1.13.2. Doctors with Africa Cuamm

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The mirage of the Millennium Development Goals

During the 1990 World Summit for Children, seventy-one heads of state and government undersigned the World Declaration on the Survival, Protection and Development of Children and its action plan, setting tangible objectives, mainly health ones, to be reached by 2000.

During the numerous summits that followed throughout the 1990s, the majority of countries continued to undersign the pledge to reach quantifiable results, which also covered health, in line with the pledge taken with the Declaration of Alma Ata in 1978, namely reach an acceptable level of health for all by 2000.

In June 2000, the United Nations Secretary General, Kofi Annan, released his "A better world for all" report, which was the result of unprecedented cooperation between the world's four biggest organizations: the United Nations, the Organization for Economic Cooperation and Development (OECD), the International Monetary Fund and the World Bank. Annan's report stated that public initiatives were insufficient and that the solution could be achieved by a partnership between different sectors of society.

The eradication of poverty and a global partnership for development are some of the core issues of the concluding declaration of the Millennium Summit held in New York in September 2000, at which the Millennium Development Goals (MDGs) were launched.

The Declaration proposed a twothirds reduction in 1990 figures for the under-five mortality rate by 2015; it also proposed a threequarters reduction in maternal mortality for the same period.

An additional objective was added to these goals: halt and begin to reverse the spread of HIV and AIDS by 2015, as well as the spread of malaria and other major diseases.

Three of the eight MDGs regard health, as do eight of the eighteen subgoals, and eighteen of the fortyeight indicators. These include a number that are not strictly healthrelated such as reducing the number of people who suffer from hunger and improving access to drinking water.

Governments worldwide, rich and poor, industrialized and nonindustrialized, pledged solemnly to increase resources, review policies and collaborate so that these goals would become reality by 2015. Unfortunately the Declaration was not associated with any document that dealt with the funding necessary to achieve this new strategy.

Despite a relative increase, the financial resources earmarked for health cooperation are still far below the levels deemed necessary to ensure the inhabitants of the most impoverished countries have access to essential health care services. Furthermore, the majority of funds from institutional donors and from the major private donors are earmarked for projects on specific diseases, the so-called vertical programmes.

All of these factors further weaken the health systems of the most fragile countries and penalize the most vulnerable strata of the population.

Furthermore, they have also seriously weakened far-reaching planning and direction at international level, as well as quality strategies and supervision.

According to the most authoritative international observers, the current funding levels and intervention policies put the health goals set by the Millennium Agenda beyond the reach of countries in SubSaharan Africa.

Our commitment to health originated with the evangelical imperative of caring for the sick and continued with the pledges taken with the Declaration of Alma Ata in 1978. Further strengthened by the emergence of a human rights culture, our commitment was called into play by the challenges of the Millennium Agenda, which made the right to health one of the pillars of the fight against poverty. In our globalized world, such gaping divides in health levels in terms of life expectancy and maternal and child mortality, are morally, economically and politically unacceptable.

Doctors with Africa Cuamm sees the failure of the health system as the root of the situation in SubSaharan Africa, but this is not the only cause. In some cases, the health system crisis manifested itself in the inability of systems to protect the poor, but in other cases contributed to heightening the social crisis.

The health-related MDGs will only be achieved if current policies are reviewed and the role of health systems relaunched.

Health policies

Current health policies are unsatisfactory. Not only are levels of health service funding insufficient and volatile, but they are also influenced by priorities that do not take into account needs and scientific evidence. With the arrival of large foundations and global funds, health policy development fragmented and intervention became vertical, which further weakened health systems. The new participation and health funding mechanisms, such as the strategic plans for fighting poverty, state budget support and sector programmes, struggle to produce tangible results in the field, while the welfare policies of developing countries are limited by fiscal and macroeconomic constraints.

Our core beliefs are: increase health investment, focus more on service quality, reallocate public expenditure and reorient public services so that they reach the most disadvantaged social strata, and reduce financial barriers to access with state subsidies and community financing.

Our interventions in the field provide invaluable information on the successes

and problems of health policies. It is essential that our experience be critically analyzed, shared, made public and discussed through widespread and careful lobbying and advocacy. To achieve this aim, it is crucial to create alliances and partnerships, nationwide, Europewide and worldwide, as well as in the countries we operate, in order to influence the actors, content and processes of health policy.

Strengthening district health systems

We believe that our interventions should be geared towards a health system model based on health districts. We need to measure health system performance within these districts as well as the impact of interventions on health and on the fight against poverty, also when they are affected by humanitarian emergencies. Before health districts can be strengthened, however, a number of issues need to be addressed.

Governance. To ensure good working order, districts and their components need a system of governance that is present and active so that public interests, as well as those of health workers and patients, are given proper consideration and respect. This aspect of good governance is often lacking, both for internal and external reasons; consequently the rights of the sick are seriously distorted with people losing any chance of influencing the policies that affect their lives. Doctors with Africa Cuamm believes that the current democracy requires local representatives to participate actively in the supervision of policy in all health facilities, be they public, private, for profit or not for profit. Doctors with Africa Cuamm also wants to invest in processes that will improve the competences of governance, particularly in not–for–profit hospitals.

Fair funding of health services. In Africa the most common and most unfair health service funding is user fees. The poor and those in need, i.e. the sick, pay proportionally more. This makes the poor even poorer as they are forced to deprive themselves of something essential, such as an animal or their child's education, to pay for their illness.

Funding equity in the health system and service accessibility are among the main challenges for anyone who works to improve public health, development and human rights.

Doctors with Africa Cuamm believes that the core duties of a health system are to improve the population's state of health and to ensure universal access to services, without discrimination, through fair financing, which includes local mutual aid societies, community finance schemes, national insurance etc. Regarding this point, we are committed to testing new forms of financing with African partners and to monitoring their impact on the poorest social and economic categories.

Human resources. SubSaharan Africa is undergoing a serious human resources crisis in the health sector. It is not only a question of quantity, which may vary from

country to country, but also a question of management, motivation and development. There is mainly a shortage of management competences. Another critical problem is the current use of financial, material and human resources, as well as the use of all other features within the health system production process. Furthermore, there are also difficulties integrating vertical programmes in district planning or redirecting resources and services towards the least privileged areas and groups in order to bridge inequalities.

Effective and efficient management of a district and a hospital is governed by the quality of their management. Districts and hospitals need to be run by professionals with skills that are still hard to come by in the countries we work. The support, development and training of these professionals will be one of our main priorities, which we hope to achieve by supporting qualified local training centres, including academic ones.

Health workers in peripheral units are also invaluable. Most public health experts agree on what the effective treatment and preventive technologies are, and on their cost, especially as regards mother and child health. Unfortunately this knowledge is not very widespread; in the places it has reached health workers apply it very little. Therefore, we need to foster medium and long-term programmes that combine a suitable mixture of training and refresher courses, alongside supervision and improved working conditions.

Family and community. The key role of the community needs to be brought to the attention of the international health cooperation effort as it has been neglected in recent years. Families, within their respective cultures and communities, play a pivotal role in promoting their members' health and are the natural allies for the success of any health initiative. The poverty in which many families are forced to live affects their lifestyles and consequently their health. Major intervention needs to be carried out on basic health determinants at both family and community level, otherwise health facilities on their own will never be able to ensure a population's health. This challenge requires everyone involved to relate with local communities in a different manner, with an approach based on the right to health and on the implementation of innovative mechanisms that will equip families with the necessary tools to develop their full potential. To achieve this, we are working on integrated programmes that recognize gender equality, economic opportunities, education, food security, environment hygiene and access to drinking water as factors that have a high impact on health. This will require the districts we work in to form programmatic alliances with other organizations operating in non-health sectors.

Knowledge, evidence and results. Comprehensive analysis, monitoring and research needs to be conducted into health policies, aid effectiveness, health district strengthening, efficient resource management, the fight against inequality, quality care and other aspects, including the complex methodologies of outcomes. This is a challenge based on knowledge, evidence of what works, how its works and in what conditions. It is not a new challenge, but one that needs to be faced differently. Modern communication tools means that today figures, information, experience

and contacts can be easily accessed and consulted, whereas once this would not have been possible of location, time and cost. We need to work harder and better on knowledge tools and methods, including routine computer systems, and on analyzing information critically. Work in the field needs to be governed by systematic monitoring and evaluation processes, and organizational logic needs to be geared towards results management. All of these factors have revealed a clear need to reorganize and strengthen our activity towards results-based management.

In order to head in this direction, Doctors with Africa Cuamm proposes to strengthen its training and refresher courses for its health workers in Italy who are about to be posted abroad; make more frequent and efficient use of local surveys; include a research goal in each project; join international networks on specific issues (e.g. the mother and child sector and contracting), participate in forums and scientific debates; increase the number of readers and consequently the donations base of *Health and Development* magazine; raise awareness among health workers and involve Italian public opinion on issues such as global health and international health cooperation.

Conclusions

Doctors with Africa Cuamm offers itself as an actor in the complicated arena of international health cooperation, working alongside the national health system in the countries it is based. It is always careful never to be a protagonist, but a discrete facilitator and, when necessary, a standin. Doctors with Africa Cuamm is convinced that health is a right and has thus prioritized its action in order influence the current unsatisfactory state of health policies and to strengthen health systems with medium and long-term interventions.

We will continue to act flexibly in order to rehabilitate facilities, provide equipment and medication, give human and financial resources, and train health workers, not as a project in itself but as a means to cooperate with governments and African communities so that health goals can be met and equity achieved.