



ANNUAL REPORT 2018

Honesty, Persistence and Engagement...

MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL

ANNUAL REPORT 2018

MESSAGE FROM THE PRESIDENT

HONESTY, PERSISTENCE AND ENGAGEMENT...

ANNUAL REPORT BY THE SECRETARIAT

A year of renewed attention to Primary Health Care

“Health cooperation beyond aid” ...and beyond the MMI discussion paper

Global Health Policy and Governance: Difficult questions, difficult processes

Medicus Mundi International: Networking and Network development

MMI: Network members

MMI NETWORK MEMBERS: “SHORT STORIES”

Memisa

Taking the Gender Turn

Medicus Mundi Italia

Burkina Faso 2018: a Tragic Year for the “Land of Honest People”

Medicus Mundi Italia

No one out! What we can Learn from David...

Medicus Mundi Switzerland

Health for All Within a Generation is Achievable. A Manifesto

Andalusian School of Public Health (EASP)

Health Information for All – in Spanish!

Doctors with Africa CUAMM

The Next Generation Programme

Cordaid

Follow the pill: Fighting HIV and Tuberculosis in DR Congo

Health Poverty Action

The pain of prohibition

Swiss Red Cross

Menstrual Hygiene Management on the Forefront

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DEAR NETWORK MEMBERS AND PARTNERS

Technological advances have allowed us to reach unprecedented life expectancy and to improve our life quality. Nevertheless, a big part of world's population is still excluded from "healthy lives and well-being for all". As an example, the huge existing gap between and within countries and populations in terms of maternal or child mortality cannot be explained by any genetic or biological reason. The real problem lies in the inequalities in both living conditions and access to health care.

At the same time, global issues become more and more relevant for the health status of individuals, communities and populations and for national health policies and systems. "Global health" does not only relate to political issues such as access to medicines or the governance of global health institutions, but includes the broader determinants of health and health policies such as climate change, the economic crisis, food preservation and renewable energy that cannot be resolved at a national level alone. All these issues must indeed be considered when we aim at more equality and "health for all".

In order to cope with today's challenges and to fulfil its mission, the Network Medicus Mundi International (MMI) has structured its work plan in two interrelated fields of work. On the one hand, many Network members strive to improve communities' and people's health conditions by means of actions and projects on the ground, directed to the most disadvantaged people. To support this action, the MMI Network and its working group on Effective Health Cooperation provide a space for joint reflection on how to do this best. On the other hand, MMI tries to influence global health policies and governance through own inputs and as a convener of civil society advocacy. The activities falling under each field of work are built on contributions by Network members coming from different world regions and belonging to different areas (NGOs, national networks, academia) and are supported by our secretariat.



Aiming high – working hard

Two main elements of MMI Network action in the past year are worth to be highlighted: The first one is our participation in events and initiatives aimed at triggering a global process of critical reflection and debate on the right to health for all. In this regard, the Network has officially taken part in the most important meetings and conferences throughout 2018: The 71st World Health Assembly in Geneva, the Global Conference on Primary Health Care in Astana, and the Fourth People's Health Assembly in Dhaka are some of the events where MMI had an active and vocal role in 2018.

The second element is directly linked to the Network members' benefits. MMI is conceived for letting members share their experiences, for promoting their work and good practices, for amplifying their voices and developing common projects. This is based on the demand and contributions by members, and we had two outstanding experiences in the past year: the symposium on "The State as health duty bearer – challenges and threats" organized by Medicus Mundi Bizkaia in February in Bilbao, and the symposium "'Health for All' by 2030: On the Right Track, or on the Verge of Failing?" of Medicus Mundi Switzerland that took place in Basel in November. MMI contributed actively to these two great occasions to gather many relevant actors among and beyond our Network(s) and to shine a light on our members' positions and work.

2019 will be another crucial year for Medicus Mundi International to follow this double track: Continuing and further deepening our work in the fields of effective health cooperation and global health governance will not only consolidate our role, but also help these fields to be mutually strengthened. The perspectives are promising.

That's why I think that it is important to keep thinking big and aiming high, reaching the most important institutions and actors with our analysis and input, at the same working hard, with the resources available at the Network members and secretariat, without ever losing sight of the realities and ambitions of the institutions we intend to bring together, nor of the people we want to serve.

Thanks to all who contributed to another successful year!

A handwritten signature in blue ink, appearing to read "Mediano", is written over a light blue grid background.

Carlos Mediano, President

Medicus Mundi International Network

HONESTY, PERSISTENCE AND ENGAGEMENT...

Sometimes, we are attracted and tempted by the smooth, clean and easy surface of things – and narratives. 2018 was again a year with many such temptations: The “partnership”, “multi-stakeholder” and “global movement” discourse of the UN Sustainable Development Goals, taken over and amplified by the new leadership of the World Health Organization, pretends that we can achieve everything (sustainable development or Universal Health Coverage) if we just do it together. The mainstream narratives on “leaving no-one behind”, “pro-poor policies”, “gender transformation” – to throw a few of the buzzwords of the past year(s) on the table – make us believe that there are easy answers to complicated realities.

And sometimes it is awkward to be the ones who challenge the easy answers, ask the critical questions, enquire about the making of an apparent consensus, and insist on blind spots or shortcomings of an analysis or strategy. But sometimes just asking the right question is as relevant as giving the answers, and most of the time, it is more honest to ask the question first...

In 2018, in its own events and statements and contributions to global meetings and working groups, the Medicus Mundi International Network continued to ask “difficult” questions such as the following:

- In the year of celebrating the jubilee of the 1978 Alma-Ata Declaration: How to translate “Health for All” into the present and future?
- How to make sure that development cooperation contributes to strengthening and not weakening national health policies and systems?
- How to ensure better transparency and inclusiveness in the making of “joint civil society statements”? Can civil society, in global political processes, really “speak with one voice”?
- How to address the root causes of sexual harassment and exploitation in the context of aid?
- How to make sure that digital health, eHealth, mHealth become a real breakthrough for public health and do not create new dependency?

You see the diversity of the topics and levels, and you might see the related challenge: If we take our Network’s culture of honesty, sincerity and persistence serious, asking the right question and insisting on them can only be the first step. We also need to find or create ourselves spaces for honest debates in view of achieving a better analysis and finding some answers, even accepting that these answers cannot be easy ones.

The Annual Report 2018 of the MMI Network will lead you to all the questions above and to more of them, to the processes they relate to and to our Network’s engagement in these processes.

The report is structured along the two main fields of activities as outlined in the MMI Network Strategy 2016-20: We continued in 2018 to engage our members and partners in a conversation on how to move health cooperation “beyond aid”. And we continued to successfully play our role as both a critical civil society voice at the World Health Organization, its governing bodies and processes, and as a convener and facilitator of civil society networking and advocacy in the field of global health and health governance. In our approach of linking practice with evidence and the local and national with the global level, the MMI Network and its members deal with these fields of work not just as separate tracks, but as a holistic one.

Translating "Health for All" into the Present and Future
Civil society workshop, 16 May 2018



Translating "Health for All" into the present and future.
Introductions to the afternoon parallel sessions

Cooperation and solidarity beyond charity. Health and
social justice as a human right and a global public obligation

Introduction and facilitation : Public Services International
and medico international



A YEAR OF RENEWED ATTENTION TO PRIMARY HEALTH CARE

The Alma-Ata Declaration of 1978 emerged as a milestone in the field of global public health. Referring to the social, political and structural determinants of health, emphasizing the importance of accountability to the people, and proposing comprehensive Primary Health Care (PHC) as key to the attainment of the goal of Health for All, the Declaration still reads as a visionary and revolutionary text.

The engagement of the MMI Network in the celebration of the Alma-Ata Jubilee in 2018 went considerably beyond our Network's focal topics of health cooperation and health governance. The Declaration of Alma-Ata being part of the DNA of MMI and many Network members, we asked ourselves – and others – how to translate the core of the Declaration into the present and future.

Translating 'Health for All' into the Present and Future: Alma-Ata Jubilee events related to the World Health Assembly. Geneva, 18 and 22 May 2018

In 2017, the MMI Secretariat took the lead in setting up a task group of the Geneva Global Health Hub (G2H2) on the Alma-Ata Jubilee. In particular, the "AA40 task group" planned and implemented a full-day civil society workshop in Geneva on 18 May 2018. The workshop started with a very intensive moment when the task group members read again the full text of the Alma-Ata Declaration. Representatives of various civil society organizations then critically revisited the Declaration and the core principles expressed in it (in particular: addressing determinants of health; global solidarity for health equity; accountability to the people and communities, access to comprehensive health care services for all through a system structured around the principles of Comprehensive Primary Health Care) for the potential to be used as inspiration and guidance in our quest for Health for All.

The workshop resulted in the statement "40 Years of Alma-Ata: Translating 'Health for All' into the Present and Future" that was used, during the World Health Assembly and throughout the year, by Medicus Mundi International and others as a key reference for our further engagement in the Alma-Ata Jubilee. All in all, event and the related communication provided a great opportunity to renew and promote a broad commitment to the values and the agenda of change expressed by the Alma-Ata Declaration.

As a result of a half-year dialogue with the PHC desk at the World Health Organization, the AA40 task group was also invited to contribute to a formal "technical briefing" on the Alma-Ata Jubilee at the World Health Assembly on 22 May. Gisela Schneider, Director of Difäm, was a strong and convincing civil society representative on the panel.



MMI contributions to civil society engagement in the Global Conference on Primary Health Care (Alma-Ata Jubilee). Astana, 25-26 October 2018

“What a difference to the black and white photographs of the 1978 Alma-Ata International Conference on Primary Health Care: The Global Conference on Primary Health Care, edition 2018, took place in the hypermodern new capital of Kazakhstan, in the great Independence Palace, with colorful opening and closing shows (the latter ending with singing ‘We are the World’), with a night at the Astana Opera and a reception by the Mayor of the city...”

As reported in our Astana blog “A future for Primary Health Care?”, our representatives at the Global Conference on PHC looked back at the Alma-Ata Jubilee event with mixed feelings. From an institutional perspective, we could be happy, as there was considerable presence and visibility of Medicus Mundi International, with our session on health cooperation (we will report about it below) and with our delegate Itai Rusike representing civil society in the final plenary. The conference itself was, in many ways, just “one of these” global meetings, with a mainly technical approach to Primary Health Care, and focusing on a superficial consensus, on showcasing success stories and on promoting “partnership” and “commitments”.



Lack of inspiration and shared direction of the Astana conference also resulted in lack of unity. In 1978, in Alma-Ata, all participants agreed and supported the conference declaration, and it was a great one. 40 years later we have one official Astana conference declaration and two competing civil society ones. And none of them will be remembered in 40 years...

However, there was also some sincere debate and deepened analysis. There was a perspective that people and communities need to be invited back to the center of policies. Participants from various backgrounds started to rediscover the holistic and political core of Primary Health Care, and there was some honest debate about how this core of PHC can be revitalized for dealing with national and global health issues across the sectors and silos.

And there were some highlights and strong political moments, such as a Ministerial parallel session on equity ("Leaving no one behind through PHC"), with a great representative of the People's Health Movement speaking truth to power. And yes, there was our own "café session" on "Calling for a New Global Economic Order – the forgotten element of the Alma-Ata Declaration" organized by Medicus Mundi International and a team of civil society colleagues:

"It is vital that we build solidarity between people within and across nations and regions. The existing system of international aid and the associated charity narrative risk legitimising an unfair economic framework which prevents national self-determination and weakens the building of strong and resilient local health systems. Health for all requires the redistribution of wealth nationally and globally."
(concept note).

Realizing the limited space given to civil society contributions and the fact that it was difficult to gather a greater number of civil society representatives at the Astana conference, we decided to set up the session as a kind of flash mob, where various colleagues are invited to make a short, compelling statement why the Alma-Ata call for an New International Economic Order is still valid. The session was then filmed, and the resulting compelling movie clip disseminated via social media.



“HEALTH COOPERATION BEYOND AID” ...AND BEYOND THE MMI DISCUSSION PAPER

As outlined in the MMI Network Strategy and in a discussion paper published in 2016, the MMI Network wants to contribute to the debate on ways in which actors in development cooperation such as international NGOs or bilateral agencies can engage in a relevant, legitimate and effective way to strengthening national health policies and people centred health systems.

Our promotion of “health cooperation beyond aid” is rooted in the engagement of MMI Network members in health cooperation, in our promotion of Primary Health Care and health systems strengthening, and in the traditional role of the Network of being a space for sharing, mutual learning and cooperation.

The activities of the MMI Network in this thematic field are coordinated by its working group on Effective Health Cooperation (MMI EHC). As the MMI Board considers this work relevant for all Network members, there is no specific membership in the MMI EHC working group, but the group is led by a small core group mandated by the Board, reaching out to all Network members for specific activities and calls.

As a starting point for a deeper conversation with Network members and partners, and referring to the 2016 discussion paper, the “MMI EHC work plan 2018-19” outlines core qualities of health cooperation as follows:

- It contributes to achieving universal access to health.
- It promotes health equity and human rights.
- It strengthens and does not weaken people centred health systems.
- It is demand driven and based on partnership between institutions and people.
- It is aware of its catalytic nature and its structural role, responsibilities and limitations.
- It promotes and includes continued learning and reflecting on approaches, methods and practices.
- It is part of an institution’s broader engagement for global health equity and human rights to address the broader determinants of health and health policies.

Moving health cooperation “beyond aid” therefore means adding these core qualities to the humanitarian gesture of “helping those in needs” in which health cooperation is historically rooted. The result shall NOT be the transformation of aid into business, but into a relationship that is based on solidarity and on shared visions and values.

The year 2018 brought some good progress in this field of work, at all levels: We deepened our understanding of rights and solidarity based health cooperation, we are happy with the outcome of our activities, and we succeeded to obtain the support – and a much appreciated grant – of the Open Societies Foundation for our work in this field, also as a contribution to our institutional sustainability.

Digital health, eHealth, mHealth: Breakthrough for public health or creating new dependency? Debate at the Geneva Health Forum. Geneva, 13 April 2018

The rapid propagation of digital technology in the health sector is not only fuelled by changing demographics, scientific progress and societal expectations, but also driven by the health technology industry and by actors in international health policy and cooperation. In January 2018, the WHO Executive Board discussed the use of appropriate digital technologies for public health. The overall tone was optimistic to enthusiastic, and there have been only few critical statements such as those by the World Medical Association and by Medicus Mundi International.

“Digital technologies have the potential to transform many fields of human activity, including healthcare. However, their impact can be predictable and beneficial only if there is strong public control on the use of such technologies.” (MMI statement at the WHO EB)

In fact, digital health technology needs a sound assessment with a focus on its impact on public health – and this requires also a political debate, which is a difficult one: Will the new technologies really be the “revolution” expected in the provision of universal access to prevention, diagnosis and treatment as part of universal health coverage? How to make sure that they will not rather lead to new dependencies and new inequity and add to the burden and confusion of those who are responsible for health care planning and delivery?

In a satellite session to the Geneva Health Forum jointly organized by MMI and Medicus Mundi Switzerland, and based on two case studies presented, expert panelists and all participants discussed the challenge of ownership, integration and adaption of technology-driven innovation within a national health policy and a people centered health system – as a public health challenge for all countries in the global South and North. In a keynote published in the MMI Network News, Bettina Borisch (WFPHA) made clear that this debate needs to be continued:

“All technology will have to be measured by the impact it has on our societal model; they may well increase or decrease existing inequities and injustice. It is our task to use them in the way we want to live as communities. For the time being, all public health professionals should be fully aware of the potential impacts of health technologies and should always consider the pressures that indirectly influence their basic values. It is our responsibility as engaged participants in the realm of Public Health to take a pro-active role and express the views for the society that we want.”



#AidToo: First do no harm – secondly respond adequately. How to address misbehaviour in international health cooperation. Public side event to the MMI Assembly and World Health Assembly. Geneva, 26 May 2018

Since 2014, the MMI Network has met once a year, for its Assembly and health cooperation workshop, in the middle of “International Geneva”, close to the Palais des Nations and the World Health Assembly (WHA). In 2018, MMI we were happy and grateful that the Graduate Institute agreed to host our Assembly and the related public side event at its beautiful “Maison de la Paix”. The topic of the side event was again a “difficult” one, also for the members of the MMI Network engaged in health cooperation: After the scandals of sexual abuse and exploitation by staff of organizations working in humanitarian aid and development cooperation reported and discussed in early 2018, it was obvious that assessments and answers about how to deal with such misbehaviour needed to be found at all levels: by the individual, by the institution (what values, norms, and regulations can they refer to in order to prevent such cases and, if they occur, to deal with them in an adequate way?), and by the sector and society as a whole.

The Board of the MMI Network concluded to address #AidToo as part of our reflection about the future of NGOs in international (health) cooperation: As Willem van de Put, ITM Antwerp, put it in a blog: “Whether or not the critique is an example of selective morality, the fact is that the humanitarian world needs to change fast if it wants to remain part of the solution, and not cause more problems.”

The side event to the MMI Assembly was open to representatives of institutions working in the field of health cooperation, to delegates at the 71st World Health Assembly and to all others interested. It provided a space for asking critical questions and sharing assessments on what is to be done to prevent and properly respond to particular cases of sexual exploitation and misconduct. But the dialogue went beyond this: What is to be done to address the root causes? Again not an easy question, as expressed in a blog published by the Global Health Centre of the Graduate Institute after the meeting:

“At the moment, many discussions take place about the need to address root causes of sexual abuse, harassment and exploitation but concrete action to identify and proactively address these causes is missing. In order to do justice to the women, men and children who are abused and exploited, we cannot just listen to them; we also need to take action to correct the skewed power structures which allow the abuse to continue and which leaves the victims voiceless and excluded. It is time to stop being part of the problem and become a part of the solution.”



**Effective Health Cooperation and Primary Health Care “at the end of aid”.
Official side event to the First Global Conference on Primary Health Care
co-organized by Medicus Mundi International. Astana 26 October 2018**

40 years ago, the Alma-Ata Declaration stated that “all countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.”

In times when the mainstream discourse on Universal Health Coverage (UHC) and health systems is about national leadership and the mobilization of national resources, it is not easy to call for a continued, honest debate about the role of development cooperation in strengthening (or weakening) health systems, as the Medicus Mundi International Network has done it over the last few years and continues to do so.

On this background, we were happy that the organizers of the Alma-Ata Jubilee Conference in Astana accepted a proposal for a one-hour official side event on the role of "aid" or international cooperation in the achievement of Primary Health Care, based on our initiative. The proposal for this event was formally submitted by a team led by the Secretariat of the International Health Partnership for UHC 2030 (UHC2030) and also including the UHC2030 Civil Society Engagement Mechanism. The side event at the Astana Primary Health Care Conference provided some important perspectives on how to reinvigorate the essence of the effective development cooperation agenda in terms of alignment with PHC based national policies, strategies and plans.



A particular challenge of the Astana session was to apply a “Primary Health Care lens” on development cooperation and health systems. The organizers framed this lens as follows:

- Empower people and communities as owners of their health, as advocates for the policies that promote and protect it, and as architects of the health and social services that contribute to it;
- Address the social, economic, environmental and commercial determinants of health through evidence-based policies and actions across all sectors; and
- Ensure strong public health and primary care throughout people’s lives, as the core of integrated service delivery.

Itai Rusike, Community Working Group on Health, who represented the MMI Network on the panel, highlighted the role of communities and their structures and organizations, to be strengthened to actively participate in public health policy making and in the provision of the health services the communities want. The support of people and communities and, overall, the strengthening of responsive and democratic national structures, should be at the core of international cooperation.

Agnès Soucat, Director Health Systems Governance and Financing at WHO, agreed that the issue of development cooperation in the context of the SDG needs to be further explored. She recalled the overall framework of the World Health Organization’s 13th General Programme of Work for driving public health impact, with a differentiated approach based on each country’s capacity, ranging from fragile to mature health systems:

- fill critical gaps in emergencies – through service delivery
- build national institutions – through technical assistance
- build high performing systems – through strategic support
- develop systems of the future – through policy dialogue

In this sense, development cooperation must be “fit for purpose” and refer to the context. If countries still need external support, it should contribute to building the foundations of a health system, through investments in national institutions and policies. On the other hand, dealing with countries in transition towards a more mature health system, it is important to “de-learn”, to shift the way of working and not get stuck in the old patterns and routine. If this shift does not happen, aid has the potential to crowd out domestic funding and to distort national policies, strategies and allocations of funds.

Panellists also agreed that global solidarity and cooperation might shift towards producing and financing global public goods such as research and regulation that will support countries in their health policies. However, it is not obvious how to shift both attention and money to these more complex fields.

The session concluded with a broad agreement that the conversation needs to be continued, and with the related expectation and mandate to the organizers, including UHC2030, to provide modalities and platforms for this.

In the public interest? The role of international health cooperation in strengthening or weakening national health systems. MMI “self-organized session” at the Fourth People’s Health Assembly. Dhaka, 15-19 November 2018

Six years ago, the MMI Network contributed to the Third People’s Health Assembly in Cape Town with its workshop „In the public interest? The role of NGOs in national health systems and global health policy”. The two sessions on “The challenge of integration” and “NGOs – the good, the bad and the evil?” found great interest and showed us that there is a need to continue the conversation in the role of international actors in national health policies and systems beyond the initial focus on international NGOs.

Bringing the topic back to the Fourth People’s Health Assembly in Dhaka, we hoped to be able to provide again a space for an open debate between NGOs and social movements, between representatives of the global South and North, about what kind of solidarity, what kind of action and interaction is needed to advance Health for All.

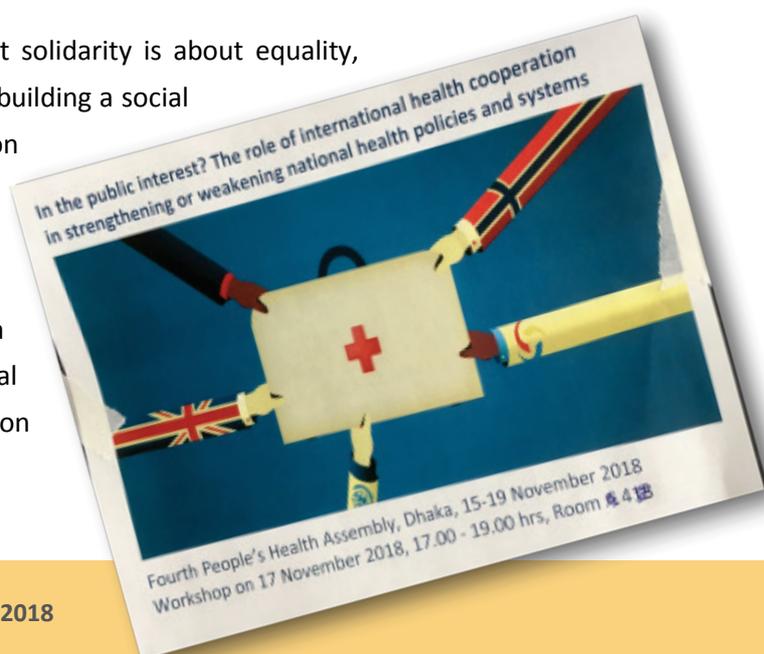
It was good to see that a debate on aid or development cooperation took place in various forms in other sessions of the Fourth People’s Health Assembly in Dhaka, in November 2018, oscillating between the call to stop aid (as it is seen part of the problem, not the solution, and cannot be “repaired”) and a critical perspective on what is needed to move cooperation and solidarity beyond aid (as the involvement of external actors in national health policies, systems and service delivery will remain a challenging reality in many countries).

In our own “self-organized session”, we expected to take along the following:

- to get a better understanding about how the role of “aid” in strengthening or weakening people centred and people owned national health policies and systems is assessed and debated by civil society representatives from various backgrounds;
- to renew and strengthen contacts among civil society experts and institutions interested to engage together in further defining a political position about what should be the role of international cooperation for global solidarity in health.

In the workshop, inputs (stories, analysis, perspectives) were provided in a lively democratic conversation by all participants and complemented by the representatives of the MMI Network who referred to our discussion paper published in 2016.

Concluding the workshop, participants agreed that solidarity is about equality, about a common fight for human rights and about building a social movement. They also agreed that the discussion about a solidarity and rights based approach in health cooperation needs to be continued and deepened. Workshop participants also concluded that efforts need to be undertaken to strengthen a critical civil society voice (beyond the typical “northern development NGOs”) in global fora on development cooperation and health.





MMI working group on Effective Health Cooperation: Work plan development and implementation

The activities reported above, and more to come, are outlined in the “MMI EHC work plan 2018-19”, a planning document adopted by the MMI Board and also submitted as a grant proposal to the Open Society Foundation (OSF).

Since the MMI sessions on “Health cooperation beyond aid” at the Antwerp ECTMIH conference in autumn 2017, OSF had shown an interest in our work in this field of work. A more structured conversation with an OSF representative took place as part of a dialogue and planning workshop of the MMI Board in February 2018 in Bilbao, related to the conference on “The State as health duty bearer – challenges and threats” organized by Medicus Mundi Bizkaia. The final version of the work plan was adopted by the Board in August, and OSF confirmed its grant in September.

The work plan and the OSF grant mainly cover the period of September 2018 to December 2019, but include references to the activities already implemented in the first semester of 2018 and provide an outlook to some follow-up activities in early 2020.

The overall objective is framed as follows: “In a rapidly changing and unstable world with increasing inequities, we promote democratic, legitimate and effective health cooperation for social justice, global solidarity, respect to human rights”. The plan covers two interrelated fields of work: Advocacy and policy dialogue at global, national, local levels; and institutional strengthening of International Health NGOs. At the level of activities, the plan also includes a section on institutional strengthening and sustainability of the MMI Network.

On 6 November 2018, the MMI Board invited Network members to an open planning meeting on “Health cooperation beyond aid - what key topics for 2019?” in Basel, related to the Symposium “Health for All by 2030: On the Right Track, or on the Verge of Failing?” organized by Medicus Mundi Switzerland.

The workshop provided some good directions for focusing the activities of MMI EHC on the realities of the Network members and other NGOs engaged in health cooperation, reacting to their specific demand – a conversation to be continued and intensified in 2019.



GLOBAL HEALTH POLICY AND GOVERNANCE: DIFFICULT QUESTIONS, DIFFICULT PROCESSES

Over the last ten years, Medicus Mundi International has become a respected and well known voice of civil society at the World Health Organization, also benefitting of its status as “NGO in official relations” and its long history of collaboration with WHO. Related to this, MMI has also developed a reputation as a dedicated and unbiased networker and convener for WHO related right-based civil society advocacy. In all these areas, 2018 was a year of intensive work – with some good progress.

Governing bodies of the World Health Organization: Watching and providing direct input

As in previous years, MMI addressed the World Health Assembly and two sessions of the WHO Executive Board with statements on various topics, in close collaboration with the People’s Health Movement and its “WHO Watch” project that is hosted in the delegation of Medicus Mundi International. MMI statements are available on the WHO Watch website and in particular in the comprehensive “WHO Tracker” provided by the People’s Health Movement.

WHO governance: Renewed engagement or shrinking space for civil society...

In the field of WHO governance, and as part of a broader civil society team, Medicus Mundi International continued to watch and critically comment on the implementation of the WHO Framework on Engagement with Non-State Actors (FENSA) adopted by the World Health Assembly in 2016. The engagement of many civil society organizations in the WHO financing and governance crisis and the need for sharing assessments, joint strategizing and coordinated interventions was also one of the roots of the Geneva Global Health Hub (G2H2) set up by a coalition of civil society organizations in 2016 and hosted since then by MMI.

In the initial period of a new WHO leadership team under Dr Tedros (elected as WHO Director-General in 2017), WHO governance has become even more dynamic, more confusing, less predictable, with a lot of new initiatives and processes. For this reason, and based on discussions among civil society advocates in autumn 2018, Medicus Mundi International and Bread for the World proposed to civil society colleagues at the Geneva Global Health Hub to set up a new civil society working group on “WHO and global health governance and financing” beyond the already established “FENSA Watch”. The new G2H2 working group was launched in December 2018. Its presentation outlines key references and starting point as follows:

“To launch this working group at this moment is based on our assessment that there are some current processes at the WHO that need our immediate attention, such as:

- WHO Engagement with non-State actors: Initial evaluation of the implementation of FENSA (2019, in preparation) and new plans for a ‘WHO Strategy on Engagement with non-State actors’;
- ‘Transformation of WHO’ with still unclear scope and consequences;
- Reform of WHO Governing Bodies and perspectives of a further shrinking space for civil society;

- Interaction of the new WHO leadership with various ‘civil society’ teams’ and related governance issues
- WHO financing: ‘Investment case’ launched in autumn 2018 and related creation of a CSO Advisory Group by the WHO secretariat;
- Preparation of a ‘Global Action Plan for healthy lives and well-being for all’ and related governance issues, including civil society representation.”

In fact, throughout the year 2018, the MMI Executive Secretary and other representatives of the Network were strongly involved in these challenging and controversial processes. As outlined in the introduction to our Annual Report, our engagement often started with being the ones who asked the “difficult” questions on objectives, governance and legitimacy. From our contacts with WHO representatives, we know that our input is both appreciated and taken into consideration.

The launch of the new G2H2 working group on WHO and global health governance will allow us to bring our engagement in this field to a new level, beyond our own capacities, with a team of civil society advocates and academics that are able to deepen the analysis and propose strategies of cooperation and joint political action. As a first step, the working group organized a half-day session on WHO governance in the civil society meetings ahead of the WHO Executive Board session in January 2019.



Civil society and Universal Health Coverage: Discussing with friends...

Sometimes it is difficult to decide if it is better to engage in a process and contribute to it from within or to critically watch it from the outside.

For Medicus Mundi International, and with our mixed membership and limited capacities, this is valid for all the multiple initiatives launched by the World Health Organization in the last year, but in particular also for the many so-called civil society initiatives and teams mushrooming in our main fields of work, mainly if we do not feel really confident about their tasks, legitimacy and governance.

In the field of health governance, we followed and critically commented on the work of a “WHO-Civil Society Task Team” from the outside, providing critical feedback on shortcomings and legitimacy issues to the Task Team coordinators, by correspondence and in meetings during the World Health Assembly and in autumn 2018 when the Task Team report was launched at the WHO headquarters.

In the case of the “International Partnership for UHC 2030” (UHC 2030) and despite the fact there are some concerns about the governance and mainstream narrative of this “multi-stakeholder partnership”, the Board of Medicus Mundi International decided in 2017 to join both UHC2030 and its Civil Society Engagement Mechanism (CSEM) as a member and to contribute to these structures from within, providing civil society input to key topics, including the role of health cooperation in strengthening or weakening health systems, but also critically watching their governance.

For partnerships and global health initiatives such as UHC2030, having a “civil society mechanism” has become a standard requirement, but as we have seen in the case of the CSEM, these civil society structures face considerable governance challenges: Financially, they depend on the money received from the partnership. They are set up in a rush and are expected to provide immediate output, e.g. in the form of “civil society statements”, while key governance and communication mechanism are still in the making. In a meeting with MMI representatives in December last year, a member of the CSEM Advisory Group put it as follows: “We know the problems, but we needed to build the ship while sailing.”

On this ground, and being an “interested”, outspoken and engaged member, representatives of Medicus Mundi International led an intensive conversation with the CSEM Secretariat and Advisory Group on the positioning and governance of CSEM and on the challenges related to the ambition of “representing the voice of civil society”. We also successfully promoted the transformation of a CSEM listserv from an instrument of one-way communication (Secretariat to members) to a space of interaction and democratic debate. At the end of 2018, we are confident that our input will be taken up in the further shaping of the CSEM. But this is not easy and needs our continued attention, and a continued conversation.

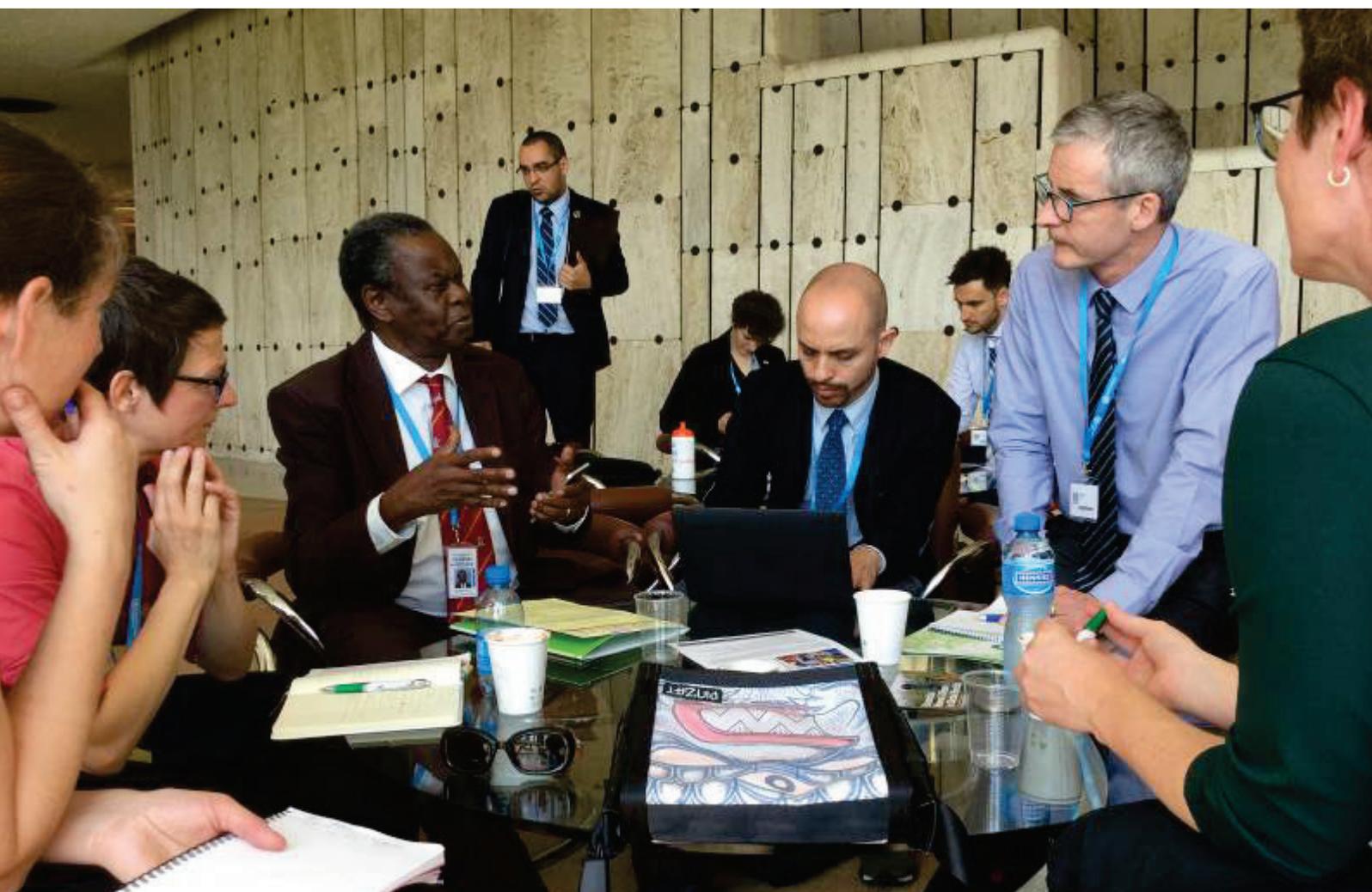


From MMI HRH to the HW4All Coalition: Raising civil society collaboration on Human Resources for Health to a next level?

The health workforce crisis and how to overcome it has been a key topic for the MMI Network since a long time. The MMI working group on Human Resources for Health (MMI HRH) was set up in 2006 and initially focused its work on the promotion of best practices among NGOs and private not-for-profit institutions (education, employment, retention of health personnel). In 2009 MMI HRH shifted its attention and work to influencing global policies and governance in the field of HRH, with a particular focus on the promotion and implementation of the "WHO Global Code of Practice on the International Recruitment of Health Personnel" adopted by the World Health Assembly in 2010. From 2013 to 2015, the MMI HRH working group was aligned with the MMI engagement in the European project "Health workers for all and all for health workers" HW4All.

In 2017, MMI HRH together with ACHEST, MSF and Wemos convened a civil society session on "How can civil society spur action on ensuring health workers for all?" at the 4th Global Forum on Human Resources for Health. As a result, MMI HRH promoted and supported the plan to bring civil society advocacy on key health workforce issues to a next level by launching a broader civil society coalition on HRH beyond the MMI Network membership.

On 20 May 2018, in a side event to the 71th World Health Assembly, representatives from a diverse group of civil society organizations, academic institutions, and health workers' professional associations and unions agreed to join forces and to establish the civil society Health Workers for All Coalition (HW4All Coalition): "The Coalition advocates access to health workers for all in order to fulfil the right to health and to reach Universal Health Coverage and the Sustainable Development Goals. We reignite advocacy on health workforce issues at the global, regional and local level."



The new coalition represents global, regional and local diverse groups of civil society organizations, academic institutions, and health workers’ professional associations and unions, and already counts more than 30 members. The secretariat of the HW4All Coalition is hosted by MMI Network member Wemos, and the MMI secretary is a member of the Coalition’s Steering Committee. However, the challenge of HW4All is quite the same as the one for CSEM: Building the ship while sailing....

After the successful launch of the HW4All Coalition, the MMI working group on HRH will continue to exist in a more informal way. Whenever necessary, the MMI Secretariat will convene Network members that are



particularly engaged in health workforce issues in order to coordinate the engagement of MMI in the new Coalition and in global HRH policy fora. Such fora include the World Health Organization and its governing body meetings, processes/consultations and hosted partnerships such as the Global Health Workforce Network and the International Platform on Health Worker Mobility. A work plan for MMI-WHO collaboration in this field was submitted to WHO in 2018, leading to the renewal of our status of being “in official relations” with WHO by the Executive Board in January 2019.

Based on the role and leadership of Medicus Mundi International in HRH related advocacy, representatives of MMI were invited by the organizers of the Fourth People’s Health Assembly in Dhaka to moderate a sub-plenary on HRH and to provide particular input into this sub-plenary. The resulting two-hour session was an intensive and inspiring moment for sharing insights into difficult realities of community health workers and other health personnel and their representatives and for discussing what can be done to make the voices of health workers better heard.

MMI hosting the Geneva Global Health Hub (G2H2)

We reported about the launch of the Geneva Global Health Hub in the Annual Report 2017. G2H2 is still a great project, and the MMI Network is proud to host its secretariat of at our office in Geneva, “outsourcing” part of our convening role in global health to this new structure.

The G2H2 Secretariat and Steering Committee directly report back to their association members. In our own Annual Report, we have therefore limited the reporting of G2H2 related activities of Medicus Mundi International to the two fields where we have been engaged, in 2018, beyond the secretariat mandate: setting up and coordinating a G2H2 task group for the jubilee of the Alma-Ata Declaration; and proposing, launching and co-coordinating a G2H2 working group on WHO and global health governance (see above).

It is good to see that both our engagement as secretariat and our leadership in some fields of joint civil society strategizing and action are highly estimated by our civil society colleagues.



MEDICUS MUNDI INTERNATIONAL: NETWORKING AND NETWORK DEVELOPMENT

Interactions among members of a network have always formal and informal elements. The Board and Secretariat of the MMI Network do not pretend to have an overview of all the informal contacts and cooperation established between Network members as a result of just knowing each other and meeting each other from time to time. To further promote such decentral cooperation, we have set up in 2017 the “MMI-cooperate” listserv, and we count on Network members using the MMI events for engaging in new conversations and maybe new partnerships.

At a more formal level, MMI continues to engage in meetings organized by Network members, promoting these events through our communication channels, inviting other members to participate and to provide inputs. In 2018 the year started with a great event organized by Medicus Mundi Bizkaia in Bilbao and ended with an equally great event organized by Medicus Mundi Switzerland in Basel, both attended by a considerable number of Network members.

The State as health duty bearer – challenges and threats. International symposium on health systems. Bilbao, 12-13 February 2018

In the symposium, experts from the health field at the international and local levels and from international cooperation discussed the privatization and commodification of health systems with a global-local approach. The lead organizers, medicusmundi Bizkaia, referred to their commitment to public health systems that guarantee access to the health of individuals and communities from an equity, inclusive and culturally relevant approach.

“The health system is a determinant of health that can contribute to reducing or increasing social inequalities in health. The way in which health and health care is considered, from a social rights approach as a public good or, on the contrary, as a commodity or private property, will determine both equal access to it by all groups of people. Population, as well as the quality of health care received.”
(medicusmundi Bizkaia)

A main quality of the very intensive two days of learning and sharing was the opportunity to compare realities and policies of countries in Central America with the realities and policies of Bizkaia, a rich region of Spain, struggling nevertheless with issues of equality and coverage..



Symposium “Health for All by 2030: On the Right Track, or on the Verge of Failing?” of Medicus Mundi Switzerland. Basel, 6-7 November 2018

The Symposium of Medicus Mundi Switzerland marked the end of the MMI involvement in the year of the Jubilee of the Alma-Ata Declaration.

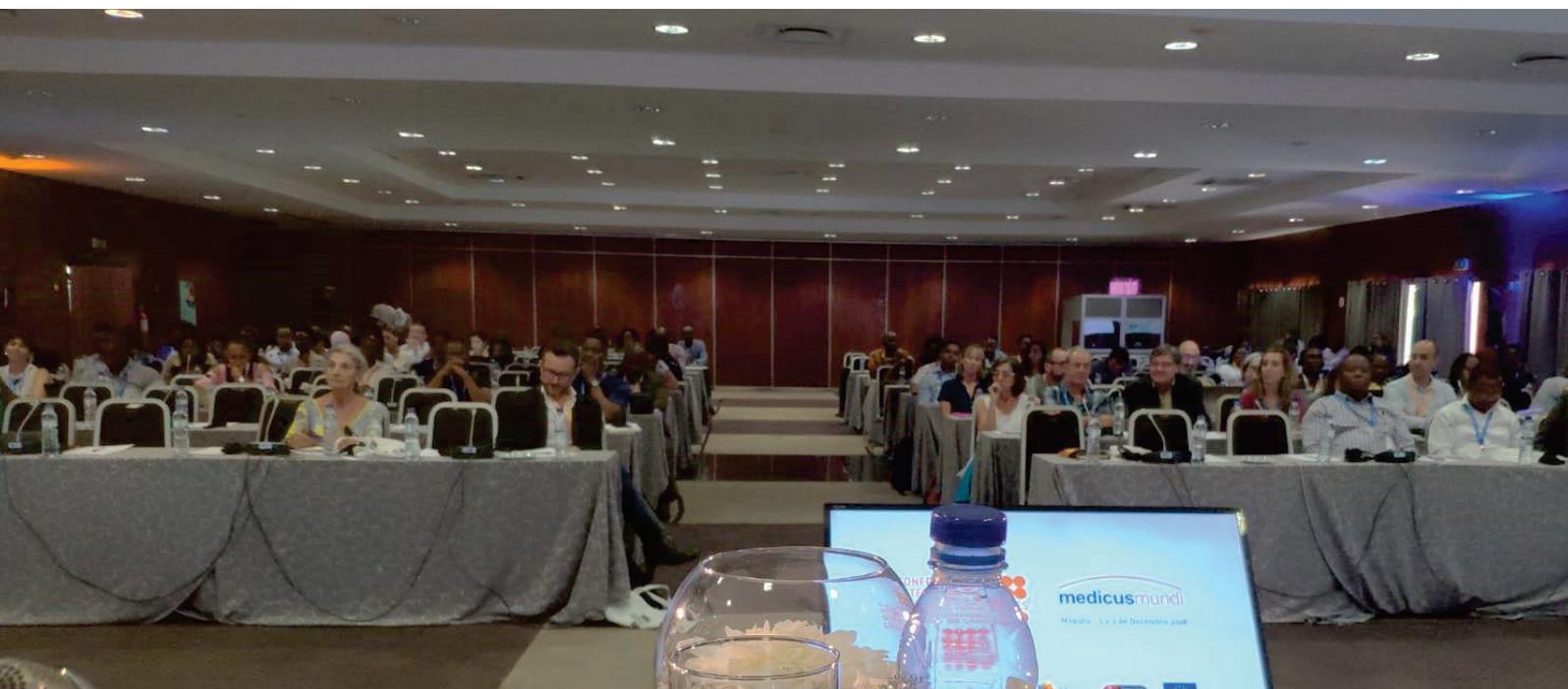
“Health is a fundamental human right. However, today inequality, poverty, exploitation, violence and injustice still prevent one billion people from accessing healthcare. To achieve the goal of “Health for All”, inequalities must be eliminated, resources better distributed by ensuring no-one is left behind, and political and economic interests must be geared towards achieving the goal. In the 40th anniversary year of the Alma-Ata Declaration, realising the vision of Alma-Ata is clearly more urgent than ever.” (MM Switzerland)

MMI contributed to the symposium with an input by the Executive Secretary Thomas Schwarz on the Astana Jubilee conference and with contributions to the concept of a well-attended film session with the movie “A luta continua” and a panel discussion with Ivan Zahinos (Medicus Mundi Mediterranea) and the former Minister of Health of Mozambique, Francisco Songane.



First African International Conference on Social Determinants on Health. Maputo, 5 December 2018

The Conference hosted by Medicus Mundi Mediterranea discussed several aspects of social determinants on health in Africa, sharing experiences of different African public and civil society organizations, with particular attention to health systems inequities, but also addressing other issues, as the relevance of socio-economic, health and environment management status among artisan small-scale gold miners in Uganda and Mozambique. Ahead of the Conference, a two-day training course was organized to explain the relationship between different social determinants (level of income, housing, transportation, working conditions, education, gender inequality, environment, social integration... without forgetting access to health services as a main issue) and the inequalities regarding how people get sick and die.



The president of Medicus Mundi International, Carlos Mediano, opened the Conference with two main ideas: the first that in our world health is exposed to an unprecedented privatization and commercialization and that health has become a relevant part of the “world business”. Secondly, he recalled that health is a social, economic, political question and above all, a fundamental human right.

This Conference was intended to be the first step towards a broader approach of how to improve population health beyond working only within the health system. But the main conclusion (and the first challenge Africa must face) was that there is a lack of studies about the grade of influence of the different factors in health’s population. This reality came to light in this Conference with the example of Mozambique, where most investigations in health are either biomedical or related to illnesses. They are not linked to the root causes of health inequities. So, the need for a new investigation national agenda in African countries is there, and it need to focus in Primary Health Care and social determinants on health if we want to enlighten their relevance to improve population’s health.

Welcome to Medics without Vacation

"Medics without Vacation comprises about 600 doctors and nurses. During their holidays they spend two to three weeks treating patients in African hospitals. Helping people who otherwise have no chance of recovery. Every week more than two teams leave for Africa. Our teams bring bandages, instruments and medication but also medical equipment

MEDICSWITHOUTVACATION
ARTSENZONDERVAKANTIE
MEDECINSANSVACANCES

KNOWLEDGE HEALS

Medics without Vacation develops long-term collaborations with partners. Our partners are hospitals and care centres in 5 African countries offering the best possible care to their patients in often difficult circumstances.

We help our partners in different ways to enhance their capacities. As such we send multidisciplinary teams of volunteers who during their stay exchange knowledge and experience with their African colleagues. In the first place via on the job training: practice support at the operating table or at the sickbed."

The Belgian NGO Medics without Vacation joined the MMI Network in July 2018. Welcome to our new member!

Photos and © info: www.azv.be/gallery



Services and sustainability: Steps to lead the MMI Network into the future

- *“MMI will promote knowledge sharing and mutual learning between actors in international health cooperation.”*
- *“MMI will provide autonomous, sustainable and stimulating spaces for the analysis and debate of global health and promote platforms for joint civil society advocacy, with a focus on the World Health Organization.”*
- *“MMI will enhance collaboration among Network members in view of joint projects and consortia.”*
- *“MMI will further invest in the Network’s consolidation and development.”*

If you compare the current Annual Report with the four main strategic directions of the Medicus Mundi International Network as outlined above and in the “MMI Network Strategy 2016-20”, it is obvious that there are two elements in the limelight and centre of our work, and two “difficult” ones, where progress is slower than expected.

While our activities and the report are focused on our work in the fields on the analysis and debate of international health cooperation and global health policies and governance and the provision of related platforms, the provision of concrete services to Network members in view of matchmaking and joint projects has not really taken off. And, as stated herewith and also visible in the financial report, we still struggle with the consolidation and further development of the Network in terms of membership and financing, ending the year 2018 again with a considerable financial loss and related decrease of our net equity, and with only one new Network member.

As a matter of life, even addressing a capacity issue depends on some core capacities available. This has been realized by the MMI Board and was addressed in its conversation with OSF about the terms for their grant. As a result, both parties agreed to add, to the two “technical” fields covered by the MMI EHC work plan and supported by OSF, a third one on “institutional strengthening and laying the ground for further activities”, with two particular fields of activities:

- Structured dialogue with MMI Network members and partners about their experiences, insights and assessments, practices/capacities and further demand for learning and sharing in view of “health cooperation beyond aid”.
- Fundraising, communication and membership consolidation and promotion

With the confirmation of the OSF grant in September 2018, MMI was not only able to increase the capacities of the Executive Secretary needed for the implementation of the work plan, but also to employing a dedicated junior staff for related fundraising, strategic communication and membership consolidation and promotion.

After the launch of a job advertisement and an intensive period of screening possible candidates, the year 2018 ended with the good news that yes, we have a “Fundraising and Strategic Communication Officer”: Vittorio Giorgetti started working at the MMI Geneva Office in January 2019. He will be supporting the MMI Board and Secretary over the next 15 months with strategies and specific activities on communication, relations with Network members and external partners, and fundraising. Welcome!

We are confident that this is an important step on the pathways to sustained relevance and success.

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Status: May 2019

network
health for all

**SHORT STORIES
BY NETWORK
MEMBERS**



TAKING THE GENDER TURN

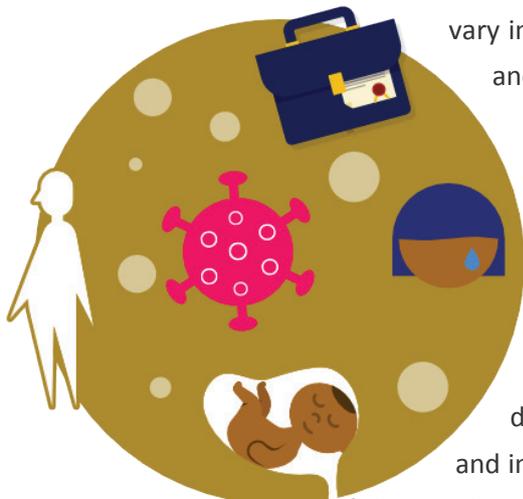
In 2018, Memisa set a new course on Sexual and Reproductive Health and Rights (SRHR) by signing an inter-organizational gender charter and training all its headquarter staff through the online e-learning tutorial "Body & Rights". Indeed, while gender and sexual and reproductive health and rights have been part of a transversal approach for Memisa for many years now, 2018 was marked by a series of specific actions to complement the previous transversal approach.

While the notion of sex refers to the biological differences between women and men, the concept of gender refers to the way in which society assigns differentiated roles and status to men and women, with, in most cases, a negative appreciation associated with female roles. These differentiated statuses vary in time and space and are determined by social, political, historical, cultural and religious norms. By intellectually dissociating the cultural and the biological aspects, the concept of gender questions clichés related to sex.

Over the years, considerable progress in gender equality has profoundly changed the way men and women perceive their future. The recognition of the rights of LGBTQI is progressing around the world under rightful pressure from broad movements claiming the right to be able to live their gender and exercise their sexuality without fear of discrimination or threats. However, these considerable advances are fragile and inequalities are far from having disappeared from the globe. Inspired by the

experience of the Gender Mainstreaming Charter adopted by the three Belgian trade unions in 2004, the NGOs and institutional stakeholders decided to embark on the project of creating a charter for gender equality. The gender charter was proudly signed by Memisa and is divided into eight specific points. Memisa therefore undertakes to:

1. In its vision-mission, fully integrate the fight for gender equality into the global mission to fight poverty and inequality
2. Promote a balanced representation of women and men in its decision-making and governance bodies (Board and other bodies) by having at least a 1/3 representation of persons of the same sex in these bodies
3. Develop a dual approach: transversal ("gender mainstreaming") and gender-specific in all aspects
4. Define a gender action plan for its organisation, with objectively verifiable monitoring and evaluation measures and a dedicated budget
5. Explicitly integrate gender equality into human resources policy
6. Explicitly integrate the gender equality dimension into the code of conduct
7. Ensure, in all its activities, that all communications ensure a non-stereotypical and balanced representation of men and women and that specific attention is paid to sexual diversity
8. Contribute to the empowerment of women and discriminated social groups



While we are well advanced in most of these commitments, it is now a matter of keeping them in mind consistently and for the long term, and translating them into concrete actions.

MANDATORY GENDER AND SRHR TRAINING

Regardless of their position, all staff at Memisa headquarters has been trained in gender issues and SRHR. The “Body & Rights” tutorial was created at the request of the Belgian Development Cooperation for Belgian diplomats and expatriate staff of the Belgian Development Agency (ENABEL). The tutorial was developed by the Belgian platform of international health actors Be-Cause Health under the coordination of Sensoa. It is a tutorial that covers the following themes:

Definition and obstacles to sexual and reproductive health: the definition of sexual and reproductive health and rights as well as the major obstacles encountered throughout the world, including cultural ones.

- HIV and STI: The tutorial presents global HIV figures and its impact on the world. The other STI are also presented.
- Family Planning: The tutorial presents the benefits of family planning, the unmet need for family planning, as well as data on maternal mortality and unsafe abortion.
- Sexual and gender-based violence: The tutorial covers the definition of sexual violence. We also see female genital mutilation and child marriages.
- Vulnerable groups: Not everyone is equal in terms of sexual and reproductive health and rights. Some groups are more vulnerable than others, such as young people, sexual minorities and migrants.
- Politics: Finally, the tutorial reviews international politics in the same way, as well as Belgium's legislative framework.



After the Belgian Directorate-General for Development Cooperation and ENABEL, Memisa is the third entity with the most members trained in sexual and reproductive health with this online tutorial. These training courses are already bearing fruit and in Memisa's actions. In Burundi and the DRC for instance, gender is no longer approached only as a transversal theme but has now a specific budget and specific expected results as well, with activities such as telemedicine, health promotion/education, improving maternal health, advocacy and protecting patients' rights.

In 2019 and beyond, Memisa will continue to build on this momentum by contributing to the evaluation and actualization of the tool, and by disseminating the "Body & Rights" tutorial and the content of the gender charter to our staff and partners around the world.

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E-tutorial, pictures: <https://www.bodyandrights.be/>*

BURKINA FASO 2018: A TRAGIC YEAR FOR THE “LAND OF HONEST PEOPLE”

In Burkina Faso acts of violence are on the rise with increasing bloodshed and dramatic consequences for the population and those who want to help. A once exemplary peaceful country is now close to the edge of a civil war. The “orange zone”, considered “discouraged unless compelling reason”, now includes the capital city, where Medicus Mundi for 15 years had an ongoing HIV-collaboration with the Hospital of the Camillian Fathers.

In 2018, more than 200 Burkinabé, most of them policemen and soldiers, were killed in terrorist attacks. In March, in the capital Ouagadougou, a double attack hit the French Embassy and the Burkinabé army headquarter. The other attacks occurred along the border with neighbouring countries, in particular near Mali and Niger, but starting from there they stretched out deep in the country, withdrawing huge areas in the north and east from state control. In these regions, more than 600 schools had to be closed in 2018 under terrorist threat – some teachers were killed for not wearing appropriate clothes or not teaching Arab, books and buildings burned. Almost 50.000 people were displaced internally. The numbers by February 2019 increased to over 1000 schools closed and 150.000 affected students. Health facilities were also closed or reduced service (1). For this reason on New Year’s Eve the President declared emergency in 7 out of the 13 regions of Burkina Faso (2).

THE ROOTS OF CONFLICT

In the wake of the crisis in Mali, also in Burkina the idea of precolonial reigns reappears. The insurgency is fuelled by the resentment of ethnic groups - in particular the Fula people (locally called Peul), traditionally cattle breeders - who live in areas that have been forgotten by national development programs: in terms of health, these are the areas of Burkina where there are fewer health facilities and consequently the highest rates of malnutrition and child mortality.

Yet, until 2016, Burkina had been spared from the Islamic terror and the separatist movements of the Tuareg and Peul populations present in Mali and Niger: the country was brought as an example of peaceful coexistence – albeit the International Crisis Group (3) warned the government to tackle the perceived discrepancy between a significant number of Muslims and their low level of public representation. In fact, ethnic and religious tensions and conflicts were present but remained limited as long as no external intervention poured gasoline on the fire: the scarce resources of Burkina did not tempt anyone. But in recent years the poorly controlled race to the unexploited treasures buried in the Sahel soil (mostly new - rare earths - and old gold, but also new - uranium - and old oil) has build up momentum at increasing speed. After invading Chad, Mali and Niger, Chinese, Canadian, Indian, and Algerian mining companies have arrived also in Burkina Faso bringing capital (and missionaries) from Saudi Arabia, Qatar and Kuwait: so a previously ignored desert, inhabited only by shepherds (but also smugglers and traffickers of weapons, cocaine and migrants) has become the center of international economic interests and intense conflicts.



Poverty is another driving force, as every terrorist receives a salary that is higher than that of a government soldier – in addition to a flat rate for the family. The social prestige and the self-esteem associated with being a terrorist is another stimulus, especially for young, poor, angry and emarginated males. Thus recruiting fighters for the low-intensity conflict strategy is not a problem for the terrorists, while the government struggles to keep the military in active duty.

THE INVOLVEMENT OF BURKINA FASO

This new “gold-rush” also involved Burkina, in short time the old “white” district of Ouagadougou – “la Zone du Bois” - has become home to dozens of foreign mining companies, whose staff goes back and forth every week from the gold, zinc and manganese mines, escorted by poorly armed Burkinabé military servicemen. Around half of the national territory is now subject to options or mining concessions. However, precolonial resentments and subsoil richness are not the only reasons why Burkina got involved in the Sahel war. Until a few years ago, it was through Burkina that the guerrillas of Mali and Niger received their arms, and it was in Burkina where its fighters, its refugees and its leaders found shelter whenever needed. In return, the Jihad and claims for territorial independence remained outside the country. This “deal” created difficulties for the governments of neighbouring Mali and Niger but generated economic benefits for Burkinabé leaders.

With the intensification of the conflict in the Sahel, and with the direct and increasingly strong commitment of France and other International forces, the new Government that took office in Burkina after the revolution at the end of 2015 would and could no longer “honour the deal”. Soon after that was evident the terrorist attacks began and kidnapping – and now killing - of Europeans, including health workers, started.

WHAT ARE THE MILITARY FORCES PRESENT

There are about 3,000 guerrilla fighters in the Sahel, belonging to various movements but united in a consortium affiliated to Al Qaeda. On the other side, 20,000 blue helmets of the UN peace mission are deployed in Mali. In addition, for the fight against terrorism, some 5,000 soldiers from France, USA, Germany, and Italy train and sustain the local military forces and bring modern equipment. But the use of armed drones against the small terrorist combat groups, that easily hide in the Savannah and its villages, is associated with significant collateral damage.

Another risk perceived during the ongoing war in the Sahel is the civil-military cooperation in support of humanitarian operations. As *Barkhane* is not a peace-keeping mission, but a full fledged “war” on terror, collaborating with one of the belligerent parties is ethically and practically difficult for NGOs – to say the least. While we gratefully rely on the military for emergency evacuation, a clear distinction between the identities, functions and roles of humanitarian and military actors is pivotal for a successful humanitarian work and the safety of both, humanitarian operators and their clients (4). The disastrous mingling between military operations and humanitarian aid that allowed to identify Bin Laden in Pakistan, besides undermining trust and thus vaccine use, still causes dozens of killed vaccine workers (5) – also here in Africa.



AND THE YEAR 2019 STARTED EVEN WORSE

On New Year's Day, guerrillas killed 7 inhabitants of a village of Mossi farmers, the major ethnic group in Burkina. In retaliation the Koglweogo, illegal armed groups of self-defense, attacked villages of Peul, killing at least 80 inhabitants and provoking the exodus of about 12,000 people (6). The problem thus is shifting ever more from terrorist attacks towards civil war, with rebellion, tribal conflicts and now also ethnic atrocities! Facing with the risk of an escalating ethnic conflict, the UN Secretary General addressed a message to the Burkinabé government, expressing his concern.

WHAT DOES THIS MEAN FOR US?

Medicus Mundi Italy closely followed the changing map of Burkina Faso (7), where the “red zones” increased rapidly and now almost cover half of the country, while the orange zone, considered “discouraged unless compelling reason”, now includes the capital city, where Medicus Mundi for 15 years had an ongoing HIV-collaboration with the Hospital of the Camillian Fathers. Over 50 young doctors, most of them residents in paediatrics from the University of Brescia, served a term of 3 to 6 months on rotation there, but given the security situation, the home institution vetoed its personnel to continue to work in Burkina, effectively closing the project for security reasons.

It's hard to depart leaving close friends to an uncertain future, but as our presence there might put the whole hospital at risk, there was no choice. At the time we write this, we still continue our other project, fighting against childhood malnutrition in 5 districts of the center-west region of Burkina Faso....

Authors

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Photos: WikiCommons (selected by MM International)

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NO ONE OUT! WHAT WE CAN LEARN FROM DAVID...

The idea to interview David O'Ranga came up because he is really committing himself in the project "No one out! Empowerment for youth inclusion in Nairobi informal settlements". David is one of the Health Care Providers engaged in activities with young people from 14 to 25 years on HIV testing, counselling and prevention in the Mathare North Health Centre, one of the public health facilities where Medicus Mundi Italia is working since April 2017.

So this is the story of David resulting from the interview: David was 17 years old when he moved to Nairobi from Migori County (Western Kenya, near Victoria Lake) with some relatives who took care of him. As soon as he arrived in Nairobi he finished the last two years of Secondary School and then he attended the Thika College for obtaining the diploma in HIV & AIDS Management. Finishing the college he decided to study for a certificate in HTC (HIV Testing and Counselling) with NASCOP (National Aids and STI's Control Programme), a programme born in Kenya 1987 in order to guide the interventions of the Ministry of Health against HIV and AIDS. NASCOP is working as an operative unit inside the Kenyan Ministry of Health.

David decided to study this topic because he lost his mother of HIV and it seems she was not aware of it and therefore she never received the necessary treatment. This is the main reason which pushed David to become what he is today. He is eager to help both youth and people living with HIV to be informed, prevented and treated. He did his internship in Mama Lucy Kibaki public hospital, then he has been employed both as an HTS Counsellor and focal person for antiretroviral in the CCC (Comprehensive Care Clinic) in Mathare North Health Centre through the Afya Jijini programme (a programme of IMA WorldHealth which is helping Nairobi City Council to supply health services with an integrated approach which means together with the public health facilities).

When the Afya Jijini programme finished to pay his salary because of some constraints, he decided to remain in the Mathare North Health Centre while looking for another job. Since April 2017 David has followed all our trainings, monthly meetings for follow-up on the community strategy through the Community Health Volunteers (CHVs) engagement and he is also taking part in all our youth awareness activities. In Mathare North Health Centre he is recognized as a friendly Health Care Provider - the youth feel free to go to him - and also his relationship with the Community Health Volunteers has improved in terms of completing referrals from the community and actions taken. He is recognizing that "No one out!" awareness activities are increasing the number of youth from 14 to 25 years volunteering for HIV testing and consequently also reducing the cases of new HIV infections. David's motto is: "HIV doesn't kill if you accept your status and work hard for it! It is possible to live!"

Why is the story of David a story to be told? Because it has a cross-section of the informal settlements of Nairobi where Medicus Mundi Italia is operating. These are not easy environments, but full of challenges and poverty where health is an important component.



The implementation of a community strategy inside the Ministry of Health curriculum has really helped to discover which are the most common diseases in those areas and how to treat them.

In fact the most important aspects about any community strategy is the creation of awareness of how health is important in life. To feel healthy or to treat as soon as possible a symptom is a behaviour that has to become a kind of life routine and especially to feel free to go to the nearest public health facility to be assisted and treated. People of the slums are often very reticent to approach the facilities because of fear of stigma and that's why the community sensitization activities have an important role.

Medicus Mundi Italia is implementing the project considering this important aspect through strengthening the relationship between the Community Health Volunteers and the Health Care Providers in five health facilities in different slums areas (Korogocho, Dandora, Babadogo, Mathare North and Kariobangi). In this way the referrals system is becoming stronger. The other aspect of the project is related to youth. Opening the health centres on Saturday morning allows to make a community dialogue on sexual and reproductive Health, HIV and AIDS testing and prevention, family planning. This contributes to a better understanding and use of the services available

The slum areas are really demanding; sometime is not easy to recognize if the implemented activities are helpful as MMI is really covering a large area but sensitization and advocacy with large number of youth and different population can become a word of mouth in the communities. From when the project has started almost 1800 youth have been reached during awareness activities.

As stated in the Strategy for Community Health 2014-2019 of the Kenya Ministry of Health, facilitating people's participation is a key element of the Community Health Strategy. The recognition and introduction of level one services which aim at empowering Kenyan households and communities to take charge of improving their own primary health care is one of its key innovation".

This is the direction that MMI is following with its intervention. The project is really working very close to the Ministry of Health authorities in order to support and improve the aspect of Community Strategy which in Kenya is well structured in terms of manuals and regulations but not always implemented.

The job of Medicus Mundi Italia in Nairobi is not a foregone job, full of challenges but also very interesting and exciting, every day is an experience which gives meaning and value to the implemented job.

Author

Grazia Orsolato, Medicus Mundi Italia, health coordinator "No one out" project

Further information

<https://www.medicusmundi.it/en/projects/projects-under-way/636-kenya-no-one-out-project.html>

HEALTH FOR ALL WITHIN A GENERATION IS ACHIEVABLE. A MANIFESTO

Since the end of 2018 we've got it on our tables – this beautiful booklet with the title “Health for All within a Generation”. Writing the so called Manifesto of Medicus Mundi Switzerland (MMS) was one of the Network's extraordinary activities last year. What looks now like a quite light text had to be developed in a complex way together with the almost 50 very diverse member organisations. It is a product of a deeper reflexion process that is linked to MMI's work on effective health cooperation.

The process was initiated by the MMS' board with the idea to take the opportunity of the Alma-Ata-jubilee for reflecting on today's significance of primary health care and the future of health for all fundamentally. The necessity to do this developed out of the knowledge that with the UN Agenda 2030 the fundamental parameter of our work had changed. And there was as well the feeling that international health cooperation as well as Switzerland's economic and political practise have to change for reaching health for all.

By this it was already clear that political decision makers and our own community of people and organisations working in the field of international health cooperation should be addressed by the Manifesto. The process of developing the manifesto was almost as important as the final product itself. The first draft version was written by a small core group including board members and representatives of member organisations. Defining the current situation and the obstacles for reaching health for all was a quite easy task. The political demands have been written easily. We could count on our constant work in the political field.

The key message of the manifesto is clear and powerful: Health for all within a generation is achievable. Today's world has the knowledge how to do it – and it has the resources to reach it. We know the political, economic and social barriers that have to be moved away for reaching the goal.

CHALLENGING OURSELVES

Once this was agreed and stated, it proved to be definitively more complex to address those issues where the civil society actors are in the driver seats themselves. Is our own work as effective as it should be for reaching health for all? Are we delivering the solutions – or are cementing structures that impede to overcome inequities? Questioning your own work is always hurtful in one or the other way. For going through this part of the process it was very helpful to rely on the debate that was already led by Medicus Mundi International and written down in the 2016 discussion paper “Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health”. Several of the questions of the discussion paper addressing NGOs working in the field of international health cooperation were directly taken up as part of a workshop that was facilitated by Medicus Mundi International. Results of the workshop were integrated in the Manifesto and approved during an assembly of the member organisations in September.



TRANSFORMING THE ROLE OF INTERNATIONAL HEALTH COOPERATION

Reaching health for all within a generation won't be possible without addressing and transforming our own role as actors in the international health cooperation. Under the title "It is not a matter of aid, it is a matter of justice" this difficult positioning on the own role and the willingness to work for change is expressed quite clearly: "As organisations active in public health, we know that, above and beyond individual aspects, it is the social, economic and environmental factors that determine whether or not someone falls ill. It is undisputed that the degree of inequality determines the state of a population's health. Against this backdrop, we are aware that our own work can contribute to the perpetuation of injustice. Nevertheless, we cannot, and will not, leave anyone alone in misery without help."

The Manifesto concludes on this: "However, we also realise that, in association with our partners here in Switzerland and around the world, we need to tackle and change the conditions that make people ill. We can and will strengthen our work further in this regard, learn from our partners and empower the local populations with which we work to fight for their rights and against discrimination within their own communities."

The Manifesto serves from now on as reference work for upcoming new strategic periods of Medicus Mundi Switzerland and it is as well the fundament for our political work. It has already shown its public relevance: In February 2019 the Italian speaking service of the Swiss Television has dedicated ten minutes to the Manifesto.

MMS Manifesto (2018)

<https://www.medicusmundi.ch/en/mms/about-us/mms-manifesto/mms-manifesto-health-for-all-within-a-generation>

MMI Discussion paper (2016)

<http://www.medicusmundi.org/contributions/reports/2016/health-cooperation-its-relevance-legitimacy-and-effectiveness-as-a-contribution-to-achieving-universal-access-to-health.-mmi-discussion-paper>



HEALTH INFORMATION FOR ALL – IN SPANISH!

Last November “HIFA-es” was launched. HIFA is the acronym for “Health Information for All”, a global social movement to improve the availability and use of healthcare information. HIFA-es is conceived as part of the HIFA family, and following the experience of the already existing forums in English, French and Portuguese as an exchange space to promote the availability and accessibility of reliable information about health and health care in Spanish.

HIFA-es is a collaboration between WHO and its Regional Office for the Americas (AMRO), the Pan American Health Organization (PAHO), the EASP and the Global Healthcare Information Network (GHI-Net). The aim is to contribute to the vision of HIFA which promulgates a world where each person and each professional has access to the information they need, about health and their care, to protect their health and that of those for whom they are responsible.

HIFA is part of a growing dynamic network of more than 18,000 members worldwide, which interacts in different languages such as English, French, Portuguese, and, as of today, in Spanish.

This HIFA-es forum of knowledge wishes to complement the mission of HIFA in the Spanish-speaking sphere. HIFA-es already has more than 400 members from 30 countries, and more than 20 country correspondents. They will help identify those projects that can give response to the shortcomings and problems that people may have to identify the target population and to prioritize activities according to the needs and peculiarities of each region. They will also help to get commitments of organizations that wish to be part of this initiative, with which they will try to reach agreements bilateral agreements that will be mutually beneficial.

During the Management Committee constitution, Isabelle Wachsmuth-Huguet presented the strategic priorities of the WHO, as well as the key elements of HIFA-es, in turn aligned with the other HIFA forums. It highlights the multilingual perspective of the HIFA initiative to overcome existing language barriers, the promotion of equitable participation, the need to build long-term trust through coherence and improve the quality of interaction between people.

Nace HIFA-es

"Información sobre salud en español"



Neil Pakenham-Walsh, Director of HIFA, presented the HIFA initiative as a whole, its purpose, objectives and expectations for the implementation of HIFA-es. He emphasized that the main purpose of this initiative is not so much to provide information on health in Spanish, but to improve the availability and accessibility of quality information on health in Spanish. Similarly, he remembered the relevance of involving all parties (health professionals, managers and health authorities, legislators, academia, citizens ...) in sharing information and making this information accessible to all people, in an effort to reduce deaths due to inadequate care due to lack of information.

Ana Carriazo highlighted the importance of the HIFA-es knowledge platform in the Spanish-speaking world and the advantage of being able to share in the portal so much documentation already generated. The Regional Ministry of Health of Andalusia has extensive and well established health networks that can contribute with reliable health information to the HIFA-es initiative. Examples of these resources are: integrated care processes (manuals for professionals, instructions for help in decision-making and guidelines for patients) that promote quality improvement, and portals, such as “Window to the Family” (to support parents in child rearing) or “In Good Age” (for active and healthy aging), strategies that can contribute with reliable health information to the HIFA-es initiative.

Diana Gosálvez presented the EASP work team for HIFA-es and the resources that the School offers to this platform. The EASP, being a WHO Collaborating Center, has a very large knowledge and human capital and there are many EASP projects that have a place in HIFA-es. It stands out, among others, the platform of the CADIME (Andalusian Center for Documentation and Information of Medicines) and its therapeutic bulletins; the Patient School, an example of a good connection of people and resources; OSMAN (Observatory of Health and Environment of Andalusia) and its guides in environmental health; OPIMEC (Observatory of Innovative Practices in the Management of Complex Chronic Diseases) with training spaces and communities of practice; and a large Documentary Repository and Video Library. Undoubtedly, the connection of the many networks, students and EASP alliances can strengthen the HIFA-es project.



Alberto Fernández described the functions and work plan of the Steering Committee, which is responsible for establishing the guidelines of the HIFA-es project. He presented the objectives for 2019 that are focused on 5 main axes:

1. Expand HIFA-es (reach thousands but at least 20 affiliates per country to get the voice from each corner), identify thematic areas and organize official launch;
2. Establish the bases for its consolidation (explore, with the help of the Country Correspondents, the support of at least 20 Collaborating Institutions by the end of 2019. Raise thematic project support.
3. Strengthen management procedures. Streamline affiliation procedures and collaboration agreements (facilitate affiliation, collaborate and contribute ideas), create collaborative data base according to thematic areas, stimulate information exchange between groups, facilitate contact and follow-up with Correspondents, operationalize the activities necessary to achieve the objectives of the dissemination plan.
4. Coordinate and develop synergies with HIFA.org and other HIFA forums.
5. Evaluation for continuous improvement. Try to design a procedure that allows us to evaluate the impact of all the effort devoted to expanding HIFA to know in which position we are and how we can improve.

Three Correspondents take part in this Committee. Daniel López-Acuña highlighted, as key points, the importance of being selective with the information to be shared on the portal (which provides value), concentrating efforts on priority areas (strategic areas in public health), reaching a wider audience but with a strategic framework (concerted expansion plan). It highlights as priorities, sustainable development and universal health coverage, the WHO objectives linked to HIFA, and linking HIFA-es to the 2030 Agenda since the language barrier is preventing the participation of many people. It also states that, if a more powerful launch of HIFA-es is planned, to take place in Geneva during the WHO World Health Assembly to take advantage of the synergies that this assembly offers us as a point of confluence of relevant people and organizations. He also proposed to do something in each country in order to link key people. With regard to affiliation of new members, he suggested to access by professional health associations in each country, as a tactic that would encourage greater participation. Consequently, it proposes a strategic approach country by country and globally rather than individually.

Pedro Brito defined public health as part of a fundamental right of the person and, in this sense, HIFA-es is an effective strategy to provide pertinent information in Spanish to all interested parties (health professionals, managers, legislators, citizenship ...) and promote the improvement of people's health. It is necessary, however, to define public health priorities and link the priorities of the political actors with the real needs of the population. It raises as challenges of the HIFA-es strategy, the efficient selection of priority thematic areas. Moreover, he underlined the relevance to set up a clear and flexible editorial framework, capable of filtering fallacies and non-relevant messages.

Joan Carles March presented the experience of the Patient School, an initiative coordinated through the EASP and funded by the Regional Ministry of Health of the Junta de Andalucía. He emphasized that patients must have a leading role in HIFA. It is a space where patients, caregivers, family members, associations and citizens in general converge to share with others the same experiences, knowledge, attitudes and motivation to empower people who suffer from some type of disease and increase their quality of life. Patient School is a space in which the concept “evidence + clairvoyance”, “evidence + experience” becomes reality; the patient is the protagonist, the trainer, people who help people, working as equals. We work on a set of defined aspects and present information to make it available to the patient (positive thinking, physical activity, well-being, healthy cooking, patient safety ...). The School of Patients can contribute to HIFA-it is the double line of therapeutic education and training between patients.

Finally, Alberto Fernández highlighted the role of the Moderator in selecting, formatting the contributions in the forum and verifying the quality of the messages to adapt to the editorial framework. The role of the Moderator is crucial to maintain order and move the debate forward. Neil Pakenham-Walsh also highlighted the importance of the Moderator as a key piece of success in the survival of a forum. Regarding the thematic areas, it proposes to consider the theme that has been developed in the different HIFA forums.

Author

Alberto Fernández, EASP

Join HIFA-ES

If you are interested in joining us in any of the languages, please go to <http://www.hifa.org/forums/hifa-spanish>; it takes less than one minute.



THE NEXT GENERATION PROGRAMME

In the village of Mwakidiga, in rural Tanzania, a child was suffering from severe acute malnutrition. At first, despite the evident worsening of her condition and despite her family's relatively safe economic situation, the parents did not want to take her to the hospital.

After taking notice of the child case through its community activities, CUAMM Nutrition team visited the village in order to meet the family and provide vital education and information to all family members on the importance of good nutrition and about the urgency of sending the child to the hospital for treatment. It was not easy in the beginning: taking the child to the hospital was not part of their traditional behaviour, and changing behaviours is always difficult.

After additional explanations and clarifications, the family agreed to take the child to the nearest hospital of Maswa, where the nurses and other health workers received the mother and her child warmly.

Seven days later CUAMM team went back to Maswa hospital to visit the mother and see the progress of the baby, and they were happy to see that the mother was grateful and satisfied with the services provided by CUAMM and, more importantly, that the child was already in good conditions, and on his way to a prompt and full recovery!

WHAT IS TO BE DONE FOR THE NEXT GENERATION

The aim of the program "Integrated Promotion of Nutrition, Growth and Development in Tanzania" which will be implemented in Simiyu and Ruvuma Regions, is twofold: 1. deliver a targeted package of interventions at scale through the health system to prevent stunting; 2. show that integrating activities for chronic and severe acute malnutrition will lead to better outcomes at lower costs. The overall objective of this program is to test the hypothesis that integrating activities for chronic and acute malnutrition will lead to better outcomes at a lower cost.

The specific objectives:

- Reduce stunting prevalence and increase the number of children successfully treated for SAM: reduce stunting in children under 5 in Ruvuma and Simiyu by up to 17%; and treat up to 16,163 cases of SAM and avert up to 77,319 stunting cases, and 1,875 deaths due to SAM;
- Increase knowledge, attitudes and practices (KAP) on birth preparedness, maternal nutrition, and appropriate infant and young child feeding practices;
- Strengthen capacity of the sub-national level health service to deliver integrated nutrition services, which are underpinned by quality data.

This project will use both government and behaviour change pathways to ensure sustainability. It will demonstrate how to integrate the delivery of services to prevent stunting and treat severe acute malnutrition, ensuring the same cadres following the same pregnant mothers and children under five across the critical points in the lifecycle and continuum of care.

If services to treat SAM and stunting in the same age children can be delivered simultaneously there is significant potential for:

1. Delivering targeted interventions along the critical 1000 day window across the continuum of care to prevent stunting;
2. More effective identification, referral and follow-up of SAM cases as a result of strong community-based component following mothers and children across the lifecycle;
3. Improving cost and operational efficiencies in the health service – the same health workers (at facility and community level) will deliver both services, ensuring targeted nutrition services for both stunting and SAM reach the same pregnant women and children from conception to age two across the continuum of care.

Integrated delivery will address these challenges and the evaluation will seek to quantify cost savings and added value generated by this alternative approach.

The Government pathway will involve embedding the program in the health system from the very beginning. The intervention will be delivered by the Tanzanian health system, supporting regional, district and community level governance and delivery structures for health and nutrition.

The behavioural change pathway will be used by CUAMM by providing technical assistance to the health services, through

- community health workers promoting complementary feeding and the importance of attending ANC so that once the program is over, these approaches can be embedded in protocols and training curricula;
- making information available to citizens, this will generate demand for nutrition services.

The program is expected to reach up to 310,453 pregnant and lactating women and 232,261 stunted children under two in the community, as well as 7,687 wasted children under 5 years of age.

Next Generation Programme

<https://www.mediciconlafrica.org/en/what-we-do/in-africa/tanzania/next-generation-programme-tanzania/>



CORDAID

FOLLOW THE PILL: FIGHTING HIV AND TUBERCULOSIS IN DR CONGO

“Thanks to this pill, I am alive”, says Rose Bomboso, while taking her ARV medication. Rose lives in an isolated village up north in DR Congo. She is one of many thousands of HIV/AIDS and TB patients in DRC that receive treatment thanks to Cordaid, our local partners, the DRC Ministry of Health and generous support of the Global Fund. The video ‘Follow the Pill: the last mile in DR Congo’ shows you what it takes to get the medication where it is needed most.

Cordaid has been active in DR Congo since the 1970s, and has built up an extensive network of partner organizations. Cordaid wants the people of DR Congo to once again be able to contribute to the development of their country’s basic facilities and work towards peace, safety and justice.

Since 2012 Cordaid is the Principal Recipient of the Global Fund for HIV/AIDS in the Democratic Republic of Congo. In close collaboration with the DRC Ministry of Health, Cordaid fights HIV/AIDS and Tuberculosis in 65% of all health zones of DRCs vast territory. In 2017, 85.806 adults received antiretroviral therapy. We do this by transporting 667 tons of medicines annually and providing other forms of support to more than 3.500 health facilities. Even in the most remote and conflict-affected areas. Transport takes place by air, by car, motorbike and, in the end, to reach the last mile, also by bicycle and by foot. This work is badly needed. Only 40% of people living with HIV in DR Congo have access to treatment. Yet for all of them, treatment and medication are matters of survival.



MEDICINE STOCKS IN TIMES OF CONFLICT

In different parts of DRC, armed conflict regularly puts ARV drug supply at risk. This is why, at all times, the Global Fund program aims to assure a 3 months stock of medicines in the health centers. “But medication is not enough”, says Dr Christian Bambako of the Lomboko health center in the village of Yangambi. “Consultations, follow up of patients and the prevention of diseases and infection is just as essential”, he continues. Dr Bambako, just like the other health centers involved in the Global Fund program, closely involves the communities in their health zones. Breaking taboos that still cling to HIV, countering discrimination against people living with HIV, preventing infections and getting people tested is what they do in villages and urban areas. “Together we are able to stop the scourge of HIV/AIDS and Tuberculosis”, Dr Bambako concludes.

This is what thousands of health centers and their surrounding communities in DR Congo do. Day in day out, in dire circumstances and with few resources.

By 2020 Cordaid is committed to:

- enroll 95% of TB and HIV co-infected patients on ARV drugs;
- ensure HIV testing of 90% of TB patients;
- maintain treatment success rates for confirmed cases of at least 90%;
- reduce the impact of human rights violations related to HIV;

More information

“We, the patients, had to find solutions ourselves.” The story of Clarisse Mawaki who runs a community care center for people living with HIV in one of the poorest quarters of Kinshasa (also supported by Cordaid through the Global Fund).

<https://www.cordaid.org/en/news/hiv-kinshasa-patients-had-to-find-solutions-themselves/>

Watch this video and follow the pill in DR Congo:

https://www.youtube.com/watch?time_continue=1&v=IZHbSd8YG2c



THE PAIN OF PROHIBITION

In its briefing ‘The hidden opioid crisis: How the so-called ‘war on drugs’ forces patients to die in pain’, Health Poverty Action examines how prohibition prevents patients accessing opioid-based pain relief such as morphine. For Health Poverty Action, like tax, trade and climate change, the failed ‘war on drugs’ demands our urgent attention.

“I have been suffering from severe pain. I travelled to receive treatment and now I travel to a village 450 km away from here just to get a prescription for morphine.” explains Nita*, a 37-year-old mother from Gujarat, Western India. She is dying from advanced mouth cancer. Her husband left his job to care for her in her final months, and, with the added travel costs to get pain relief, took on loans to meet the family's needs. Their children then had to stop going to school, so they could work as labourers to pay off their growing debts.

Incredibly, Nita is one of the ‘lucky’ ones. At least she is able to access pain relief. Many other patients die in agony due to India’s opioid paradox: the country is one of the world’s leading producers of opioid medicines, yet only four per cent of its palliative care patients receive the morphine they should be getting. Nita’s story is highlighted in Health Poverty Action’s new briefing “The hidden opioid crisis: How the so-called ‘war on drugs’ forces patients to die in pain”. Whilst our research focusses on three states in India, the story is one that’s repeated again and again across the world. 90% of the world’s AIDS patients and 50% of cancer patients live in low- and middle-income countries, yet these same

countries have just 6% of the morphine used globally for pain relief, as shown by an Independent Report of the West Africa Commission on Drugs.

This is, at least in part, a direct consequence of the so called ‘war on drugs’. Prohibition has been so aggressively implemented that heavy-handed restrictions limit access for medical use. India’s 1985 Narcotic Drugs Act introduced a 10-year mandatory minimum prison term for

violations involving narcotic drugs, along with cumbersome licensing procedures of import, export and transport between states. Following the Act, medicinal morphine use in the country dropped by a staggering 97%. Health workers told us that a combination of harsh penalties for minor clerical mistakes and complex bureaucratic regulations prohibited them from applying or maintaining licences to stock morphine due to the burden of paperwork and fear of being penalised for errors.

This is compounded by the stigma associated with opioids, and the fears they can cause addiction, exacerbated by a lack of training on palliative care. As a result, many practitioners are reluctant to prescribe opioids to relieve their patient’s pain. The result is that people are dying needlessly painful deaths, whilst others are forced to travel hundreds of miles – and rack up debts – just to access pain relief. One doctor and palliative care expert described it as the ‘collateral damage’ of the war on drugs.

The hidden opioid crisis

How the so-called ‘war on drugs’ leaves patients to die in pain





Ironically – and predictably – it’s the legally regulated area of drug use (i.e. for medical purposes) where it’s been possible for authorities to limit access to them, whereas globally prohibition has wholly failed to limit the supply of drugs for illicit use.

People dying in pain is one of many reasons why we urgently need to replace prohibition with healthier drug policies, both in India and across the world. From giving power to criminal gangs, diverting resources away from health and education and damaging the environment, this failed war hurts lives and livelihoods all over the world. Recently Health Poverty Action published the report “Punishing Poverty”, showing how this failed war fuels violence, damages the livelihoods of poor communities and locks families into poverty in both India and Brazil.

For myself and Health Poverty Action the solution is legal regulation of the drugs trade. Done with care, and with a pro poor and pro health approach, legal regulation will make products safer, take drug policy out of the hands of criminal gangs, stop the destruction of people’s livelihoods and prevent patients like Nita being the collateral damage of this colossal global policy failure.

All of us concerned with health and poverty have a moral imperative to address the monumental disaster that is prohibition. Like tax, trade and climate change, the failed ‘war on drugs’ demands our urgent attention – for Nita, and for the lives of people across the world.

Author

Martin Drewry is director of Health Poverty Action

Names have been changed to protect identities

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MENSTRUAL HYGIENE MANAGEMENT ON THE FOREFRONT

Thanks to a number of activist, organization and leaders, the Government of Nepal has constructively moved to address the specific culture and traditions around menstruation. In Nepal and in other countries where the Swiss Red Cross is working, Menstrual Hygiene Management (MHM) has become an issue.

“Death in a menstruation hut” - this sad news from Nepal was published by BBC on 4 February 2019: 21 year old Bagmati, who was confined by her family to sleep in the menstruation hut, suffocated from lack of oxygen while lighting a fire to keep her warm during sleep. This is not a single case; many more tragic stories around menstruation have appeared in the national and international news in the past.

Despite being declared illegal in 2005 and criminalized in 2017, the tradition of “Chaupadi”, mainly exercised in the Mid-West and Far West regions of Nepal, still exists including different cultural beliefs and traditional practices. In the Chaupadi, menstruating girls and women, and women after child birth are perceived as “impure” and have to follow certain rites and traditions. When girls have their period for the first time, they are not allowed to look into the sun and at male family members. In all cases, menstruating girls and women are excluded from the daily family life in various manners: they are not permitted into the kitchen, not allowed to cook and touch dishes, and are restricted from certain food items, such as cow milk and some vegetables.



They sit separately at meal times and are confined to sleep in a separate shed (so called menstruation hut) or have to sleep separately until the bleeding is over. After five days, they are allowed to take a bath for the first time, and again participate in family life. For girls, the Chaupadi often results in non-attendance at school due to lack of separate toilets for girls, lack of facilities for proper menstrual hygiene management; lack of sanitary pads and proper disposal of menstruation waste.

Traditions such as the Chaupadi, based on religious norms, are fostering exclusion, shame and a certain stigma. However, following the Chaupadi has one advantage: this is the only time for hard-working girls and women in rural Nepal to do less household chores than normal. While at a normal day they work from 4 a.m. to 10 p.m. feeding cattle, sweeping the floors, preparing meals, washing, agriculture etc. they are working mainly outside the main family house and are excused from all duties which involve touching people and food items.

The fact that a woman is menstruating is quite obvious in Nepal, all household members know. But dealing with menstruation and menstruation hygiene management is less visible and not addressed openly. Menstruation “pads” are produced in all secret from old sari cloth. The cloths are washed only by the women and are hung in a dark place, not to be seen by other household members or neighbors. Cloths often dry poorly without sunshine and are prone to develop fungus and are contaminated by flies causing chlamydia and vaginal infections. Lack of cloth or pads at school and lack of adequate water, sanitation and hygiene (WASH) facilities force girls to leave school suddenly and staying at home for a few days.

The Nepal Red Cross Society supported by the Swiss Red Cross, implements several Water, sanitation and hygiene projects in two provinces, Karnali province and Province 5 of Nepal. During project implementation in the communities and at school, the issue of menstruation management became more and more pertinent. Results from an assessment done in 2015 in 5 districts of these provinces showed that 21% of schools did not have a separate toilet for girls, 23% had no water in the toilet and almost 30% had no facility to dispose menstruation pads. But how do girls and women deal with menstruation at all? What if it starts at school? Where do pads come from? The project staff was confronted with lots of questions ...and decided to embark on the implementation of a menstrual hygiene management component.

“When the Red Cross team came to our school, I volunteered to be part of a youth Red Cross group”, says the 14 year old Kamala. “I did not know what I was getting myself into”, she giggles. The Red Cross team asked us about menstruation, what we do, where we get pads from, where our problems and challenges are. First I was a bit embarrassed, but then I realized, that this is a burning issue.

Only us girls talk among each other, but we get no outside help or ideas. Nobody in our family is interested, how we deal with our periods and if we agree to the traditions and rites. We just do it, as our mothers teach us. I got a lot of information from the Red Cross team. They showed us, and also some boys, how to sew re-usable menstruation pads, how to change them, wash and dry them correctly. And we also discussed the Chaupadi practices. I thought about them, but it is difficult to change traditions all at once, which our elders follow and introduce. One day, something very funny happened. My mother and myself had the period at the same time.

My father works abroad and sends money regularly. I have three much younger brothers. Now, both my mother and myself were not allowed in the kitchen. Nobody could cook for us. My brothers were very hungry and begged us to prepare a meal from them. So I took this opportunity to talk to my mother about the traditions. We decided to take a risk: one of us just has to get into the kitchen and cook. It was me, because my mother thought this will make the Gods less angry. All night we were both awake praying that nothing evil will happen to our family.

The next morning, we realized that all was as it is: no punishments from the Gods. We were both very relieved. Now we are very relaxed during our periods. We both cook and do our household chores. We were even able to convince my father about it. My father also allowed us to keep sleeping in our rooms. During my period, I sleep now in my room on the floor, which is already a big change”.

The Nepal Red Cross team ensures that boys and girls are participating in the classroom sessions on Menstrual Hygiene Management. They learn about menstruation and all what goes with it. The school management and teachers are involved in the teaching on how to sew menstrual hygiene pad. This is a sustainable and ecological solution, made from local material. The school also provides disposable napkins to girls, who start bleeding at school. One of the teachers is in charge of the programme, and she ensures that the disposable sanitary pads are regularly replenished. In order to ensure a safe waste management, the project team constructs gender-friendly toilets with attached incinerators, so that the disposable sanitary pads can be burnt regularly by the school caretaker. Discussions with the Government of Nepal are ongoing on how to make the sanitary pad disposal more environmentally friendly.

Besides the impact in the girls' personal lives, the project has helped to increase attention and coordination between different partners and key ministries regarding MHM. A national network, the so-called Menstrual Health Management Partner Alliance was founded in 2017 with involvement of all relevant organization working in the areas of MHM. The alliance is active on awareness/advocacy, research and upholding the importance of the topic. The Alliance is considered an advisory network for the Government of Nepal to facilitate and support knowledge management and promoting and improving issues on MHM. The alliance regularly holds exchange meetings, where new initiatives and learnings are discussed. The alliance's effort culminated in a consultative workshop which brought organizations, policymaker; researcher; public health professional; women and reproductive right activist; adolescent/youth and media together. National and international delegates shared scientific evidence as well as regional and country specific experiences with current strategies and intervention and local initiatives for MHM. The workshop has prepared recommendations on different areas of MHM; learning and education, water sanitation and health, innovation and sustainability, policy and advocacy, research and analysis for future consideration by the stakeholder as well as concerned Ministries in their plan of action for 2019/2020.



The Government of Nepal and the MHM partner alliance hosted the International Menstrual Hygiene day on 28 May 2018 with involvement of different key ministries; Health, Water and Sanitation, Women and Children and Education which expressed a commitment to eliminate and prohibit detrimental and discriminatory practices around menstruation, to support MHM friendly institutions and integrating MHM activities across all sectors.

The Government of Nepal has drafted the National Policy on Dignified Menstruation and an MHM Master Plan (2018-2020) which is in the process of endorsement by the cabinet. Furthermore, the Department of Education with involvement of the MHM expert has reviewed the school curriculum. The MHM Alliance gave their feedback and included age specific content on menstruation.

“We are very happy with these developments” says Raj Kumar Kshetri, Deputy Programme Director, Nepal Red Cross Society Community Empowerment for Health Promotion Programme. We have almost reached 10’000 girls and boys reached so far, and constructed 23 female friendly toilets in schools. Most important, we vested great interest and commitment at ministerial and policy level. Having Government policies on our side, as well as working with the young generation may eliminate discrimination, stigma and traditional practices, such as Chaupadi, forever.”

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The Swiss Red Cross is a member of Medicus Mundi Switzerland.

References and further information

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