SHORT STORIES
BY NETWORK MEMBERS
MEMISA

TAKING THE GENDER TURN

In 2018, Memisa set a new course on Sexual and Reproductive Health and Rights (SRHR) by signing an inter-organizational gender charter and training all its headquarter staff through the online e-learning tutorial “Body & Rights”. Indeed, while gender and sexual and reproductive health and rights have been part of a transversal approach for Memisa for many years now, 2018 was marked by a series of specific actions to complement the previous transversal approach.

While the notion of sex refers to the biological differences between women and men, the concept of gender refers to the way in which society assigns differentiated roles and status to men and women, with, in most cases, a negative appreciation associated with female roles. These differentiated statuses vary in time and space and are determined by social, political, historical, cultural and religious norms. By intellectually dissociating the cultural and the biological aspects, the concept of gender questions clichés related to sex.

Over the years, considerable progress in gender equality has profoundly changed the way men and women perceive their future. The recognition of the rights of LGBTQI is progressing around the world under rightful pressure from broad movements claiming the right to be able to live their gender and exercise their sexuality without fear of discrimination or threats. However, these considerable advances are fragile and inequalities are far from having disappeared from the globe. Inspired by the experience of the Gender Mainstreaming Charter adopted by the three Belgian trade unions in 2004, the NGOs and institutional stakeholders decided to embark on the project of creating a charter for gender equality. The gender charter was proudly signed by Memisa and is divided into eight specific points. Memisa therefore undertakes to:

1. In its vision-mission, fully integrate the fight for gender equality into the global mission to fight poverty and inequality
2. Promote a balanced representation of women and men in its decision-making and governance bodies (Board and other bodies) by having at least a 1/3 representation of persons of the same sex in these bodies
3. Develop a dual approach: transversal (“gender mainstreaming”) and gender-specific in all aspects
4. Define a gender action plan for its organisation, with objectively verifiable monitoring and evaluation measures and a dedicated budget
5. Explicitly integrate gender equality into human resources policy
6. Explicitly integrate the gender equality dimension into the code of conduct
7. Ensure, in all its activities, that all communications ensure a non-stereotypical and balanced representation of men and women and that specific attention is paid to sexual diversity
8. Contribute to the empowerment of women and discriminated social groups
While we are well advanced in most of these commitments, it is now a matter of keeping them in mind consistently and for the long term, and translating them into concrete actions.

**MANDATORY GENDER AND SRHR TRAINING**

Regardless of their position, all staff at Memisa headquarters has been trained in gender issues and SRHR. The “Body & Rights” tutorial was created at the request of the Belgian Development Cooperation for Belgian diplomats and expatriate staff of the Belgian Development Agency (ENABEL). The tutorial was developed by the Belgian platform of international health actors Be-Cause Health under the coordination of Sensoa. It is a tutorial that covers the following themes:

Definition and obstacles to sexual and reproductive health: the definition of sexual and reproductive health and rights as well as the major obstacles encountered throughout the world, including cultural ones.

- HIV and STI: The tutorial presents global HIV figures and its impact on the world. The other STI are also presented.
- Family Planning: The tutorial presents the benefits of family planning, the unmet need for family planning, as well as data on maternal mortality and unsafe abortion.
- Sexual and gender-based violence: The tutorial covers the definition of sexual violence. We also see female genital mutilation and child marriages.
- Vulnerable groups: Not everyone is equal in terms of sexual and reproductive health and rights. Some groups are more vulnerable than others, such as young people, sexual minorities and migrants.
- Politics: Finally, the tutorial reviews international politics in the same way, as well as Belgium's legislative framework.

After the Belgian Directorate-General for Development Cooperation and ENABEL, Memisa is the third entity with the most members trained in sexual and reproductive health with this online tutorial. These training courses are already bearing fruit and in Memisa's actions. In Burundi and the DRC for instance, gender is no longer approached only as a transversal theme but has now a specific budget and specific expected results as well, with activities such as telemedicine, health promotion/education, improving maternal health, advocacy and protecting patients' rights.

In 2019 and beyond, Memisa will continue to build on this momentum by contributing to the evaluation and actualization of the tool, and by disseminating the "Body & Rights" tutorial and the content of the gender charter to our staff and partners around the world.

**References**

E-tutorial, pictures: https://www.bodyandrights.be/
In Burkina Faso acts of violence are on the rise with increasing bloodshed and dramatic consequences for the population and those who want to help. A once exemplary peaceful country is now close to the edge of a civil war. The “orange zone”, considered “discouraged unless compelling reason”, now includes the capital city, where Medicus Mundi for 15 years had an ongoing HIV-collaboration with the Hospital of the Camillian Fathers.

In 2018, more than 200 Burkinabè, most of them policemen and soldiers, were killed in terrorist attacks. In March, in the capital Ouagadougou, a double attack hit the French Embassy and the Burkinabè army headquarter. The other attacks occurred along the border with neighbouring countries, in particular near Mali and Niger, but starting from there they stretched out deep in the country, withdrawing huge areas in the north and east from state control. In these regions, more than 600 schools had to be closed in 2018 under terrorist threat – some teachers were killed for not wearing appropriate clothes or not teaching Arab, books and buildings burned. Almost 50,000 people were displaced internally. The numbers by February 2019 increased to over 1000 schools closed and 150,000 affected students. Health facilities were also closed or reduced service (1). For this reason on New Year’s Eve the President declared emergency in 7 out of the 13 regions of Burkina Faso (2).

The roots of conflict

In the wake of the crisis in Mali, also in Burkina the idea of precolonial reigns reappears. The insurgency is fuelled by the resentment of ethnic groups - in particular the Fula people (locally called Peul), traditionally cattle breeders - who live in areas that have been forgotten by national development programs: in terms of health, these are the areas of Burkina where there are fewer health facilities and consequently the highest rates of malnutrition and child mortality.

Yet, until 2016, Burkina had been spared from the Islamic terror and the separatist movements of the Tuareg and Peul populations present in Mali and Niger: the country was brought as an example of peaceful coexistence – albeit the International Crisis Group (3) warned the government to tackle the perceived discrepancy between a significant number of Muslims and their low level of public representation. In fact, ethnic and religious tensions and conflicts were present but remained limited as long as no external intervention poured gasoline on the fire: the scarce resources of Burkina did not tempt anyone. But in recent years the poorly controlled race to the unexploited treasures buried in the Sahel soil (mostly new - rare earths - and old gold, but also new - uranium - and old oil) has build up momentum at increasing speed. After invading Chad, Mali and Niger, Chinese, Canadian, Indian, and Algerian mining companies have arrived also in Burkina Faso bringing capital (and missionaries) from Saudi Arabia, Qatar and Kuwait: so a previously ignored desert, inhabited only by shepherds (but also smugglers and traffickers of weapons, cocaine and migrants) has become the center of international economic interests and intense conflicts.
Poverty is another driving force, as every terrorist receives a salary that is higher than that of a government soldier – in addition to a flat rate for the family. The social prestige and the self-esteem associated with being a terrorist is another stimulus, especially for young, poor, angry and emarginated males. Thus recruiting fighters for the low-intensity conflict strategy is not a problem for the terrorists, while the government struggles to keep the military in active duty.

**THE INVOLVEMENT OF BURKINA FASO**

This new “gold-rush” also involved Burkina, in short time the old "white" district of Ouagadougou – “la Zone du Bois” - has become home to dozens of foreign mining companies, whose staff goes back and forth every week from the gold, zinc and manganese mines, escorted by poorly armed Burkinabé military servicemen. Around half of the national territory is now subject to options or mining concessions. However, precolonial resentments and subsoil richness are not the only reasons why Burkina got involved in the Sahel war. Until a few years ago, it was through Burkina that the guerrillas of Mali and Niger received their arms, and it was in Burkina where its fighters, its refugees and its leaders found shelter whenever needed. In return, the Jihad and claims for territorial independence remained outside the country. This "deal" created difficulties for the governments of neighbouring Mali and Niger but generated economic benefits for Burkinabé leaders.

With the intensification of the conflict in the Sahel, and with the direct and increasingly strong commitment of France and other International forces, the new Government that took office in Burkina after the revolution at the end of 2015 would and could no longer “honour the deal”. Soon after that was evident the terrorist attacks began and kidnapping – and now killing - of Europeans, including health workers, started.

**WHAT ARE THE MILITARY FORCES PRESENT**

There are about 3,000 guerrilla fighters in the Sahel, belonging to various movements but united in a consortium affiliated to Al Qaeda. On the other side, 20,000 blue helmets of the UN peace mission are deployed in Mali. In addition, for the fight against terrorism, some 5,000 soldiers from France, USA, Germany, and Italy train and sustain the local military forces and bring modern equipment. But the use of armed drones against the small terrorist combat groups, that easily hide in the Savannah and its villages, is associated with significant collateral damage.

Another risk perceived during the ongoing war in the Sahel is the civil-military cooperation in support of humanitarian operations. As Barkhane is not a peace-keeping mission, but a full fletched “war” on terror, collaborating with one of the belligerent parties is ethically and practically difficult for NGOs – to say the least. While we gratefully rely on the military for emergency evacuation, a clear distinction between the identities, functions and roles of humanitarian and military actors is pivotal for a successful humanitarian work and the safety of both, humanitarian operators and their clients (4). The disastrous mingling between military operations and humanitarian aid that allowed to identify Bin Laden in Pakistan, besides undermining trust and thus vaccine use, still causes dozens of killed vaccine workers (5) – also here in Africa.
AND THE YEAR 2019 STARTED EVEN WORSE

On New Year’s Day, guerrillas killed 7 inhabitants of a village of Mossi farmers, the major ethnic group in Burkina. In retaliation the Koglweogo, illegal armed groups of self-defense, attacked villages of Peul, killing at least 80 inhabitants and provoking the exodus of about 12,000 people (6). The problem thus is shifting ever more from terrorist attacks towards civil war, with rebellion, tribal conflicts and now also ethnic atrocities! Facing with the risk of an escalating ethnic conflict, the UN Secretary General addressed a message to the Burkinabé government, expressing his concern.

WHAT DOES THIS MEAN FOR US?

Medicus Mundi Italy closely followed the changing map of Burkina Faso (7), where the “red zones” increased rapidly and now almost cover half of the country, while the orange zone, considered “discouraged unless compelling reason”, now includes the capital city, where Medicus Mundi for 15 years had an ongoing HIV-collaboration with the Hospital of the Camillian Fathers. Over 50 young doctors, most of them residents in paediatrics from the University of Brescia, served a term of 3 to 6 months on rotation there, but given the security situation, the home institution vetoed its personnel to continue to work in Burkina, effectively closing the project for security reasons.

It’s hard to depart leaving close friends to an uncertain future, but as our presence there might put the whole hospital at risk, there was no choice. At the time we write this, we still continue our other project, fighting against childhood malnutrition in 5 districts of the center-west region of Burkina Faso....

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Photos: WikiCommons (selected by MM International)

References

NO ONE OUT! WHAT WE CAN LEARN FROM DAVID...

The idea to interview David O’Ranga came up because he is really committing himself in the project “No one out! Empowerment for youth inclusion in Nairobi informal settlements”. David is one of the Health Care Providers engaged in activities with young people from 14 to 25 years on HIV testing, counselling and prevention in the Mathare North Health Centre, one of the public health facilities where Medicus Mundi Italia is working since April 2017.

So this is the story of David resulting from the interview: David was 17 years old when he moved to Nairobi from Migori County (Western Kenya, near Victoria Lake) with some relatives who took care of him. As soon as he arrived in Nairobi he finished the last two years of Secondary School and then he attended the Thika College for obtaining the diploma in HIV & AIDS Management. Finishing the college he decided to study for a certificate in HTC (HIV Testing and Counselling) with NASCOP (National Aids and STI’s Control Programme), a programme born in Kenya 1987 in order to guide the interventions of the Ministry of Health against HIV and AIDS. NASCOP is working as an operative unit inside the Kenyan Ministry of Health.

David decided to study this topic because he lost his mother of HIV and it seems she was not aware of it and therefore she never received the necessary treatment. This is the main reason which pushed David to become what he is today. He is eager to help both youth and people living with HIV to be informed, prevented and treated. He did his internship in Mama Lucy Kibaki public hospital, then he has been employed both as an HTS Counsellor and focal person for antiretroviral in the CCC (Comprehensive Care Clinic) in Mathare North Health Centre through the Afya Jijini programme (a programme of IMA WorldHealth which is helping Nairobi City Council to supply health services with an integrated approach which means together with the public health facilities).

When the Afya Jijini programme finished to pay his salary because of some constraints, he decided to remain in the Mathare North Health Centre while looking for another job. Since April 2017 David has followed all our trainings, monthly meetings for follow-up on the community strategy through the Community Health Volunteers (CHVs) engagement and he is also taking part in all our youth awareness activities. In Mathare North Health Centre he is recognized as a friendly Health Care Provider - the youth feel free to go to him - and also his relationship with the Community Health Volunteers has improved in terms of completing referrals from the community and actions taken. He is recognizing that “No one out!” awareness activities are increasing the number of youth from 14 to 25 years volunteering for HIV testing and consequently also reducing the cases of new HIV infections. David’s motto is: “HIV doesn’t kill if you accept your status and work hard for it! It is possible to live!”

Why is the story of David a story to be told? Because it has a cross-section of the informal settlements of Nairobi where Medicus Mundi Italia is operating. These are not easy environments, but full of challenges and poverty where health is an important component.
The implementation of a community strategy inside the Ministry of Health curriculum has really helped to discover which are the most common diseases in those areas and how to treat them.

In fact the most important aspects about any community strategy is the creation of awareness of how health is important in life. To feel healthy or to treat as soon as possible a symptom is a behaviour that has to become a kind of life routine and especially to feel free to go to the nearest public health facility to be assisted and treated. People of the slums are often very reticent to approach the facilities because of fear of stigma and that’s why the community sensitization activities have an important role.

Medicus Mundi Italia is implementing the project considering this important aspect through strengthening the relationship between the Community Health Volunteers and the Health Care Providers in five health facilities in different slums areas (Korogocho, Dandora, Babadogo, Mathare North and Kariobangi). In this way the referrals system is becoming stronger. The other aspect of the project is related to youth. Opening the health centres on Saturday morning allows to make a community dialogue on sexual and reproductive Health, HIV and AIDS testing and prevention, family planning. This contributes to a better understanding and use of the services available.

The slum areas are really demanding; sometime is not easy to recognize if the implemented activities are helpful as MMI is really covering a large area but sensitization and advocacy with large number of youth and different population can become a word of mouth in the communities. From when the project has started almost 1800 youth have been reached during awareness activities.

As stated in the Strategy for Community Health 2014-2019 of the Kenya Ministry of Health, facilitating people’s participation is a key element of the Community Health Strategy. The recognition and introduction of level one services which aim at empowering Kenyan households and communities to take charge of improving their own primary health care is one of its key innovation”.

This is the direction that MMI is following with its intervention. The project is really working very close to the Ministry of Health authorities in order to support and improve the aspect of Community Strategy which in Kenya is well structured in terms of manuals and regulations but not always implemented.

The job of Medicus Mundi Italia in Nairobi is not a foregone job, full of challenges but also very interesting and exciting, every day is an experience which gives meaning and value to the implemented job.

**Author**

Grazia Orsolato, Medicus Mundi Italia, health coordinator “No one out” project

**Further information**

MEDICUS MUNDI SWITZERLAND

HEALTH FOR ALL WITHIN A GENERATION IS ACHIEVABLE. A MANIFESTO

Since the end of 2018 we’ve got it on our tables – this beautiful booklet with the title “Health for All within a Generation”. Writing the so called Manifesto of Medicus Mundi Switzerland (MMS) was one of the Network’s extraordinary activities last year. What looks now like a quite light text had to be developed in a complex way together with the almost 50 very diverse member organisations. It is a product of a deeper reflexion process that is linked to MMI’s work on effective health cooperation.

The process was initiated by the MMS’ board with the idea to take the opportunity of the Alma-Ata jubilee for reflecting on today’s significance of primary health care and the future of health for all fundamentally. The necessity to do this developed out of the knowledge that with the UN Agenda 2030 the fundamental parameter of our work had changed. And there was as well the feeling that international health cooperation as well as Switzerland’s economic and political practise have to change for reaching health for all.

By this it was already clear that political decision makers and our own community of people and organisations working in the field of international health cooperation should be addressed by the Manifesto. The process of developing the manifesto was almost as important as the final product itself. The first draft version was written by a small core group including board members and representatives of member organisations. Defining the current situation and the obstacles for reaching health for all was a quite easy task. The political demands have been written easily. We could count on our constant work in the political field.

The key message of the manifesto is clear and powerful: Health for all within a generation is achievable. Today’s world has the knowledge how to do it – and it has the resources to reach it. We know the political, economic and social barriers that have to be moved away for reaching the goal.

CHALLENGING OURSELVES

Once this was agreed and stated, it proved to be definitively more complex to address those issues where the civil society actors are in the driver seats themselves. Is our own work as effective as it should be for reaching health for all? Are we delivering the solutions – or are cementing structures that impede to overcome inequities? Questioning your own work is always hurtful in one or the other way. For going through this part of the process it was very helpful to rely on the debate that was already led by Medicus Mundi International and written down in the 2016 discussion paper “Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health”. Several of the questions of the discussion paper addressing NGOs working in the field of international health cooperation were directly taken up as part of a workshop that was facilitated by Medicus Mundi International. Results of the workshop were integrated in the Manifesto and approved during an assembly of the member organisations in September.
TRANSFORMING THE ROLE OF INTERNATIONAL HEALTH COOPERATION

Reaching health for all within a generation won’t be possible without addressing and transforming our own role as actors in the international health cooperation. Under the title “It is not a matter of aid, it is a matter of justice” this difficult positioning on the own role and the willingness to work for change is expressed quite clearly: “As organisations active in public health, we know that, above and beyond individual aspects, it is the social, economic and environmental factors that determine whether or not someone falls ill. It is undisputed that the degree of inequality determines the state of a population’s health. Against this backdrop, we are aware that our own work can contribute to the perpetuation of injustice. Nevertheless, we cannot, and will not, leave anyone alone in misery without help.”

The Manifesto concludes on this: “However, we also realise that, in association with our partners here in Switzerland and around the world, we need to tackle and change the conditions that make people ill. We can and will strengthen our work further in this regard, learn from our partners and empower the local populations with which we work to fight for their rights and against discrimination within their own communities.”

The Manifesto serves from now on as reference work for upcoming new strategic periods of Medicus Mundi Switzerland and it is as well the fundament for our political work. It has already shown its public relevance: In February 2019 the Italian speaking service of the Swiss Television has dedicated ten minutes to the Manifesto.

*MMS Manifesto (2018)*


*MMI Discussion paper (2016)*

Last November “HIFA-es” was launched. HIFA is the acronym for “Health Information for All”, a global social movement to improve the availability and use of healthcare information. HIFA-es is conceived as part of the HIFA family, and following the experience of the already existing forums in English, French and Portuguese as an exchange space to promote the availability and accessibility of reliable information about health and health care in Spanish.

HIFA-es is a collaboration between WHO and its Regional Office for the Americas (AMRO), the Pan American Health Organization (PAHO), the EASP and the Global Healthcare Information Network (GHI-Net). The aim is to contribute to the vision of HIFA which promulgates a world where each person and each professional has access to the information they need, about health and their care, to protect their health and that of those for whom they are responsible.

HIFA is part of a growing dynamic network of more than 18,000 members worldwide, which interacts in different languages such as English, French, Portuguese, and, as of today, in Spanish.

This HIFA-es forum of knowledge wishes to complement the mission of HIFA in the Spanish-speaking sphere. HIFA-es already has more than 400 members from 30 countries, and more than 20 country correspondents. They will help identify those projects that can give response to the shortcomings and problems that people may have to identify the target population and to prioritize activities according to the needs and peculiarities of each region. They will also help to get commitments of organizations that wish to be part of this initiative, with which they will try to reach agreements bilateral agreements that will be mutually beneficial.

During the Management Committee constitution, Isabelle Wachsmuth-Huguet presented the strategic priorities of the WHO, as well as the key elements of HIFA-es, in turn aligned with the other HIFA forums. It highlights the multilingual perspective of the HIFA initiative to overcome existing language barriers, the promotion of equitable participation, the need to build long-term trust through coherence and improve the quality of interaction between people.
Neil Packenham-Walsh, Director of HIFA, presented the HIFA initiative as a whole, its purpose, objectives and expectations for the implementation of HIFA-es. He emphasized that the main purpose of this initiative is not so much to provide information on health in Spanish, but to improve the availability and accessibility of quality information on health in Spanish. Similarly, he remembered the relevance of involving all parties (health professionals, managers and health authorities, legislators, academia, citizens ...) in sharing information and making this information accessible to all people, in an effort to reduce deaths due to inadequate care due to lack of information.

Ana Carriazo highlighted the importance of the HIFA-es knowledge platform in the Spanish-speaking world and the advantage of being able to share in the portal so much documentation already generated. The Regional Ministry of Health of Andalusia has extensive and well established health networks that can contribute with reliable health information to the HIFA-es initiative. Examples of these resources are: integrated care processes (manuals for professionals, instructions for help in decision-making and guidelines for patients) that promote quality improvement, and portals, such as “Window to the Family” (to support parents in child rearing) or “In Good Age” (for active and healthy aging), strategies that can contribute with reliable health information to the HIFA-es initiative.

Diana Gosálvez presented the EASP work team for HIFA-es and the resources that the School offers to this platform. The EASP, being a WHO Collaborating Center, has a very large knowledge and human capital and there are many EASP projects that have a place in HIFA-es. It stands out, among others, the platform of the CADIME (Andalusian Center for Documentation and Information of Medicines) and its therapeutic bulletins; the Patient School, an example of a good connection of people and resources; OSMAN (Observatory of Health and Environment of Andalusia) and its guides in environmental health; OPIMEC (Observatory of Innovative Practices in the Management of Complex Chronic Diseases) with training spaces and communities of practice; and a large Documentary Repository and Video Library. Undoubtedly, the connection of the many networks, students and EASP alliances can strengthen the HIFA-es project.
Alberto Fernández described the functions and work plan of the Steering Committee, which is responsible for establishing the guidelines of the HIFA-es project. He presented the objectives for 2019 that are focused on 5 main axes:

1. Expand HIFA-es (reach thousands but at least 20 affiliates per country to get the voice from each corner), identify thematic areas and organize official launch;

2. Establish the bases for its consolidation (explore, with the help of the Country Correspondents, the support of at least 20 Collaborating Institutions by the end of 2019. Raise thematic project support.

3. Strengthen management procedures. Streamline affiliation procedures and collaboration agreements (facilitate affiliation, collaborate and contribute ideas), create collaborative data base according to thematic areas, stimulate information exchange between groups, facilitate contact and follow-up with Correspondents, operationalize the activities necessary to achieve the objectives of the dissemination plan.

4. Coordinate and develop synergies with HIFA.org and other HIFA forums.

5. Evaluation for continuous improvement. Try to design a procedure that allows us to evaluate the impact of all the effort devoted to expanding HIFA to know in which position we are and how we can improve.

Three Correspondents take part in this Committee. Daniel López-Acuña highlighted, as key points, the importance of being selective with the information to be shared on the portal (which provides value), concentrating efforts on priority areas (strategic areas in public health), reaching a wider audience but with a strategic framework (concerted expansion plan). It highlights as priorities, sustainable development and universal health coverage, the WHO objectives linked to HIFA, and linking HIFA-es to the 2030 Agenda since the language barrier is preventing the participation of many people. It also states that, if a more powerful launch of HIFA-es is planned, to take place in Geneva during the WHO World Health Assembly to take advantage of the synergies that this assembly offers us as a point of confluence of relevant people and organizations. He also proposed to do something in each country in order to link key people. With regard to affiliation of new members, he suggested to access by professional health associations in each country, as a tactic that would encourage greater participation. Consequently, it proposes a strategic approach country by country and globally rather than individually.

Pedro Brito defined public health as part of a fundamental right of the person and, in this sense, HIFA-es is an effective strategy to provide pertinent information in Spanish to all interested parties (health professionals, managers, legislators, citizenship ...) and promote the improvement of people’s health. It is necessary, however, to define public health priorities and link the priorities of the political actors with the real needs of the population. It raises as challenges of the HIFA-es strategy, the efficient selection of priority thematic areas. Moreover, he underlined the relevance to set up a clear and flexible editorial framework, capable of filtering fallacies and non-relevant messages.
Joan Carles March presented the experience of the Patient School, an initiative coordinated through the EASP and funded by the Regional Ministry of Health of the Junta de Andalucía. He emphasized that patients must have a leading role in HIFA. It is a space where patients, caregivers, family members, associations and citizens in general converge to share with others the same experiences, knowledge, attitudes and motivation to empower people who suffer from some type of disease and increase their quality of life. Patient School is a space in which the concept “evidence + clairvoyance”, “evidence + experience” becomes reality; the patient is the protagonist, the trainer, people who help people, working as equals. We work on a set of defined aspects and present information to make it available to the patient (positive thinking, physical activity, well-being, healthy cooking, patient safety ...). The School of Patients can contribute to HIFA—it is the double line of therapeutic education and training between patients.

Finally, Alberto Fernández highlighted the role of the Moderator in selecting, formatting the contributions in the forum and verifying the quality of the messages to adapt to the editorial framework. The role of the Moderator is crucial to maintain order and move the debate forward. Neil Packenham-Walsh also highlighted the importance of the Moderator as a key piece of success in the survival of a forum. Regarding the thematic areas, it proposes to consider the theme that has been developed in the different HIFA forums.

Author

Alberto Fernández, EASP

Join HIFA-ES

If you are interested in joining us in any of the languages, please go to http://www.hifa.org/forums/hifa-spanish; it takes less than one minute.
DOCTORS WITH AFRICA CUAMM

THE NEXT GENERATION PROGRAMME

In the village of Mwakidiga, in rural Tanzania, a child was suffering from severe acute malnutrition. At first, despite the evident worsening of her condition and despite her family’s relatively safe economic situation, the parents did not want to take her to the hospital.

After taking notice of the child case through its community activities, CUAMM Nutrition team visited the village in order to meet the family and provide vital education and information to all family members on the importance of good nutrition and about the urgency of sending the child to the hospital for treatment. It was not easy in the beginning: taking the child to the hospital was not part of their traditional behaviour, and changing behaviours is always difficult.

After additional explanations and clarifications, the family agreed to take the child to the nearest hospital of Maswa, where the nurses and other health workers received the mother and her child warmly.

Seven days later CUAMM team went back to Maswa hospital to visit the mother and see the progress of the baby, and they were happy to see that the mother was grateful and satisfied with the services provided by CUAMM and, more importantly, that the child was already in good conditions, and on his way to a prompt and full recovery!

WHAT IS TO BE DONE FOR THE NEXT GENERATION

The aim of the program “Integrated Promotion of Nutrition, Growth and Development in Tanzania” which will be implemented in Simiyu and Ruvuma Regions, is twofold: 1. deliver a targeted package of interventions at scale through the health system to prevent stunting; 2. show that integrating activities for chronic and severe acute malnutrition will lead to better outcomes at lower costs. The overall objective of this program is to test the hypothesis that integrating activities for chronic and acute malnutrition will lead to better outcomes at a lower cost.

The specific objectives:

- Reduce stunting prevalence and increase the number of children successfully treated for SAM: reduce stunting in children under 5 in Ruvuma and Simiyu by up to 17%; and treat up to 16,163 cases of SAM and avert up to 77,319 stunting cases, and 1,875 deaths due to SAM;
- Increase knowledge, attitudes and practices (KAP) on birth preparedness, maternal nutrition, and appropriate infant and young child feeding practices;
- Strengthen capacity of the sub-national level health service to deliver integrated nutrition services, which are underpinned by quality data.

This project will use both government and behaviour change pathways to ensure sustainability. It will demonstrate how to integrate the delivery of services to prevent stunting and treat severe acute malnutrition, ensuring the same cadres following the same pregnant mothers and children under five across the critical points in the lifecycle and continuum of care.
If services to treat SAM and stunting in the same age children can be delivered simultaneously there is significant potential for:

1. Delivering targeted interventions along the critical 1000 day window across the continuum of care to prevent stunting;
2. More effective identification, referral and follow-up of SAM cases as a result of strong community-based component following mothers and children across the lifecycle;
3. Improving cost and operational efficiencies in the health service – the same health workers (at facility and community level) will deliver both services, ensuring targeted nutrition services for both stunting and SAM reach the same pregnant women and children from conception to age two across the continuum of care.

Integrated delivery will address these challenges and the evaluation will seek to quantify cost savings and added value generated by this alternative approach.

The Government pathway will involve embedding the program in the health system from the very beginning. The intervention will be delivered by the Tanzanian health system, supporting regional, district and community level governance and delivery structures for health and nutrition.

The behavioural change pathway will be used by CUAMM by providing technical assistance to the health services, through

- community health workers promoting complementary feeding and the importance of attending ANC so that once the program is over, these approaches can be embedded in protocols and training curricula;
- making information available to citizens, this will generate demand for nutrition services.

The program is expected to reach up to 310,453 pregnant and lactating women and 232,261 stunted children under two in the community, as well as 7,687 wasted children under 5 years of age.

Next Generation Programme
FOLLOW THE PILL: FIGHTING HIV AND TUBERCULOSIS IN DR CONGO

“Thanks to this pill, I am alive”, says Rose Bomboso, while taking her ARV medication. Rose lives in an isolated village up north in DR Congo. She is one of many thousands of HIV/AIDS and TB patients in DRC that receive treatment thanks to Cordaid, our local partners, the DRC Ministry of Health and generous support of the Global Fund. The video ‘Follow the Pill: the last mile in DR Congo’ shows you what it takes to get the medication where it is needed most.

Cordaid has been active in DR Congo since the 1970s, and has built up an extensive network of partner organizations. Cordaid wants the people of DR Congo to once again be able to contribute to the development of their country’s basic facilities and work towards peace, safety and justice.

Since 2012 Cordaid is the Principal Recipient of the Global Fund for HIV/AIDS in the Democratic Republic of Congo. In close collaboration with the DRC Ministry of Health, Cordaid fights HIV/AIDS and Tuberculosis in 65% of all health zones of DRC’s vast territory. In 2017, 85,806 adults received antiretroviral therapy. We do this by transporting 667 tons of medicines annually and providing other forms of support to more than 3,500 health facilities. Even in the most remote and conflict-affected areas. Transport takes place by air, by car, motorbike and, in the end, to reach the last mile, also by bicycle and by foot. This work is badly needed. Only 40% of people living with HIV in DR Congo have access to treatment. Yet for all of them, treatment and medication are matters of survival.
**Medicine stocks in times of conflict**

In different parts of DRC, armed conflict regularly puts ARV drug supply at risk. This is why, at all times, the Global Fund program aims to assure a 3 months stock of medicines in the health centers. “But medication is not enough”, says Dr Christian Bambako of the Lomboko health center in the village of Yangambi. “Consultations, follow up of patients and the prevention of diseases and infection is just as essential”, he continues. Dr Bambako, just like the other health centers involved in the Global Fund program, closely involves the communities in their health zones. Breaking taboos that still cling to HIV, countering discrimination against people living with HIV, preventing infections and getting people tested is what they do in villages and urban areas. “Together we are able to stop the scourge of HIV/AIDS and Tuberculosis”, Dr Bambako concludes.

This is what thousands of health centers and their surrounding communities in DR Congo do. Day in day out, in dire circumstances and with few resources.

By 2020 Cordaid is committed to:

- enroll 95% of TB and HIV co-infected patients on ARV drugs;
- ensure HIV testing of 90% of TB patients;
- maintain treatment success rates for confirmed cases of at least 90%;
- reduce the impact of human rights violations related to HIV;

**More information**

“We, the patients, had to find solutions ourselves.” The story of Clarisse Mawaki who runs a community care center for people living with HIV in one of the poorest quarters of Kinshasa (also supported by Cordaid through the Global Fund).


Watch this video and follow the pill in DR Congo:

https://www.youtube.com/watch?time_continue=1&v=IZHb5d8YG2c
**HEALTH POVERTY ACTION**

**THE PAIN OF PROHIBITION**

In its briefing ‘The hidden opioid crisis: How the so-called ‘war on drugs’ forces patients to die in pain’, Health Poverty Action examines how prohibition prevents patients accessing opioid-based pain relief such as morphine. For Health Poverty Action, like tax, trade and climate change, the failed ‘war on drugs’ demands our urgent attention.

“I have been suffering from severe pain. I travelled to receive treatment and now I travel to a village 450 km away from here just to get a prescription for morphine.” explains Nita*, a 37-year-old mother from Gujarat, Western India. She is dying from advanced mouth cancer. Her husband left his job to care for her in her final months, and, with the added travel costs to get pain relief, took on loans to meet the family’s needs. Their children then had to stop going to school, so they could work as labourers to pay off their growing debts.

Incredibly, Nita is one of the ‘lucky’ ones. At least she is able to access pain relief. Many other patients die in agony due to India’s opioid paradox: the country is one of the world’s leading producers of opioid medicines, yet only four per cent of its palliative care patients receive the morphine they should be getting. Nita’s story is highlighted in Health Poverty Action’s new briefing “The hidden opioid crisis: How the so-called ‘war on drugs’ forces patients to die in pain”. Whilst our research focusses on three states in India, the story is one that’s repeated again and again across the world. 90% of the world’s AIDS patients and 50% of cancer patients live in low- and middle-income countries, yet these same countries have just 6% of the morphine used globally for pain relief, as shown by an Independent Report of the West Africa Commission on Drugs.

This is, at least in part, a direct consequence of the so called ‘war on drugs’. Prohibition has been so aggressively implemented that heavy-handed restrictions limit access for medical use. India’s 1985 Narcotic Drugs Act introduced a 10-year mandatory minimum prison term for violations involving narcotic drugs, along with cumbersome licensing procedures of import, export and transport between states. Following the Act, medicinal morphine use in the country dropped by a staggering 97%. Health workers told us that a combination of harsh penalties for minor clerical mistakes and complex bureaucratic regulations prohibited them from applying or maintaining licences to stock morphine due to the burden of paperwork and fear of being penalised for errors.

This is compounded by the stigma associated with opioids, and the fears they can cause addiction, exacerbated by a lack of training on palliative care. As a result, many practitioners are reluctant to prescribe opioids to relieve their patient’s pain. The result is that people are dying needlessly painful deaths, whilst others are forced to travel hundreds of miles – and rack up debts – just to access pain relief. One doctor and palliative care expert described it as the ‘collateral damage’ of the war on drugs.
Ironically – and predictably – it’s the legally regulated area of drug use (i.e. for medical purposes) where it’s been possible for authorities to limit access to them, whereas globally prohibition has wholly failed to limit the supply of drugs for illicit use.

People dying in pain is one of many reasons why we urgently need to replace prohibition with healthier drug policies, both in India and across the world. From giving power to criminal gangs, diverting resources away from health and education and damaging the environment, this failed war hurts lives and livelihoods all over the world. Recently Health Poverty Action published the report “Punishing Poverty”, showing how this failed war fuels violence, damages the livelihoods of poor communities and locks families into poverty in both India and Brazil.

For myself and Health Poverty Action the solution is legal regulation of the drugs trade. Done with care, and with a pro poor and pro health approach, legal regulation will make products safer, take drug policy out of the hands of criminal gangs, stop the destruction of people’s livelihoods and prevent patients like Nita being the collateral damage of this colossal global policy failure.

All of us concerned with health and poverty have a moral imperative to address the monumental disaster that is prohibition. Like tax, trade and climate change, the failed ‘war on drugs’ demands our urgent attention – for Nita, and for the lives of people across the world.

**Author**

*Martin Drewry is director of Health Poverty Action*

*Names have been changed to protect identities*

**References**

- https://www.healthpovertyaction.org/change-is-happening/campaign-issues/a-21st-century-approach-to-drugs/punishing-poverty/
SWISS RED CROSS

MENSTRUAL HYGIENE MANAGEMENT
ON THE FOREFRONT

Thanks to a number of activist, organization and leaders, the Government of Nepal has constructively moved to address the specific culture and traditions around menstruation.

In Nepal and in other countries where the Swiss Red Cross is working, Menstrual Hygiene Management (MHM) has become an issue.

“Death in a menstruation hut” - this sad news from Nepal was published by BBC on 4 February 2019: 21 year old Bagmati, who was confined by her family to sleep in the menstruation hut, suffocated from lack of oxygen while lighting a fire to keep her warm during sleep. This is not a single case; many more tragic stories around menstruation have appeared in the national and international news in the past.

Despite being declared illegal in 2005 and criminalized in 2017, the tradition of “Chaupadi”, mainly exercised in the Mid-West and Far West regions of Nepal, still exists including different cultural beliefs and traditional practices. In the Chaupadi, menstruating girls and women, and women after child birth are perceived as “impure” and have to follow certain rites and traditions. When girls have their period for the first time, they are not allowed to look into the sun and at male family members. In all cases, menstruating girls and women are excluded from the daily family life in various manners: they are not permitted into the kitchen, not allowed to cook and touch dishes, and are restricted from certain food items, such as cow milk and some vegetables.

They sit separately at meal times and are confined to sleep in a separate shed (so called menstruation hut) or have to sleep separately until the bleeding is over. After five days, they are allowed to take a bath for the first time, and again participate in family life. For girls, the Chaupadi often results in non-attendance at school due to lack of separate toilets for girls, lack of facilities for proper menstrual hygiene management; lack of sanitary pads and proper disposal of menstruation waste.

Traditions such as the Chaupadi, based on religious norms, are fostering exclusion, shame and a certain stigma. However, following the Chaupadi has one advantage: this is the only time for hard-working girls and women in rural Nepal to do less household chores than normal. While at a normal day they work from 4 a.m. to 10 p.m. feeding cattle, sweeping the floors, preparing meals, washing, agriculture etc. they are working mainly outside the main family house and are excused from all duties which involve touching people and food items.
The fact that a woman is menstruating is quite obvious in Nepal, all household members know. But dealing with menstruation and menstruation hygiene management is less visible and not addressed openly. Menstruation “pads” are produced in all secret from old sari cloth. The cloths are washed only by the women and are hung in a dark place, not to be seen by other household members or neighbors. Cloths often dry poorly without sunshine and are prone to develop fungus and are contaminated by flies causing chlamydia and vaginal infections. Lack of cloth or pads at school and lack of adequate water, sanitation and hygiene (WASH) facilities force girls to leave school suddenly and staying at home for a few days.

The Nepal Red Cross Society supported by the Swiss Red Cross, implements several Water, sanitation and hygiene projects in two provinces, Karnali province and Province 5 of Nepal. During project implementation in the communities and at school, the issue of menstruation management became more and more pertinent. Results from an assessment done in 2015 in 5 districts of these provinces showed that 21% of schools did not have a separate toilet for girls, 23% had no water in the toilet and almost 30% had no facility to dispose menstruation pads. But how do girls and women deal with menstruation at all? What if it starts at school? Where do pads come from? The project staff was confronted with lots of questions ...and decided to embark on the implementation of a menstrual hygiene management component.

“When the Red Cross team came to our school, I volunteered to be part of a youth Red Cross group”, says the 14 year old Kamala. “I did not know what I was getting myself into”, she giggles. The Red Cross team asked us about menstruation, what we do, where we get pads from, where our problems and challenges are. First I was a bit embarrassed, but then I realized, that this is a burning issue. Only us girls talk among each other, but we get no outside help or ideas. Nobody in our family is interested, how we deal with our periods and if we agree to the traditions and rites. We just do it, as our mothers teach us. I got a lot of information from the Red Cross team. They showed us, and also some boys, how to sew re-usable menstruation pads, how to change them, wash and dry them correctly. And we also discussed the Chaupadi practices. I thought about them, but it is difficult to change traditions all at once, which our elders follow and introduce. One day, something very funny happened. My mother and myself had the period at the same time.

My father works abroad and sends money regularly. I have three much younger brothers. Now, both my mother and myself were not allowed in the kitchen. Nobody could cook for us. My brothers were very hungry and begged us to prepare a meal from them. So I took this opportunity to talk to my mother about the traditions. We decided to take a risk: one of us just has to get into the kitchen and cook. It was me, because my mother thought this will make the Gods less angry. All night we were both awake praying that nothing evil will happen to our family.

The next morning, we realized that all was as it is: no punishments from the Gods. We were both very relieved. Now we are very relaxed during our periods. We both cook and do our household chores. We were even able to convince my father about it. My father also allowed us to keep sleeping in our rooms. During my period, I sleep now in my room on the floor, which is already a big change”.
The Nepal Red Cross team ensures that boys and girls are participating in the classroom sessions on Menstrual Hygiene Management. They learn about menstruation and all what goes with it. The school management and teachers are involved in the teaching on how to sew menstrual hygiene pad. This is a sustainable and ecological solution, made from local material. The school also provides disposable napkins to girls, who start bleeding at school. One of the teachers is in charge of the programme, and she ensures that the disposable sanitary pads are regularly replenished. In order to ensure a safe waste management, the project team constructs gender-friendly toilets with attached incinerators, so that the disposable sanitary pads can be burnt regularly by the school caretaker. Discussions with the Government of Nepal are ongoing on how to make the sanitary pad disposal more environmentally friendly.

Besides the impact in the girls’ personal lives, the project has helped to increase attention and coordination between different partners and key ministries regarding MHM. A national network, the so-called Menstrual Health Management Partner Alliance was founded in 2017 with involvement of all relevant organization working in the areas of MHM. The alliance is active on awareness/advocacy, research and upholding the importance of the topic. The Alliance is considered an advisory network for the Government of Nepal to facilitate and support knowledge management and promoting and improving issues on MHM. The alliance regularly holds exchange meetings, where new initiatives and learnings are discussed. The alliance’s effort culminated in a consultative workshop which brought organizations, policymaker; researcher; public health professional; women and reproductive right activist; adolescent/youth and media together. National and international delegates shared scientific evidence as well as regional and country specific experiences with current strategies and intervention and local initiatives for MHM. The workshop has prepared recommendations on different areas of MHM; learning and education, water sanitation and health, innovation and sustainability, policy and advocacy, research and analysis for future consideration by the stakeholder as well as concerned Ministries in their plan of action for 2019/2020.
The Government of Nepal and the MHM partner alliance hosted the International Menstrual Hygiene day on 28 May 2018 with involvement of different key ministries; Health, Water and Sanitation, Women and Children and Education which expressed a commitment to eliminate and prohibit detrimental and discriminatory practices around menstruation, to support MHM friendly institutions and integrating MHM activities across all sectors.

The Government of Nepal has drafted the National Policy on Dignified Menstruation and an MHM Master Plan (2018-2020) which is in the process of endorsement by the cabinet. Furthermore, the Department of Education with involvement of the MHM expert has reviewed the school curriculum. The MHM Alliance gave their feedback and included age specific content on menstruation.

“We are very happy with these developments” says Raj Kumar Kshetri, Deputy Programme Director, Nepal Red Cross Society Community Empowerment for Health Promotion Programme. We have almost reached 10'000 girls and boys reached so far, and constructed 23 female friendly toilets in schools. Most important, we vested great interest and commitment at ministerial and policy level. Having Government policies on our side, as well as working with the young generation may eliminate discrimination, stigma and traditional practices, such as Chaupadi, forever.”

Authors

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The Swiss Red Cross is a member of Medicus Mundi Switzerland.

References and further information

- Nepal woman suffocates in banned 'menstruation hut' BBC, February 2019
  http://www.bbc.co.uk/news/world-asia-47112769

- The Swiss Red Cross has emphasized Menstrual Hygiene Management in many more countries. A research in Malawi brought new insights in knowledge, attitudes and practices around MHM: WASH projects in Laos and Bangladesh have incorporated MHM in all school activities. A new project will be launched in Pakistan, the first of this kind in the country.
  https://www.redcross.ch/de/shop/studien-und-factsheets/menstrual-hygiene-management

- The International Federation of Red Cross and Red Crescent Societies (IFRC) has recently launched a generic toolbox on MHM, adaptable to different country contexts.
  http://watsanmissionassistant.org/


- Menstrual Hygiene Management in Schools in Nepal (Video, 2016)