



ANNUAL REPORT 2014

“Network Health for All”

“Network Health for All”

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A LUTA CONTINUA! MESSAGE FROM THE PRESIDENT

NICK LORENZ, MEDICUS MUNDI SWITZERLAND

Travelling back to Switzerland from a conference or consultancy appointment in Southern Africa is normally a rather relaxed experience, with a good dinner and a comfortable seat in one of these big planes. In February, when I was repatriated from Mozambique in an ambulance jet after having suffered a stroke during a business meeting in Maputo, I was lying on a stretcher with all kinds of medical devices around me. At that moment, nothing was as usual, but all was excitement.

All was excitement – and at the same time relief: Yes, I survived it. I had not become another figure in a dire statistic of “preventable deaths”. I was rescued on the spot by competent colleagues who reacted immediately. I received prompt and appropriate care in a clinic in Maputo. And I was already on the way back home, expecting further professional treatment and rehabilitation.

Today these feelings are still very present. Currently undergoing rehabilitation in a specialized clinic in Basel, I am fully aware of my luck and privilege – in a sense of having access to treatment and care in a competent and supportive environment, and being free of financial worries.

Unexpectedly, “access to health and health care” has become a personal experience, one that will certainly shape my future engagement in this field.



A luta continua. The struggle goes on. This is the title of an impressive documentary produced by Medicus Mundi Catalunya and shown at the MMI General Assembly in Geneva in May. The movie refers to the achievements, challenges and difficulties in order to build a strong national health system in ...Mozambique and to improve the precarious health situation of the population in this country. What a coincidence.

“Health for All”, access to health and health care as a fundamental human right: this is what the Medicus Mundi International Network stands for and aims at. I am confident that the Network Strategy 2016-20 with its double focus on international health cooperation and global health policy is a good expression of this ambition. I am also confident that the objectives and particular contributions of the Network to the work of its members, which are outlined in the new strategy, show us clear directions on this way.

A luta continua. And I'll be with you.

A handwritten signature in black ink, appearing to be 'Nick Lorenz', written in a cursive style.

NETWORK HEALTH FOR ALL: PROGRESS AND PERSPECTIVES

The secretariat report refers to the MMI Network strategy 2011-15 (subtitles and quotes) and the three major programs developed by the Network within this framework:

- Research and evidence processes
- Human Resources for Health
- Global Health Governance

The last year was also characterized by a successful process of institutional consolidation and development of the MMI Network, resulting in the adoption of a renewed Network Policy and revisited statutes by the Assembly in May 2014 and the start of a strategy expected to lead to the adoption of a Network Strategy 2016-20 by the Assembly in May 2015. Since the adoption of the new statutes, MMI calls itself “Medicus Mundi International. Network Health for All”: our ambition has become part of our name!

Research and evidence processes

NGO Research Toolbox: In 2014, Nicole Moran, a Masters student at the Swiss TPH, successfully published her master thesis “Get evidence into NGO practice and policy. Get NGO practice into research”.

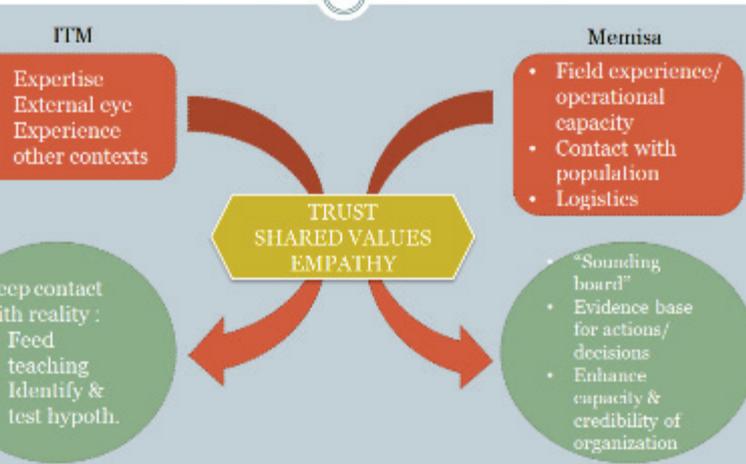
Referring to a background well known to MMI and to her overall research question “how can NGOs generate, access, share and use reliable evidence”, and in close cooperation with the MMI Network, Nicole Moran was focusing her work on “barriers, enablers and supportive tools for Health NGOs”. As a particular side-product of her thesis, she collected a “NGO Research Toolbox” and published it, together with the thesis, on the dedicated website www.ngo-research-toolbox.org.

Cape Town Symposium: In early October 2014, the MMI Network contributed to the Third Global Symposium on Health Systems Research in Cape Town, South Africa, with a session on "An ideal match! Successfully connecting NGO practice and Health Systems Research", organized by a Network team around Cordaid, Memisa and the MMI secretariat.





Win – Win situation



SEXUAL REPRODUCTIVE HEALTH

Presentation prepared by Joëlle Schwarz, Swiss TPH, joelle.schwarz@unibas.ch
 Presented by Dr. Nina Ndabihore, Swiss TPH, nina.ndabihore@swisstph.org
 and Dr. Christina de Vries, Cordaid, christina.de.vries@cordaid.nl



The MMI session targeted NGOs, researchers, policy makers and funders interested to learn how international NGOs working in the field of health development cooperation have successfully started integrating an evidence based approach into their institutional culture and operational practice. Two experiences of successful collaboration of NGOs and research institutions were discussed. The focus was less on the content of the research collaboration but on processes allowing innovative interaction between critical actors in a people-centered health system.

Christina De Vries and Nina Ndabihore presented the collaboration between Cordaid and the Swiss TPH in the Great Lakes region. Elies Van Belle and Bart Criel reported on the different forms of collaboration between Memisa and ITM Antwerp, built around the case study of a project in Mauritania. About 45 people attended our session, both from NGO as from research backgrounds, and the questions that shaped the discussion were challenging and interesting.

“Participating in this symposium was an eye opener to me, a great experience to learn and exchange, to get motivated by existing motivation, knowledge and action, relevant questioning and interesting people. It was also an excellent opportunity to share experiences and issues arising in our networks and daily work at a wider international level, and for visibility of the organizations/ networks.

On a more critical note and taking a step back, we have to stay aware and constantly ask ourselves how all this thinking and theory translates in action and change. This critical knowledge base, how will it now make things different? And how will this impact the final beneficiaries, the people, the families, the communities – the ill? This kind of critical self-reflection often came up all through the discussions though, and was in general seen as a positive and constructive note – how can we make the people participate in these discussions? How can we “package”, structure research outcomes into concrete and practical recommendations for policy makers?” (reflections by Elies Van Belle, Memisa.

In 2015, a MMI session at the European Congress on Tropical Medicine and International Health (ECTMIH) in Basel, on 7 September, will build on the Cape Town session. Its title: “How to bridge between health systems researchers and practitioners in the field of international health cooperation?”



Human Resources for Health

European project HW4All: In 2014 the MMI Network secretariat, several Network members (Medicus Mundi Spain, Memisa Belgium, Health Poverty Action, Redemptoris missio, Wemos) and partners outside the Network continued to be involved in the EU funded project "Health workers for all and all for health workers" 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. Project highlights in 2014 included:

- the publication of the synthesis report "Health workforce shortages and international mobility in the EU";
- the launch of an online collaboration platform (www.bit.ly/hw4all-open)
- the launch of a Call to Action for European decision-makers: "A health worker for everyone, everywhere! Towards strong health workforces and sustainable health systems around the world"
- the publication of a series of national case studies

The European project HW4All will be continued until the end of 2015. Over this time, proper project implementation will require a lot of attention – and work – by the involved MMI members and partners.

WHO Global Code of Practice: Over the last years, MMI has become a leading civil society actor in the follow-up of the WHO Global Code of Practice on the International Recruitment of Health Personnel. As such, but also in its broader involvement in the health workforce issue, MMI is well recognized by the WHO. This has become visible when the MMI executive secretary Thomas Schwarz was appointed as alternate representative of "Northern" Civil Society in the Board of the Global Health Workforce Alliance and was asked to represent GHWA in a WHO Expert Advisory Group on the review of the WHO Global Code of Practice.





Crucial times ahead for HRH: 2015 will be a critical year for global HRH policies, shaping the direction of the health workforce development for the coming years: First, the relevance and effectiveness of the WHO Global Code will be discussed at the 68th World Health Assembly in May, based on the report of the Expert Advisory Group. Secondly, the World Health Organization and the Global Health Workforce Alliance (GHWA) are developing a global strategy on human resources for health. Thirdly, the future institutional development of GHWA is hotly being debated, the global health initiative was created in 2006 to raise the global profile and funding of the health workforce. These processes have already started in 2014, and the HRH team of the Medicus Mundi International Network has been involved in all of them, either by providing own input or as a member of the Health Workforce Advocacy Initiative (HWAI).

Health Workforce Advocacy Initiative: In this civil society alliance, the MMI representatives play a role of a critical voice, challenging a merely “promotional” approach to advocacy. As an example, for a HWAI satellite session at the Third Global Symposium on Health Systems Research in Cape Town, the HWAI working group on migration coordinated by Thomas Schwarz contributed a paper and input on “Evidence-based civil society advocacy in the field of international migration of health personnel” which provoked a quite interesting debate on the role and limitations of country “commitments” and civil society advocacy.

Global Health Watch 4: Last but not least, and directly linked with MMI’s global health governance programme: The fourth edition of the “Alternative World Health Report” Global Health Watch published in 2014 includes a chapter on the global health workforce crisis drafted by a group around the MMI HRH team. Here some of our conclusions:

“The availability of a strong health workforce, supported by public funds, is a prerequisite for strong, universal and quality health systems. The current focus on UHC carries the potential threat of reducing the role of health workers to undertaking selective diagnosis and treatment, rather than addressing the health of people and communities in a comprehensive and integrated way, combining public health as well as individual clinical approaches. The concept of comprehensive primary healthcare, as enunciated in the Alma Ata declaration, envisages the latter. However, there is a growing imperative for health workers’ role to be guided primarily by concerns of economic efficiency. This approach inevitably emphasizes treating diseases rather than promoting health and reduces the health worker to a mere production unit. We not only need many more health workers, we require professionals working towards a society oriented to greater equity in health and wellbeing.”



Global Health Governance

Also the following section of the reports just picks up some highlights of the year. There would be much more to report on the engagement of MMI in the field of global health policy, but space is limited, so we leave some stories up for future reports...

WHO reform: Since the start of the WHO reform in January 2011 and throughout the last four years, the Medicus Mundi International Network has been strongly involved in this process. In 2014 the reform process focused on WHO's relations with "non-state actors".



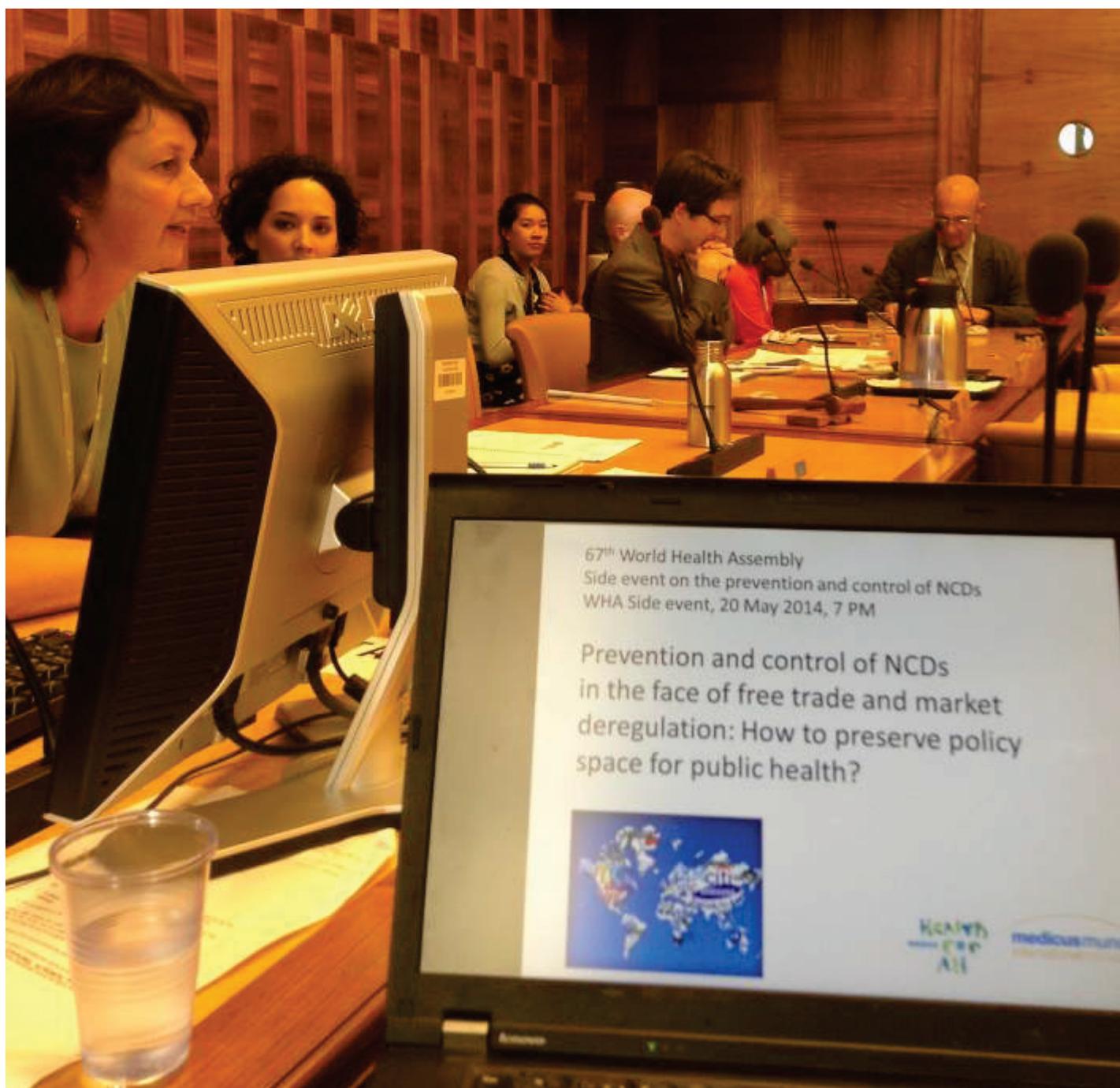
The debate on WHO's involvement with civil society is not new. Early 2000s there was already a proposition for WHO to cooperate with NGOs in a so-called civil society initiative. This proposition didn't pass the WHA in 2004, due to opposition by some member states. As part of the current WHO reform, new models for cooperation have been suggested, such as a proposal for a committee C of the World Health Assembly and a proposal for a World Health Forum. They both didn't make it either. In 2014, WHO's "non-state actors" policy was discussed at the WHO Executive Board meetings and the World Health Assembly as well as in several consultations in-between. The main debate between the member states was to what extent there should be a distinction between NGOs and private entities, and what the mechanisms should be to address potential conflicts of interest. And certainly civil society – and MMI – had a say on this. To be continued...

Ebola, global health governance and health systems: After some rather high-flying debates on global health governance (including the WHO reform) and the need to strengthen national health systems (Universal Health Coverage) in the previous years, both topics definitely arrived at the top level of global attention in 2014. And nobody really wanted this to happen...

2014 was the year of Ebola. It was the year of great efforts to fight this epidemic, and it was the year of fierce debates on global and national health caused by and related to the epidemic. Already in August, an observer noted that it "looks like every worthy global health cause (health systems strengthening, vaccination, research for neglected diseases) is now jumping on the Ebola outbreak bandwagon." In fact, in the entire second half of 2014, one could get just too much of Ebola articles, blog posts and tweets. But there was also plenty of sound and inspiring analysis, referring to the Ebola epidemic as what it continues to be: a great magnifying glass on structural crises and issues which otherwise could not be seen so clearly. As Ilona Kickbusch put it in a message on Twitter: "Could we dream that Ebola is a wakeup call for strengthening of WHO and global health governance - can something useful emerge from tragedy?"

Focus on NCDs and nutrition: In 2014, noncommunicable diseases and the related global coordination mechanisms became other “hot topics” of global health policy and governance. In the field of NCD, a Global Coordinating Mechanism (NCD-GCM) was set up by the World Health Organization, and the Medicus Mundi International Network, represented by Wemos, successfully applied for becoming a member of its civil society constitution.

A side event at the World Health Assembly organized by the MMI and Wemos together with the NGO Forum for Health underlined the potential loss of policy space for governments to address the increasing global health threat of noncommunicable diseases. The event led to a lively debate where civil society, the WHO and member states expressed their concerns related to the potency of trade and investment agreements to undermine health policies, for example related to tobacco control or the marketing of junk food. Trade deals are being made without proper assessment of the health effects and often do not take health problems into account.



Network development and Network events

Network Policy: With the successful review of the MMI Network Policy (the original version dated from 2009) by the MMI Assembly in May 2014, the Network achieved a milestone in its institutional development.

The MMI Network Policy is the basic document of the Medicus Mundi International Network. It is founded on the legally binding statutes – which were also reviewed in 2014 – and contains a set of guiding principles and operational guidelines which will be translated into more specific policies, strategic plans and regulations. The policy document includes sections on the shared vision of the Network members, on the Network's specific contribution to the efforts undertaken by its members in the fields of international health cooperation and global health policy, on Network membership and on Network organization and governance.

Besides a more open definition of the Network membership – membership is now open for all organizations working in the field of international health cooperation and/or global health, sharing the Network members' vision of Health for All and supporting the mandate of the Network, committed to actively participate in Network activities and to contribute to the sustainability of the Network and able to fulfill the related duties, including the payment of an annual membership fee – the key element of the new policy is the enhancement of the character of MMI as a Network of independent organizations, whose efforts to achieve the shared vision of Health for All are supported by the Network through a set of specific contributions, mainly:

- enhancing communication and cooperation among members and providing a platform for the development of joint activities, thematic working groups and consortia;
- fostering an evidence based approach in the members' institutional cultures and programs and promoting collaboration between the Network members and research institutions;
- providing a platform for joint advocacy at a global level, with a focus on the World Health Organization and in close cooperation with other networks and campaigns promoting Health for All;
- fostering the visibility of the Network members and their activities by publishing their news, reports, statements, events and other contributions.

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international network
health for all

Strategy development: After the adoption of the Network Policy, the Network immediately went into the process of developing a new strategic plan to orient our activities in the coming years. At a mini-symposium "Working towards Health for All: What's the count? And what role for civil society action and networking?" during the Assembly in May 2014, we made use of having many partners nearby because of the World Health Assembly to outline with them some overall perspectives for the coming years and the potential role of civil society – and the MMI Network – related to health systems, global health governance and determinants of health. It was a great informal talk with some insights into the environment of our work.





2014: FINANCIAL FACTS & FIGURES

Capital Account

Assets	Previous Year		2014	
I. Long-term fixed assets		1.00		1.00
II. Short-term fixed assets		136'574.60		136'017.69
Cash in hand	544.52		303.26	
Cash in banks	135'935.93		126'889.69	
Other amounts receivable	15.97		8'504.73	
Prepaid expenses	78,18		320.01	
Total Assets		136'575.60		136'018.69
Liabilities	Previous Year		2014	
I. Net equity		103'336.34		99'032.37
Status 1 st January	94'575.04		103336.34	
Net loss (2013: net win)	8'761.30		- 4303.97	
II. Accruals		3'475.00		2'975.00
III. Project funds not yet appropriated		10'042.00		13'032.24
IV. Other liabilities		19'722.26		20'979.08
Total Liabilities		136'575.60		136'018.69

Statement of revenue and expense

Revenue	Previous Year	Budget 2014	Accounts 2014	Budget 2015
Membership contributions	81'200.00	47'500.00	47'450.00	51'450.00
Donations and subsidies	22'315.35	23'500.00	32'119.28	23'500.00
Interest	279,73	300.00	483.40	300.00
Other income	1'103.23		1'008.10	1'200.00
Subtotal Revenue	104'618.58	71'300.00	81'060.78	76'450.00
Expenses	Previous Year	Budget 2014	Accounts 2014	Budget 2015
General expenses secretariat	57'200.00	57'200.00	57'200.00	57'200.00
Travel costs / hospitality / Network events	13'046.36	16'000.00	11'340.30	18'000.00
Projects: net expenses (HRH project)	3'746.34	6'000.00	4'597.30	6'000.00
Other expenses secretariat	3'232.05	3'000.00	3'568.08	5'000.00
Other expenses	18'632.53	4'800.00	8'659.07	4'800.00
Subtotal expenses	95'857.28	87'000.00	85'364.75	91'000.00
Net loss/win	8'761.30	- 15'700.00	- 4.303,97	-14'550.00

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 2015. The "Report on the Audit of the Financial Accounting as of December 31, 2014 for the Association Medicus Mundi International e.V." by RSM Verhulsdonk, Krefeld, Germany, is available at the MMI secretariat.



ANNUAL REPORT 2014 – PART 2

Short stories by Network members

HEALTHCARE FOR GRANNIES IN UGANDA

The “Granny Project” has been funded in 2013/14 by action medeor and implemented by PEFO Uganda in Jinja district Uganda, East Africa as a response to challenges faced by older persons in accessing health care services. The project targeted 600 grandmothers as primary beneficiaries for the pilot year 2013-2014. The project’s design based on the contextual analysis that access to services has remained a challenge in most parts of sub Saharan Africa particularly in Uganda.

In Uganda, access to health services is by far the greatest challenge affecting both middle and lower class clusters of the populace. Over the years, this situation has attracted global attention resulting into increased technical and funding support for health projects from international partners and governments. This support has been mainly provided HIV/AIDS, Malaria and reproductive healthcare leading to substantial number of malaria deaths reflecting more than half of mortality cases in Uganda. However, very limited concern is given to older persons; their health remains in jeopardy irrespective of the nature of disease or illness.

According to UNHS, 2009/10, 92.6% of older persons in Uganda reside in rural areas and depend on rain fed agriculture as their main source of livelihood; this source is very prone to shocks and stress resulting from climate/weather changes, reduced soil fertility among others. At the same time this older people are responsible for giving care to 63% of all orphans in Uganda and are caring for the sick children and grandchildren especially the HIV positive patients despite their diminishing vitality. It is important to note that in a country of approx. 34 million people, the total government health unit coverage stands at 14.3% and that of government hospitals at 0.9% (UNHS 2009/10). It is clear that Uganda’s healthcare is largely lacking to make consideration for the populace constituting 60 years of age or more a special priority.

The project for grandmothers was therefore designed to find working and sustainable measures to minimize such challenges as these mentioned before. The project’s overall strategy was garnering efforts aimed at strengthening the healthcare referral system within Jinja district. The project focused on interventions geared at strengthening the capacity of existing structures and actors to deliver qualitative good and age friendly healthcare services for older persons. In the process, the project encouraged the formation of grandmother associations, information dissemination and moral support; facilitated training in social gerontology and geriatrics to community health workers from health facilities commonly visited by grannies. The project worked together with the district health department to recruit and train registered Village Health

teams (VHTs) who work on voluntary basis, procured and distributed bicycles, gumboots and first Aid kits to VHTs. They use the bicycles between the granny homes as they conduct home visits and help carry ill grannies to the distant health facilities, conducted community medical camps for NCDs (Non communicable diseases) - the health facilities at parish level where grannies visit do not provide medical services for NCDs.

In Nakayiza's story below, we see how the project tries to support suffering and hopeless grannies in rural Uganda access healthcare services:

"In December 2013, I got involved in fatal road traffic accident in which I was seriously injured and sustained multiple complicated fractures especially on my legs. I woke up from unknown hours of unconsciousness on a hospital bed in Jinja National referral hospital where I had been taken by good Samaritans. The doctor who was by my bed narrated to me a scanty account of my ordeal and announced that I needed an urgent surgery to save my legs; a surgery he said would cost an average of Ugx 4.000.000 (€ 1,250).

I was alarmed by what I heard, I thought about my grandchildren. They were home alone and didn't even know what was going on with me. I hopelessly cried on the hospital bed with only painkillers, I couldn't move myself yet had no attendant to help move me. I asked the nurses to let me go home and figure out what I would do about the doctor's proposal but they didn't buy in. they instead helped me connect with my son whom I instructed to sell part of our farm land, and hire out the other to raise the money. He did exactly that. We lost our garden land and the people hiring are hiring for 8 years before we can use it again. I raised the money and had the surgery and a week after the surgery I Iran away from hospital.

A few months later, I started feeling pain on the scar from the surgery; the pain gradually intensified and I had challenges moving around again. Around the same time (Aug, 2014) Pefo organized a medical retreat for grannies at a health facility within my community which I attended hoping to get some tabs for the pain. The doctor booked me for another appointment and didn't tell me exactly why. When I returned, he sent me for some investigations which revealed I had a bone implant infection and the infection was to spread to all my bones if the infected implant is not removed. He referred me to Jinja Regional Referral Hospital (JRRH) for the operation. The memories of my struggles to find the money for the first operation were still so fresh and now again they needed me to pay Ugx 2.000.000 (€625).

At this point I stopped caring about the pain and about me dying I only worried about my helpless grandchildren whom I was about to leave on earth alone.



I returned home and had no adult to share with my condition until the next granny meeting day where I shared with a few friends who encouraged me to try herbs but the swelling and pain persisted. My life became so unbearable, I limped to the granny meetings which we hold once every week to relieve off some stress, my friends joked about with me and helped me lighten up for at least the hours I was with them there.

Then one day the project officer from PEFO traced me with the support from the VHT; he had shared with her the medical notes from the doctor who worked on me. She found me at the granny group weekly meeting point and asked to go with me home. She asked why I had defaulted prescriptions and referral advice from the doctors and I shared with her my financial situation and she left. She returned a few days later with two other colleagues who interviewed me and comforted me with hopes of finding me help; they encouraged my friends to visit me and help with some of the chores.

In October 2014, the project officer visited again and told me there was hope closing in as they were bargaining with the hospital to reduce the charges to an amount they could pay. She also asked if I could get an attendant for the hospital and a little money to help with meals during my admission to the ward. This good news though not confirmed made me feel healed already. I was overwhelmingly happy and wasn't even scared about the surgery at all. I was picked up at my home and admitted to the surgery ward on the evening of 17th, October and operated upon the next day.

By 1st November, 2014 the pain had greatly reduced and I was able to move my two lower limbs with minimal support and in January 2015 I was able to walk normally without any support. I owe my life to this project, because of the support I received, am back to my normal businesses and caring for my grandchildren.” (narrated by Granny Jane Nakayiza)

- Report by Justine Ojamboj (PEFO Uganda) and Jutta Herzenstiel (action medeor e.V.)
- action medeor website and project page:
www.medeor.de • www.bit.ly/actionmedeor-granny
- The Phoebe Educational Fund for AIDS Orphans and Vulnerable Children (PEFO Uganda) facilitates care and support for older persons and AIDS Orphans and Vulnerable Children households to promote sustainable development
www.pefoug.org • www.facebook.com/pages/PEFO-Uganda

AID IN REVERSE – COMPENSATION FOR HEALTH WORKER MIGRATION

Exploring the phenomena whereby rich countries have actively recruited health workers from the Global South, causing a catastrophic shortage of health workers in those countries, Health Poverty Action called upon the UK government to recognise how it has unfairly benefited from this situation and to do something about it. The latest report released by the International Development Committee, a parliamentary committee that scrutinises the UK's development work, picked up on our recommendation for compensation

The global distribution of health workers is an emblem for global health inequalities. 70% of the countries with a critical shortage of health workers are in Africa. In the UK we have 279 doctors for every 100,000 people. Sierra Leone has two. Tanzania and Liberia have one. These critical shortages impact on health outcomes. A child in Sierra Leone is 90 times more likely to die before his or her fifth birthday than a child in Luxembourg.

Many health workers from low and middle income countries are working in high income countries. In 2006, it was estimated that 25% of all doctors and 5% of nurses that were trained in sub-Saharan Africa were working in countries of the OECD. Five African countries (Sierra Leone, Tanzania, Mozambique, Angola and Liberia) have emigration rates of over 50%, meaning that more than half the doctors trained in these countries have migrated to the OECD.

At Health Poverty Action, we do not question the right of individuals to migrate, nor claim that migration is bad for development; but we do question the congratulatory focus of donor countries on the aid they provide, when in some cases the financial subsidy provided back to them – in the cost savings of training health workers – is actually a greater sum. Through this ‘perverse subsidy’ or ‘reverse aid,’ some of the poorest countries with the lowest numbers of health workers are in fact subsidising some of the richest. This is why we are part of the “Health Workers for All” project, funded by the European Union.

Of all the countries in Europe, the UK has received the most internationally-trained doctors and nurses, and is therefore a key beneficiary of this ‘reverse aid’. 26% of all doctors and 10% of all nurses in the UK were trained outside of Europe. Whilst health worker migration to the UK today is much lower than in the past – a result of the UK's Code of Practice, changes to registration criteria and increasingly restrictive immigration policies – we still have much to do to compensate for the subsidies we have received.



Take the example of Sierra Leone, currently battling the Ebola crisis. In 2010, the country had 136 doctors and 1,017 nurses. That's one doctor for approximately every 45,000 people. In contrast, the UK has 1 doctor for every 357 people. In 2000, Sierra Leone's health system was declared the weakest in the world, whilst the NHS was recently voted the strongest. Yet 27 doctors and 103 nurses who trained in Sierra Leone are currently in the UK. Whilst it is not possible to quantify the losses to Sierra Leone in terms of the value of their care or the lives that could have been saved, it is possible to attempt to calculate the financial subsidy Sierra Leone is providing to the UK. We do not know at what level or where they are working (NHS or private), but if we assume the 27 doctors are junior doctors, based on the savings generated (It costs the NHS GBP 269,527 to train a junior Doctor and GBP 70,000 to train a nurse) Sierra Leone's doctors and nurses are providing a saving of GBP 14.5 million to UK health services (EUR 19.8 million). If those doctors are consultants, the total subsidy Sierra Leone is providing to UK health services (NHS and private) could be up to GBP 22.4 million (EUR 30.4 million).

Thankfully, the UK's role in creating and sustaining global health inequalities is finally beginning to be recognised. In October 2013 Health Poverty Action produced a report and briefing, Aid in Reverse, focusing on the global health worker crisis and the UK's role in perpetuating it. Hundreds of our supporters wrote to UK Government ministers calling for compensation for countries that are providing a subsidy to UK health services.

In July 2014, along with 13 other UK and African NGOs we launched our Honest Accounts report looking at the resource flows – including health workers – from sub-Saharan Africa and calling for a more honest account of the UK's relationship with the continent. Along with other UK NGOs we have lobbied the UK's International Development Committee to undertake an inquiry into the UK's work on health systems strengthening. Their inquiry picked up on our concerns and in September 2014 they included in their recommendations a call for the Department for International Development (DFID) to “consider options for compensating source country systems”.

DFID has now committed to produce a new framework on health systems strengthening and, following further questioning in December, the Minister agreed that the UK would review international recruitment into the NHS. The outcomes of this remain to be seen, but recognising that the UK contribution to health systems goes beyond aid, and requires action on our policies and practices, is an important – if belated – start.

- More information and references:

Aid in Reverse (Health Poverty Action report, 2013): www.bit.ly/HPA-aidinreverse

Honest accounts (Health Poverty Action report, 2014): www.bit.ly/HPA-honestaccounts

They heard us (Health Poverty Action blog, 2014): www.bit.ly/HPA-theyheardus

THE NEED FOR REFORM OF ILLICIT DRUG POLICY

For health organisations, it might seem obvious that the issue of illicit drugs is a public health issue. However, current policies at the national and international level treat drugs strictly as a law enforcement problem. This has serious negative consequences, not just for people who use drugs, but for public health as a whole, including among some of the poorest and most marginalised communities around the world. Health Poverty Action has recently released a report, *Casualties of War*, discussing these consequences and calling for a fresh approach to illicit drugs policy.

Current illicit drug policies take a strictly prohibitionist approach to drug control, rooted in law enforcement and often backed up by military force. This means that people who use drugs are effectively criminalised. The net effect of these policies is to drive drug use underground, which removes any controls on drug strength and purity, and means that injection is frequently done with unsterile equipment in unsafe conditions. In fact, in a number of countries, possessing drug paraphernalia is a crime in itself, which discourages people from getting sterile injecting equipment. This increases the risk of overdose and the spread of blood-borne viruses.

Strict drug prohibition fosters stigma that leads governments to underspend on harm reduction measures such as education, opioid substitution therapy, needle exchange, and safe injecting sites, and on treatments for drug dependency. This stigma, combined with the fear of punishment, also deters people who use drugs from seeking life-saving medical care – not just for drug addiction, but for any conditions that may be linked to drug use, such as HIV/AIDS. Among people who use drugs, less than 8% have access to a needle and syringe programme, less than 8% have access to opioid substitution therapy, and less than 4% of those living with HIV have access to HIV treatment.

Those who argue in favour of strict prohibition say that it is ultimately beneficial for health, because it reduces drug use. However, the evidence shows that this is not the case. The current international drug control regime is more than fifty years old, and it has failed to reduce drug use; if anything, the drugs available on the street are becoming cheaper, and the illicit drug trade has diversified and spread across the globe in direct response to enforcement efforts.

Drug policy and pain medication

The health impacts of current drug policies aren't limited to people who use drugs and their families. Current drug policies also seriously restrict access to essential medications in poorer countries. Pain medication – a vital part of healthcare from the treatment given to patients with

terminal diseases to the anaesthetic doctors need for life-saving operations in war zones – is hardest hit. Five billion people live in countries with little or no access to pain medication. This isn't because the medicine is too expensive for those countries to afford. Opioid pain medications like morphine are plentiful and relatively cheap. But governments concerned that morphine and similar drugs, or their ingredients, could end up on the illicit market put barriers in place that make it extremely difficult for health workers to access, prescribe, and distribute pain medication. A recent study found that 84% of countries surveyed had unnecessarily high policy barriers keeping people from accessing essential pain medicines.



Wider consequences of the war on drugs

Prohibitionist policies have much wider consequences, beyond effects on harm reduction and access to medicines. In fact, the current approach to illicit drugs undermines development. Strict prohibition means that government funding is frequently channelled into the military and law enforcement to uphold drug laws, and to fight ongoing, often unwinnable wars with drug cartels. The cost of enforcing drug prohibition falls disproportionately on poor countries, as wealthier countries put pressure on poor countries' governments to spend increasing amounts on enforcement. At the same time, by keeping illicit drugs expensive, prohibitionist drug laws keep the drug trade profitable, and ensure that cartels have the funds they need to weaken or control governments through bribery and intimidation. This creates widespread corruption that diverts further funding away from health systems, social welfare, and broader measures to address poverty and inequality.

The annual global price tag for enforcing anti-drug policies is estimated at US\$100 billion – rivalling the \$130 billion worldwide aid budget. If a fraction of this money could be freed up for spending on public health, poor countries could have stronger economies and better health systems. In fact, the Overseas Development Institute (ODI) estimates that the additional financing needed to meet the proposed Sustainable Development Goal of universal health care is US\$37 billion a year - only a little over a third of the amount that is already spent worldwide enforcing failing drug policies.

Beyond these direct impacts, drug policy affects the underlying determinants of health: community security, sustainable livelihoods, and other key building blocks of public health. A law enforcement approach to drug policy fuels conflicts between governments and cartels, which can threaten the stability and disrupt the governance of already fragile countries. It also creates an environment where human rights are often treated as secondary to drug law enforcement, leading to widespread human rights violations, especially affecting ethnic minority groups. The resulting violence and instability pose serious threats to public health and to the strength of health systems.

Strict drug prohibition also deepens poverty in some of the world's most marginalised communities. Most farmers who grow drug crops do so because they lack other viable options to support their families. Criminalising these farmers and eradicating drug crops before any other livelihoods are in place punishes small-scale producers and their communities by seeking to eliminate their only sustainable source of income. Poverty places people at greater risk for ill health, and makes it difficult for them to access health services.

Time for change?

Health Poverty Action has begun working with health and development NGOs in the UK to advocate for a public health and human rights approach to illicit drug policy, in order to address the negative impacts of current policies on public health and wider development. In April 2016, the UN General Assembly will hold a special session (UNGASS) to discuss the future of international drug policy – an issue with serious implications for the fight against global poverty. This is a crucial opportunity to ensure that the needs of the world’s poorest and most vulnerable are at the centre of drug policy.

What we are calling for

1. Genuinely open and informed debate on the future of drug policy at national and international levels.
2. Evidence-based, pro-poor policies that reduce harm to people who use drugs, small-scale producers and traffickers, and vulnerable communities.
3. Analysis of impacts on poverty, health, and development as a key component of the development and monitoring of any drug policy.
4. A role for national health ministries and development agencies in determining drug policy.

- More information and references:

Casualties of War. How the War on Drugs is harming the world’s poorest.

Catherine Martin, Health Poverty Action report, February 2015

www.healthpovertyaction.org • www.bit.ly/HPA-casualtiesofwar (PDF)

Photo: Burning hashish seized in Operation Albatross, a joint operation of Afghan officials, NATO and the DEA. © DEA (taken from the cover of the “Casualties of War” report)

YOUTH TODAY: DO IT!

“Actua” (“Do it!”) is a joint project of four associations in the Navarra province, Medicus Mundi Navarra, Ilundain Foundation, Escuela de Tiempo Libre Urtxintxa, and IPES Elkartea, who are united to promote active citizenship, engagement and social involvement of young people, enabling them to participate in the society and to transform their environment, with a focus on human rights, sustainable development and prevention of social exclusion.

The project includes youth counseling sessions for social action in youth centers and institutes, strengthening of solidarity groups, development of a process of action research carried out by young people from different associations, training young people at risk of exclusion for self-employment by managing organic gardens, training of teachers and voluntary instructors that work with young people in leisure activities, and, at the end of the project, a meeting with associations working with young people to share experiences made. In the action research part of the project at least 100 young people from 10 non-formal education partnerships will make an analysis of local problems and put them in relation with the global situation. They will propose solutions to the political authorities.

The political, economic and social context strongly influences the vulnerability of the population, especially of young people. Social exclusion makes it difficult to fulfill an autonomous citizenship.



Therefore the main goal of the project is the promotion of skills and active participation in citizen action among young people. We must ask about the possibilities that exist in today's world for young people to exercise their rights and citizenship. Young people are agents of change for the future society. From a human rights approach exercising rights means that the young people involved in the project consider themselves as subjects of rights, protagonists and active agents in social transformation. It is important to develop among them skills that will enable them to deal with common goods and to implement proposals for citizen action. The focus of global citizenship is linked to the concepts of inclusion, social justice and human rights. Besides the basic qualities of active citizenship (inclusion, participation, achieving results) it incorporates a holistic vision and an interaction between the local and the global.



Ethical garden: "Fair food for 100 families"

Beatriz Calvo Tena, a biologist and technician in forest management, has been working for two years in the Ilundain Foundation and since September last year involved in the Actua project managing the construction of an ethical garden. She explains its background and objectives:

"Our ethical garden is an educational project that integrates respect for the environment and improving society through horticulture. The garden is a great place to promote care for nature and for the other people as it requires collaborative work. Moreover, the garden is also a space for social inclusion and promotion of self-employment in our valley.

Ethical gardening is more than just organic gardening: In addition to the undeniable ecological component, it provides an educational space where collaborative work and equality are promoted, not only gender related but also regarding disability and social exclusion. It intends to be a space for access to culture, job training and integration of young people at risk of exclusion.

Our ethical garden has been maintained for many years by the Ilundain Foundation, but now we want to bring it to a higher level, offering more training opportunities to young people and ensuring continuous production of vegetables with a view of creating a consumers group involving people of the valley. In this regard, the Actua project has allowed us, among other things, to build a new greenhouse, refurbishing the other two we already had and expanding the drainage system.

The idea is to expand the number of participants from the Aranguren Valley and the surrounding areas. The garden shall allow consuming healthy, environmentally friendly and affordable food for up to 100 households.

We opted for innovative and experimental work in Navarra with the idea of bringining the different associations involved together so that the can share experiences in view of a collective learning process.

Overall the Actua project aims at transferring new approaches about global citizenship to social multipliers: teachers, voluntary instructors, and groups of young people. 545 people, most of them aged between 14 and 17 will directly benefit from this project. In the midterm, it is expected to reach out to more than 10.000 people.

- More information: www.actua.social

After almost 40 years of silence population control seems to be back in the debate of global development policy. Shaped by population theories of Thomas Robert Malthus in the 19th century, the axiom that certain populations are not able to control their reproduction on their own and are therefore punished by their natural environment in not delivering enough food is repeated again in public debates – such as experienced last year in Switzerland.

In Britain the TV naturalist Sir David Attenborough told a Radio Station last January that human population growth must be limited: “We are a plague on the Earth. It’s coming home to roost over the next 50 year or so. It’s not just climate change; it’s sheer space, place to grow food for this enormous horde.” You may take this for unwise words of an old man. We see it as quite deeply rooted thinking, which takes its power in our days from insecurity and fears in the context of globalisation and ecological threats.

In November 2014 Swiss citizens were called to the ballot-box for voting on the so called Ecopop initiative that not only wanted to limit the migration to Switzerland, but asked as well that 10% of the Swiss development cooperation budget would be earmarked for voluntary family planning.

Xenophobia with internationalism

The initiative combined two issues which seemed not to be interrelated. The groups behind the initiative claimed that the reduction of migration would reduce ecological damages within Switzerland. In proclaiming so the initiative fuelled xenophobia in Switzerland. Secondly it requested the Swiss Government to invest more in voluntary family planning in developing countries – in order to reducing the population pressure from abroad. Paradoxically this claim reflected – or could be misunderstood as – an internationalist approach.

For understanding the link between the two issues one should know the background of the people behind the initiative. Ecopop is an association that was founded in the seventies of the last century. In its view overpopulation is the cause of all ecological problems – “uncontrolled” population development in developing countries would threaten our planet – neglecting that the ecological damages worldwide are mainly caused by the rich, not really “over-populated” countries.

A differentiated position of Medicus Mundi Switzerland

The initiative challenged quite many of members of Medicus Mundi Switzerland as they are working with family planning methods as part of a sound intervention to improve women's and children's health or as part of their sexual and reproductive health programmes. So shouldn't they have been happy that the issue was set on the political agenda by a broadly debated initiative? Shouldn't they have welcomed the enforced spending of money for family planning?

For good reasons, the board of the Network Medicus Mundi Switzerland as well as many member organisations clearly rejected the Ecopop initiative. Together they decided to roll out a media campaign to make our point of view heard in the public debate.

The Network Medicus Mundi Switzerland pointed out three arguments against the initiative.

1. Voluntary family planning is one of the most cost-effective investments to reduce unwanted pregnancy, as well as maternal and new-born death. But it only makes sense if it is embedded in broader sexual and reproductive health interventions. The strong focus on access to family planning would have weakened an integrated approach to improve access to sexual and reproductive health services along the continuum of care.
2. The woman's right to decide if, when and how many children she wants to give birth is a fundamental right. The Cairo International Conference on Population and Development 1994 has brought this crucial change of paradigm in population's policy. The Ecopop initiative would have gone behind these achievements.
3. By this initiative Swiss development cooperation would have been forced by the constitution to focus on the goal of reducing overpopulation globally. This would have discredited the country's whole development policy.

To promote our arguments we addressed media directly. In the beginning of the campaign we focused on talking directly with some key newspapers that have certain relevance in Switzerland. For the *Neue Zürcher Zeitung* we organised a background talk with some experts from our Network members like Imaneh, Sexual Health Switzerland, Swiss Red Cross and the Swiss Tropical and Public Health Institute. This intervention triggered off several other reports by other medias.

Our point of view competed not only with the view of the Ecopop people but as well with some other NGO's – represented by the influential network Alliance Sud – that rejected the initiative. Their arguments ignored family planning instruments as effective development measures and focused on other topics such as the need for better education and economic development. For the Network Medicus Mundi Switzerland this approach wasn't wrong, but as a Health for All

Network we didn't want to ignore that family planning may play a crucial role in improving the health status of a population.

Finally the initiative was rejected clearly by 74% of the Swiss voters. And, in the end, the arguments forwarded by the Network Medicus Mundi Switzerland could highly influence the media's perspective on family planning as part of a rights based, sound intervention for sexual and reproductive health.

- Reported by Martin Leschhorn, Director, Medicus Mundi Switzerland.
More information: www.medicusmundi.ch • www.bit.ly/mms-ecopop



INNOVATIVE APPROACHES IN THE FIGHT AGAINST LEPROSY

The Novartis Foundation has been active in the fight against leprosy for over 25 years. Building on our extensive experience with field project partners and with input from world class experts in leprosy, we developed a new strategy to reduce the incidence of leprosy by interrupting transmission of the disease. The strategy focuses on early diagnosis and prompt treatment, surveillance and response, preventive therapy for contact persons of recently diagnosed patients, and research and development of diagnostic tools. Through the new leprosy elimination strategy, the Novartis Foundation is reinforcing its commitment to the shared goal of eliminating one of the world's oldest and most persistent neglected tropical diseases.

In mid-2014, a milestone was achieved in Novartis' commitment to end leprosy: donations of multidrug therapy (MDT) reached over 6 million patients worldwide. Thanks to MDT and the efforts of the World Health Organization (WHO) and anti-leprosy community, the global burden of leprosy has been reduced by 95% since the 1980s – a huge public health success story.

However leprosy patients continue to be detected and over the last decade, the number has plateaued at about 220,000–250,000, with persistent high-burden pockets of disease across Asia, Africa and Latin America. Figures from the WHO show that 215,000 new patients were diagnosed in 2013. Although this is a reduction from 2012, for the global health community to go to the final mile in eliminating this ancient disease, focus needs to shift towards prevention to again curb the incidence of leprosy.

The Novartis Foundation is working on three key initiatives as part of our strategy: the multi-country Leprosy Post-Exposure Prophylaxis (LPEP) project, the contact-tracing project in Cambodia, and co-creation of tools to accelerate leprosy diagnosis.

The LPEP project is a centerpiece of the Novartis Foundation new strategy toward zero transmission. Launched in June 2014 in collaboration with Netherlands Leprosy Relief, International Federation of Anti-Leprosy Associations partners, Erasmus University Medical Center Rotterdam, Swiss Tropical and Public Health Institute and national leprosy programs, LPEP aims at combining early diagnosis and treatment of leprosy patients with preventive therapy of their asymptomatic contacts.



Under the LPEP project, asymptomatic contact persons will be offered a single dose of rifampicin as post-exposure prophylaxis (PEP). This decreases their risk of developing leprosy in the years following contact by as much as 50-60% (Moet et al. 2008). This year, the LPEP project will be rolled out in several pilot areas across Asia, Africa and Latin America.

Contact-tracing is at the heart of a pilot project supported by the Novartis Foundation in Cambodia, in collaboration with the Cambodian National Leprosy Elimination Program and the CIOMAL Foundation. The pilot project aims at determining the yield of early case detection when contact persons of formerly diagnosed leprosy patients are screened. Pok Sokha, a former leprosy patient in Cambodia reflects: “If I had received treatment in time, I wouldn’t have this disability. I really understand that it is important to get diagnosed early and promptly treated.”

By extending contact-tracing in Cambodia and elsewhere, we hope to diagnose many more leprosy patients like Pok and treat them promptly to halt the spread of leprosy among their families and communities. This contact-tracing approach offers a potentially cost-effective way of conducting early leprosy diagnosis in areas where incidence is low, as it enables active case detection activities to be concentrated over relatively short periods of time.

As part of the project the community is sensitized to the fact that treatment with MDT effectively interrupts transmission. “When I went to the hospital and the doctor said I had leprosy, my wife was really scared,” Pok explains, “but once I started treatment she was so happy to hear that I would recover. Now I’ve completed my treatment, the doctor said I’m fine. And luckily the disease hasn’t affected my wife and children.”

To find more patients and prevent disfigurement and disability from leprosy requires early detection and diagnosis. With no diagnostic test available, however it is often difficult to diagnose at an early stage, requiring specific skills. Therefore, as part of the Novartis Foundation’s work to accelerate elimination of leprosy and malaria by focusing on interventions that aim at interrupting transmission, we are supporting the groundwork for the future development of a laboratory test and encourage innovative solutions for leprosy detection, including a mobile-phone based leprosy referral system.

■ More information:

Website of the Novartis Foundation: www.novartisfoundation.org

Leprosy Post-Exposure Prophylaxis (LPEP) project: www.bit.ly/foundation-lpep

Contact-tracing project in Cambodia: www.bit.ly/foundation-contacttracing

Co-creation of tools to accelerate leprosy diagnosis: www.bit.ly/foundation-diagnosis

2014 started off as ‘just’ another year for Wemos, MMI and other civil society organizations attempting to get human resources for health into the limelight as an essential part of sustainable health systems, advocating for more policy coherence and a health-in-all-policies perspective and defending the regulatory, policy-making and norm-setting role of the WHO.

In our ongoing advocacy for a strong WHO, we continued to keep our eyes on the Framework for Engagement with non-State Actors. Together with other CSOs, we were able to create a critical mass and several WHO Member States are calling for the framework to include stronger language on conflicts of interest, to protect public health interest from undue influence. Wemos, South Centre, IBFAN and Society for International Development (SID) together organised a seminar for member state representatives in October 2014, to have a discussion on conflicts of interest in multilateral negotiations on health, nutrition and trade. This meeting has been instrumental for discussing critical issues with Member State representatives, sharing information and suggesting improvements for the policy document.

Our call for policy coherence and protecting health in trade and investment agreements aroused a lot of interest, as we had more participants than we could seat at last year’s side event during the WHA, organised by Wemos, NGO Forum for Health and MMI. Towards the end of 2014, the wider public started gaining interest in the impact of trade on health, nutrition, social services well-being in general and as of recent, a growing number of policy makers is turning against the widely criticized investor-to-state-dispute settlements (ISDS) that enable private corporations to sue governments over policy measures taken in the public interest, including public health.

With the project «Health workers for all and all for health workers» Wemos and CSOs from eight European countries call upon politicians and policymakers to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO Code). In this second year of the 3-year project we published an overview of crosscutting trends regarding the implementation of the WHO Code in the European region (HW4All synthesis report). As collaborating partner we provided input to the EU Joint Action on Health Workforce Planning and Forecasting making recommendations about the ‘applicability of the WHO Code in the EU-context’.

Our final call to action launched at 5 June 2014 has received endorsements from more than 80 European and global organisations. The Global Health Watch 4 includes a chapter on the global

health workforce crisis in which we demonstrate how the WHO Code can provide an anchor for a coherent health workforce policy.

In the second semester of 2014 the Ebola-epidemic kicked in hard, and made it very clear that this was not ‘just another year for global health advocacy. It is tragic though, that still the world needs crises to realise the need for change. Reminding the international community why it is so important to have a skilled health workforce in place to provide essential and universal health services. Reminding them also that we have a universal responsibility to address future outbreaks, given that we live in an increasingly interdependent world. This requires a prioritisation of policy coherence for development, including the sustainable management of health workforce migration at a global level and a strong World Health Organisation that has both the mandate and the means to formulate policies, regulate and set norms in the interest of public health.

- More information: www.wemos.nl



TRAINING DOCTORS IN AFRICA: “WHAT ARE ITALIAN STUDENTS DOING DOWN THERE?”

Since 2005, almost 200 Italian medical students decided to take a step outside of their usual habits and traditional curriculum to go see firsthand a real situation of international health cooperation in countries that are often overlooked, where Doctors with Africa CUAMM brings health services every day. It ends up not being such a difficult step from the university classroom to Sub-Saharan Africa's red earth. It takes energy, a desire to learn and to get involved, challenge yourself and explore medicine in a different place.

All the students have their own stories, different motivations that spur them to go, their own personal ways of understanding medicine and the medical profession. They all share open eyes, minds and hearts and the willingness to live in a faraway place for a month, a place that is different, where resources are limited. Here doctors have to know how to go beyond the bounds of their specialization, and patients have an approach to health and illness very different from what we are used to in Europe.

"Since we got to St. Luke hospital, we have been welcomed in a familial embrace by CUAMM's doctors who made sure we were integrated with the local personnel and the surroundings. They shared invaluable practical knowledge with us, and we talked about our life experiences over a nice bunna, the Ethiopian coffee. The first test is an ability to adapt. Limited hygiene and resources might shake you up but won't stop you. Here there's a need for "your medicine", your hands and your eyes. The ears that are needed are ones that can help understand a patient's story. The next step is to refrain from wanting to understand everything and rediscover a deeper meaning of being a doctor today, not just doing medicine." (Giulia, 22, student at the University of Rome, went for a month-long training at the hospital St. Luke Wolisso in Ethiopia)

The experience is both on a professional level and a human one. For ten years, the NGO Doctors with Africa CUAMM has been offering the students of SISM — Italian Medical Students' Association — the chance to spend a month of their university career in Ethiopia or Tanzania, taking part of the NGO's daily work in the local hospital. Students observe, listen and learn by seeing the everyday life of a context with limited resources where professional doctors provide quality care to the local population. They are immersed in a kind of medicine completely different from the Western standards to which they are accustomed. They find themselves rethinking the basic vocabulary of medicine and experience a different culture to learn to be future doctors who serve patients. They quickly have to put aside the Western mentality of "I'm coming to save you" and replace it with "I'm coming to meet you".



Photo: Matteo Fantolini

The project was originally called the *Wolisso Project* because Wolisso, in Ethiopia, was the only destination for the training at first. The field training project remains an invaluable and rare opportunity in European university systems. The project was started by young people for young people, created to give medical and surgery students a chance to encounter the world and broaden their horizons.

Over the years, the project has grown and strengthened through the experience developed. In 2015, there are plans for 48 students to go; four each month, two to Wolisso and two to Tosamaganga, Tanzania, allowing for a growing number of young people to gain experience in health cooperation. Students are involved in community life at CUAMM's guesthouse in addition to working in the hospital. The experience expands beyond a hospital internship to include the full context of international cooperation. Students are engaged both with the work of international cooperation and with African life and situations more broadly speaking.

Not just Africa

However, the Wolisso Project is about more than just the experience in Africa. The project's objectives include more broadly involving medical students and the general population by organizing seminars and conferences on international cooperation and global health. The numerous Italian locations of SISM, 37 throughout Italy, are involved in these projects to reach the widest interested group. One such example is the Frontier Semiotics course that involves seminars held by CUAMM doctors with field experience to give students information about how medicine is practiced in Africa, where there are a shortage, or total lack, of diagnostic tools.

In keeping with the principles of international cooperation and to take advantages of the resources that students have, the Wolisso Project coordinates with CUAMM's local personnel to develop projects that aim to improve delivery of health services to the hospitals that host the students. The Wolisso Project is currently supporting the training of an anesthesiologist in Wolisso, who will be committed by contract to work at St. Luke Catholic Hospital in Wolisso for at least four years after graduation. The project's principle responds to the shortage of anesthesiologists in Wolissa, part of the larger phenomenon of "brain drain" in the medical and healthcare fields in recent years in Africa at large; doctors and healthcare workers who are trained in their own countries often migrate to countries with more favorable contract terms and compensation.

A continuing story

The Wolisso Project has a history that proves its quality and stability with growth steps to confirm it, such as international recognition as the third best project in the world for medical students, received at the Project Presentation of the General Assembly of IFMSA, International Federation of Medical Students' Associations, in Baltimore in 2013.

The idea to further invest in this project is a direct result of this and takes tangible form in the renewal of agreements between SISM and Doctors with Africa CUAMM, with the intent to boost training, expanding the Wolisso Project's range of experience and seeking to involve a growing number of students in this journey that gives such an important gift to their future identity as doctors.

And now for those who would like to follow the stories, feelings and experiences of the SISM students in Africa, you can keep an eye on their new blog to hear about what these Italian students are doing and learning on the other side of the world.

- More information:

Doctors with Africa Cuamm: www.mediciconlafrica.org

Wolisso project: www.wolissoproject.org

SISM students' Blog www.educationglobalhealth.eu/blog



GUEST BOOK

Il SISM dall'altra parte del mondo



Guestbook, kitabu cha wageni, diario degli ospiti.

È usanza che nei villaggi africani ce ne sia uno e chi passa di lì, per starci un giorno o per fermarsi nel tempo, metta il proprio nome e la data. Si registrano così partenze, passaggi, arrivi, persone, ma solo si possono immaginare le storie che portano con sé.

Prende spunto da questa tradizione africana il nostro *guestbook*: un libro che ci racconta l'Africa vista con gli occhi degli studenti del SISM - Segretariato Italiano Studenti di Medicina che decidono di trascorrere un mese della propria carriera universitaria in uno dei progetti di Medici con l'Africa Cuamm. Da Tosamaganga, in Tanzania, o da Wolisso, in Etiopia, saranno proprio gli studenti a raccontarci mese dopo mese non solo arrivi e partenze ma anche preziosi accetti vite di un mondo lontano dalle aule

*On the field. SISM con l'Africa.
Dalle aule universitarie alla terra rossa
dell'Africa sub-sahariana il passo non è
poi così difficile da compiere: ci vuole
energia, desiderio di conoscenza, voglia di
mettersi in gioco e scoprire la medicina
di un luogo 'altro'. (...)*

SAFE DELIVERY IN RURAL DRC: A MOTORCYCLE-AMBULANCE PROJECT

Until recently, the pregnant women of the Kinzamba healthzone (DR Congo) had to walk or cycle for tens of kilometers to reach a hospital. The dirt roads are in such a bad state that no car can pass. This is one of the factors explaining the high level of mortality in the region. That's why Memisa put in place a system of motorcycle-ambulances. Thanks to this emergency transport system and the participation of the local population, there was an immediate impact. Every two days, a life is saved in Kinzamba.

Memisa is a Belgian medical NGO that promotes quality basic health care for people in the south. The main purpose is to provide essential and appropriate quality care, and to improve accessibility in particular for the most disadvantaged people, without distinction of race, religion or political beliefs. Memisa puts a focus on the most vulnerable groups being pregnant women and children under 5.

This is achieved mostly through sustainable development programs strengthening the local health systems, but also through small-scale initiatives promoting community involvement and through emergency aid complementary to the development programs in unstable areas. Memisa works mainly in Africa (DRC, Benin, Mauritania, Burundi, Congo Brazzaville) but also in India, and there are also some small scale initiatives in other parts of Africa, Asia and Latin America.

Our intervention in DRC is by far the largest (accounting for around 80% of the yearly budget), where we are supporting 31 health zones, covering around 4,5 million people.

Bad roads and effective ambulances

“It was my 7th pregnancy. My contractions started earlier than expected. So I went to the health center of Mosenge. It didn't look good. That's when I learned that a motorcycle-ambulance could take me to the hospital of Kinzamba where a ultrasound could be done. During my previous pregnancies I did the road by foot, it was long and perilous. So I was thrilled that I could count on the motorcycle-ambulance of Memisa” (Bavoka, age 30)

Organizing efficient referral systems from health centers to hospitals in rural DRC has always been a challenge in the fight against maternal mortality. Pregnant women have to walk or cycle for tens of kilometers to reach a hospital. The dirt roads are in such a bad state that no car can pass. This is one of the factors explaining the high level of mortality in the country.



Kinzamba, situated in Bandundu province, is an isolated village. Roads are in a very bad condition and there is no cell phone network nor public transport. It is a huge challenge for its 31.000 inhabitants to travel anywhere at all. Since transport is necessary to go from the local health center to the hospital, for example for an emergency caesarean section, many women walk or cycle the distance. There is an ambulance present in the zone, but the 4x4 jeep cannot access the most isolated areas due to impracticable roads.

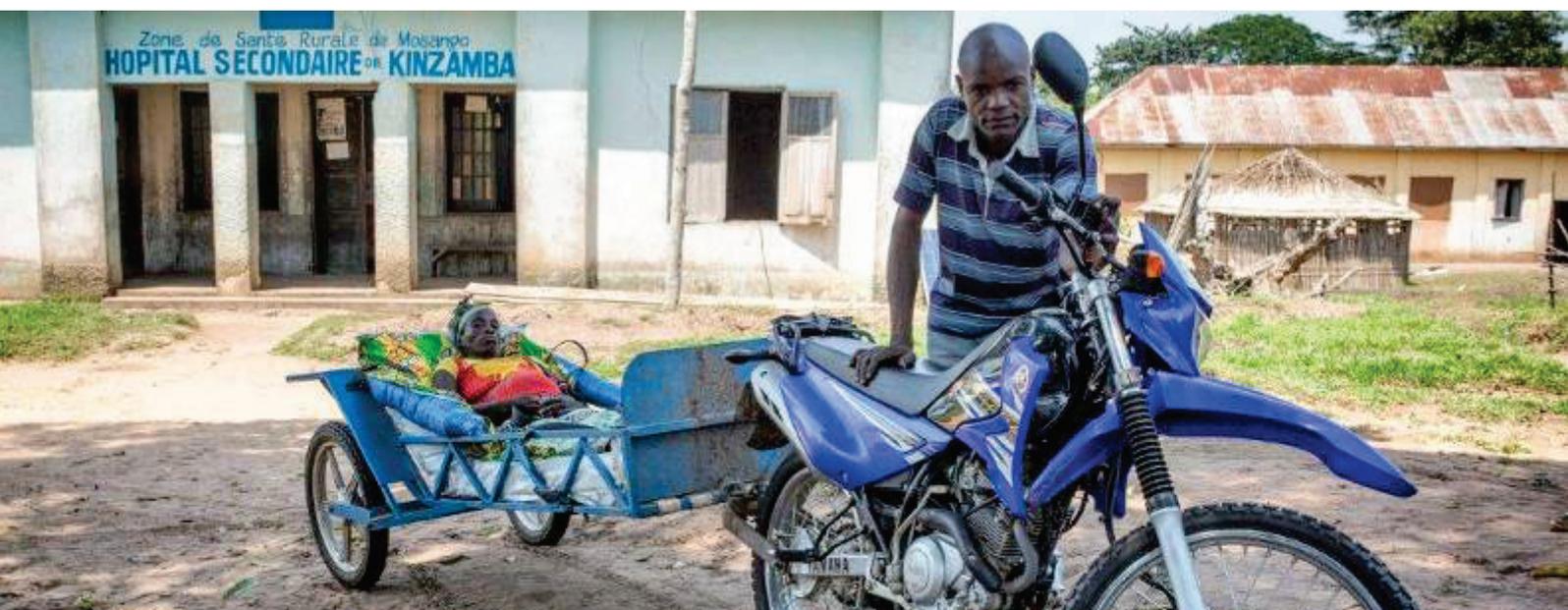
Since 2014, Memisa has been trying to put in place an innovative system of motorcycle-ambulances in several rural health districts. A metal frame constructed locally into a carriage that can hold one person lying down in a relatively comfortable position, is being pulled by a motorcycle. This emergency transport system functioning with the participation of the local population has had an immediate impact. Lives are saved every day.

The transport of pregnant women to the hospital has become less dangerous and faster. This improves their chance of survival, both for the women and for their unborn child. In parallel, a radio-based communication system has been installed in the isolated health centers, allowing staff of the health center to contact the motorcycle-ambulance in case of emergency.

The local community has been mobilized to finance the functioning of the emergency transportation (through 4x4 or by motorcycle). For this purpose a communal financing mechanism based on solidarity between patients has been put in place. This works as follows. Every patient that receives a consultation at a health center or at the hospital pays 350 Congolese Francs (about 0,34 Euros) more in addition to the regular bill. This way everyone who uses the ambulance or the motorcycle-ambulance only adds 1.000 Congolese Francs (about 1 Euro) for the transport. This system allows the driver to be paid and to pay for the petrol and maintenance without further impoverishing the population.

- More information: www.memisa.be

For the occasion of mother's day 2015, Memisa stimulates people to support the motor-ambulance system through an online donation website: www.africado.be



UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES

Until recently, many of the debates around Universal Health Coverage (UHC) addressed health coverage in middle-income countries and emerging economies. How the debates play out in fragile and transitional states is largely unknown. Therefore, Cordaid commissioned a qualitative study into perceived feasibility of pathways to UHC in fragile and transitional states.

International institutions such as the World Bank and World Health Organization have given support to UHC as one of the Sustainable Development Goals, being part of the post-2015 development agenda. However, most of the pilots concentrate on the feasibility of UHC in middle income countries. In a study published in 2014, Cordaid, having a strong track record on health interventions and focusing primarily on fragile states and contexts, asked whether the concept of UHC is applicable to fragile countries like South-Sudan and Afghanistan.

The two general aims of the Cordaid study were to understand and advance universal health coverage (UHC) in fragile and transitional states and to articulate the specific roles which civil society organizations – from local to international – may play in the process.

UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES

**A RADICAL RETHINK OF
THE POLITICAL ECONOMY OF HEALTH**

The report shows that for fragile and transitional states, the road to achieving UHC will be more complex, requiring an increased focus on community needs and national ownership in the design and implementation of health policies. Therefore, the international community – funders and NGOs alike – have to ensure that the pathway to UHC in fragile and transitional states will be given the extra attention and tailored support that it needs, taking into account their particular challenges and requirements.

The findings of the qualitative study inspire Cordaid to further its mission on building flourishing communities by:

- Focusing more on providing capacity development to local organizations and communities involved in policy dialogues.
- Supporting national governments through technical assistance in formulating better and more responsive policies for universal health coverage.
- Making the link with the international level by advocating for a rethink of existing approaches on universal health coverage in fragile and transitional countries.
- Capitalizing on the opportunities that the UHC discourse and activities provide for restoring state – civil society relations within countries.

Is Universal Health Coverage (UHC) in fragile states impossible? No, says Arjanne Rietsema, Cordaid's head of mission Zimbabwe. "But it takes two to tango: a committed state and a demanding population. Civil Society Organizations can assist communities in setting up a system for the latter."

- More information: www.cordaid.nl
- Download the report: www.bit.ly/cordaid-uhc



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