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**Introductory**

Since the foundation of Medicus Mundi training and education of local people has been one of the core activities. Many schools for recognised qualified A- and B-Nurses, Medical Aids, and Medical Assistants appeared on the hospital premises. It was called ‘autochthonization’. Slowly the output of qualified health personnel has in many countries reached nearly the national demand. One should say that the problem of scarcity has been solved by now. But not at all. Due to so many other factors as just schooling, the need for the right person on the right place is still high. Now this is called Human Resources Development. In the wide scale of HRD subjects, Medicus Mundi considers her responsibility to focus on the basic health services. HRD related to this sector will become a spearhead for action. The first article a gives further introduction to the considerations of the Board. Brain drain is part of the problem. The BMJ published recently an editorial on brain drain which is with respect copied from internet. The following article shows how our co-ordinating partner in Uganda, UCMB, deals with HRD in the field. Good stewardship appears to be essential.

The Johannesburg conference is just behind us. A lot of attendants talked about a lot of subjects. What will be the real output? A special implementation conference on “Stakeholder action for our common future” was attended by Dr Nick Lorenz of the Basel Tropical Institute and president of Medicus Mundi Switzerland. We are happy to give his comments and part of the official initial report.

In the last Newsletter Dr Venneman gave a convincing lecture on Health, wealth and Aids, showing the strong relationship between saving lives (by mass-treatment) and economic growth. As a follow-up we give the results of the December meeting of the WHO Commission on Macroeconomics and Health: Investment in “Global Health Will Save 8 Million Lives a Year”.

Contracting between NGO Health Institutions and health authorities at regional/district level keeps the Board busy. Unfortunately the expected official Resolution on contracting of the World Health Assembly 2002 was postponed to 2003. The guidelines for contracting, performed under the responsibility of Medicus Mundi, are in a final stage for publication. In the meantime Dr Widmer gives a scope of contractual arrangements and positions in the history of MMI. In a wider scope, not directly related to the district/regional level, WHO has intensified the public-private interactions for health. The Note by the WHO Director-General gives a sort code of conduct. Also the relations with the private sector including International NGO's like MMI are reconsidered in order to intensify the Cupertino. The relationship will have new rules and got a new name: Civil Society Initiative.

But what is in a name? Carefully and critically we have to follow this change. The danger of a hegemony of private consortia within WHO is not unrealistic. International NGO platforms like Forum for Health and Peoples Health Assembly can and will watch and give alarm in due time.

We wish and hope so.

*Sake Rypkema*
Human Resources Development

A continuous concern of Medicus Mundi

Human resources development has been among the key issues pursued since the foundation of Medicus Mundi and for most of its National members, to contribute to the overall sustainability of the healthcare programmes and institutions supported.

The object of most of the technical assistance was precisely the transfer of know-how and each of the many volunteers posted was implicitly or explicitly instructed to make him/her self redundant within the contract period by working on local capacity building. The provision of training and/or enhancement of local recruitment efforts plus systematic improvement of the working environment for local qualified staff, were among the main strategies applied to promote local human resources development.

Undoubtedly this policy, pursued in conjunction with so many other partners, has been successful in most of the developing countries and led to the phasing out of missionary and volunteer workers in many paramedical functions and their replacement by local workers with relevant diploma’s.

However it had been noted already, that among the higher educated medical staff, particularly when trained by medical schools in developed countries, there was a strong tendency not to return to the country of origin or to emigrate some time afterwards. Africa has thus provided far more personnel assistance to Europe than vice versa. There are more doctors of Benin origin working in Paris alone than in the whole country of Benin. India and the Philippines are among the main suppliers of doctors and state registered nurses of the USA and the UK. Doctors of Zambia, of the DRC (ex-Zaire) and even from Liberia and Sierra Leone can be found in South Africa, while highly qualified people from the latter country tend to migrate to Australia, to New Zealand, to the USA or to European countries.

Recruitment of local staff to make expatriate staff redundant is frustrated by a growing gap between supply and demand.

Increasing the output of training institutions, unless accompanied by measures to enhance the likelihood of qualified staff to stay in jobs in their country of origin, may only lead to increased losses of trained staff and not to a reduction of the gap.

Three additional developments tend to enlarge this gap even more:

- The considerable increase in the economic gap between the rich countries in the North and the poorest developing countries all too often combined with actual or menacing civil strife in those countries
- The ambitious new emphasis placed e.g. by the Global Fund and even more so in PRSP formulation on Healthcare investment as a viable strategy to boost economic growth. This in turn increases the burden on available staff and leads to an increased demand for highly qualified staff.
- The evolution of the HIV/AIDS epidemic and its impact on medical staff: Not only the sheer numbers of incurable patients to be confronted every day, tend to affect their motivation to a point where many even decide to quit the profession. Moreover a staggering percentage (above average cp. to general adult population) of the medical staff got infected themselves! The attrition rate is rising to a level unheard of in any other profession.

With a more or less stable output of new trainees, HRD now appears to lead merely to a battle against odds in most of the developing countries, particularly in Africa.

Given the fundamental contextual changes mentioned above, there is little to be expected from just continuing (even much more vigorously) the traditional practice of systematic transfer of know-how at work floor level, combined with investment in schools and in bursaries to win this uphill battle in the long run. Innovative approaches to HRD have been devised in many places to achieve more effective and viable strategies for HRD. They may apply only to a specific context, but some might be applied more generally, if only adjusted to the local setting.

Of peculiar interest, moreover for a sector in which decentralisation and privatisation are in full swing, is the evolution in the relationship between the qualified staff and the local employers (institutional authority) and the consequences in terms of

- Career planning
Participatory management
- Possibilities for ongoing education in line with both personal aspirations and with institutional development needs.
- Retirement benefits
- Fringe benefits and other additional terms of employment.

Clearly HRD, especially within the healthcare context and with a focus on its highly skilled manpower, cannot be envisaged successfully in isolation by each employer, neither on a regional or even national level. Both the employers and the individual diploma holders need to take into account the many complex aspects and complicating factors, even international trends, which influence the expectations and the decisions of qualified staff in planning their moves and their career.

Dr Guy Kegels of the Tropical Institute of Antwerp and president of Medicus Mundi Belgium, analyses the complex problem as follows:

"Accessible healthcare of acceptable quality is entirely dependent on the supply side; i.e. it depends on health care personnel that is (i) available, (ii) competent and (iii) motivated. In each of these areas there are significant insufficiencies, as well at the level of central policy making and implementation as at the level of middle management and of the operational clinical level of individual patient management.

In the area of availability there is the problem of the mobility and migration of skilled personnel in, between and out of developing countries, which is often quite serious, especially in Subsaharan Africa. This is a more complex problem, however, than the simple ‘brain drain’ terminology - popular in the sixties, and brought forward again by UNDP in the recent Human Development Report 2001 - may suggest. The present climate of globalisation, the spirit of the times and the evolutions in the concept of individual human rights force us to approach this problem in a more detailed and pragmatic way. This will require adapted conceptual frames and models, supported by a more accurate description of the phenomenon; the quality of the currently available information on migration flows of the highly skilled is quite questionable. Furthermore, still in the area of availability, the AIDS epidemic has an ever more important impact on the functional presence of health personnel that has not yet been adequately assessed, let alone understood in terms of consequences and possible solutions.

In the areas of competence and motivation (in practice both are usually strongly linked) there is a huge need for more and better knowledge and understanding. Competence includes the entire area of ‘capacity building’, covering i.a. decent stewardship, systems management capacity, the quality of clinical decision making and the individual management of good quality health care. Although this problem area is certainly not restricted to developing countries, it remains for them a crucial and often pressing problem. The identification and testing of adapted and efficient strategies for strengthening the operational capacities, at all the levels mentioned above, is therefore an extremely relevant challenge.

Concerning the problem of motivation, the number of unanswered questions is even greater. Operational health care personnel is situated in a separate segment of the labour market (service delivery), and moreover in a very specific segment of the so-called ‘professional’ service delivery. The classical financial motivation mechanisms for inducing good quality work, therefore, certainly important, clearly need to be complemented with other types of incentives, disincentives and inducements. It is in this matter important to understand better in order to formulate and implement better steering policies. Comparative description of both public and non-governmental systems, for profit or not for profit, can lead to important and fruitful insights."

MMI has committed itself to renewed action in the field of HRD, to increase the exchange of “best practice” information between its members and partner organisations as well as with relevant International organisations and local Governments to further enhance the impact and sustainability of Primary Healthcare development. MMI will continue to foster its official liaison with WHO particularly as regards HRD. Close collaboration will be sought in the promotion of HRD with affiliated technical institutes for Tropical Health and Hygiene and in particular with the ITG in Antwerp. Being aware of the increasing interest shown by Worldbank as well as the EU in furthering HRD and in response to the challenge put by them before the Board of MMI to become more active in this field, possibilities for practical collaboration in this field have to be explored and to be realised as soon as possible.
In the Internet edition of BMJ of 2 march 2002 WHO Tikki Pang et al. published an editorial on “Brain drain and health professionals” which is actualizing HRD. See next article.

Sake Rypkema
Brain drain and health professionals
A global problem needs global solutions

Migration of medical professionals from developing countries has become a major concern. This brain drain worsens the already depleted healthcare resources in poor countries and widens the gap in health inequities worldwide. It is time that international organizations collaborated to protect the value of this “intellectual property”: where medical professionals cannot be dissuaded from moving, the country that trained them should at least gain from their movement.

In Africa alone, where health needs and problems are greatest, around 23 000 qualified academic professionals emigrate annually (1). Information from South African medical schools suggests that a third to a half of its graduates emigrate to the developed world (2). The loss of nurses has been even more extreme—for example, more than 150 000 Filipino nurses (3) and 18 000 Zimbabwean nurses (4) work abroad. A recent report from the United Kingdom estimated that 31% of its doctors and 13% of its nurses are born overseas; in London the figures are 23% and 47% respectively (5).

These reported figures are likely to be underestimates as many migrate unofficially.

The cost implications are significant. With 600 of its medical graduates registered in New Zealand, the financial cost to South Africa was estimated at $37m (6).

The United Nations Commission for Trade and Development has estimated that each migrating African professional represents a loss of $184 000 to Africa (7). Paradoxically, Africa spends $4 billion a year on the salaries of 100 000 foreign experts (8).

In an example of brain drain within the country, Kenya estimates that only 600 doctors work in public hospitals out of more than 5000 registered (9); the rest have moved abroad or are working in the private sector. “Brain waste” also occurs when health workers end up working outside the health sector or as unskilled labour in the country they move to. Some benefits may also result for the exporting country. These include substantial financial remittances from expatriates, improved training, and long term professional networks. The adverse effects, however, are likely to predominate.

What factors influence medical professionals to emigrate? Key reasons include poor remuneration, bad working conditions, an oppressive political climate, persecution of intellectuals, and discrimination. Researchers cite lack of funding, poor facilities, limited career structures, and poor intellectual stimulation as important reasons for dissatisfaction. Other key reasons for emigrating are personal ones. These include security, the threat of violence (10), and the wish to provide a good education for their children.

Some countries which have shown the foresight and commitment to improve domestic conditions have succeeded in effecting a brain gain by attracting back medical professionals. Thailand and Ireland have reverse brain drain programmes offering generous research funding and monetary incentives as well as services and assistance. Developing countries need to address the structural, political, and economic problems that lead to the brain drain. Possible solutions include demanding compensation from departing professionals; delaying their departure through compulsory service; increasing salaries in the public health sector; permitting health professionals in the public sector to do some private practice; providing educational benefits for their children; and training paramedics who can fulfil many of the roles of doctors but whose qualifications are not recognised outside the country. They must aim to provide a stimulating environment for professional growth with adequate funding, facilities, and a vibrant intellectual community.

Funding agencies should put more resources into improving the conditions and training for health care professionals and researchers in low-income countries. Importantly, when such training is provided abroad it should be relevant and applicable to the problems of the country of origin so that the difficulties and frustrations experienced by those returning to a poorer environment are minimised.

On their part, developed countries should think of the impact of brain drain on health care in poorer countries and consider reimbursing these countries for the cost of training the health professionals they import. They need bilateral agreements with these countries and a recruiting process that would minimise the adverse effects on the health care of the exporting countries. The recently published guidelines by the UK Department of Health (11) address the ethical issues involved in the international recruitment of nurses and doctors. They recognise that old practices of recruitment without regard to the negative impacts in the country of origin are no longer acceptable. Clearly, we need better evidence on the extent of the problem of brain drain, its impact on both countries, and the effectiveness of measures to deal with it.
What part should international organisations play, given the global nature of the brain drain? Just as intellectual property rights need to be discussed by developed and developing countries together, so also should the preservation of the intellectual property of a nation, embodied in its health professionals, be addressed by international organisations. The World Health Organization could convene a forum of governments and international organisations such as the International Organization for Migration, the United Nations Educational, Scientific, and Cultural Organization, the United Nations Development Programme, the World Bank, the World Medical Association, and the Council of International Organizations of Medical Societies. They could agree on a declaration and an international code of ethical guidelines (12), keeping in mind the harm that migration of medical professionals may cause. Currently the office of the Pan American Health Organization is working closely with interested stakeholders and member countries on a programme of managed migration of nurses in the Caribbean, traditionally a major source for recruiters. A global perspective, agreed ethical principles between countries, and a systematic approach using the convening power of international organizations should be the way to address the problem of brain drain.

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HRD at the level of Diocesan Health Co-ordination

_Uganda Churches Health Services are well integrated in the Uganda National Health System. The Catholic Medical Bureau with her network of health institutions at diocesan (district) level endeavours to stratify her basic services with national policies of affordable primary care. Spirit and motivation besides professional knowledge look to be the key of success._

We quote from the Newsletter of the Uganda RC Medical Bureau June 2002:

Last year the UCMB commissioned a study on the effectiveness of the diocesan health Co-ordination to the Department of Health Services Management of Uganda Martyrs' University. When the results of this study were presented some co-ordinators took it to be a criticism of their performance. It is instead necessary to place the study in its right context and to consider the note of caution the team of researches has expressed:

"We would like to make it perfectly clear that our criticisms are not meant to hit the individual Co-ordinators. In most cases, given their working conditions, they could hardly do better. Without the necessary requirements, without means of work, without the necessary continuous support, the level of performance is not surprising. It is the overall system that comes under scrutiny and criticisms, not the single individuals. We would request the readers of the Report to keep this important point in mind."

The gist of the study's findings is the following:

Only few Dioceses have a health co-ordinator that is up to the needs. In Dioceses where the co-ordination is effective the key factors identified are:

1. Personal characteristics of the co-ordinator: strongly proactive attitude, very good communication skills, strong commitment, ability to learn, deep motivation, knowledge and competence.
2. Strong and visible support by the bishop
3. Significant level of external financial support: one should underline that the characteristics listed under point 1 are the basis to get external support.
4. Clear understanding of the role and the objectives of their work
5. Academic qualifications

Although the creation of Provincial co-ordinating bodies may be aimed at, the study indicated that first and foremost the main road to follow is that of continuing the slow work of strengthening the existing co-ordination. For this the study adopted the suggestions concerning the profile of the co-ordinators, namely people with:

- At least five years practical experience in public health services management
- A diploma in public health or health services management
- A detailed knowledge of the Uganda Health System and its most recent policy developments
- A good knowledge of the current global trends in Health Sector Reforms.
- Very good oral and written communication skills
- Computer literacy

and having the following attitudes:

- Share the values expressed in the "Mission Statement and Policy of the Catholic Health Services of Uganda"
- Have a high degree of maturity in dealing with others
- Be able and willing to work as a member of a team
- Be ready and willing to work long hours
- Be able and ready to assist, help and guide the Health Units personnel
- Have a strongly proactive attitude towards self-development, personal growth and the enrichment of their own professional activity.

The study also requested the Executive secretary of UCMB to present the following recommendations to the Bishops Conference:

- take notice of the job-description and profile of the Diocesan Health Co-ordinator
- study the Study-report
- check the status of appointment of current co-ordinators and check their qualifications- if not adequate consider substitution or further training
- consider request of kick start funds once the right person has been identified
- solicit/commit other funds

Background and organisation of the meeting

The Stakeholder Forum for our common Future (formerly UNED1 Forum) is a UK-registered NGO. It is a network and high profile forum on sustainable development, which has promoted outcomes from the first Earth Summit in 1992 and since 1998 has been working on preparations for the Earth Summit 2002. It is recognised as one of the leading driving forces of multi-stakeholder interaction. The Implementation Conference: Stakeholder Action for our common Future was held in the context of the Earth Summit in Johannesburg and understood itself

The meeting was financially supported by numerous funding agencies like the World Bank, the Dutch, the Finnish and German Government, USAID, but also by numerous multinationals. As for the health sector it is worthwhile to note that Novartis, and Novo Nordisk participated financially.

Eventually some 500 participants were brought together, reflecting the mix of funding agencies and institutions. However, there was also quite a strong participation from developing countries.

Content of the meeting

The purpose of the meeting was to inspire stakeholders "to create collectively, clear, measurable on-going action to deliver the Sustainable Development Agreements and the desired outcome were to be concrete, agreed and owned collaborative actions plans aimed at implementing the Sustainable Development Agreements in four specific areas: Freshwater, Food Security, Sustainable Energy and Health". These areas broken down into subgroups which are presented in table 1. The idea was to funnel the results of the forum into the World Summit.

The opening audience was addressed by the Secretary General of the World Summit, Nitin Desai. The only bilateral representative, who got an opportunity to address the plenary was John F. Turner, Assistant Secretary of State, and head of the US-mission to the Johannesburg Summit until the arrival of the Secretary of Foreign Affairs Colin Powell. However, his speech was poorly prepared and consisted basically in praising the US-efforts to address global problems. Being a (quote) "rancher", Turner mentioned that the US will address during the summit issues related to forestry, energy and food security. He did not mention health as a priority area for future support of the US government to countries with limited resources. Apart from a few Bush-like lapses like "here in Congo", when talking about him being in Johannesburg, the speech did not offer any new or encouraging insight into future policies of the Bush administration.

Four areas were discussed by the participants in respective groups. The selection of these subgroups was partly prepared but also driven by opportunities. Partly the workshops focussed also on very specific issues, like the discussion and presentation of partnerships like the Angola-Shetland Exchange. It corresponded to the set objective of the forum to bring together different levels of stakeholders.

Table 1. Subgroups of working areas

<table>
<thead>
<tr>
<th>Freshwater</th>
<th>Sustainable Energy</th>
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<tr>
<td>Water/Sanitation Supply Strategies</td>
<td>Solar Best Practice</td>
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<tr>
<td>Water Wise Campaign</td>
<td>Micro-Hydor/Biomass</td>
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<tr>
<td>IWRM Gender Mainstreaming</td>
<td>Assessing Best Practice</td>
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<tr>
<td>Local Government Capacity-building</td>
<td>Angola Shetland Exchange</td>
</tr>
<tr>
<td>Limpopo Water &amp; Health</td>
<td>Global Eco-village</td>
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<tr>
<td>Rainwater Harvesting Collective</td>
<td>Global Village Energy Partnership</td>
</tr>
<tr>
<td>Strengthening the Public Sector</td>
<td></td>
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</tbody>
</table>
Food Security | Health
---|---
- Eco-Agriculture | - Aids in the Workplace
- Agricultural Media Capacity-Building | - North-South Research Partnerships
- Research Partnerships | - Migration of Health Care Workers
- SME Development | - Nutrition
- Secure Access to Land | - Malaria
- Capacity Building for Sustainable Agriculture | - Media for Development

Two days had been allocated for the discussion of the above mentioned topics in small groups consisting of between 10 and 30 participants. Each group had a facilitator employed by the Stakeholder Forum for the event. The idea was to come up with ideas for implementing strategies, commitment for action by the necessary stakeholders and to clear immediate steps that need to be taken. Ideally it was expected to develop concrete action plans. This was clearly a too ambitious objective. Nevertheless it was possible to achieve comparatively concrete ideas for actions. The concise preliminary report on the meeting, established by the organisers is attached to this report.

The Swiss input concerned the North-South Research partnership, primarily in the health sector. The set-up of the project was in its conception phase obviously driven by Novartis, which presented its plans to establish in Singapore a research centre - and certainly intended to use the forum as a PR-tool for the company's commitment to sustainable development and partnership. Acknowledging that this approach is very specific to the Singapore setting and cannot be replicated in most other settings, the working group changed the title to Promotion of Partnership in Research for sustainable development, highlighting that there is also an important aspect. The example of the KFPE was presented and received much favourable attention.

The workshop N-S-partnerships in research generated the following outcomes:

- To promote a Code of Conduct (including guidelines) for partnerships in health research; and to identify best practice in research partnership implementation (eg. Swiss / Tanzanian programme);
- To elaborate guidelines for partnership in research
- Identify best practice of partnership in research; for example the Medicines for malaria venture or the European Developing Countries Clinical Trials Partnership
- To advocate good practice in implementing guidelines; for example the Bern conference on South-North partnership in research
- To conduct a similar seminar (for example in Ghana, in March 2003) to include further participant organisations, progress to date and develop further partnerships.
- To increase human and material resources in health research (e.g. from Global Fund).
  - Global Fund ATM should also cover R&D; for example for the MMV, GATB
  - Good example is the Ghana-Dutch collaboration, or the NCCR/North-South research programme in Switzerland
  - Promotion of South-South partnerships; good examples are in the Southern African region, where successful collaborations have been established

Possible partners for the implementation of these ideas: African Environment and Human Development Agency; Ghanaian government; Human Science Research Council; Ifakara Health Research and Development; Medicines for Malaria Venture; National Research Foundation, pharmaceutical companies; Swiss Commission for Research Partnership.

Summary:
- It was worthwhile to participate, as the presentation of the KFPE and the NCCR/N-S clearly showed that Switzerland is in the forefront of an innovative development.
- The good cause of the KFPE could be shared with a number of international stakeholders and a number of concrete ideas to improve the efficiency of partnership in research were proposed
- The KFPE holds - as it was shown during the meeting - quite a unique position in having taken the
initiative to develop guidelines for good practice in research in partnership even at a global level

- There is obviously a demand to push this initiative further, which could be exploited by KFPE
- The NCCR/North-South is a good, albeit not the only example of how partnership in research can be implemented
- The forum addressed a number of broader issues from other sectors, which might be of interest for other sections of SDC.

annex: part of the official report

Implementation Conference:
Stakeholder Action for Our Common Future

held in Johannesburg, South Africa, 24-26 August
at the Indaba Hotel and the IUCN Environment Centre, Sandton
www.earthsummit2002.org/ic

Purpose
To inspire stakeholders to create collectively, clear, measurable on-going action to deliver the Sustainable Development Agreements

Desired Outcome
Concrete, agreed and owned collaborative actions plans aimed at implementing the Sustainable Development Agreements in four specific areas

Initial Report, 27th August 2002

This report summarises the individual Action Plans (partnership initiatives) that were finalised at the Implementation Conference (IC). The event itself was a stepping-stone in a long-term process that started in the summer of 2001, and will continue and spread out after the gathering in Johannesburg.

After three days of intense activity, stakeholders have reached agreement on twenty-six new action plans, programmes and partnerships aimed at delivering sustainable development. The Implementation Conference: Stakeholder Action for Our Common Future (IC) has been acting as a hothouse for developing new, collaborative action. Some four hundred stakeholders from over 50 different countries have been working in 25 working groups, supported by 25 facilitators from around the globe, to finalise their action plans. Fourteen draft Type 2 agreements have already been submitted and final agreements will be submitted within the coming days. Many other groups are considering the submission of type 2 initiatives.

The new partnerships are about action, not about lobbying governments. Impacting policy-making is not the primary concern of the participants who gathered at the IC. They met to agree action to implement existing (and emerging) policy agreements. However, it is hoped that the stakeholders’ actions and what we learn from them will indeed feed into policy making in the future.

The new partnerships fall within one of four broad issues of Food Security, Energy, Health and Freshwater. The IC is the culmination of the first phase of Stakeholder Action for Our Common Future, which commenced twelve months ago and is aimed at contributing to the implementation of the Sustainable Development Agreements through collaborative stakeholder action.

At the opening IC plenary, Nitin Desai, Secretary General of the World Summit, John Turner, Head of the US Delegation and Gopalong Sekobe of the South African Health Department indicated their support for partnership development. Delegates were interested to learn about the discussions on follow-up
mechanisms for type 2 outcomes, which Nitin Desai reported on. We heard intriguing remarks from John Turner about funding that needs to be made available for supporting partnership programmes, while Gopalong Sekobe pointed out the need for close linkage and complementarity between type 1 and type 2 agreements.

At the closing session on August 26, Prof Kader Asmal, Minister of Education, in the South African Government, Juoni Backman, Minister for the Environment in Finland, Achim Steiner, Executive Director of IUCN, and Dan Nielsen, Ambassador for the Danish Presidency of the European Union were amongst those who received the outcomes of the Conference and related them to the wider Summit agenda.

After addressing the IC participants over lunch on Monday, 26th August, Prof Dominic Fobih, Minister of Environment, Science and Technology, Ghana, invited Stakeholder Forum to organise an Implementation Conference in Ghana, in order to develop collaborative stakeholders action for Africa. Building on the networks among stakeholders and professional facilitators, we will endeavour to help facilitate an IC process in Ghana in 2003, working closely with local and regional partners.

*From the four issues discussed (Food security, Energy, Health and Fresh water) we only reprint the issue on Health as being relevant for the preceding article of Nick Lorenz.*

### Health

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Huge strides were taken by over 75 participants working in six parallel, focused groups: each establishing an agreed context and vision before sharing experience and identifying practical deliverable outcomes. Each group identified specific action programmes with commitments for participation and timetables for implementation. Several groups developed more than one action plan to be pursued by all or several of the organisations present. Stakeholder Forum is in discussion with each group to identify needs and garner (and provide) support. One key requirement is the engagement of further participants in most of the programmes -please let us know of your interest!

"Drop the Malaria Tax" Campaign

**Vision**  
Reduce the numbers of deaths due to malaria in sub-Saharan Africa through removal of tariffs on malaria control products; and building resources to increase supply of and access to insecticide treated bed nets.

**Outcomes**
- Target five countries in year one: Burkina-Faso, Malawi, Guinea Bissau, Eritrea and South Africa. Targets identified through a pragmatic assessment of ability to target/influence stakeholder and government representatives. Target five more (tbc) in year two.
- Numerous agreed steps of campaign (and information gathering) to catalyse political will;
  - Creation of partnerships with stakeholders and governments;
  - Measurement of impact on vulnerable groups (esp. children, poor and young women).

**Partners:** Massive Effort Advocacy Campaign; Roll Back Malaria; World Health Organisation; World Vision; Stakeholder Forum.

**HIV and AIDS in the World of Work**
**Vision**
Create an African Forum of civil society stakeholders for the sharing of best practice on tackling HIV/AIDS in the workplace.

**Outputs**
- University of Ghana offered to act as Secretariat.

**Partners:** City of Cape Town; Corporate sector; Department of Health of South Africa; Global Reporting Initiative; Massive Effort Campaign; SAfAIDS, UNDP, UNICEF; UNAIDS; University of Ghana.

**Nutrition**

**A. The Indaba Declaration on Food, Nutrition, Health and Sustainable Development**

**Vision**
Food systems, and therefore diet, are fundamental determinants of human health and welfare, and integral to sustaining the natural world.

**Outputs**
- Creation of an agreed text of the nutritional causes of poor health and desired responses;
- This Declaration to be disseminated widely at WSSD; and
- Commitments to be extended, and made integral to the WHO's nutrition strategy (as introduced in the Joint WHO/FAO expert consultation paper on diet, nutrition and the prevention of chronic diseases. To include commitments to action in international advocacy.

**Partners:** WHO, UK National Heart Forum, other signatories tbc.

**B. Child Nutrition**

**Vision**
Improving nutritional status and well being in stunted children through physical activity.

**Outcomes**
Type 2 partnership proposed for collaborative research based intervention into physical activity, nutritional status and health of children, which, if successful, will impact on government policy on physical activity in schools.

**Partners:** South African universities (Orange Free State, Potchefstroom, Western Cape, Pretoria); University of Malawi; South African Nutrition Society; UK National Heart Forum; SweetspotWellness Infonet (South African NGO); US National Institute of Health; S.A. Medical Research Council; Association of Country Women of the World; Armenian Women for Health and Healthy Environment; and HelpAge.

**Migration of Health Workers**

**Vision**
"Concerned that migration has resulted in maldistribution of health resources, increasing unmet health needs globally;
Concerned that rights of individuals (migrant workers and communities served) may not be adequately protected; the group
Seeks to achieve a sustained collaboration to improve the performance of health delivery systems for vulnerable, poor, underserved and disadvantaged populations, particularly in developing countries. This will be achieved through creative solutions as well as systematic, concerted actions to enhance the potential benefits of health worker flows.

Outputs
Nine specific deliverable action plans have been identified; which include participants’ active engagement of groups not represented at this initiating event. Agreed central ongoing network management and development responsibility of the World Health Organisation (WHO).

Partners: WHO, 10M, Rockefeller Foundation, Commonwealth Secretariat, DENOSA, SA government, Thai Ministry of Public Health

Partnerships for Health Research

Vision
Strengthening Partnerships in Health Research for Sustainable Development

Outcomes
1) To promote a Code of Conduct (including guidelines) for partnerships in health research; and to identify best practice in research partnership implementation (e.g. Swiss / Tanzanian programme);
2) To increase human and material resources in health research (e.g. from Global Fund).
3) Proposed seminar (Ghana, March 2003) to include further participant organisations, progress to date and develop further partnerships.

Partners: African Environment and Human Development Agency; Ghanaian government; Human Science Research Council; Ifakara Health Research and Development; Medicines for Malaria Venture; National Research Foundation, pharmaceutical companies; Swiss Commission for Research Partnership.

Media for Development

Vision
"We believe it is necessary to leverage our networks to engage with public and private broadcasters, governments, educators and corporations, to deliver sustainable development messages."

Points of Action
1) To agree desired outcomes in engagement of public and private broadcasters;
2) To monitor content in community media on issues of sustainable development;
3) To undertake a baseline study on the role and relationship between media and sustainable development (with immediate need for project co-ordinator + funding); and
4) To present findings and set up stakeholder meeting at AMARC 8 Conference in Nov 2002.

Outcomes
Form a Media for Sustainable Development Forum to:
• Develop content and curricula;
• Develop training toolkits for sustainable development;
• Promote use of the media to disseminate sustainable development information;
• Gain private sector support;
• Increase awareness of communication as a human right
• Ensure right to community media included in all broadcasting legislation.

Partners: AMARC; APC; FEMNET; MISA; OneWorld.net Africa; Open Society of Southern Africa; PANOS Institute of Southern Africa; South African Broadcasting Corporation; Stakeholder Forum Vatican Project.
A drastic scaling up of investments in health for the world's poor will not only save millions of lives but also produce enormous economic gains, say experts in a landmark Report presented today to the World Health Organization (WHO).

A group of leading economists and health experts maintain that, by 2015-2020, increased health investments of $66 billion per year above current spending will generate at least $360 billion annually. About half of this will be as a result of direct economic benefits: the world's poorest people will live longer, have many more days of good health and, as a result, will be able to earn more. The other half will be as a consequence of the indirect economic benefits from this greater individual productivity. It will mean a total economic gain of at least US $360 billion per year - a six-fold return on the investment.

To achieve this, the experts state that a dramatic increase in resources for health over the next few years is needed. About half of the total increase would have to come from international development assistance, while developing countries would provide the other half by re-prioritizing their budgets.

"With bold decisions in 2002, the world could initiate a partnership between rich and poor of unrivalled significance, offering the gift of life itself to millions of the world's dispossessed and proving to all doubters that globalization can indeed work to the benefit of all humankind," the 18 members of the Commission on Macroeconomics and Health write in a joint foreword to their Report. The investment plan, they conclude, is needed to meet the Millennium Development Goals for health agreed by the international community at the Millennium Summit of the United Nations in September 2000.

The Report, *Macroeconomics and Health: Investing in Health for Economic Development*, was presented today by the chair of the Commission, Professor Jeffrey D. Sachs, to Dr Gro Harlem Brundtland, Director-General of the World Health Organization.

In 1999 Dr Brundtland, who chaired the UN Commission on Environment and Development 15 years ago, invited Dr Sachs to chair a commission of 18 leading economists and senior public health experts. The Commissioners worked for two years to produce their Report. Six expert working groups supported them in this task.

The Report argues that the links between health, poverty reduction and economic growth are much more powerful than has been generally understood. The Commissioners use clear scientific evidence to challenge the traditional argument that health will automatically improve as a result of economic growth. Their Report shows that the opposite is true: improved health is a critical requirement for economic development in poor countries.

**Scaled-up Investments Needed**

One of the key recommendations of the Commission is that the world's low- and middle-income nations, in partnership with high-income countries, should scale up access to essential health services for the world's poor. The focus should be on specific measures to control the deadliest and most debilitating diseases.

The current level of official development assistance (ODA) for health stands at around US $6 billion per year. This donor support should be increased to US $27 billion per year by 2007 according to the plan laid out by the Commission. The increase would allow for vastly greater health care for the poor, as well as stepped up efforts in research and development for new technologies to fight the diseases of the poor. Much of the aid would be directed towards sub-Saharan Africa, where the health emergency is most severe.

The low- and middle-income countries, on their part, would need to commit additional domestic financial resources, political leadership, transparency, and mechanisms for community involvement and accountability to ensure that adequately financed health systems can operate effectively and address the key health problems of the poor.

Under the plan, donor and recipient countries would enter into a new 'health pact' based on mutual trust and monitored performance. Contributions for health from high-income countries would amount to
approximately 0.1 per cent of their GNP. Developing countries would aim to raise domestic budgetary spending on health by an additional 1 per cent of GNP as of 2007, rising to 2 per cent in 2015. Spending would be aimed at the main illnesses of poverty such as malaria, tuberculosis, HIV/AIDS and childhood diseases.

The new 'health pact' proposed by the Report would redefine the relationship between donor and recipient countries. Under the pact, international financing of health -and the mechanisms of donor financing -would evolve to include increased debt relief and increased mobilization of tax revenues for health.

The Report foresees a major role for the planned Global Fund to Fight AIDS, Tuberculosis, and Malaria, and proposes the establishment of a new Global Health Research Fund to ensure needed research into new medicines and vaccines for diseases that disproportionately affect the poor.

"With globalization on trial as never before, the world must succeed in achieving its solemn commitments to reduce poverty and improve health," say the Report's authors. "The resources-human, scientific, and financial-exist to succeed, but now must be mobilized."

In the present environment, "it is all the more important that the world commit itself to sustaining millions of lives through peaceful means, using the best of our modern science and technology and the enormous wealth of the rich countries. This would be an effort that would inspire and unite peoples all over the world."

**Differential Pricing of Medicines Should be the Norm - Not the Exception**

The Commission outlines a new global framework for access to life-saving medicines that includes norms on differential pricing schemes, broader licensing, and bulk purchase agreements.

The Report considers differential pricing in low-income markets the best solution to ensure access to essential drugs in poor countries. Under differential pricing, rich countries bear the costs of research and development, while poor countries pay only the "baseline" costs of production.

The Report also calls for WHO, the pharmaceutical industry (both patent holders and generic producers), and low-income countries to agree jointly on guidelines for pricing and licensing of production in low-income markets to ensure access to essential medicines. This is very much in the spirit of decisions taken at the World Trade Organization's Ministerial Conference in Doha during November. Delegates agreed to put emphasis on the public health needs of the poor within international trade rules.

The industry would agree to license their technologies to producers of high-quality generic pharmaceuticals for supply to low-income countries under two conditions - when they choose not to supply those markets themselves or when the generics producers can demonstrate that they can produce high quality drugs at a markedly lower cost.

Finally, TRIPS (the agreement on trade-related aspects of intellectual property rights) safeguards would be interpreted broadly to ensure that even those poor countries that cannot avail themselves of -domestic production of pharmaceuticals through voluntary or compulsory licensing can still be assured of access to generic production from third countries.

The Report stresses, however, that the larger problem of poverty, the lack of effective procurement and distribution systems, and the inability to effectively prescribe the right medications are often greater impediments to a wider access to life-saving medicines than patent rules.

**Disease Provokes Instability**

Commissioners note that, as the world embarks on a heightened struggle against the evils that destabilise our societies, there is an increasing commitment, from world leaders, to the peaceful empowerment of millions of people whose lives are threatened by suffering and disease.

Studies demonstrate that there is a strong correlation between "State failure" (in which governments fail because of the disintegration of State functions, coups, or civil war) and high rates of infant mortality. By helping to control the diseases of the poor, wealthy countries will also benefit from the resulting political and social stability and faster economic growth in the developing world.

The Report indicates ways in which "globalization contributes to the spread of diseases. Studies suggest that a small increase in movement across borders (e.g., due to tourism, migration, business travel or flows of refugees) substantially increases the transmission -and incidence -of infectious diseases.

**A Few Health Steps Could Save Millions of Lives**

According to 1998 data, almost a third of deaths in low- and middle-income countries are due to communicable diseases, maternal and perinatal conditions and nutritional deficiencies. These can both be
prevented and treated.

Just a few diseases account for most of this ill health. These are HIV/AIDS, tuberculosis, malaria, childhood diseases, unsafe pregnancy, infant illness at the time of delivery and tobacco-related illnesses. Malnutrition exacerbates these diseases.

Effective interventions for the prevention and control of these conditions already exist. Large reductions in mortality and morbidity can be achieved almost anywhere, even in war zones. Only 10 per cent of the world's poor people live in countries where there is no infrastructure at all and the scaling up of health interventions will prove to be particularly challenging. However, it is feasible for countries to scale up health interventions for the vast majority of the world's poor people provided that financial resources are adequate. The Commission therefore recommends that donors should indeed invest amply in a bold process to strengthen the effective operation of health systems.

The Commission also shows that the highest priority for scaling up is at the community level, where actual health services are delivered. The Report terms this the close-to-client, or CTC part of the health system. Scaling up at the CTC level involves a basic strengthening of staffing at this level, an adequate supply of drugs, and an increased capacity for transport and connection with the rest of the health system.

The resources and know-how exist to save millions of lives, turn the tide on global ill health and poverty, and harness global economic development. The Commission asserts that the countries of the world cannot afford to pass by the present opportunities for effective action. Their legacy will benefit countless future generations and help safeguard the health of the people and the planet.
Facts and Figures


♦ The deaths of millions of people every year—many of them children under five—can be prevented by extending the coverage of health interventions to the world's poor. Not only would human suffering be profoundly reduced, but the economic gains would be enormous, many times the costs of the health interventions themselves.
♦ By 2010, around 8 million deaths per year in developing countries due to infectious diseases and maternal conditions could be prevented.
♦ Life expectancy at birth is 51 years in the world's least-developed countries, compared to 78 years in the high-income countries.
♦ To address the health challenges in the low-income countries, minimum financing needs to be US $30-40 per person per year to cover essential interventions, including those needed to fight the AIDS pandemic. Current actual spending on health in the least-developed countries is around US $13 per person per year.
♦ Donor finance, in conjunction with best efforts by recipient countries, is needed to close the financing gap. This will require approximately US $27 billion per year in donor grants by 2007, compared with the current level of US $6 billion.
♦ For all low-income countries, approximately US $66 billion per year above current spending levels would be needed by the year 2015, which would result in a total economic gain of at least US $360 billion per year.
♦ A world-wide alliance against our common enemy—disease—is one of the most powerful and enduring ways to achieve true international security.
♦ Disease can destabilize economies and entire political systems. The stability of the global system hinges on an international effort to fight disease and on the health of the poorest, most vulnerable people.
♦ Between 1960 and 1994 a high infant mortality rate was one of the main predictors of State failure through coups, civil war and other unconstitutional changes in regime.
♦ Disease can cross borders as easily as capital flows. For example, no country has escaped the HIV/AIDS pandemic. HIV has spread in rich and poor countries and, within countries, among both rich and poor within a single generation.
♦ Similarly, the developed world is increasingly detecting drug-resistant tuberculosis, once considered a problem exclusive to poor countries.
♦ Disease control in one part of society can "spillover" and directly benefit another. For example, insecticide-treated mosquito nets reduce malaria infection for an entire village, not just for the individuals who use them.
♦ HIV/AIDS, malaria, tuberculosis, childhood infectious diseases, maternal mortality, micronutrient deficiencies, and tobacco-related illness cause the lion's share of the avoidable deaths per year in low- and middle-income countries.
♦ HIV/AIDS Data
  - 36 million people currently live with HIV
  - 95% of these people are in developing countries
  - Nearly three-quarters of the people living with HIV/AIDS are in sub-Saharan Africa
  - 22 million people have died of HIV/AIDS
  - 12 million children in Africa have been orphaned by HIV/AIDS
♦ It is estimated that, of the 25 million HIV-infected Africans, only around 10,000 to 30,000 receive antiretroviral therapy.
♦ Differential pricing is the best solution to ensure access to essential drugs in low-income markets. Under differential pricing, rich countries bear the costs of R&D, while poor countries would pay only the "marginal" costs of production.
♦ Two-thirds of developing countries either import 100% of the medicines they consume or have very
limited production capacity.

- Mortality rates of children under five in the least-developed countries are about 160 per 1000 births, compared to six per 1000 births in high-income countries.
- Reducing infant mortality rates results in lower birth rates and higher economic growth.
- Societies with high rates of child and infant mortality tend to have high rates of fertility, in part to compensate for frequent deaths of children. Large numbers of children, in turn, reduce the ability of poor families to adequately invest in the health, education and future of each child.
- Disease control is one of the most important causal factors in a country's transition from a pattern of high mortality, high fertility, and low economic growth, to a pattern of low mortality, low fertility, and high economic growth.
- As child mortality and fertility rates decline, the average age of the population tends to rise. These demographic changes boost overall per capita GNP, savings rates, and economic growth.

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Promotion of „Contracting“
A framework for activities of MMI and its member-organisations
by Edgar Widmer

The scope in drawing up contractual relations is broad. It serves to make the best use of the available resources in view of

- the ongoing health sector reforms including privatisation
- the sector wide approach (SWAp)
- the implementation of the national health policy, especially the district health concept

I. A potentially large diversity of the contractual arrangements can be identified. Prerequisite for contracting is the clear definition of policy of each partner involved. In a participative process among equals the common policy of the partners has to be developed. Once this is reached it becomes governments’ policy. Once the contract between partners is reached it becomes the tool to implement the policy.

- There are contracts between employer and employees within a specific health structure. Kenya f.i. is making first experiments in contracting liberal specialists for work in governmental hospitals and on the other side allowing dual employment, which means governmental employees are allowed part time private practice.
- One off contracts exist for construction of health facilities, for their equipment or for the procurement of drugs. These are not durable contracts.
- Contracting ancillary services, such as outsourcing laundry, cleaning and catering, is experienced in some big towns.
- Contracts between Governments and International Donor Agencies or International NGOs concern often vertical programmes. Sometimes they risk not to be integrative part of the existing health services
- Contracts may be used as a tool to improve performances and should also be applied between governmental purchaser and provider.
- Contracts between Government and private Institutions are the main focus in our ongoing discussions. A prerequisite for contractual partnership are the criteria for accreditation. Governments will have to distinguish between Private for profit and Private not for profit with public purpose.

II. The main partners of Medicus Mundi are the local Non Governmental Health Institutions, which are not for profit and have a public purpose. Most of them are at district level, a great number are church-bound.

What do they need in view of “Contracting”?
First of all the owners of these institutions must understand the paradigm-changes due to the growing process of globalisation, of democratisation and decentralisation.
The NGO-leaders have to reach consensus on a common policy, install co-ordination among themselves and build up or reinforce structural co-operation with the governmental counterpart, knowing that all this is a learning process, both sides being aware that “there is no equity without the private provider, nor without the state” (Dr. Janclos, WHO, Addis Ababa). In many countries the already existing partnership is proceeding towards “Contracting”.

**What was the role of Medicus Mundi in this process?**

Let us have a look back into the past years. May I just mention a few highlights:

1. In 1984 MMI together with the Christian Medical Commission of the World Council of Churches organised an international seminar on strengthening co-ordination of health activities by local NGOs towards Health for All. Representatives of MOH and the Co-ordinators of local NGOs of more than 17 African countries as well as WHO were present. The seminar confirmed the consensus that NGOs and governments 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.

2. In 1985, in Dodoma, Tanzania, a Churches Consultation on PHC was held uniting the owners, administrators and doctors in charge of all church hospitals of the country together with the MOH and several International Donors and NGOs. More than 20 MM-Doctors took part. As a consequence of this meeting MMI sponsored some subsequent regional seminars and financed the training of 3 doctors in international public health courses in view of their future engagement in the Christian Social Services Commission (CSSC) of Tanzania. During the following years, up to now, Co-ordinating Agencies of Church related Health Services have been supported by Medicus Mundi Branches, especially by MEMISA. (see p.98)

3. In the WHA 1985, by initiative of MMI and some other NGOs, the Technical Discussions dealt with the importance of the NGOs contribution for the implementation of PHC in a national health policy. MMI was given the presidency for some of the meetings.

4. Meanwhile the World Bank speaking of a “Better Health for Africa” (1992) recognised International NGOs, inviting them as “development partners” to a meeting in Dakar, discussing the “Contractual Approach as a Tool for the Implementation of National Health Policies in African Countries”. Medicus Mundi International, i.e. Prof. H. van Balen, was given the honour to preside the discussions. In this meeting, the large local not for profit NGO community and their Co-ordinating offices, was not present not having been officially recognised by the organiser. MMI insisted that these NGOs be integrated in the process of “Contracting” because of their potentiality for assuring better coverage of essential health needs of entire populations, and because of their shown capacity, commitment and sustainability, offering in some countries up to 40% of the health services (see p.36).

5. In 1999 MMI had the possibility to organise a Technical Meeting on “Contracting NGOs for Health” with assistance of WHO during the World Health Assembly (WHA). As well as to submit a statement to the plenary meeting itself. (see Newsletter MMI Summer 1999)

6. At the end of 1999 MMI with the help of MEMISA held two Partner-Consultations in Africa, the one in Conakry for some 6 francophone countries, the other in Dar es Salaam for 7 anglophone countries. Involved were the respective Governments, the local NGOs and WHO representatives. A draft resolution for the WHO on “Contracting” was revised, some first experiences in contracting were shared (see Newsletter MMI Winter 1999).

7. Finally in the year 2000 the Government of Chad came up with the draft for a WHO Resolution entitled: “Improving HFA, at district level, by formalizing Partnership with Non Governmental Institutions with a Public Purpose” (see p.53).

8. At the end of the year 2000, at the occasion of Memisa’s 75 years jubilee, and in view that Church leaders as owners of so many Hospitals have the ultimate say, a Working Congress was organised in Soesterberg, the Netherlands, on the theme: “The church and its involvement with health: The healing ministry”. Bishops responsible for health matters within the Episcopal Conferences of eleven countries, their health secretaries, representatives from Cordaid/Memisa, Cafod, Misereor and Medicus Mundi International as well as various experts attended the work. (see p. 82)
9. At the WHO EB 107/SR 9 on January 19th, 2001, Dr. M. E. Mbaiong, Directeur général adjoint, Ministère de la Santé Publique, N’Djamena Chad, Vice-président du Conseil Exécutif de l’OMS, defended the above mentioned resolution (see Analysis of the discussions in the EB, p. 56).

10. On October 2001 the Belgian Government and the Antwerp Institute of Tropical Medicine came up with a call for “Health Care for All”. About 12 participants have or had straight links with MM and about 30 have gone through the Internat. Course, which formerly had been directed by “our” Prof. Van Balen. A Conclusion of this Congress was, that without consolidating the medical structures the fight against poverty and the universal strategy against AIDS, Tuberculosis and Malaria will fail. The ongoing promotion of the District Health System by Contracting as propagated by MMI has so been confirmed. (See p. 6 and comments given in Newsletter 68: “Round about the Antwerp Meeting”)

11. On November 2001, in an International Conference organised by the Pontifical Council for Health in the Vatican, on: ”Health and Power, norms determining the power of a private owner of a health Institution”. MMI has been given the possibility to illustrate the immense potential church health institutions have in order to strengthen the District Health System. The Annuarium Statisticum Ecclesiae reports for the year 1998 that in Africa alone the Church is responsible for more than 800 hospitals and some 4000 dispensaries (see p.88).

12. In November 2001 the WHO organised an Inter Country Meeting in Addis Ababa offering discussions on: “Lessons from health sector experiences in contracting in Africa”. (The local organiser himself, Dr. Jancloes of WHO-Ethiopia, is a former MM-Doctor). Seven countries were involved, Government representatives and the NGO side as well as an MMI representative.

13. In the WHO Executive Board Meeting on January 2002 the final text of the Draft Resolution was presented under the title: “The role of contractual arrangements in improving health systems performance”, the WHO-secretariat having reformulated the text according to the proposed amendments of the EB meeting 2001. Apparently Dr. Brundtland has been personally engaged in it. (See p. 61) The draft resolution has been adopted by the EB on January 18th 2002 at 5.30 p.m.

14. Finally, in spring 2002 MMI published the "Guidelines for Contracting"

What do “our” local NGOs need on their way towards contracting?

Medicus Mundi International as well as its branches or member organisation may be needed in the further steps towards Contracting, not so much as donors, but as experts. During the Partner Consultations, especially during the Addis Ababa-Meeting, these needs have been expressed.

1. Very few owners of Non Governmental Health Institutions have a clear vision and most of them lack the formulation of a policy- and strategy-statement based on consensus among the stakeholders. Uganda reached such a consensus (see p. 73).

2. The Co-ordinating bodies need strengthening of their capacity, as concerns human resources, know-how, equipment and budgets. They need clear mandates by the owners of the private hospitals, mostly Church hospitals. Therefore Church leaders have to be involved, with specific seminars among themselves and they have to be invited in workshops together with the professionals in the co-ordinating bodies.

3. National or regional training courses should be organised
   for “partnership” and “dialogue in policy”, in order to acquire skills for equal negotiations.
   for “contract design”
   for “health economy”
   for “good governance”
4. All the NGO-stakeholders need more specific information and sharing of positive and negative experiences within their country and with the neighbouring countries. Electronic-communication, publications, teaching modules, scholarships are needed. Seminars and workshops have to be organised, dialogue between North and South as well as between South-South, Private and Public, experts and learners has to be promoted. Networking is absolutely necessary.

5. In the North MM has to play a role as advocate for the needs of local NGOs through its links with the European Governments, the EU, the WHO, the World Bank and other UN-Institutions.

In such a way Medicus Mundi would rather act as an expert than as a donor. Not being associated as a donor, it might be easier to bring partners together and to develop tools that are accepted by all.

The board of MMI as well as the board of MM Switzerland having asked me to make some proposals for our future engagement in "Contracting", you may take these notes as a frame for further deliberations. It seems to me that we as MMI or as national branches and associated members should continue our efforts on a line that perfectly fits into the philosophy of Medicus Mundi.

Thalwil, January 2002

Edgar Widmer

Further documents available

• Report of Rome meeting
• Report of Dodoma meeting
• Report of Dakar meeting
• Technical Intervention Geneva: MMI Newsletter summer 1999
• Report of Partner Consultation Dar es Salaam and Conakry
• WHO- EB meeting 2000 First draft resolution
• Working Congress Soesterberg: Statement
• WHO EB meeting: Analysis of discussions concerning contracting. Introductory text of Mr. Mbaiong
• Roundabout the Antwerp meeting. Comments
• Health and Power, practical Actions to be promoted in Relation to Hospitals. Rome 2001
• Report of Addis Abeba meeting
• WHO EB meeting, the adopted resolution.
• Guideline for Contracting
• Ugandan Policy- and Strategy- Statements
Public-private interactions for health: 
WHO's involvement

Note by the Director-General

1. In the United Nations Millennium Declaration, adopted in September 2000, the Heads of State and Government resolved "to develop strong partnerships with the private sector and with civil society organizations in pursuit of development and poverty eradication". In the health field, governments and international organizations have recognized the potential of such interactions to improve health outcomes.

2. The Executive Board considered aspects of WHO's interactions with the private sector at its 105th session in 2000 and its 107th session in 2001. On the latter occasion, consideration of guidelines for Secretariat use in dealing with such interactions broadened into discussion on policy issues, such as ways in which WHO can help support effective public-private interactions for health within Member States. The Executive Board agreed to return to the subject at its 109th session in January 2002 and to have an informal exchange among members prior to that date. It was originally intended that this would be by electronic means, but instead the opportunity of the Executive Board retreat was used (Florence, Italy, 11 to 13 November 2001).

3. At the retreat, the Director-General reviewed WHO's experience to date with interactions with the private sector (see Annex), and indicated ways in which such interactions might evolve. She also indicated the range of measures WHO has introduced to manage these interactions.

4. In the discussion at the retreat, some Board members referred to their own Member States' experience of interactions with the private sector, in particular in activities relating to health systems. Possibilities were seen for lessons to be shared among Member States and for WHO to build up its capacity to advise countries on public-private interactions for health. The provision of health services, health insurance and medical supplies were mentioned as areas of particular interest.

5. Based on experience to date and the suggestions put forward at the Executive Board retreat, the Director-General intends to focus WHO's future work on public-private interactions for health on the following areas:

- **support to Member States on public-private interactions.** This will require expertise within the Secretariat to be strengthened;
- **commodity donation programmes.** WHO will build on the success stories referred to in the Annex;
- **lower prices for commodities.** WHO will pay particular attention to life-saving medicines for the poorest countries;
• **product research and development.** This will include incentives for private-sector collaboration in combating diseases of poverty;

• **advocacy and behaviour change.** This will include, for example, work in the field of noncommunicable diseases in order to improve company practices that have a negative impact on health and working with companies to develop more appropriate messages to the public;

• **corporate workplace health programmes.** WHO will collaborate in advising governments and industry on development of healthy working conditions.

6. The experience of WHO in rejecting inappropriate suggestions for interaction was also seen as valuable. It was noted that there can be risks of, for example, focusing on the production of inappropriate medicines, equipment or commodities. There is a need to ensure that health systems are not distorted by donations; that costs remain under control; and that advice is independent. There is potential for real or perceived conflicts of interest. Staff need to be trained to avoid these and a system of checks and balances needs to be in place.

7. There was interest at the Executive Board retreat in the measures taken by the Director-General to manage public-private interactions and to avoid conflicts of interest. To the extent possible, there was an expectation that these could be drawn on in helping countries with their own interactions.

8. After further review in the light of the Executive Board's discussions, the following measures are in place or envisaged:

• proposals for any interaction between WHO and the private sector will need to be accompanied by a clear statement of purpose;

• guidelines to staff on handling interactions will be updated regularly to reflect experience and will include text on recognizing and avoiding conflict of interest. Although the guidelines are primarily for Secretariat use, they will continue to be available on the WHO headquarters web site for the information of Member States and the public;

• staff training modules on issues relating to private-sector interaction and conflict of interest are being developed;

• declaration of interest forms are in use for all senior staff and WHO experts participating in meetings. These forms require declaration of any interest which may relate to the topic of the meeting or to the work of staff;

• a civil society initiative is in place to ensure input and engagement from nongovernmental organizations. This will also facilitate the input of the organizations' views on issues pertaining to public-private interactions;

• work is progressing on a tool to help assess the good standing and practices of any companies with whom interaction is envisaged;

• private sector interactions will be documented and reported to the Executive Board and Health Assembly, and will be available to the public.

**ACTION BY THE EXECUTIVE BOARD**

9. The Executive Board is invited to comment on the future focus for WHO's work in public-private interactions for health and the measures taken to manage such interactions.
WHO'S INTERACTIONS WITH THE PRIVATE SECTOR: SOME EXPERIENCES

1. Effective action to address -and in some cases overcome -major health conditions that affect poor people has been supported through well-managed interactions with the private sector that have included the donation of specific medicines. They have made possible an effective response to onchocerciasis, leishmaniasis, leprosy and African trypanosomiasis. In specific cases assistance has been provided in the form of distribution and use of drugs, as well as case detection, training and data collection.

2. Programmes also exist for vaccine and medicine development and for immunization. In these, WHO has sometimes played a catalytic role as in the Medicines for Malaria Venture and on other occasions joined with governments, international organizations and private sector or civil society partners, as in the Global Alliance for Vaccines and Immunization and the Global Tuberculosis Drug Facility.

3. Another current interaction has the aim of reducing drug prices for governments, nongovernmental organizations, and other bodies that provide health care within the poorest countries. Although systematic discussion has been under way for only 18 months, lower prices of antiretroviral and antifungal medicines for treating people with HIV/AIDS, together with antimalarial and antituberculous medicines, have been announced by the companies concerned. There is also the potential for significant reductions in the price of human insulin. Discussions have resulted in companies agreeing to similar kinds of reductions in the prices of some essential diagnostic and consumable products.

4. Work is also under way with companies-Outside the immediate health sector, such as the recent agreement by six publishers to allow almost 1000 of the world's leading medical and scientific journals to become available through the Internet to medical schools and research institutions in developing countries for free or at heavily-reduced rates. WHO is also helping to construct a "Health InterNetwork" providing public health professionals, policy makers and researchers in developing countries with relevant health information via the Internet.

5. At the level of advocacy and inspiration, WHO has been working with companies from many sectors of the economy to encourage them to take an interest in health development, for example, through the World Economic Forum.

6. As with governments in a national setting, WHO has also interacted with the private sector in its role of steward and regulator of global health. The knowledge base of the private sector has been tapped into. None the less, the science-based setting of norms and standards remains independent, with decision-making at a remove from the private sector.

7. The case of proposed cash donations from the private sector to WHO's work is given particularly careful consideration by the Legal Office and the Committee on Private Sector Collaboration in order to avoid any risk of conflict of interest. All recommendations from the Committee are subject to approval by the Director-General. All donations are reported in the accounts.
World Health Organization and Civil Society
The World Health Organization (WHO) has a long history of working with nongovernmental organizations (NGOs). However, the need to improve partnerships with NGOs and other civil society organizations (CSOs) is now more important, due to the unprecedented growth and involvement of civil society and CSOs in health.
In recognition of this, and of the contribution that CSOs make to health, the WHO established the Civil Society Initiative (CSI) in June 2001. This is in line with the WHO corporate strategy that calls for new ways of working to respond to the changing international environment - building new partnerships, catalysing action of others and developing creative ways of networking.

CSI's Goals and Mandate
The CSI's main objective is to facilitate more effective collaboration, information exchange and dialogue with CSOs and to strengthen WHO's support to Member States in their work with CSOs on global and national health issues.
WHO seeks in this way, to broaden dialogue and joint action with all those groups outside WHO that have a legitimate interest in the work and goals of the organization.

"The United Nations (UN), WHO and other intergovernmental bodies are gearing up to catalyse the changes that can result in health equity. NGOs are at the centre of this global movement for health."
Dr. Gro Harlem Brundtland, Director General, WHO

CSI's Work so far
Building on the existing linkages between CSOs and WHO, the Civil Society Initiative has been working towards its objectives by:
• Mapping WHO experiences and relations with CSOs.
• Identifying current forms of interaction between CSOs and WHO, and the opportunities and concerns to which they give rise.
• Exploring current thinking about civil society and CSO involvement in health.
• Gaining insights from other UN entities, donors and financial institutions on their policies and processes for interaction with civil society.
• Listening to the expectations of CSOs and initiating dialogue with them.
• Identifying specific areas of concern and issues that WHO needs to address.

Plans for the future
The key components of the workplan for 2002-2003 will cover five areas:
• Development of a coherent WHO policy on CSO relations, to maximise synergies and opportunities for joint work towards WHO goals, while managing the risk of conflict of interest.
• Creation of a knowledge bank on civil society actors and issues, to inform WHO, Member states and interested parties, on civil society involvement in public health.
• Improved communications and policy dialogue within WHO and between WHO and CSOs.
• Strengthening WHO capacity to support and facilitate mutually beneficial Government/CSO relations at the country level.
• Administration of official relations with NGOs.

"Good health is a basic right for every human being. Our task is to work with all parties who work for health equity as they focus on outcomes."
Dr Gro Harlem Brundtland, Director-General, WHO
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1. Highlights of the celebration of 275 years of Catholic social services, Chicago
August 1-6, 2002

Catholic Charities and the Catholic Health Association of the US had joined for the first time in a meeting
discussing: "Accessible and affordable care for all in a just health care system" and "Development of
value-based principles for transforming the delivery of health care to best meet the needs and changing
demographics of persons and communities". The two great organisations established plans for common
actions where social engagement and health promotion should be strengthened.

In the opening address Dorret Lyttle Bird, the Executive Director for Overseas Operations of the Catholic
Relief Services claimed that "the war on terror should include a war on poverty", because terrorism is a
result of impoverished and disenfranchised cultures. Compassion should reach not only the afflicted of
terrorist attacks, but also the hungry, the sick and uneducated multitudes all over the globe.

Fr. Michael Place, the president of the Catholic Health Association, and Chairman of the International
Federation of Catholic Health Institutions, drafted a short history of the specific engagement of the Church.
Concomitant with the American commitment to individual responsibility, the Church insists that some
situations call for collective responsibility in addition to individual responsibility. At times that responsibility
which might be called solidarity, was best exercised by private/charitable entities. History shows that their
performance was optimised when partnership with government could be reached. The late Cardinal
Joseph Bernardin in 1995 had to intervene, when business corporations increasingly, under the flag of
globalisation, considered health services as a commodity, by which shareholders should reach maximum
profit. In an address to the Harvard Business School Club of Chicago he spoke under the title "Making the
Case for Not-For-Profit Healthcare". He argued that the provision of health care is a "social good" and
most appropriately provided in the voluntary sector. According to him, healthcare - like the family,
education, and social services- is special.

It is fundamentally different from most other goods,
because it is essential to human dignity and the character of the communities. It is one of those goods
which by their nature are not and can not be mere commodities.

Given this special status, the primary end or essential purpose of medical care delivery should be a cured
patient, a comforted patient, and a healthier community, not to earn a profit or a return on capital for
shareholders. Bernardin considered not only the commercialisation of health care as a danger for
accessibility and affordability. The unlimited demand" no matter how effective or how expensive a
treatment or drug may be, should be put under control by discussions on what can reasonably be
expected to be covered by insurances without excluding part of the population due to uncovered budgets.
Bernardin said:"it is proper for society to establish limits on what it can reasonably provide in one area of
the commonweal so that it can address other legitimate responsibilities to the community. But in
establishing such limits, the inalienable life and dignity of every person, in particular the vulnerable,
must be protected."

The Chicago-congress confirmed the belief that as a social good, the promise of health care, is
fundamental to human dignity. And as not-for-profits they understand this as part of their role in improving
the human condition. The convening organisations formulated the following action plan:

1. Taking a leadership role in the communities.
2. Responding to the needs of the poor and vulnerable and urging others to do so as well.
3. Identifying unmet needs and working with others to meet these needs.
4. Advocating, both locally and globally, just and equitable health care policies that will lead to improved
health for all.
5. Attending to the future of health care by preparing human resources and leading health delivery
research.

By Edgar Widmer. Excerpt from the congress communications: http://www.chausa.org
2. Cordaid makes strategic decisions in its 2002-2006 business plan

Cordaid is busy putting together its medium-term strategy: work is currently focusing on the 2002-2006 business plan which details Cordaid’s strategic decisions. The business plan is to function as our guide during the coming years and shows the situation we are currently in as well as what we wish to achieve in the future.

At the end of 1999, the organisations of Bilance, Mensen in Nood and Memisa merged to form the new organisation of Cordaid. The aim of the merger was to provide more better services to people in the South, create a strong basis within Dutch society and to carry out political and social activities in the North. As far as the future is concerned, Cordaid intends to become a purposed organisation whose objective, and the means for achieving that objective, are clearly formulated. In order for this to become a reality, it is important that Cordaid also examines its own organisation and the way in which we work.

That process is not going to be initiated in a vacuum. A lot was already achieved in 2000, such as the introduction of a result oriented approach. Moreover, the job descriptions have now also been formulated in a much more result-oriented manner, so that staff and managers clearly know the areas were results are expected and which facilities, such as training are required in order to achieve those results. In addition, a provisional profile of Cordaid has been drawn up to function as the point of departure for the discussion on the course Cordaid is going to pursue during the coming years. Moreover, operational processes within Cordaid are being systematically analysed, against the backdrop of the standards imposed by the market and the needs of Cordaid’s partners. Furthermore, organisational changes have been made, such as the creation of policy units for both projects and marketing activities. Lastly, a system for internal communication has been set up.

For partners

The business plan 2006 is intended to create a new strategic added value for partners, the government and staff. The plan entails making choices to enable Cordaid to gain optimal results with the partners. But what exactly does this business plan mean for you as a Cordaid partner? In the first instance, it means that, as of February 2002, Cordaid will consult partners on the strategy that we would like to implement during the coming years. Thereafter, Cordaid will develop the plan in more detail with the definitive version being ready by March 2002 at the latest. All our partners are to be kept fully up-to-date on the plan. In April and May, consultations will take place regarding the specific regional plans. This also means that Cordaid wants to know how you experience the relationship between us and what changes and improvements you would like to see implemented. In 2002, we are going to survey the extent to which partners are satisfied with the developments on the basis of previous experience and state of the art methods. Cordaid will also ask partners with relevant experience to provide inputs.

We would like to share a couple of aspects of elements which have already been formulated of this business plan with you now. Cordaid will continue to promote itself as an organisation with its roots firmly in society, both in the North and in the South and one whose objective is structural poverty alleviation. Cordaid is doing this not only by providing financial support to partners, but also by means of lobbying/advocacy activities and by reinforcing grassroots support.

It is within the framework of this point of departure that Cordaid is seeking a proper balance between a very broad sphere of activities, covering sectors, themes and countries, and a more concentrated package. Cordaid considers it very important to make an extra effort with regard to a number of themes in order to build up expertise and achieve maximum effectiveness. The debate is still going on as to what these themes are. It is very likely that the current development themes will be used as a basis; namely conflict prevention, the quality of urban life and HIV/aids.

Cordaid considers lobbying in the Netherlands and Europe to be extremely important for its partners and wants to ensure that their voice is heard in the North. In addition Cordaid, as a Dutch social organisation, has a certain responsibility. The information that the lobbyists collect and develop in connection with the development themes is used to create a support, at national. European and international level, for the principles that Cordaid represents. Moreover, the lobbyists are able to focus the spotlight on the activities of the partners in the South.
Quality model
Cordaid would like to raise the level of quality of the services provided. In order to achieve this we are using a tried and tested quality model. This so-called INK quality model examines all the facets of the organisation, that is leadership, processes, strategy and the way in which resources are used, with a view to enduring coherence these. The model also forces us to ask our stakeholders for information about how they appreciate the efforts made within the organisation? The model examines the situation internal and external, teaches the organisation to learn and, above all, assesses the final results. The Co-financing Programme is subject to changes brought about, on the one hand, by a new policy framework that has come about partially thanks to Cordaid's contribution (emphasises the autonomy of the MFO's and therefore of the partners) and, on the other hand, by the fact that a larger share of the budget is available (at least 11% in comparison to 10% at the moment, although the OS budget might be reduced. Cordaid is assuming that between 350 to 400 million euro will be available for the coming four years. Furthermore, Cordaid has a broad network of donors and they generate between 35 and 40 million euro per year.

3. CUAMM conference ‘AIDS IN AFRICA’

Conclusions and recommendations
CUAMM intends to intensify its projects to combat the HIV/AIDS epidemic in sub-Saharan Africa. The choice of activities in the programme must be made with great attention to the local context, in accord with the population and its institutional representatives, who will be involved in planning, implementation and evaluation. Great importance will be given, as CUAMM always did, to the criteria of cost/efficacy, sustainability, feasibility, expected impact, with special attention to the respect of human rights. Absolute priority must be given to the promotion of health (with special attention to the education of the young, the role of women and reduction of their vulnerability), and reinforcing health services and their accessibility.

CUAMM considers the medical and social assistance of persons affected by AIDS and support for their families and orphans an essential and unalienable element of all projects. CUAMM considers a priority other three components of the fight against AIDS of top priority and they already feasible in the contexts in which they operate:

• safe transfusions (and not only just limited to HIV transmission);
• protection of health staff, expatriate and local, including post-exposure prophylaxis with antiretroviral drugs;
• prevention of vertical HIV transmission, including the use of antiretrovirals for prophylactic purposes and with the possibility of offering treatment to HIV positive mothers and their partners, if found HIV positive.

As all three of these components imply, at some point, HIV testing (for blood donors, operators who had an accident, source-patients, pregnant women and their partners) VCT becomes an essential and unalienable prerequisite.

At the time of writing of this document the introduction of antiretroviral drugs for therapy for HIV positive subjects, although in our opinion desirable, still appears to be a difficult goal in the contexts in which CUAMM operates. We are however convinced that it is not acceptable to deny over half of the world access to instruments that already exist to control a disease that is otherwise mortal.

The use of ARV therapies must therefore be taken into consideration, and gradually introduced and integrated with the activities of health systems and other components of control programmes. Considering the lack of information about the proper use of these strategies, CUAMM operators in the field have been given instructions to dedicate human and financial resources to assessing experiences that have already been launched, also through operational research protocols.
Even CUAMM is aware that the difficulties are enormous, we are convinced that the fight against AIDS in Africa is possible and that appropriate, long-lasting and effective actions can be put into practice to stop the expansion of the epidemic and contain the damage. We believe that Africa has the human resources and the courage necessary to face this challenge: our task, our unalienable duty, is to give concrete and consistent support from a financial and technical point of view, but also discreet and respectful, free from impositions and abuses, in a spirit of real solidarity and collaboration.


When 18 years ago, the Pontifical Council Cor Unum had invited some personalities to discuss, whether there exists any Pastoral for Health, Medicus Mundi International (MMI) was part of the workshop. The way the question was formulated, indicated that the organisers were aware that an important paradigm-shift had taken place after Alma Ata. It meant that not the sick or the disease was at the centre of interest, but health, the promotion of health as well as the human right for health. Apart from health services the engagement for peace, justice and the maintenance of the surrounding nature became just as important as factors for health. To the definition of health as the physical-, mental-, and social-wellbeing, spiritual harmony was added as a further important element for health.

The Cor Unum workshop’s plea for the creation of a specific Health Dicasterium was followed by the Motu Proprio “Dolenti Hominum”, by which Pope John Paul II seventeen years ago installed the new Pontifical Council for Health Pastoral Care. The Church’s engagement for health, for the single sick person as well as for those who work in the health sector, was summarised in the Apostolic Constitution “Pastor Bonus”. Apostolic letters, such as “Novo Millennio Ineunte” and “Salvifice Doloris” are part of the Magisterium guiding the Pontifical Council’s actions, which consist

- in spreading specific messages of the Church’s teaching
- in promoting the Healing Ministry by Sacraments, which lead to reconciliation with God, the community and oneself
- in co-ordinating the activities of the different International Catholic Health Associations and
- in promoting within the Bishops’ Conferences the understanding of their responsibility for health care.

The Holy Father, in his address to the Council at the occasion of the presentation of the new Action Plan, on May 2nd, 2002, encouraged the meeting to persevere in the defence of human dignity and to insist on the value of human life. He stressed that it is necessary to open up for generous collaboration with all kinds of international health organisations in order to reach these aims.

The new Action Plan describes about 50 different fields of actions. In the following text we will pick up those which already found our interest in the past or might be shared by Medicus Mundi in the future. The number indicates the number given in the action plan.

1. Theology of Health

   This topic has interested MMI especially at the Bishops Working Conference on the Occasion of MEMISA’s 75 years Jubilee presenting a paper on “The Healing Ministry”.

2. Health Faculties and Bioethics

   The former board member of MMI, Francisco Abel SJ has been one of the main pioneers in bioethics.

3. Publications

   On several occasions MM papers published the Council’s messages
4. **WHO**

- In 1998, when the Council discussed about the co-operation of International Catholic Health Associations with WHO, MMI strongly recommended official relationship.
- Launching a WHO-Resolution on “Improving Partnership between Governments and NGOs’ by contracts” MMI promoted an important instrument for the survival of many church-bound health institutions.
- MMI encourages the Council to deepen its dialogue with WHO not only on moral and ethical issues, but also on development strategies and on professional matters.

7. **Conferences**

The Council and MMI invite each other. Several MMI meetings were important for the church:
- 1985, Rome, Int. Conf. of MMI on “The Role of Co-ordinating Agencies of Church-related Health Services”
- 1985, Geneva, WHO Technical Discussions on the Role of NGO’s
- 1986, Dodoma Churches Consultation on PHC
- 2000/2001 Consultations in Dar es Salaam, Conakry and Addis Ababa on Contracting”
- 2000, Padova, Participation of the Council’s president in the CUAMM jubilee.

8. **The Councils’ International Conferences.**

MMI regularly participates in these Conferences. MMI contributions given to the theme “Health and Power” in 2001

9. **Research**

MMI has tight links to Tropical Institutes and shares jointly published results, especially on Health Systems Research.

11. **Dossiers**

The Council elaborates inputs from the periphery of the Church as well as from other institutions such as MMI. It had immediately dealt with the Draft-Resolution on Contracting, recommending to all the Bishop’s Conferences to give their support.

19. **Doctors**

A main task of MMI was the support of developing countries with doctors, to recruit and train them, as well as to promote human resources development in general.

20. **Nurses**

The promotion of local nursing staff has for long been an important MMI engagement.

21. **Pharmacists**


23. **Religious**
Several Congregations working in the health field have been affiliated with MMI (Medical Missionaries of Mary, Medical Mission Sisters, Fatebenefratelli).

25. Catholic Hospitals

- MMI had partner-relations to about 250 church hospitals
- MMI participated in the AISAC-meetings (Int. Fed. of Cath. Hosp) on May and Nov. 2000
- MMI is elaborating an Action Plan on Human Resources Development which will be of interest for the Council

27. Bishop’s responsible for health

- MMI and Cordaid offer support for workshops dealing with
  - the churches solicitude for health
  - the importance of the healing ministry
  - the decisive role owners have as stewards of church health institutions

- MMI tries to promote diocesan health co-ordination

- MMI supports national co-ordinating agencies of church-bound health services

33. Human Rights and Health

In the year 1999 MM Italia (Brescia) organised a workshop in Caserta on “La tutela della dignita della persona” in occasion of the 50th anniversary of the proclamation of the human rights.

The report has been published and distributed at the general assembly of the International Federation of Catholic Doctors in the year 2000.

42. Updating contacts

- MMI promotes the Council’s contacts with the Co-ordinating Agencies of Church related Health Services, just to mention here the Uganda Catholic Medical Bureau or AMCES (Association des Oeuvres Médicales Privées Confessionnelles et Sociales au Bénin).

45. AIDS

- An MMI expert participated in the Council’s workshop on Aids (cf. MMI News Newsletter Nr. 65)

47. Mental-Health

- MMI organised in 1996 a workshop on mental health in Padua (cf. MMI Newsletter Nr. 58)

Final remarks

The council’s working plan is rather oriented towards theological and ethical issues than in mission policies. We don’t find any indication on the former Pope’s’ Ecyclica “Populorum Progressio” nor any hint at Ecumenism nor consciousness of the revolutionary paradigm shift after Alma Ata. Strange is the rather weak representation within the Council of the more than 250,000 lady-religious working in the health field. No mention is made concerning relations to Catholic Donor Agencies such as
Cordaid, Misereor, Fastenopfer or Catholic Relief Service and others. All of them might need some common rethinking on the importance of investment in health in order to re-align to what World Bank and EU propagate in the fight against poverty.
Medicus Mundi’s philosophy of health promotion, its effort to promote “Contracting” and to find new ways of Human Resources Development will fit into joint actions with the Church, be it in the field or in continuous contacts with the Pontifical Council for Health Pastoral Care.

Edgar Widmer
22. 10. 2002, one week after the visit to the Council’s office in via della Conciliazione 3 in Rome
Publications

Aids in Africa. Voices from the frontline.
   Conclusions and recommendations
   CUAMM
   Cuamm@cuamm.org

AIDS Special. Memisa Medisch
   Dynamics of the HIV/Aids epidemic
   UN response to Aids
   HIV/Aids Anti-Retroviral Treatment
   Aids in Cambodia and Home-based care
   lwe@cordaid.nl

Medicus Mundi Schweiz Bulletin no 84
   Access to medicines
   Info@medicusmundi.ch

Medicus Mundi Schweiz Bulletin no 85
   ICT and Health
   Info@medicusmundi.ch

WHO Investing in Health, WHO Paper.
   Investing in Health = Investing in Development
   UN conference on financing for development Mexico March 2002
   WHO/HDE/HID/02.1