HEALTH FINANCING CRISIS

Can communities afford to pay?

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Announcements
Earlier this year, Contact 141 Financing Health Care described the changing policy and thinking in health financing. We asked you to respond to the debate about these changes from your local experiences. We were not disappointed. In this issue of Contact, we provide some of the many responses received from readers.

The first article is an interview by Contact reader Karen Anderson who works with EPES in Chile. She and a colleague spoke to two health workers from the urban squatter communities of Santiago about the effects of structural adjustment programmes (SAPs) and privatization policies on health care. World Bank adherents claim that these policies have been a great success in Chile. These health workers think differently. In particular, they say that poor communities like theirs face declining public services as more and more privatization takes place. They cannot afford to pay for private health services as they are expected to do, but they are not poor enough to be defined as "indigent" and therefore entitled to help. The reaction of these community health workers to their appalling situation is simply to strengthen their efforts to organize and fight with the poor.

The second article comes from a rural setting in Cameroon. A primary health care (PHC) programme administrator says she disagrees with David Werner's opposition to cost recovery (Contact 141, page 1-4). She says that her programme is able to recover costs in an equitable way. In answer to her letter, David Werner says that cost recovery can be benevolent if the service is something to which an individual or community aspires. Nevertheless, he still maintains that in a caring society, the state should be responsible for the maintenance of health as a right for all.

In contrast to the success in Cameroon, the experience in India (page 9) was different. Daleep Mukarji found that community cost-recovery schemes benefited the rich to a greater extent than the poor. Like David Werner, he came to the conclusion that it was vital to ensure that the service or project was the aspiration of a fully-participating community.

In the Philippines, Carl Salem, who says he has been reading Contact for many years, felt that the only way to ensure that the poor had the funds they needed to pay for health care was to create a source of reliable income. Now, all health bills are paid in kind – in ducks' eggs.

Finally, we provide an update on the Bamako Initiative which aims to bring more money into local health services. Although spreading worldwide, there remain problems. High-risk groups are excluded from services, there are risks of over-prescribing, and in some cases, community involvement is threatened by administrative burdens.

We hope that these articles will prove to be an inspiration to you. Do write and let us know. We welcome your letters.
SPEAKING UP FOR THE POOR IN CHILE

In this interview, two health promoters trained by EPES (Educacion Popular en Salud) in Chile describe the effects of health reform in their communities. They say that the poorest communities find themselves paying more for fewer, poorer quality services. The women believe that the only way ahead is to continue to organize within their communities, and to speak up as often as they can on behalf of the poor.

Introduction
The World Bank and other international financial institutions have presented Chile as a model of economic and social reforms. The results of privatization, liberalisation and deregulation have received lavish praise in international circles. But from the perspective of the poor, it is crystal clear that access and quality of health services have seriously deteriorated.

The first major decline in the quality of services began in 1973 when the military dictatorship of Pinochet came to power. After the coup, the military fired thousands of health professionals and health workers, and banned and persecuted members of the National Health Workers Federation (FENATS). The reform process led to a cut in the health budget for the first time in decades.

In 1980, also on the recommendations of the World Bank and IMF, the National Health Service (SNS) was dismantled and replaced by a set of private profit-making enterprises (ISAPRES) and the creation of the Fondo Nacional de Salud (FONASA) which manages the health services for lower income workers on public funds. During the 1980s, primary health services began to be transferred to the municipalities, and in 1986, cost recovery was introduced.

With the return of a civilian, elected government in 1990, expectations were high for an improvement in the health services. However, although health
expenditure has increased, World Bank-inspired policies are still being applied. As the crisis in primary health care deepens, the poorer municipalities are particularly badly affected. Meanwhile, the Frei government and other World Bank policy advocates continue to speak enthusiastically about the health reform process in Chile. The voices of those most affected by these reforms are rarely heard.

In this interview, Monica Maldonado and Valeria Garcia, health promoters trained by EPES who have lived all their lives in the dusty, urban poblaciones (poor communities) of Santiago, give their view of the changes.

**Question:** How do people in your neighbourhood understand the privatization process of the National Health Service?

**Monica:** People understand that with privatization, the possibility of receiving adequate health services has gone. They are gradually losing what they used to consider their rights.

For example, in this community, everyone has had to re-register at the public health clinic. This is because, officially, our community is moving out of poverty. Supposedly, because such a high percentage of this community is using ISAPRES (the private sector), we can no longer be categorised as poor.

Unfortunately, one can appear on the computer as being registered but it might not necessarily be true. My sister-in-law was able to find work last year and so she was automatically registered and had to pay for ISAPRES. But she lost her job six months later and no longer has access to private services. Nevertheless, she appears on their list of registered clients.

**Valeria:** The majority of the people are only recently becoming aware of what has happened to the health services. They feel totally vulnerable - as if there is no place to turn for help. Part of the complexity of this system is that there is a new way of classifying poverty. For example, if you have an iron or a refrigerator, you are no longer poor. The poor end up lying in order to be able to obtain the right to receive services which are now reserved only for the indigent.

**Question:** How were the services before the process of privatization begun?

**Monica:** Before, the State subsidised health care through the National Health Service. There used to be free prenatal care, dental care, immunization, well-baby care, and so on. If you were poor and needed hospital care, for example, you were guaranteed the same rights and benefits as someone who could pay. There was not really a second-class health system for “second-class citizens” as there is now.

Today, we are hearing about things in our neighbourhood which had not previously happened for many years. For example, there have been a couple of cases of women dying in childbirth in the public hospital. That should not happen in the 20th century. And who responds? Nobody.

**Question:** With so many problems from your perspectives, why do you think the World Bank promotes privatization as a model of health care for the developing world?

**Valeria:** Everything is looked at from an economic point of view, not from a human point of view. From my perspective, privatization is just one more way to line...
the pockets of the rich. There seems to be a loss of conscientiousness globally in terms of human life and human beings. Everything is related to money and consumption.

**Monica:** I am worried about who makes these decisions and based on what evaluations. When is the voice of the people most affected by these policies ever heard and listened to? Who has ever asked us what we think of privatization?

When the National Health Service in Chile began the process of privatization, we were living in a dictatorship and were not informed of the changes. Public health workers and some sectors of the population resisted the privatization process but they were repressed by the Pinochet government. Unfortunately, because of all today's one-sided hype about the reforms and "modernisation", all change is seen as "progress" for the country. We never hear about development of people, we only hear about economic growth.

**Valeria:** Inadequate health care affects all aspects of people's lives. Now that so many services must be paid for, it has become common to hear of people who have stopped eating so that they can afford to go to the doctor. We all know that this just makes you more vulnerable to illness. Once people start dying on the streets then maybe others will sit up and take notice of what is really going on.

**Monica:** We are all Chileans. We all contribute to building this country. Having access to adequate public health services is not asking for a hand-out - it is a basic human right and we deserve it.

**Question:** Do you think anything can be done about this situation?

**Valeria:** The main complaints that people have are related to the decreasing quality of the services. People feel so humiliated and frustrated by the inhuman treatment they receive. Health professionals here used to be very conscious of the reality of poor families - now it is all simply economic. There is no longer any sense of service - everything is calculated according to its economic value. The ideals of service and solidarity in this world of consumerism are not valid.

Part of our problem (with the present approach to providing health services) is that our concept of health is profoundly related to life. Health means having work, education, adequate housing, recreation, a clean environment, living without fear of government repression, and the possibility of participating actively in the policies and programmes which affect our lives. With the current privatization schemes, not only in health but also in education and other services, we are moving farther and farther away from "health for all" - not closer.

As members of poor communities, we are used to organizing and fighting to have our rights recognized. This situation is just a new moment in that struggle for us.

**Interview by EPES staff members, Karen Anderson and Lautaro Lopez, who also provided the Introduction.**
COST RECOVERY CAN WORK!

While many blame the deterioration in the health services on the World Bank's policies, Contact reader in Cameroon, Mrs P A Mitchell of the Life Abundant Programme in Kumbo, was also critical of the position taken by veteran health activist, Dr David Werner. She wrote to say that contrary to the views he expressed in "The build up to the crisis", Contact 141, February-March 1995, she had found that cost recovery could be successfully implemented for the benefit of the poor. Here is her letter in response to Dr Werner's article.

Dear Dr Werner,

I am administrator of the Life Abundant Programme (LAP), a community health initiative in Cameroon, West Africa and I should like to make a few comments regarding your article.

Cost recovery systems
Our experience at LAP over a 15-year period has been that cost recovery is an acceptable practice and works well.

a) As a community health initiative, the programme is self sustaining at village level. It encourages and builds community independence in such a way that, should expatriate personnel have to leave, it would be possible for health care to continue.

b) Because the "initiative" to have village health care always and only originates with the community, the idea of self funding and self determination is a built-in feature of the programme. People therefore understand from the outset that all income to the Health Post will be used to benefit the community. The income covers the costs of salaries, continuing education and the maintenance and improvement of equipment of Village Health Workers and Trained (traditional) Birth Attendants. Salary levels of the VHW and TBAs are agreed at the village level.

c) The Village Health Workers and the members of the Village Health Committee administer the locally-generated funds. They are all local people and are therefore able to judge with some accuracy those families who absolutely cannot afford the cost of needed treatment. In such cases, they have the right and the resources to reduce costs or even to waive them completely if they see fit. However, in practice this rarely happens. Either

- people are encouraged by the Committee to pay in instalments, or
- a method of bartering goods is found for them, or
- a formal appeal is made to the local church which may then help. In reality, this is a less common option not because the church will not or does not want to help but because the people realise that once again this represents the dependence that they have tried so hard to avoid.
Taxation
In some countries, the central government tax structure does not incorporate or is not adequate to support Health Care for All. If health is provided by outsiders or local agencies, there is the dependency that goes with it. Additionally, in the many countries where the system is corrupt, even funds raised to pay for drugs or treatment is frequently diverted, and overseas aid salted away in private bank accounts before it ever reaches those for whom it was intended. There is therefore no practical alternative to some form of cost recovery system if health care is to be truly indigenous and sustainable.

Targeting
In our programme, preference is not given in any particular individual or group. Health care and teaching are offered on a non-partisan basis to all.

While the Village Health Workers take responsibility for maintaining continuous teaching and care in their communities, qualified nurses make support visits to their group of posts and conduct vaccination and referral clinics. Funding for these visits comes from the larger Integrated Health Centres and Hospitals. These bigger centres are also funded to a large extent through cost recovery. Only about 30% of salaries and costs of these qualified nurses is met by overseas funding agencies, and this figure is decreasing annually in real terms. However, as the programme is continuing to develop, there is an increase in the overseas contribution in direct proportion to the expansion for the time being. To-date funding agencies have agreed to underwrite this cost.

Contrary to what you say in your article, the health centres find that as people's awareness of improved health standards increases, so does the utilisation rate (UR). This is a finding of this year's LAP Evaluation conducted by Bread for the World.

Thank you for the clear and concise assessment of the Health Care situation in developing countries and factors contributing to the difficulties that so often beset primary health care in these countries.

Mrs P A Mitchell SRN RMN
LAP Administrator
The Life Abundant Programme
PO Box 9, Kumbo, NW Province
Cameroon, West Africa

We forwarded Mrs Mitchell's stimulating letter to David Wemer and asked him to send us a copy of his reply to her. Please turn over.
The following are extracts from David Werner's response.

Dear Mrs Mitchell,

Thank you for your letter. Many of your points are well taken. You do well to emphasize that in your health community programme in Cameroon, cost sharing has been successful and is conductive to self-reliance. To a greater or lesser extent, this has been true of many self-determined, non-government grassroots programmes.

What needs to be clarified is that "cost sharing" can be either benevolent or malign, depending on whether it is initiated from the bottom up or imposed from the top down. When it is something that a person aspires to, either individually or collectively, then it can be potentiating. When it is something imposed in order to shirk responsibility, and as a denial of human rights, it can be oppressive.

In a similar experience to your own in Cameroon, I have been involved for many years in a community initiative run by local villagers in the mountains of Mexico. For better and for worse, most of the health care people receive is what they manage to provide or pay for themselves. As in many countries where governments administer inadequate basic health services to those in greatest need, community-level initiatives must do their best. Under such circumstances, families, neighbours and members of the community try to help each other and share costs in times of need. But this sort of benevolent "cost sharing" is quite different from the current heavy-handed global policy of imposing cuts in health budgets, and making poor people pay for services that were previously covered or subsidised by the state. Worse still, this increased burden on the poor comes at a time when real wages are falling, when landlessness and unemployment are rising, and when the gap between rich and poor is widening.

One way or another, people necessarily contribute to the costs of health care; that is to say "cost sharing". In a humane, caring society, the larger group or collective provides a helping hand to its individuals in times of hardship or illness.

We are all in favour of self-determination and shared responsibility. Certainly, each individual and family should be encouraged and helped to take the primary responsibility for their own health. But part of that responsibility is not just paying for health services. It also involves joining together in an organized demand for the social conditions and public services that make health and self-reliance possible, not just for oneself but for all. To make self-reliance possible and sustainable for all, we must be sure that land, wages, employment and education - and social guarantees in times of need or emergency - are fairly distributed. In a just society, people can be asked to pay their share of the costs when they are assured their share of the gains.

I think that basically there is much we agree upon. I thank you for your letter relating your experience calling on me to try to clarify the issue more clearly. Keep up the good work.

David Werner
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QUESTIONING THE
“ROBIN HOOD” APPROACH

Daleep Mukarji, former general secretary of Christian Medical Association of India (CMAI) and now working with World Council of Churches, has managed several major health programmes through periods of financial crisis. Here he describes the difficulties that he faced when he adopted the Robin Hood* approach of raising money from the rich to pay for health services for the poor. He concludes that if the rich are not to benefit more than the poor, the primary objective of community financing initiatives must be community involvement and serving the needs of the poor.

Like many other non-governmental organizations (NGOs) involved in health care, church-related hospital and community health programmes find it increasingly necessary to raise funds and reach some level of self-reliance. My experience comes from an involvement in a community health and rural development programme in India in 1970s. We decided that we wanted to raise funds in the community not only because we needed this money but also because we believed that some contribution and participation from the community was important. People would value our services if they paid even a small contribution.

First, we introduced fee-for-service. Our staff and health volunteers knew the community and therefore were able to grade charges, raising more funds from those who could afford to pay higher fees. However, the fees only covered curative care given at the base hospital and those who could pay and travel to the hospital benefited most. The poor did not benefit. They could not take time off to travel to the hospital, and did not have the funds even to pay for registration. We subsidized essential antenatal and child health services in order to make them more widely available. However, we were still not able to reach the whole community.

* Robin Hood was an English forest outlaw in the Middle Ages who stole from the rich to give to the poor.
WHAT ARE THE INCOME-RAISING OPTIONS?

**Community contributions**
- donations from local charitable organizations and from churches, local clubs, industry, philanthropists and wealthy community members. Donations can also be made in kind.
- fee for services in which payments are made directly by patients/beneficiaries for services.
- prepayment schemes, including a variety of community-based health insurance schemes.
- health tax/community levy is possible where all are involved in a defined community and where there is an acceptable community leadership.
- fundraising schemes, such as public entertainment shows, lotteries and subscription drives.

**Government grants**
NGOs should avoid becoming overly dependant on their government. It is also worth remembering that many NGOs spend much time and money coming to grips with the government bureaucracy and then still do not receive their grants regularly.

Governments may also assist NGOs in obtaining funds and supplies from Unicef, WHO and other international agencies.

**Donor agencies**
It is important to be clear from the start that donors have their own priorities, pressures and policy guidelines. Many NGOs have felt forced into programmes designed to fulfil the standards and reporting requirements of donors.

**The entrepreneurial approach**
Some of the tried and tested options include:

a) Income generating schemes, such as renting or leasing part of their land, buildings and equipment in order to produce an income.

b) Soft loans and special assistance from banks and financing agencies to pay for profitable ventures.

c) Providing health schemes so that local industry can offer health services to employees.

d) Endowment funds

e) Specialised services by hospital and programme staff such as offering training courses and consultancy.

f) Building trustee support among those who are members of the church, trust or group which owns or runs the NGO health project.

**Community insurance**
We therefore initiated a community health insurance scheme with which we hoped to cover the costs of preventive health services. This prepayment health insurance scheme was drawn up in consultation with several community leaders. We emphasised that the payment would be voluntary and related to ability to pay and would cover the preventive care of women and children below the age of five years.

We had great difficulty explaining the scheme and persuading the local people of its value. They wanted to see how those who joined fared before enrolling themselves. Many of those who paid the full fee (US$1) could have afforded more. When they needed services, they were not charged. Others, who had not paid the contribution, were charged. They tended to be the poor who had no spare cash but were more in need of services. We began to feel that we were
subsidising the rich while making the poor poorer. Within three years we had scrapped the scheme as a failure.

We studied similar schemes in India and found that they worked better in a semi-urban setting. There, payments could be linked to an individual's regular income, or better, to the regular contributions of an employer or cooperative.

**Donations**

Our third initiative focused on encouraging community donations to the programme. We believed that the community should be encouraged to provide facilities or to contribute in cash or kind. Again we were to see the poor suffer.

In a few villages, people offered us their homes to run clinics, organize meetings and store supplies. Inevitably, it was the rich who had rooms or buildings to spare. Some expected special favours, free treatment and even jobs for friends in return. They also objected to people from lower castes coming to their homes. Dalits, the "outcasts" of India, were therefore excluded from the services.

When we appealed for voluntary labour to help build roads, wells or a communal building, it was the poor who offered their manual labour. They were happy to do so because it was the main contribution that they could make. But this meant that the poor were again exploited this time by us. While they worked on the project, they were losing the income they could have earned working elsewhere.

We came nearer to ensuring that costs were shared fairly when the community itself organized the effort. In some villages, funds and food donated by the well-to-do could were managed by the local people. When a common facility was to be built, these resources were used as payments to those who undertook the physical work. Everything went more easily when the effort was organized by the community and only facilitated by our project staff. However, we had to make it clear that the new facilities were to be owned and used for the benefit of the whole community - and not for us. We had to show that we understood ourselves to be the outsiders.

Our experience over the years led us to the conclusion that we needed to encourage community financing but not as a way to make money for our project or organization. We did need to raise funds for the programme but the more important challenge was to reach the whole community, especially the poor. The fact that the poor were not always benefiting required us to reassess our approach.

**The way ahead**

We asked ourselves: Were the funds raised through community financing for us or to improve the health of the community? In answering this question, we began to change our role and our emphasis. It was clear that our priority was to stimulate a mechanism in which the community could take a lead in efforts to help themselves. What was needed was community education, mobilization and organization. We started to invest more in community building, encouraging local leadership, ownership and responsibility for the activities. In this way, we found that community financing could become part of an integrated approach to financial stability for voluntary agencies in health. The vital component is to keep in mind not only making ends meet but the primary objective of community health, remaining sensitive to the needs of the poor and marginalized.

A poor man in Bangalore discusses his problems with a nurse.
WHEN DUCKS PAY THE HEALTH BILLS

Contact reader in the Philippines, Carl Salem has helped set up an income generation programme to help a poor community pay for the health services they need. He supported local people in their desire for a duck rearing scheme in a remote area on the southern island of Mindanao. He believes that while poor communities are waiting for government health initiatives, there is a need to organize locally.

Kapitbahayan (neighbourhood) Health Programme has produced a breakthrough in health financing in Cotabato, southern Philippines. The programme has created some unique relationships. In an effort to provide health care, new relationships between the rich and the rich, the rich and the poor, and the poor and the poor have been created. All these relationships are based on our ducks!

We began by defining the community living around the Salem Child Health Clinic into a catchment area. Those included in this group were invited to become involved in health promotion and health education activities. In this process, we began to raise money from wealthy members of the group in support of the health needs of the poorer members.

Poorer members of the group include 500 families of the aboriginal (indigenous) Manobo tribes of village Barangis. Although nomadic and extremely poor, these people have struggled to organize in a response to their health needs. The traditional approach to this “banding together” is known locally as Kapitbahayan, which is now also the name of the alternative health care scheme. In coming together to discuss...
health and future survival, the families decided that what they really needed was some savings. They preferred the idea of a non-withdrawable, non-monetary savings scheme and therefore proposed the idea of a livestock fundraising project. In response, the Salem clinic scheme started to raise the funds to buy the chosen livestock – ducks.

The scheme works because it provides a health and food assurance. If anyone is ill and seeks treatment, the bills are paid for from the funds provided by the duck farm. No-one has to borrow to cover bills. It also works because the elders agreed that a local management committee would take charge of the preparation, construction and maintenance of the duck yard in the ancestral lands. A feeding rota involves the children in each family, and duck-feed is procured locally in order to keep costs down.

In order to prevent pilfering, the children were made the official owners of the ducks. In Manobo culture, anything that has been given to the children cannot be taken away by the parents.

There is a need to pursue innovative health financing schemes like this one. How many of our churches have allocations for health-related activities? At best, the healing mission is often reduced to “medical missions” and “free clinics”. Unfortunately, these breed greater dependency among our people. We all need to think about approaches which build self-reliance through real participation.

**SOCIAL HEALTH INSURANCE: CAN IT WORK?**

Because the duck farm scheme worked so well, Carl Salem attracted the attention of the Philippines’ Department of Health. He has now been asked to start a pilot project in social health insurance. With government support, he is asking families in the community to contribute “One peso a month for health care”. Any household enrolling all members of the family at one peso a month each for a period of six consecutive months will be entitled to preventive, promotive and out-patient curative government health services. Carl says that no-one should fear losing their money since the scheme is registered with the Department of Health’s Health and Management Information System (HAMIS), a body authorized to discover and implement innovative models of health care for the community.

**“ONE PESO A MONTH FOR HEALTH CARE”**

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**EXPIRY:**

![Social health insurance card]

We all need to think about approaches which build self-reliance through real participation.
CAN BAMAKO HELP SOLVE THE CRISIS?

How much of a contribution has the Bamako Initiative had in responding to the financial crisis? Can user fees, pre-payment schemes or revolving drugs funds provide the resources needed to stimulate community-based health programmes? Since much of the community funds are raised on drug charges, we asked pharmaceutical adviser to CMC - Churches' Action for Health, Eva Ombaka to give her assessment of the success of the Initiative.

The aim of the Bamako Initiative, launched in Mali in 1987, was to bring locally-raised funds into the public sector health care system. Primary health care services were suffering as a result of cutbacks in health budgets. It was hoped that by introducing user fees, pre-payment schemes or revolving drugs funds, there would be money available for communities to spend on improving and extending local health services.

From the start, CMC - Churches' Action for Health has had reservations about the approach. If poor and marginalised groups now had to start paying for health services, it was likely to deter them from using the services. There was also the risk that if the money was being raised on the drugs, over-prescribing might be the result. However, given the fact that health services were receiving less and less from public funds, what was the alternative to raising funds from local users of the services?

Recent reports on the progress of the Bamako Initiative show that thousands of health centres in 33 countries, mainly in African countries but also in Asia, Latin America (Peru) and the Middle East (Yemen), are now participating.

The evidence from an evaluation of Bamako Initiative activities in five African countries in 1992, makes it clear that "community co-financing" does have the potential to generate income and revitalise health centres. More people are using the health centres involved in the Initiative in Guinea, Nigeria and Kenya.

However, the poorest and more marginalized people, who need the health services most, are not benefiting from the effects of the Initiative. Although there was no evidence from these reports that the Initiative had actually worsened the situation for the poorest, our undocumented information from different parts of Africa suggests that the poor use services less once charges are introduced.

A second problem emerging from the reports is equally worrying. While the Bamako Initiative was expected to increase community involvement, it appears to be having the opposite effect. Implementing the activities involves such a range of tasks that the limited management skills of committees are being overstretched. As a result, the degree of community involvement in decision-making is being restricted. New ways of supporting communities need to be found to prevent the Bamako Initiative undermining the involvement of communities.

References are available from CMC - Churches' Action for Health.
Financing primary health care programmes: Can they be self-sufficient? is a report of the study prepared for the Christian Medical Commission (now renamed CMC - Churches' Action for Health) in April 1987. It contains case studies of the experiences of various projects in community financing in different parts of the world. It charts the strengths and weaknesses of different approaches, as well as appropriate uses, supplementary needs and common problems. Available from CMC - Churches' Action for Health in English, free of charge.

Community financing for health care provides an excellent case study from Bolivia, a country in which a system of "free" health care was followed by two types of community financing, direct user fees and then a prepayment plan. The book draws out equity and community involvement issues. It is available from KIT Press at a price of Dutch florins 15 (ISBN 90 6832 824 7).

Ecumenical Church Loan Fund (ECLOF) is working in 40 countries offering loans (through a revolving fund system) to churches, church-related bodies and organized grassroots groups. The fund promotes self-help initiatives that can achieve sustainability before the date on which the loan must be repaid. ECLOF feels that alleviation of poverty goes hand in hand with good nutrition and health. Primary health care programmes; sewage, drinking water, and, nutrition and hygiene training are funded from ECLOF Development Capital, the idea being that people can only work and develop with proper nutrition and good health. For more details write to ECLOF, c/o Contact, CMC - Churches' Action for Health. An ECLOF leaflet is available in several languages.

WCC Scholarship Programme aims to support churches and church-related organizations in training and building the capacity of their personnel. The Scholarships Committee gives priority to applications from women and younger people, and to studies that can be undertaken in facilities in the South. All applicants need to have the support of their employer. For information and application form, contact the national correspondent for the programme via your church. He or she is likely to be based in your council of churches.

Directory of European funders of AIDS/HIV projects in developing countries is an attempt to provide the information which organizations need to select the correct funder for their particular project. It also gives practical guidelines for those with little experience of fundraising and proposal writing. It costs £10 but is free of charge to those in developing countries. It is available from UK NGO AIDS Consortium for the Third World.

Directory of funding sources for safe motherhood projects was prepared on behalf of WHO's Maternal Health and Safe Motherhood Programme. It lists the agencies which responded positively to an enquiry undertaken by AHRTAG. Each entry contains information on who to contact, the types of project supported, where to apply, grant size and conditions for support. The directory also provides general advice on preparing a project proposal. A limited number of copies are available to readers from CMC - Churches' Action for Health.

FUNDING SOURCES

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<td>UK NGO AIDS Consortium for the Third World Fenner Brockway House 37/39 Great Guildford St London SE1 OES - UK</td>
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FRENCH NUCLEAR TESTING: IT'S ABOUT MORE THAN CANCER...

On 5 September 1995, when the French nuclear testing resumed in Moruroa, John Doom, WCC’s Tahitian Executive Secretary for the Pacific said, with tears in his eyes: “Now, from them (the French), it is official - we are no more a People. For them we do not exist”.

WCC believes that it is role of the churches, of WCC itself and of Christians everywhere to resist, protest and pray that the Maori, the indigenous people of Polynesia, survive so we all may survive.

The WCC’s Pacific Desk has been active for many years in supporting the call of the people of Polynesia to have these tests stopped. Concern centres not only on the increasing rates of cancer, stillbirths and fetal deformities but also on defending a people’s right to their land.

When violent demonstrations broke out in Papeete, the Tahitian capital, in September it was particularly shocking because it was against the culture of the Maori People. Feeling that their land, ocean and environment was being destroyed, they felt compelled to act.

Life and land

One man explained: “In our culture, when a woman has a baby the placenta is planted in the land to keep the spirit with the land. When I was born, my mother’s placenta was buried on the land belonging to her side (of the family). This land becomes my land and my roots. We have the feeling now that with the testing, the French are planting poisonous destruction in the motherland.”

During a WCC team visit in 1995, representatives heard that since underground testing in Moruroa had started; those living in Moruroa and Fangataufa, a nearby island, had been told by the authorities they must no longer fish, nor eat the fish.

Several men had described how difficult it was to stop make people understand why they should not eat the fish. Fish was a vital part of their lives. The irradiated fish did not look poisoned, and sometimes the resulting illness took a long time to become evident. Putting the message across was not made any easier by the fact that the French authorities did not communicate the dangers adequately. A local spokesman said: “They say, ‘Don’t eat the fish, or the coconuts’ and then make observations about the impact when people ‘disobey’.”

Cancer cases

There is also evidence that French nuclear testing in the Pacific has resulted in increasing numbers of cancer-related deaths. An investigation of the health effects of the French nuclear testing programme in June 1995 by Le Centre du Documentation et de Recherche sur la Paix et les Conflicts (CDRPC) tried to piece together incomplete information. It concluded: “This leads us to suppose that the cancer rate in Polynesia is much higher than the rate indicated in available data”.

Birth defects

During a visit in August 1995, WCC staff heard several testimonies from people with deformed children. A pastor said that a little daughter had been born to him and his wife with “no right side to her heart”. She later died. He also had a son with cancer and a third child with bone malformation. “What is heartbreaking, according to Brenda Fitzpatrick, WCC Executive Secretary for Communication, “is that this man takes on himself the guilt for what has happened to his children.” Nevertheless, she says that as well as his personal anguish, there is also anger at what has happened to himself and his people. “At one point he told me: ‘If I was not a pastor I would really make a revolution because sometimes in my heart’.”

The content of this article is taken from reports prepared by Brenda Fitzpatrick, Executive Secretary for Communication, Unit IV - Sharing and Service, World Council of Churches.
WOMEN AND HIV/AIDS: IN BEIJING AND SOUTH INDIA

At Beijing's NGO Forum in September 1995, a World Council of Churches (WCC) workshop on "Women and health and the challenge of HIV/AIDS" run by the Asian Women's Human Rights Council focused on heterosexual transmission, judgemental attitudes, the difficulty of negotiating safe sex practices, and the links between wars, poverty and HIV/AIDS.

Two Lebanese health workers, Jihane Tawilah and Seta Khedeshian, noted that in Lebanon HIV/AIDS transmission is mainly heterosexual. Sex is a taboo subject for married women, who dare not challenge their husbands on this score. In a community in which AIDS is often considered a punishment for sin, women whose husbands have AIDS are blamed, while those who are infected themselves are totally rejected.

Budi Wahyuni, a family planning worker from Indonesia, and Celia Carlos, a human rights worker from the Philippines, said that the low social status of prostitutes puts them in a weak bargaining position as regards safe sex practices. Women have no control over their own bodies or their sex life, said an Indian Daiti involved in a national information campaign on AIDS. Ruth Manorama Bawa discussed campaign work with illiterate women, but she said that the fact that the women often did not want contraception made it difficult for them to have safe sex.

CMC in India
Meanwhile, in South India, CMC - Churches' Action for Health held a parallel workshop. Thirty participants met at the Christian Medical College in Vellore, South India, to discuss the research findings of work supported by CMC in Thailand, Uganda, Brazil, Argentina and Chile.

There were many highlights. The research showed that women are particularly vulnerable in conditions of poverty, migration, injustice and oppression. From Latin America, Thailand, India and Uganda came evidence that HIV spreads more readily where women's position is subordinate, and where they lack control over their own sexuality. From Brazil, Cristina Cavalcanti's research on Women, AIDS and media provoked much reflection on the power of media to promote gender stereotypes which hide truth. Anne Skjelmerud's presentation on "Gender Analysis" provided a valuable framework for the Participatory Action Research programme in Uganda.

Helen Worth, from the USA, has been HIV positive since 1981. We were deeply moved by the openness and love with which Helen and her husband, Jim shared their own spiritual journey.

Platform of action
From her experience in shanty towns in Argentina, Cristina Gutierrez suggested that the churches, by perpetuating patriarchal assumptions and theologies, are actually promoting the low status of women. Women's lack of status often makes them more vulnerable to the transmission of HIV. The Platform of Action (see next page), when it was finally (and unanimously) agreed, took note of this perception, and challenged the churches to demonstrate, within their own lives, that they were committed to redressing the imbalances spotlighted by this research.

Gillian Paterson
ECUMENICAL PLATFORM OF ACTION

WOMEN'S HEALTH AND THE CHALLENGE OF HIV/AIDS

Introduction
The HIV/AIDS epidemic is affecting all aspects of people’s lives. Economic, social and cultural factors which perpetuate the subordination of women are contributing to the spread of the virus and exalberating its effects on the lives of women. We acknowledge the excellent work that is being done in many situations, but in general, strategies of prevention and care by governments, churches and non-governmental organizations have so far failed to influence the broader determinants of the situation of women.

What has this to do with the churches?
Where the Church is silent in the face of injustice in the lives of the people, it is not being faithful to God’s mission. The time has come, then, for the Church to examine and assess the extent of its complicity in upholding the social structures that perpetuate women’s subordination.

In some parts of the world, for instance, the churches have collaborated in the myth that the transmission of the AIDS virus is confined to commercial sex workers, homosexuals and drug users. This is untrue, damaging, and needs to be refuted.

This workshop, therefore, was initiated by the World Council of Churches, and held at the Christian Medical College, Vellore, South India from 1 through 7 September 1995.

We are a group of thirty people from five continents, from Argentina, Brazil, Chile, Costa Rica and Antigua; from Uganda; from Cambodia, India, Philippines and Thailand; from Australia and the United States of America; from Germany, Norway, Sweden, and Britain and Ireland. All of us have practical experience in working with church programmes related to HIV/AIDS. Some of us are living with HIV/AIDS.

Our task was to share experiences of ongoing work on the theme of “Women and health and the challenge of HIV/AIDS”. All of us had found that this work had continually challenged our thinking, our attitudes and our theology, and had transformed our vision. In sharing our experiences and the results of our research, we found that we do in fact have much in common; that we gained strength and confidence by exchanging perspectives; and that the issues we faced – though from widely differing contexts – were very much the same. We were able to reach unanimous agreement about an ecumenical platform of action.

Platform of Action
1. We call upon our churches to engage in self-critical examination of the Church’s participation in and perpetration of cultural biases and patterns that contribute to women’s subordination and oppress on.

2. We urge our churches to create an environment where the life experiences of women can be heard without fear of judgement, in an atmosphere of mutual trust and respect, so that the issues that emerge may be addressed.

3. We strongly recommend that the churches re-evaluate the ways in which we have interpreted the Bible, along with church traditions and images of God. Many Christians have accepted these as truth without considering how far they are (or are not) rooted in people’s daily realities, and consistent with the liberating message of Jesus.

4. We challenge the churches to acknowledge openly the sexual dimension of human experience and allow for this dimension to become part of ongoing church dialogue.

5. We commend this platform of action to our churches worldwide in the loving hope that they will remember always, in their consideration, reflection and prayers, that these issues have to do not with abstract ideas but with real people, the quality of their lives, and their well-being and health.

Vellore, 7 September 1995
Thank you for the surprise package of several back issues of Contact. I have now had a chance to go through the literature with members of the health committee. We have learnt much from sharing the experiences described in the articles. We are now taking a new perspective in primary health care. The committee felt the following issues to be especially challenging: a) empowerment, b) selective implementation of primary health care (PHC), c) funding the programme, and d) the gap between the rich and the poor.

Already we have taken certain steps which support our empowerment and the funding of the programme. We have regular review and planning meetings which involve supporting agencies; our committee is now responsible for the compilation, analysis and dissemination of the reports; training is now done locally to cut costs. We also held a mini-Harambee (fundraising event) in August 1995, and raised 11,644 Kenya shillings (US$210) to cover the cost of office equipment. It was a jubilant occasion because the community health workers and committee members who organized it thought that such an achievement would be impossible.

Our plans for the rest of the year include a Health and Development Festival in November; organizing a workshop on strategies for fundraising, and mobilizing the community into effective participation in national days. Planned activities for these events might include carrying out environmental cleaning, minor repairs to infrastructure, such as health facilities, and drama, songs and poems.

Paul Achach Magundho
Secretary, Community-based PHC programme
South Gem
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Akala via Kisumu
Kenya

USEFUL PUBLICATIONS

Child health dialogue
This new child health newsletter from AHRTAG will replace Dialogue on Diarrhoea and ARI News providing practical information on the prevention and management of the five main childhood illnesses. Appearing quarterly, new features will include an eye-catching colour design, regular columns on essential drugs and training tips, simplified research updates and quizzes. It costs £12 per year but will be free to readers in developing countries. For more information, contact: Kate O'Malley or Mary Helena, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK.

Power and participatory development
According to its subtitle, this book aims to connect theory and practice. It looks at the theoretical basis to participatory development work, drawing on related debates in anthropology, development studies and feminism. In particular, it explores the power dimensions of participatory development and research, and attempts to look at the shifts in power within communities and institutions which are needed for participatory ideas to be effective. Case studies are taken from both Mali and the UK. It costs £5.95 (ISBN 1 85339 241 3) and is available from Intermediate Technology Publications, Intermediate Development Group, 103/105 Southampton Row, London WC1B 4HH, UK.

Pictures, people and power
This book by Bob Linney is for people who want to make and use pictures for development. It is aimed at health educators and community level workers and gives practical guidelines to enable non-artists to make their own visual aids. The book is divided into two parts; the first, headed "Reflection" looks at the manner and context in which visual aids are used. The second, on "Action", looks at a range of practical ways in which the local production of appropriate pictures can be encouraged, and gives guidelines to enable non-artists to make their own visual aids. It is available from Teaching-aids at Low Cost (TALC), PO Box 49, St Albans, Herts AL1 5TX, UK. Price: £5.00 plus postage and packing (single copies: add £2.50 for surface mail or £3.00 for airmail; multiple copies: add 30% to the price of the books for surface mail or 60% of...
the price of the books for airmail). TALC accepts Visa and Mastercard credit cards.

At ease with e-mail
A handbook on using electronic mail for NGOs in developing countries is now available from the United Nations Non-Governmental Liaison Service. It emphasises the value of computer-based communications — through e-mail, bulletin board systems, computer conferencing and networking and on-line databases for NGOs, particularly in developing countries. Contents include practical considerations, such as "What is electronic mail (e-mail)?" and access to computer networks; the benefits of computer communications, and a directory of networks for Africa, Asia/Pacific, Latin America and the Caribbean. This small handbook (ISBN 0 9645188 1 3) is available in English, free of charge either from UN Non-Governmental Liaison Service, 866 UN Plaza, Room 6015, New York, NY 10017 USA, or Friedrich Ebert Stiftung, 950 Third Avenue, 28th Floor, New York, NY 10022 USA, or UN/VNGLS Geneva office, Palais des Nations, CH-1211 Geneva 10, Switzerland (e-mail address: ngl@igc.apc.org). The manual is currently being translated into Spanish and French.

Chinese translation
The Amity Foundation has translated Where there is no doctor into Chinese. Over 90,000 copies have been printed and distributed free of charge in the remote rural areas of western China. For more information, contact: The Amity Foundation, 17 Dajianyin Xiang, Nanjing, JS 210029, People's Republic of China.

ANNOUNCEMENTS

Ministries of health
In response to a letter from us, more than 30 national ministries of health around the world have asked to be included in the Contact mailing list! From Central Africa, Minister of Health for Sao Tomé and Principe Island, Fernando da C Silva, wrote to say that he was very interested in receiving future issues of Contact. He wrote: "My immediate comments are addressed to the high quality of the publication and the critical views it presents of the varied aspects of the community's involvement in health, and to the approaches to the promotion of health and integrated development."

South Centre opens
South Centre, a new intergovernmental organization, opened September 1995 in Geneva. Formerly the South Commission, South Centre already has available two major reports, "The Challenge to the South" and "Facing the Challenge". In his opening address, Dr Julius Nyerere, the centre's first chairman and former president of Tanzania, described its role as "a small think-tank of the South" which took a "people-centred" approach to development. Participants at the inaugural session heard that issues of great importance to the South were often left off the global economic agenda. A joint lobby of the South was needed to create an environment in which the problems of the South, such as debt, commodity prices and capital flows, were brought into greater prominence.
For further details write to: South Centre, Chemin du Champ-d'Anier 17, Case postales 228, 1211 Geneva 19, Switzerland.