Health cooperation and global governance: Yin and Yang according to MMI
MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL
ANNUAL REPORT 2016

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MESSAGE FROM THE PRESIDENT

WE WILL BUILD THE FUTURE NOW, TOGETHER

Dear Network members and partners,

The year 2016 has been a year of big changes in the big policies for developing our world, where the Sustainable Development Goals (SDGs) started their way towards an expected better, more equal and sustainable world. The SDGs will also strongly determine the global health agenda and the work in health cooperation for the next 15 years.

2016 has been also a special year for me personally. I took over the chair of the Medicus Mundi International Network in May, at our Assembly in Geneva. To be the visible head of an organization with more than 50 years of life means a great honour but also a deep responsibility. I will try to do my best to reach the level of my predecessors, especially the last president, Nick Lorenz, who left a mark in our lives not only due to his professional capacities but also to his human qualities.

During the mandate of Nick, our Network’s Strategic Plan 2016-2020 was discussed and adopted, leaving us a clear path of what MMI has to do in the next years in order to remain a leader in advocacy for better global health governance and in the promotion of relevant, legitimate and effective health cooperation.

It is a remarkable coincidence that one of my first tasks as president of MMI was to proudly join the president of Medicus Mundi Spain in a plenary session of the World Health Assembly in May 2016. In this plenary Medicus Mundi Spain was awarded with the WHO Sasakawa Health Prize for its project entitled “The Transformation of Public Health Systems Based on the principles of Primary Health Care (PHC)”.

However, MMI will remember 2016 mainly as the year in which our Strategic Plan started its successfully implementation.
International health cooperation

In order to achieve our goal of “promoting knowledge sharing and mutual learning between actors in international health cooperation”, we set up an MMI working group on Effective Health Cooperation (MMI EHC). Since its launch event at the MMI Annual Assembly in Geneva, this new working group has found great interest among Network members. A discussion paper on “Health cooperation: its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health” was presented by MMI EHC in September at a public workshop on “Health cooperation beyond aid” in Berlin. The paper and the workshop with its rich discussions have been first, encouraging steps in a longer reflection about the future of health cooperation in the coming years.

...and global health governance

In the area of global health governance, MMI Network participated, as in previous years, in the WHO Executive Board meeting and the World Health Assembly with an impressive list of civil society statements on key agenda items developed in cooperation with the “WHO Watch” team hosted in our delegation.

But the highlight of the year was certainly the launch of “our” project of a Geneva Global Health Hub (G2H2) in a civil society side event to the World Health Assembly. MMI Network has been deeply involved in the creation of this Hub, and the G2H2 Secretariat is hosted by MMI in an office we opened last autumn in Geneva. The goal of G2H2 is “to contribute to longer-term strategic thinking and coherent and sustained action by civil society entities involved in global health advocacy, taking account of country-level contributions and national variability”. G2H2 is trying to help civil society to contact with global health institutions based in Geneva and to re-equilibrate the imbalance of presence and inputs in global health debates between those defending the public interest and others promoting commercial interests.

There is still a lot to do. Civil society is expected to promote and contribute to better and more equitable and sustainable processes to reach the agreed global health goals. And this is a field where the MMI Network and its members have much more to say. Because the future won’t be built tomorrow. We need to build it now, together.

Carlos Mediano, President
Medicus Mundi International Network
Yin and Yang according to the MMI Network

The two main fields of work of the MMI Network are framed as follows:

- “We will promote knowledge sharing and mutual learning between actors in international health cooperation.”
- “We will provide autonomous, sustainable and stimulating spaces for the analysis and debate of global health and promote platforms for joint civil society advocacy.”

Our understanding of the interconnectedness of these two fields of work, our broad overall vision of what it needs to achieve Health for All (see next page) combined with our approach of linking practice with evidence and the local and national with the global level allow the MMI Network and its members to deal with these two fields of work not just as separate “tracks”, but as a holistic one. We express this in the current Annual Report by using the Chinese Yin and Yang (陰陽) symbol that describes “how seemingly opposite or contrary forces may actually be complementary, interconnected, and interdependent in the natural world, and how they may give rise to each other as they interrelate to one another.” (Wikipedia)

Yin, our strategic focus on international health cooperation, is built on over 50 years of engagement of the Network and its members that are both strongly rooted in health cooperation, the provision of essential health services and the strengthening of people centred health systems. In the current times of change, institutions working in this field are aware of the need of repositioning their contributions and reassessing their institutional capacities. The MMI Network provides them with an appreciated space for reflection on legitimate, relevant and effective health cooperation and with tools for mutual learning, sharing and collaborating.

Yang, our strategic focus on global health governance, has been mainly developed by MMI over the past strategic planning period, based on our assessment that Health for All cannot be achieved neither by the health sector alone nor by individual countries. In addressing global policy and governance issues, MMI has positioned itself as a strong voice of civil society, but also as a dedicated promoter and facilitator of civil society networking and strategizing.
PROMOTING HEALTH FOR ALL: 
THE SHARED VISION OF THE NETWORK MEMBERS

“For the members of the MMI Network promoting Health for All means:

- Promoting universal health coverage in a sense of universal, equitable and affordable access to quality health services (promotion, prevention, care and rehabilitation) for all people; as this is essential to the improvement of health, fighting diseases and reducing poverty;

- Promoting strong national health systems with a strong leadership by the government, strong accountability systems and a decisive role of communities and users of health services in the development, management and monitoring of health policies and services at all levels;

- Promoting policies that address the social and political determinants of health, as unfair economic arrangements and poor social programs, unhealthy living conditions, inequality and gender inequity, violence, bad politics and injustice are at the root of ill health and death.

- Linking the local and national with the global level by getting involved in global health policy, global health governance and global governance for health, as many determinants of health and health care lie outside the scope of national policies and programs;

- Promoting health policies and practices that are based on evidence.

- Critically reflecting the role and contributions of international health cooperation to universal access to health, health systems strengthening and global governance for health.”

MMI Network Policy, 2014
EFFECTIVE HEALTH COOPERATION? WE CARE!

“The environment of international health cooperation is changing. Our answers to a world where far too many people cannot meet their health needs and where people’s health is threatened by the social, economic and political conditions in which they are living might still be the right ones, but we have to adapt our questions. More than ever we need self-critical reflection on our work, finding new ways for analysing our data and experiences and creating the evidence we need for improving our engagement for the right to health.”

(Martin Leschhorn, coordinator of MMI EHC)

There is still a lack of platforms in which actors in health cooperation can critically reflect their own practices and approaches, share information and experiences, learn from each other and have an opportunity to further develop their institutional and personal skills and practices. As agreed in the MMI Network Strategy 2016-20, promoting and providing such platforms has therefore become a major focus of our Network’s activities.

MMI “FEDERAL CAFÉ” AT THE GENEVA HEALTH FORUM, 21 APRIL 2016

INTERNATIONAL HEALTH COOPERATION AND HEALTH SYSTEMS STRENGTHENING: TIME FOR A GLOBAL SYMPOSIUM?

If you are invited by the organizers of a global symposium, it could be seen as a bit unfriendly to promote and launch your session with the question “Time for (another) global symposium”? One not only accommodating some scattered participants and case stories from organizations engaged in international health cooperation, but entirely focusing on health cooperation and its contributions to strengthening – or weakening – national health policies and systems. In fact, the participants of the “Federal Café” organized by MMI and Medicus Mundi Switzerland at the Geneva Health Forum concluded that such a project is rather not feasible and that adding another global symposium to the already crowded agenda would not really make sense.

And we easily agreed with them. Beyond this initial provocation, the objective of the meeting was perfectly achieved: It provided a great opportunity for an debate about the demand and options for setting up platforms where actors in health cooperation can critically reflect their policies and instruments and learn from each other.
The keynote presentation by the MMI Executive Secretary led to an intensive conversation on both our analysis and our initial conclusions and proposals (see below) with an nice expert panel (Finn Schleimann, IHP+; Jacques Mader, SDC; Janet Perkins, Enfants du Monde; Ilona Kickbusch, Graduate Institute Global Health Centre) moderated by Thomas Vogel, the president of Medicus Mundi Switzerland.

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<th>Conclusions and proposals</th>
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<td>A crowded and contested field</td>
<td>Let us admit the limitations and challenges of health cooperation, but let us not give it up with it too easy. Health cooperation still has an important role to play.</td>
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<td>To remain relevant, health cooperation needs to move beyond aid, and its approaches, policies and instruments need to be carefully reassessed.</td>
<td>Let us renew our interest and invest(igate) in instruments and platforms and communities of practice for critically assessing our own work and promoting more effective health cooperation!</td>
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<td>There are spaces and instruments for the discussion and promotion of effective health cooperation, but self-reflection cannot be taken as granted.</td>
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<td>International health cooperation at global health conferences: No easy home</td>
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After this milestone meeting, the conclusion by all participants that new instruments, platforms and communities of practice for the promotion of more effective health cooperation are in fact desperately needed was immediately taken up by the MMI Network:

- The MMI working group on Effective Health Cooperation (MMI EHC) was launched, and an initial MMI EHC work plan for the year 2016 was adopted and implemented.

- A well attended side event to the MMI Assembly– and to the World Health Assembly – in May focused on health cooperation in fragile settings.

- With our own discussion paper and a workshop in Berlin, in autumn 2016, MMI EHC launched a still ongoing conversation on legitimacy, relevance and effectiveness of health cooperation.

Meeting documentation: MMI Website
A dialogue with the organizers of the 10th European Congress on Tropical Medicine and International Health led to their agreement to implement a track on international health cooperation in the Congress (ECTMIH 2017 in Antwerp, October 2017). We will be there!

Representatives of the working group engaged in the process of transforming the “International Health Partnership” (IHP+) into a “International Health Partnership for Universal Health Coverage” (UHC2030) with a double focusing: Promoting a continued focus on effective health cooperation (MMI EHC) and critically watching the governance and civil society engagement mechanism of this new Alliance.

**LAUNCHED IN 2016:**

**MMI WORKING GROUP ON EFFECTIVE HEALTH COOPERATION (MMI EHC)**

The MMI working group on Effective Health Cooperation was successfully set up in the past year, with a considerable number of Network members having already joined the new group. Reviewing the achievements at the end of the year, MMI EHC members confirmed the ambition that the working group shall continue providing spaces and instruments for in-depth reflection and dialogue among actors in international health cooperation. A particular challenge is to break down the political questions to the institutional level of the Network members in order to engage them further in the dialogue. MMI EHC is coordinated by Martin Leschhorn, Medicus Mundi Switzerland, and supported by the Secretariat.

GENEVA, 28 MAY 2016: MMI ASSEMBLY AND PUBLIC SIDE EVENT

PROMOTING ACCESS TO HEALTH IN FRAGILE CONTEXTS:
WHAT ROLE FOR INTERNATIONAL COOPERATION?

The General Assembly of the MMI Network took place at the Museum of the Red Cross and Red Crescent in the morning of 28 May 2016. It focused on the implementation of the MMI Network Strategy 2016-20 and the election of a new Board and President, with a warm good-bye to Nick Lorenz who led the MMI Association over the last six years as its President.

The Assembly was followed by an informal lunch and a public workshop “Promoting access to health in fragile contexts: What role for international cooperation?” organized in cooperation with the Swiss Red Cross (a member of Medicus Mundi Switzerland) and Cordaid and attended by over 70 participants. The meeting built on the side event to the MMI Assembly 2017 (“A luta continua” Strengthening or weakening health systems?) and on a MMI/Cordaid expert meeting organized in 2012 in Amsterdam (Health systems strengthening and conflict transformation in fragile states).

Pannelists and participants discussed the difficult task to implement health programmes in environments where the health systems are already weak and threatened by a wide range of political and social conflicts. Working in such fragile contexts demands a sensitive approach for not worsening the situation. But international health cooperation can also play an important role in conflict transformation by building robust service delivery institutions and integrating crisis response strategies.

Meeting documentation: MMI Website
The 2016 meeting of the Medicus Mundi International Network took place in Berlin, following an invitation by our German Network member action medeor and linked with a VENRO conference on global health on 28 September. With its public workshop "Health Cooperation beyond aid", the Network Medicus Mundi International contributed to the debate on how actors in development cooperation such as international NGOs or bilateral agencies can engage in a legitimate, relevant and effective way to achieving universal access to health. The meeting was followed by an internal planning workshop of the MMI Network.

The main input to the MMI workshop was a paper drafted and presented by members of MMI EHC: “Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health” is not intended to be a position paper representing a homogeneous view of the Network, but rather a discussion paper that feeds a core activity of the MMI Network; to serve as a platform for critical reflection on the role and future direction of development cooperation for health.

The four chapters of the discussion paper conclude with four sets of “questions for reflection”. The examples below might explain why the plenary discussion was progressively heating up – and also overlapping in the following planning workshop where the mandate of MMI EHC host and promote spaces for reflection on international health cooperation was confirmed. And we will continue to work with “questions for reflections” such as:

- How/where does your organization define the overall goals (expected outcomes) of your engagement in international health cooperation? Are you happy with this definition? Do you have a “theory of change” which defines how you expect health outcomes to be improved and your organization’s particular role and contribution?
- How are your organization’s or your local partner’s structures and programs integrated in the national health policies and systems of the countries you collaborate with / work in? How do you deal with the (potential) conflict of your solidarity with people and communities and your collaboration with government institutions?

Meeting documentation and discussion paper: MMI Website
Could you subscribe to one of the following statements: (a) “We are at the end of aid,” (b) “We need to move beyond aid.”? Please provide your own insights about if/how “aid” or development cooperation needs to change in order to improve its legitimacy.

Would you call yourself a “learning organization”? If yes, what are your instruments and structures, and who is in charge of your institutional learning?

How do you position your organization on the triangle of (a) provision of essential health services, (b) strengthening health systems and institutions and (c) addressing determinants of health on national and global level? Why? How do you use your historical and current reference points in this approach? Are you still happy with this approach?
GLOBAL HEALTH GOVERNANCE? WE CARE!

“Social advocacy aims at changing the ‘what is’ into a ‘what should be’ - a more decent and more just society. In a globalized world, social change requires advocacy beyond countries’ borders: transnational advocacy and international advocacy, based on international networks and coalitions. Joint advocacy adds a layer of value to the Network’s activities. Supporting our members’ efforts to achieve the shared vision of Health for All, our advocacy aims at influencing the policy landscape in which our members’ and their partners’ activities takes place.” (MMI Advocacy Policy)

In the MMI Network strategy 2016-2020, the engagement of MMI in global health policy and governance has become a main field of work, 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:

“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.

In addition to the MMI GHG team, the working group on Human Resources for Health (MMI
HRH) and on Effective Health Cooperation (MMI EHC) also deal with issues and processes in
the field of global health governance.

A horizontal network with strong and independent members such as MMI cannot act, in the field
of advocacy, in the same way as a hierarchically structured NGO. Nevertheless the past year has
shown once more that our engagement in global health policy and governance, with a focus on
the WHO and its hosted partnerships, is not only feasible but also relevant and well appreciated.

G E N E V A , M A Y 2 0 1 6
69 TH W O R L D H E A L T H A S S E M B L Y

As in previous years, and as an NGO in official relations with the WHO, MMI has participated
in the past year in the meetings of the WHO governing bodies, also hosting the “WHO Watch”
project developed and implemented jointly with the People’s Health Movement (PHM). Based
on a critical analysis of the agenda items undertaken by a team of civil society experts, the
MMI/PHM team contributed to the WHO Executive Board meeting in January and the World
Health Assembly in May 2016 with statements that often find considerable attention and are
mostly read by young colleagues of the People’s Health Movement, but also by MMI colleagues
such as Wemos director Anke Tijtsma. The 14 joint statements submitted alone to the 69th World
Health Assembly show that MMI has indeed become a strong voice of civil society. The MMI
part of the “quality control” for these statements has been delegated by the Board to the GHG
team and the Executive Secretary who also formally led the MMI delegation.
During the 69th World Health Assembly the MMI delegates and working groups were very active, speaking in events and briefings organized by the World Health Organization, civil society colleagues and academic institutions. As the President already indicated in his message, the plenary session when Medicus Mundi Spain was awarded with the WHO Sasakawa Health Prize will remain unforgettable for the colleagues who represented the Network and its Spanish member.
The 69th World Health Assembly adopted, after long intergovernmental negotiations and despite strong concerns, a new WHO “Framework on engagement with non-State actors” (FENSA). The MMI GHG team was engaged in civil society advocacy related this process as part of a broader team that coordinated statements and, during the World Health Assembly, published a statement of concern signed by 60 organizations and organized a press briefing at the Palais des Nations.

“Stop developing FENSA under contradictory objectives: both as an instrument to attract voluntary financial resources for WHO and, at the same time, as a safeguard to protect its mandate. It can’t be done. If WHO is to fulfill its constitutional mandate, Member States must find other financial solutions: lift the freeze on assessed contributions and increase their levels of funding. This would end WHO’s dependency on voluntary, often earmarked and volatile contributions. It would resolve the most important – financial – institutional conflict of interest of WHO and at the same time prevent wasting resources on implementing an ill-conceived FENSA.” (quoted from the civil society statement).

A luta continua... once more: Together with its civil society colleagues, the MMI GHG team will carefully watch FENSA implementation over the next years.
SUCCESSFUL LAUNCH OF THE GENEVA GLOBAL HEALTH HUB (G2H2)

At a civil society strategy meeting in January 2015, the MMI Global Health Governance team (MMI GHG) proposed to create a “Geneva Global Health Hub” in order to facilitate networking and cooperation in-between the meetings of the WHO Governing Bodies and related civil society events. This proposal found great attention and since then, MMI has been strongly engaged in the planning of this joint project and, after the formal launch of “G2H2” at a constitutive assembly in May 2016, in its implementation.

The MMI Network is proud to host the G2H2 secretariat at our office in Geneva opened in autumn 2016, and with Mariska Meurs (Wemos), a member of the MMI GHG team also became the first G2H2 President.

The Geneva Global Health Hub has been set up as a membership-based association and aims to provide a space and enable civil society to meet, share knowledge and create initiatives to advocate for more democratic global health governance, in particular:

- Follow and enable civil society discussions on Geneva global health processes through an interactive website and social media
- Facilitate online and face-to-face networking and strategizing between member organizations
- Disseminate information to members on health-related institutions in Geneva on the basis of mapping, networking and meeting attendance
- Assist members to organize Geneva-based meetings with office space and infrastructure
- If feasible: Assist resource-constrained organizations to raise funds for travel costs for meeting attendance

Website: www.g2h2.org

The MMI Network joined the new association as a founding member. Having organized and hosted, together with a few partner organizations, civil society strategy meetings and processes over the last years, the MMI GHG team is now happy to hand over much of its convening and facilitating role to the new entity.
MMI AND GLOBAL HEALTH ALLIANCES AND PARTNERSHIPS

BEFORE ENGAGEMENT AND CRITICAL “MID-DISTANCE”

In the past year, the MMI working groups on Global Health Governance (MMI GHG), Human Resources for Health (MMI HRH) and Effective Health Cooperation (MMI EHC) continued to engage in the institutional development and activities of some key “multi-stakeholder” platforms hosted or co-hosted by the World Health Organization and dealing with the development and implementation of global norms and regulations, policies and strategies. In particular:

- Transformation of the Global Health Workforce Alliance (GHWA) into a new Global Health Workforce Network (GHWN) and related processes and mechanisms at the WHO.
- Transformation of the “International Health Partnership” (IHP+) into an International Health Partnership for UHC 2030 (UHC2030), including the establishment of a UHC2030 “Civil Society Engagement Mechanism” (CSEM)
- WHO Global Coordinating Mechanism on Non-Communicable Diseases (GCM/NCD)

Meetings of UHC2030/CSEM and on Human Resources for Health (GHWN briefing and follow-up of the High-Level Commission on Health Employment and Economic Growth) took place in Geneva in December 2016. They proved to be important milestones in these institutional transformation processes, with a considerable MMI delegation taking part and actively contributing to the dialogues.

For the MMI teams, the decision to either wholeheartedly engage in the structures and activities of these partnerships (e.g. the MMI Executive Secretary having been an “alternate” member of the GHWA Board and MMI providing expert to several HRH processes and consultations undertaken by WHO and GHWA) in view of moving things from within or to keep a critical distance and providing input from the outside (our current approach on the GCM/NCD) is not easy and has been subject of strategic discussions within our teams.

For a more comprehensive overview on the MMI working group on Human Resources for Health from the point of view of an engaged member, please refer to the report by the coordinator of MMI HRH, Linda Mans, as contribution by Wemos to our Network member’s “short stories”
Engaged conversation at the UHC2030 launch event: MMI Executive Secretary Thomas Schwarz with Lancet editor Richard Horton.
MMI NETWORK MEMBERS

SHORT STORIES
The CWGH is now celebrating twenty years of work in strengthening the understanding of and capacities for community roles in health. This comes at a time when our health and health system has suffered fundamental challenges and declines. Yet the understanding that we need to rebuild our health system around people’s power has never been more relevant.

Health has long been one of the most important social concerns of Zimbabwean people. People have just expectations to live healthy lives and to obtain a reasonable quality of care when they fall ill. Not too long ago, it seemed we were making significant progress in this respect. Major gains were achieved in the 1980s, through joint action between the health sector and communities. However, over the 1990s, the combined impact of AIDS, the structural adjustment programme, a falling health budget and declining household incomes, reversed many of these gains.

The poorest communities in rural areas were most affected by the crisis of the health care system, taking on more and more responsibility for looking after the ill, by providing home-based care, paying for their health care and dealing with their health problems, but with little role in deciding on the changes to their health services. By the late 1990s a wave of strikes amongst health workers signalled that health workers were also not happy with the situation. While a lot of attention was given to the strikes by doctors and nurses, those working at clinic level and in communities also lost wellbeing and morale. As 2000 approached, “health for all” seemed like an empty promise...

It was this situation which motivated several national civil society organisations, co-ordinated by the Zimbabwe Congress of Trade Unions, to come together in 1997 to review the current state of affairs in the health sector and look at ways in which communities could achieve greater control over their own health.

The first step was to ask communities and civil society organisations: What are your perceptions of what is happening to your health? The survey, brought up concerns about the inadequacy of public funds for health, the declining quality of public health services, the negative attitudes of providers and the weakness of current mechanisms for expressing community participation in health. These views were later also found in the national Commission of Inquiry into the Health sector.
When the report on the community research was presented at a meeting of about twenty-five national membership based organisations, the participating organisations decided to form a network organisation called the Community Working Group on Health (CWGH). The organisations developed a set of strategies to remedy the problems that were identified, and discussed these with their members, with the associations of health professionals and representatives of government, churches, the private sector, NGOs and traditional health providers. The outcome of these discussions informed the work of the network of members in the CWGH for the next few years, working with health and other authorities, and building the strength of community voices and action on health at local and national level.

Since then the organisations in the CWGH have followed the path of strengthening community voice and action in health, keeping alive consultation and involvement of people in communities, stimulating local action and tapping various institutional channels to bring these views to national level.
It is often stated that people are the centre of health systems and services. People produce inputs for health, like food, provide services for health as they care for family members, use health services and contribute money for services. Most importantly, as citizens, people guide the policies that shape health systems. Reviews from all parts of the world show that co-operation between communities and health services enhance the performance of services. Work carried out by CWGH and the Training and Research Support Centre (TARSC) through the Regional Network on Equity in Health in East and Southern Africa (EQUINET) in Zimbabwe in 2012 found, for example, that where health centre committees actively co-ordinated health workers and community members there were higher levels of knowledge and uptake of services for antenatal care and tuberculosis treatment, use of oral rehydration solution for diarrhoea and improved environmental health outcomes. Similar results have been noted in other countries of the region.
Not surprisingly the 1978 World Health Organization (WHO) Alma Ata declaration made community participation a central feature of primary health care. Yet, in fact, many people do not participate in health systems, especially those from the lowest income communities. Even where people do play roles in health systems, decisions may be made outside their communities. Even though health systems perform better when they are organised around peoples needs, roles and processes, they do not always do so. Why else would we continue to treat people and then send them back to the same conditions that made them ill?

**Our work reports many aspects of the ways that the CWGH is trying to address these different aspects of exclusion** by building people’s literacy, organisation, participation and voice in health systems, together with health workers, authorities and others. Our own work, such as in developing materials and capacities for health literacy and for adolescent involvement in reproductive health, in building skills for community based and participatory research, or evidence for budget debates has shown us the significant potential that exists within communities to advance health and strengthen our health services.

The CWGH is now celebrating twenty years of work in strengthening the understanding of and capacities for community roles in health. This comes at a time when our health and health system has suffered fundamental challenges and declines. Yet the understanding that we need to rebuild our health system around people’s power has never been more relevant.

Clearly Zimbabwe now needs to prioritise resources to meet people’s just expectations to live healthy lives and to obtain a reasonable quality of care when they fall ill. In the midst of economic and social difficulty, the work of the CWGH showed that people’s power and primary health care will be the best levers around which to take action to re-invigorate and revive our health system.

- **Author:** Itai Rusike
- **Photos:** (a) CWGH Public Demonstration in Harare during ICASA 2015; (b) Graduation Day: Village Health Workers trained by the CWGH
- **More information:** www.cwgh.co.zw
STRENGTHENING OF MEDICINES SUPPLY CHAIN IN TANZANIA AND MALAWI – SETTING UP PHARMACEUTICAL WHOLESALE

The medicines supply chain in developing countries is in the hands of central medical store, usually a governmental or semi-governmental institution, faith-based organizations and private companies. Adding to the complexity some medicines and medical supplies are often provided through “vertical programs” by international organizations like the Global Fund or GAVI. In spite of different providers, the health care facilities especially in the rural areas lack essential medicines.

For more than 50 years action medeor distributes medicines and medical supplies from its warehouse situated in Germany. One of action medeor’s visions is to strengthen local capacity in the pharmaceutical sector. This is done by the so-called pharmaceutical consultancy, for example support in improving pharmaceutical education on different levels and supporting local production.

Twelve years ago action medeor decided to get closer to its partners and customers. For this reason and in order to be more efficient and cost-effective, action medeor Germany initiated the establishment of a branch in Tanzania and Malawi. From its warehouses in Dar es Salaam and Lilongwe action medeor International Healthcare serves as a local procurement and distribution unit for essential medicines and medical supplies.

Our target groups are the non-commercial health sector, the health sector of faith-based groups, of national and international non-governmental organizations and of charitable institutions in Tanzania and Malawi. The subsidiaries operate as an alternative supply system to already existing systems in the country in a complementary spirit of cooperation for the benefit of the partners.

Due to a high demand, action medeor Tanzania opened an affiliate warehouse in Masasi, located 600km away from Dar es Salaam. Although the warehouse in the city of Dar es Salaam has already closed a big gap in the supply of medicines as well as medical equipment and supplies, supplying remote health care facilities in the country’s south is much easier and quicker from the new warehouse in Masasi.

In 2016 action medeor could celebrate the third anniversary and the successful operation of this affiliate warehouse. For action medeor the second warehouse is a further step to improve medical care in Tanzania. In its first three years, the warehouse in Masasi could already supply 330 health centers. The health centers receive their deliveries either at cost price or as a donation. For the first time, also the so-called 'Accredited Drug Dispensing Outlets' (ADDOs) could be supplied. These are small, private medicine shops that often are the only source of supply for essential medicines in rural areas. By now more than 130 ADDOs have been supplied by action medeor.
action medeor is open to further decentralizing its pharmaceutical whole sale activities. Currently action medeor is in the process of evaluating various options for setting up regional non-profit wholesalers in certain African countries.

- Author: Irmgard Buchkremer-Ratzmann
- Photo: Warehouse Masasi, Tanzania
- More information:
  action medeor: www.medeor.de/en
  Tanzania: https://medeor.de/en/branches/tanzania/international-healthcare-tanzania.html
  Malawi: https://medeor.de/en/branches/malawi.html
Human resources for health were high on the agenda in 2016 – for sure at global level. The 69th World Health Assembly (WHA) adopted the Global Strategy on Human Resources for Health (HRH). The High-Level Ministerial Meeting on Health Employment and Economic Growth concluded the year “with bold commitments to action highlighting increased investments in the health workforce.” Our observations are that commitments are easily made but, like promises, not always kept.

What can we as civil society do to improve this? An answer to that question may be for Wemos in linking global advocacy on HRH with MMI to regional, national and local advocacy of our partners in the Health Systems Advocacy (HSA) Partnership.

The 5-year HSA Partnership was launched in Uganda during the project kick-off session in Kampala on 18 March 2016. The strategic partnership consists of Amref Flying Doctors, African Centre for Global Health and Social Transformation (ACHEST), Health Action International and Wemos, and is financed by the Dutch Ministry of Foreign Affairs, the fifth partner. It will contribute to stronger health systems, so that people in Sub-Saharan Africa are able to realize their rights to the highest attainable sexual and reproductive health. The partnership focuses on strengthening HRH and access to essential sexual and reproductive health commodities, while advocating for good governance and equitable health financing. The partnership does not only work in the regional and national scope but takes also the global context into account.
What promises on HRH have been made during the past year? The list is quite impressive:

“Global food for HRH advocacy” was served in May 2016 when the **Global Strategy on Human Resources for Health: Workforce 2030** and accompanying resolution got adopted. It aims “to improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, regional and global levels”. The strategy includes principles, objectives, global milestones 2020 and 2030. It provides “policy options to consider in some countries” and “recommendations to other stakeholders and international partners” too. But we are concerned that it is not explicit enough for and about implementation and called for further steps.

The **UN Commission on Health Employment and Economic Growth** wanted to avoid this “lack of implementation trap”. The Commission Report “**Working for health and growth: Investing in the health workforce**” was launched on 20 September 2016 and called for bold actions and urgent investments globally in order to prevent a projected shortfall of 18 million health workers, primarily in low- and middle-income countries, and help countries to maximise the social and economic benefits of increased health employment. The three partners to this Commission, the World Health Organisation (WHO), the International Labour Organisation (ILO) and Organisation for Economic Co-operation and Development (OECD), set out to convene relevant stakeholders by the end of 2016 to develop a five-year action plan.

Meanwhile, the Global Health Workforce Alliance transformed into the **Global Health Workforce Network**. The GHWN was launched in October 2016 as a global mechanism for stakeholder consultation, dialogue and coordination on health workforce policies on the implementation of the Global Strategy on Human Resources for Health and the recommendations of the Commission. It is important not to forget the political dimensions of stakeholders that participate in such networks. The network should include civil society organizations, because, the role of civil society is one of raising awareness too. Civil society should be there for the necessary checks and balances.

Wemos, as coordinator of the working group on Human Resources for Health of Medicus Mundi International (MMI HRH), was invited to participate on December 14-15 in a **High-Level Ministerial Meeting on Health Employment and Economic Growth: From Recommendations to Action** in Geneva. In the meeting, governments, permanent missions to the UN, employers, health worker associations and unions, as well as civil society organizations, global initiatives, and others engaged in health, education, youth, gender equality, decent work, and inclusive economic growth came together to agree on a **five-year action plan for 2017-2020 for investing in health workforce**.
In her presentation at a roundtable about accountability, commitment and advocacy, Linda Mans stressed that inter-sectoral action, dedicated political support, an equal partnership approach and sustained funding are crucially important for advancing the development agenda of equitable health outcomes, inclusive economic growth and improved health security. She referred to conclusions of research from Remco van de Pas (MMI), who studied the policy implementation of commitments of national governments and other actors made at the Third Global Forum on Human Resources for Health.

Linda’s presentation built further on Wemos’ experience in implementation of the WHO Code and how parties can be brought together (like unions, NGOs, health workforce, migrant organizations and ministries) to share “best practices” and advocacy. She emphasised that it all comes down to shared responsibilities. “We also need to return to the premise, and promote that, access to health is a right and shared responsibility (global public good), and not just an investment case.”

How then, can we link these global processes and action plans to actual increase and access to qualified health workers? Our colleagues of the Health Systems Advocacy Partnership in Zambia for instance can use the Zambian commitment made for improved availability of a skilled surgical workforce. They can monitor progress and provide evidence-based feedback to their government. And you can monitor MMI on its bold commitment to advocate equitable access to the health workforce.
Due to demographic developments and the developments of global care chains and expansion of international labour markets, health workforce migration is likely to deepen. And HRH will remain very important in the years to come. This raises ethical questions about the responsibilities of all actors involved in ensuring equitable access to services; whether in low-income settings or in more affluent regions in the world. _MMI HRH_ as one of the few organized civil society networks engaged in and experienced with the global processes is expected to deal with this vacuum in a strategic way. A new “mapping” of actors and thematic analysis will be conducted to re-convene and strategize with relevant, reliable civil society actors over the coming years. Our HSA partners are very much welcome to join.

- **Author:** Linda Mans
- **Photos:** (a) Launch ceremony of the HAS Partnership; (b) Linda speaking at High-Level Ministerial Meeting on Health Employment and Economic Growth (c) GHWN logo (c) Photo
- **More information:**
  - Wemos: [www.wemos.nl](http://www.wemos.nl)
Taking care of adolescents is an investment in a healthy, sustainable future. Doctors with Africa CUAMM is working on this major issue that is essential to current international policies to give attention to this young and often vulnerable part of the population.

“Many boats come to Gbondapi from Bonthe every week because on Tuesdays there’s an enormous market of fish and all sorts of goods. Pregnant women are among those on the boat to share the travel costs with the others going to Gbondapi. But instead of slipping in among the crowds of the market stalls, they come to the maternity waiting home where they will stay before the birth. One of these was a teenage girl named Aminata. At first, I’d thought she was there to accompany someone else. But then I took a closer look, and like all the girls I’d met, the look in her eyes spoke of how much she’d been through and showed a certain resignation. They were the eyes of those without rights, who consider having an attended birth the greatest privilege imaginable and go through a world of hardship to get it.

Seventeen years old. Seventeen years old, and, as I found out later, she’d already given birth seven times. This was her eighth birth; she was a girl who had become a woman and a mother at once and much too young. This girl, already a mother seven times over, but with only three children still living, took the long, slow boat trip. She went alone to an unfamiliar village, leaving her three children at home, and trusting those who told her that she’d find a bed and a meal for her in a faraway place. She’s doing well now, but I know Sierra Leone and our efforts there start with not just recognizing the rights of adolescent girls, but convincing the girls themselves that they have rights.” (Francesca Tognon, doctor, public health expert)

Leaving no one behind

We work every day in seven countries in sub-Saharan Africa. And every day we see women come into our health centers, having traveled many hours over great distances to seek safe childbirth in expert hands. Many are young or very young, girls under twenty who already have several pregnancies and births behind them. Consider that in countries like Mozambique, most marriages and pregnancies, 48%, take place between 15 and 19 years old, or that in South Sudan, child marriage even reaches 52%.
Given this situation, in 2010, a Global Strategy launched by the Secretary-General of the United Nations urged attention to the health and wellbeing of adolescents. *Leaving no one behind* - this is the commitment we have made for the coming years to close the gap between the global north and south, and often between areas of one country and at least diminish the inequalities.

**Taking care of adolescents: from diseases of poverty to early pregnancy**

Talking about adolescents has become a necessity and a true investment for a healthy, sustainable future. Adolescents make up a significant portion of society; there are 1.8 billion adolescents out of the world population of about 7.3 billion, and 600 million are girls. And their share is set to grow. It is forecast to rise from 18% in 2012 to 28% in 2040. But over half of the world’s adolescents, about one billion people, are estimated to live in limited resource countries, which increases the risk of being exposed to “diseases of poverty,” such as malnutrition and HIV/AIDS. In the case of young women, tied to a lack of sex education, there is also the risk of early pregnancy with consequences lasting the entire lifetime of the young mothers. In the words of Doctor with Africa CUAMM’s Director, Don Dante Carraro:

“We believe in the significance of safe motherhood, which means assistance throughout pregnancy, and it also means awareness. This is why we are working in seven countries in sub-Saharan Africa in order to raise awareness and provide HIV tests not only for future mothers, but for as many young people as possible to stop the virus from continuing to compromise the lives of thousands. Young women’s lack of awareness of their rights can expose them to violence and often to pregnancies in adolescence.”

**CUAMM with adolescents in Sub-Saharan Africa**

Because we understand the importance of this “vulnerable” part of the population, we make women, children, and adolescents the focus of our action. Our primary objectives are health education with special attention to sexual and reproductive health, providing pre- and post-natal visits and educating about contraception and HIV prevention. An excellent example is CUAMM’s work in Mozambique where clinics were founded specifically for youth and adolescents, called *SAAJs: Servicios Amigos dos Adolescentes*, which provide consulting on reproductive health, pregnancy, and HIV prevention.
Providing a service that goes beyond just treatment to include information and awareness raising is essential in a country that is high in the rankings of very young marriages (14% have not yet turned 14). The data collected show that out of the 8,300 girls who came to the SAAJs in Beira last year, 37% were pregnant.

In most countries where we work, there is a very high percentage of child marriage, which is tied to early pregnancies. When the body isn’t ready to handle a pregnancy yet, risks rise dramatically. The data collected by Doctors with Africa CUAMM in 2016 showed that most neonatal deaths were the children of teenage girls. The numbers for 2016 show this: in the Yrol Hospital in South Sudan, adolescent women (15–19 years old) were 20% of the total of the pregnant women who came to the hospital, 87% of neonatal deaths were children of adolescent girls; only one adolescent mother out of three had had at least one prenatal visit before the birth, and only 1 in 3 had a postnatal visit. The situation is similar in the other countries as well. This is where CUAMM acts to support the most vulnerable people, first providing assistance for safe childbirth and giving information and raising awareness in the communities about the importance of prenatal visits and attended childbirth.

For this reason, Doctors with Africa CUAMM not only provides treatment and care in different settings, including “maternity waiting homes”, where in the final weeks of pregnancy women come and wait for birth with the assurance of being assisted, helping to prevent complications. For instance, in South Sudan, our maternity waiting home received over 100 girls in 2016, preventing possible complications. A transport service was established for those who live far away to make it easy to use the service.

**A commitment for future generations**

Taking care of adolescent girls means acting on many levels, including social, health, and family spheres. This is the challenge set by international agendas and one that Doctors with Africa CUAMM has made its own. Recently in New York, we proved this once again at the conference *Leaving No One Behind. Healthy Adolescents: Smart, Connected, Sustainable Practices*, organized by Doctors with Africa CUAMM on March 23, 2017, at the headquarters of the United Nations, in partnership with Italy, Mozambique and Canada’s Permanent Missions. The conference was a chance for professional meeting and dialogue within the 61st Commission on the Status of Women and a chance to consider a vulnerable part of the population. Internationally prominent figures were involved, such as Zainab Hawa Bangura, a women’s rights activist and former Minister of Health in Sierra Leone, currently Special Representative for the UN’s Secretary-General on Sexual Violence in Conflict.
Investing in the health and wellbeing of adolescents lays the foundations for the health of society in future generations.

**Doctors with Africa CUAMM**

Doctors with Africa CUAMM was the first NGO working in the international health field to be recognized in Italy and is the largest Italian organization for the promotion and protection of health in Africa. Since 1950, we have been working to support the most vulnerable parts of the population with treatment and prevention programs. In villages, health centers, and hospitals, Doctors with Africa CUAMM develops long-term health projects, connecting different levels of care (community, i.e. villages; primary health centers where only basic services are provided; and hospitals, where complications can be managed to bring health to the remotest corners of Africa.

- **Author:** Chiara Di Benedetto
- **Photos:** teenage girls – and mothers (DWA CUAMM)
- **More information:** www.mediciconlafrica.org
Mozambique, one of the South Eastern-African Countries, actually ranks 181st among the 189 countries in the Human Development Index 2016. Since 2007 Medicus Mundi Italy (MMI) is working for the empowerment of the Mozambican National Health System in Morrumbene, a rural district populated by 150,000 inhabitants situated in the Inhambane Province in Southern Mozambique. MMI supports education courses and training-on-the-job of local health workers in the field of Maternal and Child Health (especially nutritional rehabilitation), Tuberculosis Control and HIV/AIDS management, and offers supervision of supported activities. The focal activity is called *Brigada Móvel*, a public mobile clinic that provides primary health care to the rural communities living in the most remote areas, far from the traditional Health Centers. Since 2011 the Brigada Móvel reach every community in the district at least once every three months, but often more frequently as needed. During 2016 a total of 164 visits were realized.

My collaboration with Medicus Mundi Italy (MMI) started in October 2014. For me it was enough to set foot on the reddish soil of Mozambique to perceive the first sharp contrast. On one hand, the enthusiasm of a young physician for having received such an important task: be the health project manager. On the other hand, the huge responsibility for the whole project. I decided not to let myself be impressed by the amount of work to do, but to focus on the implementation of a basic service, trying in the best “MMI spirit” to deliver my share of “health for all” to the Morrumbene population. No time to know the details of the local context and here I am launched on an ambulance of the *Brigada Móvel* (*BM*) that day after day provides, to the most remote communities of the District, essential health services such as vaccination for children, ante-natal care, treatment of malaria, and management of the many cases of HIV, not to forget acute and often severe malnutrition.

I spent my first six months coming around with eyes and ears wide open, to know the communities’ needs and the colleagues’ habits. After that we began the education and training courses plus the supervision to the National Health Program in the 11 Health Centers of Morrumbene.
The MMI operated support to the National Health services in the area of nutrition is included in a larger project that involves two other Italian non-governative organizations, namely Servizio Volontario Internazionale (SVI) e Servizio Collaborazione Assistenza Internazionale Piamartino (SCAIP), which support the agricultural sector and the micro-economy in order to reach higher levels of food security in the Morrumbene district. Despite the fact that the National Health System is totally free of charge, in Mozambique many children with malnutrition are not hospitalized and often not cured at all, because “thin bodies” are considered as the normality by families and health workers (in fact 44% of the Mozambican children suffer from chronic malnutrition). Other local barriers, both cultural and distance related, may also contribute to the undertreatment of childhood undernutrition.

Thanks to the BM service, we were finally able to reach the most rural communities and to implement there a comprehensive nutrition program. Starting from the screening of acute malnutrition via the management of Marasma and Kwashiokor to nutritional education, where through cooking sessions we encouraged families to take advantage of the locally available products to fight food insecurity effectively. Encountering the communities gave us the chance to discuss some other essential points in which people are still dependent on traditional authorities and healing practices such as “traditional health practitioners” and “traditional midwifes”: for example, in the Morrumbene district almost 60% of pregnant women deliver at home without skilled birth attendance. During 2016 I also worked in the pediatric ward (I should say room, as there is no ward) of the Morrumbene Health Center, focusing on improving management of hospitalized children with severe and often complicated acute malnutrition. Applying the local protocol strictly, we were able to treat 25% of all the pediatric inpatients with SAM of the Inhambane Province!

But during my 28 months in Morrumbene I also had to face difficulties in many areas, such as:

- **Training**: Working on the motivation of the local health workers was quite a difficult task, as they often showed reluctance in adopting the national health policies and protocols.

- **Language**: Despite of Portuguese being the national language, in these remote rural districts most people have not received even primary school education and thus only speak the local dialect. So, working through the local health workers is absolutely necessary.

- **Tradition**: Working in Mozambique could put you in front of some difficulties linked to “cultural differences”. For example, in rural villages often acute malnutrition is seen as a kind of damnation, in which the spirit of wild animals impedes a good development of the children. Such a curse than needs a traditional ritual of purification – which often worsens the health of the child!
But as time went by, I felt myself increasingly part of something stronger than the tropical heat in January: something rooted in the imperturbability of Morrumbene, in sharing objectives with the local group of volunteers, in the mission of Medicus Mundi. We worked a lot in these 28 months. But despite everything, as one of the many Mozambican mysteries, fatigue weighed less than the desire to think about doing even more, to direct efforts to improve the project further and offer ever more to our beneficiaries.

On the 15th of February, the day after my return from Mozambique, a tropical cyclone called Dineo–17 made landfall in Southern Mozambique, Inhambane Province, carrying strong winds exceeding 130 km/h, rough sea and torrential rain. The most affected area was exactly the district of Morrumbene where many health centers and schools I visited during my stay had their roof uprooted or were totally destroyed and the entire population suffered severe damage. Years of work were strongly struck, but fortunately none of my colleagues was killed and everyone started to help with the reconstruction.

This is what I'll bring back with: it’s mandatory to accept that not all events can be controlled. But it’s good to struggle together to change those you can!

- Author: Carlo Cerini
- Photos by the author
- More information: www.medicusmundi.it
HEALTH POVERTY ACTION

ENDING THE DRUG WAR TO SUPPORT
HEALTH AND RIGHTS FOR ALL

Around the world, punitive drug control policies continue to restrict the health and rights of poor and marginalised populations. Since it began over 5 decades ago, the global ‘war on drugs’ has not only failed in its efforts to create a ‘drug free world’ but has undermined efforts to tackle poverty, improve access to health, and protect the rights of some of the most marginalised communities and fragile environments in the world. Health Poverty Action is challenging this harmful policy paradigm as part of its OSF funded drug policy reform project, by advocating for and raising awareness both within the sector and at the UN level of the need for development focused drug policies.

It is striking the many ways in which repressive drug policies impact on poor and marginalised communities. (1) For people living in poverty in marginalised rural and urban areas, involvement in illicit drug markets is often a strategy to mitigate hunger and food insecurity where viable or sustainable livelihood opportunities in licit markets do not exist. There is also a strong link between poverty and problematic drug use, and yet punitive drug control policies such as crop eradication and imprisonment push those who are already vulnerable further into poverty and food insecurity. The right to health is significantly limited by policies which prioritise demand reduction over the provision of evidence based treatment and harm reduction services for people who use drugs. The criminalisation of people who use drugs and possession of associated paraphernalia in particular has a negative impact on incidents of HIV and hepatitis amongst the injecting drug community. Heavy restrictions on controlled medicines in many countries in the global south mean that 80% of the world’s population live in countries with either insufficient or no access to essential medicines for pain relief, such as morphine.

Existing inequalities, which for many are a significant factor in engagement with the drugs trade, are strongly reinforced by the stigma and social exclusion associated with these policies. For women this impact is felt most acutely. Gender inequality intersects with, and is reinforced by, prohibition and criminalisation, which disproportionately impact women in many ways, perhaps most evident in the increasingly high percentages of women incarcerated for drug offenses in the Americas, or the lack of gender specific care for females who use drugs.
There are also the environmental and other social impacts of the war on drugs to consider, particularly the effects of a militarised response to the drugs trade, which has actually fuelled rather than reduced violence in many places, as well as the illicit nature of the trade which continues to stimulate vast profits that facilitate bribery and corruption.

Health Poverty Action began advocating for development sensitive drug policy reform 3 years ago in order to address these harms associated with the current war on drugs approach, including since 2015 drawing attention to the impacts of this policy approach on the new Sustainable Development Goals (2).
Given the multiple ways in which punitive drug control policies impact the health and rights of marginalised communities, it is surprising that many development and health organisations have been historically absent from the drug policy debate and have often overlooked drug affected communities in their efforts to address poverty and poor health through their programming work. For this reason, Health Poverty Action has set up the UK based Bond Working Group on Drug Policy to bring together development INGOs interested in addressing these issues through collaborative policy innovation and collective advocacy, in order to challenge the current war on drugs from a development perspective.

In April 2016 this group led the call for greater coherence with the SDGs in global drug policy objectives at the UN General Assembly Special Session on Drugs (3). Since then members of this working group have contributed to UN level discussions on the implementation of the UNGASS Outcome Document and we recently attended the annual session of the Commission on Narcotic Drugs to ensure that achieving the SDGs and leaving no one behind remains high on the drug policy agenda. Health Poverty Action is also currently working to address the evidence gap in this area, through a research project which will capture the impacts of punitive approaches to drug policy as experienced by individuals and communities who depend on the illicit drugs trade for their livelihoods and for those who lack access to essential pain medicines.

Through advocating for a development first approach and greater alignment of drug policies with the SDGs, Health Poverty Action, and the Bond Working Group on Drug Policy, aim to achieve an end to the ‘war on drugs’ and policies and practices that champion development, access to health and rights over punitive approaches which undermine all of the above.

- Author: Natasha Horsfield
- Picture: Cover of “Casuaities of War” report
- More information: https://www.healthpovertyaction.org
For four months, I had the pleasure to be a part of the medical staff at Nemba District Hospital, in Rwanda’s Northern Province. The aim of my stay as a General Practitioner was working in the Service of Internal Medicine (IM) and fighting Non Communicable Diseases (NCDs).

Rwanda is one of the world’s poorest countries, devastated by the 1994 genocide. Since that time, major improvements in life expectancy have been observed. This was possible due to the development of a well organised health system based on district hospitals surrounded by health centres, and a big number of community health workers. With an additional structure of health insurance available, access to basic care was also given to the poorest inhabitants.

Back to my work: What were the patients hospitalised for in Internal Medicine? Half of them were diagnosed with infectious diseases such as malaria, typhoid fever and diarrhoeal diseases. Medications for those were widely available and treatment protocols were followed with ease by local doctors. The other half were hospitalised for NCDs such as hypertension, cardiac insufficiency, asthma, diabetes and neoplasms. This is basically what I’d have to deal with everyday as a doctor back in my country, Poland. But in Rwanda I observed a lack of knowledge about these diseases. I focused on this topic in my educational program, training doctors and nurses to provide efficient health care for NCDs patients.

As a young doctor, coming for the first time to Rwanda, I didn’t expect such a high burden of NCDs. Looking at the World Health Organisation (WHO) statistics - more than 40% of the population over the age of 20 is affected with hypertension or other cardiovascular diseases. Such a big number does not have an accurate answer in foreign aid. Still most of the programs in low-income countries (LICs), such as Rwanda, are focused on infectious diseases and maternal and child health challenges.

What are NCDs patients struggling with in Rwanda?

First, access to a NCDs Clinic located in a district hospital or in a health centre is not always easy as they might be located far from their residence.

When suffering from asthma, patients might temporarily deal with lack of access to medications. For a long time, special sprays for asthmatic patients were not available in the country which puts their life in danger and can lead to frequent hospitalisations.
Volunteers go from Poland to Africa to help the most needy and poorest

Operating since 1992 in Poznan, Western Poland, the Foundation of Humanitarian Aid "Redemptoris Missio" has created professional back-up facilities for Polish missionaries engaged in medical activities among patients in the poorest countries of the world, mainly in Africa. To support their work, the Foundation sent shipments of medical equipment, medications, hygiene and school materials. In addition, the Foundation has enabled nearly two hundred volunteers to go to the missions.

The aim of the Foundation is the professional preparation for the work in the tropics, primarily in terms of prevention of tropical and parasitic diseases. Together with the Department of Tropical Diseases and Parasitic Diseases, the Poznan University of Medical Sciences organizes training courses and conferences on health issues in African countries.

The Foundation has considerable achievements in promoting humanitarian and charitable activities. Volunteers - not only doctors and dentists, nurses and midwives but also students of medicine, nursing and midwifery - go from Poland to Africa, enthusiastic to help the most needy and poorest. The volunteers are the driving force of the Foundation, because they are the basis of our operations and the ambassadors of the Foundation in their surroundings.

The Foundation of Humanitarian Aid "Redemptoris Missio" supports mission hospitals and clinics in some of the poorest countries with regular shipment of medicines, dressing materials and medical equipment. In Poland, volunteers help with:

- package packing,
- preparation of promotional materials of the Foundation,
- assistance in obtaining funds to meet the requests of the missionaries.

In 2017, the Foundation is celebrating its 25th anniversary. Over that time, it has incessantly fulfilled the purposes for which it was established. Its help included countries in Africa (Tanzania, Cameroon, Zambia, Ethiopia, Uganda, Rwanda, Kenya, Chad, Madagascar, Central African Republic), Latin America (Guatemala, Bolivia, Jamaica), Asia (India, Nepal, Kazakhstan, Afghanistan) Oceania (Papua New Guinea) and Europe (Belarus, Serbia, Bosnia and Herzegovina, Kosovo).

More information: http://www.medicus.ump.edu.pl/
In the case of Hypertension (HT), it is difficult to achieve a compliance with patients, since HT doesn’t cause any pain or other symptoms. The discontinuation of treatment leads to a high risk of stroke which means being paralysed and thus, being dependent on care by family members.

Regarding Cardiac Insufficiency, there is a high burden of underdiagnosed young patients with rheumatic heart disease who could live longer if there was an access to basic echocardiography with trained staff.

Finally Diabetes: a condition that is easily manageable in Europe with the appropriate medical support. However, in Rwanda it is a death sentence. There is no access to the resources needed to treat this disease. 1$ to measure glycaemia once per day? No way. This is crazy.

A patient told me once: “I would rather have HIV instead of diabetes”. A shocking statement, but, after analyzing the situation, totally understandable. Rwanda’s HIV infected patients have a lifespan comparable to Europeans. Their medication is refunded by the government. Whereas with diabetes, people are left behind, dealing with complications such as blindness just after first years of illness onset. It leads to disability and social stigma. Diabetes is a lifelong condition and buying the essential insulin and additional supplies required can represent a significant proportion of the family’s income.

My conclusions: There is an urgent need to educate patients and medical staff in developing countries about non communicable diseases as the problem will be constantly growing.

- Author: Małgorzata Osmola
- Photo: Doctor Adrien and young interns during medical visit in Nemba Hospital
- Info box on Redemptoris Missio: Contributed by Jerzy T. Marcinkowski
In 2016 the Network Medicus Mundi Switzerland (MMS) has worked on its new strategy – with some remarkable results. To be honest: I was very much convinced of the quality of our former strategy which was limited to end of 2016. At the beginning of our process to renew our network strategy 2017-2019, I therefore expected that we will end up with an only slightly updated strategy. Obviously I underestimated the dynamic of the process to discuss the strategy with our 50 Swiss member organisations, all of them working in the field of international health cooperation and global health. And I underestimated that the challenges these organisations are currently facing would influence the process so strongly.

In an early stage the Board of Medicus Mundi Switzerland decided to design the new Network strategy in close cooperation with the Network members. Based on that we initiated the strategy process in January 2016 with a workshop for member organisations to outline the challenges to which the strategy was expected to respond. The next day our Board met to outline the key components of the new strategy based on the outcomes of the workshop. With these elements the MMS secretariat and Board drafted a first version of the new strategy which was, in spring 2016, sent to the Network members for an online consultation. This resulted in a renewed draft which was discussed, finalized and approved by an extraordinary General Assembly in September.
The close collaboration with our member organisations in developing the new strategy helped to design a document that reflects their current challenges and their expectations towards the Network.

During the workshop the Network members referred to the changing environment in Switzerland that is shaped by a strong isolationist political trend that tends to put economic defined self-interests into the heart of Switzerland’s foreign policy. The value of a solidary, cosmopolitan nation is getting more and more lost. Of course this is not only a Swiss, but unfortunately a global trend. However it strongly affects the work of all the organisations – NGOs and academic institutions – working in the field of international health cooperation.

Besides this political trend the Network members referred to another major change in the environment of health cooperation: On the global level the Millennium Development Goals (MDGs) have been replaced by the much more holistic framework of the UN Agenda 2030 (Sustainable Development Goals, SDGs) – a move that has brought a paradigmatic shift towards a global development plan that breaks up with the classical donor-driven aid model in favour of a partnership model, where governments of all countries share the same responsibility for sustainable development.

How does the new MMS Strategy 2017-2019 react on this changing environment? The member organisations concluded that there is a need to much better reflect their own work critically: We want to define our own the way into a world beyond aid – we don’t want to legitimize our work towards right-wing, isolationist and populist movements but towards our partners worldwide. We want to share and debate our approaches to make this world healthier in all senses, and we want to reflect self-critically our experiences.
Out of these reflections MMS decided to promote the development and implementation of best practices among its member organizations by creating a platform for critical reflection of the work of these organizations and the knowledge base for international health cooperation.

Based on this goal MMS will conduct learning processes on issues defined by its member organisations. Some of them gathered on a platform on implementation research for a still better understanding of their own work and for an NGO driven research that transforms health conditions and societies by a people owned research.

With the implementation of the strategy, we expect to become an indispensable community of practice committed to and useful for the work of Swiss institutions and organizations involved in international health cooperation. Based on this we also want to improve our skills for strengthening our political influence here in Switzerland. This is important for us as we still urge for a solidary Switzerland that recognises its responsibility for this planet.

Exactly this is reflected in our much more political vision: the Network Medicus Mundi Switzerland aims for health for all around the world and for a Switzerland that is committed to the right to health. This means conditions for all people across the world in which children can be born and grow up in a healthy manner and in which adults can participate in society, pursue work that is not detrimental to their health and can age with dignity.

We have the vision of a world in which all people, without exception, have equal access to comprehensive, affordable and quality health services. And we have the vision of Switzerland which takes a united, pioneering role in the fight for the right to health for all around the globe.

- Author: Martin Leschhorn
- Photos (a) Strategy workshop; (b) Tanzania 2015
- More information: www.medicusmundi.ch
## 2016: FINANCIAL FACTS & FIGURES

### Capital Account

<table>
<thead>
<tr>
<th>Assets</th>
<th>Previous Year</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Long-term fixed assets</td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>II. Short-term fixed assets</td>
<td>128'091.32</td>
<td>98'191.83</td>
</tr>
<tr>
<td>Cash in hand</td>
<td>214.90</td>
<td>335.43</td>
</tr>
<tr>
<td>Cash in banks</td>
<td>127'626.42</td>
<td>86'521.80</td>
</tr>
<tr>
<td>Other amounts receivable</td>
<td>250.00</td>
<td>8'518.05</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td></td>
<td>2'816.55</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>128'092.32</strong></td>
<td><strong>98'192.83</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Previous Year</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Net equity</td>
<td>91’830.84</td>
<td>81’549.77</td>
</tr>
<tr>
<td>Status 1st January</td>
<td>99’032.37</td>
<td>91’830.84</td>
</tr>
<tr>
<td>Net loss</td>
<td>-7’201.53</td>
<td>-10’281.07</td>
</tr>
<tr>
<td>II. Accruals</td>
<td>2’975.00</td>
<td>5’208.00</td>
</tr>
<tr>
<td>III. Project funds not yet appropriated</td>
<td>11’405.80</td>
<td>0.00</td>
</tr>
<tr>
<td>IV. Other liabilities</td>
<td>21’880.68</td>
<td>11’435.06</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>128’092.32</strong></td>
<td><strong>98’192.83</strong></td>
</tr>
</tbody>
</table>

### Statement of revenue and expense

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Previous Year</th>
<th>Budget 2016</th>
<th>Accounts 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership contributions</td>
<td>50’700.00</td>
<td>51’050.00</td>
<td>51’050.00</td>
</tr>
<tr>
<td>Donations and subsidies</td>
<td>22’500.00</td>
<td>16’000.00</td>
<td>22’353.98</td>
</tr>
<tr>
<td>Interest</td>
<td>268.13</td>
<td>300.00</td>
<td>268.13</td>
</tr>
<tr>
<td>Project and other income</td>
<td>4’301.18</td>
<td>13’423.71</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal Revenue</strong></td>
<td><strong>77’769.31</strong></td>
<td><strong>67’350.00</strong></td>
<td><strong>86’840.60</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Previous Year</th>
<th>Budget 2016</th>
<th>Accounts 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>General expenses secretariat</td>
<td>5’720.00</td>
<td>62’000.00</td>
<td>74’665.52</td>
</tr>
<tr>
<td>Travel costs / hospitality / Network events</td>
<td>9’369.79</td>
<td>13’000.00</td>
<td>9’951.71</td>
</tr>
<tr>
<td>Projects: net expenses</td>
<td>4’597.30</td>
<td>415.49</td>
<td></td>
</tr>
<tr>
<td>Other expenses secretariat</td>
<td>3’676.04</td>
<td>5’000.00</td>
<td>3’530.72</td>
</tr>
<tr>
<td>Other expenses</td>
<td>10’127.71</td>
<td>5’300.00</td>
<td>6’325.23</td>
</tr>
<tr>
<td>Taxes</td>
<td></td>
<td>2’233.00</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal expenses</strong></td>
<td><strong>84’970.84</strong></td>
<td><strong>85’300.00</strong></td>
<td><strong>97’121.67</strong></td>
</tr>
</tbody>
</table>

| Net loss                              | -7’201.53     | -17’950.00  | -10’281.07    |

All figures in EUR.

This is a summary of the financial statements of the MMI Network. Details and explications were given at the Network’s General Assembly in May 2017. The “Report on the Audit of the Financial Accounting as of December 31, 2016 for the Association Medicus Mundi International e.V.” by RSM Verhülsdonk GmbH, Krefeld, Germany, is available at the MMI secretariat.
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Status: May 2017
cooperation beyond aid

Workshop in Berlin, 29 September 2016