medicusmundi
international network

ANNUAL REPORT 2011

"We will focus joint ventures on issues related to health systems strengthening"

CONTENTS

Medicus Mundi International Network: Annual Report 2011

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MESSAGE FROM THE PRESIDENT

NICK LORENZ, MEDICUS MUNDI SWITZERLAND

The implementation of the Network Strategy 2011-2015 has taken off very well. This is – as often in our work – difficult to prove in quantitative terms. However, we will make efforts to measure progress and develop appropriate indicators to be used in an external review of strategy implementation planned for 2013. For the time being we have to rely on circumstantial evidence.

Nevertheless it is obvious that the MMI Network has made progress. This has become very visible in the WHO reform process which will shape the future of international health governance. The importance of civil society's say in this process is vital and is seemingly recognized by the WHO leadership. It is also highly relevant for our member organizations – and in accordance with our Network Strategy – that the Medicus Mundi International Network has been strongly involved in setting up a civil society coalition dealing with the WHO reform.

The 2011 Network meeting took place in Brescia. With the contributions of Medicus Mundi Italy and Network members plus some invited speakers the conference covered recent issues of mother and child health. The conference showed once again the added value that hands on experience of MMI member organizations can bring to the field of global health.

The MMI strategic orientation to promote partnerships between NGOs and research institutions has still a long way to go. However, it has triggered last year a widely noticed event in the Netherlands: "An Ideal Match?! Connecting NGOs and Academia in Research for Global Health".

As a spin-off of the MMI working group work on human resources, a consortium of mainly MMI Network members and under the leadership of Wemos have responded to a EC call to raise awareness on development issues. The concept note has been accepted, which is a good sign, and raises hope that the proposal will be accepted. After the "STOP MALARIA NOW!" initiative, this would be a second large scale externally funded collaboration of Network members and partners, a value in itself and more important than the funds coming with it.

As positive as 2011 was, there is also a shadow to be reported: As a "departure foretold", it is unfortunate that we have finally lost Misereor as a member organization and, as a consequence, we will also lose Nina Urwantzoff as a Board member. Your contributions to the development of the Network were outstanding, and MMI owes you a lot. Thank you!

IMPLEMENTING THE NETWORK STRATEGY: THE FIRST YEAR

Based on the new MMI Network Strategy 2011-15 adopted by the Assembly in 2010, an initial set of three Network programs was confirmed by the Board in March 2011:

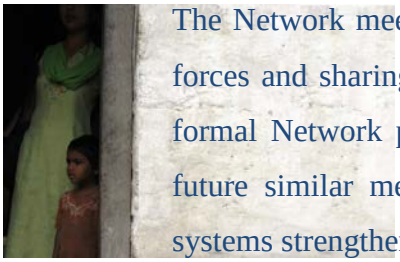
- Human resources for health: "MMI will contribute to the implementation of the WHO code of practice on the international recruitment of health personnel."
- Health systems research: "MMI will foster mutually beneficial partnerships between NGOs and research institutions."
- Global health policy: "MMI will contribute to the dialogue on global health policy and governance."

"We will focus joint ventures on issues related to health systems strengthening"

Progress in developing and implementing the Network Strategy 2011-15 and the three initial Network programs was discussed at the Assembly in Geneva (May 2011), at the Brescia Network meeting (October 2011) and at the Board meeting in Basel (March 2012) when the decision was taken to undertake, in 2013, an external midterm review of strategy implementation. Since the Network Policy and Strategy were accepted, Network membership has considerably grown. We are now 16 members instead of 10 in 2009 – and more will probably follow. This implies that we have to make an effort to integrate views and proposals by the new – and old – members into the strategy implementation.

The overall feeling expressed by Board and Network members in their recent meetings is that MMI is moving in a good direction. The updates on program implantation provided by the secretariat (see below) show that there is considerable output, but it is almost impossible to answer the basic question if MMI contributing to improving the health situation of poor people. Impact might be rather analyzed related to the concrete mission of MMI: supporting its members' efforts to achieve the shared vision of Health for All, contributing to the development of capacities of its members and providing a platform for joint activities.

Demand driven – and based on the core mandate of the Network



The Network meeting in Brescia with its focus on mother and child health proved that joining forces and sharing knowhow within the MMI Network is not limited to the given small set of formal Network programs. The inspiring event in Brescia is a model – and benchmark - for future similar meetings. The 2012 Network meeting will take place in Amsterdam. Health systems strengthening in fragile states will be the unfortunately increasingly important topic.

In 2011, among other topics, universal health coverage (and therefore health financing) and access to essential medicines have become objects of networking activities. Together with maternal and child health, the these topics have potential to get translated one day into a “proper” Network program – if there is sufficient demand by Network members and if there is somebody ready and able to take the lead.

On the other hand, addressing health and its determinants in a more holistic – and more political – way on a global level is another key issue of the Medicus Mundi International Network. However, in our involvement in global health policy and governance, it is more difficult to define from case to case the concrete “demand” by the Network members, as some the topics of our activities – such as the reform of the WHO – seem to be far from their day-to-day business of health care and health systems support.

Nevertheless the activities of the small “global health governance team” of MMI are based on a mandate by the Network members. In our recently adopted policy and strategy documents, we state this clearly: “Advocacy in the field of public health is a core activity of the MMI Network. Joint advocacy adds a layer of value to the Network’s activities. Supporting our members’ efforts to achieve the shared vision of health for all, our advocacy aims at influencing the policy landscape in which our members’ and their partners’ activities takes place.” (Advocacy policy)

Therefore the Network will continue to contribute to the dialogue on global health policy and governance, joining forces with other civil society organizations and networks. Let us develop this layer of activities step by step!

MMI Network Strategy 2011-2015 adopted in May 2010

- *“We will focus joint ventures on issues related to health systems strengthening.”*
- *“We will develop new spaces and tools for sharing know-how and joining forces.”*
- *“We will focus joint advocacy on the WHO."*
- *“We will develop new partnerships between NGOs and research institutions.”*
- *“We will develop our Network’s resources and structures step by step.”*

PROGRAM UPDATES

MMI Network program on human resources for health:

"MMI will contribute to the implementation of the WHO code of practice on the international recruitment of health personnel."

In 2011,

- ..members of the HRH working group participated actively in the 2nd Global Forum on Human Resources for Health in Bangkok (January).
- ….MM Switzerland and Wemos produced respectively a manifesto and a policy briefing on addressing health workforce migration.
- …the MMI Human Resources for Health (HRH) working group participated in a technical briefing on the implementation of the WHO code of practice on the international recruitment of health personnel at the World Health Assembly, organized by the Global Health Workforce Alliance;

- …working group members participated in the "Moving the ethical hiring of health workers forward" seminar in Madrid (June), in a side event to the UN NCD summit in New York organized by the Global Health Workforce Alliance (September) in a side event at the WHO SDH conference in Rio (October), and in a Mobility of Health Professionals (MoHProf) seminar in Brussels (December);
- …Wemos, co-ordinator of the MMI HRH working group, was selected by the Global Health Workforce Alliance to host the secretariat of the Health Workforce Advocacy Initiative (HWAI). After this appointment, the MMI secretariat declared its interest to become part of the HWAI steering committee;
- …a consortium of MMI, five Network members (Wemos, FAMME, MM Poland, Memisa, Misereor, all of them members of the HRH working group) and three external partners submitted to the EC a concept note on a joint program called "Health Workers for all and all for Health Workers".

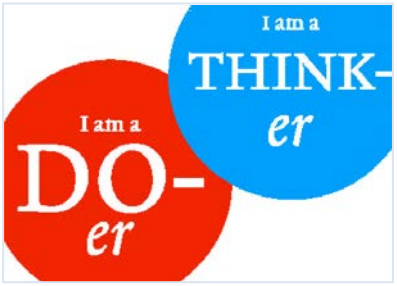
The MMI HRH working group will meet during the MMI Assembly in Geneva.

MMI Network program on health systems research:

"MMI will foster mutually beneficial partnerships between NGOs and research institutions"

In 2011,

- …the Amsterdam Symposium "An Ideal Match?! Connecting NGOs and Academia in Research for Global Health" (September) was a great opportunity for continuing the talks about NGO-research partnerships the MMI Network started in its Antwerp workshop one year ago. It was good that some Network members were present at this meeting which was co-organized by Wemos and Cordaid;



- …the plans to develop a kind of interface or market place for NGOs and research institutions have not yet lead to any concrete steps. The MMI Network is probably too small and heterogeneous to create this market place on its own. Therefore, contacts were established with Cohred and their healthresearchweb.org and see with them how to (better) integrate NGOs/CSOs on both the local/national and global level into their platform.

The MMI research working group met during the Board meeting in Basel, March 2012, for a re-launch event and will meet again during the Assembly in Geneva.

MMI Network program on global health policy:

"MMI will contribute to the dialogue on global health policy and governance."

In 2011, the Medicus Mundi International Network's "Global Health Governance" team

- …was strongly involved in the WHO reform debate, as a leading member of both the broad "Democratizing Global Health Coalition on the WHO reform" established in the follow-up of a civil society consultation in New Delhi (see below). MMI contributed to and endorsed joint civil society statements on the WHO reform, also publishing and updating a widely noticed thematic guide on the MMI ePlatform;

- …participated in the WHO EB meeting in January, the World Health Assembly in May, the WHO Europe meeting in September and the special session of the WHO EB on the WHO reform in November. MMI was invited by the WHO secretariat to a stakeholder dialogue on the WHO reform (March) and to a civil society dialogue meeting with the office of the WHO DG (December);

- …supported the WHO Watch program of the People's Health Movement in which young health volunteers "watch" the proceedings of the EB and World Health Assembly. These volunteers gather before the WHO meetings in a 3 days workshop and prepare the topics on the agenda. A written report and analysis is also used for advocacy purpose. MMI has supported this process in contributing to these workshops and facilitating NGO statements;
- …participated in an important meeting in Delhi (May) where academics, NGOs, government representatives, EU and UN delegates came together to discuss important principles for global health arrangements and the crucial role WHO has in this. Secondly it was explored to what extend legal frameworks could be developed to guide global health agreements. This led to Delhi statement (include link), that was endorsed by a broad range of organizations, including the MMI Network;
- …got involved in the debates around the UN NCD summit in New York, September 2011, and endorsed the statement "Noncommunicable Diseases: lack of clarity on role of industry" signed by over 100 NGOs;
- …contributed to the debates around the World Conference on Social Determinants of Health in Rio de Janeiro, October 2011, co-organized a civil society workshop as side event to the conference and contributed to and signed on an "Alternative Rio Declaration";
- …joined "Beyond 2015", a global civil society campaign aiming at influencing the creation of a post 2015 development framework, linking it to the debate on health governance;
- …got involved in the "Joint action and Learning Initiative" toward a Framework Convention on Global Health;
- …continued to publish "MMI global health updates" on Twitter (1900 updates, 300 "followers", including many organizations). As a service to MMI Network members, we included theses updates in the monthly MMI newsletter;
- …started its "Get involved in global health!" blog with a series of reports by Remco van de Pas from the WHO Europe meeting in Baku.

"This hectic, energetic year really put MMI to the forefront as a civil society actor working on the right to health, health equity and democratic participation on global health directions. It made the WHO and member states to reconsider new ways to work and relate with civil society organizations on health, with a focus on the public interest. MMI now also requires to translate this work towards the national level where we need to convince our governments to strengthen their efforts on global health equity and health for all." (Remco van de Pas)

FROM BASEL TO BRESCIA - WITH STOP-OVER IN GENEVA

Board meeting, 26 February 2011 in Basel: The first MMI Board meeting in 2011 had a strong focus on the implementation of the "Network Strategy 2011-15". Inputs were provided to the Board on the following issues: networking and advocacy in the field of human resources for realth; health systems research and NGOs; getting involved in the global health governance debate; institutional development of the Network.

Assembly and Board meeting, 19 May 2011 in Geneva: As in the previous years, the Annual Assembly of the Medicus Mundi International Network took place in the week of the World Health Assembly. Meeting in Chavannes-de-Bogis, a few kilometres outside Geneva, the day of the MMI General Assembly was also used for meetings and briefings of the Network's working groups and teams

Network meeting, 27-28 October 2011 in Brescia. The MMI Network appreciated very much the invitation by Medicus Mundi Italy to hold its Network meeting in Brescia. The related conference and workshop on mother and child health was timely, as improving mother and child health is a key concern of many members of the Medicus Mundi International Network, and the deadline for the Millennium Development Goals (2015) approaching…

WELCOME!

- **Memisa, Belgium**

Memisa promotes quality basic health care. The main purpose is to provide essential, quality and appropriate care, particularly for the most disadvantaged people, without distinction of race, religion or political persuasion. This is achieved through sustainable development programmes, small-scale initiatives and emergency aid in Africa, Asia and Latin America.

Memisa is a Christian organisation, which focuses on people, in the first place, the least well-off. It is a "comprehensive approach" of man, i.e. the general welfare of people in their neighbourhood and not merely the absence of disease. Memisa wants to continue the work of missionaries, who worked in the health sector.

The gradual transfer of responsibilities to promote local autonomy is central. Therefore Memisa works together with reliable local partners. This is done in an open dialogue based on equality and shared responsibility. Another dimension is to strengthen the cooperation with other NGO's and donors and also with other sectors (agriculture, economy and education).

Source: www.memisa.be

- **i+solutions, The Netherlands**

Our vision: Universal access to high quality, affordable medicines and health products. Our work is driven by the core values of: integrity (responsibility, accountability, transparency); diversity (people, valuing individuals, complementarities; team work and partnerships (integrated approach, thorough and comprehensive); customer focus (going the extra mile / tailor made services); result focus (fact and output based, impact, SMART, short and long term).

Our mission: i+solutions is an independent, international, not-for-profit organization specializing in pharmaceutical supply chain management for low and middle income countries. i+solutions offers high quality integrated supply chain and consultancy services focusing on the fight against HIV/AIDS, Malaria, and TB including their prevention and on reproductive health activities, through: innovation, information technology, creativity and effective execution.

Source: www.iplussolutions.org

NETWORK STORIES

FOCUS ON MATERNAL AND CHILD HEALTH

THE RISK OF BIRTH

Due to the shortage of funds, developing countries are often forced to decide whether to invest into the training of medical midwives or the instruction of traditional birth attendants. The international donor community is focusing on the training of midwives and is therefore ignoring the living reality of millions of women. The protection of the health of mothers and children should not and must not be an "either-or-decision". Both midwives and traditional birth attendants play an important role in supplying a medical as well as humanly acceptable quality of service, and none should be excluded from the health system.

In September 2010, a global initiative for improving maternal and child health was announced on the Millennium Development Summit by Ban Ki Moon. The professional supervision of births was to be increased. However, since there is still a lack of trained midwives, there is a need for Traditional Birth Attendants (TBAs) – but their work is being debated.

Although there have been reductions in maternal mortality globally, still about 350,000 women die in the aftermath of pregnancy or childbirth each year – 99% of whom are in developing countries. Most of them die because of complications which could be avoided if proper follow up is done during pregnancy and all deliveries take place under the supervision of trained health personnel. Forty eight million women worldwide (35%) give birth to their children without the help of medical staff and in developing countries the average is 59%. The WHO estimates that, worldwide, there is a lack of about 350,000 midwives.

Programs in Indonesia and Tunisia show that investment in trainings of midwifes and birth attendants lead to a decrease in maternal deaths. But in most of the countries of the South there still seems to be a long way to go. In Ethiopia there are only about 1000 midwives – giving rise to 1 midwife per 76,000 pregnant women. This is far less than the WHO recommendation of 1 midwife per 175 pregnant women.

Due to this gap in health personnel availability, the non-accessibility of adequate health facilities as well as cultural reasons, most of the births are accompanied only by TBAs. These are mostly women who acquired their knowledge through intuition, practical experience or skills passed down from their mothers or relatives. TBAs care for the women during pregnancy, child birth and in post-partum period as well as for their newborn babies. Depending on the country, they also serve as a bridge between the community and the public health sector and send the women to the health centers or hospitals if needed.

The support given to TBAs by a particular government differs greatly between countries. There might be rejection as well as active encouragement. As there are almost no reliable figures on the impact of the TBAs work on maternal mortality, the critics fear that they can do harm on women's and children's health. Therefore they want to reduce their role and use the limited funds for training of professional health personnel. On the other hand many stakeholders in the health sector believe that well-instructed Traditional Birth Attendants could minimize the risk of pregnancy and giving birth and could improve the women's sexual and reproductive health. In the face of inadequate funding in the health sector, the ideal of training sufficient midwives and other medical staff is too far from being reached to solve the huge challenge of maternal health in the next decade.

In contrast to the midwives, TBAs are located in the community and women do not have to travel far to reach them. There is also no language barrier and no ethnical discrimination, as TBAs come from the local communities they work in, such as in Guatemala. The low level of knowledge among women about sexual and reproductive health is another big challenge. Women often do not recognize the physical changes that take place in their bodies and about the importance of regular medical check-ups. The long reproductive phase is another cause for pregnancy risks. Only 24% of married women use modern contraceptives in Uganda, 24% in Tanzania and 44% in Guatemala. In these areas TBAs educate their patients and inform them about family planning and sexual and reproductive health issues. They reach a large number of village members and often even men listen to their teachings as TBA generally have a high reputation in the community. This is important in many rural settings as most often the men are the ones who decide about questions of sexual and reproductive health. The public health sector is not able to fulfill the task of educating and informing the population about sexual health issues.

Conclusion

For reaching the Millennium Development Goals 4 and 5 (reduction of child mortality and improvement of maternal health) different strategies have to be asserted. More funds have to go into the medical training of midwives and their number has to be increased. In order to achieve that, working conditions and payment have to be improved. Institutions of primary and secondary health care need to be better equipped – with material as well as staff resources. Health service has to be affordable and has to respect socio-cultural factors. In areas where this is not (yet) possible, the Traditional Birth Attendants' position as trusted persons during pregnancy and childbirth, as well as a bridge to the public health sector should be accepted, improved and rewarded. For achieving this, an intensive discourse with the respective national health systems is indispensable.

- Authors: Barbara Kühlen Kühlen and Frederike Möller-Frentzen, action medeor, and Caroline J. Kent, Deutsche Stiftung Weltbevölkerung.
- Photo: A Traditional Birth Attendant in Guatemala (Barbara Kühlen)

DOCTORS WITH AFRICA CUAMM PURSUES ITS COMMITMENT:

MOTHERS AND CHILDREN FIRST

Once upon a time there was Ayen, a 22-year-old woman who had been married for about two years. She had already had three pregnancies: the first had ended in miscarriage; the second was carried to full term, but she lived too far from the hospital and, after 24 hours of labour, her daughter was born but had stopped breathing. Now it is her third time to give birth. Ayen is at home when her waters break and the contractions start, getting stronger and stronger. The pain from the contractions is coupled with her fear of not succeeding this time either.

It is a critical moment. Ayen looks for help, she reaches out for her husband's hand, knowing full well that it won't be enough. The time has come to seek help. She struggles to start walking. There is a health centre not too far from her home. She has heard about other women who have been there. She can trust the place and can still count on her own two feet. She starts the journey towards young motherhood, afraid but brave.

She reaches the health centre tired out and just in time to yield to the care of a nurse. The situation is critical. She needs a caesarean section and the health centre is not equipped to perform one. She will have to be taken to the main hospital in Aber. The rush begins and things start moving quickly due to the urgency of the emergency. Aber hospital is called, the ambulance leaves, covering kilometres of dirt road enveloped by a profound, mysterious African sky that gives no clues to the outcome.

Ayen, silent and undaunted, with the typical composure of African women when they look pain in the face, puts her trust in the female doctor she has already heard about. "If I must die, I would like it to be in the hands of that white doctor." The white doctor, the "muzungu", welcomes her, prepares her and takes her into the operating room for the caesarean section.

Fear gives way to hope.
The miracle of life takes place.
Sarah arrives, almost three kilos of joy.

This is not a fairytale. And unfortunately not all the stories have such a happy end. This is what Doctors with Africa Cuamm faces every day, even now. Mothers and children, most notably the newborn, are the most vulnerable of the vulnerable.

It is an out-and-out health emergency afflicting many African countries.

Country	Angola	Ethiopia	Tanzania	Uganda	Italy
Maternal mortality	14 every 1000	7 every 1000	9 every 1000	5 every 1000	0.04 every 1000
Child mortality	130 every 1,000 live births	69 every 1,000 live births	67 every 1,000 live births	85 every 1,000 live births	3.38 every 1,000 live births

As the data show, the number of pregnancies with a negative outcome is still very high in African countries. The overall probability of dying during childbirth is, for mothers in poor countries, one in every 16 pregnancies. In developed countries it is instead 1 every 2,800. Combined maternal and neonatal mortality account for more victims every year than any other illness. Every year, approximately half of maternal deaths throughout the world (265,000 deaths, i.e. 49% of the total of 536,000) occur in Sub-Saharan Africa.

There is a multitude of causes for the dramatic maternity conditions in Africa: inefficient health systems, inadequately trained human resources – doctors, nurses, midwives –, high cost of gaining access to healthcare, long distances from health centres, lack of information on reproductive health. In sum, economic, spatial and cognitive barriers play a decisive role.

That is where Doctors with Africa CUAMM has opted to intervene, maintaining the need to put "Mothers and children first". This is a route the organization has been taking for over 60 years, in response to its pledge to uphold the right to health in the countries of Sub-Saharan Africa. Specifically, the NGO focuses the greater part of its work on safeguarding mother and child health, which is an indirect but essential indicator of how an entire health system works.

And this route has also been improved in 2011. The association undertook to develop an ambitious project, launched last 5th November and casting real hope for the countries involved: to double the number of safe deliveries from 16,000 to 32,000 per year, within five years. Four hospitals in four countries – Angola, Ethiopia, Uganda and Tanzania – will be involved, covering a catchment area of approximately 1,300,000 population. Overall the project will provide free assistance for 125,000 deliveries, of which 11,500 will require a caesarean section.

These impressive numbers highlight the staunch commitment of Doctors with Africa CUAMM to achieving Millennium Development Goals 4 and 5: to reduce child mortality and improve maternal health. The journey has begun, which Doctors with Africa CUAMM intends to pursue with determination, to ensure that many stories have a happy ending like that of Ayen and Sarah.

- Author: Chiara Di Benedetto, Doctors with Africa CUAMM.
  More info: http://www.mediciconlafrica.org/en/mothers-and-children-first
- Photo next page: © Doctors with Africa CUAMM

MEDICUS MUNDI ITALY AND ACTION MEDEOR

DEVELOPMENT OF AN INDIVIDUALIZED ARV COMBINATION SUSPENSION FOR PAEDIATRIC HIV/AIDS PATIENTS

Do not be scared if the following report smells "science". The project we present is an excellent example of how a clinical problem typical for resource poor countries identified by one member of the MMI Network could be brought to the attention of another member with the necessary expertise and resources to allow for specific analysis in yet another resource poor country and, most important, implementing the results to the benefit of the patients in need. We hope that this fruitful cooperation among Medicus Mundi members from different countries and involving a research institution from the "South" can serve as an example for many other clinical problems that still await their solution!

Development and implementation of paediatric HIV/AIDS treatment remains a priority, especially in low-income countries where most of HIV infected children live and where the lowest percentage of them is actually on highly active antiretroviral (ARV) therapy[1].

According to the current WHO algorithm for the management of HIV/AIDS in children, treatment should start as early as possible in all infected children below 24 months of age without considering a specific CD4+ threshold[2]. Furthermore, an effective ARV regimen should comprise of three drugs representing at least two different classes. Up to this date only four quality assured triple-drug fixed-dose combinations (FDC) are available in solid and dispersible forms[3]. In most countries – among them Burkina Faso - only one is available and this combination is based on the three molecules Lamivudine (3TC), Nevirapine (NVP) and Stavudine (d4T) – the latter being currently discontinued due to severe side-effects. In addition, dosing of two of those molecules (3TC and d4T) is based on body weight while the third is ideally dosed per body surface area.

By definition, a fixed-dose combination cannot satisfy this important requirement exactly, as weight and surface area do not increase in parallel. Another limitation of the available FDCs is due to the fact that they come as scored tablets, thus allowing only approximate dosing by rounding to the nearest half tablet. As explained in Table 1 (next page), which is based on the current dosing recommendations for FDC based on weight bands, this leads to significant over- or underdosing. Thus, in order to achieve correct doses, actually the only possibility is to use three different liquid formulations, each containing only one active ingredient. Given the fact that the medicines need to be taken twice daily, the care giver every day needs to measure and

administer six times different volumes, which can be quite a challenge in the real setting, where the child is crying and the care giver wishes to conceal the HIV status to other members of the household.

weight (kg)	Number of tablets	daily dose using FDC (mg/kg/day)			ideal daily dose (mg/kg/day)		% of correct d4T dose	% of correct 3TC dose
		6	30	50	2	8		
		d4T	3TC	NVP	d4T	3TC		
3	2	12	60	100	6	24	200,0	250,0
4	2	12	60	100	8	32	150,0	187,5
5	2	12	60	100	10	40	120,0	150,0
6	3	18	90	150	12	48	150,0	187,5
7	3	18	90	150	14	56	128,6	160,7
8	3	18	90	150	16	64	112,5	140,6
9	3	18	90	150	18	72	100,0	125,0
10	4	24	120	200	20	80	120,0	150,0
11	4	24	120	200	22	88	109,1	136,4
12	4	24	120	200	24	96	100,0	125,0
13	4	24	120	200	26	104	92,3	115,4
14	5	30	150	250	28	112	107,1	133,9
15	5	30	150	250	30	120	100,0	125,0

Table 1: dosing recommendations for paediatric ARVs

Furthermore, dosing of each of the three liquid formulations needs to be adjusted individually to the child's weight and body surface on a monthly basis, making the caregivers job even more difficult, not to mention that most of those liquid formulations need to be stored below 12° or even 8° Celsius – a condition that can't be reached in most of the poor households where the only "refrigeration" is a clay pot filled with water, capable of maintaining a temperature of 25°C! Usually children start to swallow tablets more easily once they reach a body weight of 15 kg.

From the financial point of view, all paediatric formulations and especially the liquid formulations have a much higher cost than the adult formulations.

In order to tackle this whole set of problems, we wanted to explore the possibility of preparing for each patient below 15 kg an individualized liquid formulation, containing all three active ingredients, each at the individual correct dose – thus allowing for a range of ratios between the ingredients dosed on body weight and those dosed per body surface area (Abacavir/Nevirapine ratio between 0.9 and 1.2). The concentration of the active ingredients should increase over time, allowing maintaining the same volume to be measured and administered for a time span of several months and a storage temperature for the solution at 30°C for 30 days. Cheap and available adult formulations were to be used as starting material. d4T was substituted by Abacavir (ABC) as the former will be phased out and is no more available in adult formulations

in Burkina Faso. Finally the compounding procedure should be simple and robust allowing the manufacture of individualized paediatric formulations at hospital level.

A joint study of Medicus Mundi Italy and action medeor was undertaken at the Pharm R&D Laboratory of the Muhimbili University of Health and Allied Sciences (MUHAS) in Dar es Salaam, in which the challenges of the Lamivudine/Abacavir/Nevirapine (LAN) suspension were scientifically reviewed and a feasible way for preparation of a stable individualized triple combination suspension was proposed. The process was started by developing an analytical method to detect and quantify all three active ingredients simultaneously; the selected method was then validated. Using adult mono ARV tablets and sorbitol 70% as a diluent, three combination suspensions for children of different weight and body surface area were prepared – by pulverizing the respective number of tablets and moistening with appropriate amount of water, triturating gently while adding the diluent to form a smooth paste – and then transferred into a graduated bottle to make up the volume to 300 ml (PET bottles) with the diluent. The stability study was conducted for 42 days at controlled tropical storage conditions (30 °C / 75% RH). The sampling was done at days 0, 5, 14, 28 and 42. The testing covered appearance, odour, pH, resuspensibility and content of active ingredients.

We found that the appearance and odour of all of the three tested formulations did not change over the total test period and there was no significant change of pH, which indicated the absence of hydrolysis. Furthermore, no problems were observed concerning the resuspensibility of the stored formulations, and the content of the active ingredients did not change significantly within the test period (figure 1) Occurring variation of the single results of the assay of the active ingredients can be explained by inaccuracies during the dosing procedure, no trend of change of the content of the active ingredients in one direction could be observed. The range of the obtained single content results of the active ingredients were 92 – 103 % for Lamivudine, 96 – 103 % for Abacavir and 92 -104 % for Nevirapine. Assuming that with respect to the normal biological variation a minimum content of 90 % of the claim can generally be accepted and that toxic degradation has not to be expected, the tested standard formulations can be regarded as stable under in-use conditions for 6 weeks.

	Day 0			Day 42		
Formulation(%)	1	2	3	1	2	3
Lamivudine (%)	93.5	92.2	100.6	92.6	92.3	96.9
Abacavir (%)	96.3	103.2	100.1	98.4	95.7	97.7
Nevirapine (%)	100.4	101.8	102.6	94.5	104.5	94.4

Table 2: Content of Lamivudine, Abacavir and Nevirapine (LAN) on day 0 and 42.

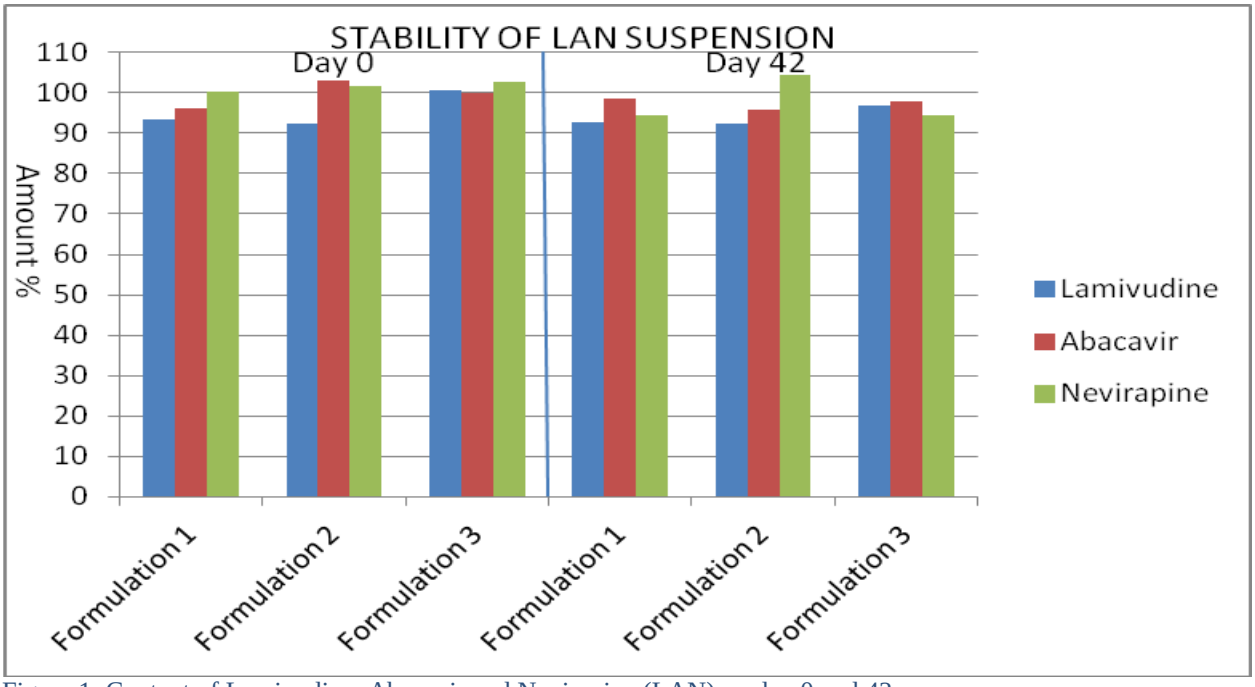


Figure 1: Content of Lamivudine, Abacavir and Nevirapine (LAN) on day 0 and 42.

The results will help hospitals to compound individual LAN liquid formulations for children of 3 – 15 kg, hence reducing the total number of administrations to twice per day and the number of bottles of the formulation for a child to one per month. The volume administered can remain stable as the concentration will be increased over the time as prescribed. This will enhance the adherence by decreasing the complexity for the care givers and the discomfort of the paediatric patients.

A decentralized preparation of the individualized combination suspensions in a hospital setting seems feasible because little material and technical equipment is needed. On the other hand, well-trained and cautious pharmacy staff is required to avoid dosing mistakes. A pilot study on implementation of this formulation is currently under way in a controlled setting in Burkina Faso.

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This project was funded by a grant from the Istituto Superiore di Sanità of the Italian Health Ministry under the "Ensemble pour une solidarité thérapeutique hospitaliere en Reseau contre le SIDA " (ESTHER) Program to the University of Brescia.

Notes

(1) Pediatric HIV — A Neglected Disease? Lallemant M., Chang S, Cohen R., Pecoul B., NEJM 365;7:581-3.
(2) Antiretroviral therapy of HIV infection in infants and children: towards universal access: recommendations for a public health approach – 2010 revision. Geneva: World Health Organization, 2010.
(3) Improving treatment outcome for children with HIV. Calmy AL., Ford N. The Lancet 377:1546-8

ANOTHER YEAR OF SMILES

In 2011 Smile Train Italia and its volunteers involved in humanitarian projects have succeeded in giving back a new smile to more than 1,650 children affected with facial malformations, giving their families a better perspective on their life.

Thanks to the continuous support of volunteers, companies and supportive care foundations, which have supported the initiatives and projects of Smile Train Italia, also in the year 2011 the association was able to successfully carry out 13 surgical missions and to perform projects of health care assistance in the treatment of craniofacial malformations and congenital facial anomalies. It has achieved significant progress in the area of mother and child health improving their lives in local communities by means of programmes focused on health, nutrition and sustainable skills training.

During this year the volunteers of Smile Train Italia have given their precious professional support and assistance in the following countries and their hospitals: Democratic Republic of Congo (Kinshasa – Cliniques Universitaire de Kinshasa), Iraq (Nassiriya – Military Forces Base of Tallil), Indonesia (Tarakan – Public Hospital), Gabon/assessment mission (Libreville – Public Hospital), Libya (Bengasi – American Centre), Benin (Cotonou – National University Hospital CNHU), Ethiopia (Addis Abeba – CURE International Hospital) and Bangladesh (Gaibandha – The Emirates Friendship).

As always during the surgical humanitarian missions, the volunteers of Smile Train Italia have identified and selected the serious and particularly relevant clinical cases for which it was not possible to surgically intervene immediately on the spot with the main goal to organize their transport in Italy and to undergo surgery in Italian hospitals of national importance and highly specialized in reconstructive plastic surgery.

During 2011 Smile Train Italia treated in Italy more than 10 children of various nationalities by means of the organization of their transfer in Italian hospitals with the standards of the most advanced international surgical care and giving continuous assistance and support to their families. Within this kind of humanitarian activities, one of the most important projects of the year focused on the story of five Afghan children with facial malformations (the youngest was 14 months old). The five Afghan children, together with their fathers, arrived in Rome on 23rd June 2011 and stayed until 6th July 2011. As soon as they arrived in Rome, the little patients were hospitalized in the Paediatric Department of the Hospital S. Pietro Fatebenefratelli, where

they were fondly welcomed by the medical and paramedical personnel of the department. The surgeries were performed by the Smile Train Italia's surgical team, directed by Dr. Fabio Massimo Abenavoli, the President of the Association. The outcome was positive and the children rediscovered the joy of smiling and of playing carelessly with their parents and their peers.

In combination with the surgeries, a medical training course in the surgical treatment of cleft lip and palate (CLP) was organized, addressed to the Afghan medical physicians who came to Italy together with the five children and to national and international reconstructive plastic surgeons and residents. The course was focused on the surgeons' professional experience and intensive surgical skills in the diagnosis, treatment and care of child facial malformations.

At the end of the post-operative phase, the children and their fathers stayed at the "Casa per Ferie Ravasco", a guest house which strongly collaborates with Smile Train Italia, providing its professionalism, willingness, warmth and kindness in welcoming and supporting the little patients. During their stay, the volunteers of Smile Train Italia organized a sightseeing tour in the capital providing a few hours of fun for the children.

In the scientific field, in this year Smile Train Italia organized and attended in various workshops and symposia in plastic reconstructive surgery and, with great honour a representative of the

association participated in the open Network Conference organized by Medicus Mundi International and Medicus Mundi Italia about the issue "Mother and Child Health – Before and Past 2005" held in October 2011 in Brescia, Italy. It was a great opportunity as Smile Train Italia had the chance to confront itself with new organizations and corporations, establishing the basis for future multidisciplinary approaches in the field of safety, prevention and assistance to mother and child health-care.

Regarding the charity fundraising activities for 2011, Smile Train Italia organized many prestigious charity events such as the "Gala delle Margherite" a famous charity event which saw a healthy participation of more than 500 people who contributed to giving smiles by supporting the projects and the main "mission" of the association. For Smile Train Italia, 2011 has certainly been a positive and satisfactory year considering the concrete results of the projects obtained and the support received from new and numerous donors-supporters and partners. The success of the initiatives of Smile Train Italia was possible thanks to the fundamental contribution given by its team of volunteers (medical doctors, nurses, anaesthetists, paediatrics, dentists and logistics), its number is in constant increase and it represents the real "soul" of the association's work. Without their professionalism, helpfulness and kindness nothing would have been possible.

- Authors: Fabio Massimo Abenavoli, President, and Marta Romagnoli, Organizational Secretary, Smile Train Italia.
- Photos: © Smile Train Italia

ECUMENICAL PHARMACEUTICAL NETWORK

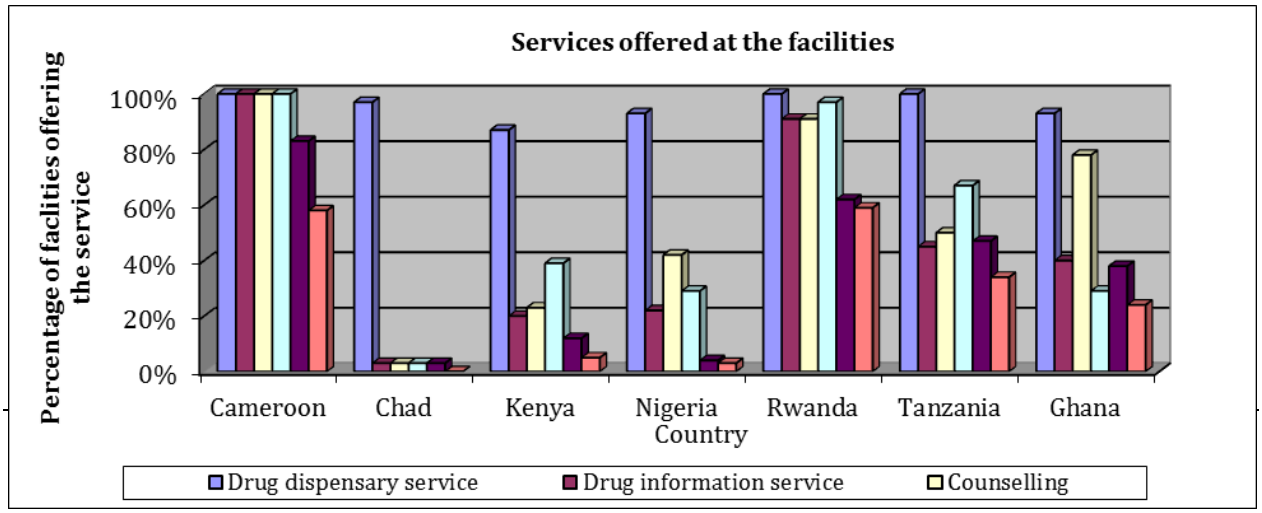
MAPPING PHARMACEUTICAL HUMAN RESOURCES IN CHURCH HEALTH SERVICES IN AFRICA

Medicines are essential tools for the treatment, prophylaxis or diagnosis in medicine. To handle medicines adequately pharmaceutical professionals are required. The statistics from WHO addressed the shortages in personnel in the medical field in sub-Saharan Africa. The Ecumenical Pharmaceutical Network (EPN) together with some of its members performed a survey to characterise the human resource situation of the pharmaceutical services in church facilities in eight countries from 2008 to 2010.

The survey was based on questionnaires. Information was gathered about training and practice of each staff working in the pharmacy department and general information about the institutions itself. Physical visits from data collectors as well as submissions from responders by mail services were used. The results: 332 facilities (70% hospitals, 28% health facilities, and 2% dispensaries) with 1009 respondents were surveyed. 70% of the health institutions included in the surveys were situated in rural areas and only 30% urban.

The staff of the pharmacies consisted of 9% pharmacists, 24% pharmaceutical technicians, 29% pharmaceutical assistants, 10% nurses, and 27% attendants. A low figure of pharmacists in the health care workforce of a country, e.g. the Chad < 0.6 per 10.000 population, is reflected by no pharmacist being available in the surveyed health institutions. In Ghana we found more than 70% of the hospital pharmacies were run by pharmacists. As an indicator to ensure quality we found 72% of all staffs being evaluated on the job. The gender distribution amounted to 52% female personnel in pharmaceutical services.

The type of pharmaceutical services offered depends on the qualifications of the personnel, the equipment of the pharmacy and the service policy of the institution management. The figure below shows the big differences of services offered:



As the institutions in Chad had a huge lack of pharmaceutical personnel the service was limited to dispensing. The institutions in Cameroon and Rwanda had either a majority of personnel qualified as pharmacists or pharmaceutical technicians and that is reflected by the higher number of services offered.

Supervision (peer reviewed audits) and evaluation of the staff is an important element of quality of service delivery (Black and Gruen, 2005). As the pharmaceutical personnel is limited as such also the supervision has its limitations:

Country	n	Six times a year or more	3-4 times a year	1-2 times a year	More than one year
Cameroon	65	5 (8)	3 (4.6)	57 (88)	0
Chad	17	4 (24)	3 (18)	10 (59)	0
Kenya	103	19 (18)	16 (16)	66 (64)	2 (2)
Nigeria	62	49 (79)	5 (8.1)	7 (11)	1 (2)
Rwanda	39	20 (51)	16 (41)	3 (8)	0
Tanzania	109	13 (12)	36 (33)	60 (55)	0
Ghana	253	23 (9)	21 (8)	201 (79)	8 (3)
Overall	648	133 (21)	100 (15)	404 (62)	11 (2)

Table: Frequency of evaluation (absolute numbers and %)

Church facilities need to ensure compliance with regulatory requirements by employing staff with appropriate training. Additionally, continuous pharmaceutical education is necessary to keep a standard of quality of the pharmaceutical services provided by the institutions.

Providing knowledge and trainings

EPN (Ecumenical Pharmaceutical Network) is an independent, non profit Christian organisation that works to support churches and church health systems (faith base organisations) in over 30 countries. Its only office is in Kenya. EPN strives for supporting quality pharmaceutical services by providing knowledge and trainings in different kinds of pharmaceutical fields. EPN has developed a syllabus for selected courses in hospital pharmacy practice. It is designed for personnel without having any chance for a formal pharmaceutical training so far. Last year the first course was held in Nairobi, Kenya. This year another course is running in Uganda and a third is planned for the francophone countries. The participants come from different countries where training resources are scarce. This initiative does not replace the task of the responsible leaders to extend the education in pharmaceutical professions. It supports its members in more than 20 countries to improve their pharmaceutical services.

- More information about the study and full references can be provided by the author: Andreas Wiegand, awiegand@epnetwork.org. Illustration next page: © EPN

STOP MALARIA NOW!

EUROPEAN PEOPLE SHOW THEIR FACES AGAINST MALARIA!

The campaign STOP MALARIA NOW! including several members of the MMI Network ended in December of 2011. Two years of activities in Germany, Spain, Italy, Poland and Kenya contributed to increase public awareness of malaria as a major health and development issue. But still there remains a lot to do in the fight against malaria. In the time it takes to read this introduction, a child will die from this preventable and curable disease. Malaria accounts for one death every 45 seconds. The vast majority of malaria deaths occur in Africa, south of the Sahara. But the disease means much more: Malaria is even a cause and a consequence of poverty. It has been estimated that malaria cost Africa more than US$ 12 billion every year in lost GDP and consume up to 25% of household incomes and 40% of government health spending. No doubt that it is time to "stop malaria, now."

The European awareness-raising campaign STOP MALARIA NOW! took place between 2010 and 2011 in Germany, Italy, Poland and Spain for the second time. Two years ago it had first been carried out successfully among those countries. Thanks to the consistently deep collaboration among the seven project partner – which have been health and development NGOs from Germany, Italy, Kenya, Spain, and Poland, almost all of them members of the MMI Network – the campaign's goal was achieved quite well: To increase public awareness of malaria related issues. Therefore, campaign activities targeted different groups, mainly supporting groups of civil society organizations, university students and youth groups as well as journalists, media professionals, national and EU decision-makers in the field of health and development. The innovative campaign approach of combining mass-communication, internet and personal-communication made a broad coverage of awareness promotion and mobilization activities possible.

STOP MALARIA NOW! achieved a broad media impact and succeeded in emphasizing the topic in all types of media, thanks to the creative and innovative ideas of all project partners. More than 150 press and online articles, radio and TV features have been initiated, new cooperation established and unusual audience reached. Highlights have been for example high visible publicity campaign adverts on buses and bus stops with images of a well-known football teams in Spain, or photo reportages in Italian and Spanish women magazines with more than 1.8 million readers each or the intensive cooperation with an Italian radio, which reaches up to

1 million people every day. The given liberty for implementing different media briefings in every country has gained a lot of advantages and results.

Organizing diverse events in a way represented the core of STOP MALARIA NOW!. More than 35.000 people were reached directly through 88 innovative awareness rising events. They included events to mark the World Malaria Day 2010 and 2011 as well as other events that were mostly associated with special anniversaries or lager events. Regard to this campaign tool all project partners proved to be extremely creative and innovative and made high efforts to popularize Malaria to the public at different occasions. Thus, the bandwidth of single and multi-day events ranged from traditional workshops, photo exhibits, seminars for students, thematic movie nights and information booths at church conventions, sports or music events, up to innovative flash mobs, street theatres performances, a story teller marathon and the installation of a huge mosquito net over a central pedestrian zone. Another key component of STOP MALARIA NOW! was a five-month exhibition and mobilizing tour through 14 cities in Europe. The exhibition strengthened established linkages among the project partner in the different countries.

Furthermore, the campaign succeeded to actively engage youth volunteers and students in malaria awareness promotion. After a small contest 13 young people with most different abilities and national backgrounds have been chosen to travel to Kenya for shooting a documentary about Malaria. Some of them are students from Italy, Germany, Poland or Spain. Others are living in Kenya in one of the biggest slums of Nairobi or are students at the Kampala University in Uganda. During the shooting they gained insight in beliefs, in everyday life in Africa and especially in, how people master their life with malaria. The documentary named “Insight Malaria” has been broadcasted on several occasions in Europe and Africa. This first hand experiences promoted intercultural learning among the participants.

“It was a great experience to live and work together with young people from different countries and continents. In Kenya, I realized how poverty can influence your life in a very unfair way. Malaria impoverishes your quality of life and limits you physically. We must be aware that also that if we in Europe don´t do anything, we prevent the prosperity of millions of people in African countries. And where is the government? Where is Europe? Where is the Church? This I was asking often myself during the shooting. I still do not have the right answer, but I'm sure that we should do something. European people have to become more conscious about the situation, because the worst thing is to be indifferent to other people. It is the time to take action and push for a change to a malaria-free world. However, Malaria is a curable disease which you can help fighting!” (A young Spanish filmmaker)

Another focus of the campaign was advocacy work. More than 5,000 campaign supporter across the globe showed 'their face against malaria' and seek to change the status quo towards a malaria-free world. At the end of the campaign the collected faces have been passed to relevant EU decision makers in form of a photo mosaic to call for increased European action for malaria control.

Bernd Pastors, CEO of action medeor e.V. and initiator of STOP MALARIA NOW! campaign is handing over the photo mosaic to Mr. Hans-Jürgen Beerfeltz, the State Secretary of the German Federal Ministry for Economic Cooperation and Development and thus required more political commitment to a world without malaria.

Moreover, STOP MALARIA NOW! did lobbying to politicians and parliamentarians through events and by letters. But due to present political and financial situation in the European Union doing lobby work for the neglected and poverty related diseases Malaria was not always easy. Despite progress, the malaria-related targets were still not reached. 216 million cases of malaria were reported and 655.000 people died of malaria worldwide in 2010 compared to about one million in 2000. This is a reduction of about 20%, achieved mainly through a vast increase in international funding for malaria control. But the WHO 2010 goal to halve the malaria burden was not achieved. Global estimates indicate that USD 5.1 billion are needed each year to fully fund the fight against malaria, but only USD 2 billion were globally disbursed in 2011. But more funding alone for procurement of current tools is not the solution to the problem. Today, malaria can be prevented, diagnosed and treated with a combination of existing tools, but given the threat

of drug resistance, new, affordable, effective and innovative health tools urgently need to be developed. In addition, currently available interventions are not easily available to the affected population. Accessibility, acceptability and affordability of control interventions remain major problems that can only be fully addressed once countries develop stronger health systems.

Only with a functioning and locally accepted health infrastructure in place, can access to prevention, diagnosis and treatment of malaria be ensured for all people in need. Strengthening local health systems therefore significantly contributes to reducing the malaria burden, offering a viable and sustainable option for development at the same time and should be included international community´s malaria control efforts. STOP MALARIA NOW! conducted a research study in Kenya to find out more about the mutual interrelation between malaria control interventions and the strengthening of local health systems. Results are provided for downloading on the campaign´s website.

The campaign came to its end, but nevertheless further lobby and awareness rising activities still remain necessary. Project partners will continuing their work and lobbing to malaria related issues and hope to continue their established network in the fight against malaria.

- Authors: Bernd Pastors, CEO of action medeor e.V., and Kristina König, STOP MALARIA NOW/action medeor e.V.
- The campaign website is still accessible: www.stopmalarianow.org

EDGAR WIDMER

CONTRACTING BROUGHT TO THE UNIVERSAL LEVEL OF THE CATHOLIC CHURCH

The promotion of the integration of private not for profit (PNFP) health facilities in national health systems has been a strategic priority of the Medicus Mundi International Network over many years. MMI has been strongly advocating the development of contractual arrangements between private not for profit facilities and Ministries. Since 2009, it has become rather quiet around the contracting issue. For MMI, there are no concrete plans how the Network shall follow-up this issue which is still highly relevant for several of its members. In his report, "contracting activist" Edgar Widmer nevertheless links a highlight of the year 2011 with an overview on MMI contracting milestones.

My highlight of 2011 certainly was the invitation by the president of the Pontifical Council for Health to take part in the first global meeting of bishops responsible for health within bishop's conferences. The conference took place in the Vatican City, on 23 November 2011, and dealt, among others topics, with cooperation between church and state in the field of health care. I was asked to explain Medicus Mundi's experience in the promotion and implementation of the WHO resolution on contracting. The fact that, after years of promoting strategic reorientation of African church health services through intensifying partnership with the state within the national health system, it was really satisfactory that the topic of contracting was brought to the universal level of the Catholic Church.

Having explained the mandate of the Medicus Mundi International Network and the definition of contracting I tried to enumerate some of the steps towards contracting and the way Medicus Mundi International succeeded to rise awareness among WHO and its member states on the importance of church health work. This was done by:

- participating, in 1983, in the Working Group on Health of COR UNUM confirming the paradigm shift "from a Pastoral for the sick to a Pastoral for health" and proposing the creation of a specific dicasterium for health;
- organising 1984 in Rome a dialogue among 17 African Ministers of Health and Christian Health Associations demanding for the first time that "NGOs and governments should move from simple collaboration and exchange of information to true agreements";
- presiding at the 38th World Health Assembly in 1985 the technical discussions dealing with "The importance of private not for profit contribution for the implementation of Primary Health Care in a national health policy";

- intervening at the World Bank Conference "Better Health for Africa" in Dakar, 1998, in favour of the Christian Health Associations, explaining their importance as "development partners";
- promoting the idea of a resolution on "Contracting NGOs for Health" in a side event during the 52nd World Health Assembly 1999 and provoking the immediate endorsement by the observer of the Holy See;
- organising in 1999 consultations among public and private health institutions in Conakry and Dar es Salaam in view of a draft for a WHO resolution on contracting;
- advocating in favour of the draft at the WHO Executive Board meeting in January 2001 and obtaining the confirmation that contracting is of global interest;
- assisting in May 2003 in the adoption of the WHA resolution 56.25 with the title "The role of contractual arrangements in improving health systems' performance";
- organising from 2000 to 2010 several working conferences among African associations of bishops conferences with the aim of awareness-building for public private partnership and by publishing their reports and declarations;
- participating together with AISAC in the preparation of "A contribution of Catholic Health Care Institutions to reconciliation through health care" for the Synod of African Bishops, in October 2010;
- analysing between 2007 to 2009 contracting challenges between faith-based health institutions and public health authorities in four African countries, presenting the results in a side event to the WHA in 2009, publishing the conclusions and recommendations ("Contracting between faith-based and public health sector in Sub-Saharan Africa: An ongoing crisis? MMI/ITM 2009) and sharing the results with the stakeholders in a workshop at the Makerere University in Kampala, in 2009.

The talks I had with representatives of 15 countries showed me that, on all the continents, the Church still plays an important role in health services provision, fillling gaps in the national health systems. Defending ethic values is rather a key concern of the central Church structures, whereas, on a grassroot level, the church is focusing on alleviating human suffering and promoting health for all. Getting better integrated in national health systems is a vision shared by most of the church representatives, even if there are no quick-fix solutions.

The year 2012 has started with more good news: The contracting study is now published in the SSHOP series the Institute of Tropical Medicine Antwerp (No. 29, April 2012).

- Edgar Widmer, former president of Medicus Mundi International. MMI "contracting" page: www.medicusmundi.org/en/topics/contracting. Photo next page: SolidarMed


POSTO DE SAÚDE

2011: FINANCIAL FACTS & FIGURES

Capital Account

Assets	Previous Year		2011	
I. Long-term fixed assets		7'979.00		1.00
II. Short-term fixed assets		116'685.99		126'961.54
Cash in hand	109.26		107.03	
Cash in banks	116'576.73		121'638.71	
Other assets	0.00		5'067.27	
Active deferral position	0.00		103.53	
Total Assets		**124'664.99**		**126'962.54**

Liabilities	Previous Year		2011	
I. Net equity		107'679.95		99'767.14
Status 1st January	97'451.07		107'679.95	
Net loss	10'228.88		-7'912.81	
II. Accruals		4'500.00		3'415.50
III. Project funds not yet appropriated		0.00		7'541.00
IV. Other liabilities		12'235.04		16'238.90
V. Passive deferral position		250.00		0.00
Total Liabilities		**124'664.99**		**126'962.54**

Statement of revenue and expense

Revenue	Previous Year	Budget 2011	Accounts 2011	Budget 2012
Membership contributions	78'700.00	80'100.00	79'100.00	74'600.00
Donations and subsidies	1'044.87	0.00	0.00	0.00
Interest and similar income	1'757.40	1'000.00	809.89	1'000.00
Income for project administration	125.67	2'000.00	0.00	0.00
Other income	0.00	0.00	519.25	0.00
Subtotal Revenue	**81'627.94**	**83'100.00**	**80'429.14**	**75'600.00**

Expenses	Previous Year	Budget 2011	Accounts 2011	Budget 2012
General expenses secretariat	48'000.00	60'000.00	62'286.32	60'000.00
Travel costs / hospitality / Network events	5'752.49	15'000.00	10'538.33	11'000.00
Other expenses secretariat	2'504.77	5'500.00	3'315.69	3'050.00
Public relations and printed matter		2'500.00	401.83	0.00
Project expenses not covered by project funds	1'170.97	0.00	0.00	0.00
Other expenses	5'504.83	6'700.00	3'821.78	6'700.00
Investment and related depreciations	8'466.00	7'979.00	7'978.00	0.00
Subtotal expenses	**71'399.06**	**97'679.00**	**88'341.95**	**80'750.00**
Net win / loss	**10'228.88**	**- 14'579.00**	**- 7'912.81**	**-5'150.00**

All figures in EUR. Budget 2012 as accepted by extraordinary General Assembly in Brescia, October 2011

This is a summary of the financial statements of the MMI Network. Details and explications will be given at the Network's General Assembly in May 2012. The "Report on the Audit of the Financial Accounting as of December 31, 2011 for the Association Medicus Mundi International e.V." by thp treuhandpartner gmbh, Krefeld, Germany, is available at the MMI secretariat.

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