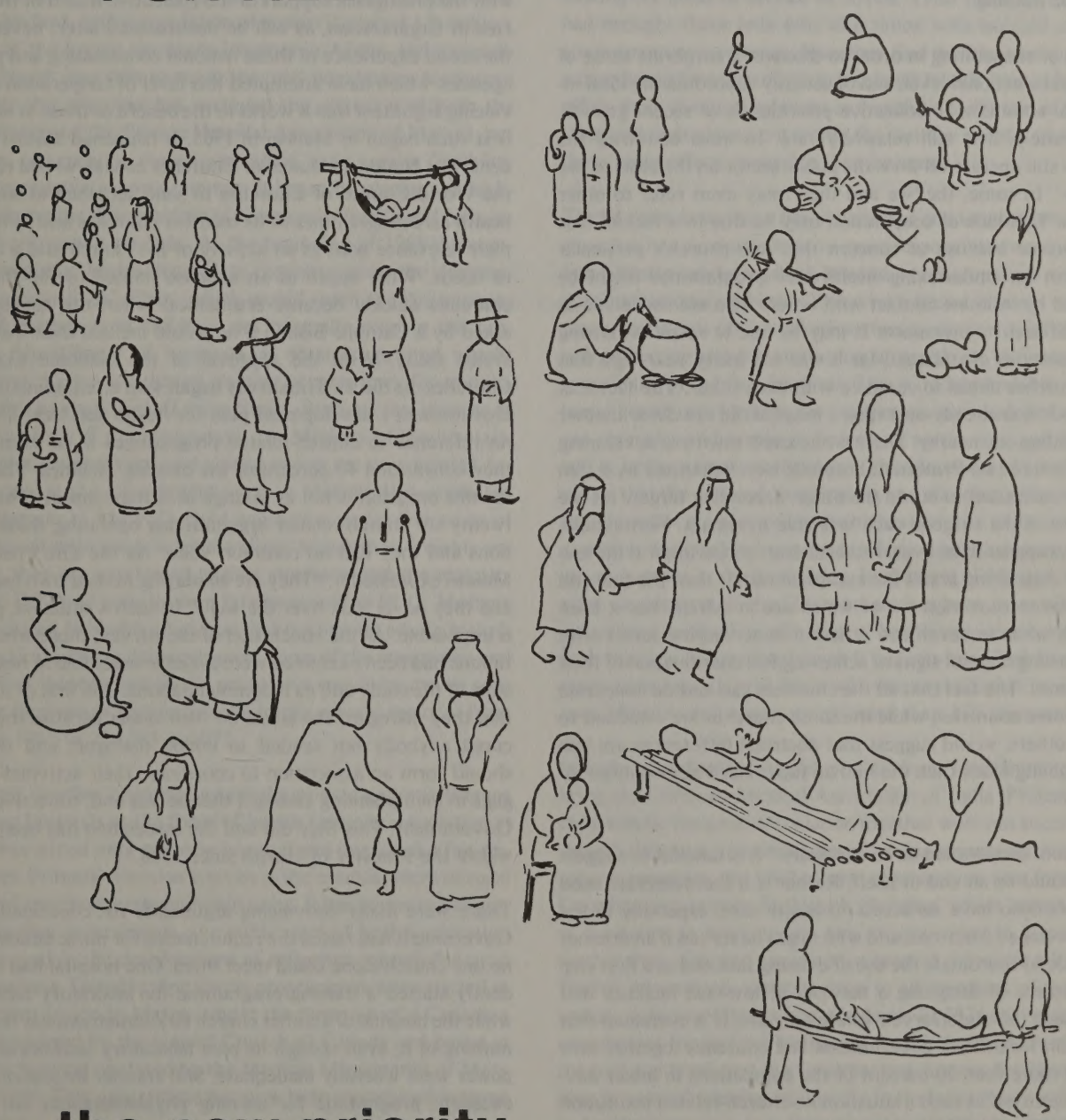
contact 26

Christian Medical Commission World Council of Churches 150 Route de Ferney 1211 Geneva 20 Switzerland

HEALTH CARE FOR ALL



the new priority

APRIL 1975

INTERCHURCH COOPERATION IN NATIONAL HEALTH CARE PROGRAMMES

Those who are familiar with Christian Medical Commission literature and reports will have noticed frequent references to national coordinating and planning agencies. This latter phrase is used to describe a situation in which those churches engaged in health care programmes, regardless of denomination, have chosen to form an organization which enables them to work and plan together for more effective service in meeting the health needs of the country in which they are situated. Cooperation, at various levels, has existed in some countries for many years, but usually in the form of separate Catholic and Protestant organizations. The motivations for cooperation were usually the need for fellowship, like with like, for sharing of experiences and problems and, in those countries where the Government granted subsidies towards costs, the need for presenting a united front in making annual requests for funding.

The idea of cooperating in order to discover a corporate sense of priorities at a national level, and of actually subordinating local institutional ambitions to collective priorities, is of recent growth. Unfortunately, it is still relatively rare. In most countries the churches still operate vis-à-vis the public sector on the basis of 'we and they'. In some, the 'we and they' may even refer to other churches. This lack of cooperation may be due to a fear of loss of identity or because of concern that one church's particular motivation for undertaking health care programmes might be weakened by intimate contact with others who are conceived as having different motivations. It may be due to suspicion arising out of centuries of mistrust, for it was not many years ago that some churches chose to compete with each other. The fact that one church was already operating a hospital did not deter another from building one nearby. There is one small town in a developing country where two Protestant hospitals were separated by a thin wall and each tried to outdo the other, depending largely on the popularity of the surgeon each was able to recruit. Fortunately, those days appear to be over. Nevertheless, cooperation at the level we are suggesting is still the exception rather than the rule and only in seven countries, six of which are in Africa, has it been achieved, while in seventeen others it is at varying levels with some showing hopeful signs of achieving full coordination of their programmes. The fact that all the churches can and do cooperate fully in some countries, while the same churches are reluctant to do so in others, would suggest that doctrinal differences are less of a stumbling block than the human factors and personalities involved.

Why should cooperation be so necessary? It is fanciful to suggest that it should be an end in itself. Rather is it the desperate need of millions who have no access to health care, especially in the lesser developed countries, and who might be served if an attempt were made to coordinate the use of existing facilities as a first step in the process of designing a network of low-cost facilities that would reach the underserved where they are. It is estimated that the present facilities of governments and churches together now reach no more than 20 percent of the populations in lesser developed countries. In such a situation no church-related institution has the right to design its own priorities. It has a moral obligation to see itself in the context of a national need – that the millions now deprived might be served. It may well be that the particular form which the individual institution takes adds to the disparity between those served and those deprived. There is one instance where a small general hospital was converted into a cardio-vascular clinic to satisfy the special clinical interests of the doctor who was assigned to it!

A further reason is that no one church alone can any longer afford to operate its own institutions. The cost of hospital-centred care has risen rapidly in each of the past twenty years. It has risen far more rapidly than the per capita income of the people to be served. Whenever hospitals have to rely on patient fees to recover costs, the gap between what they must charge and what the patient can afford to pay grows wider each year. When churches can bear each other's burdens by sharing some of these costs and by secondment of personnel, it is possible to make more effective use of the limited resources that are available.

While much of the above might be discounted as theory, even with the prestigious support of the Executive Board of the World Health Organization, as will be documented later, nevertheless, the actual experience of those national coordinating and planning agencies which have attempted this level of cooperation is a convincing argument that it works to the benefit of those in need. The first such began in Malawi in 1965. It happened almost by accident. The National Council of Churches in Malawi had requested the World Council of Churches to send someone to survey the health care programmes of its member churches and to report on their relevance both as an activity of the church and a response to needs. What began as an exercise limited to the Protestant churches quickly became ecumenical when the surveyor was asked by a Catholic Bishop if he would include their institutions in his study. With the approval of the National Council of Churches, he did so. The survey began with an examination of the Government's development plan for health services. There was no reference to church-related programmes in it, even though they constituted 40 percent of the existing facilities. The reason for this omission is not as strange as it may appear. There were twenty-six church-related organizations operating these institutions and they had no common voice. As the Life President of Malawi expressed it, "They are all playing in their own back yards and they never look over the wall." In such a situation, planning is impossible. At the conclusion of the survey, those whose institutions had been examined were asked to assemble to hear the results of the study and its recommendations. The first of these was that they disregard the labels on their doors because they never cured anybody but tended to inhibit dialogue, and that they should form an association to coordinate their activities and engage in joint planning amongst themselves and, collectively, with Government. This they did and the association has been housed within the Ministry of Health since 1966.

There were many convincing arguments for coordination. The Government had raised the requirements for nurse education and no one church alone could meet them. One hospital had independently started a training programme for laboratory technicians, while the hospital of another church 60 kilometres away had heard nothing of it, even though its own laboratory facilities and manpower were woefully inadequate. Still another institution had an excellent programme for training physiotherapists but trained only its own, whilst the Government and the other churches were in desperate need of such personnel. Through this new association, the churches resolved to carry out the following objectives:

1) to develop the highest level and distribution of health care through mutual cooperation of all the members.
2) to facilitate cooperation with the Government's Department of Health and Medical Services and to speak as the official voice

of the private sector in liaison with the Malawi Government for the furtherance of programmes, which shall be constructively related to the Government's health services.
3) to develop and coordinate training programmes appropriate to the health needs of the country.
4) to engage in regional planning.

Much of the work is done in small committees, each of which has government representation. Thus, there are committees for public health, training, nursing, material aid, new projects and priorities, and administration. No new projects are supported unless they are screened and approved by the group as a whole and have government approval.

While the initial focus of activity was centred on the development of uniform administrative practices and a sharing of personnel for more effective programmes, this shifted into a broader concern with public health activities and outreach programmes beginning in 1968. Malawi, with a population of approximately 4 1/2 million, has one of the lowest per capita incomes in Africa, and expenditure on health care fails to reach the total population. A concern to correct this situation has occupied the attention of both the Government and the Private Hospital Association of Malawi, but the latter, representing the private sector, has a greater flexibility to develop innovative programmes. It began by placing the highest priority on the development of community health and fully integrated preventive services. At the beginning of 1968 the committee on public health decided to concentrate on the development of under fives' clinics, which would reach the larger population of mothers and children, not normally seen in the outpatients departments of hospitals. It obtained printed weight charts from Kenya and began training programmes for middle-level health workers to staff these clinics. Within a few months of the inauguration of this programme, the Ministry of Health started a similar development and weight charts are now printed for both sectors at the government press in Malawi. It is estimated that 35 percent of Malawi's child population under five years of age is seen at least once in such a clinic, where their weights are checked, they are vaccinated against smallpox and the majority are given DPT and polio immunizations as well as BCG. Mothers are introduced to health education and nutritional advice including a practical cooking demonstration. Some of the integration and the scope of this new interest in preventive measures can be seen from the increase in immunizations in the private sector – from 29,735 in 1967 to 234,283 in 1972.

In contrast to other countries where the private sector continues to develop hospitals as the focus of health care, the association in Malawi has added only one new hospital and upgraded a few existing ones. Primary attention is given to the establishment of rural clinics and nutritional rehabilitation units. It has pioneered in preschool feeding programmes, the publication of health education literature, and in the development of refresher courses for rural health workers. Dental prophylactic programmes were started in the northern region in Malawi under the direction of a Canadian dentist supported by the United Church of Canada and based at a Catholic hospital operated by the Medical Missionaries of Mary from Ireland. This programme has now been introduced in three other areas.

A further advantage of coordination in the private sector has been the development of integrated health facilities across what were previously denominational barriers. Thus, dispensaries and clinics are now related to hospitals for supervision and referral services and the determination of which relates to what is based on convenience, geographical factors and population densities. Because of the growing cooperation between the Government and the private sector, this integration of services may soon extend to the national level. In fact, the present overall development plan for health services in Malawi, proposed by WHO in 1971, called for such integration. The Private Hospital Association of Malawi is represented on the government planning committee, which seeks to implement the proposal. Yet, in all these activities, the identity of each institution and its relationship to its "founding fathers" has never been lost. In addition to the above activities, the Secretariat of the Association has centralized drug, equipment, and supply purchasing for all its members. It also recruits personnel from overseas and conducts an orientation programme for them. Training programmes for nurses, medical assistants and laboratory assistants are coordinated under one central committee with government representation. This coordinated programme immediately appealed to a large group of doctors in Canada who were looking for areas of service in Africa. Their previous experience had brought them only into association with isolated church or government programmes. Now they find that their relationship to a coordinated system of church-related health care programmes offers them the most relevant and useful distribution of their services and their placement within the country enables them to render a more effective service than hitherto.

The Malawi experience has shown that cooperation amongst the churches has inevitably led to a more responsible awareness of national health needs, reaching beyond a preoccupation with individual institutional problems. The private sector in lesser developed countries has too often worked on the assumption that the prevention of disease and the promotion of health are the exclusive responsibility of the Governemnt. This is understandable when national health care systems are inappropriately modelled on Western countries and much of the private sector was, and in Africa, still is, under expatriate direction. Therefore, it is of special significance that the national coordinating and planning agencies for the private sector are now giving the highest priority to integrated programmes designed to bring more effective health care to the maximum number in the population. In the case of Malawi, the complete cooperation of the Government has been most effective in achieving a level of coordination of health service programmes at both the local and national level. It has also benefited from the arrangement, since it now deals with one organization housed in its own Ministry and representing more than 150 separate units.

In India, coordination has taken a different turn. Initial efforts to bring the Christian Medical Association of India (Protestant) and the Catholic Hospital Association together were not successful, although they took the timid step of having representatives at each other's meetings. In 1969 a new organization was formed, the Coordinating Agency for Health Planning, which hoped to serve as a catalyst in bringing the two groups together. It went even further than that, and organized in most of the states a Voluntary Health Association, which is open to all members of the private sector, including Hindus and Moslems. In 1974 the various state associations formed the Voluntary Health Association of India at the national level, and the Coordinating Agency for Health Planning is now submerging its identity in the larger body and serving as its administrative arm. One cannot resist the idea that this may be a truer representation of incarnational theology or of the parable of the seed which was cast into the earth and died (in its identity as a seed) in order to become a great tree.

In Papua New Guinea the churches fully participated with the Government in the development of a new national health plan

where each institution and programme was seen in its relationship to a national network of facilities covering the total population. Here, each facility and its personnel are part of a national effort to bring health care to all. A few tentative efforts towards a similar goal are being tried in Tanzania and Ghana. In the former, some church-related hospitals are serving as district hospitals and are so designated by the Government. In Ghana, a church-related institution serves as the supervisory and referral base for government health posts.

These, then, are illustrations of what is happening in a few places. Perhaps those who read this can find the reasons why it cannot operate in the countries familiar to them – and then weigh those reasons against the obvious advantages, the greatest of which is that more people in need of health care could be served.

* * * * * * * * * * *

COOPERATION BETWEEN CHURCHES AND GOVERNMENTS IN HEALTH PLANNING

A major theme of the World Health Organization since January 1972 has been the promotion of basic health services. It has been largely through the development of this programme that the CMC and WHO have located the basis for a greater liaison.

In one of its working papers on this subject (EB51/WP/1), the Executive Board of the WHO presented a forceful formulation of the argument for coordination of all sectors of health work, and particularly for the integration of private and voluntary agency efforts into the governmental health programme. The paragraphs that follow are excerpted from the conclusions drawn in this paper.

While health services in countries have international significance (as disease can be an international threat) their primary purpose is national. It may be considered that health decisions are an individual or personal matter, but in practice, owing to the complexities and expense of health service actions, they cannot be carried out effectively and efficiently except by groups pooling their resources. For the most part these groups must be national, even though, in order to ease administration or to increase adaptation to local needs and wishes, the executive actions of a health service may be regional, provincial or local.

The distinction between, on the one hand, the national responsibilities for stating national goals, evolving a standard health technology, and allocating resources within the national scene, and for the common use of research, training and specialized institutions, and, on the other hand, the control, configuration and administration of the services at the periphery by the consumers themselves, is a source of major confusion and error. In the Board's view, the differences between urban and rural societies, between different regional and ethnic groups, and between persons with different ways of living and values, make it essential that the interface between the consumer and the health service be influenced by the consumer and that the accepted pattern serve the needs of both the health services and the consumer. This has no disadvantage in terms of national policies and has enormous advantages as it can result in the tapping of local resources for health service purposes, make medicine "belong" to those to whom it should serve, and encourage innovation and experiment in a place within the health services that matters. The dividing line between national and local responsibility has never been adequately described. The assignment of these different responsibilities can result in insecurity and questions of control. However, the Board considers that a structuring of responsibilities within the health services which gives greater emphasis to consumer preferences need not detract in any way from the primary principle that health services must be thought of and planned as a coherent whole. Yet it seems an essential core question which must be faced and goes many steps further than the support of a decentralized federal structure in a large country.

While the reasons for developing a health service on a national basis may include economic and other factors, most successful examples have been put forward and administered to express a population's demand for social welfare and justice. For this need to be met effectively it should be expressed in terms which can be called "outputs" and which will indicate the final return to the individual in health status and in service. The protection and rights of personnel within the health service need to be removed from the consideration of this national will, and dealt with quite independently as a separate question.

Most health services authorities appear to give only token recognition to those segments of the services not under their financial or direct executive control. National health administrations often "plan" for that part of the national budget which is said to be their responsibility; provincial or regional administrations frequently act similarly. This is often done even though a large or a major part of health expenditures may be made directly by the individual, and not through prepayment or taxation. The same comment could be made about assistance from bilateral or multilateral agencies, including WHO, to countries. The actions are based upon what this or that body considers that it has the authority, resources or mandate to do, rather than upon the needs of the health services taken as a whole. This fragmentation "appears" justifiable, as it is difficult to make decisions upon matters not directly under executive control, and it may appear a harmless and innocent distortion to support one or other action in a way unrelated to the whole. However, the Board considers it unjustifiable and harmful and that some of the present health service dysfunctions are the result of such thinking. The health service must be taken as a whole, public and private; national and international; curative and preventive; peripheral, intermediate and central.

* * *

The interaction between the public (largely government or tax supported) segment of the health services and the remainder of the health care system (supported by special groups or by individual payment) is not properly understood in most countries. The non-public sector includes persons and institutions of different levels of skills ranging from the specialized hospital to the private general practitioner, the pharmacist, the village midwife, or even the local healer. It also includes persons who are supported completely by individual payments, part-time workers who may be also employed by the public sector, or even persons who have only a fringe or occasional involvement in health. All these are part of the health care system, even though the role that some of these individuals play may not be accepted as important or essential within the present view of health service practice.

The Board considers that the health services are missing real opportunities by not taking advantage of the resources in money, manpower and local organization that already exist and that could be channelled to further proper national health service goals. Their strength lies in their present acceptance by the populations, their local control, and the proportion of family and community income already assigned to health by individual decisions. Their weakness lies in confused goals and poor expression in terms of health technology, and in the lack of contact or relationship with the official health service structure. These weaknesses can be resolved.

The present position is bad but it is not unchangeable. It does not appear to be getting better and without change it is likely to become worse. Minor changes in detail will not bring about correction. Coverage can be increased or doubled, but if the present coverage rate is one per cent, a doubling is meaningless. Administrative change of "vertical services" to "horizontal ones" will not attack the important defects. A decrease of the numbers of hours spent upon anatomy and their replacement by the equivalent number of hours of community medicine in the field may not be sufficient to change a doctor's thinking and actions radically enough in later life to change the system. The need is to deal with the key features of the wider picture, rather than to make important but circumscribed reforms.

* * * * * * * * * *

THE THIRD CONFERENCE FOR COORDINATORS OF CHURCH-RELATED HEALTH WORK IN AFRICA, MOMBASA, 18-21 FEBRUARY 1975

The Christian Medical Commission had on two previous occasions called together the individuals concerned with coordinating church-related health work in Africa. The first gathering was held in Limuru, Kenya, in February, 1970 in conjunction with a conference on 'The Healing Ministry of the Church'. Those delegates specifically related to the Coordinators' Conference included 18 representatives from 12 African countries.

The Second Coordinators' Conference took place at Blantyre, Malawi, in February, 1972 in collaboration with the Private Hospital Association of Malawi and the Government of Malawi through the Ministry of Health and Community Development. The list of participants included members of the Government of Malawi, members of coordinating agencies from 14 countries of Africa, and special invited guests from donor and international agencies.

This third conference which we are reporting here represented a gathering of health workers and coordinators from 15 African nations as well as guests from funding and other international agencies. Broadly conceived, the intent of this conference was to discover the most urgent health care priorities for the churches, to examine the planning process for these, and to see how coordination contributes to this. To get at this in a concrete fashion, an agenda was proposed that included these three main topics:

1) the integration of all church-related health care programmes in national health planning;
2) the potentials within each country for development of primary health care projects as the highest priority;
3) the detailed implications of localization of staff at the senior level in both coordinating agencies and in the direction of programmes.

* * *

The first day's discussion focused on the subject of the integration of church health programmes into national health planning. The term, integration, was understood to mean the inclusion at the planning level of church-related resources and programmes into a unified national health care scheme. It was generally agreed as essential for all health services, public and private, to recognize the harmful and fragmented state of affairs now in effect. It was stressed as urgent that government and church health planners should adopt a comprehensive approach to all aspects of health provision, including public and private agencies, curative and preventive services, technical and promotive efforts, with the application of all of these to the outlying communities as well as central health institutions.

Recognizing the need for this kind of coordination and integration, the conference pointed to many of the factors which now frustrate progress in this area. These constraints can be grouped in the following way:

1) Constraints within the churches =
   a) The Theological Identity Crisis: Church leaders fear that with coordination and integration the autonomy of church administration and control of programmes will be lost. There is a major concern for the preservation of the special compassion that is thought to characterize Christian health work.
   b) The Tribal Identity Crisis: Tribal consciousness continues to be a significant influence within certain countries and has offered a restraining influence on the process of integration in those areas.
   c) The persistence of independent planning and programme development, as well as independent approaches to government

and donor agencies, even among those church programmes already relating to a coordinating agency, is a serious frustration to integration.

2) Constraints within Government =
a) The lack of a national will to integrate or include the private sector in its planning.
b) The relatively frequent changes of personnel and policy direction within Governments.
c) Political instability and upheaval.

3) Constraints within the health bureaucracy, in the Government and the private sector =
a) The lack of a sound health manpower policy in Ministries of Health and in the planning of the churches perpetuates the imbalance in the training of doctors and the training of frontline health workers. This has delayed the development of auxiliary training programmes in many countries.
b) The curative and hospital orientation of the average health professional remains an obstinate constraint. The pride in the big institutions has spread to the administrative offices in both sectors.
c) The lack of community participation in identifying needs, forming objectives, or shaping plans, is seen more and more as a serious omission in health planning. This is true largely because the health bureaucracy cannot believe that the community has relevant perceptions regarding its own health care,

4) The constraint of personality =
The dependence of the entire integration process on the personalities of decision-makers in the church, the medical profession and the Government, for good or bad, is a reality that lies behind the success or failure of many programmes.

The conference urged that each of these points should be examined honestly by health planners, and weighed against the fact that millions of people who are now deprived might be served. No longer can indifference to the suffering of these unserved millions, no longer can our callous disregard of their plight, be allowed to masquerade as uncompromising ethics, devotion to our institutions and their good standards, or the misdirected conviction that it is our Christian institutions that offer that special kind of care and compassion in the name of Christ. In fact, it is people, caring Christians and the redeeming community, that give expression to this compassion. For church health programmes, the only option is loving, intelligently planned care which is rendered to the millions now deprived, as well as those for whom it is already available. Integration of all health services is one of the keys to this kind of planning.

* * *

The Development of Primary Health Care as the Highest Priority

In the discussion about developing primary health care services, certain axioms were offered as guidelines to this process.

AXIOM 1: The provision of even basic health services is met with minimum effect, unless you provide the community with a reasonably sanitary environment, adequate nutrition, good water and the like. Primary health care must be evolved within the fabric of a total interdisciplinary approach to community development.

AXIOM 2: Designs for health programmes will not take root if they are designed for people instead of by them. Communities must first be involved by soliciting from them a declaration of their felt and expressed needs, and the priorities which are assigned to these needs. Involvement of the community in the planning and decision-making process allows health care to be an expression of the community caring for itself, instead of imposing a system from the outside that may well not meet the needs at all.

AXIOM 3: Provision of health care is more acceptable to the people if it is brought by persons selected by the community, out of the community, and who remain an integrated part of the community throughout their training and work. The training and utilization of primary health care workers is a concept that is emerging as essential in primary health care schemes.

AXIOM 4: Even without medical intervention, there is a potential for health promotion and improvement within the community that needs to be nurtured and released. This proves to be more valuable than the distant promise of medical care to be 'delivered' and to which we feel 'entitled'. It is in this light that the church as a healing community must seek to find a fuller expression, in order to extend the hand of compassion as the caring community.

Once the premise is accepted that the development of primary health care is of the highest priority, the planning must begin. Engaging in this planning is as essential for those with extensive and established programmes as it is for those who are initiating new work in an unserved area.

The process of such a planning exercise should follow a number of well-established phases and steps. The scheme presented here is one which draws on planning documents of the WHO and UNICEF as well as CMC formulations.

As the first phase, the gathering of information should cover certain points:
1) The target population must be identified and described, its perimeters and stability known, and its characteristics appreciated.
2) The epidemiological features must be known for the area.
3) The basic health needs for this population must be ascertained, as expressed by the people served, certainly, and also as perceived by the church and government health planners.
4) The resources to support the health effort must be determined and their expectations realistically known, at the local level as well as at regional and national level.

With this data as background, it should be possible to set a number of goals and objectives for the programme:
1) In contrast to the meagre 20 percent of rural, slum or remote populations that now have access to health care services, the objective of providing coverage for 80 percent of these populations would seem reasonable.
2) The programme should be capable of application within a reasonable span of time, and in full recognition of the limited resources available.
3) The development of a promising programme need not provide all the planned for elements and activities from the outset. However, growth to the full programme could be deliberately planned and achieved as a gradual process.
4) As a response to the data accumulated in the first phase, specific health improvement objectives should be set out, expressed in terms of percentage change in health indices or other parameters of expectation. These should be reasonable in number and feasible in terms of the resources available.

The activities and programmes of the primary health care system that are designed to approach the objectives set out above will ideally include most of the following:

1) Adequate immunization.
2) Assistance to families during pregnancy and at delivery; post-natal care; advice and assistance in family planning; child care ('under-fives').
3) Safe, sufficient and accessible water; adequate sanitation; vector control.
4) Health and nutrition education, including the stimulation of methods of providing adequate nutrition.
5) Diagnosis and treatment of simple diseases; first-aid and emergency treatment; facilities for the referral of serious conditions.
6) Other services that may be relevant to local conditions and health attitudes and aspirations.

The implementation of these programmes requires decision-making in several areas:

1) How the services are provided at each level; the health care facilities needed, their location and type and size; the schedule of activities at each facility and equipment needed.
2) The manpower required for these services; the specific workers required for each task and facility (auxiliaries, nurses, midwives, doctors, sanitarians, traditional practitioners and attendants and the like); the selection, training, responsibility and supervision of each.
3) The structure of supporting services at intermediate, secondary and national levels; the way that each of these supports the coverage at the frontline; communication, ongoing training, supply logistics, referral procedures; relationship of the local efforts to national health planning, preventive programmes and general community development.
4) Ways and levels of community involvement in health-related development work, planning for health projects and promotion, and in the financing and control of the health services.

* * *

The Localization of Top-Level Administrative Staff in Church-Related Health Programmes

The realities of present cross-cultural attitudes have brought a good deal of pressure to bear on the movement for localization. The reasons in support of this argument are many. First of all, nationalization, or localization, allows the churches to make maximum use of all the human resources available for action. National leaders are indeed the most appropriate persons to carry on projects within their own country, from every point of view. Second, the expatriate is by far the most expensive way to run any project or hospital. Third, the double standards for salary, conduct, and patterns of work, which will persist as long as expatriates and nationals work side by side under different contractual relationships, foster misunderstandings and ineffectiveness on the part of the expatriate. Fourth, the continued direction of programmes by expatriates perpetuates the inappropriate aspects of these programmes and prevents them from becoming an expression of the community's intent. Fifth, the continuing influx of foreign resources, including personnel, finances, and institutions, is frustrating the progress of the African churches' desire to move ahead in the way of true self-expression.

* * *

The discussion on these topics was intense and lively. There was a strong concern on the part of many that our fine institutions with their high standards are often not 'serving' the people nor meeting their real needs. Many were eager to critically re-examine the health programmes of the churches they represented in the light of national and district health planning and the needs of the total populations in their areas. It was apparent from the reports of the various countries that integration was becoming a reality in a number of them, that independent and non-community-related programme development was being discouraged.

At the same time, it was also seen that the concept of coordination was finding expression in some nations as a means to perpetuate the status quo, to dignify the financially voracious institutions with the cloak of integration. Some of the churches' medical administrators seem to be utilizing the structures of inter-church cooperation and coordination as little more than a clearing house for grant applications, improved supply logistics and visa procurement.

It is hoped that higher motivations and purpose will come to characterize coordination in all countries, so that health promotion is closely integrated with the life and mission of the church, and health care programmes become the manifestation of congregations exercising their healing ministry.

* * *

POSITION PAPER: DECLARATION OF THE AFRICAN COORDINATORS' CONFERENCE

I. LOCALIZATION OF PERSONNEL (COORDINATORS) OF THE NATIONAL COORDINATING AGENCIES

A It is imperative that African counterparts for the post of Coordinator (where the Coordinator is not now an African) be recruited within one year. The orientation and training of this person should be complete and turnover accomplished within three years.

B The participation of the church leaders should be secured in the selection and appointment. Where guidelines are present in existing constitutions, these will dictate the process and nature of the appointment. Where clear job descriptions do not exist, these should be drawn up.

C While experience in health planning or health care would be highly desirable, as would experience in development planning or administration, the Coordinator might be recruited from other fields, such as education, social work, management or administration. He/she may be sought from the ranks of church workers, but might also be found in the private sector or government service.

D Once recruited, the Coordinator should receive inservice

training. In addition, the Christian Medical Commission could be responsible for providing further training and/or experience as befits the particular person.

II. STATEMENT WITH REGARD TO EXISTING HOSPITALS

The present system of operating church-related hospitals, particularly the larger ones, has put them in a very vulnerable position. Operational budgets have increased sharply, especially in the category of staff salaries. They depend on expatriate personnel, salaried from outside sources, for many senior staff positions; localization of these positions will add enormously to the operational deficit. Church proprietors are unable to assist materially to relieve this financial strain. The pressure to increase the already burdensome and discriminatory patient-fee structure is severe. The balance which used to be possible between budgetary demands and patient fees no longer exists. Moreover, grave doubts about the end-effectiveness of hospital-centred medical care are being raised. The situation now demands an urgent change in policy.

Several courses of action may be open to the local churches. The option chosen should reflect a desire to promote the integration of our hospitals into the national health structure. It should also affirm the belief that hospitals are a necessary adjunct of primary health care programmes.

OPTION 1 The hospitals may be refashioned to come within the scope of locally available funds and personnel.

OPTION 2 A policy of partnership with Government may be pursued, such as that seen in the 'combined hospital' concept, under which the Government provides the running cost of the hospitals, including the salaries of national staff which replace expatriate staff.

OPTION 3 These institutions may be handed over to Government in a phased programme with the approval of external supporting partner and the local church.

OPTION 4 Until one of the above can be accomplished, increased support may have to be sought from overseas societies and church agencies, support which is adequate to relieve the burdensome fee structure.*

* With regard to this last option, the conference participants noted that the likelihood of substantial increases in the current level of support from overseas agencies was not very high.

III. STATEMENT WITH REGARD TO FUTURE HEALTH PROGRAMMES

Many factors compel a careful examination of the objectives of current and future church health programmes. Financially, hospital-oriented health care programmes are becoming untenable, both to the supporting church bodies and to the patient populations. Limited resources are the economic reality and framework of all church programme development. Moreover, the vast majority of African peoples are now deprived of all health care by virtue of financial, logistical and cultural constraints. These millions will simply never be reached unless a new orientation is achieved in the churches' health planning. Clearly, then, the highest priority must be placed on using available resources to provide for primary health care, meeting basic needs within the community. In the implementation of such a policy, the following points should be observed:

A Health programme development must focus on the community rather than the institution.

B Involved health professionals and church leaders need reorientation to concepts of community health programmes.

C Primary health care programmes should be low-cost in running expenses and, therefore, locally sustainable.

D This new policy direction should be seen as a joint endeavour with Government, and efforts should be made to sensitize those within government medical services as well to the imperative necessity of primary health care planning.

E Health auxiliaries fill a key role in primary health care. These are individuals, chosen by their communities to be trained as primary health care workers, to carry out health programmes which meet the communities' expressed needs.

F Where Government does not approve of the utilization of such level health workers, modifications might be made in auxiliary-level training to conform to government policy. In addition, catechist, evangelist and lay training programmes should include aspects of basic health promotion. Consideration could also be given to training traditional healers and midwives to be incorporated into the primary health care system.

* * * * * * * * * * * *

These documents were prepared by Stuart J. Kingma and James C. McGilvray
Cover design by Stuart J. Kingma