ANNUAL REPORT 2014 – PART 2

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

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

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

The project for grandmothers was therefore designed to find working and sustainable measures to minimize such challenges as these mentioned before. The project’s overall strategy was garnering efforts aimed at strengthening the healthcare referral system within Jinja district. The project focused on interventions geared at strengthening the capacity of existing structures and actors to deliver qualitative good and age friendly healthcare services for older persons. In the process, the project encouraged the formation of grandmother associations, information dissemination and moral support; facilitated training in social gerontology and geriatrics to community health workers from health facilities commonly visited by grannies. The project worked together with the district health department to recruit and train registered Village Health
teams (VHTs) who work on voluntary basis, procured and distributed bicycles, gumboots and first Aid kits to VHTs. They use the bicycles between the granny homes as they conduct home visits and help carry ill grannies to the distant health facilities, conducted community medical camps for NCDs (Non communicable diseases) - the health facilities at parish level where grannies visit do not provide medical services for NCDs.

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

“In December 2013, I got involved in fatal road traffic accident in which I was seriously injured and sustained multiple complicated fractures especially on my legs. I woke up from unknown hours of unconsciousness on a hospital bed in Jinja National referral hospital where I had been taken by good Samaritans. The doctor who was by my bed narrated to me a scanty account of my ordeal and announced that I needed an urgent surgery to save my legs; a surgery he said would cost an average of Ugx 4,000,000 (€ 1,250).

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

A few months later, I started feeling pain on the scar from the surgery; the pain gradually intensified and I had challenges moving around again. Around the same time (Aug, 2014) Pefo organized a medical retreat for grannies at a health facility within my community which I attended hoping to get some tabs for the pain. The doctor booked me for another appointment and didn’t tell me exactly why. When I returned, he sent me for some investigations which revealed I had a bone implant infection and the infection was to spread to all my bones if the infected implant is not removed. He referred me to Jinja Regional Referral Hospital (JRRH) for the operation. The memories of my struggles to find the money for the first operation were still so fresh and now again they needed me to pay Ugx 2,000,000 (€625).

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

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

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

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

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

AID IN REVERSE – COMPENSATION FOR HEALTH WORKER MIGRATION

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

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

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

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

Of all the countries in Europe, the UK has received the most internationally-trained doctors and nurses, and is therefore a key beneficiary of this ‘reverse aid’. 26% of all doctors and 10% of all nurses in the UK were trained outside of Europe. Whilst health worker migration to the UK today is much lower than in the past – a result of the UK’s Code of Practice, changes to registration criteria and increasingly restrictive immigration policies – we still have much to do to compensate for the subsidies we have received.
Take the example of Sierra Leone, currently battling the Ebola crisis. In 2010, the country had 136 doctors and 1,017 nurses. That’s one doctor for approximately every 45,000 people. In contrast, the UK has 1 doctor for every 357 people. In 2000, Sierra Leone’s health system was declared the weakest in the world, whilst the NHS was recently voted the strongest. Yet 27 doctors and 103 nurses who trained in Sierra Leone are currently in the UK. Whist it is not possible to quantify the losses to Sierra Leone in terms of the value of their care or the lives that could have been saved, it is possible to attempt to calculate the financial subsidy Sierra Leone is providing to the UK. We do not know at what level or where they are working (NHS or private), but if we assume the 27 doctors are junior doctors, based on the savings generated (It costs the NHS GBP 269,527 to train a junior Doctor and GBP 70,000 to train a nurse) Sierra Leone’s doctors and nurses are providing a saving of GBP 14.5 million to UK health services (EUR 19.8 million). If those doctors are consultants, the total subsidy Sierra Leone is providing to UK health services (NHS and private) could be up to GBP 22.4 million (EUR 30.4 million).

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

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

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

More information and references:

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

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

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

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

**Drug policy and pain medication**

The health impacts of current drug policies aren’t limited to people who use drugs and their families. Current drug policies also seriously restrict access to essential medications in poorer countries. Pain medication – a vital part of healthcare from the treatment given to patients with
Terminal diseases to the anaesthetic doctors need for life-saving operations in war zones – is hardest hit. Five billion people live in countries with little or no access to pain medication. This isn’t because the medicine is too expensive for those countries to afford. Opioid pain medications like morphine are plentiful and relatively cheap. But governments concerned that morphine and similar drugs, or their ingredients, could end up on the illicit market put barriers in place that make it extremely difficult for health workers to access, prescribe, and distribute pain medication. A recent study found that 84% of countries surveyed had unnecessarily high policy barriers keeping people from accessing essential pain medicines.
Wider consequences of the war on drugs

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

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

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

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

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

What we are calling for

1. Genuinely open and informed debate on the future of drug policy at national and international levels.

2. Evidence-based, pro-poor policies that reduce harm to people who use drugs, small-scale producers and traffickers, and vulnerable communities.

3. Analysis of impacts on poverty, health, and development as a key component of the development and monitoring of any drug policy.

4. A role for national health ministries and development agencies in determining drug policy.

More information and references:

Casualties of War. How the War on Drugs is harming the world’s poorest. Catherine Martin, Health Poverty Action report, February 2015
www.healthpovertyaction.org • www.bit.ly/HPA-casualtiesofwar (PDF)

Photo: Burning hashish seized in Operation Albatross, a joint operation of Afghan officials, NATO and the DEA. © DEA (taken from the cover of the “Casualties of War” report)
“Actua” (“Do it!”) is a joint project of four associations in the Navarra province, Medicus Mundi Navarra, Ilundain Foundation, Escuela de Tiempo Libre Urtxintxa, and IPES Elkartea, who are united to promote active citizenship, engagement and social involvement of young people, enabling them to participate in the society and to transform their environment, with a focus on human rights, sustainable development and prevention of social exclusion.

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

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

Therefore the main goal of the project is the promotion of skills and active participation in citizen action among young people. We must ask about the possibilities that exist in today’s world for young people to exercise their rights and citizenship. Young people are agents of change for the future society. From a human rights approach exercising rights means that the young people involved in the project consider themselves as subjects of rights, protagonists and active agents in social transformation. It is important to develop among them skills that will enable them to deal with common goods and to implement proposals for citizen action. The focus of global citizenship is linked to the concepts of inclusion, social justice and human rights. Besides the basic qualities of active citizenship (inclusion, participation, achieving results) it incorporates a holistic vision and an interaction between the local and the global.
Ethical garden: "Fair food for 100 families"

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

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

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

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

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

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

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

More information: www.actua.social
Family Planning as Part of Political Campaigns

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

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

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

Xenophobia with internationalism

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

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

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

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

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

1. Voluntary family planning is one of the most cost-effective investments to reduce unwanted pregnancy, as well as maternal and new-born death. But it only makes sense if it is embedded in broader sexual and reproductive health interventions. The strong focus on access to family planning would have weakened an integrated approach to improve access to sexual and reproductive health services along the continuum of care.

2. The woman’s right to decide if, when and how many children she wants to give birth is a fundamental right. The Cairo International Conference on Population and Development 1994 has brought this crucial change of paradigm in population’s policy. The Ecopop initiative would have gone behind these achievements.

3. By this initiative Swiss development cooperation would have been forced by the constitution to focus on the goal of reducing overpopulation globally. This would have discredited the country’s whole development policy.

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

Our point of view competed not only with the view of the Ecopop people but as well with some other NGO’s – represented by the influential network Alliance Sud – that rejected the initiative. Their arguments ignored family planning instruments as effective development measures and focused on other topics such as the need for better education and economic development. For the Network Medicus Mundi Switzerland this approach wasn’t wrong, but as a Health for All
Network we didn’t want to ignore that family planning may play a crucial role in improving the health status of a population.

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

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

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

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

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

The LPEP project is a centerpiece of the Novartis Foundation new strategy toward zero transmission. Launched in June 2014 in collaboration with Netherlands Leprosy Relief, International Federation of Anti-Leprosy Associations partners, Erasmus University Medical Center Rotterdam, Swiss Tropical and Public Health Institute and national leprosy programs, LPEP aims at combining early diagnosis and treatment of leprosy patients with preventive therapy of their asymptomatic contacts.
Under the LPEP project, asymptomatic contact persons will be offered a single dose of rifampicin as post-exposure prophylaxis (PEP). This decreases their risk of developing leprosy in the years following contact by as much as 50-60% (Moet et al. 2008). This year, the LPEP project will be rolled out in several pilot areas across Asia, Africa and Latin America.

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

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

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

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

More information:
Website of the Novartis Foundation: www.novartisfoundation.org
Leprosy Post-Exposure Prophylaxis (LPEP) project: www.bit.ly/foundation-lpep
Contact-tracing project in Cambodia: www.bit.ly/foundation-contacttracing
Co-creation of tools to accelerate leprosy diagnosis: www.bit.ly/foundation-diagnosis
2014 started off as ‘just’ another year for Wemos, MMI and other civil society organizations attempting to get human resources for health into the limelight as an essential part of sustainable health systems, advocating for more policy coherence and a health-in-all-policies perspective and defending the regulatory, policy-making and norm-setting role of the WHO.

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

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

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

Our final call to action launched at 5 June 2014 has received endorsements from more than 80 European and global organisations. The Global Health Watch 4 includes a chapter on the global
health workforce crisis in which we demonstrate how the WHO Code can provide an anchor for a coherent health workforce policy.

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

More information: www.wemos.nl
DOCTORS WITH AFRICA CUAMM

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

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

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

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

The experience is both on a professional level and a human one. For ten years, the NGO Doctors with Africa CUAMM has been offering the students of SISM — Italian Medical Students’ Association — the chance to spend a month of their university career in Ethiopia or Tanzania, taking part of the NGO's daily work in the local hospital. Students observe, listen and learn by seeing the everyday life of a context with limited resources where professional doctors provide quality care to the local population. They are immersed in a kind of medicine completely different from the Western standards to which they are accustomed. They find themselves rethinking the basic vocabulary of medicine and experience a different culture to learn to be future doctors who serve patients. They quickly have to put aside the Western mentality of "I'm coming to save you" and replace it with "I'm coming to meet you".
The project was originally called the *Wolisso Project* because Wolisso, in Ethiopia, was the only destination for the training at first. The field training project remains an invaluable and rare opportunity in European university systems. The project was started by young people for young people, created to give medical and surgery students a chance to encounter the world and broaden their horizons.

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

**Not just Africa**

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

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

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

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

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

More information:

Doctors with Africa Cuamm: www.mediciconlafrica.org
Wolisso project: www.wolissoproject.org
SISM students’ Blog www.educationglobalhealth.eu/blog
SAFE DELIVERY IN RURAL DRC:
A MOTORCYCLE-AMBULANCE PROJECT

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

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

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

Our intervention in DRC is by far the largest (accounting for around 80% of the yearly budget), where we are supporting 31 health zones, covering around 4.5 million people.

Bad roads and effective ambulances

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

Organizing efficient referral systems from health centers to hospitals in rural DRC has always been a challenge in the fight against maternal mortality. Pregnant women have to walk or cycle for tens of kilometers to reach a hospital. The dirt roads are in such a bad state that no car can pass. This is one of the factors explaining the high level of mortality in the country.
Kinzamba, situated in Bandundu province, is an isolated village. Roads are in a very bad condition and there is no cell phone network nor public transport. It is a huge challenge for its 31,000 inhabitants to travel anywhere at all. Since transport is necessary to go from the local health center to the hospital, for example for an emergency caesarean section, many women walk or cycle the distance. There is an ambulance present in the zone, but the 4x4 jeep cannot access the most isolated areas due to impracticable roads.

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

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

The local community has been mobilized to finance the functioning of the emergency transportation (through 4x4 or by motorcycle). For this purpose a communal financing mechanism based on solidarity between patients has been put in place. This works as follows. Every patient that receives a consultation at a health center or at the hospital pays 350 Congolese Francs (about 0.34 Euros) more in addition to the regular bill. This way everyone who uses the ambulance or the motorcycle-ambulance only adds 1,000 Congolese Francs (about 1 Euro) for the transport. This system allows the driver to be paid and to pay for the petrol and maintenance without further impoverishing the population.

- More information: www.memisa.be

For the occasion of mother’s day 2015, Memisa stimulates people to support the motor-ambulance system through an online donation website: www.africado.be
Until recently, many of the debates around Universal Health Coverage (UHC) addressed health coverage in middle-income countries and emerging economies. How the debates play out in fragile and transitional states is largely unknown. Therefore, Cordaid commissioned a qualitative study into perceived feasibility of pathways to UHC in fragile and transitional states.

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

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

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

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

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

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