements and actual disbursement by the Ministry of Finance!

The questions of the participants centred on: contracting institutions versus need for prevention and comprehensive packages (see discussion RC units and access to family planning services); the choice for hospitals versus primary level units, policy and process issues, priorities to be set and economy of scales.

In conclusion the Ghana and Zambia examples have various common aspects of which the most important are: a deliberate choice for the contractual process from both sides, the process of preparation is essential and it needs to be consultative from the start. The national coordinating office of the church health services have a key role in the process.

The discussion showed that certain principles and definitions need to be well elaborated and presented.

3. Contracting views form various sides and the plan;
Unfortunately, at the very last moment, it proved impossible for a representative of WHO Geneva office to present the WHO view. Dr. Josas Kirigia, staff member WHO Afro Regional office, agreed, on the spot, to give his views. He placed the subject of contracting in the context of the Health Care Reforms advocated by WHO. The objectives of the reforms are well known as well as some strategies like decentralization. Less attention is given to the another important strategy: improving public – private collaboration. The contractual approach is an important tool to implement that strategy towards achieving the aims of the reforms.
Mrs. Marieke Verhallen, presented the views of Medicus Mundi: as these have been published extensively elsewhere they are not repeated here.

Dr. Nangawe, Head of the Health Department of CSSC, evaluated the experiences in Tanzania with, more or less implicit, contracts between MoH and individual hospitals. (District Designated Hospitals and the Medical Grant in Aid) He poses important questions concerning some basic assumptions suggesting that quality and objective resource allocation formula are key subjects needing further elaboration, even independently from contracting. Subsequently he questioned a number of the aims and expected benefits. Next to the need for clarification of the assumptions and expectations, the problems that need addressing in Tanzania at this moment are: transparency, accountability including responsibilities and mutual trust. It is felt that the decentralization and the individual contract negotiation in fact form obstacles to adequate equitable contract that actually serve the health care improvements due to lack of views, criteria and skills. To strengthen the individual units and ensure that the common goals for health (not only services) improvements can be reached there is a need for development common views and agenda as well as skills at central and regional level of both Governmental and Non Governmental side. Trust is a precondition for collaboration and contracting. The churches are urged to stimulate this by being self critical and define their policy, role, code of conduct etc more clearly. In conclusion Dr. Nangawe strongly defended that the contractual approach should continue the Health for All strategy, recognition for and inclusion of the users in the process as well as the principle of equal partnerships.

Dr. Ger Steenbergen, Health Sector specialist of the Royal Netherlands Embassy, presented the views of a bilateral donor. He mainly explained the reasons for and form of the present policy changes at the level of bilateral donors. The Sector Wide Approaches (SWAp) for Health Development are meant to improve ownership of the program by all stakeholders in the country as well as improve the quality and sustainability of health care services and reduce donor dependency. It is hoped that the NGOs will obtain a larger role in the consultative meetings and subsequently in the actual implementation. He stressed that this approach in no way excludes contracting. His advice to the church health care providers was: ensure that there is a comparative advantage to working with and through you: ensure effectiveness and efficiency and/or take up services were none exist till now. But also make sure that you know and adapt to you clients / patients.

The questions put to him concerned the concept of 'basket funding', relation of SWAps with other donor policies like the debt relief, the 20/20 agreement for social services and specific programs. He explained that the policy is relatively new and thus details still need to be elaborated. Key criteria will be good governance, representation, accountability and equitable allocations to all sectors.

The participants then worked in country groups on the interests and obstacles to the contractual approach:

A. **Interests:**
   Some participants posed significant questions and each country enumerated a large variety of interests. Those mentioned most are:
   - increased possibilities for the government to realize its constitutional obligation of ensuring access to health care for all and for the churches to fulfil their moral obligation to the poor;
   - increasing accessibility for all and improving efficiency of services as well as efficient use of resources;
   - a framework for strengthening partnership between the parties involved in health care and rationalizing existing relationships;
   - encouraging civil society involvement;
   - increasing access to funds and institutionalization of government assistance to non governmental providers.

B. **Obstacles:**
   The obstacles listed by the country groups are numerous. The most important ones are:
   - the high vulnerability of health care funding to social, political and economical dynamics;
   - unequal information access combined with differences in understanding of the basic principles;
- lack of capacity and negotiating skills on all sides and at all levels combined with a lack of tools;
- absence of collaboration / co-ordination systems and institutionalized platforms for dialogue;
- lack of adequate mandates at the various church levels combined with a too strong wish for full autonomy;
- mutual mistrust and lack of transparency;
- lack of participation of the communities in policy making and decisions;
- concern that the government can withdraw more easily from its responsibilities;
- fear for commercialization of health care.

The factors already complicating effective collaboration are all there. Some represent exactly the reasons why MMI would want to promote the contractual approach. They all need very close attention and further elaboration in the theories, in the preparation process and practical implementation proposals.

It is surprising and raises some essential queries that in none of the lists the concept of ‘District Health System’ is mentioned?

4. The plan and draft text for the WHA resolution;

After a brief explanation by Dr. Edgar Widmer the participants discussed the plan and draft resolution text in their country group. The plan itself was not questioned. Some participants explicitly welcomed the idea. Some misunderstanding regarding the status of the text did confuse some persons and raised some questions regarding the actual influence their views could still have. The suggestions to improve the formulation ranged from adapting to the formal format of resolution, improving the logical flow, strengthening definitions to textual clarifications and additions to ensure understanding. In all groups the concern for equity and community participation surfaced clearly.

A lengthy discussion arose concerning the inclusion of the Private for Profit Health Care Providers in the resolution. To the reporters views, this discussion confirmed that there is a need for clearer profiling of the non governmental not for profit providers.(see part one and two) Also a clearer definition, that reflects that profile in such away that all stakeholders understand it in the same way, will have to be determined.

As the same question is bound to come up in the discussions with the governments, that are contacted to present the resolution, MMI will have to determine its position and arguments in this respect.

The proposal for mobilizing support in each country for the resolution differed per country but all rest on structural dialogue with the government. Uganda has already started as the UCMB was one of the organizations MMI discussed the idea with from the beginning.

5. The future: proposals for strategy outlines and phases approach to achieve equitable roles and/or contracts;

As first introduction to this group work, Dr. Jaap Koot, Public Health Consultant, put the aspect of quality on the agenda. The church health services usually present two leading principles for their involvement in health care: access for the poor and quality of services as well as management. Due to many factors the question can be asked if these principles are still realized. If the contractual approach is to succeed central and local governments will look for strong arguments to envisage contracts with non governmental institutions. Next to the ability to proved the full range of public services, quality is the best added value (competitive edge) these institutions can put to bear. Not to completely loose the head start the church health service need to under take deliberate efforts now. He advized to investigate and discuss the existing situation, develop indicators both for the actual care and for management performance, establish quality control mechanisms, develop an accreditation system and institute quality assurance and continuous improvement tools. As all these activities can not be realized at the level of individual unit level or at intermediate level, the national co-ordinating organizations should be enabled to lead and facilitate the process (new role). Last but not least he urged that, across the countries, the exchange of what is already being done is stimulated to avoid each inventing the wheel. It is here that organizations, like MMI should provide support.
Mrs. Theresa Obwaya, of CORA T Africa, presented the basic issues to be considered in developing strategies using the Task, Individual, Maintenance (TIM) concept. She also listed the important questions needing attention for the contractual approach strategy.

Each country group thereupon set out to develop a strategy for their situation. Each country’s proposal is specific and needs further elaboration. The issues and steps that return in all of them are:
- Internal reviews and re-organization to clarify views and principles, determine policy and adapt mandates at national and intermediate level;
- Ensuring the commitment of church leaders;
- Installation of structural platforms for dialogue between government and non governmental actors in health and preferably a specialized desk within the ministry;
- Capacity building;
- Trust building;
- Improving information exchange;
- Developing policy and legal framework;
- Developing accreditation systems.

During the discussion afterwards two important aspects were stressed. The process of elaboration should not be limited to the technical / professional staff: communication and dialogue with all stakeholders (from bishops to communities) is essential for success. The present lack of resources may prove to be a key obstacle.

6. The involvement of Coordinating Organizations in the WHO Afro Region NGO Liaison office.

Dr. Josas Kirigia, WHO Afro Region, explained the set up and objectives of the new NGO liaison office.

Dr. Kigadye, Director of CSSC, presented the actions undertaken in Tanzania, since the meeting in Dakar, to establish a NGO forum for Health that could liaise, in the name of all, with the WHO-Afro NGO office.

Both from Dr. Kirigia and Dr. Kigadye’s explanations it became apparent that matters are stalled at the moment. The reasons vary from difficulties to accommodate the office within the mandates of WHO (normally the contacts and actions have to be channeled through governments), to the lack of funds and the fact that the installation of the office is not widely known.

MMI clarified why this subject was added to the program: In view of improving collaboration between Government and Non Governmental providers in health care direct access of the non governmental providers to information, expertise and advocacy as well as a possibility to influence at WHO level can greatly strengthen the process. A liaison office at WHO-Afro could greatly facilitate this. However such an office should serve the non governmental organizations in the countries themselves. To ensure that this office supports these organizations according to their views and aims funding should come from them. It is for this reason that MMI declined to fund the office directly. MMI and its members are willing to contribute to the funding if the national coordinating offices request this.

Unfortunately the time for discussion was too short. A basic interest exists at the level of the coordinating offices. Direct access to information and expertise alone would be of assistance. This subject needs to be pursued with them.

Evaluative Conclusions:

The Partner Consultation was a relatively new approach for MMI and its members. The interest and high level of the participation, both formally and informally, of all the representatives confirmed that it is an approach that can contribute to stimulating development and exploring new avenues. Unanimously the evaluation reactions stressed this. The actual outcome and impact of such a consultation can be enhanced by a more careful planning and programming as well as facilitation.

With regards to the goal of the consultation ‘Updating Health Care Co-operation’ the outcome of the discussion provide MMI with a wealth of needs and options. For the further elaboration of the contractual approach the key issues are becoming more and more apparent. The
following priorities and steps, in which MMI can assist, were suggested or suggest themselves:
- A workshop with the church leaders. The main aims would be to enlist their commitment to the need and principles of government – non governmental collaboration and determining the necessary adaptations to mission statement, policy, organizational structure and mandates;
- Facilitation of the reformulation of mission statements, policy and strategies for the church health services;
- Investigating the present situation and developing expertise pertaining to all legal issues concerning non governmental institutions and future contracts (most institutions at present are not legal entities in their own right meaning that they could not be party in a contract!);
- Facilitating the installation of co-ordination platforms and/or liaison offices to institutionalize Government – Non Government dialogue;
- Develop example accreditation criteria and systems;
- Develop contract formats and checklists for the preparation and negotiation phase;
- Develop and provide training courses for the different levels;
- Facilitate exchange of information and experiences regarding quality improvement and assurance and where required assist / facilitate further development of indicators and instruments;
- Facilitate and assist in operational research for subjects that need to be clarified to enable government and church authorities to take correct decisions;
- Institute operational research regarding the contractual approach from the very beginning to ensure a process of learning while doing for all, as there is little evidence and experience that can be used.

An unexpected extra subject is the definition, objectives and functioning of the district health system. This seems to be less of a key issue for the participants as MMI thought. As we are of the opinion that, it is very valuable basis for organizing comprehensive services for a well defined population and thus for planning an collaboration, we might need to revive the issue.

Note of caution: Contracting alone cannot solve the important obstacles! The discussion regarding the obstacles proves the close relation between all the known health care problems, and the challenges or risks Ghana and Zambia cite all point to this need for caution and careful and extensive further elaboration. Or in other words: MMI and her members have a lot to do in the coming years!
Contracting NGOs for Health

Edgar Widmer

Having participated in the Partner Consultation, organised by Medicus Mundi International in Dar es Salaam on November 5-7, 1999, I try to summarise the following personal conclusions:

It is a fact that free market will not reach all people in need of health services, while it absorbs a good amount of the money available.

Nowadays Governments and NGOs agree that their health services are complementary and absolutely need optimal co-ordination.

How to improve „Health For All“ at district level by including those NG Health Care Institutions into the District Health System, which are of a Public Purpose and Not for Profit this was the question.

The criteria for Public Purpose Health Care Services are:

Accessibility for all people of a defined area in need of the level of care offered without discrimination in regards to race, gender, religion, social status or type of illness.

Contribution to the implementation of the national health policy, including the co-ordination with other institutions of the health system and the exchange of relevant information.

Services which aim to improve the health status of the communities with their active participation.

Not For Profit means that although an NG Health Care Institution aims at a balanced budget, no other alien lucrative gains are pursued.

Contracting between Government and NGOs can be a means for improving health service efficacy. In any case it is a result of a process, based on an institutionalised dialogue, where the partners become equal on the ground of shared ideals, trust, responsibility, accountability and transparency.

There are partners at national and local (district) level.

I. National NGO-Co-ordinating Body (f.e. Co-ordinating Agencies of Church related Health Services)
II. Ministry of Health, MOH.

III. Owner of the NG Health Care Institution. (Diocese, Bishop, Religious Congregation or others)
IV. District Health Management Team

Ad I. These National NGO co-ordinating bodies exist in most African countries. They have received support from International NGOs like Medicus Mundi. A loose network between them exists and needs to be strengthened. At the AFRO Regional Office of WHO they are not sufficiently represented and their real potentiality may be recognised by their very active participation and representation in the Consultations MMI has organised in Dar es Salaam and Conakry in the month of November 1999.
Ad II. The MOH in dialogue with NGOs, sets criteria and standards for quality of care, defines the teaching aims for health care workers and is responsible for the national health policy. Control can be reached by monitoring systems and adjustments and improvements may follow after regular evaluations. The MOH, while decentralising will have to build up capacity and know-how at district level.

Ad III. The owners of NG Health Care Institutions may profit for professional matters giving a mandate to the National NGO - Co-ordinating Offices, ex. concerning quality control, teaching standards and implementation of national health policy. The owners interest is to defend ethical standards, the “care for all men and the whole man”. They will aim at a balanced budget, through just allocation of money, reasonable fees and eventual donations. The owners will include into the board of their Institution representatives of the users and of the district authority. The board of the Institution will establish criteria for the employment of its staff. Accreditation systems for NG Health Care Institutions can be developed according to the technical capability and the quality of the services performed. Around 250 of these NG Health Care Institutions are local partners of the members of MMI.

Ad IV. The District Health Management Team may include representatives of the NG Health Care Institutions. They can together elaborate criteria for money allocation, the coverage of the catchment area, transports, supervision of the services and for the referral system. NGOs partnership with Government at national and local level and the relation of the local NG Institutions with the National NGO- Co-ordinating Bodies as well as the interaction on the Government’s side between MOH and the District, have to be clarified and improved. The success in collaboration depends on the human factor, the continuity of contacts and dialogue and the proper exchange of information. Real agreements and contracts will be the final product of this process.

The participants of the Dar es Salaam Consultation revised a draft for a WHO resolution to be proposed to their corresponding Governments. They agree that after the intervention of Medicus Mundi International at the Fifty-second World Health Assembly on „Contracting NGOs for Health“ their Governments should be encouraged to ask by the end of 1999 WHO to put the proposed resolution on the agenda of the Fifty-third World Health Assembly.
Extrait du rapport de mission en Guinée.

Jean Perrot and Patrick Berckmans

La mission qui a séjourné en Guinée du 06 au 13 novembre 1999 était composée de Mr. J. Perrot et du Dr. P. Berckmans, tous deux du Département OSD de l'OMS/HQ. La mission avait pour objectif principal de participer à la réunion interpays sur la contractualisation avec les ONG au niveau du district sanitaire organisée par Medicus Mundi International MMI.

La réunion de MMI

En ce qui concerne ce premier objectif, il convient de rappeler que l'approche contractuelle comme outil pour l'organisation des services de santé est un des axes de travail du Département OSD et qu'en conséquence un des thèmes de la réunion organisée par MMI s'inscrit entièrement dans le programme du Département OSD.

Par ailleurs, MMI a eu au cours des dernières années de très nombreux contacts avec l'OMS et plus particulièrement avec le Département OSD depuis la réorganisation de l'OMS. Ainsi, MMI a participé à la réunion qui s'est tenue au siège de l'OMS du 4 au 6 février 1998 et qui s'intitulait « Vers de nouveaux partenariats pour le développement de la santé dans les pays en voie de développement : l'approche contractuelle comme outil politique », puis à la réunion organisée par l'OMS et la Banque mondiale à Dakar "l'approche contractuelle comme outil de mise en œuvre des politiques nationales de santé dans les pays africains" en octobre 1998 .

MMI, avec l'appui technique du Département OSD, a également entrepris de sensibiliser les États membres de l'OMS à cette approche. Au cours de la dernière Assemblée mondiale de la Santé, MMI a invité les États membres à une réunion autour d'une brochure intitulée "Un contrat pour la santé" et est intervenue lors d'une session de l'Assemblée en tant qu'ONG ayant des rapports officiels avec l'OMS. Cette réunion a rassemblé de nombreux pays et a été conçue comme une première étape pour l'élaboration d'une résolution de l'Assemblée mondiale de l'OMS. Aujourd'hui, MMI a élaboré un projet de résolution; celui-ci est en discussion avec des États membres et nous avons apporté nos commentaires à ce projet.

La présente réunion s'inscrit dans la démarche entreprise par MMI, et l'OMS y apporte son appui. Cette réunion était organisée pour les pays francophones; une réunion similaire a été organisée pour les pays anglophones en Tanzanie au cours de la semaine du 01 au 06 novembre 1999. AFRO/DSD et HQ/OSD ont été invités à participer aux deux réunions; pour des raisons de disponibilités réciproques, OMS/HQ/OSD n'a participé qu'à la réunion en Guinée et OMS/AFRO/DSD n'a participé qu'à la réunion en Tanzanie. Néanmoins des contacts réguliers ont eu lieu entre ces deux entités.


Comme l'indique l'ordre du jour, cette réunion avait quatre thèmes à son ordre du jour:

- l'identité des coordinations sanitaires: les rôles des autorités ecclésiastiques dans la gestion et l'organisation des réseaux sanitaires des églises (formations sanitaires et coordination sanitaire). Cette session a permis de discuter tant des notions de délégation de pouvoir au sein de l'Eglise que de la responsabilité des autorités de l'Eglise dans le secteur de la santé;

- l'autonomie et l'autofinancement des structures de santé du secteur confessionnel;

- la création d'un réseau entre les coordinations sanitaires nationales du secteur confessionnel; le principe en a été retenu au cours de la réunion; l'OMS a affirmé sa
disponibilité à diffuser les documents produits par celle-ci et à inscrire cette instance parmi les récipients de documents;

- le partenariat basé sur l'approche contractuelle a fait l'objet de la session de l'après-midi du deuxième jour; la délégation de l'OMS a présenté d'une part les concepts et stratégies de l'approche contractuelle en s'appuyant sur les documents produits par l'OMS/HQ/OSD (documents qui ont été distribués aux participants) et d'autre part sur le document "Les arrangements contractuels entre les ONG et le MSP dans l'organisation des services de santé au niveau du district sanitaire", document préparé spécialement pour cette réunion par les membres de la mission. Les discussions ont été nombreuses et fructueuses; notamment, en ce qui concerne la participation des ONG, par ailleurs prestataires de services de santé, aux activités de l'Équipe cadre de district, sous une forme de co-responsabilité définie par contrat. Certaines délégations ont émis en outre le souhait de pouvoir aller plus loin dans cette approche. La mission leur a suggéré de prendre contact à la fois avec le Ministère de la Santé et la Représentation de l'OMS de leur pays pour étudier les voies et moyens de répondre à cette attente.

Par ailleurs, Medicus Mundi International a distribué aux participants le nouveau projet de résolution pour la prochaine Assemblée mondiale de l'OMS. Ce texte a ensuite été discuté par la mission en séance de travail avec le Dr T. Puls, de Medicus Mundi International.

Enfin, pour terminer sur ce thème, il a été évoqué informellement avec Medicus Mundi International l'éventualité de tenir une réunion spécifique sur l'approche contractuelle en Guinée. La coordination sanitaire guinéenne du secteur confessionnel devrait se rapprocher du Ministère de la Santé publique de sorte à en examiner l'intérêt et la faisabilité. Si une requête était formellement adressée par celui-ci à l'OMS, cette dernière serait prête à appuyer une telle réunion.
Steps towards better Efficacy of Health Care

Edgar Widmer

Health care for the prevention and promotion of health is one of the most basic human rights, but much ill-health is a result of poverty and in itself a serious barrier to breaking out of the bondage of poverty (Halifax 1977, Conference of the World Federation of Public Health Associations: "NGOs and PHC", a preparatory conference for Alma Ata). Therefore the overall development of society with social, economic, political and cultural activities and changes is needed. The call for solidarity and social justice is essential. "Reflecting the comprehensive call of the Gospel the Churches impel a concern for all people, especially the poorest members of society, to enable and empower them to play a direct role in the promotion and preservation of their own health and affirm that a people oriented concern by the Churches closely coincides with the objectives and approach of PHC". (Dodoma, 1985: "Tanzania Churches Consultation on PHC")

A seminar organised by Medicus Mundi International (MMI) and the Christian Medical Commission (CMC) of the World Council of Churches hosted by the Hospitaller Order of Saint John of God (Fatebenefratelli) in Rome, 1984 on "Strengthening Co-ordination of Health Activities by Local NGOs towards Health for All" assembled Co-ordinating Agencies of Church Related Health Services from many African countries. This seminar confirmed the consensus on the desirability of co-ordination between NGOs and Governments and suggested that one should move from simple collaboration and exchange of information to true agreements on common action at all levels, national, regional and local and that implementation of PHC needed urgently such an approach.

At that time the "District Health Concept" was not yet born. It was in 1987 that WHO organised the Harare Conference redefining the role of the peripheral hospitals in their district.

Many Church-bound hospitals fulfil the role as health care providers with public purpose and have a clearly defined ethical attitude of not for profit. But when the World Bank spoke of a "Better Health for Africa" (1992) and when the World Bank together with WHO invited "development partners" to a meeting in Dakar in 1998 discussing "The Contractual Approach as a Tool for the Implementation of National Health Policies in African Countries", the large not for profit NGO community was not included in the discussions. Their important role as development partners was not considered and not officially recognised, although they play a dominant role in many national health service networks. If contracting is being considered as a means of assuring better coverage of essential health care needs of the entire population, then at least it would be logical to consider the potential benefits of contracting those private organisations which have shown to have capacity, a commitment and a sustainability of their own and which endorse the same PHC objectives as proposed by the national health policy.

Therefore MMI has presented a statement to the World Health Assembly 1999 with the proposal to better integrate NGO hospitals into the District Health Concept by well-defined contracts and agreements. Such a statement could promote the issue of a resolution by the WHO. Of course such a resolution is only possible when Member-States endorse the subject. Therefore MMI hopes to get the support of those European Governments who have already links with its European branches as well as from those Governments of countries in which MMI co-operates with local partners. The Holy See may have an eminent interest to sustain such a statement in order to strengthen the many Church bound hospitals. It might use its diplomatic channels for such a support.

We remember that the Holy Father himself urged International Catholic Health Organisations to join WHO in its effort for Health for All when he spoke to the Vatican Conference in 1997 on "Church and Health in the World, Expectations and Hopes on the Threshold of the Year 2000". Dr Nakajima, the Secretary General of WHO on this same occasion explained how much the Church related health work is appreciated and that the world needs its holistic approach. "Unirsi per fare meglio" is the slogan.

In this context the Vatican issued a letter of recommendation in order to approach the National Episcopal Conferences to support the way of contracting by the local church related health care institutions.


Depuis longtemps, comme vous le savez, une réflexion est en cours dans le cadre des Organisations non gouvernementales opérant dans le domaine de la santé. Elle concerne non seulement la meilleure façon de remplir leur mission non lucrative en faveur de la "santé pour tous" mais aussi les voies et moyens adéquats en mesure de rendre efficace la collaboration avec les Institutions et organismes qui concourent notablement à l'amélioration des conditions de santé des populations dans la perspective d'un développement intégrale et durable.

La proposition de l'Organisation Medicus Mundi au titre significatif: Le contrat pour la santé, entend susciter une réflexion de la part des Etats et des ONG. Son intention est aussi de suggérer une stratégie dans le but d'obtenir une reconnaissance internationale des ONG sans but lucratif en passant par une simple collaboration et un échange d'informations à pacte pour actions en commun.

Comme l'a souligné l'un des protagonistes de l'initiative, le Dr Edgar Widmer, "l'importance de leur rôle comme partenaires pour le développement n'est pas tenu en considération ni reconnu officiellement nonobstant le poids non indifférent de leurs activités dans le réseau des services de santé nationaux. Du moment que, par le moyen des contrats, il est possible de mieux couvrir les besoins d'une population entière, il serait plus que logique de prendre aussi en considération ces organisations privées qui ont fait preuve de la validité de leur engagement, de leur efficacité et fiabilité, surtout en rapport avec des initiatives de pionniers en faveur des services de santé de base en conformité avec les objectifs de la politique nationale de la santé".

Il n'existe pas, du reste, une distinction claire entre le secteur public et le secteur non gouvernemental en dehors de leur appartenance institutionnelle ou non. En effet, beaucoup de services des ONG sont rendus avec une finalité publique et à des prix raisonnables.

Par conséquent, Medicus Mundi entend faire une Proposition de Déclaration à l'Assemblée Mondiale pour la Santé dans l'intention d'améliorer la réintégration entre hôpitaux et ONG dans le concept de "santé pour district" à travers les contrats et les accords bien définis. Une telle Déclaration devrait porter à une résolution de l'OMS. Celle-ci ne sera possible qu'avec le soutien des Etats membres.

Pour cela, je vous serais très reconnaissant si dans le cadre de la Fédération que vous présidez, vous faites connaître et soutenir l'initiative en question.

En vous disant ma profonde gratitude pour la suite que vous voudrez réserver à la présente, je vous prie, Monsieur le Président, de trouver ici l'expression de ma très haute estime.”

Signé: Monseiguer Javier Lozano B.

This might result in a positive co-operation from the side of the church at local level to reach the way of contracting.
¿Es posible la salud en medio de la pobreza?
Escenarios para el tercer milenio.

Imanol Apalategi
Nieves Zabala

"La pobreza es la enfermedad más mortal del mundo", esta dramática declaración que realizó el Sr. Nakajima (ex-Director General de la Organización Mundial de la Salud) nos sirvió para plantearnos la pregunta que dio título al curso de verano que, en colaboración con la Universidad del País Vasco, organizamos los días 2, 3 y 4 de septiembre de 1.999, “¿Es posible la salud en medio de la pobreza? Escenarios para el tercer milenio”.

Con motivo del 25 Aniversario de la fundación de la asociación de Medicus Mundi en Gipuzkoa, quisimos organizar un evento que permitiera crear un espacio para la reflexión alrededor de la pobreza y sus consecuencias. Hecho que motiva que muchas personas dediquemos nuestros esfuerzos a lograr un mundo mas justo y que permitió que, durante unos días, nos viéramos rodeados de los amigos de Medicus Mundi Internacional, de las asociaciones de Medicus Mundi en España y de otras asociaciones del estado español.

Es de agradecer la colaboración que las autoridades locales nos brindaron y que sirvió para dar mas realce a unos días que en Medicus Mundi Gipuzkoa serán recordados durante mucho tiempo. Los esfuerzos de mucha gente fueron recompensados con la presencia de tantos amigos y con el éxito de un curso que esperamos sirva para estimularnos a todos en la lucha por lograr un mundo mas justo y solidario.

Para la inauguración del curso contamos con la presencia del alcalde de la ciudad Sr. Odon Elorza, y con el Viceconsejero de Sanidad Sr. Guillermo López Vivanco. En la misma D. Miguel Angel Argal (Presidente de Medicus Mundi Internacional) ofreció una conferencia que, con alto contenido político, dio repaso a las causas y consecuencias del reparto injusto de la riqueza en este mundo.

Durante el curso tuvimos la participación de los miembros de Medicus Mundi Internacional como el Prof. D. Edgar Widmer que disertó acerca de “Alma-Ata y situación real de la salud en el Sur”, el Prof. D. Van Balen que lo hizo acerca de “Un contrato por la salud. La contractualización” y el Prof. Tom Puls que nos hablo de “Alternativas aplicables en África respecto a los modelos sanitarios actuales”.

También hicimos repaso al derecho a la salud como derecho individual o social (Prof. D. Andoni Ibarra), a la situación de la economía y sus repercusiones en las políticas sanitarias (Prof. D. Valpy Fitzgerald), así como a los valores éticos de la economía (Prof. D. Carlos Berzosa); a los modelos sanitarios en los países en vías de desarrollo (Prof. D. Eugenio Villar), a las alternativas en América Latina (Prof. D. Oscar Lanza); y finalmente hablamos de temas concretos como la relación de la salud reproductiva (Prof. Dª. Cynthya Indriso) y la desnutrición (Prof. Dª. Mercedes de Onis) con el desarrollo económico sostenible, así como la realidad y alternativas de la deuda externa de los Países del Sur (Prof. D. Jaime Atienza).

Finalizo el curso con las conclusiones que realizó el Prof. Alfons Sancho, miembro de Medicus Mundi y Presidente de la Coordinadora de Organizaciones No Gubernamentales de Desarrollo de España, que resumidamente son las siguientes:

Conclusiones Generales

- Hay evidencia de mejoras en la salud en los países pobres, pero en los últimos años se ha incrementado el número de países en los que la situación ha empeorado. Además la brecha Norte – Sur se está ensanchando, se han incrementado las mafias y, contrariamente a la deseable redistribución de la riqueza, las grandes fortunas se están concentrando en pocas manos.
La pobreza no es un término exclusivamente económico (un dólar / día / persona), sino que incluye la falta de capacidad de acceso a diferentes servicios y de la oportunidad de tomar parte en las decisiones que afectan a la comunidad.

Hay que pasar de defender el derecho a la salud de forma genérica (ya que en algunas sociedades es un término vacío) a concretarlo en la resolución de necesidades específicas, y ver las condiciones que son indispensables para que se resuelvan estas necesidades.

Es una realidad que el sistema de mercado es el modelo actual imperante y que las tendencias a la globalización son imparables, pero eso no es motivo para que no se actúe con el fin de:

✔ Conseguir que la globalización no sea solo de mercados, sino también de personas y necesidades.

✔ Impulsar un marco ético en las relaciones comerciales y financieras internacionales.

✔ Proponer medidas para evitar las desigualdades que genera el mercado, y evitar que las instituciones internacionales se preocupen exclusivamente del comercio.

✔ Crear instrumentos mundiales de redistribución de la riqueza: medidas fiscales a nivel internacional, impuestos sobre las transacciones financieras, inversión de beneficios en el país que se generan, tasas sobre los vuelos internacionales, etc.

Conclusiones sobre Salud

✔ La salud y la pobreza son fenómenos multidimensionales. La salud es necesaria para salir de la pobreza y la mejora de las condiciones de vida favorecerán una buena salud

✔ Aunque ALMA-ATA fue un hito importante y la participación de los países pobres fue fundamental para la definición de estrategias, hay una fuerte regresión de los principios allí declarados:
  * el sistema de salud se centra en la enfermedad y en el hospital,
  * existe un fuerte tecnoocratismo,
  * la accesibilidad es limitada,
  * el sistema se centra en los profesionales olvidando los derechos de la ciudadanía,
  * se está produciendo una disminución de la financiación pública,
  * la asignación de recursos no se realiza en base a las necesidades sino para favorecer aquellas técnicas que generan beneficios comerciales y
  * el sistema no es sostenible económicamente ya que los países tienen poco P.I.B. (Producto Interior Bruto) y el porcentaje dedicado a la salud es mínimo.

✔ La situación de estos países se complica debido a que hay un cambio en el patrón de enfermedades y junto a las enfermedades infecciosas están apareciendo las crónicas (epidemiología cruzada), hay una cambio en la pirámide de edad caracterizado por un mayor envejecimiento de la población y están disminuyendo las redes de solidaridad tanto familiares como comunitarias

✔ Ante esta situación debemos retomar los principios y estrategias de la Atención Primaria de Salud (A.P.S.) y Salud para Todos (S.P.T.), defendiendo a la salud como un bien social y no como una mercancía, y potenciando la presión social para conseguir un incremento de la financiación pública.

✔ Los servicios de salud deben dar respuesta a las necesidades de la población, sobre todo de aquella más desfavorecida, y elaborar estrategias para conseguir el acceso al poder (empoderamiento) de las mujeres, pobres, y otros grupos fundamentales como actores del desarrollo. Para conseguir todo esto es indispensable la construcción de alianzas.
• Es fundamental conseguir compromisos políticos claros, que se reflejen en una adecuada asignación de recursos y donde sea básica la participación comunitaria en todo el proceso (desde la identificación a la ejecución y evaluación) con capacidad de decisión.

• Preocuparse por la mejora del nivel de salud significa preocuparse por la nutrición, la salud reproductiva, la educación, la correcta asignación de recursos, el trabajo, el buen gobierno, la democracia y los derechos humanos y también (fundamentalmente en África) por la Paz.

• Las organizaciones de cooperación han de potenciar el papel del Estado apoyando los sistemas de salud existentes (y no creando sistemas paralelos) mediante estrategias que privilegien la formación y el asesoramiento técnico.

• Es fundamental colaborar en la definición del papel del Estado como regulador, planificador y evaluador, separando estas funciones de las de provisión de servicios que podrán ser ejecutadas por instituciones públicas o privadas sin ánimo de lucro.

• El distrito sanitario (sistema local de salud) continua configurándose como la unidad básica del sistema de salud, procurando integrar a todas aquellas instituciones que trabajan en el territorio y así, aprovechar recursos y evitar duplicidades consiguiendo una actuación armónica, eficiente, equitativa y de calidad.

• En todo este proceso de optimización de los servicios por medio de la concertación de diferentes proveedores, siguiendo la estrategia de "un contrato por la Salud " de Medicus Mundi Internacional, es fundamental:
  ∗ una descentralización bien realizada (con recursos y capacidades),
  ∗ la democratización de los poderes públicos,
  ∗ la participación de la ciudadanía y
  ∗ el fortalecimiento de las organizaciones e instituciones locales.

**Conclusiones sobre Cooperación**

• Se debe realizar un análisis y autocrítica de la acción de las ONGDs para poder continuar desarrollando sus acciones acertadas y evitar que sus acciones erróneas se puedan convertir en un freno para el desarrollo.

• Se pueden hacer muchas cosas sin dinero. No todo depende del incremento de recursos económicos.

• De todas formas, los recursos económicos existen, pero su utilización depende de decisiones políticas, aunque nos quieran hacer creer que no se puede cambiar su asignación por motivos técnicos.

• Con los fondos de cooperación se debe invertir en necesidades sociales básicas y en los países más pobres.

• Junto a las medidas económicas siempre se deben tomar medidas sociales. Cuando se propongan medidas de ajuste estructural hay que impedir que se disminuya el gasto en salud.

• Hay que proponer medidas que se lleven a cabo aquí (p. ej. es absurdo proponer disminución del gasto en salud cuando en los países industrializados se aumenta), pero al mismo tiempo hay que aprender de nuestro proceso histórico para examinar que factores contribuyeron al desarrollo de los países occidentales y ver si son aplicables en otros contextos históricos.

• Hay que continuar reivindicando el 0,7 %, impedir que se disminuyan los fondos de cooperación y conseguir que estos fondos se utilicen correctamente.
Hay que trabajar en nuevas alternativas como las propuestas del PNUD (1994) referidas a la Tasa TOBIN, campañas como la de “dividends por la Paz” y comercio justo entre otras. Mencionaremos de forma especial la campaña de deuda externa con la que debemos conseguir el compromiso de los gobiernos para condonar una amplia proporción de dicha deuda y la inmediata inversión de esos recursos en el desarrollo humano de su población así como el establecimiento de mecanismos que eviten nuevamente este endeudamiento.

Un papel muy importante a desarrollar, tanto a nivel individual como a través de las organizaciones, es el de la presión social (LOBBY) y la denuncia en el Norte y en el Sur. Hay múltiples experiencias que demuestran la fuerza de la población.

Y por último, debemos ser conscientes de que el SUR no es una unidad, sino que es múltiple y diverso y por tanto, nuestras actuaciones deben ser también múltiples y diversas.

Tenemos que ser pragmáticos, pero al mismo tiempo perseguir la utopía. Nos acercaremos a la utopía y esta se alejará, nos seguiremos acercando y ésta se alejará de nuevo. ¿para que nos sirve, entonces, la utopía? Nos sirve para avanzar.

Para finalizar, los directores del curso deseamos agradecer a los miembros de la comisión que estuvo preparando el curso durante tantos meses por no desfallecer en el intento, a los voluntarios, tanto de Medicus Mundi en Gipuzkoa como de otras organizaciones, por que sin su ayuda no hubiéramos tenido el éxito que la evaluación que los Cursos de Verano de la Universidad del País Vasco ha objetivado, a los miembros de Medicus Mundi de Suiza, Alemania, Italia, Holanda, Polonia por su presencia y apoyo, y a los socios y colaboradores del resto del estado que se acercaron esos días para compartir con nosotros su tiempo e inquietudes.
Dear Sir/Madam,

As per 1 January 2000 there will be a merger between the Dutch Catholic development organizations Bilance, Caritas Netherlands and Memisa into one new organization: CORDAID (Catholic Organization for Relief and Development). From this date CORDAID will operate from Lutherse Burgwal 10 in The Hague. Please find our new address and telephone number on our enclosed change of address card.

The Catholic development organization CORDAID is a pooling of powers from the organizations which you already know by the names of Bilance, Caritas Netherlands and Memisa. By clustering various expertises into one organization the merger aims at improving the quality of development programs, enhancing the effectiveness of the work of the partner organizations in Southern, Central and Eastern Europe and strengthening the position and role of Catholic development co-operation in Dutch society and politics.

As a Catholic development organization inspired by the Gospel and the Catholic-social doctrine, CORDAID is dedicated to the improvement of living conditions of the poorest and most vulnerable groups. In carrying out education, lobbying and fund raising for projects of the annual Episcopal Lenten Fund Raising Appeal CORDAID also wishes to express the solidarity of the Catholic supporters in the Netherlands with the deacon work of overseas churches.

CORDAID considers trust in the personal strength of people, direct support and a society in which people can participate in important decisions about their future and that of their children as a red thread for its vision on development co-operation. This presumes a connection with what is regarded as important here in the Netherlands and lobbying and advocacy being shaped by mutual priorities.

CORDAID thinks that building up of society over there should take place as a force and counter force, where contacts with politics here are vital links for the carrying out of the development policy of the Netherlands as a whole.

In short, the merger is in line with changing external social, political and ecclesiastical circumstances in The Netherlands and partner organizations overseas. The Dutch society demands increasingly visible and tangible results in development organization. More emphasis on a business approach demands another finalization of international solidarity. In addition, partner organizations are becoming more critical and independent and wish to be more self-reliant. This requires open communication, two-way traffic, flexibility, being alert and being oriented towards the partner. Apart from this, involvement, warmth, passion for the work and creativity remain essential for CORDAID's work and for its relation with partner organizations. CORDAID wishes to improve the quality of its work continuously and to learn from partners and personal experience.

The result of the merger is an organization with knowledge in all fields and representing all aspects of development co-operation: emergency aid, the war on structural poverty and building up healthcare in developing countries. All this not only means a change for CORDAID's staff but also for you. From 1 January 2000 you will only deal with one organization and contact. This enhances accessibility, effectiveness in contacts and policy consistency. You will encounter new postal, fax and E-mail addresses and new telephone numbers. The visiting address will change and in a number of cases also the person whom you dealt with until now. A summary of the composition of the XXX team is included. However, nothing changes with respect to the manner of co-operation and the expert input of our staff. On the contrary, CORDAID is meant to broaden and deepen this co-operation.

In the month of December the three organizations will move from Rotterdam (Memisa), Den Bosch (Mensen in Nood) and Oegstgeest (Bilance) to The Hague. From January onwards everyone will be working under the name of CORDAID at this new address. This is quite an operation and has temporary consequences for the accessibility of the organization. Because 440 CORDAID is going to change over to an integrated computer system, the computers will also be temporarily out of order. This may cause a temporary delay for the processing of project applications, responses to financial and specific reports and dealing with payments. CORDAID hopes you will understand. In practice this means that you will not receive any payment from CORDAID in the period from 9 December to mid January 2000. We would be grateful if you could be patient and only contact us preferably by E-mail or fax if you have received no payment by 1 February.
Most of you have already heard about the most important points of the merger during official travels by colleagues or by visits to them. Nevertheless, we thought it proper to inform you once again by this letter. We hope we have given you sufficient information. Obviously any response is always welcome.

With kind regards,

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