



contact

Christian Medical Commission
150, route de Ferney

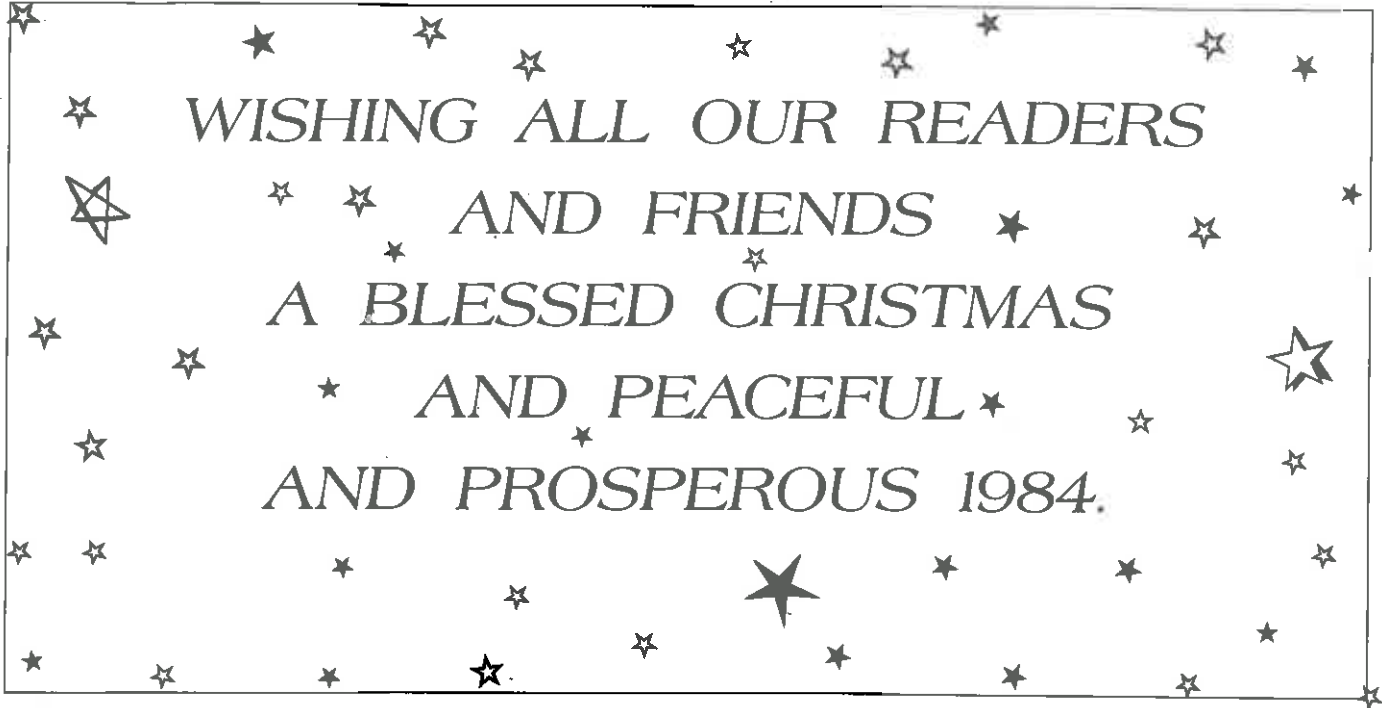
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THAT OUR CHILDREN MAY LIVE

The Work of the Christian Medical Commission of the World Council of Churches





*WISHING ALL OUR READERS
AND FRIENDS
A BLESSED CHRISTMAS
AND PEACEFUL
AND PROSPEROUS 1984.*

THAT OUR CHILDREN MAY LIVE

The Work of the Christian Medical Commission of the World Council of Churches

by Stuart J. Kingma

A very remarkable statement was recently made by the headman of a village in southern Asia. He was speaking with the workers of the local community health programme and, in thanking them for their fine efforts in his village, he said, "Our children don't die anymore!" This was indeed remarkable because, just a few short years ago, his village was typical of the thousands of villages all across the developing world; its families lived out their lives with poverty, unsanitary conditions, contaminated water, marginal farming, hungry times each year, no real access to markets or medical facilities... and high infant mortality and morbidity. But the local health and development programme had been able to change all that. And this story is beginning to be repeated in many places across the world, and even in the poor countries.

A voice from the other side of the world was heard during the recent Sixth Assembly of the World Council of Churches (WCC). A woman delegate from Scandinavia said, on the floor of the plenary hall (an approximate quotation since her words were not recorded), "I believe that the best focus for all of our discussions about development, justice and solidarity with the poor can be expressed in our concern for our children. Let us conduct ourselves in all our relations between individuals, between neighbours, between communities and between nations in such a way that we make it a good world for our children! Let us make a world in which we can be sure that our children can survive, that they will be happy and realize their potential, that they will have full educational opportunities available to them, that they will be assured of satisfying and gainful work and that they may, in their turn, raise their own families in wellbeing. If we do all of that, our other concerns for peace and justice and healing and sharing will also be satisfied."

The welfare of children is, in fact, a very sensitive indicator of the general wellbeing of a

community. They are the population most at risk and their welfare is very quick to mirror changes in the health and vigour of the community. I would like to use this focus on children as a unifying theme for this article which looks, first of all, at the global context in which the churches and the Christian Medical Commission (CMC) find the challenges for their work; then we should look at the way forward into new actions which will ensure that our children may live, and at some of the problems which are emerging in the approaches which have been adopted in recent decades.

Global Factors and Issues in the Health of Children

First, in order to put later statistics in perspective, let us look at the most recent population data and some of the health indices which are based on them. According to known census figures and certain careful projections, the world population stood at 4,725 million at mid-year 1983. Almost precisely one-half of the global population, or over 2,300 million people, live in what are termed the Low-Income countries, those countries where the Gross National Product (GNP) per capita is below US\$420.—* This is an important group of countries because this is where the greatest number of poverty-related health problems are to be found. It currently includes 38 countries, of which 25 are in Africa, 12 in Asia and one in the Caribbean. This is perhaps somewhat misleading in that it is based simply on the Gross National Product which reflects the country's annual output of goods and services. It therefore tends to exclude those countries where, by virtue of a substantial industrial sec-

* This group of countries is simply determined by the level of GNP per capita. It is almost the same as the group of countries designated by the United Nations as the "Least Developed Countries", a list of 30 countries selected by the UN system for special attention and concentrated effort at assistance and technical cooperation.

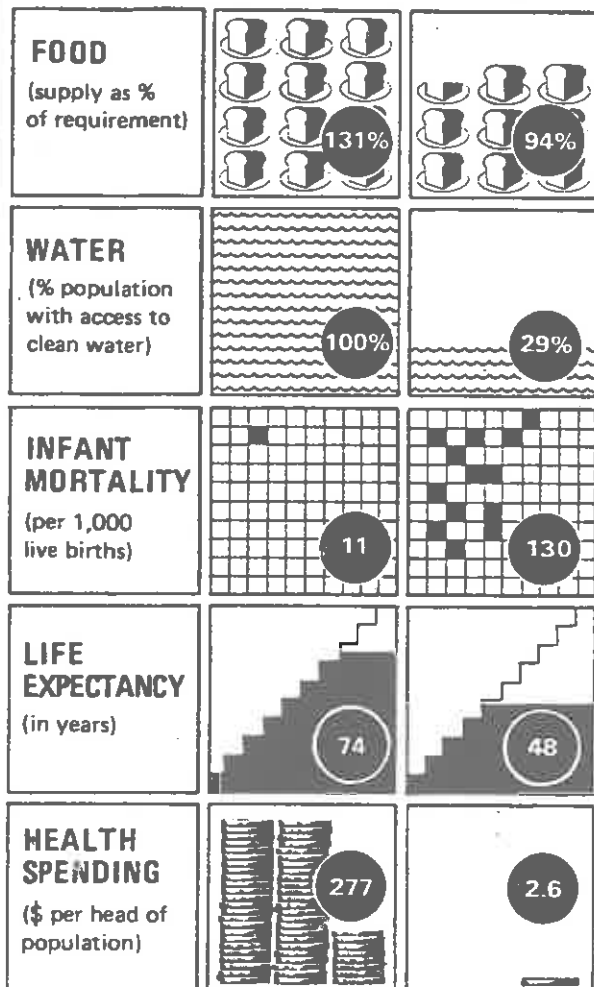
THE HEALTH OF THE PEOPLE

Infectious and parasitic diseases and malnutrition, minor problems in the rich world, are the major killers of the poor. The main cause is lack of food, clean water, sanitation and health care.

* excluding China and India

INDUSTRIALISED COUNTRIES

LOW INCOME COUNTRIES *



WHO Press Kit World Health 1983. Progress in Primary Health Care: A Situation Report.

tor or major agricultural and raw material export, the GNP is high enough to lift them out of this category. However, in many of these countries, the gap between a small wealthy population and the poor masses is wide and the same poverty-related problems apply to the majority of their citizens.

122 million children are born alive each year throughout the world. Over 12 million of those children, roughly 10 percent, die before they reach their first birthday. Another 5 million die before they reach school age, or 5 years old. This is an annual death toll of 17 million children under the age of 5. The tragedy is that 85 percent of those deaths are due to mal-

nutrition and infection, conditions which are preventable or easily treated. It is truly the scandal of our age that we make so little impact on these sad figures, year after year.

Let us look at the contrasts. The United Nations Children's Fund (UNICEF) has indicated that the industrialized countries of the West have an infant mortality rate of 11 deaths per 1000 live births and a child death rate (in ages 1-5) of 1 per 1000.¹ The greatest impact on reducing the mortality rate to this level was made during the early and middle part of the 20th century. The gains can be traced directly to improvement in safe water supply and sanitation, better housing and living standards and a general roll-back of poverty, and not, as might be assumed, simply to the improvement of health services and treatment methods. However, the Low-Income Countries have an infant mortality rate of 130 per 1000 live births and a child death rate of 22 per 1000. There are 22 countries with an infant mortality rate equal to or in excess of 150 per 1000 live births. 16 of these are in Africa and 7 in Asia.

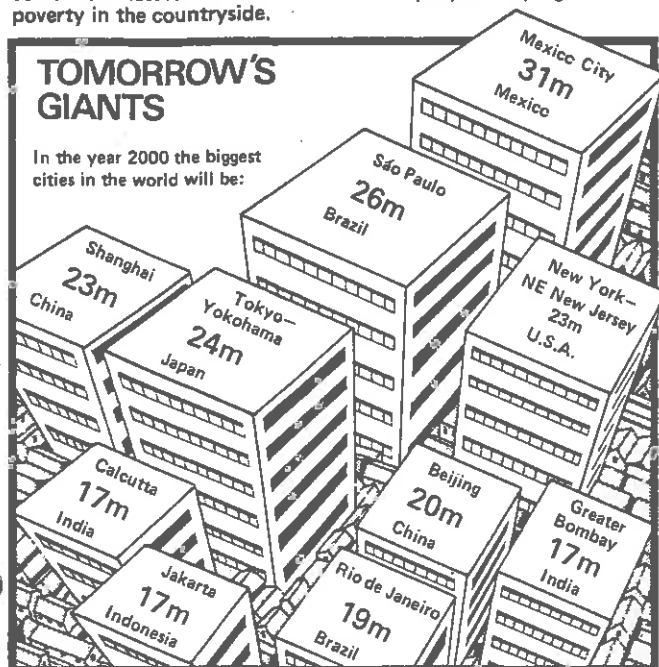
This deplorable situation is presented starkly by UNICEF: there are 40,000 preventable deaths *every day* among young children who succumb to malnutrition and infection. In 1983, that will have included a death toll of between 5 and 6 million lives from simple, curable diarrhoea. Another 5 million will have met their deaths through measles, whooping cough, polio, tetanus, diphtheria and tuberculosis.

It is important to remember the close tie between these preventable deaths and the underlying causes in poverty and unjust systems; this death toll occurs almost exclusively in families who are poor, and most heavily in countries that are poor. We have frequently discussed, in previous issues of CONTACT, the inseparable link which ties hunger, poverty, injustice, violence and preventable disease together in a vicious cycle of tragic waste. It will be discussed at great length in a CONTACT Special Series monograph to be released in early 1984.

Another factor which will become increasingly important over the next 15 years is the rapid growth of the cities and metropolitan areas in all regions. Migration from the countryside to the urban centres is accelerating so that, by the turn of the century, more than half of the world's people will be living in urban areas. This proportion will continue to grow steadily.

The Global City

By the year 2000 there will be 58 cities of over five million people compared with 29 today. Half the urban growth will come from natural increase—the rest from people escaping poverty in the countryside.



UNFPA Press Kit *The State of World Population 1982*.

Urban migration is taking place at a rate of 15,000 a day, fuelled by the poverty in the countryside which drives people to the cities for jobs, food and medical care. The United Nations Fund for Population Activities (UNFPA) now projects that 33 cities will be larger than 5 million inhabitants by the year 2000.² Mexico City will lead the list with a population of 31 million by then. The other giants on the list will include São Paulo, Brazil (26 million by the year 2000), Tokyo/Yokohama, Japan (24 million), New York metropolitan area (23 million), Shanghai, China (23 million).

Some of the capital cities in developing countries already consist of as many as 75 percent migrants from the rural areas. Their numbers and the rate at which they arrive have led to incredible crowding in urban and peri-urban housing. Many are forced to settle in slum and shanty-town areas where overcrowding facilitates the transmission of all sorts of diseases, where sanitary facilities and water supply never catch up with the constant expansion, and where basic services like health care always remain far behind the demand. This is further compounded by the challenge to city planners who can get to the demands for housing, employment and transportation only after first trying to cope with the need for food to be brought from the countryside and the docks to feed these multitudes. The future

challenges for primary health care in these urban areas will be tremendous indeed.

How Do We Get There? Primary Health Care, the Fundamental Approach and Operational Framework

The concept of primary health care was first articulated by the World Health Organization (WHO) and UNICEF nearly a decade ago. It was introduced in the UN system as a philosophy and planning approach to achieve more effective health promotion and to correct injustices in health care, particularly in its availability and accessibility. Many of the lessons on which this approach was based came out of the experiences of innovative church-related health programmes, subsequently gathered and articulated by the CMC. A very recent assessment by WHO of the progress made since 1975 is one which recognizes success in certain areas and acknowledges serious limitations to the progress in a number of other areas.³ But, to begin with, we should look at the present definition and operational framework of primary health care as it appears in the basic documents from the World Health Organization which describe it as the principal avenue by which the world can hope to achieve the social goal of Health for All by the Year 2000.

The most concise description of primary health care is contained in the Declaration of Alma-Ata (1978) in its articles VI and VII³. This remains the framework within which discussion of primary health care continues five years after these words were first set out:

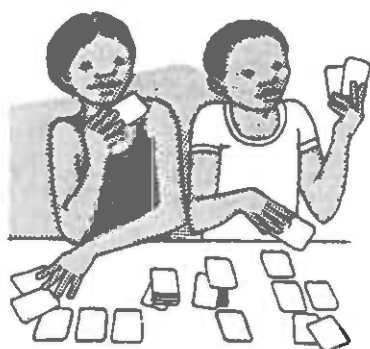
Article VI

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

Article VII

"Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political charac-



Primary Health Care

In the game of life and death many people in the world are playing against the odds:

- 1 in 2 never see a trained health worker
- 1 in 3 are without clean drinking water
- 1 in 4 have an inadequate diet

Every year diarrhoea kills 5 million under-fives; malaria kills one million people in Africa alone. These and other killer diseases are preventable. Doctors and hospitals offer cures for some. But what can really change the survival odds is a package known as Primary Health Care (PHC).



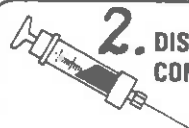
1. FOOD AND NUTRITION

- Around two-thirds of under-fives in the poor world are malnourished.
- PHC means ensuring an adequate, affordable food supply and a balanced diet.



4. WATER AND SANITATION

- 80% of the world's disease is related to lack of safe water and sanitation.
- PHC means providing everyone with clean water and basic sanitation.



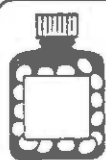
2. DISEASE CONTROL

- Some 5 million children die and another 5 million are disabled yearly from 6 common childhood diseases.
- PHC means immunisation against childhood diseases and combatting others like malaria.



3. MATERNAL AND CHILD HEALTH

- Over half a million mothers die in childbirth and 10% of babies die before their first birthday.
- PHC means trained birth attendants, promotion of family planning and monitoring child health.



5. ESSENTIAL DRUGS

- Up to 50% of health budgets are spent on drugs.
- PHC means restricting drugs to 200 essentials, preferably locally manufactured, and made available to everyone at a cost they can afford.



6. CURATIVE CARE

- 1,000 million cases of acute diarrhoea in under-fives each year.
 - 33% of people in the world infested with hookworm.
- PHC means training village health workers to diagnose and treat common diseases and injuries.



8. TRADITIONAL MEDICINE

- Traditional birth attendants deliver 60%–80% of babies in the developing world.
- PHC means enlisting traditional healers, giving additional training and using traditional medicines.



7. HEALTH EDUCATION

- Preventing ill health depends on changing personal and social habits.
- PHC means educating people in understanding the causes of ill health and promoting their own health needs.

THE WINNING HAND

The eight elements of Primary Health Care give everyone – young children and poor people especially – the best chance of winning the fight for life.

The cost of putting PHC into practice world-wide is an extra \$50 billion a year: less than two-thirds of what the world spends on cigarettes, and only one-fifteenth of world military expenditure.



teristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

First, a number of comments on the group of core or essential elements of primary health care which are described in these Articles.

1. **Food and nutrition.** Many international organizations have expressed concern about the present state of the world's food supply and the capacity of the world to feed itself and its children. In its recent publication on "The State of the World's Children - 1982/83", UNICEF indicated that: "Today, an invisible malnutrition touches the lives of approximately one-quarter of the developing world's young children... In both cause and consequence it is inextricably interlocked with the illnesses and infections which both sharpen, and are sharpened by, malnutrition itself... especially diarrhoeal infection..."

"Overall, ... the absolute number of children living and growing in malnutrition and ill health is set to increase. According to the UN's Food and Agriculture Organization (FAO), for example, a continuation of present trends until the year 2000 would see 'a horrifying increase in the numbers of the seriously undernourished to some 600-650 millions.' In other words, the number of malnourished children in the world will *increase* by approximately 30 percent."

In addition to its role in illness, malnutrition exercises a serious constraint to normal growth and development and is a significant cause of permanent disability among those who survive. WHO recently declared, in its 1983 statement on "Progress in Primary Health Care: A Situation Report", that "Malnutrition in its various forms, is one of the single most extensive public health problems affecting every region of the world."

"The many and complex factors affecting food supply and proper nutrition include drought, inflation, conflicts, level of food production and availability, wage levels of low-income groups, the prevailing cultural patterns, the growth and geographic distribution of the population, storage and distribution problems, lack of general education and lack of communications systems."

The World Council of Churches recently issued a major statement on The World Food Disorder and cited the deteriorating situation in many countries. In the course of this year, 1983, there has been a remarkable increase in the number of countries affected by major food shortages. Requests have been made to the World Council of Churches for aid and support to alleviate emergency food shortages for 24 countries. Of these, 21 are on the continent of Africa alone. On that continent, 150 million people are affected by food shortage due to stagnating food production, drought over the last 2 or 3 years, infected crops, bush fires and unstable civil situations. There is probably no single matter which deserves more intensive action and international collaboration than correction of this international crisis in hunger and food shortage.

Meeting this urgent food crisis will call for the provision of food aid (of which the world has adequate reserves) in relief operations. For the long term, counteracting the spread

and growth of food shortages and poor nutrition will require the concerted effort of governments and non-governmental organizations (NGOs). It will take new vigour and creativity to overcome the effects of drought and desertification. The nutritional side-effects of conflict and warfare will have to be dealt with by getting at their root causes and searching for ways to reach a peaceful resolution of conflicts. However, the record suggests that countries find it difficult to address the administrative changes necessary to achieve self-reliance in food where this is technically feasible. Decisions need to be made to assure an adequate allocation of farming resources to achieve the necessary volume and variety of food for local consumption. This will demand a serious approach to land reform in many countries, examining and revising land tenure policies and looking for ways to support, in particular, the small farmer. Sustaining the vigour of small farmers will call for better access to markets, increased access to credit and the right to use their output to feed themselves. In agrarian reform, redressing injustices in the system is far

more important for productivity than beginning with new fertilizers, getting new seeds and trying new technology. This will obviously require trade-offs against the attractions of cash crops and agricultural export, but decisions like this are never easy. Justice and equity also must be served as the needs of all the people in a country are considered when distribution of foodstuffs is being implemented.

Of extreme and fundamental importance in this area of food and nutrition is the whole matter of promoting breastfeeding. A renewed commitment to facilitating this important measure is demanded of all health professionals and of society, especially in the light of present trends in many countries away from breastfeeding.

Another area for concentrated effort is that of developing, low-cost supplemental and weaning foods of grain mixtures. These need to be locally grown of cereal grains acceptable to the local population, balanced in nutrition, and manageable for the local farmer without dependance on a commercial source. These food supplements will



WHO/UNICEF Photo.

BCG vaccination against childhood tuberculosis.

play an important role in raising community nutrition, helping undernourished, pregnant women and providing adequate local alternatives to imported processed infant foods. Working to evolve strategies for this kind of farming in each country is a key step in the fight against food shortage and in breaking free from the need for imported food aid.

2. **Communicable diseases.** Communicable diseases are the commonest of the illnesses requiring treatment in nearly all countries and they account for almost one-third of all cases seen in health facilities in a developing region like Africa. They are not only statistically important, but they account for a substantial amount of mortality and morbidity, impaired productivity and long-term disability.

The widespread application of immunization measures is slowly growing, and WHO has set a global target for 1983 of 50 per cent achievement for DPT (against diphtheria, pertussis and tetanus), polio and measles immunizations. WHO further recommends coverage of all newborns with BCG vaccination against tuberculosis and has set a global target for 1983 of 75 per cent for this one.

Concrete actions continue to be required for the management and control of diarrhoeal disease, respiratory infections, malaria, tuberculosis, leprosy and the other major tropical diseases. These are mostly effectively managed in the framework of a community-based primary health care programme.

3. **Maternal and child health.** Maternal and child health (MCH) is one of the most important building blocks of a primary health care approach. It addresses the health needs of the population groups most at risk and, as such, reaps high cost-benefit results.

Special attention is required to address the specific health needs of women. In fact, so much that relates to health circulates around the role of women in the family that this kind of attention should become natural. Around the globe, women are the most important food producers and food providers for the family. In addition, the role of women in health is crucial as they are the first providers of care within the home and family. Because of their biological role as mothers, women also have very special

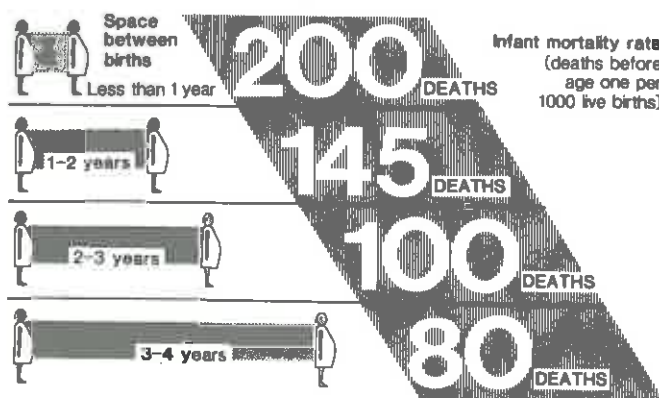
health needs. In many developing countries, mortality and morbidity related to child-bearing remains disturbingly high and requires urgent attention.

Family planning continues to receive emphasis and, in fact, plays an important role in the health of both mothers and children. There is a renewed emphasis for mothers to postpone the birth of the first child to a somewhat older age, as well as spacing subsequent pregnancies. Family planning also is aimed at limiting the total number of pregnancies and preventing childbearing in the age-group over 35 years when risks escalate considerably. Adequate provision for and education in family planning is also necessary to avoid the utilization of the last resort "birth control" measure, that is, abortion.

In their stress on "child-spacing", WHO and UNICEF indicate a very clear link between inter-birth interval and child survival. In studies with African families, for example, infant mortality rates of 200 per thousand were found in children whose birth was separated by less than one year from that of a sibling. Infant mortality rates of 145 per 1000 were found in children whose birth interval was 1-2 years. The rate drops to 100 when the interval stretches out from 2-3 years, and drops even further if the birth interval is 3-4 years.

An important element of maternal and child health services is the use of growth charts for children. Commonly referred to as "road to health charts", they have shown their value the world over as sensitive indicators of health. As they readily show trends which may mean the presence of under-nutrition, they play a crucial role in the promotion of good nutrition.

EFFECT OF INTERBIRTH INTERVAL ON INFANT MORTALITY



CDC, Atlanta, USA, from WHO/UNICEF data.

The rational approach to maternal and child health also includes careful attention to the role of traditional birth attendants, or traditional midwives. They are one of the most important categories of traditional practitioners, delivering at least 60 to 80 percent of all babies in the developing world. More and more countries are undertaking "re-training" programmes to assist them to build on the skills which they already have, to learn some appropriate new techniques and to adopt criteria for referring high-risk patients to other parts of the health system.

4. Water and sanitation. The Decade of the 1980s represents the International Drinking Water Supply and Sanitation Decade. Member-countries of the United Nations have committed themselves to substantial improvement in the standards and levels of services in drinking water and sanitation by June 1983. At this time, only 29 percent of the population of the Low-income countries have access to clean and safe water supplies. Safe water and improved sanitation are paramount for the interruption of many communicable disease cycles and, in particular, for the devastating diarrhoea of infants and young children.

5. Essential drugs. Working to assure dependable supplies of essential drugs which will support both primary health care and total health programmes remains a high priority for the Christian Medical Commission. The CMC has dealt with this at great length in previous issues of CONTACT. The situation of pharmaceutical supplies remains quite desperate in many developing countries. Internal distribution, management of ordering and stocking, corruption and the financial base are all big problem areas. One of the most important problem areas is assuring adequate financing for both those pharmaceutical items which need to be imported in their final prepared form, and for the purchase of raw materials where compounding and production has already begun.

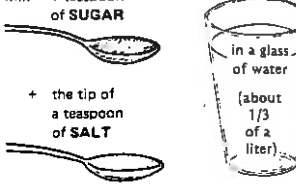
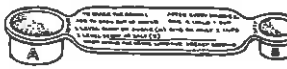


6. Curative care. The appropriate treatment of common diseases and injuries is one of the key elements in providing a just and equitable health service. Simply mastered technologies have, in fact, begun to open up the possibility to win the struggle against easily treated and preventable diseases. The time has come for putting them into *full* ap-

plication by community health workers and the mothers of the world.

One such treatment modality which merits universal implementation by all health services, public and non-governmental, is for the control of diarrhoeal disease and resulting dehydration. It needs to be kept in mind that this is the leading cause of death in the under-five age group in *many* countries, and is behind an annual death toll of over 5 million children per year. The treatment is simple *oral rehydration therapy (ORT)*, using a carefully balanced solution of glucose and electrolyte (sugar and salt). It is a technique which can easily be taught to all categories of health workers (including doctors) and is in that group of skills which can and should be taught to all mothers. This has successfully been done with great benefit; the lessons are now all there to be applied. The pitfalls of preparation and use are known and can be guarded against. It can be used in all forms of diarrhoea, from the simplest forms up to and including cholera.

Oral rehydration for diarrhoea was made possible by the discovery that adding glucose to a solution of salt and water can

Ways to prepare Special Drink

<p>First method: ordinary spoons</p> <p>Mix 1 teaspoon of SUGAR</p> <p>+ the tip of a teaspoon of SALT</p>  <p>in a glass of water (about 1/3 of a liter)</p>	<p>Third method: plastic measuring spoons</p> <p>In some places, special plastic spoons are available to measure the exact amounts of sugar and salt for one glass of water.</p> 
<p>Second method: by hand</p> <p>Mix about this much SUGAR</p> <p>+ a pinch of SALT</p>  <p>in a glass of water</p>	<p>Fourth method: homemade spoons</p> <p>Rather than depend on plastic spoons that can get lost or broken, the children can learn to make their own measuring spoons.</p> <p>Here is one example.</p>  <p>For another example, see the next page.</p>



CAUTION: Making Special Drink with too much salt can be harmful. So before adding the sugar, TASTE IT TO BE SURE IT IS NO SALTIER THAN TEARS.

Helping Health Workers Learn, by D. Werner & B. Bower.

How to prepare ORT: simple instructions for mothers and health workers.

increase the body's rate of absorption of the fluid by 2500 percent! It is as simple to make: just add eight teaspoonfuls of sugar and one teaspoonful of salt to a litre of boiled and cooled water. UNICEF estimates that if every means possible is utilized to bring this message to the mothers in developing countries, as many as 13,000 children could be saved every day. Building on this and three other scientific and social strategies, UNICEF hopes to bring about a revolution in the health and survival of children. These four strategies for concentrated effort (already becoming known as GOBI) are: (1) making use of **growth charts** routine in all child care centres, (2) **oral rehydration therapy**, (3) **breastfeeding** and (4) **universal immunization**

These strategies will have a chance of accomplishing the revolution in child health if they are employed in the broader context and administrative infrastructure that needs to be developed along with them. As UNICEF itself has said, "The backdrop to the children's revolution which we now believe to be possible is the idea that organized communities and trained paraprofessional development workers, backed by government services and international assistance, could bring basic education, primary health care, cleaner water and safer sanitation, to the vast majority of poor communities in the developing world." It should be added that part of the infrastructure that is already in place, and that will need to be involved if this is to work, is to be found in the world of voluntary and private and non-governmental groups and agencies. In many countries, the churches and other such groups are, in fact, the only ones at work in the poor communities where these methods are most needed.

7. **Health education.** Many of the elements of primary health care require a substantial involvement by mothers and, indeed, all members of the family to bring about a real and lasting improvement in the level of family health. This means that a new health education and learning dynamic needs to evolve with a more creative and engaging dialogue between health workers and the people they serve. This will be necessary if laypeople as well as health workers are to take a renewed responsibility for health and if their role in health care is to become an authentic embodiment of the idea of participation.

Problems, Both Conceptual and Concrete

The goal of Health for All by the Year 2000 was declared as a target in 1978, just before entering the last two decades of this century. Five years have already slipped by and the achievements made towards reaching that goal have been rather modest. Civil and international wars, drought and other natural disasters and a persisting international recession have worked their own hardship against the achievement of this goal. Some of the difficulties can be ascribed directly to financing requirements. Yet further problems can be found in the very limited numbers of key people who have been trained to carry the emphasis forward. There are also real difficulties in implementation which stem directly from a failure to appreciate the rationale behind the primary health care approach or the necessity for the human and administrative infrastructure to sustain it. Some parts of the primary health care programme are more easily visualized and packaged for implementation than others. Where are some of the concrete problems?

1. **What's all this about participation?** Everybody seems to be talking about participation these days. Articles are to be found on this subject as often as almost any other subject in the whole area of health care. Some have already burned themselves out in talking about it and have backed off out of frustration or an inability to understand participation in action. In some circles, it is now accepted that one only talks about community "involvement". Others seem to hold out participation as the only legitimate exercise of power and decision making.

The Christian Medical Commission has already examined participation in a number of its publications. It may be yet worth indicating that the idea suffers more in this moment from being over-stressed and romanticized than from being prematurely abandoned. It does need to be said that no social or political framework can exist with the purest form of participation by all in all decisions. At least there does not seem to be any society which runs on those principles. It may be useful to admit the existence of an interface between the decision-making and participation that is from the "top down", and which encounters participation and the exercise of power that is from the "bottom up". In any given society or within the context of any given programme, that interface may be found at dif-

ferent levels depending on questions in hand. It may in fact be legitimate for some to be administrators or managers or governors, using their special skills on behalf of others to facilitate any given programme. Perhaps the essence of satisfactory participation is achieved when the needs of all for the common good are heard and determine priorities within planning and programme, when all sectors of a society have been heard when it comes to planning or evaluating plans (although here, too, a representative element is legitimate since every single last member cannot usually be heard), when all who have the possibility to take a part in programme activities themselves are enabled to do so, and when the programme or the wider system remains **accountable to all**. Just as primary health care involves the delegation of tasks and responsibilities to all who can take a part (the passing of skills from "top down"), so authentic participation may need to accept being paired with a representative element, a conferring of confidence and responsibility on certain trained persons (passing of responsibility from the "bottom up"). This frees us all to get on with the job.

2. **Who will pay for it all and what is it going to cost?** Health care is an expensive business and inflation in the health sector tends to run ahead of the general national inflation. There are particular problems for the Low-Income countries. They are very dependent on imported supplies like equipment, drugs and consumable goods—and that takes foreign exchange with hard currency. Health institutions, like the big teaching/referral hospital(s) that are to be found in all the big cities, are high consumers of imported goods and energy and again, hard currency is required for that. In most countries, salary scale increases have been repeated and are steep amongst health staff. At the same time in the face of global recession and the sharp rise in energy costs, the public health sector has been badly hit by cuts in budget and/or reductions in access to foreign exchange credits (in comparison to national defence, communications, public works and the like). These economic stresses are upon us at the time when our commitment to primary health care (PHC) is up front in the march towards Health for All.

A dispassionate assessment of the situation in late 1983 demands the honesty to admit

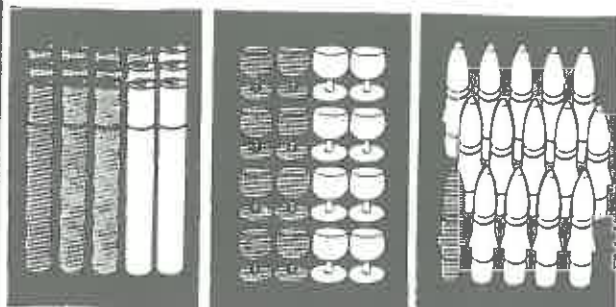
that progress has been limited. Political commitments have been made by governments, by NGOs in general and by that large NGO group, the churches. There is some evidence of an expansion of the infrastructure of PHC in a number of countries. There is less evidence that the more radical steps have been taken—steps which will be required if we are to meet our objectives on the way to the year 2000. The radical steps are those that actually reallocate funds that, as a routine, have gone for other purposes, and redirect them to water or sanitation or agricultural/nutritional efforts or training village health aides or a nation-wide blitz to stop deaths from diarrhoea... or to put into place a PHC system once and for all!

If PHC is to be successful, that is, if a true reorientation of health care systems takes place so that a minimum level of care is accessible to all, it will require new funds *and* reallocation of old money. If that financial support for PHC does not come through, global health indicators will show a continual decline in health and nutrition, the survival of the human family will become a serious question... and the opponents of PHC will be able to point to PHC's "failure". It will be a sad testimony to a lack of authentic will to try, and perhaps to a lack of caring by all of us.

At present, 88 developing countries spend less than US\$ 8 of public money per capita per annum on health (23 of them spend less than US\$ 2 per capita). 28 industrialized countries spend an average of US\$ 277 of public health funds per capita. For the Low-Income countries, WHO estimates that "additional requirements for PHC may be of the order of US\$ 10 per capita per annum for recurrent expenses on extensions of health and medical services..." This is outside of what these same countries may need for investment in water, sanitation and other health-related areas, which could come to around US\$ 5 per capita yearly for the next 20 years. In summary, this means an additional US\$ 12.50 per capita per annum from now to the year 2000 in the developing countries. If 80% of that is to be found within the developing countries themselves, it will still require that government and nongovernment sources of international aid to the health sector reach three times their current level in support of primary health care alone. We don't really have much choice if we hope to see the wellbeing of the

THE PRICE OF HEALTH

Providing primary health care — including water and sanitation, trained workers, communicable disease control and basic drugs — would cost an extra \$50 billion a year for the next 20 years. That is \$12.50 per person per year:



2/3 of world spending on cigarettes
1/2 of world spending on alcohol
1/15 of world military spending

WHO Press Kit World Health 1983. Progress in Primary Health Care: A Situation Report.

human family improved and equitably experienced by the year 2000. We will have to commit and redirect the necessary funds or face growing threats to our very survival.

For those who are seriously looking around to find where this extra money could be located, the additional US\$ 12.50 a head per year amounts to US\$ 50,000 million. That is just two-thirds of what the world spends each year on cigarettes, just half of the world's spending on alcohol. But this is the interesting one: that price tag on health is just one-fifteenth ($1/15$) of world military spending for just one year. Think about it.

Among many church-related health programmes, and this is true for a number of other NGO efforts as well, this financing for primary health care will be a bit difficult. There are certain reasons why this appears to be so, and they relate in part to the differences that exist between the pattern and flow of finances in government health care and the financing in NGO programmes. Governments decide how much of the national budget will be allocated for health (augmented by certain programme-specific external grants), and then that "pie" is divided up, so much for teaching hospitals, so much for primary health care, so much for importing drugs and supplies, and so on. Most church-related programmes, on the other hand, have access to very limited funds for recurring costs and must depend to a great extent on income generated by a fee-for-service. And it is the hospital services, and in particular the surgical services,

where one expects to generate the most income. The service aspects of these programmes are usually better than self-sufficient; they may even be able to cover some of the costs of associated training activities. But the least successful in the list of income-earners is the community-based, primary health care work. So it is not surprising that a good many NGO and church programme managers consider PHC and training as "expensive" and are reluctant to move more vigorously in that direction. They can see what is not viable financially. In spite of low unit costs and *cost-effectiveness*, PHC just doesn't appear to be affordable.

Two more facets of this complex financial story also deserve mention. Some 10 and 15 years ago, it was usual to read in grant applications for community health or PHC programmes that it was expected to be "self-sufficient in 3 years and not require any further external support for running costs". With only a few exceptions, these projections have not been realized. Health insurance schemes have not worked out as planned, income-generating activities have not been successful to the extent predicted, and in general it has been shown that poor people don't find it easy to pay for preventive health care when they are not sick. This has been discouraging for both the health personnel and the donor or church organizations involved. The answer will require, among other things, a new look at funding patterns and priorities. And that is the next point.

It seems clear that some restructuring of the financial support of health care is urgently needed, and particularly for NGO-PHC activities. At present, in those countries where the government provides some subsidy to NGO programmes, most of that is destined for hospital care, based on bed-grants and/or salary for hospital-qualified staff. In a few countries, small amounts are given for rural health centres. It is rare to find government support for voluntary-agency primary care which is community-based. It may be useful for governments to consider some shift in subvention priorities which will more favour, encourage and reward concrete activities in PHC. Church-related donor agencies might also consider accepting some degree of engagement in longer-term running cost support for PHC, perhaps in some way related proportionally to the capital

investment granted. For the NGO programmes themselves, it may be useful to consistently search for some income-generating activity to link to the health work by which the health care could draw income through profit-sharing; the link could be to some local industry, agriculture or cooperative society. Obviously, this is an area that merits a good deal more study and sharing of experience.

3. Excellence and top quality in health care – a function of justice. Health care planning continues to raise some very fundamental questions and is capable of generating very hot debates. Not least among these is the perception of justice in health care. Many doctors expect the justice of a decent institution with adequate equipment to do what they have been trained to do. The well-to-do consider it reasonable and just that excellent medical care be provided, in the capital city at the very least, that is of top international standard for them and their families. But who will even express the need of the voiceless 60-80% of the population of developing countries for justice in access to care – when none is accessible for them? For a long time it seemed possible to hold on to the old established system, the big institutions, as well as try to move at a steady and reasonable pace into PHC. We are now 15 years into the “community care” era, and 5 years into the “primary health care” era, and global indications show deterioration in too many areas. We probably can no longer have our cake and eat it also. Dr Halfdan Mahler, Director-General of WHO, has again returned strongly to the theme of justice in health, and has urged that “some for all, not all for some” is the fundamental principle of PHC. In the light of the biblical bias on behalf of the poor, it seems to this writer that the churches cannot be found urging less than that. The quality of excellence can only be applied to health care which aims to achieve a minimum level of care for all *before* any further development of first-class care for the few.

4. The imperative of training. In contrast to the persisting pattern of service programmes in most places, a new commitment to couple service with training needs to be made. No service task, however simple or complex, should be pursued without training someone else to do the job too. This can be in formal schooling or simple appren-

ticeships. Each skill and bit of knowledge passed on is another step towards self-reliance. And special consideration must be given to including disabled persons, elderly people, school-leavers and drop-outs and unemployed persons.

5. Healing and Christian health care. For a good number of years now, the Christian Medical Commission has pursued a study programme on “The Search for a Christian Understanding of Health, Healing and Wholeness”. Much has been learned in the course of this study, especially from the regional meetings which have been held in eight sub-regions of the world. This process has been reported in a number of articles, monographs and CONTACT issues. Lurking in the back of many of these discussions, but not often articulated, is the question: What is “Christian” health care?

That of course is an age-old question, but one that is not very easy to answer. It can be said that health care is *not* Christian simply because it takes place in an institution that has “Christian” in its name. Nor is it enough that a Christian church or agency supports the programme. Nor is it adequate to identify one’s motivation to get involved in health work (the “why” of the vocation) with justifying the name of “Christian health care” (because that adjective must surely say something about *how* one goes about the planning and the work). This writer also believes that it is not automatically “Christian” health care if one engages in preaching the gospel of Jesus Christ as an integral part of the health care. In fact, it can be seriously questioned how “Christian” it is to preach at someone who is confined to a bed in the surgical ward, or to preach at a mother sitting patiently in an out-patient waiting room with a sick child in her arms.

To merit the name of “Christian”, there must be something about the quality, the style, the planning of all parts of the programme that is truly distinctive. It needs to be more than fine humanitarian care and concern, more than secular wholistic health care. It must begin, I believe, with a recognition of Christ’s unique concern for the whole person and the action implications of seeing each illness as a disturbance which touches all the physical, mental, social and spiritual facets of the human person. An insight that offers some clarity in this respect is the centrality of reconciliation for healing – the need

for reconciliation with our neighbours, with ourselves, with our bodies, with the environment and with God. Equally important is the necessity to recognize the massive biblical imperative of justice on the side of the poor. There is no way to misinterpret the message to do these things "for the least of these, my brothers and sisters". The context of that message is justice and also the need to see it *for the common good*, the *many* of those who are "the least of these". Those who know the biblical text will recall the references to the hungry, the thirsty, those who need clothing and shelter and care. These concerns cover a number of matters that have to do with planning and what goes on even before a programme begins, and determines the social dimension of the actions envisaged.

It may well be that what qualifies as "Christian" care has little to do with whether it is mediated through a Christian institution or not; in some circumstances, it may be more effectively mediated through work carried out in a public or secular setting. If this is a point of view that has any merit, it may

liberate the churches to begin to look beyond institutions for ways to fulfill their concern for healing and sharing.

* * *

These few comments have perhaps shown that the frontiers in health care are still exciting, challenging and, in the face of war and increasing global hunger, not a little daunting. But if we are going to accomplish what is necessary that our children may live, it will require *real* changes—in the healing of the nations, in committing more resources to this crucial struggle, and in the orientation of how we go about our engagement in health matters. The ever-present picture of hungry and needlessly dying children is too disturbing to be tolerated. ■

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NEW PUBLICATIONS

Manual on Feeding Infants and Young Children, by Margaret Cameron and Yngve Hofvander. Oxford Medical Publication, 1983. 214 pages.

Great efforts have been made in recent years to stimulate the production in developing countries of low-cost, protein-rich foods to be used as supplements during and after weaning. The authors feel, however, that such products will, for many years to come, reach only a small segment of the child population of developing countries and that the only hope for the vast majority of these children is home-made weaning foods, using low-cost, locally-available staples. Intended for doctors, nurses, nutritionists and teachers, the book provides comprehensive information on this subject; it also covers the normal growth of the child, its nutritional needs and the fundamental importance of breastfeeding.

Price: £ 1.50 (plus postage)

Available from:

TALC
PO Box 49, St Albans
Herts AL 4AX / UK

This manual has also been published by UNESCO in a **Nutrition Education Series** intended for all levels of health and development workers involved in education for better nutrition. The series looks at various aspects of teaching, learning and communication within both the formal and informal nutrition education sectors.

Titles published to date:

1. Nutrition Education: Case Study Experiences in Schools
2. Nutrition Education: Role of Colleges of Education

3. Maternal and Young Child Nutrition
4. Primary School Curriculum Planning and Selected Case Studies
5. Nutrition Education: Relevance and future
6. Approaches to Nonformal Nutrition Education

Available from:

UNESCO
7, place de Fontenoy
F-75700 Paris

* * *

Practising Health for All, edited by D. Morley, J. Rohde et G. Williams. Oxford Medical Publication, 1983. 33 pages.

Twenty-one health and development professionals engaged in the practice of primary health care contributed the case studies examined here. Important lessons are drawn from both the successful programmes and the "failures". The practice of primary health care is considered in terms of:

- political commitment (links between political structures and the people's health);
- community participation (not just mobilization of resources, but a process by which people gain control over factors affecting their health);
- the programme development process (interaction between health planners, political decision-makers and community organizations, resulting in innovative national programmes);
- Lessons from previous experiences and principles of success and failure in planning, implementing and evaluating primary health care.

Price: £ 2 (plus postage)

Available from:

Oxford University Press
Walton Street
Oxford, OX2 6DP / UK

* * *

OXFAM's Practical Guide to Refugee Health Care, June 1983, OXFAM Working Paper No. 2.

This small booklet provides guidelines for the planning and implementation of refugee relief and health care programmes. Such programmes are seen as having three principal phases: needs assessment; an initial relief phase responding to the specific health problems which have arisen; and a consolidation phase to set up a health care system which will maintain an appropriate level of health. Thirteen technical appendices, including, for example, a checklist for refugee situations, basic information on how to determine ration requirements, or on basic water supply or immunization programmes, supplement these guidelines.

Available from:

OXFAM Medical Unit
24 Banbury Road
Oxford OX2 7DZ / UK

* * *

Simple Orthopaedic Aids: Appropriate Designs for a Developing Country, by Chris Darnell, 1983, 44 pages.

How to set up a workshop to produce orthopaedic aids, using locally available materials and appropriate technology is explained in careful detail and with simple drawings. The production of a number of useful aids, including a variety of callipers, clogs, shoes, prostheses, walking aids, splints and wheelchairs, is also shown.

Price:

£2.50 plus postage & packing (£ 0.30 UK; £ 2.— other countries) 10% discount on orders of over 10 copies

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Leonard Cheshire Foundation International
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26-29 Maunsel Street
London SW1P 2QN / UK

* * *

CMC NOTES

The Graduate School of Public Health, San Diego State University, offers a 9-month **graduate training programme in Maternal and Child Health**, leading to a MPH degree with a major in MCH. The programme covers the health of, and programmes and services for, mothers, infants, children, youth and families; education in general public health includes epidemiology, biostatistics and administration. Opportunities for field work are provided. Designed primarily for paediatricians and obstetricians, the course is intended to prepare graduate students for high-level administrative positions in government or for faculty positions in universities, and considerable emphasis is placed on career counselling.

Applications are now being accepted for August 1984. Inquiries should be sent to:

Helen M. Wallace
Professor and Head
Division of Maternal and Child Health
Graduate School of Public Health
San Diego State University
San Diego, CA 92182-0405 / USA

* * *

An 11-week Development Studies Course for Aid Administrators is offered by the Department of Social Studies, Selly Oak Colleges, Birmingham, UK, which caters for the special needs of staff of voluntary and church-related development agencies. It is designed to help them to reflect on their present and future work, to examine their assumptions and their values and to widen their understanding of the development process. This broader understanding is seen as a prerequisite to any improvement of job skills concerning the management of development aid. Within this framework, the course enables participants to take a thorough look at economic, political and social factors in the development process, international trade, communications and the management of voluntary aid programmes.

The course incorporates lectures, discussions, case studies, individual and group tutorials, visits and group exercises. The determining factor for eligibility is responsible involvement in the organization of development program-

mes at the present time or in the immediate future.

Dates:

28 April to 13 July 1984

29 September to 14 December 1984

27 April to 12 July 1985.

Completed application forms should be submitted at least 4 months prior to the start of the course.

Accommodation and fees: Students live in the Selly Oak Colleges. Tuition fee is £ 850 with an additional charge of £610 for full board and lodging. In many cases, bursary assistance is available through development aid agencies to whom applicants should make direct inquiries. Advice on this matter can be obtained from the Colleges.

Application forms are available from:

The Secretary,
Development Studies Course
Department of Social Studies
Selly Oak Colleges
Birmingham, B29 6 LQ / UK

* * *

Practically unique in its field, **TALC**, the UK-based, non-profit-making organization, offers what has for some time been a high-quality service to health workers: it sells a **carefully-selected range of teaching aids appropriate to the practice of primary health care in developing countries**, at or below cost prices. The range includes books and sets of colour slides on health topics as well as a number of accessories. Many of the books are not easily available in bookshops; slide sets are accompanied by tapes or descriptive scripts including questions and answers. "Road to Health" weight charts, weight for height charts, flannelgraphs, scales, measures and spoons for clinic and home preparation of oral rehydration fluid and Echeverri tape kits are among the accessories offered.

Current price lists and order forms can be obtained from:

TALC (Teaching Aids at Low Cost)
PO Box 49, St. Albans
Herts, AL1 4 AK / UK

* * *



As 1983 draws to a close, CMC and WCC staff prepare to bid farewell to CMC Director Stuart Kingma who leaves the WCC after nine years of service. Stuart will be succeeded as director by CMC Associate Director Eric Ram. Stuart joined CMC in 1975 as associate director and stepped into the role of director at the beginning of 1981.

As CONTACT editor since the February 1975 issue (No. 25), Stuart ensured that the philosophy and concerns of the CMC were clearly voiced through this major medium of communication with the CMC constituency. Stuart has himself contributed several important articles to CONTACT, notably on the topics of the supply and distribution of essential pharmaceuticals for primary health care (Nos. 63 and 73), of disability (Nos. 46 and 60), healing (No. 71), as well as two papers defining CMC's current thinking on major health questions (No. 62 and the present issue). This issue of CONTACT is Stuart's parting gift to the CMC and CONTACT readers.

Two major requirements have conditioned CMC's work under Stuart's directorship. Firstly, with the termination in July 1983 of the terms of office of CMC's twenty commissioners, there was a need to consolidate work in line with the aims and strategies identified by the commission and to lay the groundwork for the task of the next commission. Secondly, the need to prepare for the VIth Assembly of the WCC in August 1983 put a special burden on all WCC sub-units, including CMC.

Under Stuart's able guidance, CMC successfully weathered this transition period. The past efforts and work of the CMC were strongly affirmed by the decision-making process of the Vancouver Assembly and, indeed, new

areas of concern for CMC's attention were identified. The difficult task of locating and selecting the members of the next advisory commission for the CMC has been started and final appointments will be made by the WCC Central Committee in mid-1984.

Considerable credit is due to Stuart for translating into concrete strategies and action CMC policies in two vital areas: the promotion of collaboration between NGOs active in health and development work, and between them and governments and international agencies; and efforts to improve the supply of essential pharmaceuticals for PHC and health services in developing countries.

The formulation in 1982 by the Geneva-based NGO Group on PHC of a NGO/WHO/UNICEF Collaborative Programme in support of national health planning for PHC provided the conceptual and administrative framework for concrete action in this area. CMC provided the principal leadership both of the Group and of this initiative. Southern Africa was chosen as the target area for the first phase of the programme. A special consultant visited the target countries in the first half of 1983 in order to initiate local contacts. This effort has yielded concrete results in three countries to date: in Swaziland, an NGO coordinating agency was formed and a major PHC seminar scheduled, while in Lesotho and Botswana, health management skill training workshops will be held in early 1984.

In its efforts to encourage the establishment of cooperative pharmaceutical purchasing and distribution services for church-related health services in developing countries, CMC held a consultation in December 1981 which targeted six African countries for priority attention. A field consultant visited these countries during 1982 and 1983 to assess the PHC and pharmaceutical needs, problems and potential resources. His findings were reported back to an informal pharmaceutical advisory group composed of several pharmaceutical supply and development agencies associated with CMC. As a result of these efforts, a number of concrete steps to improve the supply and distribution of pharmaceuticals in these countries have already been undertaken by the national NGOs themselves.

Stuart leaves the CMC to take up a post in the division of Coordination at WHO headquarters in Geneva, a position and location that promises many opportunities for continued contact and collaboration with CMC.



Science 1961, an MPH in Public Health Education 1968 and a PhD in Public Health 1971 from the University of North Carolina at Chapel Hill, USA), Eric's particular interest and portfolio has been family health within the context of integrated health and development and primary health care.

Within the CMC team, Eric has participated in the full range of activities carried by programme staff, including:

- consultancies/evaluation in Geneva and in the field;
- collaboration within the WCC through serving in a number of task forces, notably on disability/rehabilitation, family education, aging, the WCC resource-sharing system, as well as two regional task forces; he has taken his full share of CMC's Assembly preparations workload;
- collaboration with health-related NGOs, regional and national church councils, mission boards, etc., and health-related UN agencies such as WHO and UNICEF;
- fund-raising for the CMC programme;
- joint planning of the series of CMC regional consultations linked to its Study/Enquiry on the Christian understanding of health, healing and wholeness; and
- the CMC leadership training programme addressed to the needs of selected individuals in key positions in church-related health work and offering special scholarships as well as South-South orientation/training experiences.

The announcement, following the WCC Assembly in August 1983, of Eric's appointment as CMC director—a post he will take up in January 1984—was warmly welcomed by CMC friends and associates concerned that there be a continuity in CMC orientation and activities.

Previously director and head of the Miraj Medical Centre's Department of Community Health and its Integrated Health Services Pilot Project (which he described in CONTACT No. 44), Eric came to CMC from India in 1977 to fill the vacant post of consultant in family health. In 1978 he assumed the post of associate director. Specializing in public health (with an MSPH in Public Health Environmental

CONTACT is the periodical bulletin of the Christian Medical Commission, a sub-unit of the World Council of Churches. It is published six times a year and appears in four language versions: English, French, Spanish and Portuguese. Present circulation is in excess of 23,000. The papers presented in CONTACT deal with varied aspects of the Christian communities' involvement in health, and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development.

The editorial committee for CONTACT consists of: Stuart Kingma, Director and Editor, Miriam Reidy, Editorial Assistant and Heidi Schweizer, Administrative Assistant. The rest of CMC staff also participate actively in choosing topics for emphasis and the development of materials: Eric Ram and Cécile De Sweemer, Associate Directors, Jeanne Nemec, Secretary for Studies, Melita Wall, Consultant. Fernande Chandrasekharan, Secretary, is responsible for the CONTACT mailing list, assisted by Valerie Medri and Minnie Carles-Tolra, Secretaries. CONTACT is printed by Imprimerie Arduino, 1224 Chêne-Bougeries/Geneva, Switzerland.

CONTACT is available free of any subscription payment, which is made possible by the contributions of interested donors. In addition, regular readers who are able to make a small donation in support of printing and mailing costs are encouraged to do so.

Certain back issues are available on request. A complete list of these is published regularly and appears in the first issue of each year in each language version. Sets of selected back issues or bulk orders of a particular issue going to industrialized countries will be charged at SFr. 1.— per copy plus postage.

Articles may be freely reproduced, providing appropriate acknowledgement is made to: "CONTACT, the monthly bulletin of the Christian Medical Commission of the World Council of Churches, Geneva."

Poster/Calendar Contest

The General Assembly of the United Nations has designated 1985 as *International Youth Year: (Participation, Development, Peace)*

As part of the contribution towards it, the Sub-Unit on Youth of the World Council of Churches invites *YOUNG ARTISTS* (born after 31 December 1952) everywhere to submit a poster-calendar design interpreting the IYY theme.

A first prize of SFr. 2000.— and three honorable mentions will be awarded by a special international jury. The prize winning poster will be published in *ONE WORLD*, a monthly magazine of the World Council of Churches, as a special insert and distributed internationally. The designs may also be used as magazine and book covers, article illustrations and art exhibits.

The WCC reserves sole rights for the publication of all designs, unless otherwise stated by the artist at the time of submission. All due care will be given to entries, but the WCC accepts no liability for their loss or damage.

The WCC will retain all designs, unless otherwise requested, in which case an addressed label and correct postage must be included.



Technical specifications

- Each poster must carry the following:
 - the words: INTERNATIONAL YOUTH YEAR: Participation, Development, Peace.
 - either version of the WCC symbol as shown below.
 - the whole 1985 calendar year.
- Posters may be in full or limited colour.
- Photography and collage may be used as well as any form of painting, drawing and design.
- Posters should be submitted in the "A2" format (42 cm x 62 cm: 17" x 24,5"). Consideration should be given to the possibility of the designs being reproduced in smaller or larger format.
- Each poster design must carry a label on the back with the artist's name, address and date of birth.
- Works submitted on illustration board are preferred, but they may be sent in mailing tubes if this does not damage the design or make it difficult to exhibit.

Designs should be received at the following address before 1 July 1984:

IYY Poster Contest
WCC Sub-Unit on Youth
150, route de Ferney
1211 Geneva 20, Switzerland

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