

## **Integrated Solutions**

*Chuck Stephens*

### **The need for integrated solutions**

The term “integrated circuits” became a part of our vocabulary with computer hardware. Later, when software became a household word, we heard of integrated solutions.

We have also become familiar with the term “integrated development”—a way of “connecting the dots” for example between a rural clinic, community water projects and agriculture extension, because health is not just about medicine but about potable water and food security as well. The notion of development emphasizes prevention over cure and dealing with causes, not just the effects.

The problems people face are not just material or economic. A graphic example of this is the scientific studies that repeatedly indicate that prayer promotes overall healing of people convalescing in hospital. In some wards they even keep a dog around, because of the way animals reduce stress and make people feel better. At this level of integration, the buzzword used is “holistic care.”

Aside from these broad bandwidths, there are also three levels of actors in the human services arena. The first level is the Task. This is the technical side, and requires individual expertise, such as doctors, nurses, or pharmacists. Then there is the Group. This is the managerial side. The verb organizing has been changed into a noun during the past few decades—organizations. There was no such word in English usage before World War II. Since then, there has been a proliferation of nonprofit groups. Thus you hear of human resource development or HRD at the first level and organization development or OD at the second.

The third level in human service delivery is that of networks, coalitions and consortiums. To borrow another phrase from IT, these are about “connectivity.” We need more than the technical expertise of individual activists, and more than the managerial know-how of nonprofit organizations. We also need institutional collaboration for higher levels of engagement like advocacy.

This also applies to disaster management. We used to speak of Relief & Development, suggesting that in the case of an emergency, relief would be administered, otherwise, interventions would be developmental. Just as prevailing views on development now promote integration, the common understanding of disasters has broadened. Relief is now but one mode of response; there are other modes as well—rehabilitation, recovery, reconstruction, mitigation and preparedness. We do not

speaking any more of disaster prevention, but mitigating the damages. This has come to be seen as a cycle. Thus there can be pre-disaster interventions as well as post-disaster. That is basically why we fasten our seat belts, place life rings beside swimming pools, and keep fire extinguishers in the kitchen. These are part of an integrated strategy or safety net that provides protection—before, during and after a disaster event.

The articles in this compilation follow this logic. First they look at prevention measures, then at care/support interventions, and finally at mitigating the after-effects. This roll-out follows the disaster cycle. Each presentation is part of an overall, comprehensive and integrated response.

Most African nonprofit groups are relatively small and local, in comparison to some large western-based agencies. While one of these multinational agencies might offer a full suite of services—from prevention to aftermath—this makes them large, and as such relatively cumbersome. While they do try to hire local people, they will never be grassroots organizations, close to the people. One of my personal concerns about such agencies is that their governance structures are usually far removed from the settings of intervention. Very often these structures are not representative of the target beneficiaries, and perhaps a bit patronizing. Thus they cannot and do not constitute good role models in terms of volunteerism emerging in developing countries. The local people see paid executives, and the true distinction between a voluntary organization and a business gets blurred to such an extent, that in some countries, the pay scales of international agencies are higher than those of government. This causes distortions.

The work that I do through the Pan East Coast AIDS Network (PECAN) generally involves smaller, indigenous organizations. Although Schumacher said that small is beautiful, it also has its disadvantages. For one thing, it is harder to integrate what you do in your specific sector and setting with what others are doing elsewhere, even though there are potential commonalities and cross-linkages that could be mutually beneficial. That is where networks come in. They provide a higher level of integration and engagement. For example, when it comes to lobbying or advocacy, one small group is but a voice crying in the wilderness, whereas a network or consortium can speak out on behalf of its membership much more credibly.

One example that comes to mind is the Zimbabwe Association of Church-related Hospitals or ZACH. Ninety-five percent (95 per cent) of rural health care in that country is delivered through ZACH members. Government health care exists mainly in the urban setting. By connecting the dots between all these rural healthcare institutions, there is a voice that government and society listens to.

This third level of institutional connectivity adds value to what individuals can do at the first level, and organizations at the second. One excellent example of an advocacy campaign that was part of an integrated solution was the lobbying that South African NGOs undertook to convince government to widen access to ARVs. This was a concerted effort, and succeeded. One small step is all that one NGO can take—one giant step can be taken when civil society asserts itself collectively.

Another challenge will soon need joint action. South Africa is very conscious of exploitation and with good reason, given the history of apartheid. Therefore, in light of the proliferation of nonprofit organizations—which now employ more people in South

Africa than the mining industry, on which the country's economy is based—the Department of Labour has recently introduced a minimum payment for volunteers. To some of us this appears to be a contradiction, like a vegetarian butcher. How can voluntary organizations afford to pay volunteers, even at a minimum level?

Volunteers are going to be needed more and more—for peer education, for home-based care, and for orphan care. Small groups that exist at the grass roots are not going to find it easy to contest this, especially in a country where the ruling congress includes the coalition of trade unions. This kind of challenge calls for NGOs to pool their resources and raise a collective voice.

PECAN is a network of groups that has been formed to serve as a template. At this stage, to find such a varied portfolio of best practice models, you have to cover a lot of ground, including Zimbabwe, Mozambique, Swaziland and South Africa. The current situation is that there are diverse and commendable AIDS interventions, but each of these are focused on a specific function and area. In other words, these are scattered; it is difficult to find a full suite of them in one place.

The vision of PECAN is a day when every African community will offer the full suite: ongoing prevention strategies, care and support including ARVs, counselling, home-based care and hospices, and coping mechanisms for the aftermath, including safety nets for orphans and outlets for them to express themselves, lest a pent-up backlash cause a social tsunami that is as foreseeable as it is understandable.

This is the case for integrated solutions, from the perspective of the beneficiaries on the demand side. Now let me turn to the supply side and talk about integrating solutions in Canada.

### **The means for an integrated response**

Between my high school in Toronto and my favourite summer camp in Manitoba, I earned my bronze medallion at age 15. I became a lifeguard, by learning swimming skills and life-saving techniques. This was my first step towards protecting lives at risk, which is what all disaster responses amount to in general and AIDS interventions in particular.

I learned that it was inadvisable to dive into the water to try to save a drowning person, because in panic mode, they become so incredibly strong that they can endanger your life, even as you go about saving them. We acquired techniques like how to approach them from underwater, to gain a strategic advantage, since the last thing they want is to go underwater. We learned how to get behind them so that their arms would be away from us; how to get under them with our arm over their chest, buoying them up so they can breathe. However, actually going out to get them like this was to be the last resort. First we were told to row, throw, or tow. Only if all those were ruled out, or failed, should we ever go.

*Row* means take a boat. Get near them, giving them something to hang onto, then row them in to safety.

*Throw* means get a life ring or life jacket and throw it to them, if possible, then pull them in using the rope attached.

*Tow* means to get an object between you and them, maybe a canoe paddle or stick, to haul them in. But keep at a safe distance lest they take you down with them.

Or *go*. But only as a last resort.

On the supply side, speaking of integrating solutions to the AIDS pandemic in far-away Africa, I can't think of any better advice to give you than this: row, throw, tow, *and go*. We must replace the "or" with an "and."

### ***Row***

Get on board. Support the life-saving efforts of a church, an agency, a community service club, and paddle hard! These are soundly constructed vessels designed to deliver help to those in harm's way. This would include volunteer and missionary organizations which deliver people as opposed to grant funding or food aid.

Some of these organizations are hands-on or operational with staff on the ground in many countries. Others are really grant-makers that fund local interventions run by indigenous organizations. Both play a huge role, and both are needed. Although a preference for the paradigm of partnership is reflected in the PECAN template—that is, letting local organizations take the lead, with Canadian organizations playing a tandem role—I recognize that in an emergency situation like the tsunami earlier this year, even the local groups can get swept away, and you always need the operational agencies.

Philanthropic groups like foundations and missions are a safe and secure way to go about helping in this way. They assure that there will be vessels of mercy lifeguarding in all societies and cultures. They add value to local capacity, and strengthen the fabric of civil society. However, these are but one of the delivery channels, and have their limitations like all the others.

### ***Throw***

Toss out something useful: you can contribute expertise, advice, technology, materials, equipment, and so forth. Sadly, resource mobilizers don't get past the subject of money soon enough. This causes distortions, because there are a range of contributions that people can make, and these all need to be integrated.

One of the key challenges here is that Canadians do not always find it easy to deliver resources to Africa, especially for the AIDS crisis. This is because AIDS is not treated as a disaster. Perhaps this is due to the approach of "mainstreaming," which upgrades AIDS to a cross-cutting issue like gender or the environment, relating it to all sectors. The stigma of AIDS could also explain this, obscuring the devastation and with it the fast-tracking of assistance that is standard procedure for disasters. Or could it be because AIDS is a slow-onset disaster, like a drought, which differs from a rapid-onset disaster like an earthquake or tsunami? Surely the biggest disaster in human history in terms of loss of life should be treated as an emergency,

It is standard procedure in emergencies for international aid to be delivered without having to pay duties. AIDS inputs, especially those for pre-disaster interventions, do not

tend to enjoy such exemptions. Medicines are high value commodities, and duty is an important source of revenue to many African countries; that is, if you can import them at all, in the protectionist trading environment that still prevails, favouring local producers. It is high time that channels of assistance to AIDS victims be regarded as a full blown emergency. Pre- or post-disaster, these deserve exemptions and fast-tracking.

Integrated solutions are required to cope with this pandemic. We cannot stop prevention schemes just because we get busier than ever with care and support of AIDS victims. And mitigating the after effects is very much part of the holistic response. AIDS is not a rapid-onset disaster, like many other medical emergencies. But just because it is so complex and far-reaching doesn't disqualify it as a disaster. Special provisions are the order of the day, to ensure that Canadian expertise, technology, material and equipment reach the victims expeditiously.

### ***Tow***

Approach the person you want to help, from a distance, keeping an object between you and them for safety's sake.

This could mean twinning churches, cities, or provinces; institutional partnerships, mentoring relationships, development tours, repeated business visits, equity investment, even pen pals.

As a lifeguard, when there isn't a vessel or anything to throw, this strategy is the wisest alternative. You get near, being cautious to keep some distance there too. Your presence can have a very calming effect, and the object that you are holding by one end can be a real lifeline.

Our province of Mpumalanga is twinned with Alberta. Our newly formed Anglican diocese is currently looking for another diocese somewhere in the world to twin with, possibly one in Canada. Our local Rotary club supports a youth exchange program. These are examples of towing—a bit near and a bit far.

The PECAN consortium in Canada is composed of several resource agencies. Its lead agency, EMAS, sends mainly Canadian healthcare professionals out as volunteers while other consortium partners offer other inputs. On the African side, PECAN hopes to develop further relationships involving technical mentoring, church partnerships, and business collaboration.

Partnership is our prevailing paradigm. Groups like HPIC and EMAS on the Canadian side work jointly through the PECAN consortium in Canada, to support a network of indigenous organizations like Masiye Camp in Zimbabwe, ACTS Clinic in South Africa, the RCHS HIV/AIDS Christian Network in Mozambique and the New Hope Centre in Swaziland. PECAN allows projects to be “bundled,” affording a number of relatively small but vital groups the prospect of tapping resources that would otherwise be beyond their reach as individual groups.

**Go**

But only as a last resort.

Some go as volunteers for a year or two. Others approach it as a career, with a salary or missionary support from the sending country. Another paradigm is basically self-propelling, by trying to resource the work you do in the country of engagement. As the African proverb says: *A goat eats wherever it is tethered*. A fourth option is to emigrate, that is, to resettle permanently in the service location.

That is not as simple as it sounds.

A recent WHO news release stated that 100,000 healthcare professionals are presently required in Africa to shore up its health services. And that's just one sector—health. Meanwhile, thousands of people are immigrating to countries in the North, including Canada. At the Brain Drain conference in Addis Ababa, it was revealed that 10,000 Africans with tertiary degrees emigrate from the continent every year. There are no less than 3,000 South African doctors in Canada.

Recently, South Africa's health minister actually lamented that for every doctor lost to a country, that country should send a doctor to Africa. She must have no idea how hard it is for Canadian professionals to settle in South Africa. The prevailing market conditions of affirmative action, usually called “black empowerment,” make it almost impossible to compete in the entry and settlement process.

Could Africa's “positive discrimination” be one of the bottlenecks to coping with the AIDS crisis? The time has come for reciprocity so that there can be joint engagement. An old proverb says: “All hands on deck when the ship's on fire.” Integrating solutions should include an open door for Canadians to settle in Africa, to shore up local capacity. This is not re-colonization. Canada was never a colonial power. In fact, it was a developing country until recently, and is evidence that integrating immigrants into the work force can be a resource for development.

Canadians can help by writing about this joint engagement issue to the media, to their MP, to CIDA, or even to Stephen Lewis at the UN, to lobby for reciprocity.

As in lifeguarding, going it alone to save lives can be perilous, but it needs to be included in the multiple strategies that we call “integrated solutions.”

**Connecting the dots**

“Integrated solutions” is a phrase borrowed from computer technology, but it suits the AIDS crisis well. While responses may be distinct—whether peer education in the prevention mode, or a hospice for the dying in care/support mode, or psycho-social camps for orphans in the aftermath mode—they need to be complementary. PECAN has connected the dots into a full suite by linking various interventions in four countries into a single network, to serve as a template. Its solutions are integrated, cross-border, grassroots role models. Before long, every community in Africa will need to offer this full suite of solutions. Prevention measures need to be maintained vigilantly. Care and

support can keep AIDS victims living productively for years and even decades. Mitigating the after-effects will last for several generations. No single group offers the full suite, but when networked with others, a comprehensive template emerges.

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