



ANNUAL REPORT 2015

*A luta continua! Redefining our Network's
contributions to achieving Health for All*

MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL ANNUAL REPORT 2015

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MESSAGE FROM THE PRESIDENT

THE BEST IS STILL TO COME

Dear Network members,

It was in May 2010 when Guus Eskens handed over to me the chair of the Medicus Mundi International Network. The white plastic chair I received outside Château de Bossey was in fact not so heavy, but already at that moment I was quite aware that this was just a beginning, and that the heavier duties and processes were to come. And I was right...

In the six years of being president of MMI, I learnt that the successful development of our Network depends on a mix of “essential ingredients”, and if one of them is not available, the sustainability of the whole project is at risk. I am talking about:

- A clear identity;
- A convincing plan;
- Good output;
- Strong institutions;
- Strong leadership and ownership.



With the MMI Network policy reviewed in 2014 and the Network strategy 2016-2020 adopted last year by the Assembly, we have further shaped our Network's *identity*, and we have a convincing *plan* elaborated in a intensive participatory process involving many Network members.

So yes, let us “promote knowledge sharing and mutual learning between actors in international health cooperation”. Let us “provide autonomous, sustainable and stimulating spaces for the analysis and debate of global health and promote platforms for joint civil society advocacy, with a focus on the World Health Organization”. And let us “enhance collaboration among Network members in view of joint projects and consortia”.

We can also be proud of having achieved, over the last years, a considerable *track record*: Our contributions to the technical dialogue on health systems strengthening, Universal Health Coverage and international cooperation (with our Network meetings as milestones and highlights) and to the political debate on global health and health governance (focusing on the WHO and its events and institutions) have been well received within and beyond the Network.

With the current and future Board and secretariat (I employed Thomas Schwarz 20 years ago as secretary of Medicus Mundi Switzerland when I was their president, and since then the two of us have shared a long journey...) and with our current thematic working groups, we also are lucky to have the *institutions and leadership* needed for successful work. However the secretariat's capacities are not sufficient to implement all we want to do, and this is directly linked with the strongly limited financial resources. So let me nevertheless put a question (or exclamation?) mark behind “strong institutions”.



And let us be clear about this point: A Network is what its members want it to be and what they are themselves able to contribute. So for the sustainability and the success of our Network, both *further growth of membership and enhanced ownership* by its current and future members are a must.

Seven years ago, at the end of his last “message from the president”, Guus Eskens stated that the future of Medicus Mundi International is in its members' hands. Today I subscribe to this statement. And I am convinced that the best is still to come!

It was a privilege to serve on the MMI Board and as its president.

Nicolaus Lorenz

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

A LUTA CONTINUA! REDEFINING OUR NETWORK'S CONTRIBUTIONS TO ACHIEVING HEALTH FOR ALL

This is the last secretariat report that refers to the *MMI Network strategy 2011-15* and the three major programs developed by the Network within this framework:

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

In these three programs, the MMI Network and its working groups successfully continued the activities undertaken over the last years within the framework of the “old strategy”.

On the other hand, with the adoption of the *Network Strategy 2016-20* by the Assembly in May 2015, we defined new strategic directions of the Medicus Mundi International Network for the coming years. The MMI work plan 2015 “Exploring and preparing the ground, first steps and feasibility checks”, developed by the Board after the adoption of the strategy, outlined preparatory steps to be undertaken already in the year before the formal start of strategy implementation. We will therefore also report on initial progress on our Network’s “way into the future”.

MMI HRH: HUMAN RESOURCES FOR HEALTH

European project HW4All

In 2015 the EU funded project "Health workers for all and all for health workers" in which the MMI Network secretariat, several Network members (Medicus Mundi Spain, Memisa Belgium, Health Poverty Action, Redemptoris missio, Wemos) and partners outside the Network have been involved since 2013 came to its peak – and at the same time to its end.

The project has become the catalyst of the Network’s involvement in the field of Human Resources for Health and for the time being replaced the MMI HRH working group. To get an insight into the relevance of this work for a Network member, you might have a look at the

“short story” by Wemos in the second part of our Annual Report.



HealthWorkers 4all

Rooted in health cooperation and in advocacy at a global level, the MMI Network itself got through the HW4All project valuable new insights into health workforce and health migration realities and policies at European regional and national level. Linking between the regional, national and global level will certainly help us to continue and enhance our advocacy at all levels.

Project highlights in 2015

Side event and statements at the World Health Assembly: The WHO Global Code of Practice (Code) on the International Recruitment of Health Personnel was adopted by the 63rd World Health Assembly on 21 May 2010. The resolution requested the first review of the relevance and effectiveness of the Code to be made during the World Health Assembly in May 2015. An expert advisory group (EAG) was convened to carry out the review and submitted its report to the 68th WHA for consideration. The side event organized by HW4All and formally hosted by the MMI Network provided a good opportunity to get insights and assessments from members of the EAG before the formal WHA debate. With a packed room, over 120 participants and some inspiring statements, the side event was a strong and encouraging call for making the Code what we want it to be: a real instrument for change.



Workshop at the European Parliament in May: The workshop jointly organised by HW4All, the European Federation of Public Service Unions (EPSU) and the European Public Health Alliance (EPHA) discussed the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel in the European context, marked by increased professional mobility. 80 participants attended the meeting and five Members of European Parliament provided their input.

European Conference in December: With the final conference “Exploring the migration-development nexus: Global health aspects of the implementation of the WHO Code of Practice” that took place in Brussels, the HW4All project and EPHA organised an event on policy coherence for development in the context of the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. The event focused on the impact of brain drain on countries of origin and discussed solutions for sustainability. As a highlight, the "European Call to Action" and a list of 175 signatures of European and national key actors were handed over to the representatives of the European Commission.

Outlook: Keep a high profile and continue the engagement

As indicated above, there have been considerable synergies with MMI advocacy at a global level, at the World Health Assembly, the Global Health Workforce Alliance and the Health Workforce Advocacy Initiative, in the analysis and assessment of the processes, in the development of inputs and advocacy statements and in the organisation of events, notably the side events at the World Health Assembly.

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 and other key actors in this field. 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 the Alliance in a WHO Expert Advisory Group on the review of the WHO Global Code of Practice that took place in early 2015.

Towards the end of the HW4All project, in a workshop held at the MMI Assembly in The Hague in October 2015 and in a meeting of the HW4All project, interested MMI Network members reassessed the perspectives for 2016 and the next years and the potential tasks for a renewed MMI HRH working group. They agreed that there was “plenty to do” and felt enough commitment by MMI Network to relaunch and revitalize the working group, with a double focus

on (a) global policies, strategies and governance and (b) continued engagement at a European level, as outlined in the group's work plan for the year 2016 submitted to the MMI Board.

MMI RES: FROM A FOCUS ON RESEARCH AND EVIDENCE PROCESSES TO BROADER ATTENTION ON EFFECTIVE HEALTH COOPERATION

In 2015 the MMI working group on evidence based work reached the end of its life cycle due to a lack of leadership and dedicated capacities by its members. Nevertheless the engagement of the MMI Network in this field will be sustained, although in a different form.

In 2009 a small advisory group "Research and evidence process within the MMI Network" was set up in order to develop a MMI research policy. After a meeting on research partnership in Antwerp, the advisory group developed the MMI Network program "MMI will foster mutually beneficial partnerships between NGOs and research institutions" and launched a proper MMI working group on evidence based health cooperation.

In this line, the MMI secretariat hosted a session on "How to bridge between health systems researchers and practitioners in the field of international health cooperation" at the 9th European Congress on Tropical Medicine and International Health in Basel (ECTMIH), in September 2015 which was organized by the Swiss TPH, a member of Medicus Mundi Switzerland (MMS). The inputs to the MMI session were mainly contributed by members of MMS and included:

- Challenges and solutions in collaboration between non-governmental implementing organizations and local research institutions in developing countries;
- Key determinants for a successful collaboration between NGOs and Universities in health research;
- From well-researched, tested and documented pilot interventions to health impact for all; from laboratory systems research to changing lives: in search of the holy grail of scalability;
- Improving programme implementation through embedded implementation research (iPIER);
- Fairness in international collaborative research partnerships for health, time for a certification process.



...aiming at the next level

The ECTMIH event marked the end of a successful series of MMI hosted events on the “researchers – practitioners” topic. In the Network Strategy 2016-20, the promotion of evidence based work and the dialogue on its implementation are integrated in the overall plan of the MMI to “promote knowledge sharing and mutual learning between actors in international health cooperation”, and the dialogue on evidence based cooperation will be part of the broader dialogue on effective health cooperation. A respective working group (“MMI EHC”) is being prepared and will be launched at the General Assembly in May 2016.

MMI GHG: GLOBAL HEALTH GOVERNANCE

The MMI Global Health Governance team was established during the last strategic period (MMI Network strategy 2011-15) with a first work plan covering the years 2012-13. Since then, MMI GHG has remained operational as a small and rather informal team, with strong institutional and personal involvement of the team members who regularly meet and intensely cooperate in view of and during the WHO governing body meetings and the related processes.

A critical civil and constructive society voice

As in previous years, MMI participated in the meetings of the WHO governing bodies, also hosting the “WHO Watch” project, developed and implemented jointly with the People’s Health Movement. As reported above, MMI contributed to the World Health Assembly with a side event on the implementation of the WHO Code of Practice and with a MMI Workshop linked with the MMI Assembly and promoted as informal WHA side event.

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 the reform process. In 2015 the process focused on WHO’s relations with “non-state actors”, and there is a fierce debate on this matter – which is still ongoing. A dedicated “thematic guide” on the MMI website provides a comprehensive overview on the process and the key issues at stake.



www.bit.ly/whoreformguide



Press briefing of the civil society coalition on the WHO Reform during the World Health Assembly

Besides these WHO governing body meetings, MMI continued to act as a critical civil society voice and provided, together with the respective working groups and civil society partners, input to “multi-stakeholder” platforms that deal with global norms and regulation, policies and strategies such as the WHO hosted Global Health Workforce Alliance and the Global Coordination Mechanism on Noncommunicable Diseases. Our engagement was well received by both WHO and civil society partners.

Fostering cooperation among civil society organizations

Related to the WHO EB meeting in January and the World Health Assembly in May 2015, MMI organized two full day civil society strategy meetings in Geneva. This initiative of revitalizing and strengthening cooperation among civil society organizations was a great success and will certainly be sustained.

“Geneva global health hub” project: At the civil society strategy meeting in January 2015 MMI launched the idea of a “Geneva Global Health Hub” (G2H2) which found great attention. Since then the MMI GHG team actively contributed to the planning of this project.

After the strategy meeting in May 2015, an interim steering committee was set up and, in December, a discussion paper on the planned G2H2 was shared with potential civil society partners.

The project intends to facilitate civil society collaboration and strategy-building in three main areas: strengthening the WHO’s critical role in global governance for health and its fundamental core roles in regulation, norm-setting and policy-making; addressing processes of other multilateral institutions in Geneva, global health initiatives and philanthropies, and their implications for WHO’s mandate and capacity to implement; and addressing the influence of organizations and processes in related sectors – such as trade and investment treaties – on the policy space for governments to promote and protect health.

The services provided by the hub are framed as follows:

- **Exchange:** G2H2 members will be enabled to network and communicate between them electronically and in face-to-face meetings
- **Information:** G2H2 members will benefit from information gathered on health-related institutions in Geneva on the basis of mapping, networking and meeting attendance
- **Logistical support:** G2H2 members will find help to organize Geneva-based meetings, an office space and infrastructure, and assistance for resource-constrained members to raise funds for travel costs for meeting attendance.

The story of the implementation of the Geneva Global Health Hub will be told in the Annual Report 2016...



Outlook

In the MMI Network strategy 2016-2020, the engagement of MMI in global health policy and governance has become a main strategic field of work (“We will provide autonomous, sustainable and stimulating spaces for the analysis and debate of global health and promote platforms for joint civil society advocacy, with a focus on the World Health Organization”), and a set of particular objectives and activities have been framed, covering both main fields of engagement by the GHG team over the last years. In particular:

- **MMI will be a strong voice of civil society at the World Health Organization, its meetings and processes.** “MMI will further enhance its WHO related advocacy developed over the last strategic period. The Network’s engagement will continue aiming at strengthening and protecting the regulatory, policy making and normative role of the WHO. In “multi-stakeholder” platforms that deal with global norms and regulation, policies and strategies such as the Global Health Workforce Alliance or the NCD Coordination Mechanism, MMI will continue to act as a critical civil society voice.”
- **MMI will foster cooperation among civil society organizations involved in global health.** “MMI will further develop its profile as a reliable and effective networker and convener, fostering systematic sharing, strategizing and alliance building among those civil society institutions and representatives that are strongly involved in WHO related advocacy, participate in the governing body meetings of the World Health Organization and aim at defending and strengthening the regulatory, policy making and normative role of WHO. In order to play this role effectively, MMI will continue to cooperate with other global and regional civil society networks and platforms promoting Health for All and will participate, when adequate and feasible, in joint activities related to WHO processes and beyond.”

These strategic statements can be considered as a strong mandate for the MMI GHG team to continue its work and to lead the MMI engagement in this field.

After the MMI Assembly in October 2015, the MMI HRH working group was relaunched and a new MMI NCD working group created, both (also) dealing with WHO and global health governance related work, and both of them submitting work plans 2016 to the MMI Board for their specific fields of activities. The MMI GHG team can therefore focus its own work on topics and processes not covered by these two MMI working groups. The MMI GHG team will, on the other hand, support these working groups with analyses and links to the overall global health governance debates and processes.

WORLD FORUM

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EMERGENCY

YES, WE HAVE A PLAN! REDEFINING OUR NETWORK'S CONTRIBUTIONS TO ACHIEVING HEALTH FOR ALL

As indicated in the previous chapters, MMI achieved a milestone in its institutional development with the adoption of the “Network Strategy 2016-20” by the Assembly in May 2015. The MMI Network Strategy 2016-2020 defines the following main strategic directions of the Medicus Mundi International Network in the coming years:

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

The two “technical” fields of work (international health cooperation and global health) build on key strengths of MMI: its character as an open, inclusive network and its track record.

The shared overall approach on the promotion of Health for All, combined with professionalism and dedication and the aim for linking practice with evidence, remain the binding elements in the MMI Network and in the contributions to the members' work.



2015: Preparing the ground

The MMI work plan 2015 “Exploring and preparing the ground, first steps and feasibility checks” outlined preparatory steps to be undertaken already in the year before the formal start of strategy implementation. Most of the related activities have already been reported above.

Three strategic fields of work were specified in the work plan 2015; for one (“MMI will enhance collaboration among Network members in view of joint projects and consortia”) the Board agreed, for capacity reasons, to start implementation only later. In its meeting in early 2016, the Board reviewed the implementation of the workplan, acknowledged the successes but also concluded that there are strong limitations of planning and developing new activities if they mainly build on the MMI secretariat being in the driver seat, as the secretariat struggles itself with a lack of capacities (110 days in 2015; only 100 days in 2016).

The Board also adopted a simple tool for continuous planning and (internal) monitoring of the strategy implementation:

- Annual plan with objectives, milestones, activities, timelines, process owners
- By the end of the year: Assessment of results and achievements, state of activity, opportunities and risks, lessons learnt, proposed measures for next year

In early 2016, based on the review report, on the guidance provided by the Board and on the already agreed template, and complementary to the sectorial work plans, the Board mandatet the secretariat to draft a detailed overall work plan 2016. This plan will be presented to the Assembly in May.



"A luta continua". General Assembly and workshop in Geneva, May 2015

"A luta continua" ("the struggle continues") was the rallying cry of the FRELIMO movement during Mozambique's war for independence. The phrase is Portuguese but was used by FRELIMO leader Samora Machel to cultivate popular support against the Portuguese colonial presence. Today, "a luta continua" is a strong slogan for the ongoing need to reflect about the influence of international health cooperation and a globalized health business on national health systems.



"Since achieving independence in 1975, Mozambique is a country in constant change. In this context, governments, foundations, NGOs and companies declare noble intentions in order to improve the precarious health situation of the population. The documentary 'A Luta Continua' reviews the achievements, challenges and difficulties in order to build a health system for all in an increasingly unequal country where, sometimes, aid strategies do not always walk in the same direction." (Introduction by Medicus Mundi Catalunya).

Based on the documentary "A luta continua" produced by Medicus Mundi Catalunya, and referring to the case of Mozambique, an internal workshop for the participants and guests of the Annual Assembly of MMI provided an opportunity for the dialogue on what it takes to strengthen – or weaken – a national health system.

As indicated, the MMI Assembly focused on Network Strategy 2016-20. We are confident that its adoption is a milestone in the further development and consolidation of the Network.

MMI Network meeting in The Hague, October 2015

The MMI Network event in autumn followed the successful model of the four last years. The internal MMI events took place on Wednesday 7 October (planning workshop in the afternoon) and Thursday morning (Extraordinary Assembly) at the Cordaid office in The Hague.

Topics addressed in the planning workshop:

- HRH related work in 2016, after the end of the European "Health Workers for All" project;
- Noncommunicable diseases and international cooperation / global health policy and governance: What are the Network members' interests and priorities for getting involved in a MMI working group and in the NCDs Global Coordination Mechanism?
- How to launch the planning process for a MMI symposium on international health cooperation.

After the General Assembly, MMI Network members were invited to participate in the jubilee symposium "innovation brainstorm" of i+solutions.



*MMI Planning workshop
The Hague, 7 October 2015
Welcome!*

MMI NETWORK MEMBERS

SHORT STORIES



Tuberculosis (TB) is one of the world's most deadly infectious diseases, striking men, women and children alike. Medici con l'Africa CUAMM is working hard to do its part in combating tuberculosis in the countries where it is active, developing and carrying out projects to diagnose and treat the disease in accordance with the respective TB control programs of each country.

“Coughing, coughing, coughing, then fever and all that sweating at night. And then losing so much weight so quickly. In the end I came to Matany Hospital from Amudat – a long, long trip. It was hard in the beginning, but now things are much better. I'm not coughing anymore and I feel strong again.” (Paolina is a patient with pulmonary tuberculosis in the TB Ward of Matany Hospital).

The World Health Organization (WHO) estimates that in 2014 some 9.6 million people fell ill with the disease worldwide and more than 1.5 million died from it, including 890,000 men, 480,000 women and 140,000 children. 29% of all TB cases are found in Africa, which has the world's highest incidence and mortality per capita for the disease.

In 2015 in the 18 hospitals where CUAMM is active in Africa, some 10,000 people underwent screening for tuberculosis; around 2,500 patients were confirmed positive, 1,000 of whom were found to be putting the communities they lived in at risk for contagion.

“What we're doing here is but a drop in the sea, but where we work, in the areas of greatest need, finding and treating tuberculosis patients in the appropriate manner can make an important difference” (Don Dante Carraro, director of Medici con l'Africa CUAMM).

In Angola, CUAMM acts as a consultant to the government on its national strategic plan to combat TB and is developing guidelines for the work done in diagnostic laboratories, the training of health workers and program supervision. In partnership with the World Diabetes Foundation, we are also carrying out an innovative research project that aims to detect diabetes in individuals already being treated for TB.

In Uganda, alongside our activities to detect and treat cases of so-called “ordinary” TB, CUAMM is also working on multidrug-resistant tuberculosis (MDR-TB), a particularly aggressive form of the disease that can require up to two years of treatment. To do this we make use of the GeneXpert system, a very effective tool for TB diagnosis especially in areas with scarce resources.



“For me TB has meant staining lots and lots of slides as I look for mycobacterium, and deciding lots of people’s treatment with a ‘+’, ‘++’ or ‘+++’. GeneXpert machine is very easy to use, a sort of printer with four cartridges that can identify Mycobacterium tuberculosis DNA as well as resistance to rifampicin, a drug used to treat TB. You just dilute your sample and load it into the slot. After two hours you’ve got your results (with more traditional culture-based methods, it took 4 to 8 weeks)” (Simon Amei works in the Matany Hospital laboratory).

CUAMM uses GeneXpert in Ethiopia, as well. In partnership with various partners including the World Health Organization, we have launched a project there to detect latent TB infection, doing contact tracing to identify people who live or are in frequent contact with TB patients and detect other cases of the disease early on. In addition, CUAMM is working on an integrated screening project for TB, HIV and cervical cancer in Ethiopia. Indeed, TB is often associated with HIV, fueling the spread of the disease and leading to dangerous situations of co-infection that are difficult to treat both from a clinical and psychological standpoint. According to Dr. Mario Raviglione – director of the WHO’s Global TB Programme – 75% of the world’s cases of HIV-associated TB are found in Africa, and the number of deaths from co-infection is still very high.

In conclusion, TB- and HIV-related mortality rates remain extremely high, making clear the need to integrate programs to combat the two diseases in order to make treatment for both more effective.

“For me getting TB meant learning I had HIV too. I’d gotten very weak and begun coughing up blood all the time... I was nearly dead when they brought me to the hospital. They gave me lots of medicines and slowly I began to get better. It’s still not easy to accept having HIV; I’ve been worried about being ostracized when I go back home. But things are much better now and I’m glad to be alive” (Joseph is a patient with both TB and HIV who is being cared for at the Morulinga Health Centre and by the Matany Hospital’s TB Team).

In 2014 the World Health Assembly adopted its new global tuberculosis strategy, the “End TB Strategy”. Underpinned by a vision of “a world without tuberculosis”, the strategy aims to eliminate the disease worldwide. It is based on three main pillars that outline the key interventions that need to be made.

The first pillar calls for a patient-centered approach focused on high-quality early diagnosis, treatment and prevention of TB. Among its components are diagnosis and treatment both of TB (including MDR-TB) and of HIV infection, screening, management of co-morbidities (including HIV infection) and administration of the BCG vaccination to newborns.

The second pillar calls for the adoption of TB-sensitive and TB-attentive health policies that are buttressed by strong health and social systems. Specifically, it highlights the need for adequate financial resources to be committed for TB care and prevention, the engagement of communities, civil society organizations and the private sector, the use of efficient notification systems and the appropriate use and quality of medicines.

“For me, TB meant taking lots of medicines for a very long time, but never getting any better, and then starting again and still not getting better. [...] But TB has also meant getting to know the doctors and nurses working at Matany Hospital. They’ve taken care of me and even helped me with food and transport. [...] Anyway, I went through some very hard times and I often thought about just giving up. But then I started to get better and to put on weight, and I even went back to work, selling tobacco.” (Lino is being treated for Multidrug-Resistant (MDR) TB at the Iriiri Health Centre; he’s looked after by the Matany Hospital’s TB Team).

The third and final pillar calls for intensified research, both basic and operational, to ensure the development of innovations and make them rapidly available and widely accessible.

According to the WHO’s estimates, adopting and implementing the End TB Strategy on a global scale would lead to a much faster decline in the TB incidence rate, with a 90% reduction in the number of new cases of TB and a 95% reduction in deaths from TB by 2035. At the same time, TB patients and their families would no longer run the risk of facing catastrophic costs due to the illness.

“TB is the quintessential disease of poverty, and helping to prevent and treat it means not just improving health conditions but also tackling the social injustice faced by a poor people such as the Karimojong.” (Currently a CUAMM JPO at Matany Hospital, Nicola Cocco is training to be an infectious disease doctor).

TB is a disease that must be prevented.

And tracked down. And cured.

Let’s unite to end TB.

- More information: www.mediciconlafrica.org

HEALTH FOR ALL: THE WALK

How long does it take for a pregnant woman to reach a clinic? In the “most boring film” **THE WALK**, a Cordaid film team joined Chanceline who lives in a remote rural area of the Democratic Republic of Congo and, for just a simple check-up, has to walk 27 km and back again. **THE WALK** was presented by Cordaid at the Universal Health Coverage Day 2015 and was an eye-opener for many.

The motivation behind the development of the Cordaid Universal Health Coverage (UHC) film **THE WALK** came from the recognition that there is a need in urging greater action and progress on delivering UHC. It also wanted to raise awareness among different target audiences on the discrepancy of health service delivery around the world.

The most effective way to demonstrate the importance of UHC was to show what it meant for a pregnant woman in the countries where Cordaid works in. Not only was it to show the importance but also show how far countries are from achieving this goal. Organisations, donors, communities are all working to achieve UHC but it’s still not enough.

Given Cordaid’s long history in DRC especially in its health programming, it was decided to identify a pregnant woman in the communities we work in and show her reality of accessing healthcare services. The purpose was to remind ourselves and the world, we still have work to do. This becomes incredibly confronting by filming a pregnant woman walking 5 hours for a health check up and showing the entire walk.



This film demonstrates the need to apply the Sustainable Development Goals (SDGs) so they matter most for women: maternal, sexual, and reproductive health and rights include better access to health services.

But also gender equality, education, environment, transport and economic empowerment would make the distance for women like Chanceline to health services in one or another way smaller.

Why watch a video for hours of Chanceline's walk to the doctor?

Chanceline is a pregnant woman living in the remote village of Mulamba in Democratic Republic of Congo, one of the least developed countries in the world. For just a simple check-up, Chanceline has to walk 27 km and back again. During each pregnancy, she has to walk to the health facility five times. That is a total of 270 km by foot because she cannot afford transportation. It is an enormous challenge, even though she can be considered one of the lucky ones: 400 million others worldwide do not have access to essential healthcare services. In the 5 hour real-time video we join her for 27 km of her “crippling”, “agonizing” and “arduous” journey as described by the international press.

Walking is the only option for Chanceline. She has to walk through the dry lands on her own, for hours. Rain storms? Burning sun? People bothering her? So much can happen during these hours. A camera accompanied Chanceline on her walk, giving you the opportunity to join her during her forced adventure.

“A pregnant women's 27 km agonising walk for one of the most important human rights.”
Leonard Foster, Journalist Flavour Mag, UK



Outreach of THE WALK

In weeks leading up to Universal Health Coverage Day, Cordaid produced a teaser which was shared widely amongst our network, through traditional outlets and new media. THE WALK premiered on UHC Day and within the first three days it had 52,701 views on Youtube. The outreach achieved on social media was 524,967. It was shared mostly shared on Twitter, with Facebook coming in second and LinkedIn in third.

For 2016, THE WALK is the health campaign within our Communications strategy. Thus it will be continuously promoted and updated throughout the year with check-ins with Chanceline. The main aim of this video was for other like-minded organisations and platforms to use it to illustrate the importance of UHC in low and middle income countries. So please share widely.

Universal Health Coverage

Cordaid believes that healthcare should be available to anyone, anywhere. Worldwide, 400 million people lack the most basic life-saving health care. Health is a right not a privilege: 17% of people in low- and middle-income countries are pushed or further pushed into poverty (US\$2/day) because of health spending. Up to one-third of households in Africa and Southeast Asia borrow money or sell assets to pay for health care. By working on accessible and affordable healthcare in the poorest, often conflict-affected, areas, Cordaid help achieves this goal by supporting local (health) organizations to improve their services and build stronger health systems through using a Results-Based Financing (RBF) approach.



Follow-up

This past January 4th, 2016 at 3AM, Chanceline delivered her 3kg800 baby, Anne Emmanuelle. Chanceline had to again walk to the clinic to deliver her baby. At nine months pregnant, she went four days before her delivery and the walk took her 3h30 until she finally reached the clinic. “All went well. I was accompanied by my girlfriends while my husband stayed at home working and taking care of our two other children” she said. According to nurses and doctors, the delivery went well. After the delivery, Chanceline returned home, walking again the 27 kilometers but this time holding Anne-Emmanuelle in her arms. However, two days after her return home, she had to return to the clinic to vaccinate her child. She will have to undergo the same journey every month until Anne-Emmanuel is nine months. An equivalent of almost 250 kilometers to walk not alone this time but with her baby too.



“This story is a powerful reminder of why we must keep working to deliver universal health coverage - quality, affordable care for everyone, leaving no one behind.”

Michael Myers, Managing Director The Rockefeller Foundation

For Cordaid, we will continue to strengthen health systems to ensure better access to maternal & child health services and this will be done by advocating for UHC at in the countries that we work in. At the global level, we will support advocacy networks such as MMI to influence global policies for setting up standards of coverage for health services. Finally, we encourage every organisation that works on health to share the link of the film and show the film to demonstrate the plight of women in accessing much needed health services.

- Watch THE WALK: www.cordaid.org/en/healthforall/



HOW TO...: REACHING SUSTAINABILITY IN A RURAL HEALTH CENTRE IN CHIAPAS, MEXICO

Everyone who deals with this topic knows it: Ensuring financial sustainability of social services is very hard work. Especially health services are nearly never fully financially sustainable businesses. This is not even the case in Germany and other so-called “industrialized countries” and much less in countries of the global south where financial resources are even scarcer.

In most of the cases, public health services must be subsidized in order to be able to provide affordable and reasonable services to all its constituents. This concerns particularly the less affluent but very in need patient groups who cannot afford the often present expensive, private clinics in developing countries.

action medeor just finalised a project with our long-term partner Madre Tierra Mexico that provides a good overview on possible successes, difficulties and problems that can appear. The aim of our project was to reach the provision of primary and basic health care for mainly indigenous and small-scale farmers’ families through a health centre and training of health promoters focusing on sexual and reproductive health and rights. The duration of the project, originally 3 years has been extended to 4 years by action medeor and our co-funding partner the German Federal Ministry for Economic Cooperation and Development in order to reach better long term sustainability. Particularly, during the last year, together with our local partner, we focused strongly on building financial sustainability.

Sustainability does not only refer to the financial aspect but has many different facets including a social one which we thought in our case is mainly related to creating acceptance and ownership within the local target group. Although considering it as a potential risk in the beginning, acceptance and ownership did not turn out to be a problem which is probably partly due to the fact that the health centre established by the project constitutes the only health service offered within the region and its far-spread, surrounding rural communities.



Excellent social sustainability, contributions from various actors

In fact, the centre was excellently accepted. The local council donated the territory as well as working hours over hours to move ground, dig trenches, cultivate the health centre's garden, painted the centre and helped with everyday work. The population happily visited the health centre, brought their families, and saved time and money because they did not have to visit any of the other far situated health institutions any more. In the beginning the services provided by the health centre were also highly in demand due to the fact that they were offered free of charge. However, afterwards when small fees were introduced to increase financial sustainability together with our partners we made the bitter experience that even very low fees could not be paid by the target group. This was also due to the fact that the shortage of personal and familiar financial resources was intensified by a severe drought and the effects of the El Niño-phenomenon that still haunts large parts of Central America.

Could this situation be solved at all? And if yes how could it be solved? Both questions have to be answered taking different point of views into account:

From rather negative news...

First of all, it has to be said that the problem was not solved and unfortunately will not be solved unless a government develops or adopts a suitable health strategy, manages to budget sufficient funds for an affordable health care for all its citizens AND at the same time achieves to implement all planned elements. Mexico is not an exceptional case, also Guatemala and other Latin American countries are in a process of privatization of health and other social services guaranteed by the human rights carta. In fact, all the mentioned problems will most likely never be solved unless monetary poverty can be eradicated.



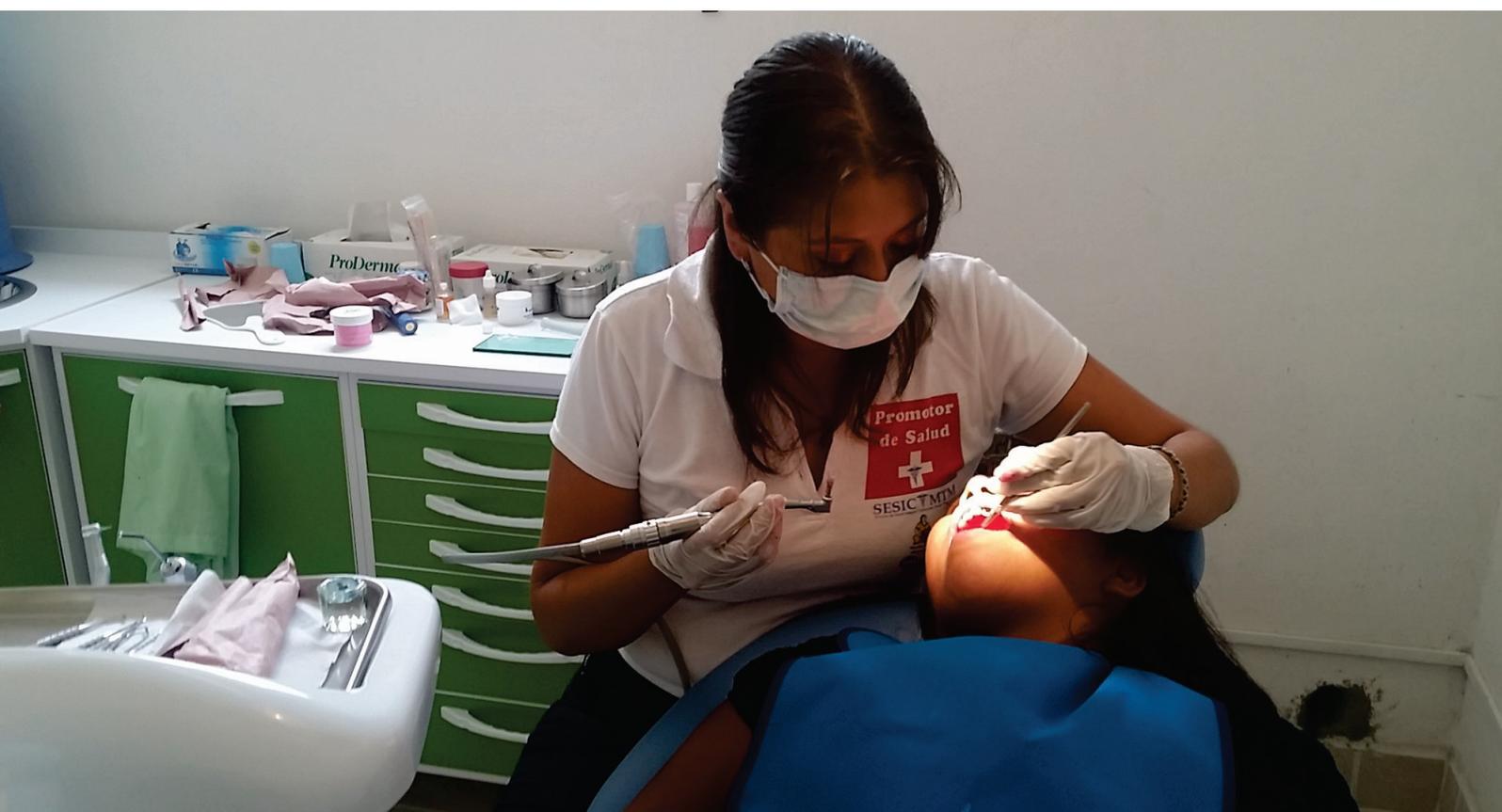
...to quite positive news:



“It is still possible to at least partially achieve financial sustainability of health services. The partners we worked with are extensively active in developing relations with external actors. Exchange of knowledge and resources, publicity, a favourable culture of recommendation, affordable prices, friendly services, etc. are crucial in an environment that does not offer monetary incentives.”

During the 30 months of health services offered in the project period, the health centre received several times direct financial support in order to pay salaries for medical personal over the period of 12-18 months (i.e. for the dentist and the general practitioner) and were offered administrative services of an employee of another international NGO. Our partners are moreover cooperating with international volunteers that are qualified for medical specializations offered at the health centre, and in the future with brigades that possess expertise in additional medical fields that cannot be offered at the health centre. This not only saves money that may be spent for other expenses, but also fosters the exchange of knowledge and contacts. Glasses can be sold as a result of cooperation with an international NGO.

Although the financial support was mainly received from international sources, successful cooperation with local authorities could be achieved in several cases. An example for this is a local foundation which equipped the health centre's dental office with furniture, instruments and consumables, another example is the good relationship with the regional civil protection institution which now regularly uses the existing rooms for training measures. In exchange, it installed a mobile radio communication system, lent general support in risk-related communication for emergency medical treatment, and provided an alarm system.



The local police seems to consider the service of the health centre as valuable as it supports each night from 22pm to 6am with security staff. 11 health promoters resume medical and administrative tasks, offering by this a permanent service. They maintain the routine i.e. when the medical personal changes. The promoters receive a regular salary (better: a rather small stipend) generated by the incomes of the pharmacy. Additionally, these health promoters offer primary health services in their community as well as perform a health, nutrition & hygiene programme in the regional radio at prime time on friday afternoon. Further, being a registered health centre, it also attracts national medical students during their practical year.

An attempt to summarize a difficult question

Despite all these encouraging activities, there is still a constant monetary pressure on the successfully established integrated health centre for indigenous and small-scale farmers' families: the payment of the medical staff – sums that again and again have to be raised from private funds, as public support will also in the future not be a probable source of income. In summary, the response of the question in the beginning can partially be answered positively by referring to the illustrated diversification of efforts and of services.

- A report by Charlotte Nelles (action medeor e.V.)
- Read more about action medeor maternal & child health care projects:
<https://medeor.de/en/projects/development-cooperation/maternal-and-child-health.html>
- Photos: Health center from outside (page 27); health promoters in the pharmacy (page 28); dental clinic (page 29); laboratory assistant (page 30)



SCRATCH-OFF LABELS ON PHARMACEUTICAL PACKAGING - A RESPONSE TO THE THREAT OF COUNTERFEIT MEDICINES

Counterfeit drugs represent a major health risk for the public health and the individual patient. They lower the confidence in medicines, harm the manufacturers, the importers and the whole health system in the affected country. With the project REAL (Rapid Electronic Authenticity Labels) action medeor e.V. developed an efficient, cheap and user-friendly verification system for medicines based on a label with a unique hidden code that can be checked via internet database. The pharmaceutical personnel as well as the buyer are enabled to ensure the authenticity of the purchased product with the help of a smartphone or a computer with internet access. The REAL scratch-off labeling is being tested until May 2016.

Counterfeit medicines may contain no active ingredient, the wrong active ingredient or the wrong amount of the correct active ingredient. They often are produced in very poor and unhygienic conditions by unqualified personnel. Contamination with bacteria or unknown impurities or fatal levels of the active ingredient might cause very serious damages to the health of the consumer.

While counterfeiting is primarily motivated by its potentially huge profits, it benefits from a lack of efficient national drug regulations, deficient supervising authorities and weak penal sanctions and a lack of efficient national drug regulation in some countries. There are counterfeit medicine cases in every part of the world. In some countries trade in counterfeit medicines is more profitable than dealing with drugs or weapons.

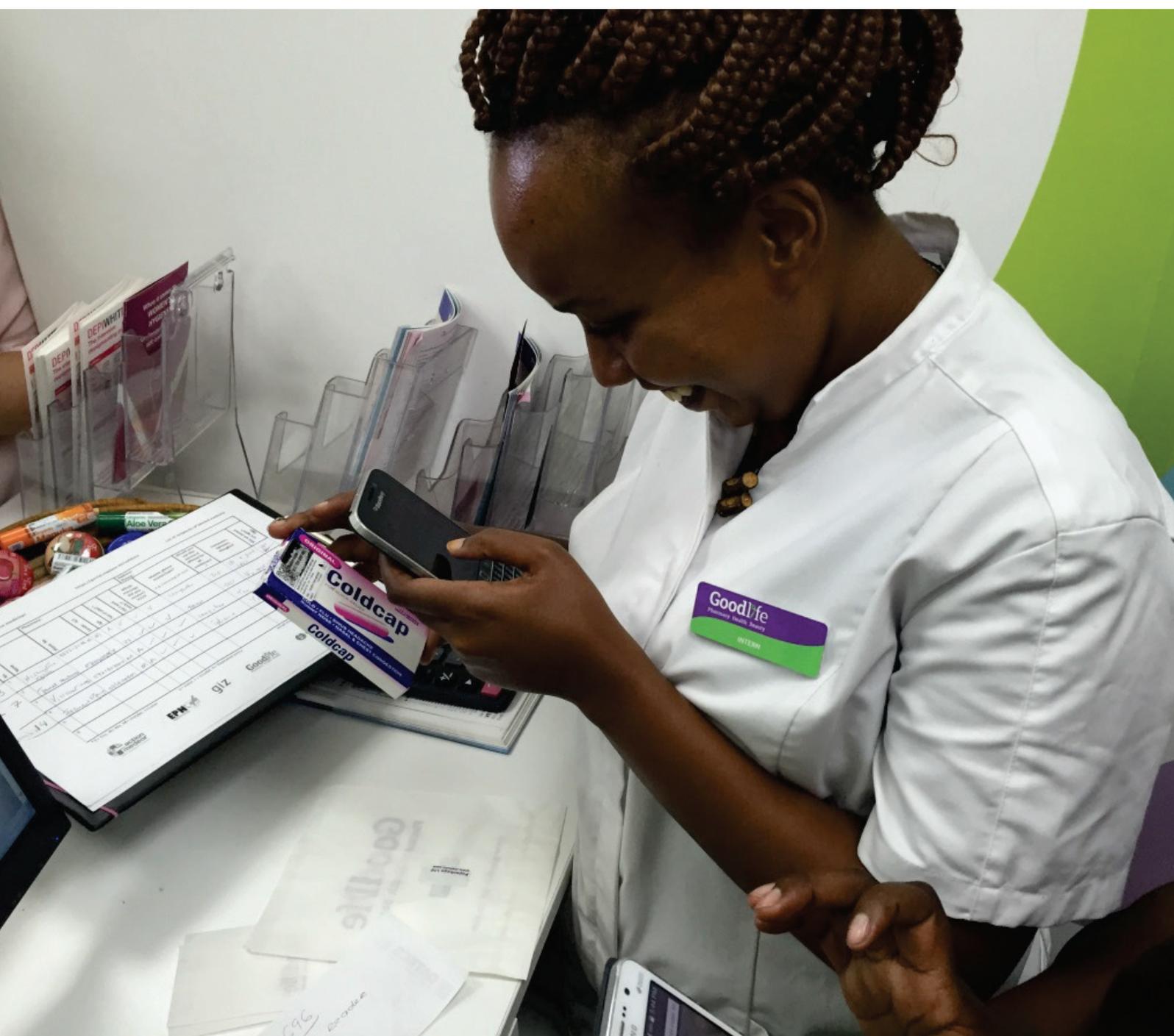
Patients lose their confidence in medicines

The visual detection of substandard and counterfeit drugs is difficult because they are usually designed to appear identical to the genuine product. The falsified medicines may not necessarily cause an adverse reaction but often they fail to properly treat the disease or the condition for which they were intended. Hence the people do not find out that the drugs they were taking were counterfeit and lose their confidence in medicines.

Apart from the direct impact on individuals, counterfeit drugs can cause resistance to medicines especially antibiotics or antiviral drugs. Malaria is a prime example, where Artemisinin and its derivatives already show resistance rates of over 70%. Antimicrobial resistance has become a huge threat to public health.

Providing high quality medicines with ensured authenticity

The challenge for action medeor, acting as a wholesaler and involved in the distribution of drugs, is not only to provide high quality medicines but also to provide information about the authenticity of the delivered goods. Therefore action medeor wanted to set up a verification system for pharmaceutical personnel and patients to ensure them the authenticity of their medicine. The system should be portable to different settings, open for various manufacturers and markets. The “scratch-off technology” seemed to be a good solution because of the high consumer acceptance for other goods in this technology in developing countries, especially in mobile phone services.



The label which is applied to the medicine packaging at the manufacturing site consists of a not covered serial number and a covered unique code. After scratching the metallic covering off, the unique code will be revealed and the product can be verified by using a smartphone, tablet or a computer with internet access. Using a smartphone, a QR code reader app can read the QR code and takes the user directly to the website where the code will be justified against a database. Within seconds the end-user receives a response whether the two numbers are matching and hence he has an original product in his hands. A picture of the medicine packaging and the package insert are also available. If the numbers are not matching or the numbers have been requested before, the consumer will be warned.

Trial phase in Kenya just started

After the development and testing of the authenticity tool by action medeor in Germany in January and February, the scratch-off labels were provided to the pharmaceutical manufacturer REGAL Pharmaceuticals in Kenya. REGAL Pharmaceuticals experienced that one of their products, Coldcap, a common cold remedy, had been falsified earlier. Thus a test product was found. Coldcap was labelled and distributed for free to 12 branches belonging to the pharmacy chain Goodlife. The pharmacists and the sales staff were trained by Dr. Irmgard Buchkremer, a pharmacist, Margret Müller, project coordinator from action medeor Germany and pharmacist and program officer Susanne Kuehle from EPN (Kenya). The pharmacists of the 12 chosen Goodlife branches are now able to advise the costumers and give them instructions for the appropriate verification of the product they purchased. In addition, the branch managers of the involved pharmacy branches were trained at their monthly meeting. Local contact point and coordination partner in Kenya is Ecumenical Pharmaceutical Network, in particular Susanne Kuehle. EPN office is in contact with the pharmacy chain management and the pharmaceutical personnel of the branches. EPN is also ready to answer questions from buyers, in case of problems with the technology or they receive a warning from the system.

The trial phase in Kenya will continue until the end of April 2016. There is a great deal of interest in the project from different stakeholders like the supervising authority in Kenya, PPB, technology companies and pharmaceutical manufacturers. However, a careful evaluation of the acquired data is necessary and the results are to be considered carefully before deciding whether to prolong of the project in Kenya or to expand to other African countries.

- A report by Irmgard Buchkremer (action medeor e.V.) and Susanne Kühle (EPN)
- Project page: <https://portal.medeor.de/validate>
- Project partners: www.medeor.de, www.epnetwork.org

IRAQ, NASSIRYA 2008-2016: THE BRIDGE OF TRUST

When Emergenza Sorrisi NGO (past Smile Train) performed its first mission in Iraq, in 2008, in the American Military Camp of Tallil on a Mobile Surgery Unit donated by the Italian Government, nobody could imagine that this would have been the first step of a long time fruitful cooperation between Italy and Iraq.

We have reached Tallil on U.S. Sherpa flights which were supposed to fly only night time together with armed soldiers from USA, Australia, Romania, young adults who sometimes have left their town for the first time catapulted in a world of sand storms and war.

This was our first time everybody was looking at us as we were crazy: a group of medical volunteers travelling with helmets and bulletproof vests.

Yet in that remote corner of Iraq unusual meeting point of sick children, hopeful parents, local doctors and nurses who had perhaps never met Italian civil doctors, happened the unexpected, the US militaries came to Mittica, leaving the gun to pick the children up and lull them trying to make them smile with dolls and little presents, local Doctors and Nurse who at the beginning were looking at us with suspicious claiming for a too long job day, began to work with enthusiasm tired less side by side with us, that piece of humanity in that place in that moment through knowledge and trust, thanks to the restored smiles of so many children, had rediscovered compassion and equality of human beings.





After the closure of the Military Camp Emergenza Sorrisi has performed many other missions in accordance with the Ministry of Health of Thi Qar, working in Nassyria city in Habobby Hospital hosted by the Government guest house, more than one thousand patients have been treated in these years and, more important, as a consequence of constant training of surgeons anesthesiologists/intensivists and nurses Habobby Hospital has become a reference point for the treatment of cleft lip and palate and burn sequels, not only for Thi Qar Region, but for the whole Iraq.

We have also started with Iraqi Ministry of Health a campaign of prevention through supplementation of folic acid to prevent defects of neural tube closure, especially for the women who already had a child with cleft lip and palate. The more difficult cases are taken to Italy and treated in Italian Hospitals accompanied by surgeon and nurse who are trained during their stay in Italy.

Now we fly with Touristic flights and arrive in Bassora Airport where we are met by our counterpart and taken to Nassirya, travelling across the desert. The number of patients who show up on screening day leave us always astonished, hundreds of children and young adults having on their body sequels of burns or face congenital malformation. We are just back from last February burn sequels surgery mission and another one is already scheduled in June 2016.

A local NGO Emergenza Sorrisi Iraq is currently under registration. It has been created, in accordance with Emergenza Sorrisi Italia NGO, by a local Scientific Committee which deals with health improvement in Thi Qar Region, including multidisciplinary treatment of patients, follow up of their condition and creation of safety protocols for the surgery treatment and post operative care.

The bridge of trust that has been built in these difficult years for that country has overcome obstacles and prejudices and managed to improve the health of so many young patients and their families suffering from cleft lip and palate who are now treated in accordance with the European protocols.

- www.emergenzasorrisi.it

Gideon Dapaa, 49, a high school teacher from the Lower Manya Krobo District in the Eastern region of Ghana, was diagnosed with hypertension six years ago. He admits that at the end of a long day at work he prefers to watch TV rather than do exercise. To help patients like Gideon manage their disease, the Novartis Foundation has expanded its work to improve the control of hypertension by making services more accessible in the community while empowering individuals to take more responsibility in the management of their own health.

We are at a crucial point in global health where we see health systems in low- and middle-income countries (LMICs) still overburdened with infectious disease and maternal and child health challenges, and now struggling with the emerging crisis of non-communicable diseases (NCDs), such as hypertension, diabetes, chronic respiratory diseases and cancer. Almost 70% of all deaths globally are associated with NCDs and four out of five of these deaths occur in LMICs. Despite this high burden, only 4.6% of overseas development assistance for health was allocated toward NCDs in 2013.

High blood pressure and hypertension are the leading cause of cardiovascular disease worldwide. More than three quarters of deaths from cardiovascular disease take place in low- and middle-income countries (LMICs); and at 46% the African continent has the highest prevalence of raised blood pressure in the world. The World Health Organization's most recent estimate of the prevalence of hypertension in Ghana is 27.3%. Yet few control efforts are in place, and as a result only one in twelve people are actively managing their hypertension.

Deaths from hypertension are estimated at 9.4 million people annually globally, which is equivalent to the mortality of all infectious diseases combined. In Ghana, more than a quarter of the adult population has hypertension, but only 4% of these patients have their blood pressure under control.

The Novartis Foundation works with local and global partners to catalyze scalable and sustainable healthcare models to improve access and health outcomes. Previously much of our work focused on infectious disease and maternal and child health issues in rural Africa, while in recent years we now focus on programs that also address NCDs. Among these diseases, the Novartis Foundation chooses to pioneer new health service models to tackle hypertension, as it is the prime risk factor for cardiovascular disease, the number one burden of disease globally.



We work together with diverse partners, from different sectors and disciplines, to build evidence on what works to address this new global health crisis across low- and middle-income countries.

Our first innovative model to address hypertension was launched in 2015 in Ghana: the Community-based Hypertension Improvement Project (ComHIP), a three-year program that brings together partners from the public and private sectors, uses digital technology to connect providers at different levels, and empowers patients to take more responsibility in the management of their own health. The intervention maximizes opportunities for screening, diagnosis and treatment of hypertension, outside the health system, while strengthening existing community-based healthcare services. The model aims to build evidence on the impact of task shifting and involvement of non-traditional health providers in hypertension management, and will assess the impact on blood pressure control at population level.

Partners of the Novartis Foundation in this ComHIP program are FHI 360, the Ghana Health Services (MOH), the London School of Hygiene & Tropical Medicine Centre for Global NCDs, the School of Public Health at the University of Ghana, VOTO Mobile and many local partners.

Carried out in a district close to an urban center in Ghana, ComHIP shifts the point where patients access healthcare from the hospital, which is often distant and crowded, to the community. Local businesses and healthcare workers based in the community are trained to screen and care for hypertensive patients.

The program has launched with 44 community health nurses from the Ghana Health Service. Each of them makes around 100 home visits a month to patients with various medical needs.

The community health nurses have been provided with blood pressure (BP) measuring equipment and will additionally screen every patient they see for hypertension following the other duties of their visit. Besides the nurses, attendants in 46 local drugstores have been trained to offer a BP screening package to their customers, including a BP measurement and a hypertension information package.

As digital health technology can empower patients in the management of their disease, expand patient reach and make healthcare more efficient, digital health components have been integrated into ComHIP, in collaboration with a Ghanaian technology company VOTO mobile. ComHIP includes e-guidelines for health workers as well as healthy living tips for patients via SMS to reduce risk factors for cardiovascular disease and to support adherence to therapy.

Available in four languages – English, Krobo, Twi and Ewe – the messages are aimed at helping patients adhere to their treatments and keep check-up appointments, while also providing lifestyle tips. For example: “Hello! Remember to take your pills today to control your blood pressure and stay healthy!” and “Avoid adding too much salt to your food. Try replacing salt

with some herbs or local spices to enhance the natural flavor. Your food can still taste great!” Messages will also be sent to the community nurses to alert them if their patients are not turning up to their scheduled appointments.

Now, patients like Gideon can better manage their condition through the ComHIP interventions that help patients address their disease with the care of local nurses or staff at a nearby drugstore without the need for time-consuming trips to the nearest hospital.

ComHIP will run until December 2017 and will also include a second district as a comparison site where current hypertension services will be provided without program interventions. The impact is being evaluated by teams at the London School and the University of Ghana, both on health outcomes and the cost-effectiveness.

The results of the project will be used to inform future Ghana Health Service programming and will determine whether a community-based model can be applied in other contexts and low-income settings. The foundation and its partners will share the results with the global health community and also plans to incorporate learnings into our future programs.

The Novartis Foundation’s goals extend beyond Ghana and hypertension; we seek to build evidence on what type of healthcare delivery models and technologies are effective, and then adapt and apply them to help manage the overall dual burden of infectious and non-communicable diseases that low and middle-income countries are facing.

The Novartis Foundation continues to provide platforms to catalyze new thinking, currently leading a dialogue series on the need to urgently address non-communicable diseases. Last year’s edition took place in London to discuss innovation and scale in hypertension management, (<https://www.youtube.com/watch?v=I44B9sy7eGw>), the forthcoming edition will bring experts together on 29 November 2016 in Basel, Switzerland.

- Read more about the ComHIP project: <http://www.novartisfoundation.org/programs/more/614/community-based-control-of-hypertension>

EQUITABLE ACCESS TO QUALITY HEALTH FOR THE MOST VULNERABLE: VISION OR REALITY? EX-POST IMPACT STUDY

The core aim of the Swiss Red Cross (SRC) health projects is to enable equitable access to quality health services, particularly for the most vulnerable. While regular evaluations confirmed improved access during project implementation, the long-term effects after SRC phase out have never been reviewed. An analytical review of selected health projects was commissioned in 2014/2015 to two consultants to understand the long-term impact of SRC interventions on equitable access two to five years beyond project termination.

Five country reviews were conducted in Laos (Health Financing; since 2002 ongoing SRC support), Cambodia (Quality of Primary Health Care from 2004-2011), Bolivia (Health Promotion and Empowerment from 2002-2012), Ghana (Eye Care from 1996-2006) and Nepal (Community Health from 2005-2012) between July 2014 and January 2015. A common methodology based on selected OECD/ODAC evaluation criteria and the framework of access to health care developed by Levesque et al. (2013) was used. The Levesque framework describes access barriers from the health provider side and the demand side and analyses the corresponding abilities to overcome the respective access barrier. Semi-structured interviews were held with local authorities, service providers, beneficiaries and SRC local delegations. Information was triangulated with secondary data from previous project reports and evaluations, the local Health Information Management Systems, as well as from transect walks and observation.

A meta-analysis of the individual country reviews was conducted and results grouped by the five pairs of dimensions of accessibility associated with the service provider and the health system users. A sixth dimension of “support to community based prevention and promotion” paired with “ability to prevent ill health and improve well-being” was added, which is specific to the SRC approach. It is important to note that dimensions also overlap and influence each other.

Preventive community actions may not relate directly to access per se, but impact on the need for individuals, families and communities to seek and pay for care. Health promotion, health education and working on determinants of health have improved health behaviour and practices and well-being (e.g. reduction of diarrhoea in children because of access to safe drinking water). However, only where Governments acknowledge its impact on health, health promotion will become an integral part in public health services. Where synergies and inter-dependence with other projects, programmes and partnerships was created and still remains functional, a greater impact, effectiveness, scope and sustainability of multiple approaches is assured.



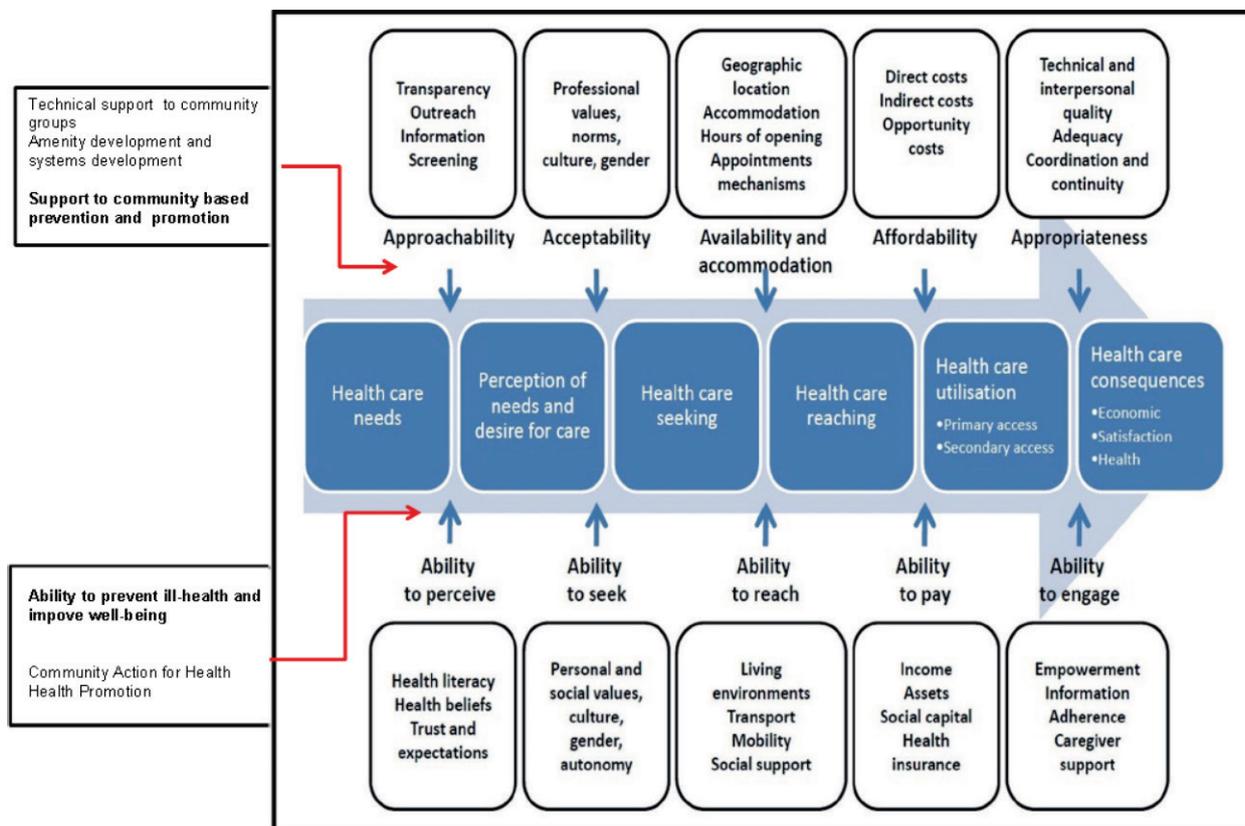


Figure 1: Dimensions of access to health care by Levesque et al (2013) plus additional dimension by Kate Molesworth.

Approachability of services and communities' ability to perceive care

Establishing community groups and local “champions” for certain health topics as well as conducting outreach services has positively influenced health information, perception and health care seeking during and to some extent also beyond project duration. Communities are better informed and a change of traditional beliefs and health practises is observed. However, maintenance of community groups after project completion is challenging and fragile and depends on organisational capacity-building and the establishment of sound funding mechanisms to sustained functioning and motivation of group members. Likewise, outreach services are generally poorly maintained after phase-out because of high costs and thus limit the access to care and information particularly for the rural poor.

“I have referred several people to an eye doctor. I am the action member on eye care in our community. People come and ask me for advise and where to go.” (A community group member in Nepal)

Acceptability of services and ability of individuals to seek care

SRC project approaches that integrate traditional practitioners into the formal health sector with enabling roles, reduce conflicting beliefs among communities regarding the formal and informal health systems on offer. In addition to context-appropriate human resourcing (local staff with a common language for example), integration of traditional medicine and care practises as well as

patient-centred care enhance longer-term sustainability in health system access and use by marginalised and poor community members. Acceptability is fostered where health workers serve their own community and when Government policy supports staff retention with low job rotation.

“*When I go for delivery, I can choose between our traditional birth-giving or the “Western style. I am delivering at the health center now, because I can do it our traditional way”* (A mother in Bolivia)

Service availability and accommodation and communities’ ability to reach care

Project objectives were better attained when a “light” health facility support was included. However, only projects which enabled a certain financial autonomy of the health facility or where external donors other than Government chipped in (e.g. religious organisations), this support could be maintained. Incentive payments on staff and overall facility performance are highly effective in raising professionalism related to strengthened service quality and reliability. Financial support that addressed opportunity costs associated with accessing and taking up health care (e.g. transport, food and accommodation) enhances access. When direct payment of transport is not sustained post-project, there is a rapid decrease in the ability of the rural, remote and poor population to reach services.

“*Our work is still based on performance and we receive a bonus from the Government. Even though the Government does not continue with the same top-ups as during the SRC project intervention, we are still happy and continue our work in good quality”* (Health provider Cambodia)

Affordability of services and the ability of people to pay

Financial enabling mechanisms such as free health benefit packages, health equity funds, transport payments and community-managed revolving safe motherhood funds had strong impact on access to care, particularly for the rural poor. Continuing these mechanisms depends on the ability of projects to influence policy level on the one hand and to create sustainable pro-poor business models which can be handled by the local communities on the other hand. Where mechanisms continue, patient co-payments are reduced and catastrophic health expenditure are averted. In projects where these mechanisms collapsed, the profile beneficiaries shifted from the project’s rural pro-poor focus, to one where the majority of users are from the urban middle-class.

“*I use my own money to pay volunteers to keep working and bringing patients to the clinic, so that they can get services”* (eye care provider in Ghana)

Appropriateness and ability of communities to engage

Except of outreach services, in all projects health care services continue to function well and health care utilisation is steadily on the increase. Projects and services, which initially registered a dip in patient load, picked up services and work load over a certain period of time. Adequate job descriptions and human resource policies, trainings and financial incentives increase the bonding of the service providers to their facility which in turn increase quality and continuity. Community groups have an important role to play in creating demand and ensuring that health systems provide the most appropriate services with which communities can optimally engage. Therefore enhanced roles of community groups in M&E and feedback to health services might not only ensure the appropriateness of service provision for community needs, but also acts to maintain service accountability to users after project completion.

The review found that all projects have improved access to quality services on the long-term by strengthening quality of health services and enhancing community's engagement in health. However, access to the poor and remote population seems to have declined again in those cases, where investments and health financing was not sustained. Two over-arching features which impact on the sustained access to health services found in the review were i) the effectiveness of SRC establishing strong partnerships with regional and central government and influencing local health policies; and ii) the potential of SRC adopting in some cases a stronger business model and sustained ownership of its investments post-completion in order to maintain aspects of access to health which are poorly taken up by national authorities. These include elements such as transport, direct and indirect costs and outreach service funding, autonomous health facility budget, supervision and motivation of community groups and "champions". The maintenance of these elements are pivotal to sustained access of the rural and remote poor. The findings and lessons learnt will be integrated in new project designs. In the future, monitoring and evaluation shall make more use of disaggregated data trying to better understand, create, test and adapt access mechanism to make them more sustainable for the poor within SRC's broad portfolio in very diverse cultural, economic and geographical contexts.

- Study undertaken by Dr. Kate Molesworth (Swiss Tropical and Public Health Institute, Basel) and Dr. Walter Flores (Center for the Study of Equity and Governance in Health Systems, Guatemala City)
- www.redcross.ch/de/das-rote-kreuz-handelt-global



LIGHTING UP ST. PAUL HOSPITAL IN KASHIKISHI

The story repeats itself frequently: In a remote place in Africa there is a poor hospital, the hospital has helpers, helpers install hardware, helpers leave, hardware flops, everybody is unhappy, end of engagement, everybody is disenchanted... However, this is a story of how the sad ending is cheated out.

Kashikishi is located on the northern border of Zambia with the Democratic Republic of Congo, a 20-hour bus ride from the capital Lusaka. The whole region is poor, and the people live off the fish in Lake Mweru. The beautiful lake, 100 km long and 50 wide, provides the main source of animal protein to several hundred thousand inhabitants living on its shores. Agriculture yields vegetables, but depends very much on the whim of the changing downfalls in the wet season, and there is only kasav root to be milled into flour for nshima, the main national dish.

As the Basel Association of Medical Cooperation, founded by Swiss physicians, also including many persons interested in knowledge exchange and aid to isolated small hospitals in several countries, started a project with St. Paul Hospital in Kashikishi, Zambia 23 years ago. The main goal was to trade knowledge and experiences with doctors and nurses in a tropical region. Soon however, the poverty of the hospital in basic infrastructure became a pressing issue. It became obvious, that in order to install a cooperation on even terms, something had to be done to alleviate the many problems of the hospital team, working under harsh conditions. The patients themselves also faced great hardships while undertaking hour-long, sometimes day-long journeys to get help from malaria, tuberculosis, difficult birth problems or serious trauma, to mention only some. Many pressing problems were solved since, like the water supply, sewage disposal, biogas production, lack of instruments and machines, sanitary services, and the Basel team members became familiar faces to the Kashikishians. Working alongside the local doctors and nurses small legends, anecdotes and adventure stories were born, and remain cherished memories to all. One of them is a successful Caesarean section performed in the night, by the light of a battery biker's headlamp after all power sources failed, including the only diesel generator on the premises. Students from Swiss medical schools, having spent a month or two in the hospital, remember many similar stories. Many have left their heart in Kashikishi, and are returning whenever possible, maintaining several online blogs about their various experiences. However, the so frequent electric power failures regularly play a role in many of them. The power-hungry mining industry, combined with a hopelessly antiquated, crumbling infrastructure, make power breakdowns an everyday calamity. Francis, a technical person on the hospital and

one of our fast friends, was very articulate about this on every possible occasion. The only viable answer to the problem was the introduction of solar energy.

Here is where Herbert Albrecht enters the story. Herbert is a wiry, ascetic technical engineer, and a habitual development helper, whose knowledge and experience we had the fortune to engage for our project. He, and a team of five students of various German universities, spend 10 weeks of their holidays within 3 years in Kashikishi. In high temperatures of the summer 2014, hot even for Zambian standards, they assembled a 15 kW photovoltaic electricity plant, mounted 100 square meters of solar panels on the roof of the hospital, had a solid battery house with instrument panels built, and laid more than a kilometre of cables. These cables feed special sockets in critical places around the hospital. The operating theatre, the maternity ward, the laboratory, the emergency room and the administration now function around the clock, no one is worried about having to perform an adventurous Caesarean section again, or live to see the life of machines and computers being sadly shortened by the variations in the power grid. The trip to the toilet at night, the coping with emergencies in the wards during darkness hours, the loss of precious plasma products in the lab freezers, all this is now history.

The finalization of this and other projects in the hospital was celebrated: The vice-minister of health and a number of personalities visited the premises, were impressed with the technical details, there was a religious service and a great party well into the night, everyone had fun. Well, how about the rest of the story? Is it all going to end in a few years for lack of maintenance and personal care by the builder?

The plane having barely landed in Zürich, Herbert wearing a secretive smile opens his laptop and wants to find out if “his” solar power plant is functioning properly. He clicks himself into the instrument panel, securely fastened to the wall of the battery hut in Kashikishi more than a thousand miles away. Immediately, he discovers that a rogue user in the operating theatre has connected a “forbidden” appliance into the solar power socket (turned out to be a power-hungry drill). A VOIP call to the maintenance team: the real success story begins here.

Besides doing the hard work of installing the hardware, Herbert has picked a team of four able-bodied men with interest for support work. The day always started early over many weeks, with a morning meeting. The men wear blue dungarees and have a smartphone each, compliments of Herbert. Late comers to the morning meeting pay a fine, albeit small, but due in cash on the spot. Herbert himself pays too! The men have been given personal instruments and tool sets of high quality. At the meeting, jobs are assigned for the day. Daily, solar energy technique in general, as well as electrician’s tasks in particular are explained. The men are tested for knowledge in questions of maintenance, on weak spots of the system, and in trouble shooting. With time, self-assurance and pride settled in. The men are recognized on sight on the hospital area. Team spirit

prevails, and all jobs get done. Of course, Herbert still visits the instrument site, even when away in Nepal on another project, but he now rarely has to call. Rather, he waits for a call from Francis or another of the able bodied men in blue. He can advise and help them solve problems, which were all mastered to date.

We now continue planning an upgrading of the system, so that avid power users, like the x-ray machine, can be plugged in the system at any time. We now know, that there is a way to ensure continuity of care. We also know, that this process changes the way our friends see themselves, finding pride in what they do, and finding themselves appreciated in the eyes of their peers. Therefore, we find that building maintenance teams is a way to solve technical problems and to fasten bonds between us in the future as well. It is also a very nice picture to carry in one's mind: The hospital, now shining in the darkness, is pair to the magically beautiful chain of lighted dots on lake Mweru, where fishermen work through the night.

- Photo: The maintenance team of the solar power plant in Kashikishi
- More information: www.globalmed.ch/



Burkina Faso is a land-locked country in Western Africa. The Human Development Index ranks it 183rd among 187 countries. Since 2002 the University Hospital of Brescia, Italy has an ongoing collaboration with the Mother&Child department of the Hospital of the Camillian Fathers in Ouagadougou (HOSCO). This report shows the hidden side of political turmoil, which too often hits out of eyeshot the most vulnerable.

The Hospital of the Camillian Fathers assists normally 3000 birth/year and has one of the largest neonatal units with 50 cots. There is also a large malnutrition Day Hospital and an HIV service with actually over 150 children on Highly Active Anti-Retroviral Therapy (HAART). Furthermore around 100 children are seen every day for general illnesses and vaccinations.

On October 2014 a peaceful revolution overthrew the 27-year old regime, the ruling president fled and a transitional government was installed. On September 17th 2015 the country was hit by a coup from the very well equipped guard regiment of the former president against the interim government. The elite soldiers stormed a cabinet meeting and seized the interim president and the prime minister along with other officials. Supporters of the interim government assembled in the streets and trade unions immediately proclaimed an unlimited strike, which was widely observed even by the health personnel. Furthermore, the military enforced a 24/24 curfew; closing of the borders and shooting on the streets contributed to paralyze all normal activities quickly.

In this situation most of the public and many private hospitals were shut down, but the HOSCO stayed wide open and consequently had to face a significant increase in patients in need.

In fact during the 10 days running from Sept 17 to 28, 888 women were seen (about an eight-fold increase to the normal affluence). 318 normal births were attended and 107 C-sections were performed (>10-fold increase). Forty-one of those neonates were retained in the hospital and another 33 showed up for emergency care and hospitalization as other clinics in the city were closed. Another 461 women came for other pregnancy-related pathologies.

Of course other services (like vaccines, routine post-pregnancy and healthy baby visits) were suspended. From the 72 HIV+ children scheduled for follow-up and – more important – pharmacy refill, only 49 were able to come before running out of stock (some of them defying the curfew), while 23 had an interruption of the HAART, which may cause them resistance problems in near future. None of the children hospitalized for malnutrition or HIV was discharged. One abandoned boy of about 10 months was also brought there by a fire brigade.



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"Servir les malades comme une mère assiste son unique fils malade"

2264



In addition, though not an hospital equipped for other than obstetric and neonatal emergencies, a couple of injured (fire arms, accidents) patients were also cared for. All this was possible as most of the personnel did come to work and many stayed there for double shifts. In order to assure safe travel between the homes and the HOSCO, ambulances accompanied staff back and forth. In addition, many Camillian Sisters and Fathers, also those usually not involved with the Hospital, joined forces and the young Italian paediatricians even decided to live in the Hospital 24/24 for the whole period to assure assistance to those in need.

In the end, the regular army – which stood with the people and the transitional government – surrounded the insurgent regiment, seized control of their base and disarmed them, allowing the legitimate government to organize general elections, which were held in November 2015 and won by Mr Kaboré in the first round.

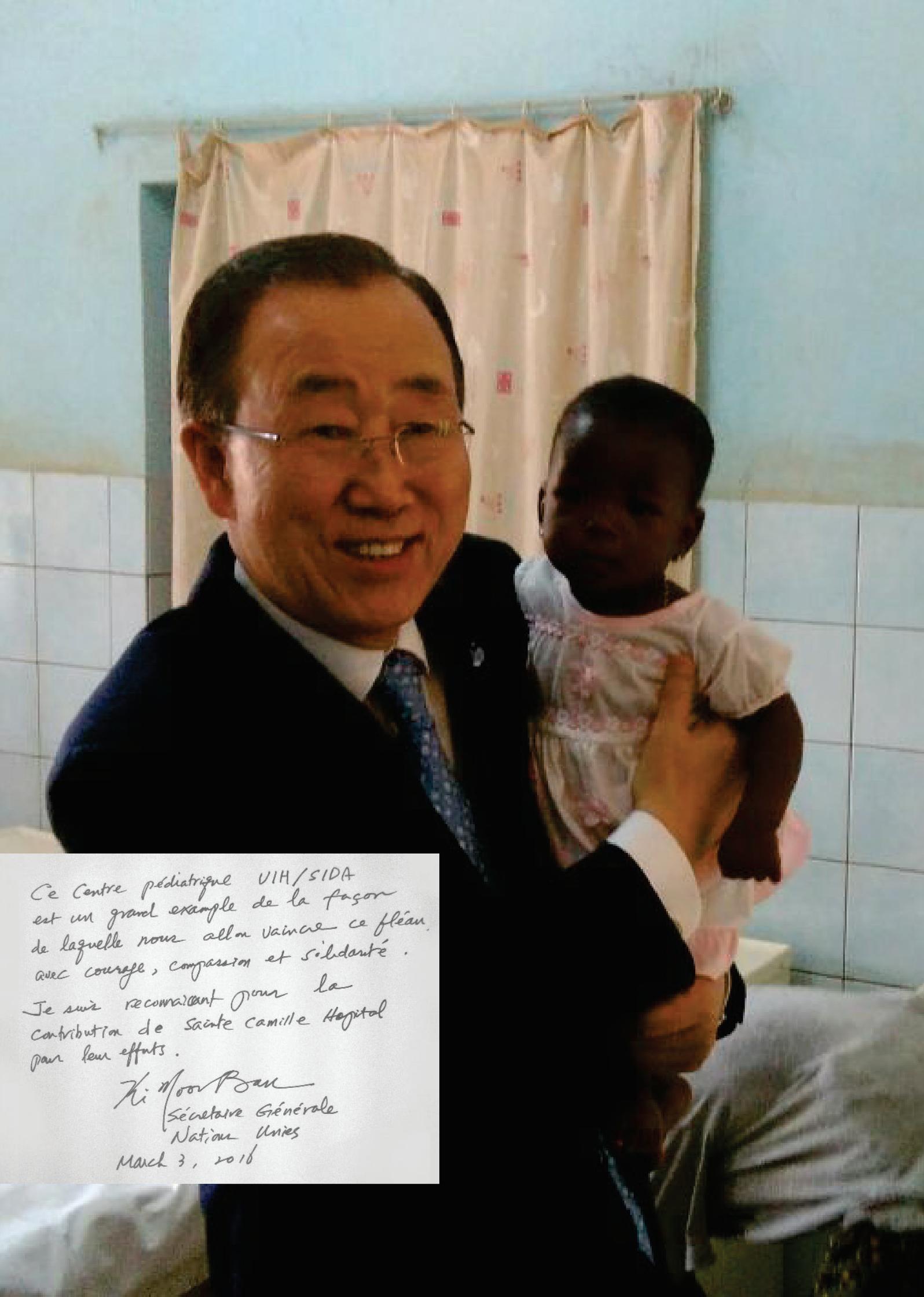
Healthcare workers and patients quickly returned to normal, but more than 3 months after the putsch, further fall-out of this disgraceful event becomes evident, as the national ART-distributor is running out of paediatric drugs for HAART and reagents needed urgently for timely diagnostics and therapy-control, which seem not to have been ordered during the turmoil...

In addition, the effect of the supply disruption and consequently discontinuation of the antiviral therapy during and after the coup in some of our patients on the development of resistance of their viral clade will become fully evident only in future, but worries us already now.

While still working to resolve this shortage, on January 15, 2016 an Al-Qaeda-linked terrorist commando attacked a near-by Café and Hotel, taking hostages and killing 27 people (among them also a child!), leaving 54 wounded on the streets. The ensuing man-hunt in the region led again to a curfew, paralyzing (shortly) the country one more time.

But let us finish with a positive note: On March 3rd, 2016 the Secretary General of the United Nations, Mr Ban Ki-moon, in order to show his solidarity and support, visited this hard hit country – and our Unit at HOSCO!

- Contributed by P. Ouedraogo, L. Sampebre, C. Distefano, V. Folsi, P. Villani and RF Schumacher; institutions represented: Hospital of the Camillian Fathers in Ouagadougou, Burkina Faso; Medicus Mundi Italia, Brescia, Italy; University Children's Hospital, Brescia
- More information: www.medicusmundi.it



Ce Centre pédiatrique VIH/SIDA
est un grand exemple de la façon
de laquelle nous allons vaincre ce fléau
avec courage, compassion et solidarité.

Je suis reconnaissant pour la
contribution de Sainte Camille Hospital
pour leur efforts.

Ban Ki-moon
Secrétaire Générale
Nations Unies
March 3, 2010

TWO CULTURES UNITED IN RIGHT TO HEALTH DEFENSE

This is a story about a project which started in 1972 bringing Navarra (Spain) closer to a District Hospital in Nemba (Rwanda) and is still today creating emotional links between people on both countries, joined in a common effort to defend the Right To Health.

Medicus Mundi Navarra-Madrid-Aragón (MM NAM) is an association part of Medicus Mundi Spanish Associations Federation (FAMME), developing its activities at Navarra, Madrid and Aragón. It counts more than 1.600 members, about 140 yearly active volunteers and 20 permanent staff; in addition to local personnel who collaborates with our diverse projects at Bolivia, Peru, El Salvador, Guatemala, Nicaragua, Congo DR, Mali, Rwanda, Uganda and Senegal.

The creation of the bond with Rwanda

Medicus Mundi was born in Navarra back in 1972, to support the building and daily activities of Nemba District Hospital (Rwanda). This project, promoted by several catholic missionaries living in the area, was also the first to be sponsored by the Navarra Government.

The opening of the hospital, in 1974, was achieved following a call for the population to donate heralded at the main local media. The process forged an extraordinary bond between the Spanish region and the Rwandese district where the hospital lies (Gakenke). Nowadays Nemba Hospital is owned by Ruhengeri diocese and included in the Rwandan Health System. However, the special bond has ever since been maintained and translated into economic and technical help evolving throughout the years.

Rejuvenating the commitment

2016 brought one step further. An initiative was started with the main objective of creating new links between Rwandese and Spanish people and hence advocate for our work: field trips to gain a first-hand impression. For twelve days, during February first fortnight, 8 Spanish people (5 men and 3 women, between 35 and 72 years) led by the MM NAM Rwanda project coordinator travelled to Rwanda.

During the trip, team members were able to expand their knowledge about the country troubled history in the last century, the social and health situation in Gakenke; and the Nemba Hospital and health centres organization. They amazed themselves noticing how hundreds of steep hills are cultivated to provide food, hills so steep farmers need to secure themselves with ropes to stop themselves from rolling down. They learnt how cattle, farming and handicraft cooperatives built

by many women and some men are enabling families to escape poverty and fight malnourishment. And they noticed how Rwandese women role has evolved in the last fifty years, dramatically improving and facing challenges not too dissimilar from those found in Spain nowadays.

All this was put in context by thorough pre travel working sessions in Spain and accompanied by Rwanda's tremendous potential as a tourist destination, showcasing peaceful lakes, dramatic volcanoes and thousands of hills, not to leave aside its hospitable people.

Understanding and assimilating all they felt, listened and saw has not been an easy task. Everyday brought a new surprise: Some 8 years old girls that joined the group for hours asking tirelessly for shoes. An empty food warehouse supposed to store provisions to fight against resource less children and adult malnourishment, but depleted after funds donated with this purpose had been fully used up. A dismaying Intensive Care Unit that made their hearts shrink from its appearance and when figuring how interned patients could feel. Spotless pigs kept in a simple yet neat pigpen in the hills, generating revenue and breaking the poverty vicious circle for the Community Health Agents that had built the cooperative. A singing women group who welcomed the travellers as they came near to see how their children were measured and weighted.

Many different stories, which have filled their backpacks of experiences, emotions, doubts, contradictions and enthusiasm to keep on fighting for health to be an affordable right for everyone.



After the trip

12 days is nothing to know a country. Although is also quite a lot. It changes you. It teaches you. It helps you see from another point of view. It moves you from the inside. It makes you think. It makes you notice the privileges we enjoy in the North of this unequally distributed planet. And it encourages you to get more involved in an organization such as Medicus Mundi, which even after 40 years keeps its engagement in the Nemba Hospital and works to get more resources to support the Rwandese population's fight to improve their living condition.

Throughout these years our approach to cooperation with Rwanda has evolved quite a lot. Nemba Hospital is no longer the only focus of interest, which is now extended to the whole Gakenke District. Neither is to strengthen the public health system anymore the only objective, but also to identify the main factors that hamper health in the area to act over them, or to look for someone who could.

Union makes strong, and a lot of strength is still required to improve 350.000 Gakenke District inhabitants' living conditions. Thanks to the trip there are 8 more people contributing to make it a reality. Media interviews, conferences, fundraising... these some of the already ongoing actions.

In view of good results, it is the intention of MM NAM to repeat similar trips in the next years. Because a lot of people are needed to accomplish our mission: generate structural changes and promote solidarity and a commitment culture that makes affordable health access right a reality. Feeling the need to change things, have a first-hand experience of existing inequalities, name and face injustice, these are the best motivations to unite the fight for Health Access Right.

- Trip blog with personal impressions: www.ibaruwa.es (in Spanish)
- www.lasaludunderecho.es (in Spanish)



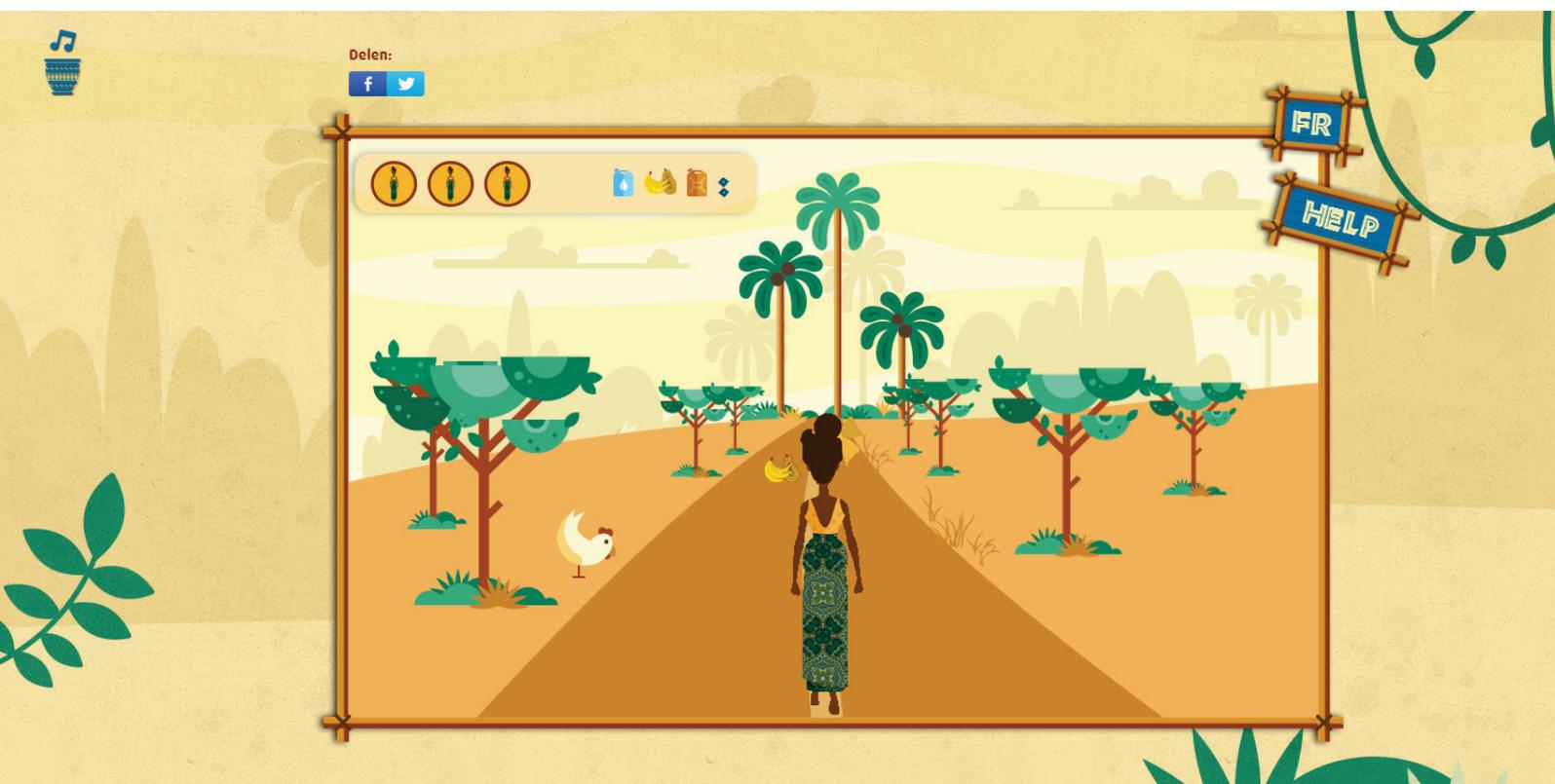
GIVING BIRTH IS NOT A GAME

In October 2015, Memisa launched the online videogame “Giving Birth is not a game” to sensitize the Belgian public about the problem of maternal mortality worldwide, and especially in the Southern hemisphere. Memisa invests in emergency transportation for patients in D.R. Congo to help decrease the high mortality rates.

Memisa is a Belgian medical NGO that promotes access to quality basic health care for those who need it most. We participate in the fight against poverty and for equity. Access to health care is a fundamental right, also for the most disadvantaged populations. without distinction of race, religion or political beliefs. Memisa puts a focus on the most vulnerable groups such as pregnant women and children under five.

The interventions of Memisa are mainly in sub-Saharan Africa and support existing health facilities together with local partners. We improve working conditions for the staff and provide quality medicines, medical material and equipment. Memisa also runs an educational campaign to sensitize the Belgian public on international solidarity and the existing worldwide problems of access to quality health care.

In October 2015 Memisa produced an online videogame to sensitize the Belgian public about the problem of maternal mortality worldwide, and especially in the Southern hemisphere. In the videogame we see a young African pregnant woman who has to walk, row and drive several kilometers to reach a hospital. It is a real challenge for her to arrive on time at the hospital. That is part of the explanation why 800 women a day die due to pregnancy or childbirth.



Memisa put in place a system of motorcycle-ambulances and boat-ambulances to bring patients faster to a hospital, also when the roads are very bad or inexistent. This way, a pregnant woman can be transported to the hospital where she can give birth under medical supervision, which increases significantly her own and her child's chances of survival.

In this game the challenge of arriving (on time) at a hospital, is projected into these 3 levels. As a player you have to achieve all of them before arriving at the hospital. You are challenged and it is a projection of how it feels to be a young African pregnant woman to go to the hospital.

By playing the game, the Belgian public is informed and sensitized about the difficult circumstances pregnant women face in some African villages.

The game was spread through our social media and thanks to good online press return. The game can be consulted online for free and will be used as an educational tool until October 2016 when we will launch the new campaign. It is a good tool to sensitize people and promote international solidarity in a world where social media, internet, smartphones and tablets are mainstream (although mainly in northern countries).

To attract players, we organized a competition at the launch of the game. Players could win all sorts of prizes: the biggest was a return airplane ticket from Brussels Airlines to Africato a destination by choice. There were also chocolates, world maps, books, cycle tours, and many more presents. All prizes were kindly donated to Memisa.

We also had support from famous people (an actress, 2 singers, a photographer, a rapper, soap actor) from our country who stimulated their audience and fans to play our game. They also testified why this game, this action is imported to them.

We launched the game with a press release in the center of Brussels. There was a giant screen on the market where passer-by could play the game. The Secretary of State for Health was present to support our action. Besides the official launch, we also promoted the game at several events: students played the game at school in their classrooms, provincial actions were held on different marketplaces (one during a Christmas market) where people could play on a big screen, hospitals organized the possibility to play the game in their main hall on a big screen, etc.

The game was a result of a cooperation with our partners of the project "hospital for hospital". Memisa works with a network of about 50 hospitals spread all over Belgium. These hospitals are our target groups for our educational and sensitization campaigns (the staff, patients, visitors). Several workgroup meetings a year are organized where we brainstorm together on the content of different actions, amongst them our national campaign.

- Videogame (Dutch and French): www.bevallenisgeenkinderspel.be
- www.memisa.be

DEVELOPING CULTURALLY APPROPRIATE HEALTH SYSTEMS - KEY PRINCIPLES

Health Poverty Action has 30 years of experience in working to improve the health of marginalised groups. We consistently find that cultural barriers provide a fundamental obstruction to accessing health services, and consequently realising the right to health. As a response, we have developed particular expertise in the provision of culturally appropriate health systems. We work with groups including indigenous people in Latin America, ethnic minorities in Asia, and mobile pastoralists in the Horn of Africa.

We advocate an approach that recognises that traditional and Western medical professionals have much to learn from each other. By bringing expertise together in a spirit of mutual respect, solutions can be developed which work with the grain of indigenous cultures. Our programmes demonstrate the value of these simple but effective approaches, rooted in local community experience.

In our contribution we provide practical examples from our own experience of addressing the barriers to health faced by the minority groups that we work with. Drawing on these, we present key lessons and suggest some key principles that can be incorporated into the design and delivery health systems, in order to meet the needs of marginalized groups and help realise the primary commitment of the SDGs to Leave No One Behind.

Critically, we maintain that the disaggregation of data by ethnicity is fundamental in order to expose the barriers faced by minority groups, in order that these can be addressed.

Addressing cultural barriers to health - the rationale

Women from minority groups face multiple and intersecting forms of discrimination. These compound, and are in turn heightened by other forms of exclusion such as poverty, isolation and low levels of education. Recent research by the Overseas Development Institute ODI (1) found ethnicity is a key marker of social exclusion. Their findings include:

- In Guatemala the chances of being poor are up to 2.6 times higher for indigenous households compared with non-indigenous ones.
- In Vietnam, in relative terms the probability of child death for ethnic minorities was 1.5 times that of the ethnic majority in 2006, which increased to 1.8 times in 2011



In Nigeria the Fulani are eight times less likely than Yoruba to have access to sanitation, three times less likely to have had a substantial education and more than twice as likely to belong to the bottom wealth quintile.

Cultural barriers to healthcare can mean women dying in childbirth at home rather than using a system that is completely foreign to them and their practices.

Barriers to accessible health services

Mainstream health services may be inaccessible to minority groups for a range of reasons. Ethnic minorities face practical barriers to development. They are more likely to live in the most remote places, lack transport and have higher rates of poverty than mainstream groups.(2) These practical barriers are compounded by cultural ones. These include:

Language: Minority groups often have a different first language to that of the mainstream population. Failure to accommodate this presents key barriers to health education, building trust and communicating with health staff, and accessing health information, particularly on sensitive topics.

Discrimination. Many minority groups report being discriminated against patronised or treated harshly by health workers when engaging with health services.



“I’d be happy to give birth in hospital if it weren’t for the way they talk to us”
Indigenous community member, Nicaragua

Alternative concepts of health: Many indigenous communities have a different concept of health to mainstream social groups. Often this does not focus on the individual, but is a holistic concept which encompasses the collective well-being of their community and ecosystem. This leads to alternative approaches to dealing with illness. Many indigenous communities will initially seek traditional healing, before ‘other’ (western) treatment when advised to by a healer. Often a pragmatic combination of traditional and ‘western’ approaches to health and well-being is used.

Inappropriate services: These are a significant obstacles to improving the maternal health of indigenous women. For example, Mayan women in Guatemala, and other indigenous women in Latin America, usually give birth in a crouching position. The woman supports herself with a rope strung from the rafters or in the arms of her spouse. Instead of painkillers, a woman is also helped by putting her braided hair between her teeth and biting down on it. Attending health clinics which refuse to accommodate these practices and instead force women to adapt to mainstream practices such as wearing hospital gowns, giving birth lying down, and involving male doctors. These – in conjunction with issues of language and discrimination – can make

giving birth a frightening and humiliating experience for many women. Further, the lack of recognition of Traditional Birth Attendants (TBAs) - a pivotal role which in many communities goes far beyond antenatal and delivery care - and poor cooperation between health authorities and TBAs can make many women reluctant to attend health services.

Migration: Mobile and migrant populations are often composed of different ethnic groups and a mix of various minority and majority groups. Migratory status is by nature transient. A group which would be the mainstream ethnic group in their area of origin becomes a minority group as a result of the migratory activity. Such groups require specific approaches on the basis of their migrant status at a given time.

Lack of participation: A key reason for the above barriers is the systematic exclusion of minority groups in the design and delivery of health systems.

Addressing barriers and providing appropriate healthcare - key principles

Health Poverty Action believes the following key principles are fundamental when designing appropriate health services. This is not intended to be an exhaustive list, but based on our experience, are key considerations which we believe should inform the design and delivery of health systems in order to meet the needs of marginalised communities, and deliver the commitment to Leave No One Behind. These are:

Enabling participation and community feedback: The inclusion of marginalised communities in the design, delivery and development of services is vital. This can be incorporated in a variety of ways. One method we have found useful to facilitate this is thorough participatory methods such as community conversations – a transformational participatory methodology which engages diverse members of communities in interactive discussions to consider sensitive issues. The method draws the community's attention and focus to the issue, and facilitates exchange of various views. Other examples we have effectively used include establishing specific feedback mechanisms, such as Village Health Support Groups or community health committees to collate feedback from communities and act as a formal liaison between communities and health authorities. We are also currently running a client satisfaction software system in Peru and are piloting a mechanism in Somaliland to enable patients to give feedback via toll free phone number.

In Peru, Health Poverty Action developed SUMACC ('System to Measure Quality of Attention', in Spanish), an innovative client satisfaction software system. This is designed to help health centres to develop plans that directly respond to the indigenous populations' demands. The software allows users to cross variables; view results in PDF or Microsoft Word format, and

generate satisfaction index reports and general reports from the information gleaned from interviews with health workers and key informants. The system was validated in a trial in three district health facilities in Ayacucho, Peru, and, as a result of its success, was then formally adopted by the regional government for implementation at a regional level. SUMACC has been shown to be highly valued as a direct and sustainable contribution to the improvement of health services; it was found that the vast majority of health centres with access to SUMACC had used the system to create and implement a plan for improvement of services in line with the feedback they received. These improvements have included the posting of timetables for health staff, explanations of services, and flow chart pregnant women can use to understand which health centre to attend for exams and birth.

Appropriate communication: The provision of health information and education material in relevant languages is essential both to ensure information is understood and to establish trust and openness, especially with regard to the discussion of sensitive health issues. Where communities have oral traditions, health information using pictorial material may be relevant alongside other means of transmitting health messages, such as drama, songs and radio.

In 1999 Health Poverty Action set up and supported an independent local organisation to produce and broadcast Urunana ('Hand in Hand'), a radio soap opera in Rwanda and parts of Burundi. The show tackles subjects such as HIV/AIDS, family planning, domestic and sexual violence – issues that were previously considered taboo. It has proved hugely popular, bringing health information to an estimated audience of 10 million people each week and the show's actors have attracted cult status nationally. 74% of Rwanda's population regularly tune in to the twice weekly episodes and 36% now use the radio as their main source of health information.⁽³⁾ Our partner Urunana Development Communication now functions autonomously, raising its own funds and producing programmes.

Culturally appropriate services: HPA has piloted and advocated for health systems that combine modern medicine with positive local practices, especially with regard to birthing. This can include adapting existing health services to incorporate appropriate elements of indigenous cultural and spiritual beliefs; introducing key interlocutors such as traditional birth attendants to assist with births; or, in some cases the provision of complementary services, for example birth waiting homes (see case study below).

Forging links between communities and formal services: This as an important part of building trust between communities and health services and encouraging referrals. It can involve working with interlocutors who are trusted by communities and can play a key role in engaging both with communities and health services.

“TBAs can see problems from the health centre staff and villagers points of view”. Midwife at San Dek Chas health clinic, Cambodia

In many places we have found that Traditional Birth Attendants (TBAs) are ideally placed to fill this role. TBAs play a key a major role in maternal health across the world. Their longstanding role and status in communities mean they are present in remote locations, respected by the people they serve and provide important practical and emotional support for women. The WHO recommends collaboration between skilled birth attendants and TBAs in order to provide an ‘unbroken chain of care between the community and the health system’ as an interim step of a longer-term plan for training and providing sufficient skilled attendants (4). We have found that training and supporting TBAs to work as ‘link workers’ between health facilities and women in communities can be a highly successful way of bridging the gaps with formal health services (see case studies below).

Monitoring and data disaggregation: Ensuring people are not left behind requires appropriate indicators for measurement. Coverage indicators are typically easy to measure but do not tell us who is utilising the services. For example, coverage could be achieved, whilst the range of barriers that prevent marginalised groups from using health services remain. Indicators that measure utilisation rather than coverage can be a more meaningful indicator of the efficacy of a health system. Assessing whether services are reaching marginalised groups requires measuring availability and quality of services, in conjunction with the barriers to accessing health services and health outcomes. These must be appropriately disaggregated.

Disaggregating data by the full range of social and economic groups is essential in realising the core commitment of the SDGs to Leave No One Behind. In particular we find that data disaggregated by ethnicity is vital in tracking those missed out by health services. Whilst this is often presented as a technical challenge, much of the data or methods for disaggregating by ethnicity already exist. Household surveys, Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) all provide the option to include questions on ethnicity or to use proxy measures such as religion or language where relevant - it just requires that they are utilised.

There are also existing examples of good practice in data disaggregation that can be built upon. For example, in Nicaragua forms for outpatient information capture ethnicity. In the RACCN this is analysed and used to research and monitor the health outcomes of different ethnic groups. Lessons can be learnt from these experiences such as these.

One clear barrier is the absence of incentives to disaggregate due to a lack of demand by national or donor governments. Donors and national governments can provide a strong incentive for data disaggregation at all levels by requesting it as standard across implementation of the SDGs.

Despite the commitment of the SDGS to disaggregate data by a wide range of social groups outlined in target 17.18 and para 74g of Agenda 2030, we have grave concerns that the proposed indicator framework wholly undermines this, and consequently the commitment the Leave No One Behind. Please see the briefing by Health Poverty Action and Minority Rights Group, “Disaggregation by ethnicity: protecting the commitment to Leave No One Behind”, for further details on data disaggregation.



Recommendations

We recommend that the above key elements: enabling participation and community feedback; appropriate communication; culturally appropriate services ; forging links between communities and formal services; and monitoring and data disaggregation can offer lessons and key consideration when working with marginalised groups, and suggest these are systematically considered in the design and delivery of all health programmes. In addition donors should:

- Disaggregate data by ethnicity across all programmes
- Systematically request and support all ODA recipients to report results disaggregated by ethnicity as well as other marginalisation factors.
- Within the current UN led indicator discussions, push to amend indicator 10.2.1 to include all disaggregation factors listed in the state agreed target.
- Insist that disaggregation of data by all social groups outlined in Para 74g and target 17.18 of Agenda 2030 applies across the entire indicator set both at the global and national levels.

■ www.healthpovertyaction.org

■ Footnotes

(1) Overseas Development Institute, 2016, <http://bit.ly/20Ro8mO>

(2) NDP and Indigenous Peoples, (accessed 01/04/2016), <http://bit.ly/1MZxOGy>

(3) <http://bit.ly/1VNHfyS>

4) Making pregnancy safer: the critical role of the skilled attendant, A joint statement by WHO, ICM and FIGO, 2004 <http://bit.ly/1pxE8N4>

■ Photos: Peru, culturally appropriate delivery room (vertical delivery)
Cambodia: Mother and child

THE GLOBAL CHALLENGE OF HEALTH WORKFORCE

Worldwide, there is a shortage of skilled health workers. Wemos advocated for health workforce worldwide within the EU-funded project Health Workers for All. In 2015, we succeeded in pushing the implementation of the WHO Global Code of Practice higher on the agenda of the European Commission. Although the project finished by the end of February 2016, we will continue our work within the Health Systems Advocacy Partnership, a five-year collaboration with organizations in the Netherlands, Kenya, Uganda and Zambia.

On our visit to Uganda in November 2015, it was striking to hear the head of a District Health Team in central Uganda tell how frustrating it is to have too few staff on all locations within the district. As a consequence, existing health workers get overworked; some may even decide to turn their backs to the health profession. The permanent lack of basic medication is another reason of frustration among the health workers in Uganda. A midwife told us how harsh it is not to be able to give any oxytocin to women during their delivery. Also simple diagnostic tools are missing.

The facts of reality in Uganda and other African countries pinpoint the urgency of drawing attention to the shortage of staff and basic medication on a global scale. Within the Health Systems Advocacy Partnership, we hope to draw attention to the problem, not only in Uganda or other African countries, but also at the World Health Organization. The recruitment, training and migration of health workers should be regulated globally.



In the Health Workers for All (HW4All) project (1), we have advocated for the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Based on the principle of Policy Coherence for Development, HW4All urged EU Member States not to overly rely on foreign trained health workers and support low- and middle-income countries in strengthening their health systems and health workforces. As a result of our activities, the Code is now higher on the agenda of the European Commission (2). At the 65th session on the WHO Regional Committee for Europe in September 2015 the WHO European Region also launched the report 'Making progress on health workforce sustainability in the WHO European Region' (3) with references to the work of HW4All, and emphasizes the critical role that civil society plays in support of national health workforce sustainability. As member of MMI, Wemos' Global Health Advocate Linda Mans addressed the need for inter-sectoral action for health systems strengthening and sustainable health workforces in several joint civil society statements.

Wemos continues its work at national, EU regional and global level, also as coordinator of the renewed MMI working group on HRH (4). Linda Mans emphasizes the importance of the cooperation. "With joint forces of civil society and examples from the three African countries we can enforce our message to the Dutch government and to the European Union as well. The priority of health above economic and other vested interests stands in the core of our advocacy. We believe that the WHO Global Code, when implemented, can serve as the entry point to a broader focus on developing national-level health workforce policy and planning mechanisms. As a Ugandan health worker aptly told us, 'You come to a point where you want to change things.'"

- The organizations participating in the five-year Health Systems Advocacy Partnership are Amref Flying Doctors, African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI) and Wemos, and is financed by the Dutch Ministry of Foreign Affairs, the fifth partner.
- References:
 - (1) <http://www.healthworkers4all.eu/home/>
 - (2) <http://bit.ly/1VxmZ4e>
 - (3) <http://bit.ly/1qLEGzO>
 - (4) <http://www.medicusmundi.org/en/hrh-working-group>

2015: FINANCIAL FACTS & FIGURES

Capital Account

Assets	Previous Year		2015	
I. Long-term fixed assets		1.00		1.00
II. Short-term fixed assets		136'017.69		128'091.32
Cash in hand	303.26		214.90	
Cash in banks	126'889.69		127'626.42	
Other amounts receivable	8'504.73		250.00	
Prepaid expenses	320.01			
Total Assets		136'018.69		128'092.32
Liabilities	Previous Year		2015	
I. Net equity		99'032.37		91'830.84
Status 1 st January	103'336.34		99'032.37	
Net loss	- 4'303.97		-7'201.53	
II. Accruals		2'975.00		2'975.00
III. Project funds not yet appropriated		13'032.24		11'405.80
IV. Other liabilities		20'979.08		21'880.68
Total Liabilities		136'018.69		128'092.32

Statement of revenue and expense

Revenue	Previous Year	Budget 2015	Accounts 2015	Budget 2016
Membership contributions	47'450.00	51'450.00	50'700.00	51'050.00
Donations and subsidies	32'119.28	23'500.00	22'500.00	16'000.00
Interest	483.40	300.00	268.13	300.00
Other income	1'008.10	1'200.00	4'301.18	
Subtotal Revenue	81'060.78	76'450.00	77'769.31	67'350.00
Expenses	Previous Year	Budget 2015	Accounts 2015	Budget 2016
General expenses secretariat	57'200.00	57'200.00	57'200.00	62'000.00
Travel costs / hospitality / Network events	11'340.30	18'000.00	9'369.79	13'000.00
Projects: net expenses (HRH project)	4'597.30	6'000.00	4'597.30	
Other expenses secretariat	3'568.08	5'000.00	3'676.04	5'000.00
Other expenses	8'659.07	4'800.00	10'127.71	5'300.00
Subtotal expenses	85'364.75	91'000.00	84'970.84	85'300.00
Net loss	- 4.303,97	-14'550.00	-7'201.53	-17'950.00

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 2016. The "Report on the Audit of the Financial Accounting as of December 31, 2015 for the Association Medicus Mundi International e.V." by RSM Verhülsdonk GmbH, Krefeld, Germany, is available at the MMI secretariat.

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