FINANCING HEALTH CARE

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Strengthening partnerships to protect the poor
No one would doubt that there is a need to increase the amount of money spent on health care in the developing world. Nor is there any doubt that efficiency in health care expenditure needs to increase.

But is the World Bank's World Development Report (WDR) 1993 entitled "Investing in Health" able to provide solutions for greater and more efficient financing? The report argues that more competition means more efficiency, with more money coming into health sector. But we believe that competition is often wasteful and that the poor are suffering.

The report was introduced in a period of economic crisis coupled with massive increase in demand for health services. The economic crisis, often coupled with structural adjustment programmes, has led to a decline in the role of government in health care, while the AIDS pandemic has led to a massive increase in demand for services and a decline in government morale in many countries. The prevailing atmosphere is one in which the role of private sector and market forces are wrongly seen as the only way ahead.

There has been enthusiasm towards the report on the part of some donors, health professionals and national health policy makers. However, many of us in the non-governmental organizations (NGOs) and private voluntary organizations (PVOs), involved in advocacy for health and justice issues, received the report with considerable suspicion. We have problems accepting that an organization which was showing little commitment to the major causes of ill-health, namely poverty, might have credible standards to prescribe or policies to promote for the health sector. Nor are we able to accept the narrow, medical perspective of the report and its strictly economic analysis. According to a CMC study on healing and wholeseness, published in 1990, health is not primarily medical. The major causes of disease in the world are social, economic and spiritual, as well as bio-medical. This makes the technocratic solutions for coping with the medical part of ill health outlined in the WDR difficult to accept.

Nevertheless, the approach to health care financing reform provided by the WDR is now being widely discussed around the world. This is why we decided that it was essential to be aware of both its pitfalls and its strengths.

In this issue of Contact, we want to chart a course ahead. We begin with the life-story of primary health care so far by publishing an extract from a paper by veteran campaigner, David Werner. He shows how the original understanding and principles of primary health care have been gradually broken down over the years leading up to the introduction of the World Bank approach within the health sector in 1993.

Next, we provide the World Bank's summary of its World Development Report 1993 on "Investing in Health". It shows not only the principles on which World Bank thinking on health is based but also outlines the policy approaches and strategies.

Thirdly, we publish the World Health Organization's response to the World Bank approach to the health crisis. It highlights the need for advocates of the World Bank approach to emphasize the role of increasing poverty when considering health strategies, and of the need for partnerships between communities, governments and donors if health is to improve.

Finally, our fourth article describes how to make the most of the report - to make the most of the World Bank's focus on health and to create an opportunity to develop our own approach and strategy for dealing with the crisis. We also begin to set priorities for action.

Later this year, we shall publish an issue of Contact looking at the responses to the financial crisis. In particular, we hope to include articles from our readers.
THE BUILD-UP TO THE CRISIS

Health activist David Werner presented a paper at a recent meeting of CMC - Churches' Action for Health on the privatization of health care. The following is an edited extract from his paper entitled "Turning health care into an investment: the latest high-power assaults on primary health care". The article provides the historical setting into which the World Bank’s World Development Report on “Investing in Health” was introduced in 1993.

By the late 1970s, wide recognition that the western medical model was failing to adequately improve health in the Third World led to a growing demand for reform. In 1978 the World Health Organization (WHO) and UNICEF convened a global conference in Alma Ata, Kazakhstan, former USSR.

To advance towards the goal of Health for All by the Year 2000, the Alma Ata declaration, endorsed by practically all governments, called for a potentially revolutionary approach. Primary Health Care (PHC) was conceived as a comprehensive strategy that would not only include an equitable, consumer-centred approach to health services, but would address the underlying social and political determinants of health. It called for accountability of health workers and health ministries to the common people, and for social guarantees to make sure that the basic needs – including food – of all people are met. In recognition that socially progressive change only comes from organized demand, it called for strong popular participation.

Unhappily, the high expectations of Alma Ata have not been met. Today, 17 years later, it is painfully evident that the goal of Health For All is growing more distant, not just for the poor, but for humanity. Some critics say that PHC has failed. Others protest that it has never really been tried.

Three major events have sabotaged the revolutionary essence of PHC: the introduction of “Selective Primary Health Care” at the end of the 1970s; structural...
adjustment programmes (SAPs) and the push for cost recovery or user-financed health services in the 1980s; and the takeover of Third World health care policy-making by the World Bank in the 1990s. These three monumental assaults on PHC are a reflection of prevailing regressive sociopolitical and economic trends.

Selective Primary Health Care
No sooner had the dust settled from the Alma Ata conference than top-ranking health experts in the North began to trim the wings of PHC. They argued that in view of the global recession and poor countries' shrinking health budgets, a comprehensive approach would be impractical and too costly. If any health statistics were to be improved, they argued, high-risk groups must be "targeted" with a few cost-effective interventions. This new politically-sanitised version of PHC was dubbed Selective Primary Health Care. Soon compromising with this view, UNICEF through its so-called Child Survival Revolution prioritised four interventions: growth monitoring, oral rehydration therapy (ORT), breastfeeding, and immunization. Although it later added food supplements, female education and family planning to this limited package of health technologies, in practice and in most countries PHC became even more selectively reduced to the "twin engines of child survival": ORT and immunization.

The global child survival campaign quickly won support from many health professionals, governments and USAID. It promised to improve a widely-accepted health indicator, the child mortality rate, while prudently overlooking the social and economic inequities underlying poor health.

But while technological solutions are sometimes helpful, they can only go so far in combating health problems whose roots are social and political. Predictably, the child survival initiative has had less impact than was hoped. An estimated 13 million children still die each year (roughly the same number as 15 years ago, although the percentage is somewhat reduced). Most of these deaths are still related to poverty and under-nutrition. In the late 1980s and early 1990s the decline in child mortality rates has slowed or halted and, in several countries (especially in sub-Saharan Africa) is now reversing.

Equally disturbing has been the backsliding both in oral rehydration therapy usage, and immunization coverage. ORT's disappointing and in some countries diminishing impact can in part be explained by the dependency-creating, disempowering way it was introduced.
From the start WHO, UNICEF and USAID promoted factory-made packets of oral rehydration salts (ORS), thus "pharmaceuticalizing" a simple solution and creating dependency on a product whose price and availability lie outside family and community control. At first ORS packets were distributed free. But when health budgets were slashed by adjustment policies, health ministries privatized their production and distribution.

Today, the price of a single packet of ORS is equivalent to one-fourth of the daily wages of some poor families. Since under-nutrition is the predisposing (underlying) cause of death from diarrhea, it is easy to see how social marketing that induces poor families to spend their limited food money on ORS packets may be counter-productive in terms of lowering child mortality.

In the last few years both WHO and UNICEF have begun to place more emphasis on less costly and more rapidly and reliably available - home production of ORS (home fluids) and continued feeding (including breastfeeding). But after a decade of marketing the packets as a wonder drug, it is proving difficult to reeducate people.

**Structural adjustment and cost recovery**

The next big setback to PHC was the introduction, during the 1980s, of structural adjustment programmes (SAPs). Engineered by the World Bank and the International Monetary Fund (IMF), SAPs are a package of policies purportedly (supposedly) designed to assist the economic recovery of Third World countries whose economies have stagnated due to huge foreign debt and deteriorating terms of trade.

SAPs usually include: cutbacks in public spending; privatization of government enterprises; freezing of wages and freeing of prices; increased taxation; increase of production for export rather than for local consumption; reducing tariffs and regulations and creating incentives to attract foreign capital and trade; and reducing government deficits by charging user fees for social services, including health.

These policies hit the poor hard. Budgets for so-called "non-productive" government initiatives such as health, education, and food subsidies are ruthlessly slashed. Public hospitals and health centres are sold to the private sector, thus pricing their services out of reach of the poor. Falling real wages, food scarcity, and growing unemployment due to government layoffs all join to push low-income families into worsening poverty. And ill-health.

World Bank claims that Third World health has improved over the past 30 years shrewdly downplay or conceal the fact that, in many countries, improvements slowed down or stopped after the mid-1980s and even more so since the beginning of the 1990s. In some, under-nutrition, tuberculosis, cholera, sexually-transmitted diseases, plague and other indicators of deteriorating conditions have been drastically increasing.

The World Bank and IMF are not the only international bodies to promote user-financing and cost-recovery schemes,
society takes from the more fortunate to benefit the less fortunate. It also means that for those in greatest need, health care is no longer a basic right.

**World Bank takeover**
A first reading of the World Bank's 1993 development report "Investing in Health" is encouraging. A summary of the report appears on pages 5-8. The report acknowledges that sustainable development requires direct measures to eliminate poverty and its strategy for improving health status worldwide sounds comprehensive, even modestly progressive. It seems the bank has turned over a new leaf.

On further reading we discover that, under the guise of promoting an equitable, cost-effective, decentralised and country-appropriate health system, the report's key recommendations spring from the same sort of structural adjustment paradigm that worsened poverty and further jeopardised the health of the world's neediest people in the 1980s.

Stripped of its humanitarian rhetoric, its chilling thesis is that the purpose of keeping people healthy is to promote economic growth. Were this growth to serve the wellbeing of all, the bank's intrusion into health care might be more palatable. But the economic growth it promotes has invariably benefitted large multinational corporations, often at great human and environmental cost.

Broadly speaking, the "new" health policy is little more than old wine in new bottles, and the report the last nail in the coffin of PHC. "Turning health into investment" would be a better title, for the bank takes a dehumanisingly, mechanistic, marketplace view of both health and health care.

David Werner is author of "Where there is no doctor", a manual which has been translated into more than 50 languages and which is used by village health workers in over 100 countries. A fervent advocate of Primary Health Care (PHC), he worked for many years in a community-based health programme in Chiapas, Mexico, and is currently active in HealthWrights, a work group for people's health and rights based in Palo Alto, California.
WORLD BANK'S VIEW OF
"INVESTING IN HEALTH"

In 1993, the World Development Report outlined the World Bank's approach to health financing. According to the leading medical journal, The Lancet, the publication of "Investing in Health" marked a shift in the leadership on international health from the World Health Organization to the World Bank. The report received mixed reactions from different sectors. Here, we reprint excerpts from the World Bank's summary of the report.

Investing in Health
"Health conditions around the world have improved more in the past forty years than in all of previous human history," according to "Investing in Health", World Development Report 1993. Life expectancy at birth in the developing world rose from 40 years to 63 years. The number of children who died before their fifth birthday decreased from almost three in ten to one in ten. Smallpox, which killed more than five million annually in the early 1950s, has been eradicated entirely.

"Yet developing countries, and especially their poor, continue to suffer a heavy burden of disease, much of which can be inexpensively prevented or cured," writes World Bank President Lewis T Preston in a foreword to the report. Child mortality rates in the poorest countries today are about ten times greater than those in the richest nations. Complications of pregnancy and childbirth claim the lives of about 400,000 women each year in developing countries where maternal mortality ratios are up to 30 times higher than in high-income nations.

"Millions of lives and billions of dollars could be saved," the report argues, even in the face of three major health chal-
A high priority for government spending should be a limited package of public health measures and essential clinical interventions, the report declares.

A slave to the colourful little pills? Let's learn to use them in moderation.

challenges over the next few decades: the aging of populations, AIDS and drug-resistant strains of disease. The report proposes that governments adopt a three-pronged policy approach to health reform:

- foster an enabling environment for households to improve health;
- improve government spending in health; and
- promote diversity and competition in the provision of health services.

Problems of health systems
There are major problems with health systems that will slow the pace of progress in reducing the burden of premature mortality and disability. These flaws also will frustrate efforts to respond to new health challenges and emerging disease threats. They include:

- Misallocation of public resources by spending on health interventions with low cost-effectiveness while critical and highly effective programmes are underfunded.

- Inequity, reflected in the disproportionate amount of government spending that benefits the affluent while the poor lack access to basic health services and receive low-quality care.

- Inefficiency in the choice of pharmaceuticals, in the development and supervision of health workers and in the utilization of hospital beds.

- A cost explosion in some middle-income developing countries, resulting from rising numbers of physicians, new and expensive medical technologies and the link between expanding health insurance and fee-for-service payments to physicians.

Policy recommendations
Since overall economic growth and education contribute to good health, governments should pursue sound macro-economic policies with a pro-poor focus and expand basic schooling, especially for girls. They should sharply redirect spending from the top levels of the health system to basic public health programmes such as immunization and AIDS prevention and essential clinical services such as family planning and treatment for tuberculosis. Governments should foster competition in the supply of health inputs, such as drugs and equipment. They should encourage a wide range of organizations, including non-governmental agencies and private doctors and hospitals, to provide health services. Government regulation of privately delivered health services is also required to ensure safety and quality. Regulations of public and private insurance is needed to achieve broad coverage of the population and to discourage practices that lead to overuse of services and escalation of costs.

Increasing the income of those in poverty is the most efficacious (successful) economic policy for improving health, the report asserts, adding that the poor are most likely to spend additional income on improving their diet, obtaining safe water and upgrading sanitation and housing. Even without income growth, health promotion can be achieved by expanding schooling, since better-educated people seek and utilize health information more effectively than those with little or no schooling. Schooling of girls is particularly beneficial, in view of the pivotal (influential) role of women in household nutrition, health care and hygiene.

Public health and essential services
A high priority for government spending
should be a limited package of public health measures and essential clinical interventions, the report declares. The most cost-effective public health activities include immunization, school-based health services, information about family planning and nutrition, programmes to reduce tobacco and alcohol consumption, and AIDS prevention. Essential clinical care in all countries should involve at least prenatal and delivery care, family planning, basic care of the sick child and simple treatments for tuberculosis and sexually-transmitted diseases.

This minimum package could cost as little as US$12 per person annually in low-income countries and reduce the current burden of disease by about 25%. Adoption of the package in all developing countries would require a quadrupling of expenditures on public health, from US$5 billion at present to US$20 billion annually and an increase from about US$20 billion to US$40 billion in spending on essential clinical services. In middle-income countries, this will require a redirection of current public spending for health. In low-income countries, it will require some combination of higher spending by governments, donor agencies and patients along with a reorientation of existing health expenditure.

Reorienting spending on health
In many countries public investment and spending are concentrated unduly on highly specialized services, facilities, training and equipment, despite the fact that the most cost-effective public health and clinical interventions are best delivered at the level of the district hospital or below. Public policy can play a useful role in redressing the imbalance. International aid for health in recent years has shifted away from hospitals and high-technology curative medicine toward primary and preventive care, but more can be done.

By reducing spending on services outside the national package, governments can concentrate on providing essential care to the poor. Spending can be reallocated by increased cost...
Countries willing to undertake major reforms in health policy should be strong candidates for increased external assistance, the report argues, including donor finance of recurrent costs.

Village health centre in Padhga, India.

Reform and aid
"The world's diversity of health care systems is matched by the diversity of reform movements," the report notes and cites some common themes of reform:

- Governments are increasingly recognizing the centrality of their own role in public health.
- They are exploring ways to introduce more competition and private sector involvement in the delivery of clinical services.
- New approaches to finance and insurance are being examined which ensure broad coverage of the population, avoid public subsidies for the affluent and control health care spending.

Reform is difficult, however, since an array of interest groups may stand to lose and because many of the changes will require the development of new institutional capabilities. Nevertheless, the report observes, a number of developing countries have shown in recent years that broad reforms in the health sector are possible when there is sufficient political will and when changes to the health system are designed and implemented by capable planners and managers.

Countries willing to undertake major reforms in health policy should be strong candidates for increased external assistance, the report argues, including donor finance of recurrent costs. An increasing number of donors, including the World Bank, which has quadrupled its lending for health over the past six years, are now supporting these broad reforms. Stronger donor coordination would improve the effectiveness of aid. An increase of US$2 billion annually in donor assistance—raising health's share of total official aid from 6% to 9%—is needed to improve services to the poor and to help control such diseases as tuberculosis and AIDS.

If developing countries and donors embrace the key health policy reforms contained in the report, improvements in human welfare in the coming years will be enormous. A large share of the current burden of disease—perhaps as much as one-fourth—will be prevented. And people around the world, especially the more than one billion people now living in poverty, will live longer, healthier and more productive lives.
WORLD HEALTH ORGANIZATION SAYS
“BETTER HEALTH NEEDS MORE THAN THE HEALTH SECTOR”

Almost two years have passed since the publication of the World Bank’s “Investing in Health”. We asked John Martin, who is WHO’s Associate Director of the Division of Intensified Cooperation with Countries (ICO), to describe the current perspective of WHO on the thinking outlined in the 1993 World Development Report.

From WHO’s perspective the world is facing a health crisis in which the immense achievements of the past three decades are being undermined, chiefly as a consequence of rapid political, economic and social changes which have occurred in the aftermath of the Cold War. We can see signs of rising infant and child mortality in Africa and falling life expectancy in countries of the former Eastern Europe, to give but two examples. Serious outbreaks of communicable diseases, whether plague in India, cholera in Peru, or diphtheria in Russia, are further signs of the deterioration of health systems. All deserve an urgent and vigorous response.

Of the many underlying and related causative factors one stands out above the rest - POVERTY. The number of extremely poor people in the world has more than doubled since 1975 and now stands at a staggering 1.3 billion. Moreover the gap between rich and poor, educated and uneducated, in developed and less developed countries is increasing. In 1960, the income of the richest 20 per cent of the world’s population was 30 times greater than that of the poorest 20 per cent. By the early 1990s, it was more than 50 times greater. In 1975, there were 27 Less Developed Countries (LDCs); today, there are 47. This increase in inequity and the poverty which stems from it is literally a matter of life and death. The poor literally pay the price of social inequity with their health.

Falling health expenditure
At the same time, per capita spending on health in the poorest countries has plummeted - a combination of severe, real cuts in government expenditure and in official aid, particularly for Africa. An unpublished OECD report estimates that overall official development aid dropped by almost US$5 billion between 1992 and 1993.

Poor housing in Venezuela: Poverty is a major cause of ill-health.

In recent years, per capita spending on health in the poorest countries has plummeted...
Such a serious situation requires solutions which match the dimensions of the problem. For the poorest countries, the harsh reality is that the health sector, alone, cannot ensure better health even if it were able to function at maximum effectiveness. We must accept that we can no longer deal with health while ignoring poverty. To halt, and then reverse, the decline in health status in the poorest countries requires a highly focused attack on poverty and its health consequences through an approach which is multisectoral. Both governments and the donor community need to adjust to this concept.

At the time when the World Development Report 1993 was produced this harsh reality had yet to be fully realized in some international circles. Today, there is a growing sense of urgency about the dimensions of poverty in the world and its multiple consequences, including for health. The forthcoming Social Summit in Copenhagen is evidence of that. Those who are intimately involved with health must seize the opportunity which this concern provides. It is not the time for health to become marginalized in a discussion about the cost-effectiveness of the health sector. It is the time to again remind the world that health is the responsibility of society as a whole and not of a sector of the national economy. This means combining the forces of a big cast of actors, including all whose actions and responsibilities impinge on health status.

**WHO response**

As part of its response to the growing inequities in health, WHO initiated a programme of intensified cooperation with the poorest countries in 1988. Currently, 26 countries are involved. The following comments are based on our experiences of working with these countries. There are two fundamental issues which have to be addressed.

**First,** there is an overall, absolute shortage of money for health care in the poorest countries. This fact must compel us to seek all feasible and effective ways of generating sustainable resources for health and not just for health care. Undoubtedly, more effective use of health sector resources is an important issue but when the poorest countries cannot afford the estimated cost of US$12 per capita for the delivery of selected health care interventions this, in itself, is not a solution.

From our perspective, it is essential that governments increase their budgetary obligations to health care financing. In many poor countries current allocations are often below five per cent of the national budget which is too low. Additional sources of funding are needed. Good potential is offered by health insurance schemes which seek to provide universal coverage to primary

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**WHAT DO COUNTRIES SPEND ON HEALTH?**

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Expenditure figures include both public and private expenditure on health. Source: “Investing in Health”, Table A.9 Health expenditure and total flows from external assistance, page 210.
health care, with an emphasis on the poorest people. WHO is supporting work to develop such schemes in Bolivia, China, Mongolia, Vietnam and Zambia.

Provision of medical care for profit is a fact of life in many countries. However, we remain unconvinced about its role in improving the health of the poorest. At the very least, a strong government capacity is required to ensure that appropriate care is made accessible to those who need it at a price they can afford and with a level of quality which will ensure an impact on health. Unfortunately, this is one of the many capacities which are lacking in the poorest countries.

For the poorest of the poor, the services provided by NGOs may be their principal source of health care. It is our impression that ministries of health are sometimes inclined to take non-governmental organizations (NGOs) for granted whilst NGOs are often wary of establishing a close relationship with government. The resulting lack of dialogue interferes with the establishment of partnership and coordination of effort which is essential if the limited resources of both are to be used effectively in providing access to the most vulnerable. Much more attention needs to be given to this issue. It is our observation that full NGO involvement in the formulation and implementation of health policies is a vital step in building stronger working relationships.

The second fundamental issue which needs to be addressed is the fact that health is not the responsibility of the health sector alone. Effectiveness of health interventions is heavily dependent on the involvement of the poorest people themselves. This was much more widely acknowledged ten years ago than it is today. It is high time that governments, donors and members of the health professions accept that marginalizing the poor whilst implementing projects in their name simply leads to failure. In Guatemala WHO has responded to this reality by decentralizing its country staff to five regional offices in very poor areas in order to provide support to community representatives and the local health workers.

Moreover, as we approach the year 2000, it is necessary to remind ourselves that access to adequate food, shelter, water and sanitation remain essential elements of an effective health strategy. Protection from crime and violence will often need to be added to the list. We should remind ourselves that it is precisely the lack of investment in basic public health measures in many poor countries that has given rise to the dramatic outbreaks of cholera and other eminently controllable communicable diseases which have occurred in recent years.

Community decision-making in action.

...second, health is not the responsibility of the health sector alone. Effectiveness of health interventions is heavily dependent on the involvement of the poorest people themselves.
WHO BACKS BUYING GENERIC DRUGS

Studies indicate that brand-named drugs are at least five times as expensive as their generic equivalent.

Essential drugs are those that satisfy the health care needs of the majority of the population. Their package may bear the symbol of the WHO Action Programme on Essential Drugs.

One of the strategies proposed in the 1993 World Development Report "Investing in Health" is to take advantage of competitive procurement of generic drugs, and to make more systematic use of the non-proprietary, or generic, names of these drugs when purchasing them.

A drug has at least three names: the chemical name (eg N-acetyl p-aminophenol) which is a precise chemical description but is too long for routine use; the non-proprietary or generic name given by national committees (WHO is also working on Proposed International Non-proprietary Names) which aims to indicate in a user-friendly form the chemical class to which the drug belongs (eg paracetamol); and the brand name given by the manufacturer (eg Panadol, Tylenol, etc). A drug may be marketed under many different brand names once the patent is expired. Before the expiration of the patent, however, the drug is the exclusive property of the patent holder and cannot legally be sold or manufactured by others except with the permission of the patent holder. During this period, prices are high as there is no competition. When a drug's patent has expired, other manufacturers are allowed to produce the drug, either under their own brand name or under the non-proprietary or generic name. With increased availability, the product becomes more competitive and its price falls. Studies indicate that brand-named drugs are at least five times as expensive as their generic equivalent.

Buying essential drugs under generic name is therefore a key element of a sound procurement policy. It has been advocated for more than 15 years by the WHO Action Programme on Essential Drugs, and is now used by many countries. To be fully successful, it should be part of a more comprehensive policy aimed at improving efficiency and increasing availability of an essential drug supply.

Pascale Brudon, WHO Action Programme on Essential Drugs
Despite our reservations about the World Bank’s thinking on health policy as reflected in the “Investing in Health”, there is a need to emphasize the good in the report. Sigrun Mogedal, the author of this article, is co-moderator of the World Council of Churches’ unit in which CMC - Churches’ Action for Health is based. She is also an expert in the organization and management of primary health care. Here, she sets out a programme for action for what she calls “private voluntary organizations”.

The impact of the World Development Report (WDR) on health policy and health reform in countries with economies under strain remains considerable. While pointing out that the report fails to deal with broader health and justice issues, it is still important to examine and debate its recommendations for coping with the crisis in health services.

Appropriate health services form an essential part of an adequate response to ill-health, even though they are not a sufficient response, nor even the most important aspect of responding to health needs. Private voluntary organizations (PVOs) have been involved in the provision of care for a long time. Yet, they have often been poorly coordinated with public services. Therefore, when the

Getting together to discuss: private voluntary organizations need to engage in a self-critical examination of their own role.
WDR calls for new partnerships in service provision, including both the “for profit” and the “not-for-profit” private sector, PVOs need to engage in a self-critical examination of their own role and experiences. They need to identify how they can better contribute to solving the health care crisis.

Two of the core concerns of the report — equitable access to basic care and an environment which enables health — are concerns which the non-governmental organization (NGO) community shares. They provide a link to the struggle for empowerment of people and for community influence in matters affecting health. The main issues for debate are therefore what kind of care is “basic” and how can basic care be made more equitably available. The WDR has launched its own approach and philosophy in this debate. Rather than reject the debate, the NGO community should be more ready to develop and present their alternative approaches and strategies.

What kind of care is a basic right?
When claiming “the principle of universality” — that health care is a basic right for all, a distinction needs to be made between the kind of care which can be seen as a right in a given country, and additional care options which go beyond what can be regarded as affordable or appropriate as a public responsibility. All countries face a situation in which cost, rather than available technology, limits the diagnosis and treatment that can be offered. Even within the Nordic welfare model, where health care is paid by progressive taxation and, in principle, equitably available, the kind of care available within the system has to be limited. Criteria have to be established for how to deal with individual cases which require more than the system can provide.

The WDR introduces Disability Adjusted Life Years (DALYs), which express the estimated loss of healthy life due to different diseases, to measure the burden of disease and for calculating cost-effectiveness of interventions. Those interventions which are best able to reduce the overall disability due to disease at an affordable cost, come out on top of the priority list for the basic care package. However, although DALY calculations give the appearance of being accurate and value neutral, they actually imply the need to make informed guesses and value judgements.

Setting priorities will always be painful, but the process [...] should be open and transparent, and subject to political accountability.

Even with these limitations, the WDR comes up with priorities for essential health services which are fairly similar to the primary health care components as defined at the original conference at Alma Ata. Rather than labelling the WDR approach as another compromise of selective primary health care, an option open to the NGO community is to make active use of the status of the report to promote comprehensive and integrated health care delivery systems, organized as close to the people as possible. A strength of the WDR is that it also stresses the need for essential first line hospital care, such as in reproductive health services. It is true that the WDR
does not deal with the unjust context in which people live and where their health is being undermined. But it does speak of the need to address underfinanced, fragmented and disintegrating health care delivery systems which operate within this context and on which people depend for treatment of life-threatening disease. The proposed essential packages of care, clinical and preventive, represent a minimum of public commitment, below which no country should fall.

How can basic care become equitable?
Equitable distribution of cost-effective, basic care is a complex task for national health systems. It requires capacity in the public administration to mobilise resources, plan and monitor, make efficient allocations, regulate, manage and coordinate, in order to make the most of the scarce resources and to increase responsiveness to clients and communities. The WDR was presented at a time when many health systems were becoming increasingly inequitable, ineffective and unaffordable, whether or not they were victims of structural adjustment policies. The need to find additional sources for financing, and the need to coordinate, balance and integrate the provision of care was obvious. For most health systems, these were priorities that urgently needed to be undertaken by different providers and at different levels in order to ensure equity, quality and sustainability.

The need for reform therefore need not be questioned. It is the policy advice given in the report, with its prescription of a slim public sector, privatization and market based competition which should be questioned and debated. So far, little experience is available to show that the WDR prescription actually works to improve equity and health status. Rather, experience so far indicates that privatization undermines equity if there is not a strong public capacity for regulation and coordination, and that direct user charges for services represent a real barrier for the poor while doing little to meet the need for additional resources and increased cost recovery.

There is therefore a need to avoid blueprint prescriptions, to develop alternative approaches to reform, and to identify necessary preconditions for effective reform. The fact that PVOs are already active as service providers and change agents as well as health and justice advocates, makes them well-placed to participate with governments in examining reform options and developing equitable service delivery models, tailored to the special situation of each country. A strength of the PVOs would be to bring in experiences and perspectives from peoples’ health movements, in order to have health systems so designed that they enable and empower people for health, support people’s own efforts and invite their influence. Participatory methods should also be encouraged for setting priorities and for monitoring indicators for equity and quality.

Participatory methods should also be encouraged for setting priorities and for monitoring indicators for equity and quality.

Partnerships
In the new private/public mix advocated by the WDR, PVOs are seen as partners which can be contracted by the government for the provision of essential services. The WDR appears to regard PVOs as service-providing contractors rather than advocates or representatives of interest groups in the civil society. The self-perception, and choice of role and purpose, of the PVO is therefore increasingly important. Some roles are incompatible. It may not be possible to work closely with government and to act as advocates for the rights of the poor.

Twins delivered in the safety of a maternity unit in Ethiopia.
Yet, there is a need for representatives of people and groups in society to act as advocates. There is also a need for people to organize and claim their rights. Finally, there is a need to serve with acts of healing as well as to build up a just and effective health care system.

**Church health services**

Churches have often been service providers without relating to any of these needs. A self-critical analysis of their own role in ensuring equitable basic care up to present is required. A partnership in service provision also requires willingness to be coordinated, and an acceptance of other partners. And it requires coordinating capacity and administrative clarity in the public system.

Governments cannot ensure equitable provision of basic care without access to additional resources for health purposes. Because there is global mal-distribution in the international economic system, there is a need for increased transfers of external resources to countries in special need, along with efforts to address the factors which sustain imbalances. The WDR's call for more external investment in health is supported by both the Programme of Action of the International Conference on Population and Development in Cairo and the UNICEF, UNDP and UNFPA proposal of a 20% allocation of all external aid for the social sector, to supplement a 20% allocation from the national government budget in each country. Other proposals for mobilization of additional international resources are currently being discussed, which should be followed with interest.

This does not however take away the need for more effective use of available resources and for mobilizing more resources for health at the national and local level. The WDR points out the need to decide where the scarce money available can bring most benefit to most people. This is a concern which needs to be taken seriously. To expand the financial base, national budgets need to find room for higher allocations to the health and social sectors. Imposed limitations through the structural adjustment programmes give little space for increasing public expenditure. It is therefore largely a question of reallocations between sectors, and one of increasing public income. Progressive taxation is an option which is receiving surprisingly little interest. As insurance systems are complex to manage, and often only favour people who are formally employed, the only option left to supplement national resources is charging the users. So far the debate has been more about the principle of charging for care than about pricing structures, exemption mechanisms and effective management of income. Here the PVOs, such as the churches' health services, have a long experience, which should be systematized and shared.
The PVO sector needs to respond to the health crisis at many levels. The responses need to be credible and creative. The contribution of the WDR is to create a common awareness of the crisis, and of the need to act. While the prescriptions can be challenged, there is sufficient common ground for PVOs to accept a role as partners in dealing with some of the critical issues of health services delivery. At the same time, it creates new opportunities for other alliances for dealing with the underlying causes of ill health.

PRIORITY FOR ACTION

Private voluntary organizations (PVOs), while constantly providing themselves and others with a reminder of the unjust context in which people live, can usefully build on the World Development Report. They should:

1. Welcome the focus given to health and use it as an opportunity to develop alternative strategies and approaches to those being promoted by the World Development Report.

2. Build these alternatives on wide-ranging current and past experience of work in the health sector.

3. Promote "the principle of universality" on the basis of the need to define what kind of care can be considered a basic right in a given country.

4. Participate in debates which affect the setting of health priorities.

5. Make active use of the status of the report to promote comprehensive and integrated health care delivery systems.

6. Support the need for reform in the health sector. However, make clear the fact that where governments have not shown a capacity to regulate health services, the experience of privatization has been to undermine equity. At the same time, direct user charges for services represent a real barrier for the poor while contributing little to the need for additional resources and increased cost recovery.

7. Participate with governments in examining reform options and developing equitable service delivery models. Encourage the participation of peoples' movements and further development of participatory methods.

8. Make a critical self-appraisal of the self-image and role, and accept the associated responsibilities in terms of partnerships.

9. Promote WDR's call for more external investment in health, which is supported by the Programme of Action, ICPD, Cairo, and UNICEF/UNDP/UNFPA proposal of a 20% commitment on external aid for the social sector to boost a 20% allocation for health from national government budgets.

10. Keep in mind the need for more resources. PVOs may find they have useful information to share about user charges. Rather than concentrating on the principle of charging for care, a sharing of experiences on pricing structures, exemption mechanisms and effective management of the income from user charges might prove very useful.

The World Bank's World Development Report is being widely discussed around the world. Whatever our reservations about it, let's take it as an opportunity to develop our own approach and strategy.
“RENEWING OUR MISSION IN HEALTH”

CMC—Churches’ Action for Health staff met with four World Council of Churches Unit II commissioners and a group of consultants from a number of countries in London, 24–28 October, to help sharpen the Unit II’s focus in health and healing programme areas. The theme was “Challenges in a Changing World: Renewing Our Mission in Health”. Papers and discussion included a history of CMC, the reorganization of the British National Health Service, and an address on future challenges by the David Jenkins, retired Bishop of Durham.

Ana Langerak, Unit II director, outlined recent world changes and their implications for the healing ministry of the churches. Participants reported on the health care situation in the Middle East, Asia, Africa, Europe, the Pacific, Latin America and the USA. These reports revealed realities common to all these areas, characterised by increasing privatization, fewer services and worsening health for the poor.

The Churches’ Commission on Mission (Council of Churches for Britain and Ireland) acted as host to the consultation, and a number of exposure visits were arranged to local programmes engaged in health-related issues.

CMC—Churches’ Action for Health programmatic work was dealt with in depth. It was reported that Contact magazine, which continues to be published bi-monthly with a circulation of 30,000, is currently being evaluated. Work with the churches on HIV/AIDS emphasizes the impact of AIDS on women who are vulnerable because of their low status in male-dominated societies.

Considerable time was given to a study of the sustainability of Christian hospitals. The aim is to provide the churches with useful tools for analyzing their future involvement in the healing ministry. The group also looked at the role of Christian health coordinating agencies and discussed items that should be on the agenda of a 1995 consultation. The report of the London meeting underscores the need for the pharmaceutical programme to continue to work with developing countries. The work includes assisting in the promotion of the essential drugs concept and in planning for the proper management and use of safe, low-cost generic drugs.

Other topics that generated much interest were the use of popular education techniques for the training of health workers and the role of traditional medicine, especially as an illuminating theme for the study on “Gospel and Cultures”.

David Jenkins, former bishop of Durham, with co-moderators, Martin Morgan (left) and Gwen Crawley.

Carlitto Salem, a participant, during an exposure visit.
Financing primary health care programmes: Can they be self-sufficient? reported a CMC study which identified the principles of successful community-based health care programmes. The original report was published in a booklet containing more detailed information, graphs and charts.

Financing health care in developing countries is the title of a list of books and journals available in the WHO library. The list is available from Office of Library and Health Literature Services, World Health Organization, CH-1211 Geneva 27.

Beyond adjustment: Responding to the health crisis in Africa includes chapters on health and health care delivery, the current crisis, a critique of the World Bank's vision of health, and "an alternative vision", including a section on the role of African churches in enhancing sustainability. It is available from Inter-Church Coalition on Africa (ICCAF), 129 St Clair Ave West, Toronto (Ontario), Canada M4V 1N5. It is also available in French from ICCAF or from Centre d'information et de documentation sur le Mozambique et l'Afrique australe (CIDMMA), 3680 Jeanne Mance St, 4th Floor, Montreal (Québec) Canada H2X 2K5. Cost: 7 Canadian dollars (bulk and special discounts available).

Financing health care

This book offers examples of different financial structures which have been implemented in response to a variety of community health care needs. Oxfam Practical Health Guide No 8 costs £4.95, plus 25-35% to cover postage and packing. Write to: Sales Ledger clerk, Oxfam Publishing, PO Box 120, Oxford OX2 7FA, UK.

Health Alert, Issue 147, "World Bank: Investing in Health" contains the World Bank summary (as published on pages 5-6) of the World Development Report 1993. It also includes The Lancet editorial on the report and letters to the editor, as well as UK's Save the Children Fund's perspective on the report. Health Alert is produced by Health Action Information Network (HAIN), 9 Cabanatuan Road, Philam Homes, Quezon City, Philippines.

New publication

Jamkhed: A comprehensive rural health project

This book describes how two dedicated doctors, Mabelle Arole and her husband Rajanikant, worked together to provide care in Jamkhed, one of the poorest districts of India, to make it one of the best primary health care projects in the world. The book tells how they developed their programme over a period of 23 years and how they helped rural communities acquire skills to collect and analyze health information and support health workers.

Jamkhed is available from TALC, PO Box 49, St Albans, Herts AL1 5TX, United Kingdom. Price £5 plus £2 postage and packing. Visa and Mastercard orders accepted.

LETTERS

Your October 1994 issue on "Rational use of drugs" was excellent, and we gratefully applaud your attention to this topic.

We were, however, alarmed by one statement made by Richard Laing (Promoting rational drug use, page 1). Concerning parenteral vs. oral chloroquine, he writes, "The common 5 ml dose normally given only contains 200 mg, while the correct four tablet initial dose contains 600 mg. This practice constitutes under-treatment." Laing's implication is that the initial dose of injectable chloroquine should be the same as the initial dose given orally. This is not the case. Intramuscular or subcutaneous chloroquine is rapidly absorbed, even in seriously ill patients. Within less than an hour it reaches a peak plasma level which is much higher than the eventual peak of a similar dose of oral chloroquine. Unless infused very slowly (over eight hours), an initial parenteral dose of 600 mg should be expected to be toxic, and possibly fatal. The usual recommended initial dose of intramuscular or chloroquine injections

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subcutaneous chloroquine is 200 mg base for adults or 3.5 mg base/kg for children, repeated 6-9 hourly until oral medication is tolerated. A total dose of 25 mg base/kg should be administered.

Considering the influence your publication has on health workers in many parts of the world, we believe this point should be clarified.

References are available on request.

Ellen M Einterz, MD, MPH&TM
District Medical Officer
Kolofata, Mora
Cameroon

Myra E Bates, MPH
Director of Administration and Health Promotion
District Health Service
Kolofata, Mora
Cameroon

Richard Laing comments:

Dr Einterz and Ms Bates are correct about rapid absorption of chloroquine injection. My point is that chloroquine injection should not be used for the treatment of uncomplicated malaria. Chloroquine is 55% bound to plasma proteins, and for this reason an initial loading dose needs to be given which can only be given safely as an oral dose.

If parenteral chloroquine is to be given, it should be given to inpatients who are carefully monitored. A malaria patient who is too ill to swallow needs to be admitted. The routine use of a single 200 mg injection of chloroquine followed by oral tablets should be discouraged.

Richard Laing
INRUD
Management Sciences for Health
Boston, Massachusetts
USA

“Compatible”
equipment donations

Regarding the equipment donation insert in Contact 139 on “Rational use of drugs”, I wish to add that whether equipment is “standard” or not, compatibility with existing equipment is an essential consideration as is (for some equipment) the ability to “grow” with new generation components as they become available.

Yvan Gyozo Somlai
Management Advisor, Health Development Project
Tribhuvan University Teaching Hospital, Maharajgunj
PO Box 1535, Kathmandu, Nepal

Editor: Thank you for this valuable comment. We do refer to the need to ensure that “a new addition will conform with existing equipment” (page 13, col 1, line 14). However, we agree it is important to give emphasis to this point.

ANNOUNCEMENTS

A world without polio is the theme of this year’s World Health Day, 7 April 1995. Available is an advisory kit to help you and your organization participate in the world-wide celebration of humanity’s next step forward: the eradication of polio, is available from WHO headquarters, Avenue Appia, 1211 Geneva 27, Switzerland. Tel: (41 22) 791 21 11. Fax: (41 22) 791 07 46. Information also available from WHO regional offices in Brazzaville, Congo; Washington DC, USA; Alexandria, Egypt; Copenhagen, Denmark; New Delhi, India; Manilla, Philippines.

News from Nyankunde
CMC - Churches’ Action for Health supported the participation of sixteen students in the programme at the Institut Panafirican de Santé Communautaire, Nyankunde, Zaire during 1994. Patricia Nickson, who is the course organizer, a former CMC staff member and currently CMC - Churches’ Action for Health consultant, says that seven students were from the Ebelowa (Presbyterian) Hospital in Cameroon, three were from RCA, two from Rwanda and four from the North West of Zaire. Of these CMC-subsidized students,

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Pat Nickson says that nine have already been followed up in their own countries. "They have all done very well," she says. Some have completely changed the orientation of their programme. "In Cameroon, for example, the health programme is changing fast, and we were happy to be able to facilitate a seminar for other staff members during our follow-up visit."

**Fund for Technology Transfer (The Fund)**

This is a loan and technical assistance programme within PATH, the Program for Appropriate Technology in Health. PATH is an international organization dedicated to improving health in developing countries.

Because the health of women and children is of particular concern to PATH, a majority of programmes are focused on this area. For more information about programmes and services of The Fund and PATH, please contact, Seattle Headquarters, 4 Nickerson Street, Seattle, WA 98109-1699, USA.

Contact is planning a second issue featuring the health financing later in 1995. We hope to publish your constructive responses to the crisis, particularly initiatives which are benefiting the poor. Meanwhile, Contact 142, April 1995, will feature "Tourism and health."

*Contact* is a periodic publication of "CMC-Churches' Action for Health" of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya, and Arabic in Cyprus. Present production exceeds 32,000 copies.

*Contact* deals with varied aspects of the community's involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to: *Contact*, the publication of CMC-Churches' Action for Health, WCC.

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