



ANNUAL REPORT 2012

*In the center of the debate:
health systems strengthening
and global health governance*



MMI Network: Annual report

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Medicus Mundi International Network: Annual Report 2012

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For your donations, please mainly consider the MMI Network members. Thank you.

MESSAGE FROM THE PRESIDENT

NICK LORENZ, MEDICUS MUNDI SWITZERLAND

In many aspects 2012 has been a good year for the Medicus Mundi International Network. We have been able to make headway with the implementation of our strategy 2015. And the voice of the MMI Network continues to be heard at international level.

In particular in two areas the Network's contributions are outstanding: in the Global Health Governance discussions where MMI is supporting the WHO reform and involved in the debate on health post-2015, and in the field of Human Resources for Health. Also in the area of linking research and evidence process within the MMI Network we have made substantial progress.

The positive development is reflected by the fact of four new organizations joining the Network. On a less visible side we have strengthened our monitoring system and are now in a better position to document progress in the implementation of our strategy. The external review planned for 2013 is an additional element of our monitoring.

In 2013 the MMI Network will celebrate its 50th birthday. In an annex to this report, we collected voices and portraits of the Network's presidents since its origin. I am convinced that also in the jubilee year the Network will continue to be in the centre of the debate of health systems' strengthening.



A handwritten signature in black ink, which appears to be 'Nick Lorenz'. The signature is stylized and written in a cursive-like font.


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50 years 1963-2013

IMPLEMENTING THE NETWORK STRATEGY: FROM INITIAL NETWORK PROGRAMS TO SYSTEMATIC WORK PLANS

In its meeting in March 2012, the Board concluded the discussion on the first year of implementation of the MMI Network strategy 2011-15 as follows: “The first programs have been developed in an informal way, starting from an overall task, doing things, making experiences, learning and continuously adapting plans. After these experiences it is now time for more rational planning. This shall be done on both the strategy and program level.”

In May, the Board agreed on detailed work plans 2012-13 proposed by the secretariat and the existing working groups for the following areas:

- Research and evidence process within the MMI Network
- Working Group on Human Resources for Health
- Global Health Governance Team
- Network development

We will structure the following report along these work plans. Each sections start with a quote of the main objectives for the years 2012-13 such as stated in the respective plan.



RESEARCH AND EVIDENCE PROCESS WITHIN THE NETWORK

- *The MMI Network will develop a set of tools for NGOs interested in “getting evidence into NGO practice and policy and getting NGO practice into research”.*
- *The MMI Network will establish and test a platform/marketplace for NGOs “in search of research” and young researchers.*
- *The MMI Network will strengthen its role as NGO platform for knowledge sharing and information brokering related to action research and research partnerships, using and further developing the Network’s existing structures and communication tools and supporting related activities of its members.*

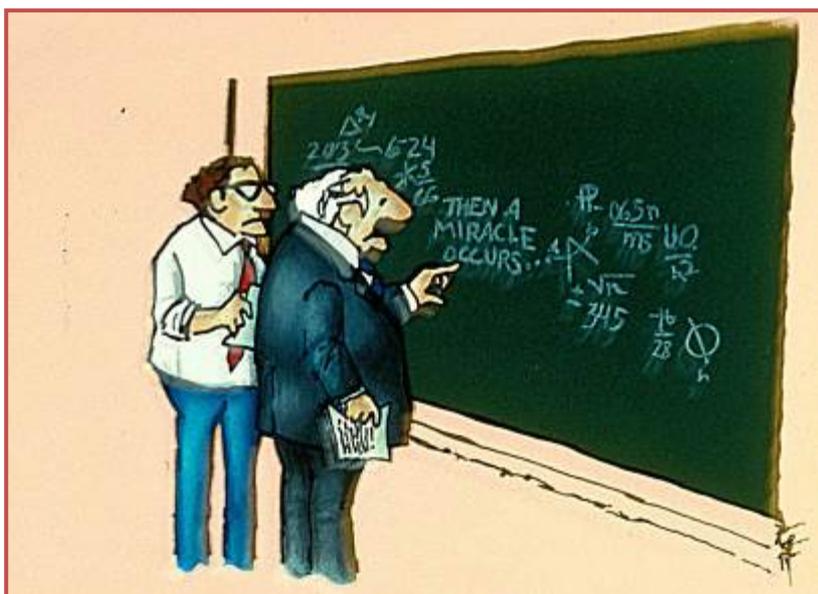
In January 2012 a MMI delegation met with the Council on Health Research for Development (Cohred) in Geneva. We introduced, in a lunch event attended by all staff of Cohred, the MMI Network and its work in the field of research partnerships. We then shared with Cohred our plans to create a structural interface/marketplace/platform for cooperation between research institutions and NGOs both in the North and South. Having had a closer look at the Health Research Web (www.healthresearchweb.org) developed and run by Cohred, we were briefed by Cohred how this networking tool is used and how the specific needs of NGOs could be integrated. Since then, informal contacts with Cohred have been sustained, and a representative of the Council participated in the MMI meetings in May and October.

In March 2012, the Board organized a re-launching event of a wider MMI research working group as a side event to its meeting in Basel. Elements of a work plan were discussed, and we had talks and a visit at the Swiss Tropical and Public Health Institute in order to see how they did operational research and what they could offer to the MMI Network and its members. The input by Kaspar Wyss, Swiss TPH, on “Health Sector Reform in Tajikistan: accompanying operational research adds spice” led to a discussion if the way the Swiss TPH makes use of students who need to do research for their MSc and PhD thesis could be a model for NGOs: “The advantage is obvious: there are no staff costs involved. On the other hand, the young researchers need to be supported and well introduced in the local context, the NGO’s project/program and the research questions. In addition to European students and research institutions (TropEd) that could be asked for such ‘low cost’ partnerships, a challenge would be to identify national or local institutions and researchers in the countries NGOs are working.”

This then led the way to the development of the MMI “marketplace” project.

In May 2012, a master student at the Swiss TPH, supervised by MMI president Nick Lorenz, started a thesis project on “getting evidence into NGO practice and policy and getting NGO practice into research”. Referring to the background well known to MMI and the overall research question “how can NGOs generate, access, share and use reliable evidence”, and intending to do the study in close cooperation with MMI, Nicole Moran started to develop and collect a set of related tools. In addition to the expected concrete results, the involvement of the MMI Network in this master thesis project is itself a concrete case study of a partnership between an NGO (MMI), a young researcher and a research institution. The analysis of the related process will inform the further development of such partnerships.

In June, Medicus Mundi Switzerland focused its technical workshop of 2012 on the topic of “evidence based work” and the related needs and capacities of small NGOs. Medicus Mundi Switzerland invited the MMI executive secretary to organize this workshop together with them. Thomas Schwarz afterwards inquired at the MMI Network members if there were any



further plans of national workshops on evidence based work and NGO-research partnerships: If yes, they certainly can build on the existing experiences.

“Getting evidence into NGO practice and policy”: At a workshop hosted by HealthNet TPO during the MMI Network meeting in Amsterdam, in October 2012, members of the Medicus Mundi International Network and other NGOs working in the field of international health cooperation learnt from the new Network member HealthNet TPO and from Memisa Belgium how they deal with the challenge of getting evidence into their practice. In a second part, NGOs and representatives of research and teaching institutions discussed the feasibility of the project initiated by the MMI Network to create a “marketplace” for NGOs and young researchers. After that workshop, concrete preparation of the “MMI marketplace” started, and the project was launched in early 2013.

- *MMI Network – get research into policy and practice!*
Documentation and thematic guide: www.bit.ly/mmi-research

WORKING GROUP ON HUMAN RESOURCES FOR HEALTH

- *The MMI Network will become a leading civil society actor in the follow-up of the WHO code of practice on the international recruitment of health personnel (agreed MMI Network Program)*
- *The MMI Network will become an active and leading member of the Health Workforce Advocacy Initiative (HWAI), linking HWAI with Network members and activities.*
- *The MMI Network will strengthen its role as NGO platform for knowledge sharing and information brokering related to addressing the human resources for health crisis, using and further developing the Network's existing structures and communication tools.*

MMI was strongly involved in the development of the WHO code of practice on the international recruitment of health personnel and in the advocacy for its adoption at the 63rd World Health Assembly in May 2010. Since then, the Network and some members have been advocating on an international (mainly European) and national level for proper Code implementation.

In March 2012, Remco van de Pas, Wemos, was invited as a speaker to a conference organized by Action for Global Health in Berlin. His three theses on “Negotiating global health at the World Health Organization: The case of the Global Code of Practice on the



International Recruitment of Health Personnel” were afterwards published in MMI’s “Get involved in global health” blog. The main conclusion is still valid:

“We should look beyond current short-term political goals and consider longer term health workforce requirements for health systems within Europe as well as in countries with crucial shortages. In each member state separately, and at EU level, we should ask to what extent WHO matters for global health policies and norm setting. We might become more dependent on foreign health workers than we can envisage now, hence it is important that we provide WHO with enough resources and mandate to fulfil its tasks regarding health worker migration, regulations and to link this with the structural determinants of health development.”

At the 3rd People’s Health Assembly in Cape Town, in July 2012, Linda Mans, Wemos, and the MMI executive secretary Thomas Schwarz contributed to a sub-plenary on human resources with an input on “Human resources for health – key global issues and debates”.

In September 2012, when WHO Europe held its Regional Committee meeting in Malta, Remco van de Pas, Wemos, was invited as a speaker at a technical side event on “Action towards achieving a sustainable health workforce and strengthening health systems: implementing the WHO Global Code of Practice in the European Region”. He presented civil society reports on Code implementation in nine European countries, mainly collected by MMI Network members. These case studies, later on also published in the Bulletin of Medicus Mundi Switzerland, found great attention and were even quoted in the WHO secretariat’s report on Code implementation to the 66th World Health Assembly, in May 2013: “A nine-country case study from the European Region has shown that civil society has also played a considerable role in monitoring health workforce migration, adopting a rights-based approach that considers both the rights of health workers along with the need for equitable and sustainable health systems.” But this will be a next chapter...

As a member of the Global Health Workforce Alliance (GHWA), and within the process of reviewing the GHWA strategy, MMI made, in June 2012, a strong plea for better alignment of the Alliance and the HRH desk at the World Health Organization: “Relationship between and mandates of both WHO and GHWA require to be clarified and cooperation needs to be seriously improved. As a large NGO network we have observed ourselves the difficult relation between the two organizations. Except for the work on the global code of practice on the international recruitment of health personnel, we have rarely seen the two organizations speaking on the same panel, conducting joint programs and planning or providing joint reports or communication on particular HRH aspects. This requires consideration as both secretariats are actually hosted in the same WHO headquarters building in Geneva. Indeed, the Country Coordination and Facilitation (CCF) program of GHWA and its technical components actually overlap with the mandate of WHO to conduct normative and technical work.”

After the decision of Wemos, in July 2012, to withdraw from running the secretariat of the Health Workforce Advocacy Initiative (HWAI), the MMI executive secretary, as a member of the HWAI Steering Council, was strongly involved in several processes related to the future of HWAI, such as a dialogue with the Global Health Workforce Alliance about their relationship to HWAI, the finalization and adoption of the HWAI Network Policy (using the MMI Network policy as key reference) and the selection of a successor of Wemos for the HWAI secretariat.

EU project "Health workers for all and all for health workers" involving the MMI Network and several members and partners: In November 2011 a consortium led by MMI member Wemos and involving the MMI secretariat, several Network members (Medicus Mundi Spain, Memisa Belgium, Health Poverty Action, Redemptoris missio) and partners outside the Network submitted to the EU their project proposal “Health Workers for all and all for Health Workers”, focusing on advocacy and awareness building for Code implementation in eight European countries. The proposal was accepted in Summer 2012. Since then, preparation of the project implementation started. The secretariat reported on this project at the Assembly in Amsterdam, also regarding organizational and financial aspects of the Network’s involvement.



The project aiming at increasing coherence between development cooperation policies and domestic health policies and practices of European Member States with regard to the strengthening of the health workforce in countries with a critical shortage of health workers will cover the years 2013-15.

- *MMI Network – Human resources for health
Documentation and thematic guide: www.bit.ly/mmi_hrh*

GLOBAL HEALTH GOVERNANCE TEAM

- *Within the “Democratizing Global Health” Coalition, the MMI Network will be a leading civil society actor in WHO reform process, with a focus on establishing better relations between WHO and public interest NGOs and improving coordination of WHO related civil society initiatives.*
- *The MMI Network will, as an affiliated network, establish strong links to the People’s Health Movement, with a focus on contributing to the better definition of the relations between NGOs and social movements.*
- *Global health governance, right to health, health equity, health and sustainable development: MMI will establish and strengthen links with existing initiatives, platforms and campaigns such as JALI (Framework Convention on Global Health), Beyond 2015 (post MDG) and campaigns.*
- *The MMI Network will strengthen its role as NGO platform for knowledge sharing and information brokering related to global health policy and governance, using and further developing the Network’s existing structures and communication tools.*

After an informal start in 2011 with two team members only, the “global health governance team” involved, in 2012, representatives of Wemos, medico international, Medicus Mundi Spain, CWGH and Health Poverty Action, and the MMI executive secretary. Communication platforms such as the [“get involved” blog](#), the [“MMI updates”](#) on Twitter and the [thematic guides](#) on the MMI website have been further developed.

Since the start of the WHO reform process in January 2011 and throughout the year of 2012, the Medicus Mundi International Network has been strongly involved in this process, first as an NGO in official relations with WHO, but also contributing to the creation and implementation of a “Democratizing Global Health Coalition on the WHO reform” (DGH). In 2012, the MMI secretariat was not only participating in all related events and hearings organized by WHO and DGH, but acted as an informal communications hub for the DGH Coalition and for civil society involvement in the WHO reform, publishing related events and statements in a thematic guide on the MMI ePlatform and through other channels such as e-mail and twitter.

An example of the active involvement of MMI in this process: In April, MMI submitted to the WHO secretariat, after consultation with like-minded NGOs and the MMI Board, a proposal for a “open space for civil society” at the World Health Assembly. Unfortunately this proposal for “affirmative action” was never seriously considered.

At the World Health Assembly in May 2012, MMI hosted a civil society side event on the WHO reform. The well attended event at the Palais des Nations provided the venue for an open and public dialogue on issues that civil society organizations considered critical for building a healthy and democratic future for the WHO. The panel also presented some ways forward to be considered by member states to ensure WHO's policy leadership on health, its ultimate responsibility.

MMI also continued its support of the “WHO Watch” program of the People’s Health Movement in which young health volunteers follow the proceedings of the EB and World Health Assembly. These volunteers gather before the WHO meetings in workshops and prepare the topics on the agenda. A written report and analysis is also used for advocacy purpose. MMI contributed to these workshops, hosted the WHO Watchers in the Network’s delegation and facilitated joint statements.

Otherwise, in the field of global health governance, right to health, health equity, health and sustainable development, new initiatives have continued to be mushrooming, and their relevance and sustainability has not always been obvious. The MMI global health governance team carefully weighs the value of these initiatives and whether there is a complementary value for MMI to be involved. Formal membership needs to be approved by the Board.

In spring 2012, the MMI secretary participated in a strategic meeting of JALI, the Joint Action and Learning Initiative on National and Global Responsibilities for Health, contributed to the development of the JALI manifesto “Health for All: Justice for All. A Global Campaign for a Framework Convention on Global Health” and signed the manifesto before it was published in May 2012.

In early 2012, MMI joined the Partnership for Maternal, Newborn and Child Health (PMNCH), a global health partnership launched in September 2005 to accelerate efforts towards achieving Millennium Development Goals (MDGs) 4 and 5 – to reduce child mortality and improve maternal health. According to Stefan Germann, Civil Society representative in the PMNCH Board, NGO influence in the agenda setting of PMNCH is limited; other constituencies are stronger. Therefore monitoring and challenging PMNCH are a task for civil society members, in addition to using the Partnership as a platform for sharing and joint advocacy. Nevertheless, Stefan Germann, at the MMI Network meeting in Brescia in October 2011, very much encouraged the MMI Network and its members to join the Partnership, which was agreed by the Board in March 2012.

In May, MMI also joined a “Civil society call for action on Universal Health Coverage”, calling for states to deliver universal access to health systems according to their legal commitments to the Right to Health. However, in autumn 2012, when the debate on health in the post-MDG development agenda started to heat up (see below) and Universal Health Coverage (UHC) was promoted by WHO as the new overarching and universal health goal, MMI hesitated to follow the pace of the “UHC enthusiasts”, as coverage alone cannot be sufficient, good governance of the health system (including strong accountability mechanisms and continuous participation of a representative civil society in the policy making) and good quality of health care services are equally important. And we have not even yet talked about ‘globally Universal Health Coverage’. The international solidarity mechanisms towards countries unable to realize a decent level of coverage needed for UHC should be truly comprehensive instead of a selective package. And we have not talked about the political, economic and social determinants of health and the underlying power relations not addressed by UHC: The conditions in which people are born, grow, live, work and age, including the equity of these conditions, have a greater impact on population health than health care services. A topic and discussion to be followed up in 2013.

And last but not least, MMI joined the People’s Health Movement (PHM) as an affiliated Network in spring 2012. As its name says, PHM is a movement, not an organization. PHM started with activism since its initiation in 2000 and is getting more formalised now. Invitations to MMI and other networks such as TWN, IBFAN, HAI to join the PHM as affiliate networks and the documents MMI received from the PHM secretariat showed this process of institutional development. Published in 2000, PHM’s “People’s Charter for Health” is still a strong and inspiring document.

At its meeting in Basel, March 2012, the MMI Board decided to endorse the People’s Charter for Health, to join PHM as an affiliated Network, requesting at the same time the MMI secretariat to contribute to the further institutional development of PHM towards a Network of Networks, including international NGOs. Later in 2012 MMI got formally involved in PHM’s Steering Council via a representative seat. PHM affiliation will be reviewed and eventually confirmed by the Board within the coming two years, based on a report by the MMI Secretariat on the outcome of the further institutional development of PHM and the development of cooperation between MMI and PHM.

The third “People’s Health Assembly” (PHA3) organized by the People’s Health Movement took place at the University of the Western Cape in Cape Town, South Africa, in July 2012. The MMI secretariat together with Network members and other NGOs contributed to the Assembly with two workshops entitled “In the public interest? The role of NGOs in

national health systems and global health policy”. The workshops provided space for a critical reflection on the role and the future of private not for profit health service providers and international NGOs: What does it need to make NGOs part of the solution and not the problem? We linked the discussion on the integration of NGOs in national health systems with debates on the role of NGOs in global health governance and civil society.

NGOs and social movements for health – this is not an easy relationship. Two tribes, two cultures, two languages and quite a bit of bad experiences, prejudice, mistrust and misunderstanding. The two well attended workshops led to some intensive debates which made it clear that the dialogue between representatives of NGOs and social movements – even if both share the goal of health for all – needs to be continued and deepened. We did a start – and are looking forward to more.

In autumn 2012, health in the post-2015 development agenda became the key issue to follow, dominating the discussions on global health policy: UN was putting in place a series of thematic consultations on the post-MDG development agenda. Health was one of the 11 topics covered. The consultation on health led by WHO and UNICEF took place between October 2012 and February 2013. It included a web-based consultation, the development of a series of background papers (both on lessons learned from the current MDGs as well as future directions) and a series of consultative meetings with Member States, non-governmental organizations, private sector partners and academic and research institutions.

Having joined “Beyond 2015”, a global civil society campaign pushing for a strong and legitimate successor framework to the Millennium Development Goals, already in 2011, MMI was asked to coordinate the drafting of a Beyond 2015 position paper for the consultation based on input by a wide range of civil society organisations and in particular on the perspectives of the Global South. The drafting process coordinated by the MMI executive secretary started with the collection of initial input received from Beyond 2015 members, a discussion on initial bullet

points and with a first draft by lead authors Mariska Meurs and Remco van de Pas (both Wemos). After an intensive drafting process, the report was submitted to the UN team at the end of the year.



...what next?

The MMI secretary was also invited to report on the topic of “health post-2015” at events organized by Action for Global Health in Madrid and by the Geneva based NGO Forum for Health at the International Labour Office in Geneva. This helped to strengthen the already well established links between MMI and these two “sister” Networks. We believe that it was crucial for MMI to get involved in the thematic consultation and the related debate and publications: It created great opportunity for building bridges, discussing and developing civil society positions, and finding an overall understanding on the role of health in the future we want. To be continued in 2013!

- *MMI Network – Global Health Policy and Governance*
Documentation and thematic guide: www.bit.ly/ghgovernance

NETWORK DEVELOPMENT

- *The MMI Network meetings will become milestone events for linking Network members and jointly working on key topics within the overall framework of health systems strengthening.*
- *MMI will further develop and promote its electronic platform as key tool for information sharing among the Network members (also project related: who works where/in what fields?).*
- *The MMI Network will provide a platform for reflecting and discussing the role and responsibility of NGOs in national health systems.*
- *Integrating the “universal health coverage” approach, MMI will establish and strengthen links with existing initiatives and platforms dealing with health systems strengthening and related topics.*
- *Networking between NGO networks: The MMI Network will analyze and strengthen its relations with those members being themselves networks (EPN, ACHAP, MM Switzerland and Spain) and with sister networks.*
- *The MMI Network will further promote Network membership.*

The MMI Network strategy states: “The Network intends to become really global – also regarding the membership – and invites organizations from the South and the North dealing with international health to join in. We will develop easy procedures for the admission of new Network members, including new regulations on membership contributions. We will

systematically involve the newcomers in the further development of the Network, its governance structure and its programs.”

Since the Network Policy and Strategy were accepted, the Network membership has considerably grown. After the Amsterdam Network meeting in October 2012, MMI counts 20 members instead of 10 in 2009. This implies that we have to make an effort to integrate views and proposals of the new members, keeping at the same time the leadership and ownership of the “old” members alive. Members’ involvement in Network activities is growing, but still ranging from zero to full power. On the other hand, with MMI involved in the WHO reform debate, in the institutional development of the Health Workforce Advocacy Initiative, in various initiatives related to global health governance (see above) etc., other NGOs active in these fields have become aware of the Network and its role/value and might be animated to join the Network.

Network development and consolidation became also a topic of discussions in the Board and the Assembly:

An external midterm review of strategy implementation to be undertaken in 2013 shall collect members’ voices about how the activities undertaken relate to the Network’s mission: contributing to the development of capacities of its members and providing a platform for joint activities.

The structure (or not really visible rationale structure) of the current membership fees and the obvious differences among the new members and between the new members and the old ones led to a discussion. The current contribution key is both grown over time (old members) and negotiated (new members: based on the estimated financial potential). Even if members agree that there is “value for the money” and that the future of the Network will depend on the quality of our work and its benefit for each member, there is a need to investigate into a harmonized, more rational overall membership key and into possible new sources for broadening core funding. The Amsterdam Assembly therefore requested the Board to put the membership fees structure on the agenda of its next meeting in March 2013.

The MMI Network event in Amsterdam was much more than just a gathering! On the 11th October 2012, the Medicus Mundi International Network organised a one day expert meeting, hosted by Cordaid at the Royal Tropical Institute (KIT) in Amsterdam, on the theme of “Health Systems Strengthening and Conflict Transformation in Fragile States”. The meeting was very much inspiring and, as the event in Brescia in the previous year, a model for future similar Network events. In the following paragraphs, we quote the meeting report by Egbert Sondorp and Selma Scheewe:

The Mauritszaal in KIT was filled to capacity. MMI members and representatives of a range of NGOs and academic institutions came together. The purpose of the meeting was to explore if it is possible to strengthen health systems and address fragility at the same time, or as Egbert Sondorp (Senior Advisor, KIT) summarized it: “Can we kill two birds with one stone? How and what are the various pathways? And can we measure and get funding for it?”

The meeting brought together approximately ninety MMI members and representatives of a range of NGOs and academic institutions. The purpose of the meeting was to explore if it is possible to strengthen health systems and address fragility at the same time. It intended to facilitate learning and information sharing on health sector initiatives that aim to improve health outcomes, contribute to longer term, sustainable health system strengthening and conflict transformation, in order to inform programming, policy, advocacy and further research.

The participants were welcomed by Nicolaus Lorenz, President Medicus Mundi International Network, who chaired the day. Health systems strengthening and fragile states was one of the research areas identified as being important for MMI partners. This conference was organised to help MMI partners to translate NGO practice in research questions and forge partnerships between NGOs and the research community in line with the above mentioned Network Strategy. See also; <http://www.medicusmundi.org/en/network-programs>.

The day consisted of a mix of plenary presentations, working groups and discussion. The day was then started with a set of introductory remarks by Cordaid and KIT and a keynote speech by a representative of the UK Overseas Development Institute (ODI) to introduce the theme of health system strengthening and conflict transformation. In three working groups, a total of 11 country case studies were presented and discussed covering real life examples around this theme. In the afternoon, a range of different perspectives came across through five short Pecha Kucha presentations, followed by a plenary debate and concluding remarks.

- www.bit.ly/mmi-amsterdam2012



FROM BASEL TO AMSTERDAM – WITH STOP-OVER IN GENEVA

Board meeting, 16 March 2012 in Basel: The Board meeting of the Medicus Mundi International Network hosted by the Swiss Tropical and Public Health Institute included a re-launching event of a wider MMI research working group and discussions with staff of the Swiss TPH.

Assembly and Board meeting, 25 May 2012 in Geneva: As in previous years, the Assembly took place in the week of the World Health Assembly. We met at the Ecumenical Institute Château de Bossey. The agenda included the admission of HealthNet TPO as a new Network member and the election of Fabian Schumacher as a new Board member. Congratulations! A dinner on Thursday evening and meetings of the MMI working groups on research and human resources as well as a Board meeting were the main side events to the Assembly.

Network meeting, 10-11 October 2012 in Amsterdam. The highlight of the Extraordinary Assembly of the MMI Network hosted by HealthNet TPO in Amsterdam, on 10 October 2012, was the admission of three new Network members (medico international, CWGH, Health Poverty Action). The statutory meetings of the Network were complemented (and more than this!) by a workshop on NGOs and research and by the expert meeting on health systems strengthening in fragile states – see specific reports.



According to the statutes of the Medicus Mundi International Network legal persons and nationally or internationally organized groups of individuals ready to adopt and able to promote the aim of the organization, may become members of the organization. The General Assembly decides on the admission of new members. The Network Policy defines the condition for MMI membership as follows: MMI Network membership is open to private not-for-profit institutions that are working in the field of international health cooperation or advocacy; share our vision of Health for All; are committed to joining forces toward achieving shared goals, participating in Network activities and contributing to the development of the Network; are able to fulfil the related duties.

In 2012, the Network welcomed four new members.

HealthNet TPO, The Netherlands

HealthNet TPO is a “knowledge-driven aid agency building health and community systems in fragile states”. Its mission is “to enhance the ability of communities in fragile countries to better manage and maintain their own health and wellbeing”. HealthNet TPO uses “health” as both a goal and means: the goal is to reach accessible health care for all. By working on that together with local communities HealthNet TPO uses “health” as a means to bring people together and to restore mutual trust.

Mission and vision: Our mission is to enhance the ability of communities in fragile countries to better manage and maintain their own health and wellbeing. Our vision is to do this by using “health” as both a goal and means. We do not provide emergency or development aid. We try to close the gap between the two by working on reconstruction., which means we apply a developmental approach in prolonged emergency situations.



Research: HealthNet TPO is a knowledge-driven organization. This means our activities are based on scientific research and we continuously monitor their efficiency. We also develop new methods to improve the health of people in distress, which are regularly adopted by colleague organizations.

Themes: The health of a population is more than the sum of its parts, while people cannot heal in an “unhealthy” society. We therefore use an integrated approach through which problems are addressed from several angles.

Activities can roughly be divided into four main themes:

- Mental Health and Psychosocial Support
- Disease control
- Health financing
- Community Systems Strengthening

Fragile States: HealthNet TPO mainly works in areas where war, violence and natural disasters (still) have an impact on daily life. These areas, the so-called “fragile states”, are characterized by a lack of infrastructure, resources and political strength to build or re-establish public services. Peace agreements are one of the first steps towards social recovery, but such agreements are impossible without community trust. Since 1992 we have implemented projects in 27 countries. At the moment we are actively working in six countries.

Source: www.healthnettpo.org

medico international, Germany

Medico international struggles for the human right to the best possible access to good health. In doing so we support local partners, primarily in Africa, Asia and Latin America, in their endeavours to create the economic, social and cultural conditions which allow each person to attain the highest health standard possible. In particular medico stands by those who are in situations of emergency and in poverty, including refugees and the victims of war.



medico international

Medico works ... with partners. The assistance provided by medico is more than the supply of relief goods in emergency situations. We see our work as an element within comprehensive social action that aims at the implementation of the right to health. In this effort we are not focused on short-term "interventionist aid missions". Our concern is to cooperate in a spirit of solidarity and trust with people who are our autonomous partners and anything but mere recipients of aid. Our common point of departure is marked by the political and social aims that we share with our partner organizations in the South. The continuous exchange of experiences, openness in our interactions with the partners and a constant reflection of existing dependencies and individual interests also form part of these aims.

Medico works ... in context. Those who through ignorance of important political and cultural linkages do not understand the root causes of human distress will not be able to react adequately to such distress. Wars and affliction are never a bolt from the blue. They have underlying reasons that must be challenged. Medico adheres to the principle of context-oriented assistance, even

though the media at present publicly celebrates mostly direct hands-on support that does not dwell on political issues before getting started. The aim of our efforts is not simply targeted at alleviating humanitarian crises, but at overcoming them permanently.

Medico works ... for change. Any assistance granted to people leaves traces that will remain long after the original intervention. Therefore, assistance aimed at overcoming the status quo presupposes a socio-political vision of a different and more just world. It must develop strategies that can serve as a roadmap. There are no humanitarian solutions to humanitarian crises. We believe that assistance is an element within social action that fights for democracy, social justice and respect for human rights – together with the victims of destitution and despotism.

Source: www.medico.de

Community Working Group on Health, Zimbabwe

The Community Working Group on Health (CWGH) is a network of civic/community based organizations who aim to collectively enhance community participation in health in Zimbabwe. The CWGH was formed in early 1998 to take up health issues of common concern.

Over the years the CWGH has positioned itself as a voice in the health sector and built community power, organizing involvement of communities in health actions within their communities and around Primary Health Care, whether within the community on environmental health, or mobilizing resources to support health centres. These are being done through community level initiatives with limited external support.



The CWGH will consistently engage with the stakeholders and the government to make PHC a more central policy principle, and will strengthen community structures such as health centre committees and boards and committees at district and national level to organize public efforts to achieve this principle.

At an international level, CWGH is partnering with the People's Health Movement in the Right to Health Campaign; it is also a member of the Regional Network in Equity in Health in East and southern Africa (EQUINET), and the Health Civil Society in East and Southern Africa.

Source: www.cwgh.co.zw

Health Poverty Action, UK

Health Poverty Action's role is to strengthen poor and marginalised people in their struggle for health, prioritising those missed out by almost everyone else. Health Poverty Action sees itself as having been born out of the primary health care movement, a few years after Alma Ata. Health Poverty Action has a distinct approach, summarised as a combination of three factors:

We emphasise the need for justice rather than charity. We work to tackle not just the symptoms of poor health, but its root causes. In particular, we recognise the profound importance of the social and economic determinants of health – hence our name, Health Poverty Action.

We prioritise those missed out by others. Development initiatives exhibit a natural tendency to cluster together, the same factors leading numerous organisations to the same areas. This leaves large populations with almost no support at all. They may be living in hard-to-reach areas, or are difficult to support for some other reason.



We specialise in providing a holistic approach. This is especially important for the poorest and most marginalised with little support. They face so many threats to their health. Tackling one in isolation might give the appearance of success, while in reality doing little more than changing the cause of death. Tackling numerous factors together can bring lasting improvements – and also give rise to creative linkages and innovations.

Source: www.healthpovertyaction.org



MMI MEMBER ORGANISATIONS:

SHORT STORIES

THE DOCTOR IS WAITING FOR A SMILE

A smile is one of the first signs that a malnourished child is regaining strength and recovering. A smile is what many doctors await as confirmation of effective treatment. The wait is particularly intense among young doctors at their first experience of the harsh reality of Africa where malnutrition is often, too often, a fact of life for many families.

Daniel is one such doctor, who left Italy at 27 years, having decided to spend six months in Mozambique in the company of Doctors with Africa CUAMM.

“Over the last week or so there have been a few changes to my working day. Initially, I spent part of my time in hospital and part at the city’s peripheral health centres. Now I work in the hospital every day and only occasionally go to the health centres. My schedule has been reorganised because this month I will be working in the Malnutrition ward where patients need to be seen on a daily basis by the same doctor.

The first thing I had to come to terms with was the very existence of a ward dedicated to malnutrition. There is no such facility in Italy. There again, Malnutrition wards are set up in social settings with insufficient access to food, where the children are the first to suffer. The lack of food affects not only the energy required for daily activities (playing and, in many parts of Africa, working), but also the energy needed for growth and development. The situation is complicated by the fact that children obviously cannot find food for themselves and depend on their carers, who in Africa are all too often not the actual parents. What is more, in many families meals are served on a single plate and children are unable to get their fair share and end up eating too little.

This partly explains why children suffer from malnutrition. But why is a ward (the biggest in the Paediatric department) needed to strengthen them up? Why can’t the doctor simply make sure they start eating as they should?

The problem is that these children have not just been malnourished for several weeks. Rather, the malnutrition process develops over months, sometimes years. Children reach a precarious equilibrium enabling them simply to survive. Everything in their totally debilitated bodies weakens and starts wasting away. They have no fat and muscle tissue and lack the strength to move. They don’t even have the energy to think. Their gaze is lost in space and their reaction to any stimulus is simply to weep. Their immune system is weakened, making them vulnerable to all sorts of infection, from respiratory to intestinal. They are unable to eat normally since their intestine is no longer accustomed to receiving and assimilating food. They can’t even drink as

much as they would like, since their heart is used to working with minimal amounts of liquid and would fail if subjected to a sudden increase in volume.

Doctors and nurses have the job of accompanying these children on the long road back to everyday activities. I have therefore learnt how to defend them from infections, defeat existing ones and commence the slow, gradual return to feeding, with small quantities of high-energy preparations to boost their reserves of key vitamins, iron and other micronutrients. The whole process takes from three to six weeks.

According to most of the medical literature I have read, the return of the smile a few days after a malnourished child starts eating again is considered a positive prognostic sign. I was pleasantly surprised to find mention of this kind of sign in what are otherwise impersonal medical articles and manuals. I witnessed a few of these smiles for myself and each time they seemed to say: 'I've made it. I'm back on my feet again.' It is very satisfying to see a child 'back on his feet'. You feel you are doing something worthwhile".



Caring for others, particularly children, is part of the daily routine at Doctors with Africa CUAMM health centres, where African staff, expatriate Italian doctors, students and residents from Italian universities work side by side to guarantee access to treatment.

This is where many young resident doctors in Italy, like Daniel, decide to spend part of their training pathway. Here they learn from others, gain experience in resource-scarce settings and find out how to provide effective medicine with the limited means available in an endeavour to materially implement their role of physician.

So each year we see Italian residents from various disciplines arriving at the African headquarters of Doctors with Africa CUAMM. They are full of energy and very knowledgeable but also concerned about coping with the demands of the immense, often invisible continent of Africa for the first time.

Each resident spends a period of between 6 and 12 months in Africa, during which time they are supervised by a doctor. This is referred to as the JPO (Junior Project Officer) project and over the last 10 years has involved 56 residents in Surgery, Gynaecology and Obstetrics, Infectious Diseases, Internal Medicine, Paediatrics, Hygiene and Public Health, from 15 Italian universities.

A JPO is a period of professional training where doctors “learn on the job”, alongside more experienced physicians. Trainees learn to apply the “essential”, sustainable approach, working with minimum resources, and focusing on intuition and reasoning. Pathologies studied just on paper often become real live cases and there is room for operations research work in a clinical or organizational setting.

Doctors with Africa CUAMM firmly believe in the JPO project and continue to invest in training young people whose skills and energy can overcome the geographical and cultural barriers between the north and south of the world, in the name of truly global health.

- *More information:* www.mediciconlafrica.org



THE SWEET SMILE OF ALEXANDRA

In October 2012 Emergenza Sorrisi – Doctors for Smiling Children N.G.O. and N.P.O. (formerly Smile Train Italia) has completed a humanitarian project to give joy to smile to a 3 years old Ukrainian child called Alexandra.

In the world thousands of children cannot smile because of cleft lip and palate (CLP), a malformation that in the world's poorest countries affects about one child in every 700 births. Cleft lip and palate is an orofacial birth defect in which there is an opening in the lip and/or palate (roof of the mouth) that is caused by incomplete development during early fetal formation. This kind of malformation disfigures the faces of babies and children who are affected, resulting in difficulty also in nutrition, problems with speech and often also a serious social problems caused by the isolation and marginalization to which local cultures condemn these little ones.

In July 2012, the grandmother of Alexandra, who lives in Rome (Italy), went to the office of Emergenza Sorrisi – Doctors for Smiling Children, looking for support and a helping hand to operate his little granddaughter, Alexandra, who lives with her mother in Lutsk, a city in northwestern Ukraine, and who is suffering since her birth by cleft palate.

Collecting all the needed documentation to be submitted to the Embassy to get the visa for medical treatment, the staff of Emergenza Sorrisi – Doctors for Smiling Children organized the trip to Italy for Alexandra and her mother in October 2012.



Upon their arrival the baby was admitted to the hospital in Rome "San Pietro Fatebenefratelli" where she was operated on the following day by Dr. Fabio Massimo Abenavoli, President of the association. The surgery was successfully performed and then Alexandra was hospitalized for three days in the Operative Unit of Pediatric Surgery where she and her mother were supported and helped by all the hospital staff and the team of association.

This humanitarian project has been made possible thanks to the great support and donation received by a supporter of Emergenza Sorrisi – Doctors for Smiling Children, who became aware of the appeal of the Alexandra's grandmother and took this story personally.

The supporter has remained close to Alexandra's mother, grandmother and the baby for the all duration of their stay in Italy giving Alexandra toys and especially clothes, and giving love and affection to the mother of the little baby who did not speak Italian and had many difficulties to understand and relate to. But with the love of our supporter the understanding in gestures and looks came instinctive and spontaneous. Actually Alexandra returned home, she now plays happy and she smiles to her future.

Besides this humanitarian project, during 2012, Emergenza Sorrisi – Doctors for Smiling Children carried out many projects and humanitarian surgical missions giving back the smile to 1.931 children affected by malformations of the face, burns and other types of facial diseases.

Until now, the medical volunteers of Emergenza Sorrisi – Doctors for Smiling Children have offered their assistance and professionalism to doctors and professional figures of the visited countries such as Benin (Cotonou – National University Hospital CNHU), Gabon (Melene – Regional Hospital), Iraq (Nasiriyah – Imam Hussein Teaching Hospital), Indonesia (Tarakan – Public Hospital), Uganda (Gulu – Lacor Hospital), Iraqi Kurdistan (Erbil – Regional Hospital) treating facial malformations and even dental and eye problems and war burns.

During these surgical missions the medical volunteers of Emergenza Sorrisi – Doctors for Smiling Children have set up professional training courses addressed to surgeons, anesthesiologists, nurses of the visited hospitals by providing them with new guidelines on plastic surgery, anesthesia and guidelines for pediatric basic life support.\$

- *Authors: Fabio Massimo Abenavoli and Marta Romagnoli.*
- *In 2013, Smile Train Italia changed its name and became Emergenza Sorrisi – Doctors for Smiling Children an Italian N.G.O. and N.P.O. who inherits and enhances the wealth of experience gained from Smile Train Italia in its five years of activity. More information: www.emergenzasorrisi.it/*



BRIDGING THE GAP BETWEEN COMMUNITIES AND FORMAL HEALTH SERVICES

Despite the indicator of 90% of births attended by skilled health personnel under Millennium Development Goal 5 (to reduce maternal mortality by $\frac{3}{4}$), 52 million births still take place without a skilled birth attendant every year.¹

The statistics on skilled birth attendance highlight the huge inequalities both between and within countries. Across upper middle income countries the rate of skilled birth attendance (SBA) is 99% in comparison with 49% in low income countries, with lows of 10-12% in some areas. In Bangladesh, SBA is 75% among the richest fifth of the urban population whilst for the poorest fifth the figure is only 6%.² SBA is particularly low amongst indigenous women, who are much less likely to access skilled attendance than other groups.³ For indigenous women and those from other cultural and ethnic minorities, the numerous practical barriers – which can include user fees, underfunded and ill-equipped health systems, shortage of health workers and lack of transport – are compounded by cultural ones. Culturally inappropriate services which dictate how women should give birth, widespread discrimination, and language barriers make accessing mainstream health services a frightening and humiliating experience for many women. It is therefore not surprising that many choose to give birth instead with the assistance of Traditional Birth Attendants (TBA).

With concerns about the safety of attendance by TBAs, from the 1970s to 1990s the World Health Organization (WHO) actively supported the training of TBAs as a strategy to mitigate the high rates of maternal mortality.⁴ However, this is widely considered to have been ineffective in reducing maternal deaths⁵ and globally focus has now shifted towards skilled birth attendance. Yet as the statistics show, we are still a long way from achieving this.

Some have argued that this siloed approach to improving maternal health care is the reason for these failures and that an integrated approach that combines the medical knowledge of skilled attendants, with the local knowledge and community acceptance of TBAs is needed.

This is the approach taken by Health Poverty Action. In almost all the countries in which we work, many women give birth at home in the presence of a TBA rather than going to health facilities for skilled birth attendance. In many communities, TBAs may be the only 'health worker' in the vicinity, as often there is neither a health facility nor health outreach services.

Our programmes recognise that TBAs are generally the first level of contact for pregnant women in the communities and that they are in an important position to influence women (and their

family's) decisions. They largely have the trust of village women (and men) and can be formidable advocates for health-seeking practices in relation to a pregnancy.

Health Poverty Action works to change the role of TBAs, while still acknowledging them as trusted and respected members of the community. We train TBAs to take on a revised role which can include identifying and visiting pregnant women in their communities, encouraging them to attend antenatal care visits, and looking for risk factors in pregnancy. They are also trained to provide accurate advice on topics such as nutrition and breastfeeding. When women go into labour, TBAs often accompany them to the health centre, acting as a translator and advocate for the women with the health staff, reassuring women and acting as a cultural bridge between them and the health workers. Our programmes create strong links between the trained TBAs and health workers within the formal health system. In many cases TBAs and health workers are given mobile phones and credit so that they can keep in touch with each other and the ambulance for effective referrals of emergency obstetric care cases.



Abeba is a Traditional Birth Attendant in a pastoralist area of South Omo, Ethiopia. Since receiving training on safe delivery and a delivery kit from us three years ago, she has delivered over 60 babies. She enjoys her work and says she feels happy when a new baby is delivered into this world.

In areas in which SBA is currently impractical, we believe there must be recognition that TBAs remain necessary to conduct deliveries, at least as an interim measure, and we provide support, training and clean delivery kits. For example, the introduction of Free Health Care in Sierra Leone in April 2010 abolished user fees for pregnant women, lactating mothers and children under five introduced in conjunction with a ban on TBA delivery.

Following the ban, Health Poverty Action developed an innovative scheme whereby TBAs are trained and re-positioned and re-branded as Maternal Health Promoters. In this new role their focus is to refer pregnant women to health facilities for anti-natal care and delivery, as well as supporting women through the pregnancy with nutrition, breastfeeding, monitoring malaria prevention and signposting for family planning, rather than actual delivery. We have also established Birth Waiting Rooms, rooms provided by community members to lodge pregnant women who are waiting to give birth. Health Poverty Action is now working with government and other NGOs to expand the Maternal Health Promoter curriculum more widely in the country.

In addition to the removal of the financial incentive, (prior to the 2010 changes TBAs would receive payment following delivery and a share of the user fees paid to health services) a key challenge in redefining the role of TBAs in Sierra Leone has been poor communication between TBAs and health systems, leading to TBAs feeling devalued and posing a barrier to referrals. We have therefore found that strategies that work to strengthen the relationships between TBAs and health centres are vital to improving referrals for skilled birth attendance.

- *For more information: www.healthpovertyaction.org*

Notes:

1. World Health Organisation (2012) OPTIMIZE MNH. WHO recommendations. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting.
2. www.who.int/gho/urban_health/services/skilled_birth_attendance_text/en/index.html accessed 03.03.2013
3. Sabine Gabrysch, Claudia Lema, Eduardo Bedriñana, Marco A Bautista, Rosa Malca, Oona MR Campbell & J Jaime Miranda, Bulletin of the World Health Organization, 1 July 2009.
4. "Making Every Mother and Child Count." World Health Report 2005, page 70.
5. Interim Report of Task Force 4 on Child Health and Maternal Health 2004, Millennium Project (UNDP), quoting: Rosenfield and Maine 1985; Greenwood, Greenwood et al. 1987; Greenwood, Bradley et al. 1990; Maine 1991; Goodburn, Chowdhury et al. 2000; Smith, Coleman et al. 2000

Like many other women from Burkina Faso, Miriam lives in Ivory Coast with her husband. Her family had emigrated there to find work. After some years, still in her twenties, she goes back to her native village in Burkina. She has lost weight, feels miserable, alone, abandoned by her husband and excluded by everyone because she does not have children. She has only had several miscarriages and stillbirths, and everyone thinks she is a cursed woman.

She probably wants to prove to herself that she is very well able to have a child. Miriam now has a new partner and gets pregnant. She goes to the medical center for antenatal consultation, and lucky enough, finds Rosine there, an excellent midwife who immediately performs an HIV test on her. The results turn out positive. Rosine sends her to the district hospital, where she is hospitalized and undergoes ARV therapy. She even receives a small amount of money and some food, which helps her have a slightly better life. She gains weight and her health increases; she has no problem in carrying on the pregnancy till the term of delivery. She gives birth to a beautiful and healthy child. At the age of two months, he is tested for HIV the first time and the results are HIV-negative. His mother is happy. The next and definite check-up will take place when he is 18 months old, after the weaning phase. Miriam will receive support throughout this phase: she will be provided with nourishing flours suitable for infants, and she will be taught how to prepare baby food for her child.

Miriam is one out of many burkinabé women “cursed by barrenness” who managed to have a child – and a healthy one who grows in a normal way as well – thanks to the national program for the Prevention of Mother-to-Child Transmission of HIV (PMTCT). In particular, in the Nanoro district, the program is extremely successful, thanks to the collaboration among several project partners: the national health service (from the central services to the district health centers), the Hôpital Saint Camille of Nanoro, a private structure operating as reference hospital for the health centers, and the NGO Medicus Mundi Italy.

The health centers perform HIV-screening with pregnant women. They monitor pregnancies of HIV-positive women, and the child's birth and growth, ensuring basic PMTCT. In case of symptomatic positive women, the centers encourage them to go to the district hospital, where ARV-therapy against HIV/AIDS is available and covered by national health service.

The Hôpital Saint Camille – thanks to its special agreement with the government – has competent staff trained to treat HIV/AIDS patients, both as in-patients and out-patients (Day-hospital). It also has a center for nutritional recovery and education (CREN), with staff trained to

monitor and eventually improve the nutrition of children born to HIV-positive mothers. Mothers are given advice and complementary food during the weaning phase.

In this system, the NGO Medicus Mundi Italy works as a link between different parties to achieve the implementation of Millenium Developmental Goals Nr 4, 5 and 6 (reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases). Represented by a doctor and a logistic technician based at the hospital, the NGO:

- provides a small stock of reagents, medicine and consumption goods necessary to cover the inevitable delays of supplies in products coming from the central health service;
- helps the district in managing and distributing supplies to the different health centers to avoid service interruptions;
- keeps in contact with health centers to follow up clinical cases, gives advice (from the ill woman refusing hospitalization to the dosage of drugs for mothers and children) or reports a case;
- purchases enriched flours for the CREN to be given to infants of HIV-positive women.

So, from 2008 to 2012, all indicators, from the number of women tested to the coverage of prophylaxis on mothers and newborns, have continuously improved and have reached the WHO/UNAIDS goals for the elimination of pediatric AIDS:

Year	Pregnant women in ANC screened for HIV	HIV screening coverage in ANC	HIV+ pregnant women	Newborns of HIV+ mother	HIV+ mothers receiving ARV therapy or prophylaxis		Infants of HIV+ mother receiving ARV prophylaxis	
					n	%	n	%
2008	1,288	24.1%	23	21	10	48.3%	10	48.3%
2009	2,767	49.7%	41	37	17	46.1%	18	48.8%
2010	3,919	69.6%	47	42	23	54.4%	27	63.8%
2011	5,247	92.1%	41	37	30	81.3%	31	84.0%
2012	4,909	94.2%	38	34	30	87.7%	32	93.6%

- *More information:* www.medicusmundi.it

COMMUNITY SYSTEMS STRENGTHENING: ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

HealthNet TPO is a health organization that works with violence-affected communities in fragile states to enable them to take control of their own health and wellbeing. We have been developing and piloting the Community Systems Strengthening (CSS) approach over the last 2 years in order to operationalize this principle of empowerment. We are now preparing to use it as a core component for complex and scaled-up health interventions in several of our project countries.

Community System Strengthening (CSS) is an approach that aims to improve the overall health, wellbeing and resilience of communities in fragile states. The participatory, community-based approach is part of a wider trend in public health and development, which increasingly recognizes the Social Determinants of Health. These are the societal conditions that we are born into that affect our health and wellbeing on many different levels. As you can imagine, they are powerful forces wherever you come from, but in fragile states, they are particularly salient: institutional, political and legal systems designed to protect and support people malfunction or have disappeared. Frequently, conflict causes damage to the (health) infrastructure and destruction of economic capital, resulting in an increase in poverty. On a deeper level, the social fabric of the community is often destroyed; families are scattered, and community members mistrust each other. Throughout its history of working in such contexts, HealthNet TPO has learned that these issues must be actively addressed, if we are to have a lasting effect on the health of individuals and communities.

The term ‘CSS’ was coined by the Global Fund in the framework they developed for actors and organizations dealing with major health challenges (Global Fund, 2011). However, its roots go as far back as the Alma Ata declaration of 1978, which defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." As such, it shifts the focus from service-delivery to community systems in order to approach health promotion from a more holistic standpoint. This reflects our belief (based on theory and practice) about the importance of social processes in creating ‘health enabling environments’.

CSS in Practice

Achieving this is, of course, a complex process and must be carefully monitored and developed to suit the context in which it is being applied. Nevertheless, HealthNet TPO has been working

to create a replicable model, which is based on these core principles and lessons learnt and can be applied in many settings and interventions. The key components are as follows:

- Conducting community mapping exercises to identify, describe and analyze the individual and collective mechanisms that help or hinder the sustainable development of services for the health and well-being of the local population
- The establishment of networks at different levels of society to build trust and social cohesion
- Development of concrete action plans in close collaboration with the population
- Capacity building of local actors in a process of education and direct empowerment
- Community activities/ interventions implemented by empowered key figures and/or referral towards more specific service delivery

CSS in Burundi

Currently, this approach is being implemented in the context of the Dutch Consortium for Rehabilitation's (DCR) 'Pamoja' project, which HealthNet TPO is a key player in. The consortium aims to rebuild the infrastructure of post conflict zones in African countries, including our CSS focal points: South Sudan, Congo and Burundi. Burundi has provided the most recent and fruitful data on the functioning of the approach, and is the setting for a forthcoming large-scale intervention, in which CSS is the core strategy. The CSS pilot project has been successfully implemented in three provinces in Burundi: Makambia, Muyinga and Gitega.

Where are we now?

In 2011, 'Community mobilizers' were employed by HealthNet TPO to lead the community mapping and network formation, and to supervise and report on activities in each colline. The activities now take place within community networks: the *reseaux collinaires* is a large village network of up to 100-200 members, who elect a smaller *comité collinaire*, who receive and pass on the capacity building and training to the wider community. Representatives from each *reseau collinaire* and other influential actors from different professional sectors (police, health professionals, local administration etc.) in the district form the *comité communale*. These representatives play advisory and support roles. They are at the heart of the creating a functional referral system.

At the end of 2012, we conducted a process evaluation of the approach, which helped to validate our model and fine-tune the practice of CSS in the field. Generally, the members of the networks felt the biggest changes lay at the family level: with reductions in SGBV and increased awareness about family planning and registering children and marriages. The community

mobilizers on the other hand, saw the biggest change in the way that the community as a whole dealt with problems:

“Now many health and social problems are solved at the colline [community] level, and people trust that they can refer to the commune [district] network if this is not possible” (Community mobilizer, 43, Makamba Province)

Integration and scaling-up

The next stage is to use this approach within a more focused intervention, while lobbying for the attention of CSS at the national policy level and strengthen its collaboration with the MOH/Directorate of Health Promotion & Hygiene. This year, HealthNet TPO is engaging in a large scale, multi-layered Sexual Reproductive Health and Rights (SRHR) programme in Burundi, funded by the Dutch Embassy of Bujumbura, in which i) family planning, ii) use of sexual and reproductive health services by youth and iii) a support/care system for survivors of SHRH violations, are jointly addressed.

Our research and experiences of CSS since its inception have convinced us that it is a vital element of complex health-related interventions such as this one. HealthNet TPO is therefore using it as the central strategy within the programme; for example, through connecting National level family planning programmes with civil society groups (via the networks) to expand the access to family planning commodities and services. Here, the link between strong social structures and successful service delivery is clear, and even begins to bring a new meaning to what we understand by the social determinants of health: whilst man-made disasters such as war create ill-health and malfunctioning systems, community mobilization approaches can create the conditions for healthy and resilient communities.

Process evaluation findings

Methods

A combination of structured (quantitative) and semi-structured (qualitative) interview questions assessed each component of a model developed by HNTPO, which was based on the Global Fund framework for CSS (Global Fund, 2011). The data was collected from stakeholders in the 3 Burundian provinces in which the approach is currently being piloted. The sample (N=178) comprised of 3 groups:

- **Network Members (NMs, N=168):** Community members who are part of the reseaux collinaire (village network). The sample was selected randomly at the colline level from a set of 18 collines. The collines were situated in 7 communes in 3 provinces (2 communes in Muyinga, 2 in Makamba and 3 in Gitega).



- **Community Mobilizers (CMs, N=7):** All 7 employees of HealthNet TPO who initiate, supervise, monitor and report on CSS activities in the field. This group was purposively sampled.
- **CSS coordinators (Cs, N=3):** The HealthNet TPO project coordinators based at the Burundi office. This group was also purposively sampled.

Main findings

- The overarching message from network members is that motivation and satisfaction with the way that the project is coordinated is high. Activities in the initial stages, such as community mapping are considered particularly relevant and useful to the community network.
- There is less commitment at the commune (district) level than the colline (village) level and there are issues with attendance. This is because members feel they need material compensation (in the form of fuel cost or resources) for their energy and expertise.
- All networks were seen to be highly inclusive and heterogeneous, although there is an absence of Batwa people and traditional healers.
- Putting ideas into practice in the community is not always easy and problems of implementation tended to cluster in stages around and after the action planning stage.
- The Community Mobilizers (CMs) displayed confidence in the progress of the project and in their own abilities to lead it but they stress the importance of training and capacity building activities (both for network members and themselves)
- Overall, the data substantiates the conceptual model: although some steps need fine-tuning and further research, no element was found to be absent, unacceptable or entirely unfeasible in the field.

Recommendations for the field

Training of Community Mobilizers: According to the responses of NMs, CMs would benefit from training in family planning and the reduction of SGBV, conflict resolution (specifically those related to family and land) and primary health and mental health care (eg how to deal with epilepsy and how to improve basic nutrition). If coordinators feel that this is outside of the mandate of CMs, they should ensure that CMs know where to refer network members to, if confronted with these problems.

Provincial level network formation: Collaboration with the MoH and more specifically, with the Director of Health Promotion and Hygiene, is necessary to create networks at this level. Comité

communale members were said to be connected to structures at the provincial level: these connections should be utilized as entry points for establishing a higher level network.

Action Planning: Although respondents had a clear idea of what their goals for the community are, they were not clear on the steps they needed to take to get there. CMs expressed that the ToC training was not long enough, so further input from HealthNet TPO trainers at this level would be beneficial to the NMs.

Top-down and bottom-up processes: The results suggest that CMs may not involve individuals or less socially dominant groups in community mapping. This indicates that greater use of ‘bottom-up’ processes (such as approaching representatives from minority groups) will ensure that there is a balance between working with existing structures and challenging hierarchies/ social exclusion.

Recommendations for further research

Low commitment at the commune level: The present research did not include a separate sample of network members who were representatives at the commune level. More in-depth investigation, could help to deduce reasons for low attendance at the commune level networks.

Validation of intermediate preconditions: The model and present findings suggest that a “sense of future perspective/ hope” and “social connectedness” are intermediate steps towards the end goals of CSS. In order to substantiate this, it is recommended that validated tools such as the Adapted Social Capital Assessment Tool (A-SCAT, Harpham, Grant and Thomas, 2001) and the Prism of Sustainability scale (Valentin & Spangenberg, 2000) are administered at more than 1 time point.

External Validity: This should be explored by conducting equivalent process evaluations in the other settings that CSS is being piloted in (South Sudan and Congo). Any conflicts between the data sets, in relation to the general CSS process as it is defined here, can help to refine the model so that it can be made as broadly applicable as possible.

Effectiveness evaluation of the approach: A clear operationalization of ‘collective efficacy’ must be defined and indicators for whether networks are successfully addressing their health and wellbeing should be developed. It is then recommended that the framework for designing and evaluating complex interventions designed by the Medical Research Council (Campbell et al., 2000; 2007) is used to guide the evaluation.

- *More information:* www.healthnettpo.org



Medicus Mundi Poland was created on the basis of “Redemptoris Missio” Foundation in Poznań, Poland. The Foundation started at the Clinic of Tropical and Parasitic Diseases, University of Medical Sciences in Poznań, Poland in the year 1992, and in 2012 has celebrated its 20-years anniversary. The major aims of the Foundation were: (1) professional medical support to Polish missions abroad and missionaries; (2) promotion of an interest in international health among the students and a population at large. The Foundation’s Council consists of university professors and medical students. The icons of the Foundation are late Marian Żelazek, SVD, creator of an ecumenical Leprosy Center in Puri (India) and Dr h.c. Wanda Błęńska, creator and medical doctor working over 42 years in Buluba (Uganda) Leprosy Hospital. The Foundation is well collaborating with Catholic Church institutions in Poland (including Caritas), with Medicus Mundi International as well as with CUAMM, action medeor and European Community project offices. The activities are financed mainly by individual donations, by Poznań Medical University, by non-governmental and governmental institutions support, by participation in international projects and by some promotional actions. The annual budget is usually less than 100.000 Euro.

Medicus Mundi Poland started as an affiliated member of Medicus Mundi International in 1994 and became the full MMI member in 1997 – fifteen years ago. The MMI membership greatly enriched the Foundation’s activities and made its closer to international health requirements and policy.

Shortly after the Foundation’s creation the training in basic tropical medicine and hygiene has become a regular part of missionaries formation at the Mission Formation Centre in Warsaw. Thirteen annual training courses for students, medical doctors and nurses (so far over 400) have been organized in Poznań. Forty three issues of a quarterly journal Medicus Mundi Polonia, 1000 copies each, has been published up to now.

For over 25 years the Clinic of Tropical and Parasitic Diseases Medicine takes care about the missionaries health both by hospitalization – if needed – and by preventive screening and ambulatory treatments. In 2008 a modern health center has been built in Kiabakari (Tanzania) and passed to be run by local Church authorities. Several medical visits have been organized to Puri (India), Madang (Papua New Guinea), Bangassu (Central African Republic), Garoua Boulai (Cameroon). Up to now all together 42 medical doctors and 10 nurses were working in various mission’s medical centers abroad.

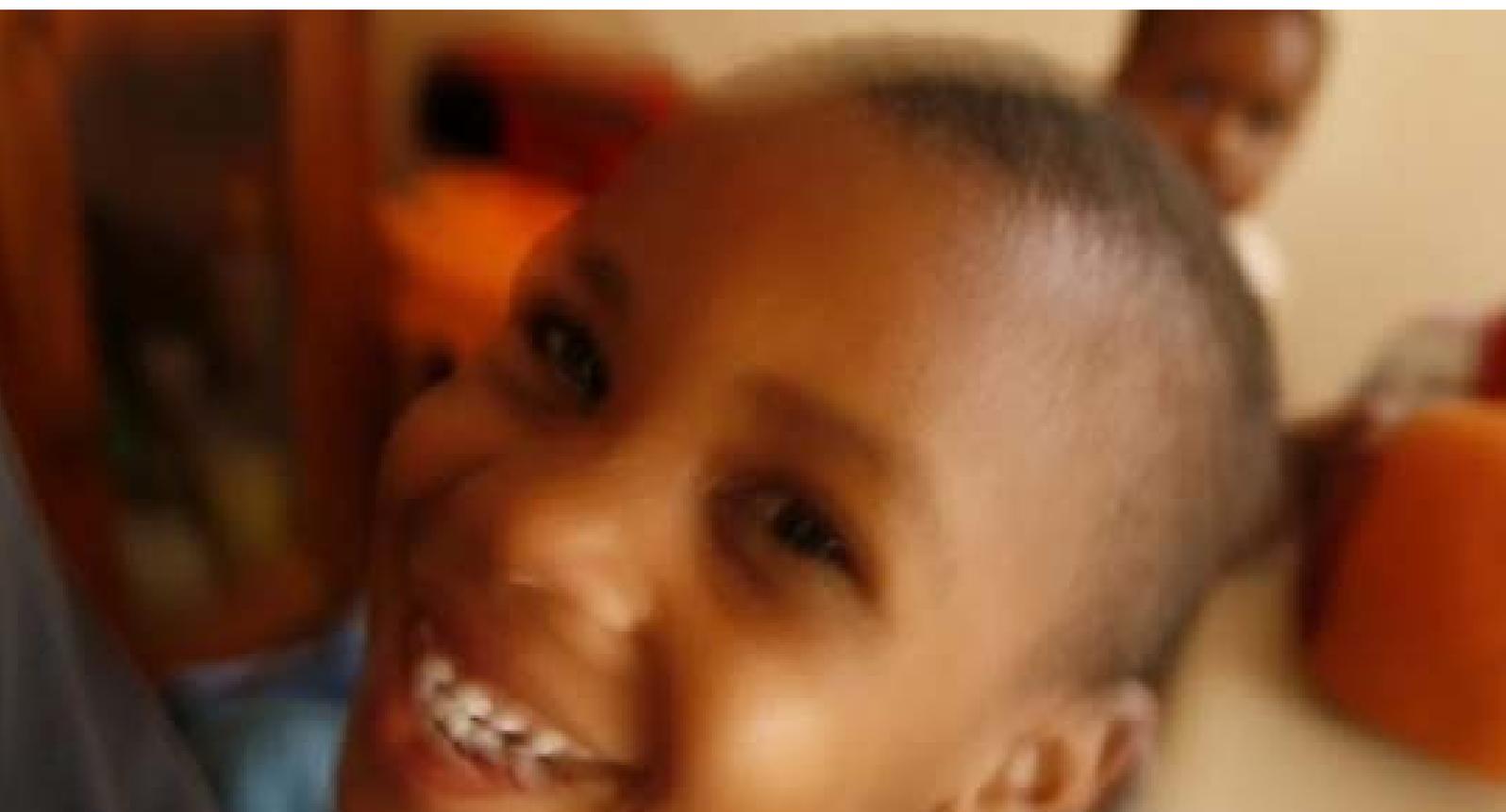
A lot of activities are performed by volunteers, mainly students; every year there are about 40 of these working in the Foundation's Voluntary Center and organizing promotional activities outside. All together 67 medical students had their 3-months summer medical practices in the missions, mainly in Africa and in India. The contact with the poorest segments of world population and humanitarian activities had an impressive impact on their future professional life. Several of them have chosen their carriers in international health institutions.

Over 20 years the Foundation send to Catholic missions in 4 continents more than 2200 parcel with medicaments, dressings, educational materials and other requested items. A part of humanitarian help was passed by sending money (e.g. to hunger areas in East Africa) or by sending equipment such as dentistry units, incubators, microscopes or ultrasonographs.

The interest of population at large in humanitarian actions was promoted by distributing a quarterly magazine, meetings with school children, distance adoption (67 children and 2 students), provision of some educational materials, sending warm dresses for Afghanistan children, collection used tins for earning money. The Foundation is organizing the annual concerts for 800 people, issuing leaflets, books, expositions and films. The Foundation has over 3000 faithful individual supporters in addition to some supporting institutions.

As long as the marginalized people exist a medical, educational and humanitarian help is our obligation. This should be best realized through non-governmental missions, working in the peripheral poor areas. Such a message has to be popularized in better off societies in order to reduce the existing inequalities.

- *Authors: Anna Tarajkowska, Jerzy Stefaniak, Zbigniew Pawłowski.
More information: www.medicus.amp.edu.pl*



ESSENTIALS OF PHARMACY PRACTICE COURSE

“She is now very competent and assists patients in the dispensary. She is able to carry out her responsibilities with confidence.” This is a feedback of the supervisor at a community hospital in Dedza district Malawi three months after her staff returned from the Essentials of Pharmacy Practice course.

In 2012 the Ecumenical Pharmaceutical Network (EPN) ran five courses on the Essentials of Pharmacy Practice (EPP) in five countries training more than 130 pharmacy staff. Three twelve week courses were conducted in Uganda, majority of the students from South Sudan, in the Democratic Republic of Congo, and Malawi. Two shorter two weeks courses were organised in Central African Republic and Sierra Leone.

The target group is staff working in a hospital pharmacy or comparable institution of a health facility. They never have been exposed to any formal pharmaceutical training. The pharmaceutical schools offer training for people who have finished school. The capacity of the school often is low to meet the need of qualified staff in a short time.

The EPP course consists out of six modules covering the most important elements to improve the pharmaceutical services within the health institutions and towards the patients receiving the medicines.

Module	Subject
1	Pharmacy and Health Care
2	Fundamentals of Pharmaceutics
3	Medicines Supply Management
4	Basic Therapeutics
5	Rational Use and Dispensing
6	Hospital Pharmacy Practice

From our own survey in eight countries investigating 332 facilities (70% hospitals, 28% health facilities, and 2% dispensaries) with 1009 respondents EPN knows that the majority of pharmacy staff lacks any formal pharmaceutical training. Thus, EPN developed the EPP course, consisting out of six modules which be conducted separately or in one course. Each module takes two weeks to be taught.

In 2012 the evaluation performed before and after the courses demonstrated the direct impact on the performance of the staff: improving stock management of medicines, adopting the FEFO-system (first-expiry, first-out), keeping the right medicines in the fridge, calculating average month consumption, explaining the use of medicines to the patient.

Church facilities need to ensure compliance with regulatory requirements by employing staff with appropriate training. The EPP courses do not aim to replace any formal pharmaceutical training but to reduce the gap of missing education.

Beside EPN there is no other organisation offering a course covering all basic aspects of pharmaceutical services for untrained personnel which was allocated to pharmacies.

EPN would like to express appreciation to our members, experts from various countries, and The Strengthening Pharmaceutical Systems Programme, USAID, and Bread-for-the-World who enabled our network to create and conduct these courses.

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.

■ *Author: Andreas Wiegand. More information: www.epnetwork.org*



Medicus Mundi (medicumundi) Navarra is promoting an intercultural, comprehensive and inclusive healthcare model in Guatemala, Bolivia and Peru which aims to transform the continent's healthcare systems in order to guarantee universal coverage for communities that are traditionally excluded.

Florentina, a woman who lives in Las Barrancas community (Guatemala) is worried because for days she has been very tired, has had a fever, has been feeling generally unwell, has had difficulty opening her eyes and lifting her head, and has suffered a loss of appetite and weight. She says in her native language (“mam”) that she has “ojeado”. Elena has just given birth in Churcampa (Peru). She looks proudly at her baby and feels satisfied because her husband, by grasping her waist with the “chumpi”, has managed to prevent the “profundo suspiro”. According to the quechua's world view this can cause the mother to die. Humberto, from an Aymara community, is worried because he has “Karkati”. In other areas of Bolivia they call it a “tembladera”. He feels worse and worse.

It is difficult for these three people to be cared for in a healthcare system based purely on “modern biomedicine”. Not only economic, but also linguistic, cultural, social and gender barriers can present an obstacle to millions of people seeing their right to healthcare satisfied by the public healthcare system. In a continent like Latin America, with its great ethnic and cultural diversity, it can be worst: 40% of Guatemala is indigenous peoples, there are 36 ethnic groups in Bolivia, 64 in Peru...

An ambitious project which is being developed in three “pilot” areas of the continent

medicumundi, with the support of the European Commission and the Government of Navarra, has been supporting the design and implementation of an intercultural, inclusive and comprehensive healthcare model in Guatemala, Bolivia and Peru for more than 10 years. This model could become a reference point for the whole Latin American continent. The initiative has an extensive plan of work in these three countries, with teams of local experts in public health coordinating with local authorities and international organisations. Advocacy activities are also planned at national, regional and European level.

The objective is to make operational a healthcare model designed to guarantee universal healthcare coverage for communities traditionally excluded from it. By combining “modern/western” medicine with traditional medicine, these pilot schemes are validating the model which is designed not only to benefit the 155,709 people in the community where it is

working in the field, but also in the medium term to be extended to all society within these three countries (50 million people) and, in the long term, to a large part of the American continent which shares quite similar sociocultural characteristics (rural and/or indigenous communities).

This project is reaching its most interesting point; As result of this, there have been interesting technical meetings, at local and international level, alternating with intense work in the pilot areas. Together with practical experience in the field, the initiative already has a long series of publications and technical documents at the level of theoretical consideration which will be put together in a key-document: a proposal to transform the primary healthcare models in the region of the Americas.

Key Aspects of the project

Comprehensive and community health, not vertical. The project deals with a multidimensional perception of health (individual, family and community) centred not only on the problem but also on the risks. It includes the areas of prevention, promotion, care and rehabilitation and is a new way on the cooperation scene which is more inclined towards vertical programmes with basic packages...

Inclusive healthcare for all. Health Systems in Latin America are imported from more homogeneous western societies, and it has excluded majority groups in the population, in particular women, rural and indigenous communities. The project includes these groups, bearing in mind their own uses of traditional medicine, but also provides a model for the entire population, beyond specific groups: hence its inclusive feature.

Health as a right, not a privilege. Health is a right without any exclusion for reasons of sex, age, race, economic condition or geographical situation. The public system has an obligation to guarantee health coverage. Bearing in mind the different levels and the components of interculturalism, gender and environment, it is a basic step to move from “words to actions” in a systematic and sustainable way.

“If the problems are similar, the solutions will not be very different.”

medicusmundi has a huge amount of experience in promoting comprehensive healthcare schemes which look to ensure that no group, for reasons of gender, ethnicity or culture, remains outside of access to the basic right to healthcare. medicusmundi has been experimenting for a long time, with different rhythms and intensities, a comprehensive approach to healthcare with three axes (health right, intercultural and gender equity) and three levels (individual, family and community) in these countries. A comprehensive healthcare model which is inclusive. A model which adds (“modern/western” medicine and traditional) and does not take away.

In Guatemala, the model took on the name “Modelo Incluyente en Salud” (MIS – Inclusive Healthcare Model), and it has had 12 years of positive experiences in various healthcare districts

as well as the support of the Ministry of Health. In Bolivia it has worked around SAFCI Model (Intercultural Community Family Health) in the last few years, and in Peru there are projects with a similar philosophy to comprehensive healthcare (MAIS-BFC) based on the family and the community. Acronyms don't matter, what counts is the ideas and practices. And above all, that they are systematic models tested in real life situations which are exportable and can be extended given the same circumstances. This is the purpose of the multi-country project supported by the European Commission.

The protagonists speak

Juan Carlos Verdugo, from Inclusive Health Institute (ISIS) in Guatemala: “In Guatemala, we have spent 12 successful years working to promote inclusive and comprehensive healthcare models at the first level of healthcare with the aim that they will be incorporated as part of the healthcare policy. The exchange of mutual learning and experiences in the healthcare field with Peru and Bolivia will be fundamental for improving healthcare models in Guatemala; and it will enable a regional initiative for public healthcare policy in those countries and suggest an alternative way to develop the international cooperation in healthcare”.

Fernando Carbone, former Health Minister of Peru: “In Peru, maternal and infant deaths have decreased greatly in recent year due to interventions which mainstream gender, intercultural and family focus, experiences in which Medicus Mundi has participated. Now it wants to apply these focuses throughout its healthcare model. This moment of transition is an opportunity to share achievements and lessons learnt and incorporate the experience of neighbouring countries.”

Javier Román, from Medicus Mundi in Bolivia: “Bolivia can give much to, and receive a lot from, this project. In our country we are developing the SAFCI, a model which includes concepts such as interculturalidad. It is also planned in the project, but we can help to introduce others concepts like the environment and, above all, we can facilitate their effectiveness. At the same time, we have experience and accumulated tradition regarding models of comprehensive and inclusive healthcare which can help to develop a system which is not only applicable to our three countries but also to a large part of Latin America, especially wherever there are communities excluded from access to healthcare.”

To achieve these results, it requires not only an exchange of experiences and a demonstration that the model works, but also that society and governments make this initiative as own. One key aspect is its connection to the public healthcare system in order to guarantee access to healthcare for the whole population. medicusmundi and its members are dedicating their efforts on it. This is a challenge as much ambitious as interesting. A utopia which can be made a reality, healthcenter to healthcenter, person to person, family to family, ministry to ministry, country to country. The road is long and plagued with obstacles.

■ *More information:* www.saludintegralincluyente.com



2012: FINANCIAL FACTS & FIGURES

Capital Account

Assets	Previous Year		2012	
I. Long-term fixed assets		1.00		1.00
II. Short-term fixed assets		126961.54		102465.72
Cash in hand	107.03		32.62	
Cash in banks	121638.71		98199.41	
Other amounts receivable	5067.27		1293.66	
Prepaid expenses	103.53		2940.03	
Total Assets		126962.54		102466.72
Liabilities	Previous Year		2012	
I. Net equity		99767.14		94575.04
Status 1 st January	107679.95		99767.14	
Net loss	-7912.81		-5192.10	
II. Accruals		3415.50		3475.00
III. Project funds not yet appropriated		7541.00		4287.84
IV. Other liabilities		16238.90		128.84
Total Liabilities		126962.54		102466.72

Statement of revenue and expense

Revenue	Previous Year	Budget 2012	Accounts 2012	Budget 2013
Membership contributions	79100.00	74600.00	74580.00	81200.00
Donations and subsidies (2013: review, HRH)				13250.00
Interest and similar income	809.89	1000.00	543.32	1000.00
Other income	519.25		1000.00	
Subtotal Revenue	80.429.14	75600.00	76123.32	95450.00
Expenses	Previous Year	Budget 2012	Accounts 2012	Budget 2013
General expenses secretariat	62286.32	60000.00	62400.00	55000.00
Travel costs / hospitality / Network events	10538.33	11000.00	11229.54	16000.00
Projects: net expenses (2013: HRH project)				8000.00
Other expenses secretariat	3315.69	3050.00	3433.15	5400.00
Public relations and printed matter	401.83			
Other expenses (2013: including review)	3821.78	6700.00	4252.73	20700.00
Investment and related depreciations	7978.00			
Subtotal expenses	88341.95	80750.00	81315.42	105100.00
Net loss	-7.912.81	-5150.00	-5192.10	-9650.00

All figures in EUR. Amended budget 2013 as proposed to the General Assembly in Barcelona, May 2013

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 2013. The "Report on the Audit of the Financial Accounting as of December 31, 2012 for the Association Medicus Mundi International e.V." by ttp treuhandpartner gmbh, Krefeld, Germany, is available at the MMI secretariat.

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Status: December 2012