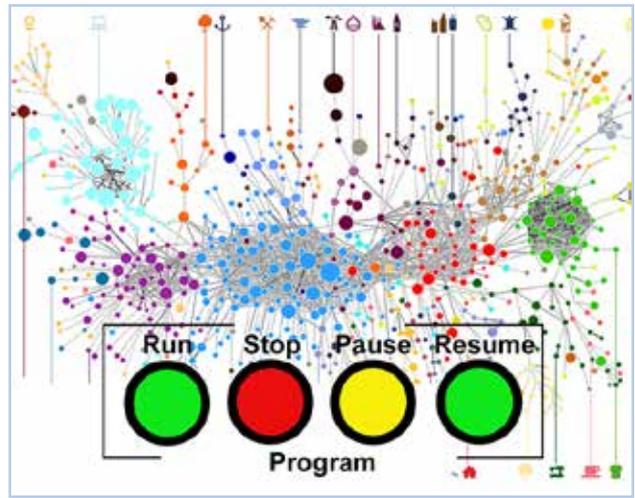


ANNUAL REPORT 2013

*Universal Health Coverage,
complexity, and a birthday...*



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Medicus Mundi International Network · Murbacherstrasse 34 · CH-4013 Basel
 Phone +41 61 383 18 11 · office@medicusmundi.org · www.medicusmundi.org
 Bank EUR: Pax-Bank · D-52064 Aachen · BIC GENODED1PAX · IBAN DE23 3706 0193 1011 1340 13

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

MESSAGE FROM THE PRESIDENT

NICK LORENZ, MEDICUS MUNDI SWITZERLAND

For its 50th anniversary in 2013 Medicus Mundi International had deliberately decided not to make a big splash, but to celebrate it quietly in the logic of our network that is to keep our member organization in the centre. It was therefore a very nice opportunity to celebrate in Barcelona, in June 2013, with one of our key members, MM Spain, which is of the same – excellent – vintage as MMI.

Last year a main topic of MMI was the review of the current strategy. The review report did not generate concrete new ideas for our Network strategy 2015+. However it drew our attention to the fact that certain core elements of our identity – such as being a Network of independent members and focusing on joint advocacy at a global level – need to be re-confirmed before we can go ahead. We therefore revised the MMI Network policy and adapted our statutes and regulations. All this is now ready for consideration and hopefully adoption by our General Assembly in Château de Bossey. At the same time we expect the Assembly to be a milestone for the development of the MMI Network strategy 2015+ in terms of content definition. To initiate and stimulate the discussion we will draw on the inputs and views from external advisors and sister networks.

As for the strategy the Board decided that there is no need "to chase another pig through the village." This German expression, meaning pushing a new cause before finishing an old one, applies quite well for the situation of MMI, as we do not intend to develop a new strategy from scratch. It is quite obvious that international cooperation in health care including health systems, global health policy and joint advocacy will be at the core. Grounds for these themes have been laid within the current strategy and we can and should build on. Certainly we will have to put more emphasis on the monitoring and evaluation of expected outputs.

To address the sustainability of the Network will be key. Last year we have lost two long term members, Misereor from Germany and Fatebenefratelli from Italy. The reasons are different, partly explained by the fact that health is going down on the agenda of a number of organizations, but perhaps partly also due the fact that the orientation towards global advocacy of MMI did not meet the expectations of these organizations for a network organization like ours any more. Although this a normal



development in a living network, where some leave and others join, we have to be attentive. A broadened, but also stable membership basis is vital. In the first place in terms of contributing to the discussions and the development of joint positions, but also for securing the financial sustainability of the MMI Network which, as we all know, depends entirely on the membership contributions.

The year 2013 saw also the re-emergence of the membership fee discussion. Reflecting the difficult economic environment and based on a Assembly decision to introduce two standard classes of membership fees, a number of member organizations announced, for the years to come, to reduce their contributions to the standard fee. This will lead to a tangible loss of income. On the positive side this sensitive topic has now been hopefully settled for some time to come and more importantly we have now clear reference figures, which will facilitate the recruitment of new member organizations.

Another highlight of the past year was one more successful Network meeting in Brussels, where “complexity” was the topic. The meeting was – as usual – very well organized by our local partners. It showed one of the key strengths of the Network, where like-minded organizations can meet and exchange. It was also good to have the opportunity to join in Memisa for its 25th years anniversary meeting. Our host provided an excellent example of how an organization is going strong and has been able to adapt to a changing environment.

In Brussels we started the discussion of having a Network meeting for the first time outside Europe. Although it has not worked out for 2014, the interest has been confirmed and will be followed up. In autumn 2014 Medicus Mundi Switzerland will host the annual Network meeting and link it to a symposium on the very relevant topic of Sexual and Reproductive Health and Rights.

Led by our dynamic secretariat, our input into the global discussion on Human Resources for Health, global health governance and health policy have continued and are well recognized. Looking back on a successful 2013 we can be confident for the future.



Our report refers to the MMI Network strategy 2011-15 and to the related workplans for the years 2012-13 developed by MMI working groups and the secretariat. Progress was discussed in November 2013 at the Network meeting in Brussels, together with the perspectives for the year 2014.

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 strengthen its role as NGO platform for knowledge sharing and information brokering related to action research and research partnerships.
- The MMI Network will establish and test a platform/marketplace for NGOs “in search of research” and young researchers.

In 2013, Nicole Moran, a Masters student at the Swiss TPH, undertook 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 to her overall research question “how can NGOs generate, access, share and use reliable evidence”, and in close cooperation with MMI, Nicole Moran was focusing her work on “barriers, enablers and supportive tools for Health NGOs”. As a particular side-product of her thesis, she collected a “NGO Research Toolbox”.

At the Brussels Network meeting, Nicole Moran presented findings and in particular her “NGO Research Toolbox”. Her presentation led to a lively discussion on what could be the role of MMI in further promoting research and evidence processes among its members and partners and in creating related NGO platforms and/or interfaces for NGOs and research institutions in a more structured way.

At the MMI Board meeting in March 2012 and at the “Getting evidence into NGO practice and policy” workshop during the Network meeting in Amsterdam, in October 2012, MMI members and representatives of research and teaching institutions discussed the feasibility of a project to create a “marketplace” for NGOs and young researchers. After that workshop, concrete preparation of the “MMI marketplace” started, and the marketplace project was launched in early 2013 on the MMI ePlatform.

So far, the project has not really been successful: The MMI secretary who took the lead has, in its initial phase, not succeeded to convince Network members to put a sufficient number of “research proposals” on the marketplace. The marketplace being restricted to Network members (enhancing the problem of achieving a critical mass), and with its focus on the niche of partnerships between NGOs and young researchers, the practical feasibility of the project still needs to be proven. At the Assembly in Brussels, Network members therefore discussed if we shall invest some more energy and time to move this project into gear (eventually opening the marketplace up to non-members of the Network) or rather try to address the research partnership issue at a more general or higher level.

The Third Global Symposium on Health Systems Research in Johannesburg, October 2014, could be used as a milestone and catalyst for such an effort. The Symposium’s goals include “building the capacities of researchers, policy- makers, practitioners, activists and civil society organizations to conduct and use health systems research related to the theme” and “strengthening learning communities and knowledge-translation plat- forms working, to support people-centred health systems across disciplines, sectors and countries and, particularly, bridging practitioner, activist and researcher communities.“

A MMI team around Cordaid, Memisa and the secretariat successfully submitted a proposal for a MMI session on “Successfully connecting NGO practice and Health Systems Research”. So we will be there, and we expect the Global Symposium to inspire the further positioning of the MMI Network in this field of work.



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.
- 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.

Since 2013 the MMI Network secretariat, several Network members (Medicus Mundi Spain, Memisa Belgium, Health Poverty Action, Redemptoris missio, Wemos) and partners outside the Network are involved in the EU funded project "Health workers for all and all for health workers" (HW4All) 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. The project has become the catalyst of the Network's involvement in this topic and for the time being replaced the former MMI working group. For once, also the MMI secretariat is directly involved in an EU project (as European press officer and organizer of the WHA side event).

Since the beginning of this project, MMI involvement in the follow-up of the WHO code of practice has even become stronger. On the other hand, the visibility of MMI as an actor needed to be shared with the involved individual organizations and the HW4All project.



WHO Global Code of Practice
on the International Recruitment
of Health Personnel

**Stoking up the
fire for Code
implementation!**

Side event to the 66th WHA
Wednesday, 22 May 2013
5.45 – 7.45 PM, Room IX

HRH related events in 2013 included, among others, a side event and statement at the World Health Assembly (May), the participation in a consultation on Human Resources for Health for high income countries (September) and in the WHO high-level meeting "Health systems for health and wealth in the context of Health 2020" (November) and a strong presence at the Third Global Forum on Human Resources for Health in Recife, Brazil (November). Analytical statements on the health workforce crisis and on health workers migration by several Network members were published on the MMI "get involved" blog. The "MMI updates" and the thematic guides on HRH and health workers migration were also systematically used by the MMI secretariat for knowledge sharing and information brokering related to the HRH issue within and beyond the Network. Currently a MMI team is preparing to contribute a chapter on the health workforce crisis to the 4th edition of the "Global Health Watch" (2014), the alternative World Health Report coordinated by the People's Health Movement.

Things are moving in the field of global advocacy for HRH. After the Third Global Forum the Global Health Workforce Alliance (GHWA) declared to concentrate itself on advocacy at global level, watching accountability (e.g. monitoring and evaluating commitments made) and convening stakeholders. As this is about the same as the plans for positioning the civil society Health Workforce Advocacy Initiative (HWAI), the future of HWAI is uncertain.

Over the last two years, MMI has become a leading civil society actor in the follow-up of the WHO code and as such also recognized by the WHO. MMI's own contributions and its role as platform for knowledge sharing and information brokering related to political (and not technical) aspects of the HRH issue are well acknowledged. Our related European project HW4All will be continued in the years 2014-15. Over this time, proper project implementation will require a lot of attention – and work – by the involved MMI partners.

On the other hand, we consider the key issues of the global HRH crisis as being part of a broader picture: the need to strengthen national health systems and health systems financing (including a systemic approach to universal health coverage), the need to address the social and political determinants of health and health systems (including fiscal policies), and the challenges related to global health governance.

Therefore MMI is currently dealing with the HRH crisis rather as a political/governance issue than in the traditional sense of sharing technical know-how among NGOs and mutual learning for their program work. For the current approach, and given our limited capacities, it makes sense to build on the good synergies with the HW4All project and with the work of MMI's Global Health Governance team.

GLOBAL HEALTH GOVERNANCE

- 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.
- The MMI Network will strengthen its role as NGO platform for knowledge sharing and information brokering related to global health policy and governance

Since the start of the **WHO reform process** in January 2011 and throughout the last three years, the Medicus Mundi International Network has been strongly involved, not only as an NGO in official relations with WHO, but also contributing to the creation and implementation of the “Democratizing Global Health Coalition on the WHO reform” (DGH). The MMI secretariat was participating in all related events and hearings organized by WHO and DGH and often 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. This role of MMI in the WHO reform process has been well recognized by the WHO (see report on midterm review of MMI strategy).

Now that the focus of the reform process is on WHO’s relations with “non-state actors”, the process has become heavy and painful, with uncertain perspectives also regarding the future of the MMI Network’s status as an “NGOs in official relations”. In the whole debate, NGO accountability and transparency regarding funding and membership etc. have become an issue.

MMI is currently involved in the **People’s Health Movement** (PHM) at various levels, such as the global steering committee of PHM, the joint “WHO Watch project” and the production of the next “Global Health Watch” report. The relations with the PHM and other “sister networks” shall be analysed within the definition of the next MMI Network strategy.

In 2012 MMI coordinated the drafting of a “Beyond 2015” position paper on **health in the post-2015 development agenda**. After this well appreciated initial input in the debate, MMI could not keep the pace. The hype around “post-2015” has just become too big, and, related to this, it is now a “business” for certain big NGO actors who have the finances and capacities to invest in order to get the expected high profile.

MMI, with its limited capacities, could not participate in all the meetings around the World, but continued to contribute to the debate both at the secretariat level and as individual members (such as MM Spain, medico international, Health Poverty Action) whose statements have been disseminated through the MMI Secretariat.

For the time being, we prefer to reflect on global health policy and governance issues in a more fundamental way, without being structurally involved in the “big circus”. The issue will be how to broaden this dialogue within the MMI Network. A discussion paper on global health governance – as we developed it in 2013 for the UHC topic – might be a way forward.

In this sense the MMI secretariat joined a group of organizations in a process coordinated and hosted by medico international. The group gathered, in September 2013, in Rome for a two days meeting on **health as a common good** and explored, in an interdisciplinary dialogue, alternative governance mechanisms and an alternative agenda of priorities for global health. The next steps of this “Rome track” still need to be defined.

In 2014, **noncommunicable diseases** and the related global coordination mechanisms will certainly “hot topics” of global health policy and governance. And for sure the hype around **universal health coverage** is far from being over. Finally we also expect a come-back (hopefully at an even higher respectively broader level) of the political debate on **social determinants of health**, also related to the post-2015 process. Therefore, in addition to the topics reported above, there are enough opportunities for MMI and its Network members to “get involved”.

MMI might test again if there is enough interest by Network members to start, eventually in an informal way and until the definition of formal Network programs in the next Network strategy, a working group on NCDs. Otherwise, and as our attention is currently focused on its governance aspects, the NCD topic might also be tackled by the global health governance team.

From a communication perspective, we can see that the MMI weblog “get involved in global health” is regularly used and appreciated, the same as the “MMI updates” on Twitter and the thematic guides on the MMI website.

As positions “supported by MMI” at times have to be developed on the spot (e.g. statements at the World Health Assembly, the civil society statement at the Third Global Forum on HRH, the DGH comments after the WHO non-state actors consultation), it is a challenge to define how / if advocacy position positions need to be endorsed by the whole network. Referring to some statements in the report of the midterm review of the Network strategy, the secretariat recommended to the Brussels Assembly – as part of the review of the Network Policy – to review and refine the related regulations of the MMI Network, in order to find an acceptable and feasible way between delegation and systematic consultation. The proposed regulations will be submitted to the 2014 Assembly for consideration.

Photo next page: over the roofs of Barcelona (MMI Assembly 2013)





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.

After a focus on the role and responsibility of NGOs in 2012 (mainly: workshop at the People’s Health Assembly), the year 2013 was dominated by the discussion on **universal health coverage**. The related MMI discussion paper was largely disseminated through all the relevant online fora and also referred to by David B Evans, WHO, at the symposium of Medicus Mundi Switzerland, in November 2013, on “Universal Health Coverage and global health after 2015”.

Good working relations have certainly been established with Action for Global Health, but on the other hand, there is also quite some competition among networks and big NGOs regarding thematic leadership and branding in hot issues in global health. Nevertheless the midterm-review of the Network strategy shows that our contributions are appreciated for their soundness and independence and that our voice is heard (see above, on global health governance).

There was certainly some progress in the **MMI membership development** over the last two years. After the Amsterdam Network meeting in October 2012, MMI counted 20 members instead of 10 in 2009. However, with Fatebenefratelli and AGEH leaving the Network afterwards, the trend of membership growth came to a temporary halt.

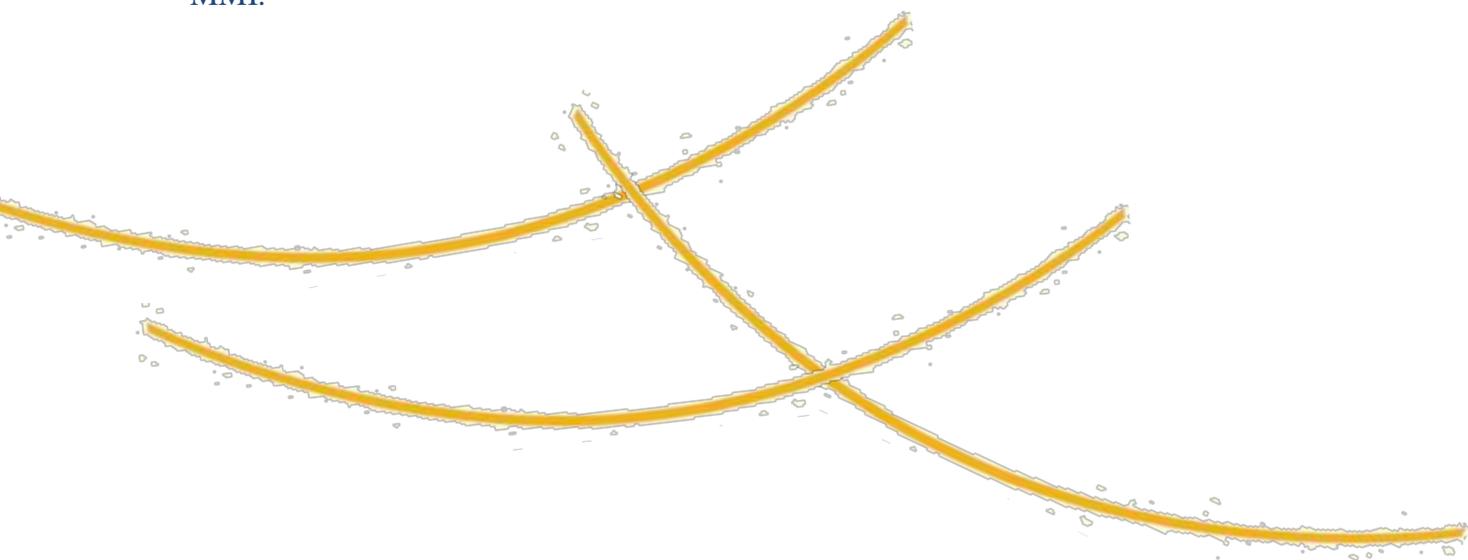
The not rational structure of the membership fees and the obvious differences among the new members and between the new members was finally addressed by the MMI Assembly in June 2013. The Assembly agreed on two standard classes for membership fees: 5000 EUR as regular fee, and 1000 EUR for financially weak members (determination by self-declaration), with the regulation that members facing an augmentation of the fee beyond their capacities could request acquies or a reduced augmentation.

The financing dialogue with Network members undertaken by the Secretariat in August confirmed that, referring to the new formula, several Network members will considerably reduce their membership fees and only a few members will pay a higher fee than today. Together with the loss of Fatebenefratelli and AGEH as two strong contributors, this will lead for the next

years, until the gap will (hopefully) be filled by new members, to a structural deficit which can only be partially covered by "sponsoring members" (current members able and willing to pay more than the regular fee).

In August 2013, the report on the **midterm review of the MMI Network strategy** was disseminated by the secretariat within the Network. To our surprise, the focus of the review report was rather on the institutional development of MMI than on our strategy 2011-15 and the related tasks and programs. The report highlighted concerns of some Network members that, with the new members and the Network's recent focus on global advocacy, MMI might risk its internal coherence and face an "erosion of its natural genes". The review therefore proposed to develop a "master plan" for membership development before continuing to actively recruit new members.

With these statements and recommendations, the Board and Secretariat hesitated to launch a membership promotion campaign based on the new, rational formula for members' contributions. On the other hand, we proposed to the Network members not to directly implementing the recommendation of the review ("master plan for membership development"), but to dig one level deeper, discussing and eventually reviewing the **MMI Network Policy** (2009) with its key statements on the identity, mission and membership of the Network. We hope that we will find soon new solid ground for the further institutional and strategic development of MMI.



Basel, 15 March 2013

The Board meeting of the Medicus Mundi International Network in 2013 dealt with, among other items, the external mid-term evaluation of the MMI Network Strategy 2011-15 and the future MMI membership fee policy.

Barcelona, 7-8 June 2013

Primary Health Care and cooperation: A utopia?

Jubilee Assembly 50 years of Medicus Mundi Spain - 50 years of Medicus Mundi International Network

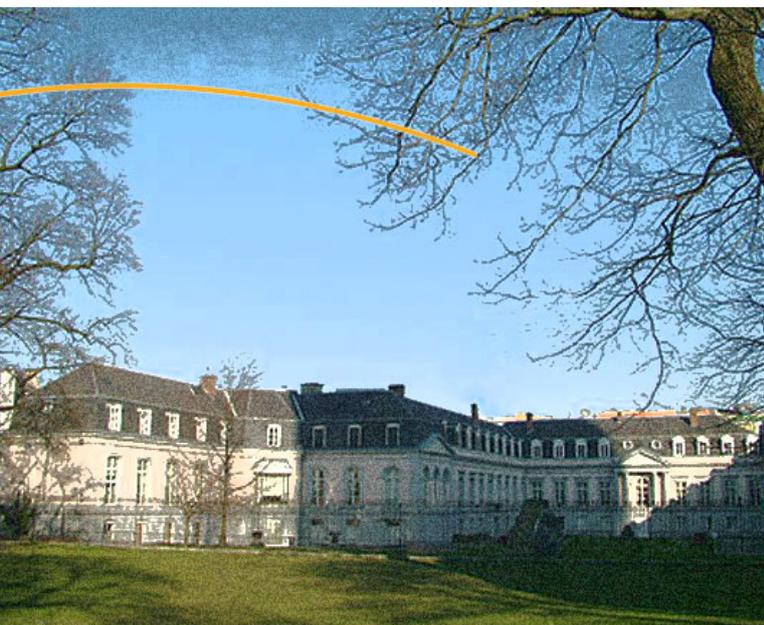
The Jubilee events of the Federation of Medicus Mundi Spain (MM Spain) started with a scientific conference on “Primary Health Care and Cooperation: A utopia?”. The Assembly of MMI on Saturday morning was held in parallel with the MM Spain Jubilee Assembly. Further jubilee side events took place from Friday to Sunday. Many thanks to MM Spain and to Medicus Mundi Catalunya for having invited MMI to Barcelona!

Brussels, 27-29 November 2013

Health-y answers to comple#ity: Are we able to move beyond the control panel?

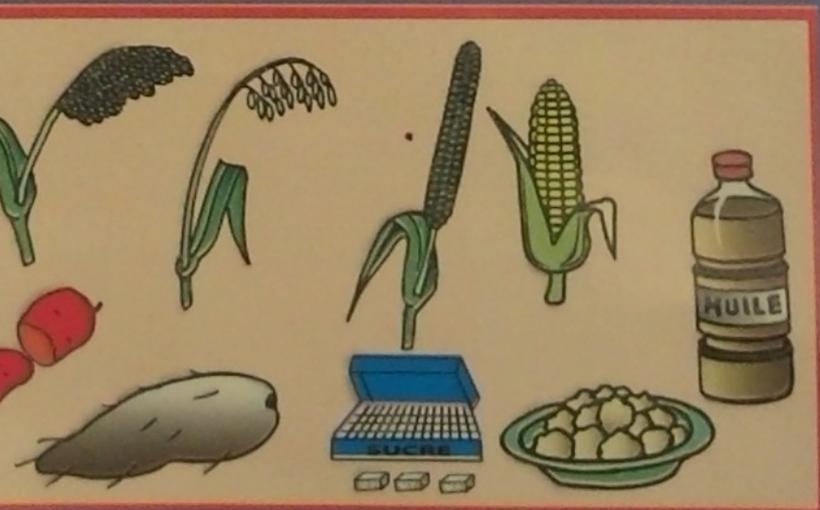
Seminar – MMI Network meeting – Jubilee events 25 years Memisa

The meeting of the MMI Network Medicus Mundi International Network was hosted by Memisa celebrating its 25 years jubilee and linked to the annual seminar of Be-cause Health. If the working title of the seminar was confusing, this might even be intentional: the conference was all about providing health care in a complex environment and how to deal with this complexity. MMI Network members were also invited to the jubilee events of our Belgian Network member and appreciated very much the great preparatory work and the hospitality of the local hosts.



MMI NETWORK MEMBERS

SHORT STORIES



Lokang Peter Dario is Pharmaceutical Assistant at Omeo Dispensary in Eastern Equatoria, South Sudan. When he was entering the small pharmacy of the health facility he had to pick all the medicines for dispensing from different boxes on the floor. Lokang never received formal pharmaceutical training.

At the time Alex Schei, project manager at Ecumenical Pharmaceutical Network (EPN), first visited Omeo all medicines were stored in carton boxes. There were no boards and no shelves. There were no stock cards or any other system in place for inventory control. Lokang used an exercise book to write down prescriptions and dispensed drugs which already made it hard to determine consumption. This is the situation in almost all health facilities in South Sudan.

Omeo Dispensary is in the South-East of South Sudan and can be reached in 30 minutes from Magwi town during the dry season. South Sudan is Africa's youngest state currently shattered by violent conflicts between different tribal groups. The health system of South Sudan is very weak and lacks infrastructure, financial resources, medicines and medical equipment and qualified health staff. In the whole country are less than ten trained pharmacists. Most people working in the pharmacies have not undergone any pharmaceutical training.



EPN in cooperation with action medeor initiated a project targeting untrained pharmacy staff in South Sudan. The aim of the project that started in January 2013 was to improve pharmaceutical service quality in 20 selected health facilities in Eastern Equatoria. In order to reach that goal an initial assessment was made and participants for the Essential Pharmacy Practice training were selected.

On 4 March 2013 Lokang and 22 other colleagues from governmental and faith-based health facilities started with the first cycle of the Essential Pharmacy Practice training in Torit, Eastern Equatoria. In the two-week long training Lokang learned about good storing practice, stock management, calculation of consumption and medicine orders. At the end of May the second training cycle focused on dispensing of medicines. Both trainings contained a lot of exercises and field trips to enable participants to put training contents into practice.

One of the main findings of the assessment and a major obstacle for participants to put training contents into practice was the lack of shelves to store medicines. Therefore, 5 health facilities were equipped with shelves and all 20 got stock cards.

When Alex returned to Lokang's pharmacy for the follow-up visit some weeks later the picture was completely different. All medicines were well-arranged in the shelves. Those with the shortest shelf-life were at the front to be taken next (first-in-first-out). Every medicine had a separate stock card where incomings and outgoings were noted which allowed for determination of consumption.

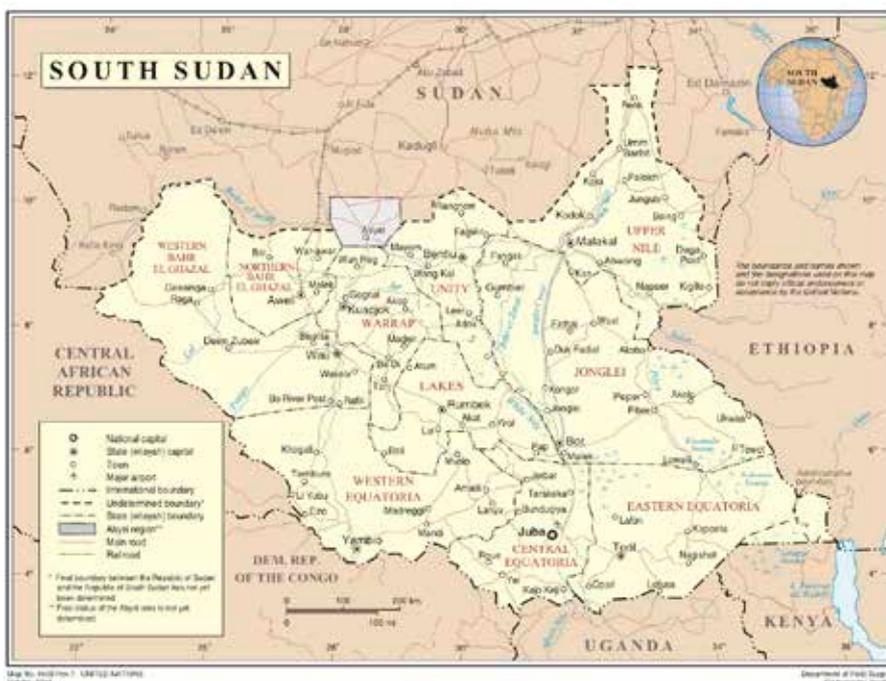


Training institutions and universities cannot meet the demand for qualified health personnel in many developing countries. Therefore, EPN has developed an Essential of Pharmacy Practice Course for pharmacy staff without pharmaceutical training. In 2012 the full twelve-week long course was attended by South Sudanese pharmacy staff in Uganda. Two modules of the complete course were used for the training in South Sudan in 2013. This year (2014) EPN in collaboration with CHAK, KCCB and action medeor conducts a training of trainers in Northern Kenya. This project includes essential pharmaceutical training and on-the-job trainings for pharmacy staff of 50 health facilities in the region.

Today the charitable, non-governmental organization action medeor e.V. is the largest medical aid organization in Europe. In cooperation with local partners action medeor supplies around 10,000 health centers with medicines and medical equipment. The organization also conducts healthcare projects in Africa and Latin America and works in the areas of emergency relief and pharmaceutical training and technology transfer. action medeor is a member of EPN, a network of mainly faith-based organizations.

The origins of EPN date back to 1981 when the Christian Medical Commission (CMC) of the World Council of Churches (WCC) decided to provide advice and consultation in the area of pharmaceutical services to church health programs, particularly in Africa. EPN is now operating from Nairobi and has 81 members from over 30 countries, mainly from Sub-Saharan Africa.

- More information: www.epnetwork.org, www.medeor.org



The Republic of South Sudan

Independence: 9 July 2011

Capital: Juba

Population: 10,84 Million

Life expectancy at birth: 54 years

Infant mortality: 84/1000

Under-five mortality: 106/1000

Maternal mortality: 2054/100.000

Poverty headcount ratio: 50.6%

Underweight prevalence: 30.3%

(figures: various sources)

For several years HealthNet has been working in addressing the needs of women and vulnerable people in Afghan communities and provinces. After a 3 year programme, this year we see it is time to “harvest” results.

Together with the Afghan Women’s Resource Center (AWRC) and the Afghan Women Educational Center (AWEC), HealthNet has set out a programme to reinforce the ability of women to undertake culturally appropriate action towards the improvement of their living conditions. In close collaboration with local authorities and local religious and educational leaders, community groups and organisations have been actively

- mobilising women at a community level to take control and determine the direction of their lives;
- exploring local definitions of family violence and harmful practices and identifying cultural appropriate solutions;
- building the capacity of local organisations and relevant authorities, enabling them to address violent practices and to protect its victims;
- reinforcing the collaboration with the Ministry of women’s affairs (MoWA) according to the recommendations and priorities as described in the national action plan for women’s affairs (NAPWA).

According to a recent baseline report (Afghan Women’s Network, Cordaid, 2013), the security of Afghan women has again deteriorated in the past years, particularly in rural areas where armed opposition groups have gained ground. Women’s freedom of movement has been severely curtailed, as has their access to employment, education and health care. Women face problems on the street when they go to work, a health clinic, or take their children to school. Our experience has taught us that promoting and supporting women to generate income and to improve their educational level, is an important way towards women empowerment.

Why is this a priority for HealthNet?

We work on the social determinants of health in order to improve access to health care for women and simultaneously works in the same provinces on improvement of service delivery in health care and training of community midwives. It is the combination of programmes that have an impact in the mentioned provinces.

The programme

Where? Kapisam Lagman, Ghor, Kunar, Kunduz, Nangarhar, Logar, Daikundi and Uruzgan provinces, Afghanistan

Why? Because in Afghanistan women and girls are still repressed and at serious risk: about 87% of the Afghan women regularly experience sexual and/or physical violence in their lives. Also still an estimated 60% of the girls is forced to marry before the legal age of 16. Young girls often end up in the hospital with severe physical injuries and psychological trauma.

Donors: European Commission

Participating women experience positive change

Between 2011 and 2013, the project resulted in self-organized provision of tailor made services for 3432 vulnerable women and children. Through the establishment of supportive networks at different levels of society, some 150 female focal points were able to start up 180 micro-projects. These include tailoring, carpet weaving, cow keeping, farming, and providing English and holy Quran courses. They act as mobilizers for their surroundings by encouraging others to start up similar activities. In each target province campaigns were organized to create a supportive environment about Women's Rights. An evaluation of the project revealed that more than 90% of the participating women experienced social, psychological and economic growth from the micro-projects they were involved in.

How to sustain the achieved results?

Given the magnitude of the problem and the means available, services must be provided on a substantial level and organized in a way that they become financial and socially sustainable. Our local staff therefore supported the women in establishing four female Community Based Organizations (CBOs), enabling them to continue their activities after the program ended in December 2013. The results look promising but more time is needed to develop guidelines, by-laws and reinforce organizational capacity. Once officially registered these CBOs will have more power and mandate to undertake effective action in line with national policies towards the promotion and actual implementation of women's rights in Afghanistan.

Continuation and extension

In 2013 HealthNet together with the Ministry of Women Affairs organized a National Conference where participants shared results, best practices and challenges in the presence of the minister of Women Affairs. We are proud that the minister expressed her satisfaction about the years of collaboration between the MoWA and HealthNet. She requested to continue our efforts

and extent both the duration and coverage area of women projects. Also the European Commission, the funding partner, emphasized that they “are in for the long haul”. HealthNet has just established an independent Afghan NGO that will help us to move forward through different funding channels and will create more opportunities to support the CBOs and start new initiatives.



An illustration of the increased autonomy within the traditional setting of family and community life: In the Afghan village of Borjhay lives Karima with her husband and seven children. Being a farmer, her husband does not earn enough money to sustain the family livelihood. Karima was given the opportunity to take part in a five-day training in which women learn about the various opportunities to improve their situation. Then Karina began a chicken farm. That was difficult in the first instance as the village elder was not in favor of the idea, and nobody wanted to invest and participate in the plan. Together with our local officers she eventually succeeded to convince her community that a small investment can make huge difference. Eighteen months later 27 women from the village earn a private income which has improved both their economic and social situation.

- More information: www.healthnettpo.org

REALISING THE RIGHT TO HEALTH WITH DISAGGREGATED DATA

The health of the most poor and marginalised communities around the world will not be improved without better data collection practices. The Millennium Development Goals (MDGs), which run until next year, and the data collection practices behind them hide the truth about the health of ethnic minorities and hinder global development.

We know that across the world, ethnic and cultural minorities are marginalised. They experience more poverty and worse health outcomes than the rest of the population. However, there is a lack of statistical information to show this. The MDGs measure national averages, and do not disaggregate the data into sub-national groups. Improvements for one section of a country's health can hide a lack of progress for those communities more marginalised and more difficult to help (perhaps due to remoteness, language or cultural barriers).

Better information on health and poverty will improve understanding of how to address the health inequalities faced by marginalised people. Reliable and disaggregated data can ensure that no section of society is overlooked in the efforts to achieve the MDGs and whatever goals are set in the new development framework beyond 2015.

Health Poverty Action works with some of the poorest and most marginalised communities around the world. Our experience in countries across Asia, Africa and Latin America shows that ethnic minorities are being left behind. Ethiopia is one of the countries in which this is happening.

Ethiopia: Semi-mobile pastoralists left behind

Health Poverty Action prioritises those missed out by others and we are working in Ethiopia to improve the health of pastoralists, with a particular focus on women and children.

Ethiopia has one of the world's highest maternal mortality rates, alongside one of the world's lowest rates of health spending per person. Across the country as a whole, 350¹ mothers die for every 100,000 live births and about nine in 10 births are not attended by a skilled health worker. Whilst these statistics are stark, at Health Poverty Action we know that the figures for pastoralist groups are actually much worse. There is some data to back this up, using the proxy of

¹ The United Nations Population Fund (UNFPA), (2013), 'State of world population 2013 - Motherhood in Childhood; Facing the challenge of adolescent pregnancy', p. 101

geographic regions with a concentration of pastoralist populations. For example, the use of family planning methods helps to avoid mother and child deaths by preventing unwanted pregnancies and the occurrence of illegal abortions that often have complications that prove fatal; despite their importance, only 9.5%² and 5%³ of women use contraception in the Afar and Somali regions respectively, compared to a national average of 29%.⁴ These regions traditionally have a high concentration of pastoralists, giving an idea of the huge disparities amongst different groups. But for a comprehensive picture on which to base targeted and effective development policy, there needs to be much more information on the specific health situation faced by pastoralists.



² Central statistical Agency [Ethiopia] and ICF International, (2012), 'Ethiopia Demographic and Health survey 2011', Addis Ababa, Ethiopia and Calverton, Maryland, USA, p. 101

³ Ibid.

⁴ Ibid

There are approximately 12-15 million people belonging to 29 different ethnic groups⁵ in the pastoral regions of Ethiopia. They are dependent on nomadic livestock production and are often isolated from the already poorly equipped health services. In the Hamar and Dassenach Districts of South Omo, a midwife working with Health Poverty Action speaks of the challenges facing health workers working in poor conditions: there is no electricity in the delivery room, “so when a mother gives birth at night we only use torches.”

As well as poor equipment, there are not enough health workers in these regions of Ethiopia. The Government of Ethiopia has deployed a huge number of Health Extension Workers (HEWs) in the last few years in order to increase access to and coverage of health services. But coverage remains low and turnover high in the remote regions where pastoralists live. Health Poverty Action is supporting these workers to improve the quality of these health services through on-the-job training.

Beyond the general problems of poor equipment and staffing, there are specific interventions that can be used to adapt health services for nomadic communities, such as mobile/outreach clinics and community-constructed birthing huts/maternity waiting homes. Non-Governmental Organisations like Health Poverty Action can implement these culturally appropriate measures with small numbers of communities, but to get these rolled out to all pastoralist communities, the state authorities need to be persuaded of the scale of the problem and the need for intervention. If health data were broken down, the problems faced by pastoralists could be more widely understood and highlighted, and the impact of any culturally sensitive measures could be tracked.

At Health Poverty Action we believe that everybody has an equal right to the best chance at good health. Whilst there are some huge gains being made towards this goal it cannot be realised until the truth about the inequities in health and well-being is exposed via the use of disaggregated data. Health Poverty Action is urging the UK government to champion the disaggregation of data by ethnicity, including advocating for the indicators set to measure progress in the post-2015 framework to be broken down by ethnic and cultural group, and substantial investment to be made in national level statistical capacity building.

It is only when the truth about the inequities faced by millions of the poorest and most marginalised people is exposed, that millions of people will stop being denied their right to health.

- More information: www.healthpovertyaction.org

⁵ Pastoralist Forum Ethiopia (PFE), www.pfe-ethiopia.org/about.html

“MY OBJECTIVE IS THAT WE HAVE ZERO TEENAGE PREGNANCIES BY THE END OF NEXT YEAR”

One determined nurse is making sure no more teenagers in her community will get pregnant against their will. Christina de Vries, reproductive health advisor at Cordaid, was impressed, as she reports from a visit in December 2013, to Myoye, Rwanda.

I was travelling to a remote place in the north of Rwanda, high in the mountains, with my Rwandese counterpart Ariane. The scenery of green mountains is awesome and so beautiful in the eyes of a Dutch person. But Ariane grumbled: “That’s what all the tourists and especially Dutch visitors say, but if you have to make your living in these mountains, all your life, it is a harsh environment. You can give me a flat country any day.”

The trip took us off the tarmac roads, and up and up we went over windy and bumpy roads and increasing coldness and fog. We were visiting health centres, who were due to open youth-friendly services. Rwanda is faced with a very young population and with a high rate of teenage pregnancies, which relatively often end in the tragic death of a girl. We work with schools, youth centres, district authorities, religious leaders and peer educators to decrease this rate. The youth-friendly services are part of this effort and will provide education and support to young people.

On this trip, we visited remote health centres with polite and wellwilling health staff. Some of them had not quite understood the idea yet. They had emptied a store room or a consultation room, and put a sign above the entry door marked ‘youth-friendly service’.

In those cases, Ariane entered into a discussion with the health staff: “What is so youth-friendly about this place? Do the local youth know about this special room? Why would they come here? What are you organizing with them? What kind of changes would you like to make, and how can we help you?”

Close to heaven

And again, up we travelled to the next rows of mountains. Finally, at the point I imagined we couldn’t get any closer to heaven in Rwanda, a sign board appeared: Miyove Health Centre. There was nobody around. After some moments, a nurse with an apron and wet arms ran out of a door to greet us: “I am Constance, please come along, I am busy cleaning the house next door for the youth meeting.” She hurried back to the house, and she showed us around. Once the ice was broken, she did not stop talking.

“The Next Generation programme of the Cordaid consortium is so timely. I saw thirty desperate teenage girls last year, being pregnant against their will. Heartbreaking. Girls from my community. They are school girls, made pregnant often by an adult man. Or they work as a household maid, and have been taken advantage of by the men in the household. Others are girls working at the mines who have got themselves into trouble for a small amount of money. We have many teenage boys who are HIV-positive as well. Young people don't get proper education on sexuality and on how to prevent pregnancies or the transmission of HIV. We need to change that, otherwise these kind of problems will keep destroying the lives of teenagers and of entire communities.”

Through the back door

Constance continued in a firm voice: “I decided that I don't just want a youth-friendly corner in my health centre, but I want an entire house for the youth. They can come through the front door for youth meetings and youth activities. And if they want personal counselling, on HIV, STDs, suspected pregnancies, problems with their parents or their boyfriend or girlfriend, or whatever, then they can come through the back door, where nobody can see them come or go.”

And in a determined manner: “I don't want to accept this situation anymore. I tell you, my objective is that we have zero teenage pregnancies by the end of next year!”



“Don't get your life messed up”

We walked back to the main room of the house, and to my amazement in this remote place, the room had filled itself with young people. Some were even standing in the back and others were standing outside looking through the door and the windows.

Constance spoke to them: “This is your house, you can use it for yourselves and for your friends. Have fun, learn things, get any help you need. The health staff is always there for you and will always give you what you need. Don't get your life messed up with HIV or early pregnancies.”

Constance: she made my day, she gave me hope, but most importantly she is giving hundreds and hundreds of teenagers the opportunities in life they deserve. Communities can change. The flame of one person can be enough to light the fire for flourishing communities.

- More information: www.cordaid.nl

We called her Chantal – her parents had not thought of a name yet, as they weren't sure she would make it. In fact her twin brother already died a couple of months ago. Chantal probably was about 2 years old, but her bodyweight was only 5,050 g – not much more than a newborn! And too much of this weight was concentrated in her legs: both presented pitting oedema. We found Chantal in a small village in Burkina Faso near Leo on the border to Ghana. With only 10.4 cm of mid-upper-arm-circumference (MUAC) she was diagnosed with complicated severe acute malnutrition (SAM) and brought to the district hospital. Unable to drink on her own, a feeding tube was placed through her nose in her stomach and treatment started immediately. During the first two days Chantal received a special malnutrition formula feeding every 2 hours – day and night, but nevertheless her weight decreased further.....

The 2012 Sahel food crisis compounded food insecurity and malnutrition in Burkina Faso, one of the poorest countries in the world, ranking 181 out of 187 countries on UNDP's Human Development Index (2011). The most recent emergency food security assessment found 1.7 million people at-risk of food insecurity, and nationwide more than 10% of children under age 5 years showing weight for age more than two standard deviations below the median for the international reference population. Of those malnourished children, 20% fulfil WHO criteria for severe acute malnutrition.

The situation is further complicated by the fact that some people consider malnutrition a curse or a punishment so the child may be called a snake or a monkey and nobody wants to be in touch with him. But malnutrition is also a sign of poverty, which is considered shameful, so the poor child may be hidden by the family and not brought to a nutrition center – until it is too late.

Emergency project against severe acute malnutrition

By mandate of the national health authorities and in order to strengthen the implementation of their malnutrition programme, the European Community Humanitarian Office called for projects that would tackle this important emergency. Working in Burkina Faso continuously for over 10 years, Medicus Mundi Italia (MMI) was in a position to offer help and together with Lay Volunteers International Association (LVIA) designed a pilot project. In May 2012 we started in two districts in the North-Western region and since March 2013 the project was extended to cover the whole region (5 districts totalling 21,700 km²) with a population of 1,415,000 people.

Five Doctors, 12 nutritionists one nurse from MMI and LVIA supported by logistic staff, care for a population of 245,000 children aged 6-59 months of whom 13,400 are estimated to suffer from SAM every year. We expect to find 90% of those patients by three screening campaigns and aim to treat at least 80% of those identified. Our 1-year goals are:

- Strengthening of the local health system in the management of SAM and reducing SAM-related stigma, by supporting the regional hospital and the five district hospitals with logistics, equipment and staff.
- Equipment and training for almost 2000 community health agents or nurses – based in 170 health posts throughout the region - in the detection (by MUAC measurement) and treatment of malnutrition
- Organization and implementation of three region-wide door-by-door MUAC screening campaigns (to identify all the children that never went to a community health centre) with the help of the trained health work force.
- Free procurement of ready to use therapeutic food (donated by UNICEF) for moderately malnourished children and free treatment of those affected by SAM (including transport to the hospital, medical treatment, hospitalization fee, meal for accompanying person)
- Support for the collection, transmission and analysis of data on malnutrition. The target is a cure rate of >85% for the outpatients and > 75% of the inpatients, with a mortality rate < 10% for inpatients and < 3% for outpatients while no more than 10% should be lost to follow up.

Directly linked is a project for the production of fortified therapeutic food to prevent SAM. In four villages women are trained to produce a MiSoLa-type of supplementary food which is based on locally available ingredients.

The results:

- As of December 2013 we trained 1700 community health workers and 350 nurses.
- During the first ten months from March to December 2013 in two rounds 257,748 and 267,526 children were screened respectively, and on the basis of a MUAC < 115 mm 1819 and 1971 children were diagnosed with SAM and referred for treatment. In addition during the first ten months the health centers identified additional 5298 patients suffering from SAM among those visiting the centers for various reasons.
- The total diagnosed was thus 9,088, and 8,818 (97.0%) of them started treatment. Of the children with SAM, 1,513 (17.1%) had complications (mostly oedema or loss of appetite) severe enough to be treated on an inpatient basis. (In a third campaign in January 2014

among 273,476 children screened, 1662 were identified as suffering from SAM; data on outcome not available yet).

- Cure rate (defined as achieving 85% of the target weight) was 85.7% for the outpatients and 92.6% for inpatients while unfortunately 43 outpatients and 56 inpatients died (death rate 0.7% and 6.3%).
- Drop out rate (missing three consecutive appointments for outpatients – while being actively searched) was 13.7 and 1.1% respectively.
- Children with moderate malnutrition (defined by MUAC <125 and \geq 115mm) were supplied with a lipid-based ready-to-use food supplement. 20 tons of this fortified flour were produced by the four production sites created by the project.

Conclusions

Door by door malnutrition screening through MUAC by trained health care workers is very efficient in identifying children with SAM, allowing to discover also patients that would not show up at a Health Care Center by their own. Furthermore, despite cultural obstacles, almost all parents of the patients identified, accepted treatment. Last but not least, treatment proved effective as shown by a extremely low mortality rate. We hope that the MUAC-screening is now implemented as a health post- routine. However, hygiene, clean water, logistics and culture remain obstacles for a durable malnutrition management. It is questionable how in-hospital care for malnourished children will continue once families will be asked to pay for all the related costs. All together our results show that with strong input much can be done to fight malnutrition even in the poorest and most hit regions of sub-Saharan Africa.

...and Chantal? Yes, after the first critical days her weight gradually increased, she started to drink and improved slowly but steadily. Oedema disappeared and after 17 days she went home – walking her first steps ever!

A contribution by G. Cattaneo, V.Pietra and R.F. Schumacher for the ECHO-LVIA-MMI (European Community Humanitarian Office, Lay Volunteers International Association, Medicus Mundi Italia) project team and S. Barro, M. Kagone and R. Kargougou for the team of the Direction Régional Santé du Centre-Ouest du Burkina Faso. Special thanks to all the community health workers and the personnel of the Community Health Centers and District Hospitals of Koudougou, Leo, Nanoro, Reo and Sapouy in the Central-Western Region of Burkina Faso.

- More information: www.medicusmundi.it

MINISTÈRE DE LA SANTÉ

.....
RÉGION DU CENTRE OUEST

.....
DIRECTION RÉGIONALE DE LA SANTÉ

COMMISSION EUROPÉENNE



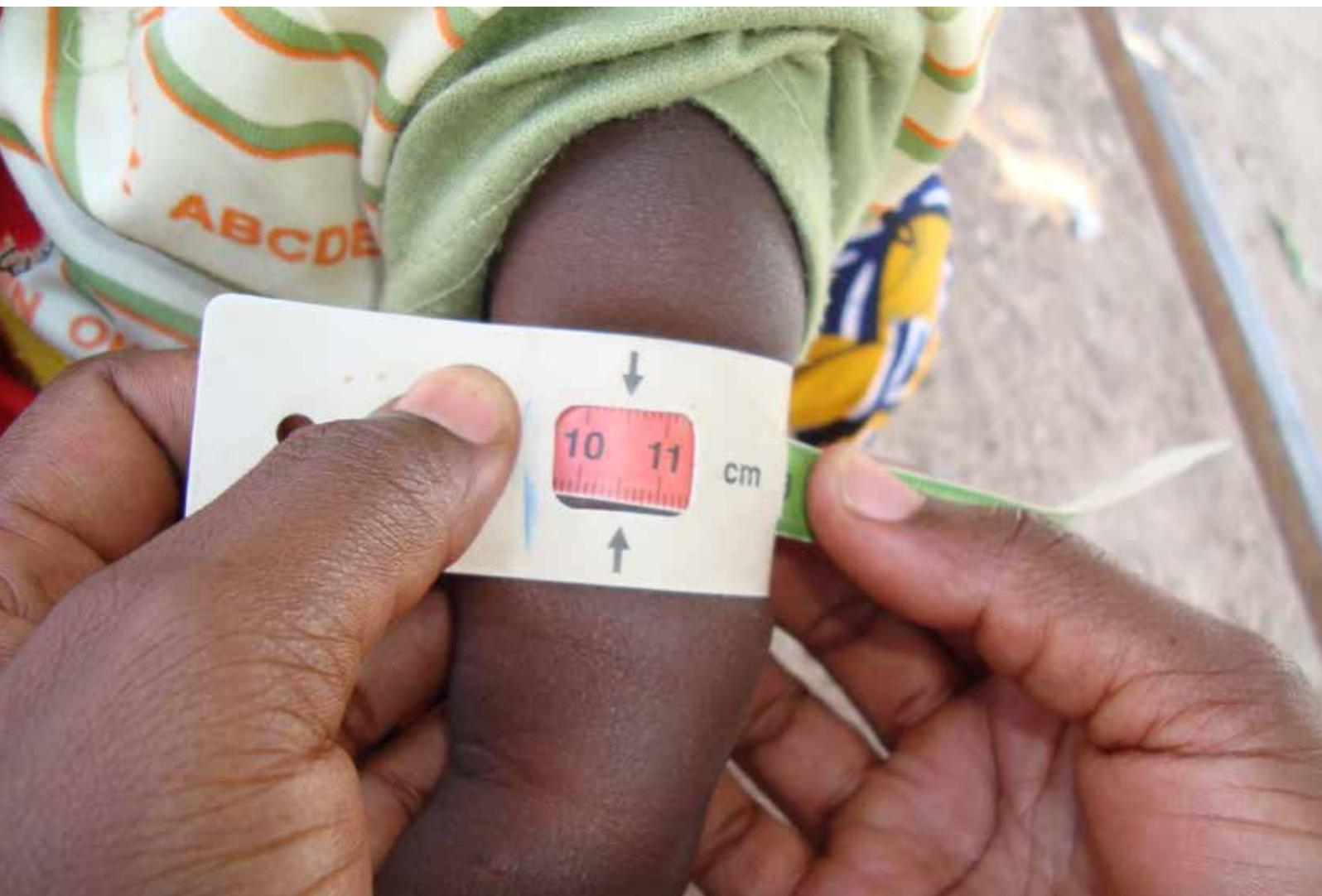
Aide humanitaire et Protection civile

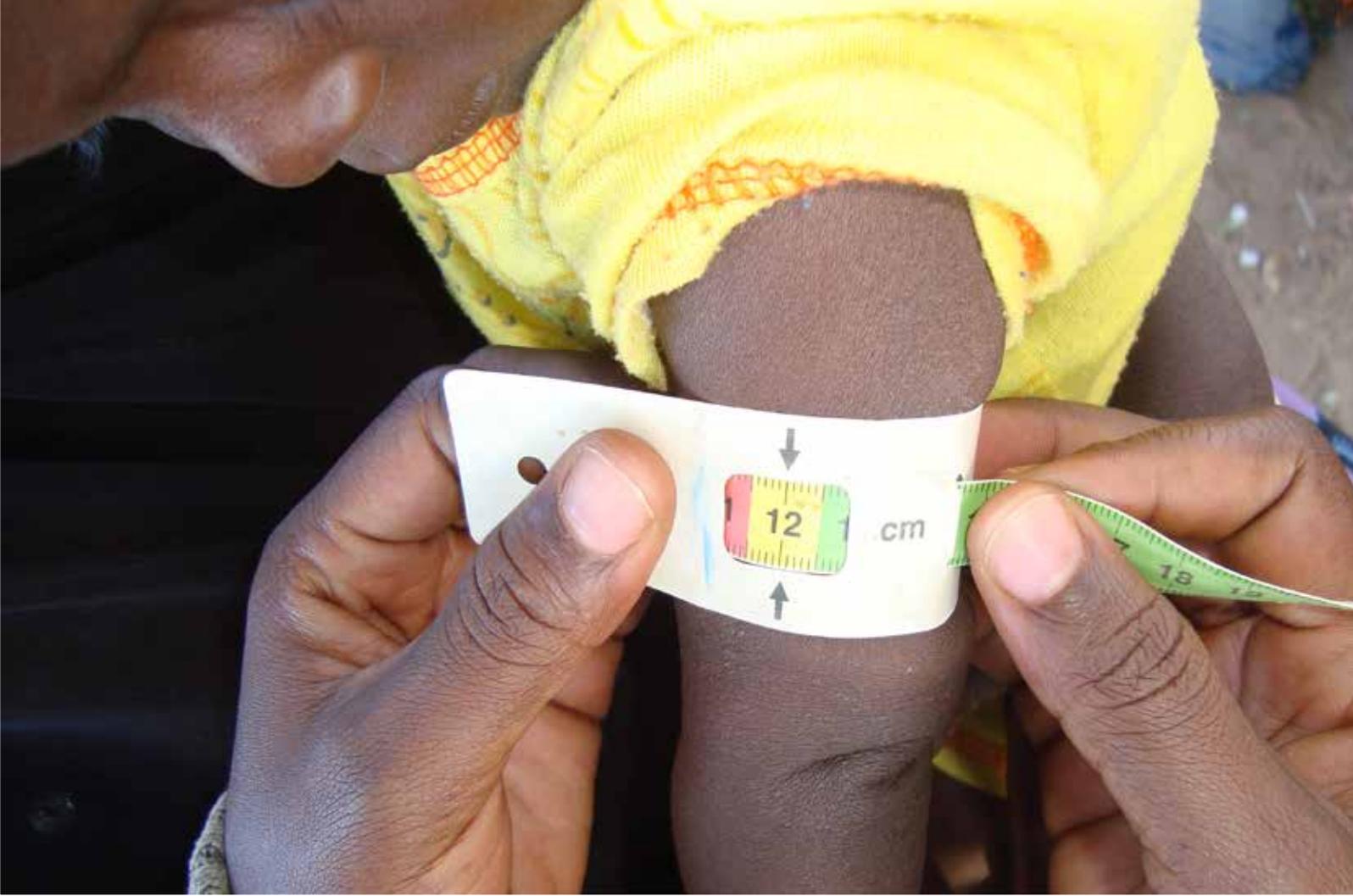


Projet ECHO/-WF/BUD/2013/91003

**PROJET D'URGENCE CONTRE LA MALNUTRITION
AIGUË SÉVÈRE
DANS LA RÉGION DU CENTRE - OUEST
Phase 2**

ONG LVIA / MMI: Tél: 50 36 38 04 - email : nutribf@lvia.it





Zine is a little boy who came to Italy when he was only 7 months old. He lives in Iraq, born in a poor and humble family, which, as many other in Iraq, suffers the consequences of uncontrollable and negative historical events. When Zine's mother was pregnant all the family components were very excited and involved in the joyous and happy preparation of the birth of the baby.

Unfortunately things did not develop according to the hopes of everyone. Zine was born with a severe malformation of the lip and the palate known as “cleft lip and palate”. His lips were open, as well as his palate, making his little face seriously disfigured. The opened palate prevented him from eating and drinking normally. Zine got sick very frequently, he was much more subject to develop infections than other children. He was much smaller than his same age boys. When he was 7 months old he did not seem to be even 4. In addition the cleft lip and palate were not the only his health problems, but just the most evident ones. Zine was also suffering from a severe heart disease, a congenital heart defect that made him risk his life every day. Zine was weak, too weak, his life was really hanging by a thread.

Seven months after his birth Zine came into contact with the reality of Emergenza Sorrisi, a non-governmental organization of volunteer doctors who performs reconstructive plastic surgery missions in the poorest countries of the world with the aim of operating children suffering from serious facial malformations, cancer, war traumas and burns. Emergenza Sorrisi is active since years in Iraq with an important project of health and surgical assistance which permitted to operate more than 800 children.

In December 2013 Emergenza Sorrisi started a project named “Settimana della solidarietà” (The Week of Solidarity) whose objective was to move to Italy particularly severe clinical cases that couldn't be operated during surgical missions. The project was founded to offer a possibility to children with serious birth defects who couldn't be operated in their countries. The aim of the project was to guarantee that 10 children, accompanied by a parent, would be undergoing a free surgery in Italy. The project provided the transfer to Italy of the patient and his companion, the organization of their arrival and their stay, the accommodation service that meets the standards of excellence, the free of charge surgical treatment and health care of the patients. In the course of an entire week these children were surgically operated in the hospitals of Rome, Bari and Naples. Together with the patients and their parents, also arrived in Italy 5 doctors who followed the activities of the project and participated in training course specifically organized for them in Italy.



Part of the patients involved came from Iraq, where local doctors have carried out an information campaign and the recruitment of patients with very serious malformations. Zine was one of the babies involved in this project. Of course his family was very happy for the possibility to give him hope for the a normal future and for not missing this opportunity the parents omitted to report to the association about another health problem that affected the boy: a serious heart disease.

That journey was too important, it was the only way to change Zine's life. The concern was to admit the existence of another disease and thereby risk the possibility of leaving. The child's parents knew that he could not be operated on the face because of the cardiac malformation, but this was for them the trip of hope, the hope of providing a future for their Zine. Zine came in Italy with his grandmother. Immediately during the first medical examination our volunteer doctors became aware of the heart disease problem, which prevented the child to undergo the plastic surgery operation for the correction of lip and palate.

Suddenly many questions crossed the minds of our doctors. Was it possible to send Zine home without offering him any solution? Was it possible to permanently delete the hopes of a family? Not for Emergenza Sorrisi, it was impossible for us to be so rational. A way had to be found, we had to look for an alternative. And so was intensified the network of volunteer work, thousand of phone calls were made looking for a solution, and this solution arrived, unexpected and so much appreciated.

The solution came from Naples where Dr. Giampaolo Tartaro and Dr. Raffaele Rauso, involved in the "Settimana della Solidarietà" project, were already operating other little patients who came in Italy together with Zine. The story of this baby had strongly captivated the attention of the two doctors and, thanks to them, another hospital could be involved in the project: the Monaldi Hospital in Naples with the cardiac surgery department directed by Dr. Caianello. Zine's little heart was operated at the Monaldi Hospital, and this surgery saved his life, a life otherwise condemned to not seeing any future. The doctors operated the heart first and the lip in a second moment.

All the operations to which the child has been subjected were extremely delicate and risky but the smile, the life and the future of that child had become objectives that could not fail. Many hands and many hearts are needed to give a smile. Zine met willing hearts and generous hands, desirous to write the happy ending story of his life.

- More Information: www.emergenzasorrisi.it

The Humanitarian Aid Foundation Redemptoris Missio was designed as medical facility for polish missionaries who work in the farest corners of the world for the most needy people. From the beginning we shared the vision of contributing to health for all, but not through policy making and advocacy but direct action. Last year was exceptional because of many successful projects. Our doctors, nurses and midwives worked in Cameroon, Ethiopia, Namibia, Jamaica, Republic of South Africa and India.

“Hocus-Pocus-EyeGlasses” was the most important Redemptoris Missio initiative in 2013. In response to requests from doctors and missionaries who work in Jamaica, we started to collect used prescription glasses. During few months we collected several thousand of glasses from donors who brought them to the headquarters of the Foundation in Poznań. Then our volunteers evaluated the power of lenses with the frontofocometer. Ophthalmologists from Poznań University of Medical Sciences prepared guidelines for missionaries on how to choose the strength of lenses in tropical conditions. The problem of refractive defects in people who live in developing countries was heavily accented in one of the last issues of the Dolentium Hominum journal. About 500 millions of people are affected by refractive problems, and 90% of uncorrected defective eyesight affecting people in developing countries. One of the conclusions was that to carry out “eyeglasses recycling” can be difficult. However, our observations show that a properly collected, marked and prepared glasses can greatly help combat the refractive defects of the poorest people in the world. Why “Hocus-Pocus-EyeGlasses”? Because for many people in developing world, a significant improvement in vision only through the assumption of a piece of glass on the nose is just like a magic!

We still continue the project “Dentist for Africa” which is co-founded by Polish Ministry of Foreign Affairs. Thanks to this close collaboration Redemptoris Missio can participate in competitions for development aid projects and is able to send medical students from Poznań University of Medical Sciences as interns to tropical countries.

The volunteer center of the Foundation still performs the arduous work of preparing packages of drugs and dressings materials for shipment. Last yer we sent more than 1,700 parcels, some of them also containing warm clothing and school supplies for poor people in Afghanistan and Kosovo. Shipping these parcels was made possible thanks to the cooperation of Polish military contingents based in those countries.

Moreover, we published 3 issues of *Medicus Mundi Polonia Magazine*, which in large part was focused on our new field of activity – the global and national problem of health workers shortages due to health workers migration – thanks to our participation in the European *Health workers for all and all for health workers* project. Last year the Foundation gained extensive knowledge and experience about the scale of migration, pull and push factors – and many useful insights about conducting a project co-financed by European Union. The most important finding from this activity was that in Poland there is still no proper space for discussion about health



workforce and planning and no shared broad horizontal vision of how to improve the national health system, also by regulating the migration problem. And the second conclusion: still we have a lot to do!

Furthermore, we like to highlight trainings provided by doctors associated with the Foundation, from the Department and Clinic of Tropical and Parasitic Diseases, Poznań University of Medical Sciences. These courses for missionary candidates place three times per year in the Center of Missionary Formation in Warszawa. We believe that the courses increase awareness of future missionaries to help and enhance their safety during their stay in the tropics.

Also it helps in identifying the medical needs of the society they serve, and thus allow to look for effective solutions!

The Foundation faces many daily difficulties. However, thanks to enormous contributions of selfless people, we keep up with our objectives and achieve them in a very satisfactory manner! Awareness that our work contributes at least a bit to improve the health of people in the poorest countries of the world is the greatest satisfaction!

- More information: www.medicus.ump.edu.pl

CAMEROON AND TANZANIA: HOW TO ADDRESS THE SHORTAGE OF CHILDREN'S MEDICINES

A significant proportion of the health care resources at any level is spent on medicines and health supplies. Unfortunately in spite of this, access to medicines remains a global challenge. One of the millennium development goals that are directly impacted by access problems is MDG 4 that seeks to reduce the less than five mortality rate by two thirds. The major killers of this age group are pneumonia (18 %), malaria (16 %), and diarrheal diseases (15 %). All these conditions are largely treatable with low cost medicines which should be available right from the lowest level of care.

Following this EPN decided to investigate the state of medicines for children in the church sector. EPN developed tools and a methodology for investigating the availability, pricing and factors impacting availability of medicines for children modelled along the one used by WHO. The tools and methodology have been validated and studies carried out in Ghana, Kenya, Uganda and Chad in previous years.

In 2013 EPN wanted to engage further improving the access to children's medicines. Mission for Essential Medicines and Supply (MEMS) in Tanzania and Presbyterian Church in Cameroon Health Services Central Pharmacy (PCC) in cooperation with Cameroon Baptist Convention Health Bureau (CBCHB) collected data in 50 faith based health facilities in both countries.

Objectives

- To investigate the availability and pricing of selected medicines at national level of the key suppliers for church health facilities and at facility level.
- To investigate health facility factors that might impact on availability of medicines for children.
- To identify measure to improve the access to children's medicines

Method

Two standardised questionnaires were used to characterise the facility, size, staff, services, and the medicines according the international defined essential and priority medicines lists (WHO) and national guidelines. In Cameroon 34 health centres and 16 hospitals were visited. In Tanzania data from 15 hospitals, 5 health centres and 30 dispensaries were collected.

PHARMACY



Results

Cameroon	Tanzania
<p>In 15 hospitals the data collectors found only 2 pharmacists, 22 pharmaceutical technicians and 14 pharmacy assistants. In health centres they counted 10 pharmaceutical technicians and 15 pharmacy assistants. Other staff was trained on the job.</p>	<p>In 15 hospitals we found only 8 pharmacists, 14 pharmacy assistants and 20 pharmaceutical technicians. At lower level facilities formally trained pharmaceutical staff is missing.</p>
<p>About 50% of the health facilities have reference books or guidelines on how to use medicines in children.</p>	<p>Access to specific information on children's medicine is limited: 80% of facilities have no guidelines specifically for children. Only 3 hospitals have the WHO Model Formulary for Children or a BNF for Children and Only 2 out of 50 facilities have access to internet.</p>
<p>Overall 76% of the health facilities had Oral Rehydration Salt (ORS), 24% could offer a package combination of ORS plus zinc tablets but the rest had almost no zinc tablets on stock.</p>	<p>While the most important medicine to treat diarrhoea ORS is available at 94% of the facilities only half can dispense zinc tablets although they should be given in combination.</p>
<p>Ceftriaxone was only available in 33% of the health facilities at all. Like in Tanzania the majority stored only the adult strength.</p>	<p>Ceftriaxone is mostly available as a 1g ampoule. Lower doses for children have to be withdrawn and the rest discarded.</p>
<p>If Salbutamol is available as an inhaler over 90% of the health facilities can't offer any spacer for children and do not know how to simply use a clean used plastic bottle to build one.</p>	
<p>The mark up exceeds often more than 200% compared to the price asked by the drug supply organisation. Health facilities tend to finance other expenses for staff and buildings through medicine prices.</p>	<p>Some patients have to pay 50 to 140% more than the most commonly asked price for a medicine. The mark-up of a price for a patient can be up to 200% above the facility price.</p>

Conclusions

Measures at different levels of the health system should address the shortages of children's medicines. Health facilities need to update their treatment guidelines and stock lists. Drug supply organisations should offer children suitable medicines in terms of strength and dosage forms. Proper inventory management skills can reduce stock outs and improve the overall access to children's medicine.

In both countries experts from different institutions and health facilities discussed the results and defined useful interventions to improve the situation. Thus, EPN runs follow up programmes in order to address the shortages on the different levels of the health systems to improve the access to children's medicine in 2014.

- More information: www.epnetwork.org



2013: FINANCIAL FACTS & FIGURES

Capital Account

Assets	Previous Year		2013	
I. Long-term fixed assets		1.00		1.00
II. Short-term fixed assets		102465.72		136574.60
Cash in hand	32.62		544,52	
Cash in banks	98199.41		135935,93	
Other amounts receivable	1293.66		15,97	
Prepaid expenses	2940.03		78,18	
Total Assets		102466.72		136575.60
Liabilities	Previous Year		2013	
I. Net equity		94575.04		103.336,34
Status 1 st January	99767.14		94575.04	
Net win(loss)	-5192.10		8761,30	
II. Accruals		3475.00		3475.00
III. Project funds not yet appropriated		4287.84		10042,00
IV. Other liabilities		128.84		19722,26
Total Liabilities		102466.72		136575.60

Statement of revenue and expense

Revenue	Previous Year	Budget 2013	Accounts 2013	Budget 2014
Membership contributions	74580.00	81200.00	81200.00	47500.00
Donations and subsidies (2013: review, HRH)		13250.00	22315.35	23500.00
Interest and other income	1543.32	1000.00	1103.23	300.00
Subtotal Revenue	76123.32	95450.00	104618.58	71300.00
Expenses	Previous Year	Budget 2013	Accounts 2013	Budget 2014
General expenses secretariat	62400.00	55000.00	57200.00	57200.00
Travel costs / hospitality / Network events	11229.54	16000.00	13046.36	16000.00
Projects: net expenses (2013: HRH project)		8000.00	3746.34	6000.00
Other expenses secretariat	3433.15	5400.00	3232.05	3000.00
Other expenses (2013: including review)	4252.73	19675.00	18632.53	4800.00
Subtotal expenses	81315.42	104075.00	95857.28	87000.00
Net loss/win	-5192.10	-8625.00	8761.30	-15700.00

All figures in EUR.

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 2014. The "Report on the Audit of the Financial Accounting as of December 31, 2013 for the Association Medicus Mundi International e.V." by thp treuhandpartner gmbh, Krefeld, Germany, is available at the MMI secretariat.

NETWORK MEMBERS

action medeor
St. Toeniserstrasse, 21
47918 Toenisvorst
Germany
www.medeor.de

**Africa Christian Health
Associations Platform**
P.O. Box 30690
GPO Nairobi, Kenya
www.africachap.org

AMCES
08 BP 215, Cotonou
Benin
www.amces-benin.org

**Community Working Group
on Health CWGH**
114 McChlery Avenue
Eastlea, Harare
Zimbabwe
www.cwgh.co.zw

Cordaid
P.O. Box 16440
2500 BK The Hague
The Netherlands
www.cordaid.com

Doctors with Africa CUAMM
Via San Francesco, 126
35121 Padova, Italy
www.cuamm.org

**Ecumenical Pharmaceutical
Network EPN**
Lenana Road 51, Kilimani
00606 Nairobi, Kenya
www.epnetwork.org

Emergenza Sorrisi
Via Salaria, 95
00198 Roma, Italy
www.emergenzasorrisi.it

Health Poverty Action
Ground Floor
31-33 Bondway
London SW8 1SJ
United Kingdom
www.healthpovertyaction.org

HealthNet TPO
Lizzy Ansinghstraat 163
1072 RG Amsterdam
The Netherlands
www.healthnettpo.org

i+solutions
Westdam 3b
3441 GA Woerden
The Netherlands
www.iplussolutions.org

medico international
Burgstr. 106
60389 Frankfurt am Main
Germany
www.medico.de

Medicus Mundi Italy
via Martinengo da Barco, 6/A
25121 Brescia, Italy
www.medicusmundi.it

**Medicus Mundi Poland
Redemptoris Missio**
ul. Dabrowskiego 79
60529 Poznan, Poland
www.medicus.amp.edu.pl

Medicus Mundi Spain
c/ Lanuza 9. Local
28028 Madrid, Spain
www.medicusmundi.es

Medicus Mundi Switzerland
Network Health for All
Murbacherstrasse 34
4013 Basel, Switzerland
www.medicusmundi.ch

Memisa
Kerkstraat 63
1701 Itterbeek (Dilbeek)
Belgium
www.memisa.be

Wemos
Ellermanstraat 15-0
P.O. Box 1693
1000 BR Amsterdam
The Netherlands
www.wemos.nl

Status: December 2013

