ANNUAL REPORT 2017
Moving health cooperation beyond aid
MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL

ANNUAL REPORT 2017

MESSAGE FROM THE PRESIDENT

MOVING HEALTH COOPERATION BEYOND AID
Reports by the MMI Secretariat and working groups

MMI NETWORK MEMBERS: “SHORT STORIES”

action medeor
A new midwifery school in Bo district, Sierra Leone

Medicus Mundi Asturias
The strain of the growers. Senekela Sisibere

Doctors with Africa CUAMM
Getting out Among the People. Awareness-Raising and Fighting HIV in Tanzania

Community Working Group on Health
Recurrent Typhoid and Cholera Outbreaks in Zimbabwe

Andalusian School of Public Health (EASP)
Migration of Healthcare Professionals: An Opportunity for Shared Development

Ecumenical Pharmaceutical Network EPN
Until every church health facility has qualified pharmaceutical staff

Health Poverty Action
The Alternatives – policies Towards a Life in Full

ITM Antwerp - International Health Policy Unit
The WHO We Want: Engaging with non-state actors

Redemptoris Missio
What’s up with Smart?

Wemos Foundation
Global Health Cafés

medico international
“We have been doing this work for so many years and we are still called volunteers”

Medicus Mundi Italia
Aiming for Autonomy: A Journey through Cultures

Novartis Foundation
Health in the Cities: Reimagining Health in Urban Populations

MMI: FINANCIAL FACTS AND FIGURES
MMI: NETWORK MEMBERS

The Annual Report 2017 of the Medicus Mundi International Network was published by the secretariat of Medicus Mundi International. The report can be freely distributed, reproduced and published, if the source (Medicus Mundi International Network) is correctly indicated. There are no hardcopies available.

Cover photo: Medicus Mundi Italia
Photo Carlos Mediano: Prosalus

Medicus Mundi International Network · Murbacherstrasse 34 · CH-4013 Basel
Phone +41 61 383 18 11 · office@medicusmundi.org · www.medicusmundi.org
For your donations, please mainly consider the MMI Network members. Thank you.
DEAR NETWORK MEMBERS AND PARTNERS,

The world is changing fast. New technologies are completely modifying our lives, as everybody immediately can be connected and knows what happens in the most remote part of the world. In the economic field, unfortunately, we have experienced the downside of this globalized and interconnected world that at the same time lacks a functional global governance mechanism. Let us not forget that it was a local problem in the United States that caused the last world economic and financial crisis...

While we are used to apply a global perspective in the fields of economy or communication, we don’t have the same global vision for the right to health. Health inequities in the world are still a big problem that makes a lot of people suffer and die, even if we have the knowledge and capacities to end most of it. Moreover, diseases do not need passports and we can’t stop them at the borders, as we can see in some epidemics such as Ebola, but also in other global problems such as diabetes or hepatitis.

Improving health services is essential, but better health for all cannot be achieved without addressing poverty, social protection, gender equity, nutrition: the social, political and economic determinants of health and health policies. The World Health Organization is rightfully promoting Universal Health Coverage (UHC), but we can’t forget the determinants of health and the political context of health care and health cooperation if we really want to change the present situation. The Sustainable Development Goals (SDGs) and the commitment by all countries to achieve them by 2030 are based on such a global vision necessary to build a better and sustainable world. It is high time to move from rhetoric to action!
The MMI Network has adapted its activities to the challenging environment. We are successfully implementing our Network Strategy 2016-20 with the two main fields of international health cooperation and global health policy and governance, at the same time aiming at having more organizations on board to expand our influence and activities. In 2017, we have welcomed two new members, the Andalusian School of Public Health (EASP) and the Health Policy Unit of the Institute of Tropical Medicine Antwerp (ITM). MMI is also looking for innovative ways of funding our work, exploring ways to achieve a sustainable financing.

As you will see in this Annual Report, the activities of our working groups on Global Health Governance (GHG), Effective Health Cooperation (EHC) and Human Resources for Health (HRH) are strongly interrelated.

In the area of global health governance, we continued with our work related to the World Health Organization and its processes and governing body meetings. We are happy to have seen the successful start of the Geneva Global Health Hub (G2H2) hosted by the MMI secretariat. With our engagement in the G2H2 meetings and working groups such as “FENSA Watch” or the task team “40 years of Alma Ata” for the celebration of the jubilee of the Alma Ata declaration in 2018, we benefit ourselves considerably from this new facility.

In 2017, we focused a lot of attention and activities on continuing and deepening our reflections about health cooperation beyond aid, at the same time engaging in the International Partnership for UHC 2030 (UHC2030) where we hope to contribute a critical and constructive civil society perspective: To reach health for all, more aspects than just health coverage need to be addressed.

Our working group of Human Resources for Health (HRH) had a complicate path in 2017, due to the complex environment, a period of transition between former global structures (GHWA and HWAI) and not yet fully established new ones, in which our Network is involved. Even so, the active participation of MMI in the 4th Global Forum on Human Resources for Health in Dublin shows that this work is still relevant.

Overall, and beyond our own work, the year 2017 has again ended with more questions than certainties. The international institutions are quite confident that they know what needs to be achieved in global health, but there is no consensus in how to do this. So there is “enough” work ahead, also for the MMI Network. We are confident that we are on our way. And we look forward to the Jubilee of the Alma-Ata Conference that took place in 1987 and its Declaration that inspired so many of us - and continues to do so.

The MMI Network is first and foremost a member-based association and the participation of its active members is key to its results. Therefore I heartily thank all our members for their ongoing engagement and support, but also my SC colleagues, the working group coordinators and members and the Executive Secretary for making MMI a lively and inspiring community.

Carlos Mediano, President
Medicus Mundi International Network
Moving Health Cooperation Beyond Aid

Our understanding of the interconnectedness of our two main fields of work, our broad overall vision of what it needs to achieve Health for All 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.

In our Strategy 2016-20 adopted by the members in 2015, the Medicus Mundi International Network framed the two main fields of work of the MMI Network 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.”

In the last year, the interconnectedness of these two fields of work has become particularly visible in the MMI working group on Effective Health Cooperation (MMI EHC) which has been engaged, at the same time, in advocating actors in international health cooperation to “move cooperation beyond aid” (see the current chapter) and in addressing governance challenges in the international institutions dealing with the promotion of Universal Health Cooperation (see the chapter on global governance). We will focus in the current report on this working group, without neglecting to include reports on activities and achievements in our other fields of work.

Promoting Relevance, Legitimacy and Effectiveness of International Health Cooperation

The MMI Network aims at contributing to the debate on ways in which actors in development cooperation such as international NGOs or bilateral agencies can engage in a relevant, legitimate and effective way to achieving universal access to health. Our work is historically rooted in the engagement of MMI Network members in health cooperation, in the promotion of health systems strengthening and the structural integration of “private not-for-profit” organizations in national health systems, and in the promotion of evidence based health cooperation, but also in the traditional role of the Network of being a space for sharing, mutual learning and cooperation.

In our understanding, expressed in a discussion paper published in 2016, relevant, legitimate and effective health cooperation has some “core qualities” as follows:

- It contributes to achieving universal access to health.
- It is fully aware of its structural role, responsibilities and limitations.
- It continuously reflects on how to improve its approaches and practices.

Moving health cooperation “beyond aid” – our slogan of the past year – therefore means to add these core qualities to the humanitarian gesture of “helping” and “filling gaps” in which health cooperation is historically rooted. The result shall NOT be the transformation of aid into business, but, again, renewed and strengthened relevance, legitimacy and effectiveness of our efforts and contributions.
“We invite institutions and professionals engaged in health cooperation to critically position themselves, to refer to the criticism of development cooperation and to participate in an intersectoral dialogue on how to do things better. If we take this seriously, we might need to accept that a paradigm shift is required that breaks with the continuum process of development cooperation for health as it has been conducted during the last 50 years.” (MMI discussion paper)

When the MMI EHC working group presented, in September 2016, its discussion paper on “Health Cooperation: Its relevance, legitimacy and effectiveness as a contribution to achieving universal access to health” at a workshop in Berlin, it was clear to us that this was just the beginning of a journey, and not the end of it. And we invited the MMI Network members and partners to join us in this journey.

Since then, and in the past year, the joint reflection within and beyond the MMI Network on “health cooperation beyond aid” has led us from Berlin to Geneva and Antwerp.
Since 2014, the MMI Network has met once a year, for its Assembly and health cooperation workshop, in the middle of “International Geneva”, close to the Palais des Nations and the World Health Assembly (WHA). This arrangement allows Network members to link their participation in the Assembly with attending the WHA as a member of the MMI delegation; on the other hand WHA delegates can join the MMI meeting and in particular the workshop as our guests.

Our health cooperation workshops are therefore promoted at the same time as public side events to our General Assembly and as side events to the World Health Assembly.

“I international health cooperation in today’s world calls for a major renewal. We need less of the classical Official Development Aid (ODA) approach, and more of modern, second-generation, cooperation principles and practices among countries and civil society organizations which can catalyze national health efforts and resources.” (Daniel Lopez Acuña)

The 2017 workshop on “Health cooperation beyond aid” followed the structure of the MMI discussion paper published in 2016 and its questions for reflection. The vivid conversation benefitted of the mix of participants due to the venue and timing of the meeting: MMI Network members, other actors in the field of health cooperation including representatives of bilateral agencies, but also member states and civil society delegates at the World Health Assembly and representatives of the WHO secretariat participated in the lunch event.
Our conversation about “Health Cooperation beyond aid” culminated at the 10th European Congress on Tropical Medicine and International Health that took place in Antwerp in October 2017 and in which the MMI working group on Effective Health Cooperation was strongly engaged.

We were particularly happy to see that our proposal to integrate a track on international health cooperation in the formal congress programme was implemented by the organizers. MMI Board member Remco van de Pas represented the Network in one of the plenary sessions, and we organized, in partnership with Be-cause Health, two well attended workshops.

In addition to this formal engagement, the MMI Network and some of its members could be "visited" in a marketplace booth throughout the congress week: i+solutions, Medicus Mundi Switzerland, Memisa and Wemos, having reacted to a call sent out by the MMI Secretariat in summer, joined this visibility partnership that was well appreciated by the participating members.
16 October 2017: Health Cooperation Beyond Aid? Engaging Belgian Actors on Global Health with Regards to the Relevance, Legitimacy and Effectiveness of our Work in an SDG Era

Our Belgian colleagues of Be-cause Health invited the MMI Network to co-organize an ECTMIH pre-event on the topic we have addressed, in our working group on Effective Health Cooperation, over the last two years.

This event brought together researchers, practitioners, policy-makers and influencers to exchange insights on how they are adapting their work to a changing environment, and reflect on how changes in their approach is influenced by shifts in (health) development cooperation. The debate was lively, and the participation of a young academic audience added some spice to it, as expressed in a blog published by an ITM intern:

“As always, it is only when reunions culminate that ideas abound. Strikingly, the panel debate failed to venture beyond the classical aid dilemma despite the goodwill of experienced panellists and strong push from the audience. Hence it appears that moving the focus of discussions from aid to a systematic analysis of the potential and the inherent challenges of collaboration is harder than we think. Good news remains that it is on everyone’s agenda. As for the necessity of reaching out rather than the usual inward-looking approach in the aid community, this is yet another challenge even experts could not find an answer to.”
17 October 2017: Health Cooperation Beyond Aid. ECTMIH Session Organized by MMI, with Lecture of Natalie Sharples, Winner of the MMI Essay Contest

Our application for an organized session on "Health cooperation beyond aid" jointly submitted by MMI and Be-cause health was accepted by the scientific committee of ECTMIH 2017.

"Funding for international development aid is under pressure. Post-fact & post-truth policy framing overshadow evidence-based policy making. Humanitarian, development and security objectives have become blurred. Current global health challenges are of a transnational, universal, nature and not only a matter anymore of bridging the gap between developed and developing countries. This requires a reassessment of how international health actors transform themselves to engage in a strategic way with a new global health agenda."

Speakers from a variety of organisations provided an initial input to this question. One of the speakers was Natalie Sharples, the winner of an essay contest organized by MMI:

"Achieving health justice requires radical change. Change in policies that create poor health, change in the global distribution of power and resources, and change within the health justice movement itself. At our organization, there are a number of things we are proud of. We don’t create parallel systems. We work closely with local authorities, district health committees and national governments to build effective health systems that are appropriate and accessible to those who need them. We look to challenge power imbalances from local to global levels. And we tackle the root causes of poverty without pretending that aid and charity are solutions. There are a number of other areas to which we are committed, but require ongoing struggle and reflection..."

The reader of the MMI essay contest, a selection of contributions from members and partners of the Medicus Mundi International Network, was also launched at this ECTMIH session and is since then available online. Contributors were asked to discuss their “theory of change” (if any) which defines how they expect social and health outcomes to be improved while reflecting on their organization’s particular role and contribution: How do health development cooperation and the actors involved need to change to remain relevant and effective in the 21st century? How is their organization’s or their local partner’s structures and programs integrated in the national health policies and systems of the countries they collaborate with / work in? How do they handle the dilemma between working on a rights based approach to health while having to address institutional financial challenges? The six essays selected for the online publication give answers to these challenging questions and provide “food for thought” in an exemplary way from both the personal and institutional perspective of the authors.
Everyone must have access to essential medicine
GLOBAL HEALTH POLICY AND GOVERNANCE

“Getting involved in global health” has become a formal objective and field of work of the MMI Network only after 2010 (Strategy 2011-2015). And, in fact, since then, the MMI Network has successfully got involved in debates on global health policy and governance and can now be considered as a valuable, respected and well known voice of civil society at the World Health Organization, also benefitting of its status as “NGO in official relations” and its long history of collaboration with WHO.

Related to this, MMI has developed a reputation as a dedicated and unbiased networker and convener for WHO related right-based civil society advocacy. In this context, MMI and its working groups have established good working relations with international social justice movements, networks and coalitions promoting Health for All.

Therefore, with the Strategy 2016-20, we decided to further invest in this field:

- Promoting good governance in their fields of work, the thematic working groups pay particular attention to the governance of the, providing “critical constructive” input and, if possible, engaging from within the global mechanisms and platforms such as the World Health Organization and its hosted partnerships and coordination mechanisms (MMI GHG), the International Partnership for Universal Health Coverage and its Civil Society Engagement Mechanism (MMI EHC) and the Global Health Workforce Network and related mechanisms (MMI HRH).

- Providing direct input to health policy debates at the WHO and its consultations and governing body meetings, in partnership with People’s Health Movement and other civil society colleagues and hosting the “WHO Watch” project in the MMI delegation.

- Being a dedicated networker and convener, in particular by hosting the Geneva Global Health Hub (G2H2).

In all these areas, 2017 was a year of intensive work – with some good progress.
MMI GHG: WATCHING AND PROVIDING INPUT

As in previous years, MMI addressed the World Health Assembly (9 statements) and three sessions of the WHO Executive Board with statements on various topics, in close collaboration with the People’s Health Movement and its WHO Watch project hosted in our delegation. MMI statements continue to be available on the WHO Watch website and in particular in the nice “WHO Tracker” (http://who-track.phmovement.org) provided by the People’s Health Movement.

In the past year, the election of a new Director-General of the World Health Organization, the implementation of the WHO Framework of engagement with non-state actors and the development of the 13th WHO General Programme of Work attracted our particular interest. As part of broad civil society coalitions, and beyond our statements at the WHO Governing Body meetings, MMI provided input in consultations and public statements in these fields. To highlight some of them:

MMI co-signed open letters to the members of the 140th Session of the WHO Executive Board of the WHO on the need to address the recommendations included in the report of the United Nations Secretary-General’s High-Level Panel on Access to Medicines (UNHLP) an on the insufficient Conflict of interest safeguards to protect WHO from influence of regulated industries (January 2017).

MMI signed the civil society statement “The WHO we want and the leadership WHO needs. A message from civil society” (March 2017) and an open letter to WHO DG candidate: ”Keep policy and priority setting free of commercial influence” published in The Lancet in May.

MMI contributed with written statements to the online consultation on the WHO General Programme of Work (September 2017) and to a related Special Session of the WHO Executive Board in November.

Co-signing a campaign or a joint advocacy statement as Medicus Mundi international Network requires consultation of the Board by the Network member or institutions who promotes it and does not mean that the statement reflects the position of all Network members.
WORLD HEALTH ASSEMBLY ANALYSIS AND SIDE EVENT

During the 70th World Health Assembly, the MMI Secretariat published the daily bulletin “WHA Today” collecting critical analysis and promoting civil society events. This pilot, undertaken in collaboration with G2H2, the Third World Network and the People’s Health Movement, was appreciated by many, but cannot be sustained unless there are increased capacities available at our secretariat.

MMI Network was co-organizer of a crowded side event to the World Health Assembly on “Responding to the Challenge of Antimicrobial Resistance (AMR): Perspectives of Civil Society, Intergovernmental Organizations and Developing Countries”, together with Médecins Sans Frontières (MSF); Drugs for Neglected Diseases initiative (DNDi) and Health Action International (HAI).

In our understanding, if we look at Antimicrobial Resistance mainly/only as a medical issue (research and development, use of and access to medicines), key aspects are not properly addressed, in particular:

- Structural and commercial determinants of AMR, such as the environment and climate change and the transmission of AMR via the food chain;
- Global governance aspects of handling AMR beyond just seeing it as a health security issue;
- AMR as a challenge to the health system as a whole, in particular in LMIC.

We therefore invited Garance Upham, Vice-President of the World Alliance Against Antibiotic Resistance (WAAAR), to represent our Network in this meeting and to provide an input on these “blind spots”.
MMI EHC: ENGAGEMENT IN UHC2030

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. The UHC narrative takes up key elements of our Network’s understanding of “health for all”: Strengthening people-centred health systems and promoting universal access to essential health services as a shared responsibility of national governments and international actors.

The MMI Network therefore joined, in November 2017, the “International Partnership for UHC 2030” (UHC2030) as a civil society member. We want to contribute to this new international partnership from within, as a critical civil society voice. The MMI EHC working group and its members actively participated in the process of transforming IHP+ into UHC2030, providing input on governance matters, the drafting of the guiding documents and the principles and modalities of engaging with civil society. We are happy to see that an MMI representative, Itai Rusike (Community Working Group for Health, Zimbabwe), was elected into the first Advisory Group of the UHC2030 Civil Society Engagement Mechanism.

In an interview with the UHC2030 newsletter, the MMI Executive Secretary expressed some expectations about how this new global partnership can best harness its potential:

“The interests and political agendas of diverse UHC2030 partners deserve critical assessment. It is rather easy to agree on UHC as a goal. But the implication that all members of the UHC2030 ‘movement’ agree on how to move towards UHC would be misleading. However, having so many diverse actors and interests assembled in UHC2030 can be useful to create spaces and structures – both public and protected – for critical reflection, political debate and mutual learning about how UHC can be achieved. This needs an agreement that, within the ‘movement’, dissent is possible and welcome.”

This kind of critical constructive input was much welcomed, as well as our working group’s input on governance issues, challenging the legitimacy and quality of processes and products. This was well received and contributed to a greater attention in both bodies on governance issues.

In December 2017, some MMI Network members participated in the global UHC Forum in Tokyo, providing input on key topics such as financing for UHC, as part of a big civil society delegation.
MMI HRH: HUMAN RESOURCES FOR HEALTH
- CONVENING IN AN EMPTY SPACE

In the field of Human Resources for Health, MMI and its HRH working group coordinated by Wemos are known as both a strong and outspoken civil society voice and a dedicated networker and convenor promoting good governance of global (strong structures, representation, strong instruments, addressing root causes), with a focus on the implementation of the WHO “Global Code of Practice on the international recruitment of health personnel” (adopted 2010 by the WHA) – but also beyond this topic. Our role and contributions are well recognized by civil society colleagues, but also by the WHO and other key actors in this field.

Setting up the Global Health Workforce Network” (GHWN) as a “light” follower of the former “Global Health Workforce Alliance” (2016) has taken the WHO Secretariat longer than expected, mainly due to lacking financial support and limited capacities. By the end of 2017, we still wait for the appointment of a 12 member multi-sectoral Strategic Advisory Committee (SAC) to provide strategic advice to the Network and for the establishment of a Global Platform on Health Workforce Mobility. MMI HRH has expressed to WHO its interest to actively engage in both structures.

At the end of GHWA, also the “Health Workforce Advocacy Initiative” (HWAI) in which MMI HRH was strongly engaged, collapsed, and for more than a year there was no follower ahead. 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 must be conducted to re-convene and strategize with relevant, reliable civil society actors.
Joint civil society strategizing was undertaken at the 4th Global Forum on Human Resources for Health that took place in Dublin from 13-17 November 2017. At the Forum, a team around MMI and the HRH working group leader Wemos gathered civil society colleagues to the well-attended civil society session "How can civil society spur action on ensuring health workers for all?". The participants agreed upon setting up, if feasible, a civil society initiative within the Global Health Workforce Network.

However this proved to be difficult. At the end of the year it rather looks as if a feasible approach will be to promote civil society participation in the thematic hubs of the GHWN (that are: community-based health workers; data and evidence; education; labour market; HRH leadership; youth; and gender equity) and explore, at the same time, how to set up a civil society initiative on HRH outside of the WHO/GHWN umbrella to remain a critically constructive watchdog to these structures and apply a perspective to addressing the root causes of the global health workforce crisis as it is today. To be continued in 2018...
MMI AND THE GENEVA GLOBAL HEALTH HUB (G2H2)

At a strategy meeting held in Geneva in January 2015, civil society organizations discussed the need for more continuity in their exchanges on global health. In addition to meeting twice a year around the meetings of the WHO governing bodies, there was a wish to have a platform for continuous cooperation, exchange of knowledge and strategy development. After a period of consultations and planning, the Geneva Global Health Hub (G2H2; “the Hub”) was formally launched and established as an association under Swiss law at its Constitutive Assembly held on 21 May 2016 in Geneva. After the Annual General Assembly in May 2017, the G2H2 Steering Committee approved in June a biannual work plan for 2017-18 with four modules as follows:

- Networking, communication and collaboration
- Convening and facilitation of civil society strategizing and advocacy
- Provision of services to individual G2H2 Members
- Governance, accountability, institutional development
Hosting the G2H2 secretariat – and engaging beyond this

The MMI Network is proud to host the G2H2 secretariat at our office in Geneva opened in autumn 2016 for this reason, and with Mariska Meurs (Wemos), a member of the MMI GHG team also became the first G2H2 President, followed in 2017 by Andreas Wulf (medico international), another member of MMI GHG. The G2H2 secretariat and Steering Committee directly report back to their association members; we therefore limit the related reporting to fields where MMI is engaged beyond its secretariat mandate.

Medicus Mundi International has been, for many years, a fierce promoter of good governance at the WHO, and continues to do so, with own statements and in cooperation with like-minded civil society organization as reported above. When we “outsourced” some of our related engagement to the Geneva Global Health Hub and its working groups, in particular watching the implementation of the WHO Framework on Engagement with non-state actors (FENSA) and the promotion of transparency and inclusiveness in WHO meetings and processes, we remain nevertheless strongly engaged, both institutionally and personally through the MMI secretariat and Network members active in the G2H2 and its working groups. Two examples

Promoting transparency and inclusiveness at the WHO

Referring to talks the MMI Executive Secretary had with representatives of the WHO DG’s Office during a farewell lunch with the former Director-General Margaret Chan, Andreas Wulf (medico international, G2H2 President) and Thomas Schwarz had the opportunity to meet, in November 2017, the newly elected Director General Tedros Adhanom Ghebreyesus at the WHO headquarters, and to submit to him a series of memos, including one on practical issues regarding transparency, inclusiveness and ‘user friendliness’ of WHO processes and meetings.

Preparing for the Alma-Ata Jubilee in 2018

The “AA40 task team” hosted by G2H2 and co-ordinated by the MMI Secretariat was established in 2017 to plan and implement a civil society led event in Geneva in 2018 to commemorate the 40 year jubilee of the Alma-Ata Declaration. The event and the related communication shall allow to critically analyse the state of implementation of the main Alma-Ata Declaration principles (in particular: addressing determinants of health; global solidarity for health equity; accountability to the people, access to comprehensive health care services for all through a system structured around the principles of Comprehensive Primary Health Care) and to renew and promote a broad commitment to the values and the agenda of change expressed by the Declaration.

A concept note for an official WHA side event was submitted in November 2017 to the WHO secretariat. At the end of the year, the decision if the event will be attributed one of the available eight slots during the week of the World Health Assembly. In the meantime, we can confirm the good news that the event will take place – to be reported next year!
Medicus Mundi International – Network Health for All (MMI) is a network of organizations working in the field of international health cooperation and global health. MMI is a non-profit association according to German law founded in 1963 and, since 1978, an NGO in official relations with the World Health Organization. According to the statutes, “The aim of the association is the promotion of Health for All in a sense of access to health and health care as a fundamental human right.”

MMI being an association according to German law, the governance mechanisms and institutions are defined by the statutes. Formal institutions of the association are: the General Assembly, the Board, the Executive Secretary and the secretariat, and working groups.

The Network members, currently 20 NGOs, NGO Networks and academic institutions, are the owners of MMI. They bear the overall responsibility for the MMI Network and its development and define the aims – and how to reach them: Members are systematically involved in the development of the MMI Network’s policies, strategies and work plans, including the periodical definition of thematic focal areas of the Network.

**Welcome to EASP and the ITM IHP Network!**

We are absolutely happy to report that the MMI Network is growing: In 2017 the Escuela Andaluza de Salud Pública (EASP) and the International Health Policies Network (IHP Network) of the Institute of Tropical Medicine Antwerp were accepted by the MMI Boards as new Network members. Both new members are coming from the academic arena where they have a great reputation, and both have a lot of experience and background in the fields of global health governance and effective health cooperation, so their contributions will enhance the work of our Network.
COMMUNICATION

The website/electronic platform of the MMI Network mainly features our current activities and the work of the Network members. The “Network” section provides links to key MMI documents and to a list of Network members with short profiles of each organization and recent contributions. Some promotional material is also available online. MMI Network News are sent by e-mails to MMI Network members and other institutional and individual contacts. Recently, the newsletter has been partly replaced by the “MMI-cooperate” mailing list for internal horizontal communication between Network members. Two Twitter channels are regularly fed by the MMI Secretariat: “MMI global health” (14’200 tweets, 2’600 followers) and “Health Workers for All” (2100 tweets, 850 followers), leading to lively interaction and contributing to the visibility of the Network at a broader audience.

FINANCES

As a general rule, the core/central structure of the MMI Network has always been financed by the Network members, through regular annual membership contributions and, in particular since standard membership fees have been introduced, through additional extraordinary contributions by a limited number of members. The income generated via such contributions has been sufficient to sustain a small secretariat (one part-time staff, currently 60 percent including G2H2 secretariat) and to finance key Network events. The overall budget of MMI has been quite small (below 100’000 EUR) and stable. However, the budget does not properly express the overall “turnover” by the Network, as it does not show all the investments by the Network members (staff capacities, travel expenses, events) in the Network and its working groups and activities. In the past ten years, only the project “Health Workers for all” (2013-2015) set up by a consortium of MMI Network members and partners, funded by the EU and including a particular mandate of the MMI Secretariat, generated some substantial external project funding. Since summer 2016, the small income generated by MMI hosting the secretariat of the Geneva Global Health Hub has contributed to sustaining the Network secretariat: 30 of totally 130 days/year of secretariat capacities are currently financed via G2H2.

In a changing funding environment for international health cooperation, the decreasing “free income” of Network members has made it more difficult for them to provide substantial extraordinary contributions to the MMI Network. This has led to a series of deficits over the last years and underlined the necessity to increase the number of (financially strong) Network members to guarantee the financial sustainability in the mid-term. A related field of activity “We will further invest in the Network’s consolidation and development.” was introduced in the Strategy 2016-20. We are still working on its implementation...

At a Network meeting linked to the ECTMIH Congress in Antwerp, in October the MMI Board therefore continued and deepened a key conversation that has kept us busy over the last year: How can MMI strengthen its financial foundations and overcome its underfunding? Our members were invited to contribute to this conversation – and to help us sustaining our Network. With a potential institutional donor showing interest in our Network and its activities, we hope that we can report, in the next year, some progress at this level.
SHORT STORIES BY NETWORK MEMBERS
Due to the high demand for trained midwives in Sierra Leone, action medeor and the local partner organization Caritas Bo, in close consultation with the Ministry of Health and Sanitation, developed the project concept of setting up a midwifery school in the southern region of the country. The project concept was preceded by an intensive participatory planning phase including a feasibility study, which was elaborated in 2015. The school opened in 2017 and can be seen as an important contribution to strengthening the health system in Sierra Leone.

Sierra Leone ranks 181 out of 188 countries of the Human Development Index. The country fights one of the world's highest maternal and child mortality rates and a shortage of qualified medical professionals in an overall weak health sector. From 1991 to 2002, today’s Presidential Republic was devastated by civil war. Due to the Ebola epidemic in 2014 the already tense situation in the health sector has further worsened especially for pregnant women, breastfeeding mothers and children under five. Many health workers, among them many midwives, lost their lives while caring for the sick during the Ebola epidemic. This led to an increased demand for counteraction in order to avoid a lack of well-trained medical professionals, particularly midwives.
CRITICAL SHORTAGE OF MIDWIVES IN RURAL COMMUNITIES

With only 311 practicing midwives and 222,000 deliveries per year, Sierra Leone suffers from a critical shortage of midwives. Furthermore, 65 percent of the midwives work in major cities. This leads to a shortage of maternity care in the rural communities. Additionally, more than 80 percent of the midwives are between 40 and 60 years old, therefore the chronic undersupply tends to become even worse in the future. According to the Human Resources Division of the Ministry of Health and Sanitation, only 24% of births occurred in the presence of a skilled birth attendant. An additional 3,000 midwives are needed to ensure adequate care during pregnancy and birth.

Action medeor, the German Medical Aid Organization, has many years of experience providing high quality medicines and medical supplies with various partners in Sierra Leone. Since 2014, action medeor has continued to support Ebola Emergency Relief projects in collaboration with local partner organizations in Sierra Leone, especially in the district capital Bo, in the South and its surroundings.

Before setting up the midwifery school in Bo, Sierra Leone had two midwifery schools. One school was located in the Western area in the capital Freetown and one in the Northern district in the city of Makeni. Both schools had an average of 100 midwives graduating annually. These two institutions lack sufficient capacities to cover the minimum requirement of training around 3,000 midwives. Due to their locations midwives are currently trained primarily in the western and northern part of the country. According to the “Post Ebola Recovery Plan” of the Government two more midwifery schools are needed to fill the gap of health workers, one in the Eastern and one in the Southern province. In Bo district 8 midwives are currently working in the 121 primary health stations which serve a population of around 570,000 people.

THE MIDWIFERY SCHOOL IN BO

In October 2017, with the financing of the German Federal Ministry for Economic Cooperation and Development (BMZ), the School of Midwifery Bo (SOMBO) has been inaugurated. The school is currently educating 50 students to become midwives during a two year vocational training. The students (48 female and 2 male) are state enrolled community nurses, who are trained in teaching modules at the new school and practical lessons in hospitals and health centers.

With the new school, the gap of health workers for the southern region could be closed. Through the School of Midwifery Bo every year 50 newly graduated midwives will be available for the labor market. These midwives will particularly work in the underserved rural areas in the south of the country and thus reduce the risks related to pregnancy and childbirth. The school contributes significantly to improving the health of pregnant women, mothers and newborns and contributes to an overall strengthening of the health sector.

Author: Christina Padilla, project manager

Photo: State enrolled community nurses on their way to become a midwife

THE STRAIN OF THE GROWERS
SENKELELA SISIBERE

Life is not easy for widows in Africa where a very traditional society puts too strong a pressure on them. Sometimes, a woman that becomes a widow soon becomes the wife of her brother-in-law, if there is one. But most of the times, when their husbands pass away, women lose all their rights, properties and source of income. “Senekela Sisibere” which means “The strain of the growers” in Bambara, a language spoken by 80% of the population of Mali as a first or second language, is a development project in the field of international health cooperation focused on widows.

Medicus Mundi’s mission is promoting Universal Health Coverage in the sense of universal, equitable and affordable access to quality health services for all people; as this is essential to the improvement of health, fighting diseases and reducing poverty.

Economic independence for women is an imperative to achieve true equality, and to improve their and their families’ socio-economic condition. That’s why Senekela Sisibere is supporting women from diverse communities to create cooperatives in various fields (farming, sewing and so on) to enable them to increase their chances of securing an income in the future. The project aims to improve their skills in retail and leadership; but it gives them much more than just work experience.
Close to the Niger River, in Koulikoro, there is now a group of fourteen widows between 65 and 85 years of age that are being supported in the management of their vegetable gardens and are also being trained in bookkeeping, administration and farming. All throughout 2017 their quality of life and their physical and nutritional condition were improved quite considerably thanks to the purchase of new seeds and farming tools. They were trained in civic participation, leadership, and networking; in addition, they received the advice of a group of agronomists that helped to increase productivity by means of a change in the gardens design.

Significant achievements were made, such as farm diversification; garden redesigning and adaptation to efficacy and efficiency standards; increased productivity of the gardens, with lettuce, green beans, celery, African aubergine, peppers and onions planted. For the first time in their lives, the widows have obtained a volume of production enough for self-supply, but there is also a surplus that allows them to contribute to the cooperative, sell the garden products and keep some cash for themselves.

In 2017, Medicus Mundi was awarded the Luis Noé Fernández Prize. The award honours “the extraordinary work of the organisation in Koulikoro, Mali, empowering local communities, particularly the most vulnerable ones, to defeat poverty and hunger”. Senekela Sisibere has had a great social and economical impact by generating real changes in the cultural values of the area, and has contributed to expand the initiative to nearby villages.

Hardly realising it, this group of widows has become an example to follow for other women across the region, proving that it is never too late to start a life project and, thanks to their effort and sacrifice, change the destiny that seemed written for them.

More information (in Spanish):
https://www.youtube.com/watch?v=6akBwzgsmDA
DOCTORS WITH AFRICA CUAMM

GETTING OUT AMONG THE PEOPLE.
AWARENESS-RAISING AND FIGHTING HIV IN TANZANIA

Francesca takes her place at the center of a small basketball court, where about twenty colleagues await her from the Ngokolo health center, where she has been working since the start of the year. She recognizes Director Katambi, with his impressive stature and good-natured eyes, the nurses who follow her on her rounds every day, the administrators, the pharmacy employees, and the Muslim workers who give patients support and comfort. None of them is wearing the work uniform today. Today’s outfit is dark pants or skirts and a colourful t-shirt with the logo of “Test and Treat”, the Doctors with Africa CUAMM’s project against HIV in Tanzania. It’s a special occasion: the Shinyanga city government organized a musical event for the public, and as, fortunately, happens more and more, they chose to invite CUAMM workers so they can give HIV tests to the many young people in attendance.

For the entire ten days of the event, a CUAMM gazebo is set up on the side of the basketball court and trained CUAMM workers invite people to get tested and give them information about how to avoid contracting and spreading the virus.

But Francesca and her colleagues are here today for another reason. They have decided to form a choir and take part in the event, leaving the health center for a few hours to get out among the people. Being in direct contact with people also helps counteract the distrust that often keeps people far from health facilities.

Before their performance, a group put on a breakdance show; this is the most popular kind of dance among youth and the many people lining the court are thrilled. Young people and adults are standing, sitting on the ground or and leaning against bikes. They are having fun, watching curiously, chatting, and, most importantly, they are glad to get tested.

Arianna Bortolani, in a double role today as the project manager for Test and Treat and as contralto in the chorus, says “Raising awareness among young people is key. Young people start having sexual relations very early, and because they are healthy, they are less likely to go to health facilities, to get tested and to learn the basic rules. This puts them at risk of catching and spreading the virus; they are our main focus.”

By the end of the event, CUAMM tested 258 people, 20% of whom were adolescents. Only six people tested positive, three men and three women. And none were adolescents.

There is still a long way to go. In 2017 CUAMM has launched a dedicated 5 years project in the regions of Shinyanga (HIV prevalence 5.9%) and Simiyu (HIV prevalence 3.9%) to provide free care and treatment for HIV, introducing the Test&Treat approach, as suggested by WHO guidelines. The previous approach to the disease did not suggest immediate treatment for HIV-infected patients. Indeed, only those whose CD4 blood count was below 350 cells/mm3 received antiretroviral therapy. Due to geographical distances, the possible worsening of the disease and social stigma, there was major risk
for the patient to get “lost”, and an even greater one to transmit the disease to others. The new Test 
and Treat approach recommends free HIV test and treatment to all those resulted positive. The project 
aims to test 300,000 people in five years and it involves hospitals, health centers and local 
communities in a continuum of care. It aims to decentralize HIV services from hospitals to primary care 
facilities and to shift tasks from doctors to nurses and community health workers. Indeed, moving 
from health facilities to a community-based model, should make it easier to reach and manage 
patients that live in peripheral and more isolated areas. In order to reach as many people as possible, 
project activities include testing campaigns in health centers; testing campaigns in villages, schools, 
working places, worship places and local events; and sensitisation campaigns through radio, TV and 
SMS to raise awareness on the topic, reduce stigma, advertise testing and provide useful information. 
The tight-knit, dynamic staff includes local and international workers always ready to organize and 
take part in local events, committed to reaching a goal that, though still far, is possible.

More information (in Italian language): https://www.mediciconlafrica.org/blog/la-nostra-
voce/news/test-treat-lancio-del-progetto-per-le-regioni-di-shinyanga-e-simiyu/
COMMUNITY WORKING GROUP ON HEALTH

RECURRENT TYPHOID AND CHOLERA OUTBREAKS IN ZIMBABWE

Zimbabwe continues to experience frequent outbreaks of cholera and typhoid – archaic diseases that were completely eliminated in other parts of the world – resulting in thousands of avoidable deaths and unnecessary human suffering. Since the cholera outbreak of 2008/9 that killed over 4,500 people and affected over 100,000 people, the frequency at which the outbreaks of both cholera and typhoid occur in Zimbabwe has alarmingly increased. It is ironic that the majority of the deaths were recorded in Harare, the country’s capital city, and a municipality vying for World Class City status by 2025.

The country’s major cities, particularly Harare and Chegutu, continue to experience intermittent water supplies, blockages to the sewerage systems, development of squatter settlements and irregular rubbish collection service, all key drivers of the outbreak of typhoid and cholera.

It should be noted that some suburbs of Harare have gone for over a decade without running water forcing residents to resort to drinking water from contaminated boreholes, swallow wells and sewage-clogged streams. The sewer pipes, which were laid during the colonial era, are old and always leakages resulting in the sewerage mixing with treated drinking water. Even the Mayor of Harare has openly admitted that the city’s water was not safe for drinking because of a critical shortage of chemicals to treat the water to make it safe for human consumption. It is therefore true, residents of Harare are exposed to serious health hazards as they are drinking contaminated water. This is despite that the provision of clean water is a basic need and a human right. The government should therefore be guided by the Constitution which rightly states that access to potable water is a fundamental human right as stated under the Declaration of Rights, Chapter 4, Section 77.

It is worrying and disheartening that the country’s political leadership continue to promote illegal settlements mostly in peri-urban areas across the country for political expediency instead of actually addressing the drivers of cholera and typhoid. This lack of political will has been worsened by endemic corruption mostly in local authorities which in most cases go unpunished. Money collected from residents for water and refuse rates is never used for the intended purposes but to sustain the fabulous live styles of certain individuals.

The current concentrated and rapid urbanization in Harare and other cities has overstretched the available limited resources and services. It would be prudent if the government could prioritize the provision of formal housing, water and sanitation services to avoid future outbreaks. This also calls for increased transparency and accountability in the use of available resources.

It is true that the current health crisis does not emanate from the health sector alone but from wider economic decline and the increasing extent to which people are not accessing basic public services like clean running water, housing, clean air and a clean environment – which are major determinants of health. It is in that in mind that it would be more logical for the government to rally all other departments, related ministries and other stakeholders to join hands in the fight against future outbreaks of these waterborne diseases.
The government needs to develop a sustainable health strategy backed by a sufficient budget and implement that strategy religiously. It has to regularly collect garbage, building proper toilets and quick fixation of burst sewerage pipes to avoid spillages into water bodies that supply drinking water to residents. In fact, all the mentioned problems will be properly managed if the government show political will to address the key drivers of cholera and typhoid in the country.

It is surprising that the Harare City Council has been toying with the idea of introducing a typhoid vaccine in a bid to prevent future infections without adequately addressing the key drivers of the disease. It has been noted that the recurrent outbreaks of typhoid in Harare are being caused by erratic supply of clean water, supply of contaminated drinking water, burst sewer pipes and poor hygiene.
CWGH believes that the typhoid vaccination should only complement service provision and should not be taken as the main intervention strategy in the fight against the outbreak. It does not make sense to treat people for preventable diseases and send them back to the conditions that made them ill in the first place. It also should be noted that vaccines do not come cheap; raising serious questions about the sustainability of that approach as the major weapon to fight the disease given the current limited national resources Zimbabwe has.

For years now, Zimbabwe has been failing to adequately provide for the health sector. It has never met the 15% Abuja target despite acceding to the Declaration over a decade ago. With limited resources, the country will have to rely on the support from development partners such as the Global Vaccine Alliance (GAVI) for the vaccine, which is not sustainable given that donor assistance is never permanent.

The continued disparities between urban and rural areas regarding knowledge of key tenets of primary health care (PHC) which are much less available in urban areas remains a major cause of concern. CWGH is concerned that the promotion of hygiene practices (prevention services) has continued to receive inadequate attention, especially in urban areas, despite its potential to prevent the outbreak of water borne diseases and saving lives. It is also worrying that prevention services in the country are still underfunded with the health sector in general always receiving a paltry allocation from Treasury.

These outbreaks have obviously not spared the economy. No sane investor or tourist would want to visit the country under the current situation and yet Zimbabwe pins its hopes for economic turnaround on foreign direct investment and tourism inflows.

On our part as CWGH, we have played a key role in health literacy, thus sensitising communities about cholera and typhoid, particularly in the Hatcliffe suburb of Harare, which was one of the several areas affected by typhoid last year. The organisation also installed in-line chlorinators on several boreholes to ensure that communities drink clean and treated water.

On a national level, Zimbabwe needs to urgently put in place long-term and sustainable mechanisms that address the key drivers of typhoid and cholera that include regular collection of garbage, provision of clean water, housing and other related services to prevent further deaths and suffering from these medieval diseases. It also calls for urgent finalization of the Public Health Act (PHA) Amendment Bill and strengthening its enforcement mechanisms in order to protect the public from poor service provision. This calls upon the government to strengthen surveillance system to prevent these diseases.

Authors: Itai Rusike, Caiphas Chimhete and Tanyaradzwa Munouya

Photo: CWGH Clean-up campaign in Harare during the Typhoid outbreak in 2017

The Community Working Group on Health (CWGH) is a network of civic and community-based organizations that aim to collectively enhance community participation in Zimbabwe, including improving social determinants of health and alleviating poverty.
MIGRATION OF HEALTHCARE PROFESSIONALS: 
AN OPPORTUNITY FOR SHARED DEVELOPMENT

This report sets out the lessons learned from the European action Migration of Healthcare Professionals: An Opportunity for Shared Development (MPDC), carried out between 2013 and 2016 by the Andalusian School of Public Health (EASP) in partnership with the Pan-American Health Organisation (PAHO/WHO) and the Uruguayan Ministry of Public Health (Technical Secretariat of the Ibero-American Ministerial Network for Migration of Healthcare Professionals [RIMPS]). The action was covered by a funding contract between the European Commission and the EASP.

In a context of heightened awareness of the phenomenon of migration by healthcare professionals, coinciding with the development of the WHO’s Code of Practice on the International Recruitment of Health Personnel, the MPDC action was intended to contribute towards the effective management of migratory flows of doctors and nurses in the Ibero-American and EU space, by analysing the practical implementation of experiences of migration-flow management based on bilateral agreements, increasing the capacity of countries in the region to be fully aware of the migration process and its effects, improving processes for planning human resources, obtaining knowledge of the impact of the migration process on health services, and further strengthening the ministerial capacities and networking already begun in Ibero-American countries.

Work was done in the following areas:

- Analysis of the design, practical implementation, systematisation and socialisation of experiences of managing migration flows that foster mutual benefit and the drawing-up of best practices to foster their application in the Americas and other WHO regions that could put them to positive use.
- Improving information and exchange systems between countries to monitor the efforts made and the migration phenomenon in the health sector.
- Training in planning human resources with a view to achieving self-sufficiency, taking into account the migration phenomenon.
- Analysis of the impact of migration by healthcare professionals on health services at different levels in provider countries and the associated economic impact.
- Strengthening the RIMPS and supporting the implementation of its action plan for responsible management of migration.

Here are some of the most relevant conclusions and lessons learned after reflecting on the running of this initiative, which may be of interest for similar projects:

**Political liaison** between the countries involved is essential in order to build shared agendas to tackle the phenomenon of migration as a whole, in terms of managing information on migration flows and strategies to ensure sufficient supply while maintaining the workforce and professional development. This liaison can and should be managed and studied in order to obtain lessons learned, as has been done with this action.
Ministerial networks, like the RIMPS, are an excellent instrument for fostering this liaison and implementing a consensus in the relevant countries on the resulting strategies, proving to be an effective instrument for turning global policies into action at a national level. However, this “political/technical” space in turn needs support and maintenance strategies that are difficult for a single technical secretariat to handle alone, no matter how effective it may be. Constant changes at ministries mean that political commitments constantly have to be renewed in existing cases of dialogue — ministerial sector meetings, subregional-integration spaces — and in this sense the role of the PAHO/WHO and other support institutions is crucial.

The RIMPS allows intervention strategies to be devised that are based on multilateral dialogue, which is essential when addressing the issues arising out of the phenomenon of migration by health professionals, making it possible for stakeholder countries to exchange information and for work and group initiatives to be developed at regional and international forums. It also enables funding to be obtained, thanks to its own nature (as a network in the framework of the Ibero-American Secretariat General) and because of the match between its goals and strategies and targets for international development aid. A political and technical space has been consolidated in consonance with the WHO’s global code to strengthen international dialogue, in this case in such a large geographical space as the Ibero-American regions.
Professional networks have proven to be powerful instrument for fostering and developing political dialogue and transferring political undertakings to technical fields and obtaining results. Studying how to strengthen networking among members and making the sharing of information both useful and desirable — especially in such a sensitive topic area as that of migration by professionals — has become a development area to be strengthened going forward.

The flow-management experiences reviewed show that initiatives are already in place in the region, all with advantages and setbacks that can be taken into account when developing new proposals and formalising multilateral agreements for the appropriate management of migration flows. Fostering circular migration and the integration of professionals who return after migrating clearly contributes towards improving countries’ health systems.

Information systems, although they have improved considerably, are still lacking when it comes to characterising the migration phenomenon. The mandate granted by the conference of Ibero-American Health Ministers to the RIMPS Technical Secretariat, which this action has fostered through the RIMAIS, to work on an effective communication system for characterising the phenomenon, has mobilised the will and resources needed to develop an IT application with a module for characterising migration and a standardised register of professionals to work with. Again, the RIMPS has proven to be a key instrument for developing initiatives of this kind.

We still find that the migration phenomenon calls for multisection cooperation and coordination (migration, health, employment, national statistics, etc.), both in countries of origin and in destination countries, to assure rights in the migration process and equal treatment in destination countries. This partnership is particularly relevant if we wish to explore the economy of migration in greater depth, and we believe this could benefit from the methodological development that our proposal offers.

Analysis of the impact of migration by healthcare professionals should be extended to include a vision of the effects involved for migrating professionals or those for HR-management systems on the loss of resources (paying attention to this question when there is an increase), but that is not all; it should be extended to incorporate the visions of the teams that these professionals join, those of outgoing and incoming professionals, while also exploring social perceptions of the phenomenon to counter inaccurate ideas and intervene to address foreseeable issues that could affect these people’s basic rights.

The initiative to improve planning processes for healthcare professionals that has been undertaken by the MPDC action is positively valued, and the training process that has now been revised and built into the PAHO and EASP virtual campuses will continue. The pilot scheme adapting this course into Portuguese calls for certain adjustments to be made in order for it to be subsequently replicated. These adjustments are still under study at the time of drafting this report, in partnership with the WHO’s Africa office.

As mentioned, it has become clear that the phenomenon of migration by professionals continues to be yet another of the many complex factors behind the lack of human resources in healthcare in the countries. Working on the topic of migration therefore means coming up with solutions, ideas and proposals to address the work being done in other related sectors.

It is still of paramount importance to keep working on the creation of information and registration systems, on improving processes and implementing HR-planning strategies, and on improving
professional and employment conditions for people working in the health sector in countries of origin, all with a view to building effective, efficient and equal-opportunities health systems.

**Coordinated work by three institutions that have such different characteristics**, such as those involved in this action — a Latin American sector ministry (Uruguayan Ministry of Public Health), a technical-support body within the United Nations system (PAHO/WHO) and an institution specialising in public-health knowledge management in Europe (EASP) — poses a challenge that can only be overcome by **integrating into the action matching or complementary objectives** of the three institutions, such that the action represents an opportunity to work in synergy-based partnership, avoiding duplicating efforts and creating significant economies of scale.

Creating **synergies between the objectives of the action and those of the institutions involved**, strengthening existing areas, by avoiding duplication and wasted effort, benefiting from team work and task-sharing, makes it viable to develop an action on this scale, which would not be feasible for one institution alone. This partnership and integration of activities into common strategies enriches the process, providing complementary experiences and approaches, different perspectives in analysis and generates a better understanding of the needs (different and joint ones) that the countries must address in their distinct roles as senders and receivers of migration of subject to both.

Likewise, these factors have enables us to determine the **specific areas to continue to work on going forward** in this area, which are:

- Political dialogue, as the basis for reaching agreements on a global scale.
- Strategies to retain professionals or build their loyalty.
- Bi- and multilateral agreements on migration by healthcare personnel.
- Information/registration systems for professionals.
- Continuing to support the WHO’s Global Code of practice on the International Recruitment of Health Personnel, which, despite its limitations, is still a good instrument for dialogue and commitment.

The best practices developed by the Steering Committee include the creation of a manual of standards and procedures for managing the action, **clarification of the regulatory framework, transparency in management, participation in decision-making for the design of operational plans, and regular accountability between the partners**. Also of interest is the creation of a technical secretariat with the capacity to monitor processes not only administratively, building in technical components that have enabled methodologies to be standardised and protocols to be defined for the development of the work contracted, as well as permanent contact and monitoring with the research groups or consultants handling the specific tasks undertaken in the framework of this action. The protocols and methodological proposals used can be accessed from the MPDC website and are fully replicable by any other expert groups interested.

The project’s website has shown its usefulness both as a vehicle for communication between the people who are directly involved and as a depository for documents on all the administrative processes developed over the course of the project, as well as for disseminating the products and results of the action and making them available for any interested persons or institution, requiring it to be updated constantly.
Consolidation of the RIMPS as an Ibero-American network under the auspices of the Ibero-American Secretariat General strengthens and sets out the political will that exists in the region to continue working on this topic and facilitates its incorporation into the strategies international-aid strategies and subregional-integration spaces that are under way in Latin America, strengthening the design and development of intervention strategies based on multilateral dialogue.

We trust that the lessons drawn from these experiences will be found to be use by any group interested in the topic of professional migration, specifically in the healthcare area, in seeking mechanisms and experiences for the effective management of professional flows, which, while respecting the rights of those who decide to migrate, will enable processes to be built that not only do not widen the gap in the capacity of health systems to address their populations’ basic needs but actually contribute towards a new vision of fairer and more equal healthcare worldwide.

Author: Juan Ignacio Martínez Millán, Director of Action MPDC and Lecturer of International Health at the EASP

For further information on this action and access to all the products generated as part of it, please visit www.mpdc.es.
Here is the reality: The lack of trained pharmaceutical personnel in the church health sector has been an ongoing problem. Many Church Health Facilities (CHFs) in sub-Saharan Africa struggle to attract and retain trained pharmacists, pharmaceutical technicians or assistants. Healthcare in least developed countries relies heavily on medicine-based interventions and therefore it is critical that those responsible for their management have a basic understanding on how to handle them in a manner that optimizes their benefit to patient care.

What typically happens is one of two things: (1) overwhelmed trained professionals train the available low-level staff to take over some of their duties; (2) pharmaceutical duties are run by someone who isn’t formally trained but has had on-the-job-training. Why does this happen, you may ask? Well, many Church Health Facilities are located in remote rural and/or peri-urban areas. These rural towns and villages are underdeveloped and underserviced; therefore, turnover of qualified staff is high. Another reason is that the salaries offered by CHFs can barely compete with salaries from the private and public sectors. Further, many CHFs are not allocated a resource budget line within national budgets and as a result, they are underfinanced and heavily dependent on funding and donations.

Here is the effect if we do nothing: Irrational use of medicines is the blanket threat which deconstructs to a host of issues some of which include i.e. violation of standard pharmaceutical practices; poor commodity management e.g. stock outs; incorrect medication dispensing and prescribing practices, all which typically leads to a plethora of adverse effects to the general public such as addiction, increasing the threat of AMR and even death due to miss-prescribed medication.

Here is the logic: The unqualified pharmaceutical staff working at the CHF pharmacies are truly “diamonds in the rough”. Though untrained, they have already bought into the duties of healthcare service and are familiar with the health facility, the locale, and its community members. The choice to leave employment and forfeit a steady salary, in order to pursue formal education, has adverse effects on their and their families’ livelihood. Besides, formal education in pharmacy is beyond their financial reach. It simply isn’t an option. What is a logical option is to reward their commitment and support their training. Therefore, the overall goal of this project is to fill the pharmaceutical human resource capacity gaps in Sub-Saharan Africa as a means to increase professionalism and good governance in the church health systems.

Here is the plan: The Ecumenical Scholarship Program (in pharmaceuticals), run by the Ecumenical Pharmaceutical Network (EPN), is a scholarship program to formally train pharmaceutical staff within CHFs. The ESP initiative is funded by Bread for the World and is deployed through the EPN members, mainly from sub-Saharan countries. Church Health Associations across 37 member countries identify and nominate pharmaceutical staff without formal training to enter the ESP initiative. Reputable tertiary institutions and universities are recognized and these candidates are placed in pharmaceutical diploma programs in their countries of residence. This is a very relevant move towards improving the pharmaceutical capacity gaps in targeted facilities: as a sustainability and knowledge transfer measure,
candidates commit to returning to their facilities or placed in other facilities with a greater need, for a period equal to the years of sponsored study.

**Here is where we are today:** Between 2011 and 2017 a total of 56 candidates from 9 countries, South Sudan, DRC, Cameroon, Kenya, Uganda, Tanzania, Ghana, Chad, and Zambia, have been supported by the ESP initiative. To date, over 90% of candidates from hospitals in disadvantaged areas were enrolled for training that led to successful completion and awarded a recognized pharmacy qualification. A 2014 external evaluation on the impact of the scholarship program reported that administrators involved confirmed that the newly graduated staff had improved skills, knowledge and confidence and embarked on increasing the capacity of their colleagues. Additionally, the 2014/17 scholarship announcement received 80 applications from 9 countries; an indication of continued need.

**Here is one example,** the Chitokoloki Mission Hospital in Zambia under the Church Health Association of Zambia (CHAZ). The Mission Hospital is a 200-bed hospital that serves a patient population of 150,000 in the Northwest Province of Zambia. The hospital is located on the Zambezi River. The hospital facility includes four large wards and three smaller wards including a 25-bed pediatrics ward and a 25-bed OBG ward. There is also a seven-bed ICU, an ER, pharmacy, kitchen, and a laundry area. Another block of buildings houses three operating theatres, an X-ray department, and an eye and dental clinic. There is an on-site outpatient clinic that services up to 400 persons each day. A laboratory, an HIV/AIDS clinic, a 110-bed leprosy/TB colony with its own staff completes the campus. The hospital is usually filled to capacity with extra mattresses on the floor. Current hospital staff includes both nationals and expatriates.


<table>
<thead>
<tr>
<th>Cadre</th>
<th>No. in place</th>
<th>No of positions available</th>
<th>Percentage filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors / Clinical Officers</td>
<td>7</td>
<td>10</td>
<td>70%</td>
</tr>
<tr>
<td>Nurses</td>
<td>23</td>
<td>40</td>
<td>51%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pharmtech</td>
<td>3</td>
<td>2</td>
<td>110%</td>
</tr>
</tbody>
</table>

*data as of December 2017

Emmanuel is a recipient of the ESP initiative and currently placed at Chitokoloki Mission Hospital. On a weekly basis, Emmanuel is involved in dispensing medicines; in the pharmacy and in the hospital wards; managing ARVs; labeling and repacking medicines, and at the end of each month, he generates consolidated reports and submits them to the Central Medical Stores.

“The EPN scholarship support and training at college made a positive change in my life”, he said, “with all that I learned and the support from facility staff, I have been able to fit in well and apply my knowledge and skill extensively. In the 9 months at this hospital, I have managed to improve the medical stores, inventory management (updated Stock Control Cards) and ensured documentation of all transactions following a ‘first expiry, first out’ (FEFO) system, thereby averting wastage.”

**Here is who ultimately wins**: The final beneficiaries of the improved pharmaceutical care are patients. Increased access and availability of quality-assured medicines is always a priority, however, care in dispensing and prescribing is just as important – if not more so. The ESP initiative remains an active program and we envision it spreading to other Network members. However, it is a vital stepping stone to making everyone a winner: patients, pharmacists, and Church Health Facilities.

Author: Kareen Shawa-Durand. Communications Officer, EPN

More information: www.epnetwork.org
The Alternatives – Policies Towards a Life in Full

“Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people’s talents and abilities to enrich each other; a world in which people’s voices guide the decisions that shape our lives.”

(People’s Charter for Health)

The world has more than enough resources to realise the vision of the People’s Charter for Health. Yet for the last 40 years, international financial institutions and many governments have largely pursued an approach that has often undermined people’s health and well-being. This approach – based on an ideology commonly known as neoliberalism, but perhaps better described as “market fundamentalism” – promotes the notion that the best way to organise society is through an economic model that combines privatisation, fiscal austerity, deregulation, reductions in government spending and a reduced role of the state. Its results have often driven us headlong into poor health, poverty, insecurity, and vast inequality.

Market fundamentalism is so firmly embedded in many cultures that alternative voices often do not even feature in debates about tackling poverty and inequality. But there is hope. In many places around the world there is evidence of a different track, where people are pursuing alternative policies that improve people’s health, strengthen public health systems, reduce inequality and improve people’s lives. Health Poverty Action’s new report, The Alternatives - policies towards a Life in Full, takes an in-depth look at some of these alternative approaches from a range of countries which have – to varying extents - successfully promoted inclusive development or indeed, alternatives to Western ideas of development itself. For example:

**Ecuador** has recently seen gains in welfare and reductions in poverty and inequality, and achieved the world’s most “inclusive” growth. The Correa government of 2007 – 2017 explicitly rejected market fundamentalism and enshrined the right to a good life in the Constitution. Other policies that contributed to this include large increases in direct taxes (mainly corporation taxes), bringing the central bank under political control; a variety of tariffs on imports, renegotiating oil contracts with multinationals to raise state profits from oil revenues; investments in renewable energy, education, health and poverty reduction and a refusal to pay illegitimate debt.

**Mauritius** has increased, on average, its people’s income more than threefold from the early 1970s to the late 1990s and is the only country in Sub-Saharan Africa where average household expenditures increased significantly between 1990 and 2008. It has eliminated malaria and achieved (alongside the Seychelles) the lowest under-five child mortality rate in Sub-Saharan Africa. The government of Mauritius has pursued strong intervention in the economy, including high levels of trade protection and promotion of domestic business, combined with business-friendly policies and sequenced, gradual liberalisation.
the Alternatives

Approaches towards a Life in Full
In just over half a century, **South Korea** has journeyed from chronic poverty to aid donor. It has achieved an astronomical rise in gross national income per capita while its citizens enjoy a life expectancy of 82 and low maternal, child and infant mortality rates. Key to these achievements has been strong government intervention in the economy, with key policies being: gradual and carefully sequenced opening of markets; nurturing of domestic firms (especially to promote exports); restrictions on foreign investment; government ownership of banks; and the state’s promotion of technology and research and development.

Our research also examined two countries that are often cited as success stories of the market fundamentalism approach: Botswana and Chile. We found that – in sharp contrast to the “received wisdom” about their experience – the progress that they have made in addressing poverty and improving health cannot in fact be attributed to their pursuit of market fundamentalism.

It is important to recognise that none of the countries that have rejected market fundamentalism have been successful on all fronts, and there remain deep problems in some. In Ecuador, government policies have often oppressed or ignored indigenous peoples, failed to tackle labour abuses and continued some market fundamentalist policies, for example by promoting private health care. Mauritius has achieved success while offering itself as a tax haven to global investors. And whilst South Korea has achieved massive reductions in poverty, its people report low levels of wellbeing - although this has been attributed to a recent shift to more market fundamentalist approaches.

But the underlying message is clear: there are alternatives to market fundamentalism which can provide inspiration for those of us concerned with improving people’s health and well-being.

**Recommendations to reach a Life in Full**

On the basis of our research into what has worked to improve people’s health, Health Poverty Action has formulated the following recommendations to reach a Life in Full:

- The World Bank must stop undermining health through its ideologically driven promotion of market fundamentalism and stop promoting private care through public private partnerships.
- Donor governments must end aid that promotes market fundamentalism such as opening up markets or supporting private healthcare in their own ideological interests.
- All governments should explore alternative measures of health and wellbeing, rejecting GDP as the main indicator of progress.
- Governments and NGOs should give greater recognition to, and learn from alternative approaches such as indigenous concepts of health and wellbeing.

NGOs must:

- Ensure that aid projects are not simply part of broader market fundamentalist approaches on the part of donors.
- In all public communications about our work providing services, articulate the political and economic climate driving the need for it.
- Refuse to take part in projects or events which deny space to alternative voices.

I was able to attend my first WHO high level gathering, and participate in the 142nd Session of the WHO Executive Board, in January 2018. Prior to the meeting, I anxiously went through relevant literature, discussed with mentors at ITM about the nature of EB meetings, and thoroughly read some of the WHO background documents for the meeting. I was both excited and nervous about attending a meeting of such calibre at the WHO headquarters, but I knew that the preparatory civil society meetings would be engaging and enlightening too.

At the civil society meeting organized by the Geneva Global Health Hub (G2H2), sessions on the WHO General Programme of Work (GPW) and on the WHO’s Framework of engagement with non-state actors (FENSA) were the focus of attention. The biggest challenge to implementing the inspiring and highly ambitious GPW seemed to be financial, followed closely by the challenges related to engaging with multiple diverse stakeholders including the private sector, at both the global and national levels. Luckily, I had read preparatory documents such as “The WHO we want”, and this provided me with good insights into the struggle at the global health stage. I went to these meetings to listen and participate in discussions that were particularly related to NCDs in the context of global health; I have worked within this domain for the past five years in my home country, India, and I am passionate about it. In this context, the discussion around non-state actors and conflicts of interest at the G2H2 preparatory meeting provided me with food for thought.

The civil society meeting was participatory, with ample space for members of the audience to voice their concerns/opinions, and contribute to panel discussions in a number of open sessions. The fourth session of day one at the civil society meeting was by far the most interesting session for me. There was a heated discussion on how the FENSA could safeguard the WHO from conflicts of interest, when at the same time, formal NSA (Non-State Actor) roles are being assigned to private entities. The session opened with a briefing on FENSA’s priorities and challenges in implementation, and it was startling to discover that conflicts of interest not only affect local governments and action, but have deep roots at higher levels such as in the functioning of the WHO itself. Many discussions were focused on organisations which fund the WHO, and which themselves have conflict of interest issues. Unsurprisingly, among the WHO allied organisations, those with the most conflict of interest issues were in the NCD domain; little wonder this is one of the most underfunded items in the GPW. The WHO representative who was present tried to convince the audience by saying that the WHO is all about member states; however, some member states have bigger interests in private profit-making agencies, and it is hard for them to always zero down on conflict of interest. This line of defence was however not very successful! This led the other panellists and audience to the question of the “WHO
we want”: Is not the World Health Organization, because of its constitution, an autonomous, strong and credible global health keeper? Isn’t it supposed to follow the human-rights based approach, set priorities and be normative, while setting standards that should be seen as mandates, rather than voluntary targets; implement key decisions and priorities as binding legislation in member states, for the improvement of global health?

The evening culminated with the screening of a shocking (well, shocking to some young researchers at least!) video titled “WHO in the Hand of Lobbyists”. I could relate this to the extent of conflict of interest in the health sector in my own country, India, where the largest public sector insurance firm also has investments in the biggest private tobacco manufacturing company.

All my preparation and the civil society meetings set me up nicely for the much bigger meeting, the 142nd Session of the WHO Executive Board at the WHO headquarters! I thought I would see lots of discussion on FENSA, NCDs and of course how to slow down climate change, in the proposed GPW, during the EB week. However, once I stepped into the first morning session of the EB meeting, I realised that these were just pipedreams.
This is perhaps the usual format for WHO meetings, but to a newcomer like me, it felt like such a bureaucratic way of proceeding. Much of the morning session was spent on voting on different agenda items, with representatives of member states nodding to signal a “yes” or “no”. There was an extensive session on the GPW and feedback on it was given by all the member states. The meeting had a one-way communication flow, and was very different from the earlier civil society meetings which I had attended.

Finally, on day two I got to see the feedback on the GPW from a range of “non-state actors”. I think it is more relevant to discuss how the WHO has framed its definition of “non-state actors” rather than to describe the feedback, where the chairperson gave the same, very quiet response of “Thanks for your suggestion, we will look into it” to almost all statements by so-called “non-state actors”.

With regards to the WHO’s definition of non-state actors, it was disturbing for me to see that there was absolutely no differentiation between the very different kinds of organisations. As the global health watchkeeper and a UN specialised agency, the WHO should have different criteria and approaches to all these diverse entities. For example, private for profit organisations and civil society non-for profit organisations whose aims and even understanding of “public health” as a concept are completely different, were lumped together in the “non-state actors” category and given the same slot to speak in the big executive hall. How can one expect private organisations primarily funded by profitmaking private conglomerates (I’m sure you can name a few examples yourself) to be conflict of interest free in their advancement of the global public health agenda?

At the end of the event, I was able to write about some of my experiences at my first ever EB meeting on the IHP blog - A “make or break year” for WHO, and while I hope to see the implementation of the ambitious GPW, in reality, I can’t help but think back to the jibe from the Turkish delegate in the EB meeting, “moving the caravan on the road”. With the current level of engagement with “non-state actors”, the side-tracking of civil society voices at the highest level, as well as the many instances of countries turning their backs on civil society, I am quite sceptical of a positive environment in global health, and concerned about the global health governance at WHO. Nevertheless, there are positive signals as well, and the new WHO Director-General Dr Tedros himself seems quite committed to working with civil society.

Since coming back from Geneva, I have gone through various literature on the WHO as a global health governance body, in order to gain more insights as a public health researcher. One that struck a chord with me is the article by Sara Van Belle et al. on the need for the WHO to take up the meta-governor role in global health governance, and how it should become a learning organisation within a matrix of networks, actors and issues. Informally, it is known among my colleagues at ITM as the “Queen B” paper.

**Author: Manoj Kumar Pati**


*Sara van Belle et al., Queen bee in a beehive: WHO as meta-governor in global health governance, http://gh.bmj.com/content/3/1/e000448*
Two months have passed since I arrived in Kenya. I already know that work in Kithatu Health Centre is not boring at all. Every day is different from the previous one. New patients and their cases and stories. That day also brought something new.

Sister Claire of the Missionary Sisters of the Holy Family, who keeps watch over the children in Day Care, asks me if I could visit a woman who is the grandmother of Smart, a three-year-old girl. Apparently that woman has a wound which has not been healing for a long time. I don't even hesitate for a second. After all, I came to Kenya in order to help people. So we take some disinfectant, gauze, bandages and little Smart. We get into the car and set for a trip. This is going to be my first "home visit" in Kenya.

The road in the equatorial bush is bumpy, so the journey takes a while. I have some time to ask Claire about the case. She tells me that Smart has been under the Sisters' protection for a year. During the day she spends time with other thirty children in Day Care, which is an institution similar to a kindergarten. She gets three meals daily, she is dressed and bathed. However she needs to go back home every night, which is unfortunate.

Smart lives in the outskirts of a village with three of her siblings and their grandmother. Her father is a criminal. He used to abuse their mother and left the family. The mother has abandoned the children because of poverty and out of fear of her husband. Sister Claire knows that at least one of her children starved to death. Right now she lives in another village and supposedly she sometimes sends some money to the children. In this way those little ones were left in their grandmother's care.

The word "care" might actually not be very accurate in this situation. The woman is old and sick and she hardly ever leaves home. She doesn't work. The family supports itself of what they can find in the forest and harvest on a tiny plot. Sometimes their neighbours or the Sisters bring them food and other supplies.

Eventually we park our car. The rest of the way we have to go on foot. We get to a little wooden hut placed in the middle of nowhere. In front of it there is a fireplace – the kitchen. Three hens are strolling around. A few pieces of children clothing get dry on strings. There is no one at home. Sister Claire tells me that when she was here for the first time a year ago, this place looked even worse. The chief of the village asked her for help. The children were naked and the youngest one – Smart, was undoubtedly sick and malnourished. The Sisters took care of her right away.

At last some people show up. The children at first, and then their grandmother. The old lady limps. On her left ankle she has a dirty bandage. We say hello to her. The woman doesn't seem to be surprised or embarrassed by our visit, although we haven't announced it. I think to myself that perhaps it's all the same to her. I get to work. Firstly I chase away flies that circle around the woman's leg. Then I take off the filthy bandage, disinfect the wound and put on a new dressing. I am very precise because I don't know how soon there will be a chance to change it. She needs hospital care for sure, which unfortunately is unobtainable for her.
Patients have to pay for any medical procedure in Kenya. If there is not enough money for basic needs, how could she afford treatment? Apart form this, if she left home for a couple of days, the children would stay without any care. It looks like I will have to visit that woman regularly...

I wrote and published this essay in one of Polish newspapers eight months ago. The reason was to help Smart rather than her grandmother. The fact is, that however extreme their story may sound, it is not that special. I spent three months in Kenya, from July to September 2017, working as a medical volunteer in Divine Mercy Kithatu Health Centre. During my stay I managed to witness many families struggling just as much as that of Smart.

So what was our way to help them? In this case we, the Redemptoris Missio Humanitarian Aid Foundation, decided to support and develop Day Care – the Sisters’ initiative that we believe is doing much good for children like Smart. Since June 2017 we were collecting money in order to build Children’s Centre – an institution based on Day Care, big enough to house over one hundred children. With help from private donators, other organisations and Ministry of Foreign Affairs of Poland, we completed the fund-raising. In January 2018 the construction of the new Children’s Centre in Kithatu was finished and it started operating. At this moment there are thirty-seven children in Day Care and another twenty stay in the Centre day and night. They are fed, washed and most importantly safe. We hope that thanks to this help, they will have happy lives.

Author: Miłosz Jakubek
Together with the media platform ViceVersa and other civil society organizations, Wemos started in 2017 a cycle of public venues with the aim to raise awareness on critical global health issues, facilitate African voices, to engage public and discuss health policy strategies worldwide.

The topic of the first venue in November 2017 was held at the Tropical Health Institute (KIT) in Amsterdam on the topic of health workers. It included speakers from the Netherlands, Belgium, Uganda and South Sudan. Also the Dutch Member of Parliament for the Green Party Corinne Ellemeet was present; Ellemeet is her party’s health spokesperson. The venue was moderated by publicist and former diplomat Petra Stienen. At our invitation, Amanda Banda, advocacy coordinator for the African region at Medécins Sans Frontiers, participated in the panel discussion.

In her contribution, she emphasized the need for more better trained and paid health workers. The health workers should also be more evenly distributed, so that also the rural areas – where still most people live in Africa – are covered. “A good health system finds people where they are, it is easily accessible when and how people need it”, she stated in the panel.

Parallel to the venue, ViceVersa is publishing articles on the topic of each venue. In November, ViceVersa interviewed Wemos’ director Mariëlle Bemelmans on health worker shortages in Africa. In the interview, she referred to her own experiences when working in Malawi, where maternal and child mortality remains high, due to lack of jobs for trained nurses and midwives. Governments should allocate more budget to health, and more of that budget should be used for creating jobs for health workers. The cycle will continue in 2018 with three further events on topics such as sexual and reproductive health and rights, and financing for health.

Announcement of the first Global Health Café:
http://hetnieuwe.viceversaonline.nl/events/eerste-global-health-cafe/

Interview with Amanda Banda:

Interview with Mariëlle Bemelmans on ViceVersa (in Dutch):
http://hetnieuwe.viceversaonline.nl/mondiale-gezondheid/nieuwe-wereldtekort-zorgpersoneel/
South Africa is celebrated for its ARV roll out programme – the biggest worldwide – which brought down AIDS related death rates, but without the approximately 70,000 community health workers, most of them women, this would not have been possible. Now they start raising their voice.

Community health workers are the link between individual patients and families in the communities and the formal health system, they are involved in counselling, support in treatment adherence, prevention and caring, even much beyond HIV and AIDS, they are going from house to house five days a week. Yet they are still called volunteers and only get short term contracts with an extremely low “stipend” payment below minimum wage level. A 2016 Mail&Guardian survey found that CHW were the lowest paid of all vulnerable workers in South Africa, “subsidizing the cost of health services through low wage or no wage work”.

In addition CHW often feel undermined by nurses and other clinic staff who don’t acknowledge their work and leave them alone with the overwhelming challenges in poor communities. In a first meeting of 50 CHW from all around the country in 2015, Usche Merk, the medico project coordinator describes: “They were desperate, divided and in despair. They were frustrated about the indignity of their situation but did not know what to do about it.”

Since then, CHW have slowly started networking and sharing their experiences. They were scared to speak out individually for fear of being further victimised. They realized that in order to improve their situation they have to become organised and develop a public voice within provinces and nationally. Through a national network of six progressive South African NGOs, the CHW receive support with logistics, funding, political education and advocacy.

In 2017, the CHW in Gauteng managed to set up a self-organised structure, the Gauteng Community Health Workers Forum, which now represents over 1700 CHW from 105 clinics, a total of 26% of all CHW workers in the Gauteng province. In a very democratic and participatory process they have elected a leadership structure and appointed two full time organisers. They opened up an office, set up a Whatsapp group and a Facebook page, produce regular newsletters and developed a logo. However they are very conscious of not creating a power differential in their structure. “We don’t want to create elites,” says Zoleka Mbotshelwa, the chairperson of the Forum, “everything needs to be reported back to members”.

Through their discussions they have united and defined their campaigning goals: To be integrated into the formal health system as permanent employees with at least a minimum wage.

Their campaign is organised on several levels including challenging the legal status of CHW as volunteers, political education of other CHW and mobilising for protest actions and marches.
A first success was a ruling from the labour court acknowledging their status as employees, not volunteers. But the Department of Health is reluctant to absorb CHW into the formal health system, claiming that it is not “affordable”. The Gauteng CHW Forum realizes that this is a long struggle ahead: “Our solidarity will carry us forward, we need to stay strong, stay together” says Zoleka.

When the process started, stakeholders in the health sector expressed concern that if CHW become organised they will lose their caring focus on their communities and become too self-interested. But in a participatory research project in 2017 the opposite was found – the CHWs concern for the wellbeing of their patients and communities increased. They don’t only want decent working conditions; they want a dignified, quality health service for their communities.

Since 2014, medico international is supporting a network of six progressive South African NGOs (section27, Khanya College, PHM South Africa, Sinani, Wellness Foundation, Sophiatown CPS), which collaborate nationally to assist community health workers with logistics, funding, political education and advocacy so that they can build up own structures and raise their voice for better working conditions in the interest of community health.
It is more than 50 years now since Renato Monolo Hospital has been established in Kiremba, Northern Burundi. Back then, the Diocese of Brescia, Italy, wanted to offer a gift to its fellow citizen, the newly elected Pope Paul VI, and decided to build a new hospital in one of the world’s most underserved regions. Young physicians from Brescia were among the initial staff – and founded Medicus Mundi Italy in support. From then on other organizations gradually flanked the founder, until in 2014 “ATS Kiremba” (a Purpose Temporary Association) was created, including, beside the Diocese of Brescia, the “Ancelle della Carità”, the Poliambulanza Hospital, Museke Foundation, AsCoM Association and Medicus Mundi Italia. An alliance with the main purpose of guiding Kiremba Hospital towards financial autonomy and full self-governance thus empowering it to stand on its own legs, and (eventually!) walk further.

Far back in 1965 Kiremba really was a small village, lost in a swampy marsh, that was inhabited by crocodiles and hippos. Actually, that was the very reason for the choice to build a hospital right there: to bring medical care to the poorest and most derelict people, settling, living and dying in an authority-abandoned, malaria prone region.

In these 50 years, countless missionaries, doctors, nurses, technicians and volunteers of any kind contributed, every single one of them bringing his personal share: sometimes little grains of work to be done in short and others bringing huge experiences and long-term commitments. Altogether made Kiremba what it is now: a 190 beds District Hospital deploying 9 doctors, 80 nurses and some other seven dozens employees including technical support, administrative and auxiliary staff.

They run a gynecology and obstetrics ward that helps mothers give birth to 160 newborns every month; a 42-beds pediatric unit taking care to a mean of 90 children each day plus a surgical/orthopedic unit performing 80 interventions per month (among others, they also treat children affected by hydrocephalus or osteomyelitis). An internal medicine ward and an emergency department complete the picture, along with a clinical analysis laboratory, a radiological service, a physical-therapy facility and last but not least, a nutritional unit.

On the support side, technicians installed an oxygen extraction device that delivers medical quality oxygen to several wards, an intravenous fluid production unit, a sterilization system, and a housekeeping and maintenance facility including carpentry and mechanics. Electricity is assured 24 hours per day to the whole hospital by a small hydropower plant, located a 30 minutes’ walk east through the gorgeous valley,

Every year the whole facility admits more than twenty thousand patients for hospitalization, and several ten thousand more are followed on an outpatient basis.

Well, at this point it looks like the small Kiremba Hospital in five decades has grown up to be a full working, perfectly tuned never-stopping health machine. But…..
Realities like the one we live and work in here, and there are many, where international cooperation is under way for a very long time and so much has been achieved, now face a new challenge: to hand over the whole hospital, including its managerial accountability, to locals and allow for the much demanded autonomy and full self-governance.

This is something that needs to be dealt with in a cultural framework, and often leaves both sides of the partnership unprepared on a little-traveled road.

To manage a hospital and thus to organize and provide healthcare necessarily includes a definition of health itself; that definition is depending and influenced by the cultural context. Every definition of illness and suffering is cultural, and the definition of what it means “to take care of” as opposed “to cure” is. One has to be embedded deeply in the local culture, to understand and define the needs and to understand the best approach. This doesn’t mean that proposing a model is unnecessary, it is rather something that must be done to avoid being merely external donors; both local staff and international partners have to walk together through each one’s expectations, longtime established habits that must be challenged and new ones that need to be created, new perspectives to build along with changing priorities; to guide with respect, to allow to be guided without dodging responsibilities. To let go and to go on! Finding this balance is now the hardest part of the job.
Add to this cultural side the economic momentum: Receiving money for years can lead to think that this is enough to face problems, rather than a correct work method is; for funders, to hand resources and money out along with already made expertise is easier – and, in the short run, more effective – than to teach beneficiaries how to exploit them. And getting money is becoming harder, for international NGOs and even more for stand-alone locals.

And now, Burundi. Let’s consider the place. Recent history of this country is terrible and dramatic, still deeply marking people’s capability of trusting each other and to see reliability as an asset in relationships. To be an international cooperator here means that you must keep doing soul-searching, knowing that never mind how much you struggle to do the best, you always should’ve done better, in a context where mistakes always matter more than successes.

Partnership in the late phase of longstanding cooperations, like Kiremba is, demands a full paradigm shift: what you think right, may be wrong in your partners’ mind, and sometimes you need to silence the voice in your head that yells “Hey, you are right!!” Instead trust and foster the (sometimes long hidden) capabilities to find innovative solutions. You don’t need to deny your principles, but they may be different from those who welcomed you long ago (and may change over time). While trying to build autonomy, you are challenged by your own reluctance to leave the driver’s seat, to let things go even if you don’t agree with the new direction – you don’t have to agree.

You feel reluctant to clear the field, not ready to turn roaring days into memories, for as slowly and progressively it might be, and you observe concerned the partners looking for the balance between the pride of true self-governance and the fear to be abandoned by the organization that has been backing it up for so long; a matter of trust.

Just to give an example, in Kiremba some years ago both sides agreed on the need for an isolation ward to be build. Contagious patients, namely those with active pulmonary tuberculosis, were hospitalized side by side with uninfected patients, hence creating conditions for easy spread of TB.

Looking with European eyes, we proposed to finance the construction of a brand-new ward in the upcoming years. Local managers enthusiastically accepted, we raised money, and project proposals were drawn up. Now that the time to place the bricks has come, diversity of standpoints shows up: local manager always thought (or perhaps gradually shifted to think) that the new building was meant to be mainly used as a private room block! This let to quite some confusion, as obviously the project specifics are very different, and thus the planning process had to be restarted, money and time are wasted.

So what went wrong? It’s our fault? Maybe we are accountable for a lack of sharing thoughts? Was there not enough joined analysis of needs in the early phase? Maybe we are responsible for bad communication management? Or are the local partners to blame? Did they know from scratch that such a specialized and resource-consuming ward, that furthermore falls out of the recent National Guidelines, was not among the top priorities of a low-income-country, poor-oriented, charity-inspired and autonomy-aiming District Hospital? If so, did they never argue because they were afraid of losing aid? Maybe they simply changed their priorities and failed to communicate. What else? It’s easy to walk on different and diverging rails, sometimes.
We listened to each other and ended up with a common solution: refurbish the existing structures and enlarge the medicine ward adding four single-bed isolation-rooms with filters and forced ventilation (and save excess resources for further projects in Kiremba). And so we are reworking once more, together, understanding better and trusting more in self-governance and receiving the confidence it takes to support our friends on their way to long run sustainability.

This is the biggest challenge in autonomy: trust, understand that you have shown the direction now others hit the road to reach the common goal: health for all!

Author: Dott. Alfredo Caprotti, Kiremba, Burundi
HEALTH IN THE CITIES: REIMAGINING HEALTH IN URBAN POPULATIONS

The world is becoming increasingly urban. More than half of the global population lives in cities and this number is only expected to rise. Undoubtedly, there will be many positive consequences: cities are vibrant, connected and relatively well-resourced. But such rapid and unplanned urbanization is already having a significant impact on people’s health, and we face a major global health crisis if we don’t act now.

People living in cities increasingly lead lifestyles characterized by unhealthy nutrition, reduced physical activity, stress, excessive alcohol and tobacco consumption, all risk factors for the development of noncommunicable diseases (NCDs). Every year, around 39 million deaths are the result of NCDs such as diabetes, respiratory disease and cancer, and over 75% of these occur in low- and middle-income countries (LMICs). Managing NCDs is a huge challenge for health systems in LMICs because they still face a high burden of infectious diseases. In addition, current development aid is almost exclusively directed to addressing infectious diseases and maternal and child health issues, while less than 2% of the total development funding is allocated to fighting NCDs.

The “silent killer” · Over 10 million people are estimated to die from hypertension (high blood pressure) globally every year. Because hypertension doesn’t show any symptoms, it is often referred to as the “silent killer” and is the prime risk factor for cardiovascular disease. If left unaddressed, it can lead to stroke, heart- or kidney failure. There is a lot of evidence on how to prevent, treat and manage hypertension but it continues to be poorly controlled, especially in LMICs where health systems are typically geared toward acute care and not set up to provide care for chronic patients like those with cardiovascular problems.

Cities as public health tools · Urbanization is undoubtedly a key driver behind the growing burden of NCDs such as hypertension, but we must also recognize cities’ unique potential as a tool for addressing public health issues. A high concentration of people and sectors - and of healthcare workers and facilities - means that cities provide the opportunity to enact change at scale. This was the thinking behind the Novartis Foundation’s Better Hearts Better Cities initiative which aims to improve cardiovascular health in low-income urban populations.

Better Hearts Better Cities · To truly thrive, cities must become ecosystems of health and wellbeing, where each part works towards one goal: extending and improving people’s lives. Ulaanbaatar in Mongolia, Sao Paulo in Brazil, and Dakar in Senegal are the first three cities selected to demonstrate Better Hearts Better Cities’ integrated, multisector approach. Selected based on high unmet cardiovascular health needs and the strong commitment of local authorities to improve cardiovascular health, these first cities aim to establish conditions for the successful integration of the approach in other cities worldwide.

Better Hearts Better Cities builds networks of partners, reaching beyond the health sector. Partners can include healthcare providers but also digital and telecommunication organizations, food suppliers, employers, insurance funds, social enterprises and civil societies. Made up of both public and private
organizations, these networks operate globally and at the local level.

Crucial to the success of Better Hearts Better Cities is local ownership; to achieve long-term impact and sustainability it is essential to work hand-in-hand with local governments and partners to innovate and strengthen health systems for the future, and this needs to be from the design and planning stages of the initiative. The multisector approach integrates complementary capabilities and resources to tackle hypertension from lifestyle choices, to prevention, screening, diagnosis and patient management.

Digital technology makes cities more inclusive, connected and vibrant. Digital health technology can support healthcare providers and empower patients to better manage their disease. It provides better data reporting, enables real-time, data-informed decision-making and can reduce costs while increasing overall quality of care. When its full potential is realized, digital technology can have a transformational impact on the way healthcare is delivered and health systems that fully embrace it will only be further strengthened in the future.

As cities become home to an ever-increasing proportion of the world’s population, new challenges and opportunities will arise for digital health to improve population health outcomes. Through partnership with companies such as Intel Corporation, Better Hearts Better Cities brings together complementary expertise to co-design digital health solutions to enhance the way health systems are performing.

What will success look like? The complex nature and heavy burden of NCDs around the world means we cannot afford to wait. Better Hearts Better Cities aims to operate at scale from the outset following a multisector approach for systemic and sustainable change. Through its initial focus on hypertension, Better Hearts Better Cities aspires to reimagine the way chronic diseases can be prevented and managed, as an example that can be applied to other noncommunicable diseases.

Author: Dr. Ann Aerts, Head of the Novartis Foundation

References are available in the online version of the report.
2017: FINANCIAL FACTS AND FIGURES

CAPITAL ACCOUNT

<table>
<thead>
<tr>
<th>Assets</th>
<th>Previous Year</th>
<th>2017</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>98’191.83</td>
<td>98’191.83</td>
</tr>
<tr>
<td>Cash in hand</td>
<td>335.43</td>
<td>335.43</td>
</tr>
<tr>
<td>Cash in banks</td>
<td>86’521.80</td>
<td>86’521.80</td>
</tr>
<tr>
<td>Other amounts receivable</td>
<td>8’518.05</td>
<td>8’518.05</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>2’816.55</td>
<td>2’816.55</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>98’192.83</td>
<td>98’192.83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Previous Year</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Net equity</td>
<td>81’549.77</td>
<td>81’549.77</td>
</tr>
<tr>
<td>Status 1st January</td>
<td>91’830.84</td>
<td>91’830.84</td>
</tr>
<tr>
<td>Net loss</td>
<td>-10’281.07</td>
<td>-10’281.07</td>
</tr>
<tr>
<td>II. Accruals</td>
<td>5’208.00</td>
<td>5’208.00</td>
</tr>
<tr>
<td>III. Project funds not yet appropriated</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>IV. Other liabilities</td>
<td>11.435.06</td>
<td>11.435.06</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>98’192.83</td>
<td>98’192.83</td>
</tr>
</tbody>
</table>

STATEMENT OF REVENUE AND EXPENSE

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Previous Year</th>
<th>Budget 2017</th>
<th>Accounts 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership contributions</td>
<td>51’050.00</td>
<td>56’050.00</td>
<td>57’550.00</td>
</tr>
<tr>
<td>Extraordinary contributions by members</td>
<td>22’353.98</td>
<td>14’000.00</td>
<td>25’000.00</td>
</tr>
<tr>
<td>Revenue related to projects (G2H2)</td>
<td>13’010.06</td>
<td>19’450.00</td>
<td>18’694.15</td>
</tr>
<tr>
<td>Other revenue</td>
<td>426.56</td>
<td>300.00</td>
<td>14.78</td>
</tr>
<tr>
<td><strong>Subtotal Revenue</strong></td>
<td>86’840.60</td>
<td>89’800.00</td>
<td>101’258.93</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Previous Year</th>
<th>Budget 2017</th>
<th>Accounts 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>General expenses secretariat</td>
<td>74’665.52</td>
<td>80’600.00</td>
<td>76’836.71</td>
</tr>
<tr>
<td>Travel costs / hospitality / Network events</td>
<td>9’951.71</td>
<td>19’200.00</td>
<td>12’186.46</td>
</tr>
<tr>
<td>Other expenses secretariat</td>
<td>3’530.72</td>
<td>3’000.00</td>
<td>3’623.73</td>
</tr>
<tr>
<td>Other expenses</td>
<td>6’740.72</td>
<td>6’500.00</td>
<td>9’623.80</td>
</tr>
<tr>
<td>Taxes</td>
<td>2’233.00</td>
<td>500.00</td>
<td>1.51</td>
</tr>
<tr>
<td><strong>Subtotal expenses</strong></td>
<td>97’121.67</td>
<td>109’800.00</td>
<td>102’272.21</td>
</tr>
</tbody>
</table>

| Net loss                                   | -10’281.07    | -20’000.00  | -1013.28      |

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 2018. The “Report on the Audit of the Financial Accounting as of December 31, 2017 for the Association Medicus Mundi International e.V.” by RSM Verhulsdonk GmbH, Krefeld, Germany, is available at the MMI secretariat.
NETWORK MEMBERS

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

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

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

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

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

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

**Ecumenical Pharmaceutical Network EPN**
Rosami Court, Fourth Floor
Kilimani Muringa Road
Nairobi, Kenya
www.epnetwork.org

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

**Escuela Andaluza de Salud Pública EASP**
Campus Universitario de Cartuja
Cuesta del Observatorio, 4
18011 Granada
Spain
www.easp.es

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

**i+solutions**
Polanerbaan 11-A
3447 GN Woerden
The Netherlands
www.iplussolutions.org

**International Health Policy Network, ITM Antwerp**
Nationalestraat 155
B-2000 Antwerp
Belgium
http://www.internationalhealthpolicies.org/about-ihp/

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

**Medicus Mundi Italy**
Via Collebeato 26
25121 Brescia, Italy
www.medicusmundi.it

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

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

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

**Memisa**
Square de Meeûs 19
B – 1050 Brussel
Belgium
www.memisa.be

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

Status: May 2018