

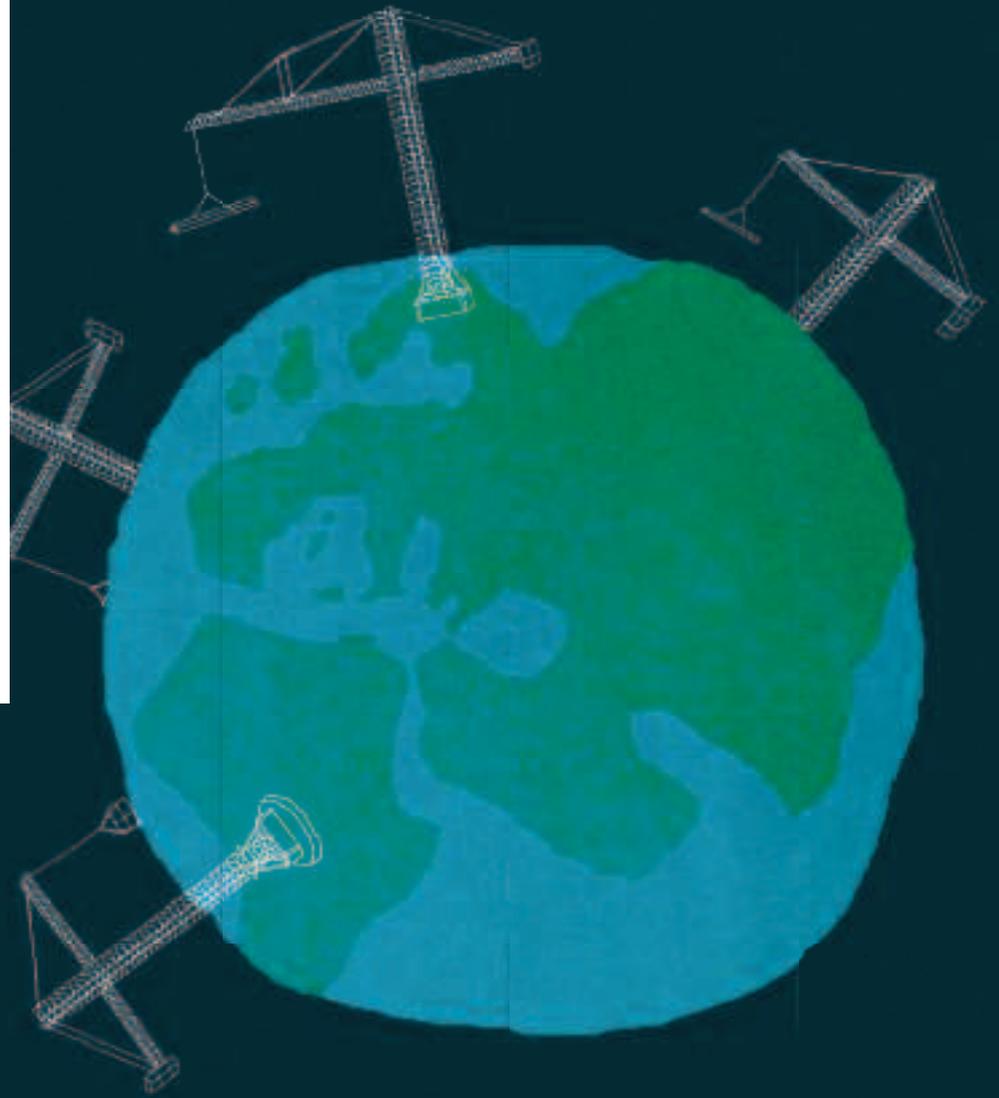


**DOCTORS  
WITH AFRICA**  
CUAMM



## **HEALTH AND DEVELOPMENT**

Magazine on  
International Development  
and Health Policy  
November 2014 — No. **70**  
double issue



# HEALTH BEYOND 2015

November 2014/ n° 70





## NEWS

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### When the government has second thoughts

**“If the nation fails to get serious about prevention then recent progress in healthy life expectations will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness”. The review goes on to assert: “The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health”.**

Britain’s conservative-led government is having second thoughts. Privatization and the “marketization” of health care have not worked, and the next general election is just around the corner...

<http://www.saluteinternazionale.info/2014/11/nhs-si-cambia-in-meglio-si-spera/>

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**FIGURE /** THE COVER OF THE “FIVE YEAR FORWARD VIEW” PAPER PUBLISHED LAST OCTOBER BY THE CAMERON GOVERNMENT. FOLLOWING THE REFORMS OF RECENT YEARS, THE REPORT SEEMS TO SET OUT A NEW VISION FOR THE NHS

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Cover illustration by Ramon Pezzarini.

*Health beyond 2015.* What will global health look like post-2015? An intense international debate is underway, in search of the best strategies and models to ensure primary care and health support for the world's peoples. This issue takes an in-depth look at the evolving scenario.



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## DIALOGUE

### FROM AFRICA TOWARDS THE FUTURE

This November 29th in Turin at CUAMM's annual meeting, *Mothers and children first*, we'll be talking about the future. We'll describe the work done in 2014 and listen to the experiences of our aid workers. And the most important participants at the event will be young people. It's impossible, in fact, to reflect on the world we want without listening to youth.

TEXT BY / DON DANTE CARRARO / DIRECTOR OF DOCTORS WITH AFRICA CUAMM

As 2015 approaches, we inevitably begin to take stock, first and foremost of the year that has just gone by. It's been an intense one, full of passion, commitment and daily hard work. More than ever before, 2014 called on us to be on hand where the most vulnerable members of society live, and where in recent months the civil war in South Sudan and the Ebola outbreak in Sierra Leone have made our work even more dramatic than usual. Despite these challenges, or perhaps because of them, we resolved to stay in the field with our doctors and medical staff, doing our part by continuing to work in support of local communities.

With 2015 just around the corner, we're also reminded of how urgent it is to undertake deep, forward-looking deliberations on the MDGs and related strategies and policies for upcoming years. It's not enough to point out that these goals, defined in 2000 and meant to be achieved by 2015, have been met only partially; there's an ever more pressing need to define sustainable, purposeful policies in order to keep the promises made back then, including with regard to global health. The international debate on the post-2015 agenda continues to rage; it includes a broad spectrum of voices – institutions, governments and civil society – all of them aware of the interdependence between economics, politics and health. Indeed, these seemingly distinct spheres are all part of the same integrated, complex system, and only by working together will we succeed in creating a less fragile world where health is truly a right for all.

As we discuss the future of health, the concept of care is being replaced by that of coverage; as 2015 draws closer, in fact, the prospect of universal health coverage (UHC) has appeared on the horizon. The current edition of *Salute e Sviluppo* devotes a good deal of space to this topic. Doctors with Africa CUAMM is taking part in this reflection, elaborating new strategies in line with the changes taking place and continuing its work to improve the accessibility, equity and quality of health care in every part of Africa where our staff are present. For us, *this* is the meaning of the change we want. UHC means being there to ensure primary health care for communities. We do this first of all by looking after the health of mothers and children, which can be considered an indicator of the overall performance of health care systems. The results of our work in 2014 show that the services provided by the *Mothers and Children First* program continues to grow, and to gain people's trust in the four countries where it is being implemented.

We'll be talking about the future that lies ahead this November 29<sup>th</sup> in Turin. We'll describe the work done in 2014, from the ordinary activities (which are actually never that ordinary) to the more unpredictable one, at least until a short while ago, of handling a massive public health crisis like Ebola. We'll listen to the experiences of those who've left and those who've come back, trying to grasp what drives them to travel so far from all that is familiar in order to bring care and support. And the most important participants at this event will be young people.

It's impossible, in fact, to reflect on the world we want, the world that awaits us post-2015, without listening to youth. Doctors with Africa CUAMM is well aware of the professionalism and energy that medical students and young doctors have to offer, and it's for this reason that we continue to invest in their training, to hand down the knowledge we've gained on the field, the vision of a truly global world, and help drive the change towards a more just society.

Precisely with a view to a shared future, a few weeks ago Doctors with Africa CUAMM drew up a formal document tying our organization to the Italian Medical Students' Association (SISM). This means there will be more joint activities for a mutual exchange of experience and know-how, from training courses on global health in Italian universities to the possibility of fieldwork that CUAMM offers second-year medical students in Ethiopia and Tanzania, two of the countries where we're active. There will also be a specialized training project, JPO, that will enable specializing students to experience first-hand the role of doctors in countries with limited resources.

In Turin we'll be talking about all of this, together with institutional and governmental representatives, the young people with whom we share a path, and our volunteers. And it won't just be an occasion for taking stock; most importantly, it will be a chance to give impetus to a better future. We look forward to seeing you!



## DIALOGUE

# TO THE SUSTAINABLE DEVELOPMENT GOALS

From the Millennium Development Goals to the Sustainable Development Goals:  
A post-2015 agenda.

“Health is a precondition, consequence, and indicator of all three dimensions  
of sustainable development: economic, environmental, and social”.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

In 2000, when 189 nations adopted the Millennium Declaration affirming their commitment to achieve the Millennium Development Goals, and laying the foundations for doing so, the idea of focusing the interventions around a limited number of conditions and diseases was seen as being the right strategy for improving the health conditions of the world's peoples, most importantly those living in the poorest parts of the planet. This approach was typical of the “season” of globalization from the very start: that of “vertical programs”. Since that time some results have certainly been achieved, yet we are still far from meeting the objectives set out in 2000, especially in Sub-Saharan Africa which, unlike other parts of the world, is still behind even with regard to Goal One: reducing the number of people who live in conditions of extreme poverty (56% in 1990, 48% in 2010). This selective attention to specific types of interventions has exacerbated the fragmentation of health care systems, already in grave difficulty due to lack of resources, privatization, and the flight of the best-qualified personnel.

When the United Nations member States convene in 2015 to set the development objectives for coming years, they will have to take into account not only these issues, but also the emergence of new global health problems such as the epidemic of chronic disease and climate change.

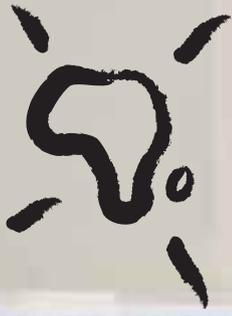
At the behest of the United Nations, groups of experts and members of civil society are actually already at work on an agenda whose founding principle will be sustainable development, in accordance with the conclusions of the Rio+20 Conference held in Brazil in June 2012 and its seven thematic priorities: job creation, food security, water, energy, sustainable cities, oceans and disaster prevention. The Millennium Development Goals (MDGs) will be transformed into the Sustainable Development Goals (SDGs).

In terms of health, the post-2015 objectives – the SDGs – will surely include universal health coverage (UHC), a topic we discussed in our editorial in Issue 69 and to which we have dedicated a full article in the present issue (see pages 6-7). On this point, a recent piece in *The Lancet* contained an appeal by seven national Ministers of Health (from France, Germany, the Ivory Coast, Malaysia, Mexico, Morocco and Senegal) that stated: “*While countries are negotiating to agree on a new set of objectives for the development framework after 2015, the undersigned Ministers of Health from seven countries want to underline that UHC is crucial to increase healthy life expectancy, eradicate poverty, promote equity, and achieve sustainable development. Moreover, UHC gives people the peace of mind that the health services they might need are available, affordable, and of good quality.*” However, the Ministers added, “*A large number of factors outside immediate health services have an impact on population health, including conflict, income levels and distribution, consumption and production patterns, working conditions, sanitation, access to clean energy, environmental conditions, and education. To improve the health of their citizens, governments should work to strengthen performance in all these areas, and measure the impact of all policies on health.*” They concluded their appeal with the assertion that “*Health is a precondition, consequence, and indicator of all three dimensions of sustainable development: economic, environmental, and social.*”<sup>i</sup>

Lastly, we must not overlook the fact – as the article by the International Federation of Medical Students' Associations (see page 8) reminds us – that in the poorest parts of the world, Sub-Saharan Africa in particular, the MDGs have been only partially achieved. The Ebola epidemic that is currently ravaging several countries in West Africa is a terrible sign: in areas where health systems are extremely weak, not only is there no guarantee of acceptable levels of infant and maternal health care or adequate control of “traditional” epidemics such as AIDS, tuberculosis and malaria; an entire continent is now being exposed to the uncontrolled spread of other “new” and lethal epidemics as well.

## REFERENCES

<sup>1</sup> Tourane M. et Al., *Universal Health Coverage and post-2015 agenda*, *Lancet* 2014; 384:1161.



**CUAMM IN SIERRA LEONE: A NEW ISOLATION CENTER TO FIGHT EBOLA**

Since 2012 Doctors with Africa CUAMM personnel have been at work on a program to safeguard neonatal, maternal and child health in Pujehun, a rural district in southern Sierra Leone. In May 2014, with a team of 5 Italian aid workers working in cooperation with local government personnel, CUAMM also began to tackle the Ebola virus outbreak in the area.

After securing the Pujehun Hospital, building an isolation center in the Zimmi area (the center of the outbreak in the district), and training more than 300 health workers to carry out contact tracing activities and monitor for victims of the disease hut by hut, village by village, Doctors with Africa CUAMM is now taking on a new challenge: the construction of a new isolation center five kilometers from the Pujehun Hospital.

ISOLATION  
T





## UNIVERSAL HEALTH COVERAGE: BRAZIL VERSUS CHINA

In the last decade, both countries have significantly expanded health insurance coverage, but they have done so using quite different strategies: Brazil, by strengthening its primary health care services, China by improving access to hospitals. Various versions of Universal Health Coverage have been developed all over the world, each with different characteristics.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

While the 1978 Alma-Ata Conference concluded with a call for “Health for All”, more recently the World Health Organization and even the United Nations have opted for the expression “universal health coverage”, or UHC. They might have chosen “universal health care”, a concept comparable to that of “health for all” (albeit with one important difference: the notion of “health care” is more limited than that of “health”, as it disregards the social determinants of the latter). Instead, they decided on the term “coverage”.

What is the reason behind this focus on coverage, which is but a component of care? Why is there such concern over the financial aspects of assistance – i.e., coverage – and why has less attention been given to the issue of the organization and delivery of services – i.e., care? There are different answers to these questions, also when viewed through a political lens.

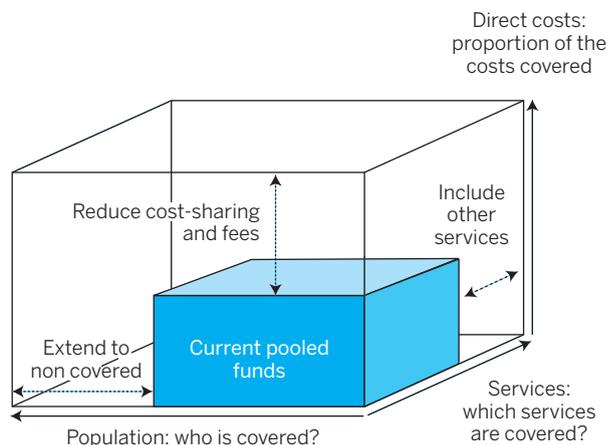
The first and most important explanation is that radical neoliberal policies – sweeping cuts in public health expenditure, the privatization of services, catastrophically high expenses for households, people’s inability to seek treatment – had led to a situation that was no longer socially, nor even humanly, sustainable or tolerable. If we look at the two most populous countries alone, China and India, in the early 2000s, less than a third of the overall population of 2.3 billion had some form of health insurance coverage. Things were slightly better in Mexico, where less than half of the country’s 100 million inhabitants had insurance coverage: those employed in the official economy or those who were able to purchase a policy on the private market. But the situation was much worse for people living in Sub-Saharan Africa; only a tiny minority there had any coverage, with the great majority being obliged to pay, either officially or under the table, for any service they might be in need of, whether it be malaria treatment, a delivery, or a surgical operation.

Seen from this perspective, the political pressure of the WHO with respect to UHC, followed by the UN General Assembly’s pledge of support for it, can be taken as an implicit condemnation of previous neoliberal policies (which were accepted without complaint for years by these same international institutions) and the beginning of a new, more promising phase for global health – as we shall see, something that was already underway in some countries.

Nevertheless, the principle underlying UHC limits public sector intervention while leaving plenty of room, instead, to the private sector, both in terms of financing and of the production and

delivery of services. With regard to financing, governments must ensure that everyone has access to coverage: public coverage (for example, national health services), but also private or mixed coverage, with policies to regulate the health insurance market, whether it be profit or non-profit, and the possibility for the public sector to intervene should certain sections of the population be left without coverage. With regard to the production and delivery of services, governments must ensure that both public and private providers function in an appropriate manner and meet the needs of the population.

FIGURE / MEASURING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE IN THREE DIMENSIONS



The **figure** below shows the three dimensions of UHC, or rather the three directions in which insurance coverage can be expanded:

- Extending coverage to the non-insured, in order to reach the highest possible number of people and reduce to a minimum, or even to zero, the number of non-insured individuals;
- Increasing the number of treatments and services included in health insurance plans;
- Reducing co-payments and out-of-pocket payments so as to cut down on direct payments by households for services.

A broad range of health systems, each different from the next in terms of accessibility and equity, can ensue, depending on the

mix of these possible solutions. Indeed, various versions of UHC have been developed, and are being developed, around the world, each with quite different characteristics – advanced or restrictive – that reflect the history, culture, economy and politics of the different countries.

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## BRAZIL

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The turning point for Brazilian health care came in 2002, the year that Luiz Inácio Lula da Silva was elected as president. His government decided to strengthen the public health sector, in particular the area of primary health care, through the relaunch of a program – the *Programa Saúde da Família* (PSF, or Family Health Program) – that had been introduced many years earlier, in 1974, but that had until that time only been used as a tool for assisting the poor. PSF provides for the setting-up of primary health care teams formed of a doctor, a nurse, a nurse's aid and from 4 to 6 *agentes comunitarios de saúde*. Each team works in a health center and meets the primary health care needs of some 600 to 1,000 families within a clearly defined geographical area. For every two PSF *équipes*, there is also an *equipe de saúde bucal* (ESB) made up of a dentist, an oral hygiene technician and a dental lab assistant; its primary goal is to provide preventive care, both individual and collective, but it provides some treatments as well.

Under the Lula government funds for PSF were constantly increased, quadrupling by 2010; the number of *équipes* and of municipalities covered by the *estratégia saúde família* (5,251 out of 5,564) also grew.

The community assistance model also enables access to secondary and tertiary care provided by public structures or private ones operating within the national health service. It has improved the population's access to treatment as well as expanding activities for prevention and health promotion for the most vulnerable social groups, particularly in Northeast and North Brazil, which prior to the institution of PSF had access only to community health agents, or were obliged to resort to hospital emergency services where they existed.

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## CHINA

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In 2003 44.8% of the urban population and 79.1% of the rural population lacked health insurance. Because of this, 12% of households found themselves faced with catastrophic health expenditures; in the same year, 30% of poor families attributed their circumstances to excessive health care costs. In 2003 the SARS (severe acute respiratory syndrome) crisis revealed to the

entire world how weak China was in terms of its ability to control epidemics and handle health emergencies. It is no coincidence, in fact, that the Chinese government decided that year to improve its health care system both in terms of public health – setting up a new national system for the surveillance of infectious diseases – and in terms of insurance coverage for the population, particularly for people in rural areas. To this end, a new type of insurance was introduced for individuals living in the countryside – the Rural Cooperative Medical Care insurance scheme – and a similar system was introduced for people living in urban areas who lacked insurance coverage, with the end goal of achieving universal coverage by 2020.

Public health expenditure has gone up over time. In 2003 the health insurance premium for individuals was 30 yuan (about 3.5 euros), a third of which was the responsibility of the insured person and the other two-thirds of the government; in 2013 the portion paid by the government increased considerably, and today it is almost 240 yuan per person (the more developed a province is, the higher the governmental contribution). The insurance scheme now extends to nearly the entire population, an outcome achieved well ahead of schedule.

As a consequence, access to hospital structures has increased by two-and-a-half times, with the rate of hospitalization growing from 3.6% in 2003 to 8.8% in 2011. Moreover, this increase has lessened inequalities both between the various regions of the country and between its urban and rural areas; for example, the number of assisted deliveries in hospitals has grown by 13.3% in rural areas and 4% in cities. The portion of hospital expenditures covered by health insurance has also increased, rising from 14.4% in 2003 to 46.9% in 2011. As a result, there has also been an increase in the amount of services delivered, many of which are considered either excessive – for example, pharmaceutical prescriptions – or inappropriate, such as Caesarean sections, which accounted for 19.2% of deliveries in 2003 but rose to 36.3% in 2011.

In terms of financial protection, however, the expanded health insurance coverage, according to the data, has not achieved the hoped-for outcome. In fact, “catastrophic expenditures” – defined as medical expenses that are equal to or exceed 40% of the household income remaining after subsistence needs have been met – befell 12.2% of households in 2003, 14% in 2008, and then dropped slightly to 12.9% in 2011. This meant that 173 million people were at risk of impoverishment in China because of illness. Behind the numbers are stories of terrible human suffering and deaths that often could have been avoided, tragedies that impact the most vulnerable members of the population most heavily; indeed, in 2011 China's poorest households incurred catastrophic expenses twice as often as its wealthy ones. Another limitation of the Chinese health insurance system is its focus on reimbursing hospital expenses, something which encourages investment and consumption exclusively in this area.



## MEDICAL STUDENTS AND THE POST-2015 AGENDA

The year 2015 – the MDG target date – is fast approaching. It is important that everyone, including national governments, civil society, and non-governmental organizations, commit to finish the as-yet unfinished MDG agenda. IFMSA has been involved in the international discussion in order to ensure youth engagement and to advocate for health.

TEXT BY / CLAUDEL P-DESROSIERS<sup>1,2</sup>, STIJNTJE DIJK<sup>1,3</sup>, MICHALINA A. DREJZA<sup>1,4</sup>, MARIA JOSE CISNEROS CACERES<sup>1,5</sup>, IVANA DI SALVO<sup>1,6</sup>

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### IFMSA TOWARDS THE SUSTAINABLE DEVELOPMENT GOALS

For the past 14 years, the eight Millennium Development Goals (MDGs) adopted by 189 United Nations Member States in 2000 have steered international development. Although there have been some unprecedented gains, only a fraction of what was aspired to when the MDGs were first laid out has been achieved thus far. Throughout the process, the International Federation of Medical Students' Associations (IFMSA) has been the leading voice for medical students, working to ensure meaningful youth engagement and constantly advocating for health to be fully integrated into the next generation of goals, the Sustainable Development Goals (SDGs).

The post-2015 agenda has been discussed all over the world and the UN has taken advantage of the opportunity to connect and engage with millions of individuals everywhere. Starting from the 2010 MDG Summit, UN Secretary-General Ban Ki Moon has been tasked with overseeing the Post-2015 process and managing the difficult job of aligning its priorities with the outcomes of the Rio+20 Conference. The findings and conclusions of the many working groups, summits, high-level meetings and conferences on the post-2015 agenda will guide international and national policies and impact global development for the next twenty years and beyond. In order to protect intergenerational equity, it is critical that we balance society, environment and economy, the three pillars of sustainable development. The challenges facing the global community – climate change, for example – are incredibly complex and require joint solutions. The commonly used siloed approach has become insufficient; more than ever, stakeholders and global actors need to envision actions that are inter- and multidisciplinary.

### "THE FUTURE WE WANT"

IFMSA has put the post-2015 development agenda at the center of its advocacy priorities in order to ensure that it continues to strongly and meaningfully represent young people and health issues. The Federation, which includes 124 associations from 117 countries, is one of the largest international student-run organizations in the world, and as such, is in an optimal position to make

sure that the voices of young people are heard and continue to play a key role in shaping the healthy and sustainable future we want. We understand that the responsibility of reaching the targets and achieving the goals of the post-2015 agenda will be ours. Our engagement in the process began a few years ago and has grown ever since. At the Rio+20 Conference on Sustainable Development in June 2012, we worked to ensure that health was integrated into the discussion as a transcendent pillar of sustainable development; indeed, the final outcome document of that conference, "The Future We Want" declaration<sup>1</sup>, happily dedicates a full chapter to the topic. Our participation as members of civil society in the United Nations Open Working Groups (OWGs) on the SDGs has enabled us to engage in discussion with stakeholders directly on the ground<sup>2</sup>. We have also strengthened the Federation's capacities, notably by giving students the opportunity to be trained on the post-2015 agenda and on their role as youth agents of change. Early in 2013, the Federation adopted a policy statement on the post-2015 framework<sup>3</sup>; we have subsequently updated it at each of our general assemblies. The statement calls for health to be seen both as a precondition of sustainable development and as a beneficiary; therefore, health should be used as an indicator for measuring the progress made in this area. Because good health plays an integral role in human capabilities and well-being, IFMSA believes that all sectors impact health, and that health impacts all sectors.

### ENGAGEMENT AND AWARENESS FOR HEALTH BEYOND 2015

Our commitment to work for global health saw us take part in IFMSA's most recent General Assembly in Hammamet, Tunisia, in March 2014, discussing "Health Beyond 2015" and we adopted the Hammamet Declaration on Health Post-2015. [4] In the Declaration we promote health as a human right for all; advocate for improving gender equality and sexual reproductive health worldwide; call on policy makers to adapt their strategies to the changing burden of disease; underline the importance of taking an approach that recognizes the social determinants of health, in order to ensure health equity around the world; and encourage stakeholders to implement policies to mitigate the consequences of climate change, so as to reduce its negative impacts on people's health and the global burden of diseases.



## A NEW EXAM

A new exam for entry into Italian medical postgraduate specialization schools, has been adopted in 2014. The point of view of the Italian Medical Students' Association (SISM)

TEXT BY / CHIARA RIFORGIATO, VERENA ZERBATO, STEFANO GUICCIARDI  
SISM - ITALIAN MEDICAL STUDENTS' ASSOCIATION

In 2014 the Italian government adopted and put into effect new rules for the competitive exams for entry into Italy's *Scuole di Specializzazione*, or medical postgraduate specialization schools. Of the many changes made, the most significant is that candidates are now screened nationally rather than locally. This is very important as it guarantees greater transparency in the evaluation of recent medical graduates. The Italian Medical Students' Association (*Segretariato Studenti in Medicina*, or SISM) played an active role in the debate that led up to this change, working hard to ensure that access to specialized training would become as meritocratic and sustainable as possible, and making available the competences the Association has built up over the years, particularly in the area of medical education.

One of the main ways in which SISM has made people aware of the change underway and of the training needs of medical students is its dissemination of weekly alerts to members and students; it has also publicized events and demonstrations organized by recent graduates and students in various Italian cities in order to raise awareness among the public about the precarious and uncertain circumstances faced by young doctors. In addition, SISM has launched a dialogue with two associations of specializing students – the Italian Association of Junior Doctors (SIGM) and the Federation of Specializing Students (*Federspecializzandi*) – and actively participates in many of the initiatives organized by these groups to draw the attention of civil society to the inadequacy in recent years of programs for medical and specialized training, with serious negative repercussions for everyone.

Thanks in part to our own efforts, the new rules for competitive exams for entry into postgraduate specialization schools are undoubtedly a positive development. Even so, if the intention is to create sustainable and high-quality training and job prospects, then a broader response is required. The aforementioned change is insufficient in and of itself; what is called for is a multifaceted intervention and well-reasoned, long-term programming that takes into account timing and human and economic resources in the context of an appropriate legislative framework.



The year 2015 – the MDG target date – is fast approaching. It is important that everyone, including national governments, civil society, and non-governmental organizations, commit to finish the as-yet unfinished MDG agenda. We can work at the national level to advocate to our Ministers of Foreign Affairs with respect to what we would like to see included in the SDGs. For example, ACT!2015 is an initiative of the PACT, a collaboration of 26 youth-led and youth-serving organizations including IFMSA working on HIV and sexual and reproductive health and rights (SRHR).

### THE NEXT GENERATION OF GLOBAL HEALTH DOCTORS

Almost half of the world's population is under the age of 25. We believe that vibrant political engagement by youth is critical, as it is *our* generation that will ascertain that the political agenda matches the SDGs, thereby ensuring that the goals are achieved. As physicians-in-training we will contribute to healthcare delivery around the world, and we would like the people who will become our patients to have equitable access to health, as well as a quality of life that allows them to be productive members of society. In addition, we must stop thinking of health as a question of medical intervention alone. *All* policy domains impact and are impacted by health, and we hope that this will be reflected in the final SDG resolution. As World Bank Group President Jim Yong Kim said in his May 2013 speech at the World Health Assembly in Geneva, "Many countries are challenging themselves, measuring outcomes and achieving remarkable progress" [...] "in the spirit of social and environmental justice" [...] "Unfortunately, none of WHO's 194 Member States has yet built the perfect health care system. [...] Today, we have resources, tools and data that our predecessors could only dream of. This heightens our responsibility and strips us of excuses"<sup>5</sup>. We at IFMSA are hopeful for the future. We have seen and met creative, ambitious young minds from all corners of the world, people who are determined to improve the health and well-being of their communities, both locally and globally, through a sustainable development framework. We have seen during the post-2015 process that we are not the only ones who believe it is possible to strive for equity both between and within nations. We shall continue to work collectively to maximize every human being's potential, in order to shape the future we want.

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**WORKING FOR THE RIGHT TO HEALTH CARE IN UGANDA**

Doctors with Africa CUAMM has been working for more than 50 years in Uganda, a country whose severe lack of progress in the areas of maternal and neonatal health has many causes, including poverty, the geographical configuration of the territory, difficult access to health care facilities, poor quality of health care support and poorly motivated health workers. Mortality rates for Ugandan mothers and infants are exceptionally high, especially in the most remote rural areas of the country.

In the Oyam District, CUAMM is carrying out a pilot project in support of the *Mothers and Children First* program; it offers incentives to pregnant women with the aim of increasing their use of skilled delivery attendance services.







## EXPERIENCES FROM THE FIELD

# UNIVERSAL HEALTH COVERAGE IN UGANDA. WHERE ARE WE?

Progress towards achieving the health-related MDGs – particularly those related to maternal health and HIV/AIDS – has not been what was hoped for, mainly because of the low level of coverage of key health services. In order to progress more quickly in these areas, it will be essential that Uganda embrace UHC in 2015 and beyond.

TEXT BY / PETER LOCHORO / MEDICI CON L'AFRICA CUAMM

### INTRODUCTION

As we approach 2015, discussions have begun to include the concept of universal health coverage (UHC) and the development agenda beyond 2015. This paper looks at the recent debate vis-à-vis the Ugandan health system.

Located in East Africa, Uganda has 112 administrative districts, each subdivided into counties, sub-counties and parishes. With an annual population growth rate of 3.2%, Uganda's population was projected to reach 36.6 million in 2014<sup>1</sup>. A majority (56%) of Ugandans are below 18 years of age. The high population growth rate is fueled by a high fertility rate of 6.2<sup>2</sup>. Most Ugandans (82%) live in rural areas, but the percentage of the population living in urban areas is growing fast.

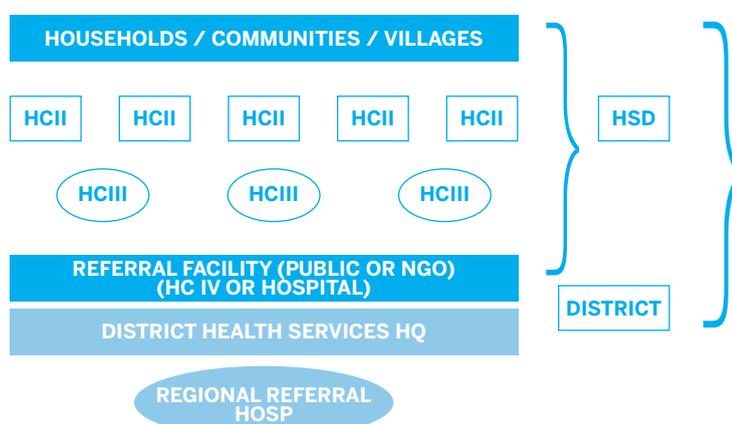
The proportion of people living below the poverty line has declined sharply, from 56% in 1992-1993 to 24.5% in 2009-2010<sup>3</sup>. In 2013 the country's GDP was US\$ 21.48 billion, or US\$ 572 per capita<sup>4</sup>; that year the economy grew at 5.8%. Uganda is determined to reduce its dependence on foreign aid for development; domestic revenues will cover 81.8% of the total 2014-2015 fiscal year budget<sup>5</sup>. Ugandan health status indicators are still typical of those of low-income countries: life expectancy at birth is 51.5 years<sup>6</sup>, the maternal mortality rate is 438 deaths per 100,000 live births, under-5 mortality is 96 deaths per 1,000 live births, and the child stunting rate is 33%<sup>7</sup>. While Uganda has seen improvement in a number of health status indicators, the maternal mortality rate has remained virtually flat over the last ten years. Uganda is a signatory to the MDGs; the government has stated its commitment to maximize the country's progress towards these goals<sup>8</sup>.

### ORGANIZATION OF THE UGANDAN HEALTH SYSTEM

To improve the efficiency and effectiveness of service delivery, the government of Uganda has decentralized direct provision and management of health services to districts and health sub-districts (HSD). The Ministry of Health's mandate has been<sup>9</sup> narrowed to policy formulation, planning, standard setting, quality assurance, resource mobilization, capacity development and monitoring and evaluation.

The diagram below shows the structure of the health system.

FIGURE 1 / STRUCTURE OF UGANDA'S HEALTH SYSTEM



Health services in Uganda are delivered by public and private health facilities and organizations. Currently, of the country's 4,496 health units, the government owns 66%, private not-for-profit (PNFP) providers own 20%, and the rest is owned by the private for-profit sector<sup>10</sup>. PNFP providers own 63 hospitals, compared to the government's 65. The private sector is estimated to provide about 50% of service outputs<sup>11</sup>. As is the case in many Sub-Saharan countries, there is a shortage of human resources for health in Uganda; currently only 63% of health positions are filled<sup>12</sup>.

Partnership with the private sector is a key objective of the National Health Policy. In 2012, the country approved a policy for public-private partnership in health that recognized three private sector sub-sector partners: PNFP health providers, comprising mostly faith-based institutions, private health practitioners (PHP) and traditional and complementary medicine practitioners (TCMP). The Ugandan government provides subsidies to the PNFP providers and a few PHP facilities and training institutions. The private sector partners are also engaged in several policy and review fora of the Ministry of Health and districts. The PNFP providers are by far the most organized of the partners, and are deeply engaged in partnership with the government through their umbrella organizations, the medical bureaus.

Health services in Uganda are mostly financed by out-of-pocket (OOP) payments and a public tax-based system supported by health development partners. Total health expenditure (THE) is US\$ 1.6 billion (9% of GDP); of this, the government contributes

**TABLE 1 /** PROGRESS OF HEALTH-RELATED MDGS IN UGANDA – SELECTED INDICATORS

MDG	INDICATOR	BASELINE	CURRENT STATUS	2015 TARGET
4: REDUCE CHILD MORTALITY	4.1 UNDER-FIVE MORTALITY RATE (PER 1,000 LIVE BIRTHS)	156 (1995)	90 (2011)	56
	4.2 INFANT MORTALITY RATE (PER 1,000 LIVE BIRTHS)	86 (1995)	54 (2011)	31
5: IMPROVE MATERNAL HEALTH	5.1 MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)	506 (1995)	438 (2011)	131
	5.2 PROPORTION OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL	37.8% (1995)	58% (2011)	100%
6: COMBAT HIV/ AIDS, MALARIA AND OTHER DISEASES	6.1 HIV PREVALENCE AMONG POPULATION AGED 15-24 YEARS	2.9% (2004/5)	7.3% (2011)	NO TARGET
	6.6 PROPORTION OF CHILDREN UNDER 5 SLEEPING UNDER INSECTICIDE-TREATED BED NETS	9.7% (2006)	42.8% (2011)	NO TARGET
	6.8 PREVALENCE RATE ASSOCIATED WITH TUBERCULOSIS (PER 100,000 POPULATION)	410 (2001)	183 (2011)	103

Source: Uganda MDG Progress Report 2013

22%<sup>13</sup> and per capita THE is US\$ 52. Households contribute 42% of the THE, with US\$ 22 being spent per capita as OOP expenses. In 2009/10 the government of Uganda spent 7% of its national budget on health, far less than the 15% target agreed to by the heads of state of African Union countries in the 2001 Abuja Declaration. It is well known that when THE is heavily financed by OOP expenditure, inequities in health widen and the incidence of catastrophic health expenditures increases<sup>14</sup>. It is exceedingly difficult to achieve UHC in a situation of high OOP expenditure. In 2009/10 only 14% of THE was spent on reproductive health, and 14% on child health. The Ugandan Ministry of Health plans to implement prepayment mechanisms in the form of health insurance and community-based financing schemes with an option to subsidize the poor for up to 80% of the premium. A voucher scheme is also being considered to address demand-side constraints<sup>15</sup>.

The Health Sector Strategic and Investment Plan defines the Uganda National Minimum Health Care Package as a basic cost-effective package that addresses the major contributors to the burden of disease. Elements of this package have been identified and grouped into four clusters: maternal and child health; prevention and control of communicable diseases; prevention and control of non-communicable diseases (NCDs); and health promotion and community health initiatives. While the majority of the elements address communicable and maternal and child health conditions, it is recognized that the NCD burden is rising fast, as is the case in many developing countries<sup>16</sup>. For example, indicators for coverage along the continuum of care for maternal and newborn health are low: satisfied demand for family planning is 47%, fourth antenatal visit attendance is 48%, skilled birth attendance is 57%, postnatal care is 33%, exclusive breast feeding is 62%, and measles coverage is 82%<sup>17</sup>.

## UNIVERSAL HEALTH COVERAGE, THE MDGS AND THE POST-2015 AGENDA

### Universal Health Coverage

In 2005 all WHO Member States made the commitment to achieve universal health coverage (UHC). Seen as a powerful

mechanism for achieving better health and well-being, and for promoting human development<sup>18</sup>, UHC is defined as “all people receiving quality health services that meet their needs without risk of financial ruin or impoverishment”<sup>19</sup>. Recently many high-level meetings have focused on the need for governments to work towards achieving UHC. Already high on the development agenda, UHC is now increasingly seen as a priority for the post-MDG agenda and the sustainable development goals being debated at the UN as well. The UHC concept encompasses three critical dimensions: who is covered, which services are covered, and what quality and proportion of the cost is covered<sup>20</sup>.

In Uganda UHC is only implicit: the National Health Policy and Health Sector Strategic and Investment Plan do not expressly mention it in the context in which it is being understood internationally. However, this is due in part to the fact that Uganda's current policy documents were developed before the topic rose to such prominence in discussions at the international level. It could be argued that Uganda is already working to achieve UHC, particularly if we consider its Minimum Health Care Package and planned health financing strategy. The key global health initiatives in Uganda have been the MDGs.

### The MDGs in Uganda and progress so far

Uganda has had mixed success in achieving the MDGs<sup>21</sup>. Of the 19 key indicator targets for the 8 MDGs, 10 have been achieved, 6 are stagnant or slow, 2 had no results and 1 has reversed. In terms of the health-related MDGs (Goals 4, 5 and 6), the indicator for reducing child mortality (MDG4) is on track to being achieved, while the two indicators for improving maternal health are either stagnant or slow. For MDG6 – combating HIV/AIDS, malaria and other diseases – two indicators are on track and one has reversed. Below is a 2013 summary **table** of health-related MDGs in Uganda.

A number of factors are considered to have contributed to Uganda's progress in achieving the MDGs:

- A rise in household income
- Improvement in infrastructure (key examples are rural feeder roads and electricity)
- Complementarities between the MDGs: the outcomes of some accelerated progress towards others
- The penetration of new technologies, particularly mobile phones.

### Uganda beyond 2015: what is the policy direction?

The starting point for the way forward in Uganda in 2015 and beyond are the drivers of the MDG progress mentioned above. Their implications for the post-2015 development agenda are now being discussed<sup>22</sup>; the success factors will guide decisions as to which policy interventions to prioritize in order to accelerate this progress up to and beyond 2015.

At the international level, there is an ongoing debate on what should succeed the MDGs. The emerging theme is that the world needs to tackle the root causes of underdevelopment rather than just its symptoms, as was the case with the MDGs. The Ugandan strategy, as laid out in the National Development Plan, is based on the idea that the ultimate objective of improving human welfare has to be achieved through a development strategy focused on the underlying drivers of economic progress. This is very much in line with the emerging international theme beyond MDGs.

The new planning frameworks for Uganda contained in Uganda Vision 2040 and the National Development Plan and sector plans involve a shift in government focus: from ensuring macroeconomic stability and the provision of social services, to taking on an additional, more ambitious role, bringing about a structural transformation in the economy through improvements in productivity and a dramatic increase in infrastructure investments, especially for oil, energy (electricity from renewable sources), transport and information and communications technology (ICT)<sup>23</sup>.

Economic development and improvements in the institutional architecture of government service delivery are expected to dramatically increase health development outcomes, including those related to the MDGs. Increased economic growth is expected to lead to increased public resources for services; this will need to be matched with public sector efficiency and new institutional arrangements, including public-private partnerships.

Modeling simulations indicate that Uganda's education, health and access to water and sanitation MDGs, which were set internationally, are very ambitious and may not be achieved even by 2030 in the business-as-usual scenario. The Uganda Vision 2040, however, is expected to deliver much larger gains<sup>24</sup>. For example, the infant mor-

tality rate target is expected to fall from 63 to 4 deaths per 1,000 live births, the maternal mortality ratio from 438 to 15 deaths per 100,000 live births, the under-5 mortality rate from 96 to 8 deaths per 1,000 live births, and the child stunting rate from 33% to 0%. Whatever is done, the biggest challenge in achieving the health-related MDGs is to ensure that all women and children, and indeed the entire population, have access to life-saving interventions along the continuum of care. This is why reference to and work towards UHC is important in any policy strategies adopted by countries. Current levels of intervention coverage are too low, and mean missed opportunities<sup>25</sup>.

### Conclusion

UHC is increasingly high on the international development agenda, and may become the main resolution in the post-2015 agenda. In Uganda's health policy and plans, UHC is not yet a well-developed concept; however, the country's package of services and implementation and financing strategies work implicitly towards UHC. Uganda has embraced the MDGs and made important progress in a number of these goals. Progress towards achieving the key health-related MDGs – particularly those related to maternal health and HIV/AIDS – has not been what was hoped for, mainly because of the low level of coverage of key health services. For this reason, if Uganda wants to progress more quickly in this sense from 2015 onwards, it will be essential that it embrace UHC.

Uganda must review its current health financing mechanisms, reduce the heavy reliance on OOP funding for health services and increase public funding to health for both public and other key actors, particularly the PNFP sub-sector. Should the current funding mechanisms remain in place, there is almost no hope of achieving UHC. Uganda has laid out a very ambitious development vision and plan for 2015 and beyond. It is largely focused on a transformation of the Ugandan economy and economic growth that is expected to deliver more for human development and health than the current scenario does. However, serious questions remain regarding the validity of the claim that economic development will indubitably lead over time to improved health and health care for Uganda's people<sup>26</sup>.

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## EXPERIENCES FROM THE FIELD

# THE MIRAGE OF UNIVERSAL HEALTH COVERAGE IN ETHIOPIA

As the end date of the twenty-year plan for developing the country's health care system nears, the Ethiopian Ministry of Health is working on a new plan for the next twenty years whose objective is to achieve universal health coverage (UHC) through a further expansion of primary health care. Will this be possible?

TEXT BY / FABIO MANENTI / DOCTORS WITH AFRICA CUAMM

### SOCIOECONOMIC AND POLITICAL CONTEXT

Ethiopia is a federal republic made up of nine regional states. It occupies a vast area of around 1.1 million square kilometers and has a population of over 96.6 million inhabitants, with an annual population growth rate of 2.89% (2014 CIA estimate). Eighty-three percent of the population lives in rural areas with poor access to health care facilities due both to the lack of transportation and passable roads and to the limited number of such facilities. With a Human Development Index of 0.396<sup>1</sup>, the country ranked 173 out of the 186 countries surveyed by the UNDP in 2013. Thirty-nine percent of the population lives below the poverty line (US\$ 1.25 per day), with a gross national income (GNI) per capita of US\$ 410 (World Bank 2013). Life expectancy at birth is 59 years for men and 62 for women. Ethiopia's overall per capita health expenditure is US\$ 16, well below the minimum recommended by the WHO (US\$ 40).

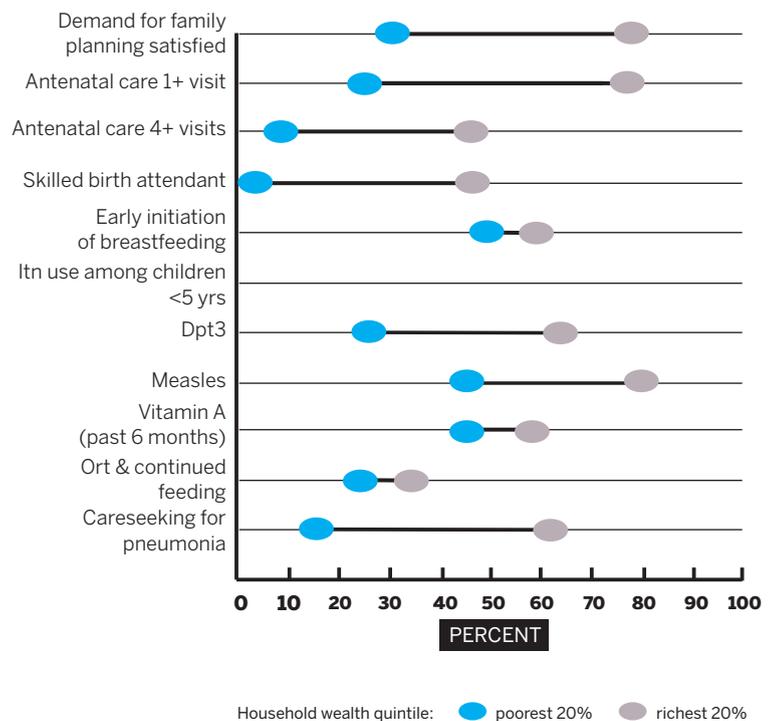
### HEALTH CONDITIONS: THE MILLENNIUM DEVELOPMENT GOALS, PROGRESS AND LIMITS

A twenty-year development plan launched in 1995 is about to draw to an end. Structured in four stages, it has helped to improve the health status of Ethiopians through a massive expansion of primary health care. This was made possible by the launch of an initiative known as the "Health Extension Programme" that provided for the training of community-level health workers ("health extension workers") and mid-level professionals (nurses, obstetricians and health officers), as well as a major expansion of health care centers and posts and, more recently, of district hospitals.

In accordance with the United Nations Millennium Development Goals, the plan has helped to achieve Goal Four (reducing child mortality) and many of the targets for Goal Six (combating HIV/AIDS, malaria and other diseases), while there is some evidence that Goal Five (improving maternal health) might be achieved by 2015 thanks to the extremely focused efforts that have been made at every level over the past four years. Although the 2011 Ethiopia Demographic Health Survey (EDHS) failed to show any real reduction in the maternal mortality rate since 2005 (676 maternal deaths per 100,000 live births), more recent

(2013) data<sup>2</sup> seem to point to a 70% reduction since 1990, with the maternal mortality rate having declined to 420 maternal deaths per 100,000 live births. This is in contrast to data provided at the MDG Countdown 2013: assisted delivery coverage for around 10% of expected deliveries (while the official 2012-13 figure is 23.1%<sup>3</sup>), with major inequality still existing between the poorest (2%) and richest (47%) quintiles, as shown in **Figure 1**.

FIGURE 1 / SOCIOECONOMIC INEQUITIES IN COVERAGE



### THE HEALTH CARE SYSTEM: ORGANIZATION, PUBLIC AND PRIVATE FINANCING, HUMAN RESOURCES

Despite major developments in terms of infrastructure, the Ethiopian health care system is still highly inadequate with respect to the size of the country and of its population. The latest available figures<sup>4</sup> show a total of 16,048 health posts, 3,245

health centers, 132 primary care or district hospitals, 122 general hospitals and 2 national specialized hospitals. Most of these facilities are public; there are around 60 private hospitals<sup>5</sup> (30 in Addis Abeba alone) and just 10 non-profit ones, run by various faith-based organizations. There are also other private facilities, clinics of varying levels of quality, both middle and high; most of these are for-profit.

The public health care system has a three-tiered pyramid structure: health posts (around 1 for every 5,000 inhabitants), whose activities are largely preventive; health centers; and district hospitals. The best-equipped hospitals are the zonal, regional and top national ones. The private system interacts to some extent with the rest of the system; it is not truly integrated with or complementary to it, but it does make up, at least in part, for the serious deficiencies of the public system. Use of outpatient services is the same as it was ten years ago, with 0.34 such visits per capita per year, and the same holds for the use of the few hospital beds available (with an average occupancy rate in recent years of around 35%; a 2009 study<sup>6</sup> surveying 13 hospitals reported a rate of 68.9%). There are numerous reasons for this situation, including the relatively poor quality of services, both real and perceived (absenteeism, lack of motivation or of skilled medical staff), the frequent non-availability of medicines and, last but not least, the price of services, which are theoretically free but usually end up costing patients, at least for the medicines, due to the facility's policy or non-availability.

In order to tackle these problems and increase use of health care facilities, the Ministry has introduced a series of financing mechanisms aimed at improving the quality and availability of services. These include:

- the possibility for facilities not only to charge user fees, but also to keep a part of them for improving services;
- support for exemption from payment by the poorest; at the request of the interested party, the public authority certifies his or her economic status and reimburses the health care

facility for costs incurred. In reality, data from 2012 indicate that for the more than 2.5 million such certificates issued, reimbursements to health care facilities amounted to only around 25 million Birr, i.e., around 10 Birr, or 30 Euro cents, per person;

- private in-hospital services: 45 public hospitals provide private services for a fee, generating revenues that in some cases could theoretically cover up to 60% of the health care facility's recurring costs;
- community and national insurance systems. Current experiences seem to show that the community insurance system could generate about 40 Euro cents for every individual actually using health care services in the same period; the national insurance system for civil servants is not yet active, especially due to its obvious limitations in generating sufficient resources (given the lowness of wages) to cover the cost of the services.

The biggest constraint for building a universal health care system in this country remains the dearth of government resources allocated to health care, which in 2012-13 were just over 4 Euros per capita, even though they accounted for 9.75% of the national budget. According to the latest World Bank figures, out-of-pocket expenditure by patients amount to 80% of private health expenditure, i.e. about 50% of global health expenditure<sup>7</sup>. Finally, the relative lack of skilled human resources continues to be a problem despite strong growth in training at every level. The only WHO target achieved – indeed surpassed (1:2,311) – is that of one nurse for every 5,000 inhabitants. There is only one doctor in Ethiopia for every 26,943 inhabitants, far from the 1 per 10,000 WHO target; similar problems exist with respect to the number of obstetricians and anesthetic technicians. “Accelerated” programs have been put in place to tackle the problem, but there are serious doubts with regard to the quality of the training, in particular that of obstetricians, who due to a lack of on-the-job training are not learning the skills necessary to guar-

TABLE / MATERNAL HEALTH INDICATORS

INDICATORS	EFY 2005 BASELINE	EFY 2005 PERFORMANCE	EFY 2005 TARGET	HSDP IV TARGET (EFY 2007)
ANTENATAL CARE COVERAGE	89.1%	97.4%	90.6%	90.0%
PERCENTAGE OF DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL	20.4%	23.1%	49.2%	62.0%
CLEAN AND SAFE DELIVERY COVERAGE (PERCENTAGE OF DELIVERIES ATTENDED BY HEWs)	13.2%	11.6%	35.2%	38.0%
POSTNATAL CARE COVERAGE	44.5%	50.5%	70.1%	78.0%
CONTRACEPTIVE ACCEPTANCE RATE	60.4%	59.5%	76.2%	82.0%
PERCENTAGE OF PREGNANT WOMEN COUNSELLED AND TESTED FOR PMTCT	36.7%	54.9%	76.0%	83.0%

Source: Efy 2005 Baseline, Performance and Target and Hsdp IV Target

antee the so-called “BEmONC” package in the country’s health centers, including the application of vacuum extractors, manual removal of the placenta and neonatal resuscitation.

## THE POST-2015 AGENDA: UNIVERSAL HEALTH COVERAGE

As the end date of the twenty-year plan for developing the country’s health care system nears, the Ethiopian Ministry of Health is working on a new plan for the next twenty years whose objective is to achieve universal health coverage (UHC) through a further expansion of primary health care.

Given Ethiopia’s rapid and steady economic development – the annual GDP growth rate is around 10% - the country is expected to be able to become a lower-middle-income country by 2025 and a middle-middle income one by 2035, and strategies for developing the health care system and achieving UHC are being defined based on these projections.

Since the main strategy is the expansion of primary health care, accompanied by an evidence-based national health care program with realistic targets translated into annual operative plans at the district level, the key focus is on the development of health infrastructure, equipment and human resources. The areas of priority<sup>8</sup> identified are:

- Mobilizing communities to identify and meet their own health needs through prevention or organization at the community and individual level (for example, creating women’s groups to promote maternal health and ensure that female neighbors have assisted deliveries);
- Strengthening primary health care units and services;

- Strengthening human resources for health, both in terms of quantity and quality;
- Engaging the private sector – which is seen as a potential partner for increasing resources and capacities for the health care system – in support of the Ministry of Health’s vision;
- Developing innovative financing mechanisms with enhanced monitoring, particularly national health insurance;
- Developing the Ministry of Health’s management and control capacities, based on evidence and the formulation of workable policies and rules aimed at achieving UHC.

While one can concur with this type of analysis and comparison with the situation of middle-income countries, overall it seems evident that the current state of Ethiopia’s health care system is precarious, and its real capacity to respond to primary needs doubtful. The intention is to expand the system with a special focus on non-communicable diseases and traumatic injuries; these are certainly emerging problems, but ones that will bring further and even more complex challenges. Likewise for the financing of the health system, where the intention to involve the primarily for-profit private sector overlooks the fact that said sector is less concerned with meeting primary health care needs than selling solutions to them, or indeed even stimulating them. The national health insurance system will in reality be based on the current level of public wages, which tend to be very low and able at best to generate US\$ 30-40 per capita for the insured, who will remain a minority for many years; and all of this in a context where 39% of government expenditure on health is covered by international donors.

In conclusion, while these strategic decisions and goals are certainly ambitious and laudable, their feasibility is highly dubious; the implementation of UHC in a country like Ethiopia is equally uncertain.

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### **MOTHERS AND CHILDREN FIRST IN ETHIOPIA, TOO**

For Doctors with Africa CUAMM, “Mothers and Children First” is not just a slogan; it’s a serious commitment to care for the most vulnerable members of the population. A five-year initiative launched in 2012, this program involves specific interventions aimed at reducing maternal and neonatal mortality and ensuring free access to skilled delivery attendance and neonatal care in four health districts in Angola, Ethiopia, Tanzania and Uganda. Despite major developments in terms of infrastructure, the health care system in Ethiopia is still inadequate with respect to the size of the country and its population; one of the main reasons is government policy, which led to just over 4 Euros per capita being allocated to health care in 2012-2013.







FORUM

## THE VOICE OF THE COMMUNITY IN TANZANIA

“Beneficiary feedback mechanism” is the name of a pilot project that Doctors with Africa CUAMM is implementing in Tanzania’s Iringa District. Begun in mid-2013, the project aims to assess the suitability of ongoing health care interventions in order to fully grasp operational limits and the needs of the local population, and subsequently to strengthen these services in terms of access, quality and equity.

TEXT BY / EDOARDO OCCA / DOCTORS WITH AFRICA CUAMM

### A PILOT PROJECT

“Beneficiary feedback mechanism” (BFM) is a pilot project being carried out in Tanzania’s Iringa District with the participation of Doctors with Africa CUAMM. Begun in mid-2013 and funded by the UK Department for International Development (DFID), the project’s aim is to assess the suitability of the health care interventions being implemented in the region. Under the supervision of World Vision, which is in charge of the assessment, CUAMM has been testing out a system that motivates the beneficiary population to offer their impressions, suggestions and critiques vis-à-vis these services, and collects them for analysis.

The final objective is to appraise the efficiency of the maternal and child health care projects that Doctors with Africa CUAMM has been implementing in the area for years. By measuring the perceptions and use of the health care services by the people living there, the project is expected to provide valuable indicators for improving and strengthening their access, quality and equity, in the context of an integrated “continuum of care” approach. With this information in hand, efforts will then be made to take action at multiple levels in support of the District’s health policies and centers.

The BFM project, which began in August 2014 and will conclude in March 2016, will end up involving some sixteen villages in the division of Kizonpelo, for a total of around 42,000 people.

### HOW BFM WORKS

BFM is being tested out simultaneously in nine different projects in countries in Asia and Africa. It works by way of an innovative new technology based on Frontline SMS, an open source software that makes it possible to gather and send information via text messages and free telephone calls to a special project hotline. Mailboxes and boards will also be set up at strategic points in villages and health centers to ensure that those who do not own a mobile phone can also take part in the project. In this way the local population for whom the health care services are provided will be encouraged to submit their impressions, suggestions and critiques with regard to CUAMM’s health care projects.

The fact that mobile phones are being used to gather data should not be surprising; in fact, even though this is a society still based on subsistence agriculture, their use is quite widespread. One survey carried out in the areas involved in the project found that some 60% of households made up of people of reproductive age own a mobile phone.

The project hinges on its ability to develop a positive relationship with the local population, earning their trust so as to stimulate their willingness to provide suggestions and feedback. The involvement of community health workers (CHW), along with local leaders such as the mayor, health committee and council of elders, is essential in this sense; thanks to the esteem in which these individuals are held by the community, they are able to make people aware of the project’s existence and urge them to take part in it by explaining the positive impact this can have on the quality of health care services available in the area over the medium term. This phase of the project, currently underway, involves the setting up in each village of focus groups made up of the project’s target individuals: primarily pregnant women, their husbands or partners, the elderly and young people of reproductive age who are not yet parents. At this time 64 focus groups have been organized, with the involvement of 458 people; as is to be expected due to local custom, slightly more men (249) have taken part in them than women (209). Explanatory materials will soon be distributed to the group participants; in the meantime the hotline number for offering feedback, managed by a person with relational and social sciences training, is already in place and some initial hesitant responses have been coming in.

The assessment is not being carried out through the use of questionnaires or structured questions. Instead – at least in this initial phase – it involves the spontaneous gathering of the impressions, comments and critiques of the local community during the focus group sessions. The priority areas and needs of the target population will thus emerge, and only subsequently, depending on the quality and quantity of the responses, will decisions be made regarding whether to use structured questionnaires or possibly conduct surveys on specific topics.

Given the sensitive issues involved (pregnancy, sexuality, relationships between the community and local health care facilities, as well as other entities), the work is being carried out in close cooperation with the area’s social services and the health care district, so that particularly delicate matters can be dealt with by the appropriate individuals.

## IRINGA DISTRICT

There are around 250,000 inhabitants, 140 villages, a governmental regional hospital and a district hospital, 8 health centers and some 65 dispensaries in Iringa District. The large number of health care facilities makes this district virtually unique in Tanzania; indeed, around 90% of births there are assisted by skilled attendants within health facilities, and there is nearly universal access to PMTCT (Prevention of Mother-to-Child Transmission) programs. However, a serious problem exists in terms of the quality of health care services. Health facilities are drastically understaffed in comparison with the standard number of personnel called for by the government: there are usually just one or two health care workers in each dispensary, usually obstetrical nurses, while health centers generally have a clinical officer and nurses, but no medical graduates. There are also serious shortages of medicines and materials at the facilities, and often no electricity or water.

To ensure effective projects on the ground, organizations must have direct, in-depth knowledge of the context in which they are being implemented, not merely in terms of knowing the statistics, but also being familiar with the beliefs and values of the project's beneficiaries. For example, working in liaison with both the formal and informal governing bodies of the village has proven to be decisive in the concrete implementation of BFM; indeed, it is crucial to understand that in the culture of Tanzania and of the Wahehe people, figures such as the council of elders continue to be invested with great moral authority and acknowledged as the community's formal leaders. Given this sociocultural context, projects must be sure to take into account not only the authority of governmental institutions but also that of village leaders.

## WORKING TOGETHER WITH THE LOCAL COMMUNITY

Doctors with Africa CUAMM has a significant presence in this area: thanks to its ongoing support to the dispensaries and health centers there and its extensive work within the community, the organization has achieved very positive results in terms of increasing access to prenatal and postnatal visits and expanding HIV testing (at 9.1%, Iringa has the second highest HIV prevalence in Tanzania), exclusive breastfeeding, preparation for delivery and men's engagement in their partners' pregnancies. Because the local community is already familiar with our work, we hope that it

will take part in the data collection project without undue reluctance or apprehension.

## DATA COLLECTION

Although the local population is not accustomed to being consulted on matters that have always been the exclusive prerogative of the authorities, it has begun to offer information, suggestions, critiques and ideas. Specific issues are clearly emerging, including complaints about the lack of cooperation by health workers and/or local authorities and requests to be kept better-informed about the educational campaigns run primarily by community workers. There have also been many reports of domestic violence, malnourished children and/or abuses of other sorts, as well as cases that are normally settled by customary law (which is orally handed down), a system that is still used alongside official civil and criminal law. We have also received queries having to do with the use of arable land, water, communal areas, i.e. rights of an "everyday" nature. Given the sensitive nature of some of the reports received, it is CUAMM's policy to refer the most complicated cases to the appropriate district departments, not just the one in charge of health matters, but also the social and administrative services, which are asked to respond to the situations promptly with the double aim of showing people the utility and efficacy of sending their text messages.

## LISTENING TO THE VOICE OF THE COMMUNITY TO ACHIEVE A COMMON GOAL

It is our hope that over time, this initiative will not only generate a greater sense of belonging on the part of local people, but also make available a substantial enough number of suggestions to help shape ideas for future projects, enabling us to respond even more effectively to people's real needs.

It is encouraging to report that eight villages not currently involved in the BFM initiative asked immediately to be allowed to take part in it – a sign that the project is being talked about, generating positive dynamics and a desire for active participation among the community.

For CUAMM, the BFM project is a unique, invaluable opportunity to pay respect to the rights of the individual, encouraging the communities with whom we've embarked on a common journey to speak out, then listening to what they have to say and helping them to achieve their right to health.



## TAKING A CLOSER LOOK

### STIMULATING HEALTH CARE SERVICES DEMAND

A pilot project in support of the Mothers and Children First program aims to assess the effectiveness of incentives such as transport vouchers and baby kits on pregnant women's access to, and use of, health care facilities. *Initial* results and an assessment from Uganda's Oyam District.

TEXT BY/ MARIA NANNINI / GRADUATE OF THE UNIVERSITY OF FLORENCE'S BACHELOR'S DEGREE PROGRAM IN ECONOMIC DEVELOPMENT AND INTERNATIONAL SOCIO-MEDICAL COOPERATION

#### MATERNAL AND NEONATAL HEALTH IN UGANDA

Uganda lags far behind with respect to maternal and neonatal health, with persistently high mortality rates: maternal mortality is 360 deaths per 100,000 live births and neonatal mortality is 23 deaths per 1,000 live births. The coverage rate for skilled birth attendance, a key factor in preventing maternal mortality, is still low: on average just 58% of deliveries are handled by a skilled attendant. Moreover, coverage for maternal and neonatal services is much more limited for those living in rural areas and for the most vulnerable segments of the population<sup>1</sup>.

Underlying this lack of progress are various types of obstacles, including financial constraints, poor geographical accessibility to health care facilities due to transport difficulties and long distances, women's lack of decision-making power, the low quality of health care, poorly motivated health care workers, and women's preference to be assisted by relatives, friends and/or unskilled birth attendants.

Various strategies can be implemented in order to improve access to maternal and neonatal health care services, using both a supply side approach that focuses efforts on the delivery of services, and a demand side approach that gears interventions directly towards the users of the services. The former type of approach involves strengthening the health care system, allocating more resources to it, and offering performance-based incentives to health care personnel. The latter involves transferring resources to the most vulnerable members of the population, including both monetary and non-monetary incentives aimed at encouraging the use of services; conditional cash transfer (CCT) programs are the best-known scheme of this type.

Like many other developing countries, Uganda has adopted a number of strategies to improve access to skilled birth attendance services; most have focused on the supply side, with less attention being given to the demand side. Hence with the pilot project titled "*Evaluation of the effect of demand side incentives on utilization of delivery services in Oyam district: A study protocol*", Doctors with Africa CUAMM aims to examine the impact that providing women with two types of incentives, transport vouchers and baby kits, can have on the demand for birth attendance services.

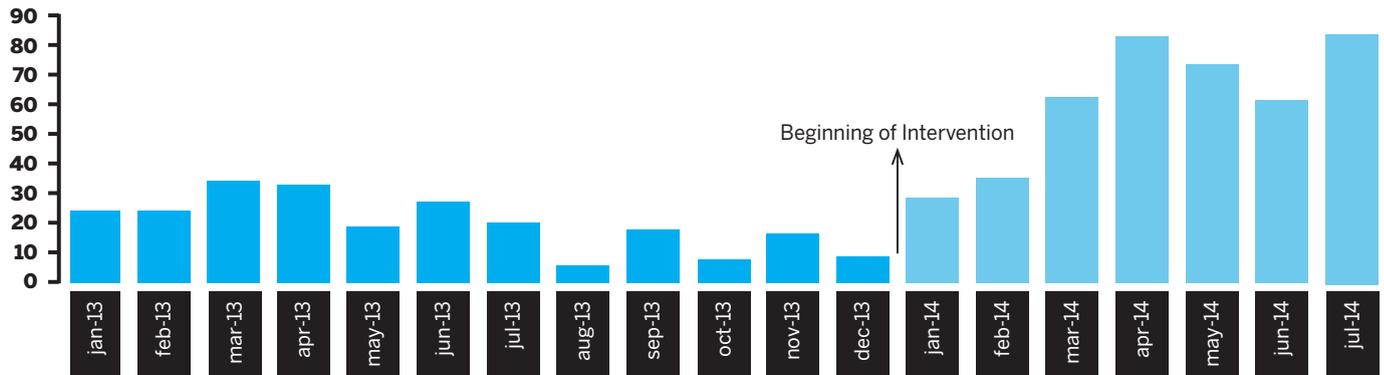
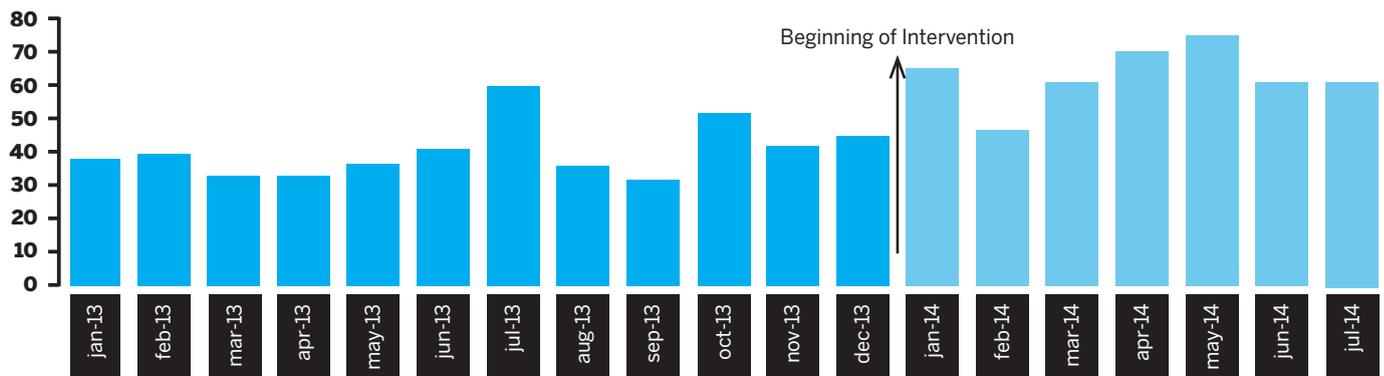
#### TRANSPORT VOUCHERS AND BABY KITS: HOW TO SPUR DEMAND FOR HEALTH CARE SERVICES

Oyam District, located in Northern Uganda, is particularly weak in terms of maternal and neonatal health. Due to a range of barriers impeding access to services, most women give birth at home, and only 40.8% of deliveries are attended by skilled health care workers.

With the *Mothers and Children First* program in 2012, Doctors with Africa CUAMM launched a 5-year initiative to guarantee free access to maternal and neonatal health care in the district, with the aim of increasing access to, and use of, these services. To this end, the program adopted a mix of strategies both on the demand and supply sides, including reducing or eliminating user fees, improving the health system in question, mobilizing the community, and improving the quality of care being offered at health facilities.

In addition to the standard intervention, which was carried out throughout the entire district, Doctors with Africa CUAMM decided to also implement the pilot project, which focuses on using incentives to try to influence demand. The primary aim of this study, in fact, is to assess the effectiveness of transport vouchers and baby kits as incentives for increasing the use of birth attendance services in the poorest administrative units in Oyam District. In addition, it aims to:

- compare the cost-effectiveness of transport vouchers and baby kits for assisted deliveries, in order to implement the best strategy in the other units of the district;

**FIGURE 1 / ASSISTED DELIVERY TREND IN HEALTH UNITS WITH DISTRIBUTION OF TRANSPORT VOUCHERS****FIGURE 2 / ASSISTED DELIVERY TREND IN THE HEALTH UNITS WITH DISTRIBUTION OF BABY KITS**

- assess the impact of the incentives on the use of antenatal and postnatal health care services.

The project will run for twelve months, from January to December 2014.

The research uses a comparative approach, with a quasi-experimental scheme that includes two intervention arms and two control arms. The two incentives – transport vouchers and baby kits – are being implemented separately in the two intervention arms in order to assess them separately; in addition, the performance of the two control units is being monitored. In the Achaba administrative unit, transport vouchers are given to pregnant women who go to health care facilities to receive antenatal care. The vouchers make it possible for the women to use any type of local transport available (motorcycles or bicycles) to get to the health care unit in question (one of two second-level Health Centres) for help with delivery or obstetric emergencies.

The aim is to minimize their transport costs.

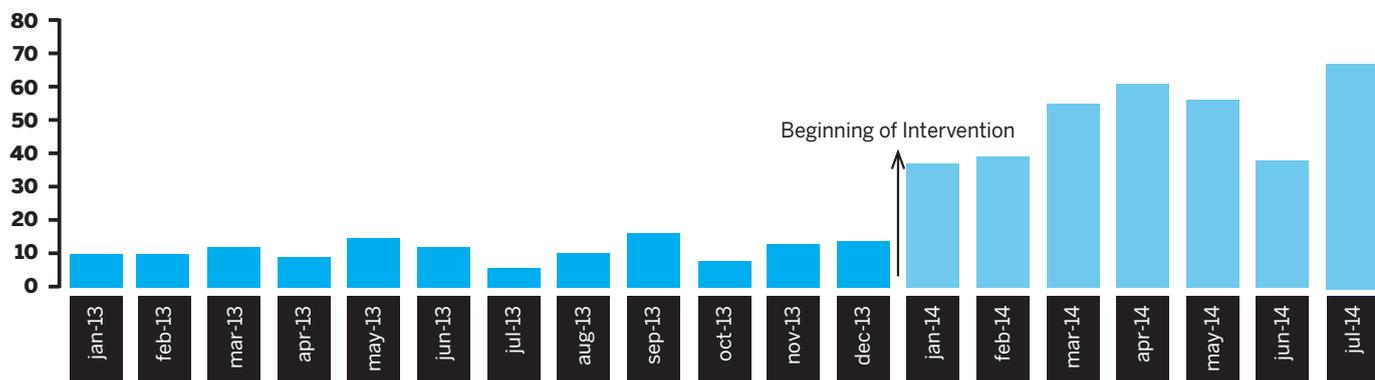
In the Ngai unit, baby kits are distributed to all the women who give birth in the health care unit in question (a third-level Health Centre). Each kit includes:

- a plastic basin;
- half a bar of soap;
- a sheet;
- a piece of fabric to wrap the newborn in;
- half a kilogram of sugar.

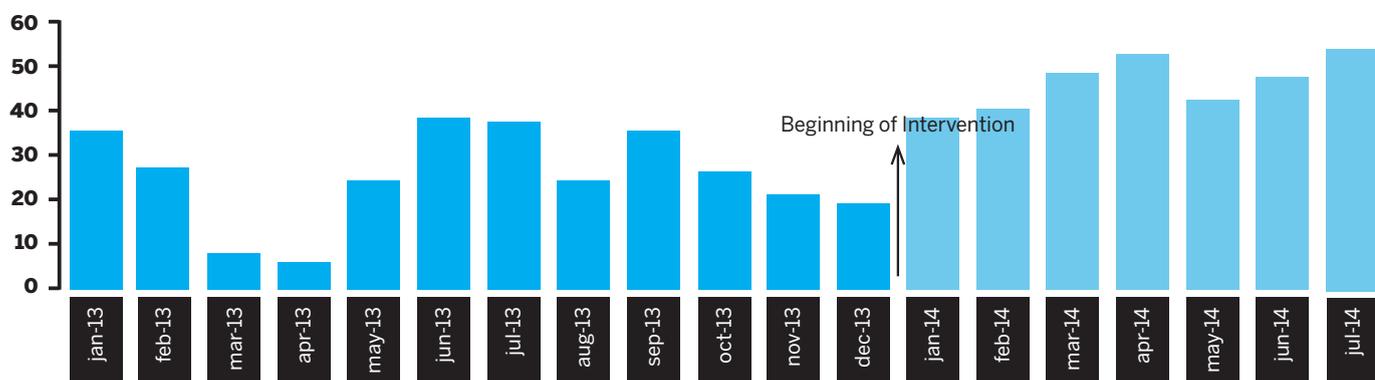
The aim here is to cut down on the costs of caring for the newborn.

In order to assess how the two incentives work, the primary outcome is considered to be the rate of skilled birth attendance coverage. The use of antenatal and postnatal health care services are considered secondary outcomes. Thus data collection in each of the Health Units includes monthly recording of the number of deliveries, prenatal visits (first and fourth) and initial postnatal visits. Another parameter considered is the number of outpatient visits, which serves as an indicator of the general performance of the Health Units under observation; the aim of this measurement, meant as a means of verification, is to confirm the causal relation between the intervention and the outcomes.

**FIGURE 3 /** FOURTH PRENATAL VISIT TREND IN THE HEALTH UNITS WITH DISTRIBUTION OF TRANSPORT VOUCHERS



**FIGURE 4 /** FOURTH PRENATAL VISIT TREND IN THE HEALTH UNITS WITH DISTRIBUTION OF BABY KITS



The data collected include results for the 12-month period prior to the intervention, from January to December 2013 (which constitute the baseline for analysis) as well as those for the 12-month period of the intervention, from January to December 2014, in all of the Health Units under observation.

**INITIAL PROJECT RESULTS**

An interim review carried out in August 2014 and assessing the first seven months of the intervention (January to July 2014) showed the initial impact of the incentives on demand for maternal and neonatal health care services.

In the Health Centres where the pilot project is underway, there was a significant increase in the number of assisted deliveries: both incentives ended up boosting demand for quality maternal health care services. In particular, the transport vouchers led to a 137% increase in the number of assisted deliveries, with the coverage rate rising from 17% to 40%. In the Health Unit where the baby kits were provided as an incentive, assisted deliveries increased by 57%; thus the percentage of women using the service rose from 26% to 46%.

The incentives had a secondary effect on demand for antenatal visits, as well; in fact, use of the fourth visit went up by 377% when the transport vouchers (which are provided in the course of the visits) were used as incentives, and by 83% when the baby kits were used as incentives.

In conclusion, although we have to await the final data collection in order to have the full picture, the initial project results already show that both types of incentives are effective in increasing access to quality maternal health care. However, we still need to take into account the fact that the success of the pilot project, which has addressed the issue from a demand perspective, is taking place in a setting where actions to improve supply are also being implemented. In fact, inadequate progress in terms of quality, coverage and equity can be successfully tackled through the right combination of demand and supply strategies, in such a way as to provide adequate health care services and simultaneously bring benefits to the most vulnerable segments of the population.

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## THE CHALLENGE OF RWANDA

The rebuilding of the health care system was made possible through a community-based health insurance system, the training of village-based community health care workers, and increased spending on health care, both as a higher percentage of government expenditure and thanks to the contribution of international donors.

TEXT BY / SILVIO DONÀ / PADOVA UNIVERSITY HOSPITAL

Twenty years have gone by since the Rwandan genocide took place in 1994: in just a few months one million Tutsis were brutally slaughtered, another two million were forced to flee the country, a quarter of a million women were raped, with the HIV virus being used as a weapon of war, and Rwanda found itself on the edge of the abyss, its socioeconomic and health care systems nearly completely wiped out.

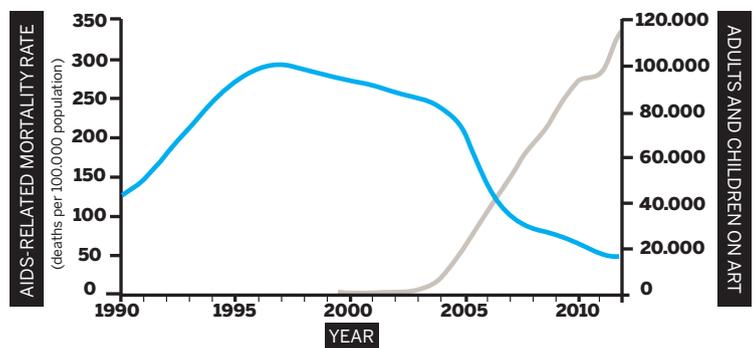
Today, despite the pessimistic predictions of the experts, Rwanda has gotten back on its feet thanks to the leadership of a government that in 1998 instituted a forward-looking plan for national development – “*Vision 2020*” – and later, in 2003, drafted a Constitution that set out the principles of social cohesion and people-centered development. The latter was founded on the precept of equity in health care, defined in turn as an inalienable right.

The rebuilding of the health care system was made possible through a community-based health insurance system (*Mutuelle de Santé*, later refined through *Ubudehe*), the training of village-based community health care workers, and increased spending on health care, both as a higher percentage of government expenditure and thanks to the contribution of international donors.

Initially, the health insurance system called for a set fee to be paid irrespective of income level, thereby exposing the most vulnerable to the risk of a so-called “health catastrophe” in the case of severe illness. This was later changed, with the institution of three different fee levels based on one’s socioeconomic status; moreover, the very poorest – some two million Rwandans – were in effect exempted from both fees and co-payments for services received, thanks to contributions by the PEPFAR and Global Fund programs. A performance-based payment system is used to ensure that national guidelines are properly implemented and that health care personnel are monitored so as to prevent unsafe practices, demotivation or negative behavior toward patients. The system remunerates personnel based on the services actually provided, rather than distributing incentives indiscriminately. Its effectiveness is linked to a computerized medical surveillance system.

The results have been impressive. The widespread availability of antiretroviral therapy, for example, has led to a sharp drop in mor-

FIGURE 1 / HIV/AIDS IN RWANDA, 1990-2012



tality (see **Figure 1**). The response to the AIDS crisis has acted as a catalyst for strengthening primary health care, ensuring the availability of a package of basic health care services at the village level. Currently over 97% of Rwandan children are vaccinated for ten diseases – diphtheria, tetanus, whooping cough, polio, measles, German measles, hepatitis B, pneumococcus, Haemophilus influenza and Rotavirus – and 69% of births take place in health care structures. Infant and maternal mortality rates and mortality rates from malaria and tuberculosis have also fallen sharply, and are beginning to approach world averages and the Millennium Development Goal targets.

Despite these success stories, we cannot look away from various unresolved problems that could jeopardize the further progress of Rwanda. The government led by President Paul Kagame, in power for two decades now, has maintained its hegemony through political repression and the violation of human rights. President Kagame has also been accused of fomenting the conflicts and political instability that have always existed in the Great Lakes region, particularly in the neighboring Democratic Republic of Congo. It is critical that solutions to these problems be found in order to ensure continued improvement in the conditions of the Rwandan people, who are – and this is a direct quote from an article by the Minister of Health, Agnes Binagwaho – the “nation’s most precious resource”.

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## REPORT

# THE NEW INTERNATIONAL DEVELOPMENT COOPERATION

An important change for NGOs – or perhaps we may call them civil society organizations – that employ public administration personnel as aid-workers (in the case of CUAMM, doctors, nurses and obstetricians in particular): the right to a renewable leave of absence of up to four years.

TEXT BY / ANDREA BORGATO / DOCTORS WITH AFRICA CUAMM

On 1 August 2014, the Italian Senate definitively approved a new law on international development cooperation, which is considered as an “integral and key part of our country’s foreign policy”. Even the new name given to the governmental bureau testified to an unmistakable, practically unanimous political will; the new law (no. 125/2014), in fact, changed the bureau’s name to the “Ministry of Foreign Affairs and International Cooperation”.

Thus after the unsuccessful attempts of several past legislatures to reform and modernize the Italian regulatory framework, in part due to the evolving international scenario and the increasing number of interlocutors, both institutional and otherwise, the Italian Parliament finally responded to the urgent requests of groups such as the country’s NGOs to move beyond the obsolete 1987 law on development cooperation (no. 49/1987).

The new law seems more straightforward and open to civil society than the former one. At the same time, holding firm to its commitment to the founding values of international solidarity, it is also more exacting with respect to the efficiency and the effectiveness of interventions. The law is based on the principles of the United Nations Charter and the EU’s Charter of Fundamental Rights, and its aim – in keeping with the tenet underlying Article 11 of the Italian Constitution – is «to contribute to the promotion of peace and justice, and to seek to advance sound and equal relationships among the world’s peoples based on the principles of interdependence and partnership».

Formulating the law was not an easy process, yet it was unquestionably a participatory, open one involving a broad range of stakeholders – NGOs, the profit and non-profit worlds, institutions, foundations and others – in a way that probably had not occurred in the past. It is likely – indeed, perhaps inevitable – that the final outcome was unable to fully satisfy everybody. However, the new law appears to “have what it takes” to enable Italy’s development cooperation bureau to proceed on an equal footing with those of other countries, doing more and doing it better.

From now on there will be closer coordination among the various actors involved: the Ministry of Foreign Affairs and International Cooperation, which will now have a Vice Minister for Cooperation,

will be in charge of political orientation, while a new independent body, the Italian Cooperation Agency, will have management and control functions and will therefore be responsible for carrying through the aforesaid political decisions.

Italian development cooperation is now for everyone. All-inclusive, it has broadened to involve small and medium-sized businesses in the private sector as well, helping them to internationalize within a self-governing regulatory framework. The reform also calls for the creation of a National Council for Development Cooperation whose aim will be to bring together the interests and sensitivities of the different stakeholders involved, enabling ongoing consultation and exchange.

Another innovation, in line with the policies of other EU member states, is the role of the *Cassa Depositi e Prestiti*, or Deposits and Loans Fund, which will act as the “financial arm” of Italian development cooperation, channeling EU resources allocated to Italy for international aid and improving access to and control and coordination of other multilateral international funds.

The law brings an important change for NGOs – or perhaps we may call them civil society organizations – that employ public administration personnel as aid-workers (in the case of CUAMM, doctors, nurses and obstetricians in particular): the right to a renewable leave of absence of up to four years. Until now there had never been such openness, something that takes on even more significance given that civil servants involved in other projects not necessarily financed by or directly linked to development cooperation will also have this right.

The implementing decrees that will enable the new law to be put into effect are currently being formulated. This is an important technical transition, one on which the future functioning of the organisms that it instituted and the workings of the relationships between the various parties will depend. It is our hope that the method used to devise the law – a process that gave voice to all stakeholders – will now provide further opportunities for dialogue, with the end goal of cutting down on red tape and other obstacles and allowing the law to be implemented swiftly and innovatively.

# HEALTH CARE FOR IMMIGRANTS IN ITALY

It is crucial that the inclusive approach taken by legislators be coupled with a similarly constructive stance by local administrations, which have over time become the real protagonists behind the social and health care policies for foreign nationals in Italy.

TEXT BY / SALVATORE GERACI / SIMM - ITALIAN SOCIETY OF MIGRATION MEDICINE

## AN INCLUSIVE STRATEGY

The right to health care coverage for non-European Union nationals in Italy – even those lacking the necessary documents for entry and stay – is guaranteed thanks to Legislative Decree 286 of July 1998, the “*Consolidated Act of Provisions concerning immigration and the condition of third-country nationals*”. The principles and provisions contained therein became easier to put into effect with the enactment of the regulations for implementation provided for by the Act itself (Presidential Decree no. 394 of 31 August 1999) and by the Ministry of Health’s Memorandum no. 5 issued in March 2000. The stated objective of this political and regulatory approach is to fully incorporate into the system of health care rights and duties those immigrants who are legally in Italy and holders, for the most part, of medium- or long-term permits (for reasons of work, family or asylum), matching their conditions and opportunities to those of Italian citizens. Thus the Act eliminated a series of requirements (having to do with residence, permit duration, differentiated tax rates for enrolment in the National Health Service, or SSN) that had acted in the past as impediments, and introduced principles of equity such as obligatory SSN enrolment regardless of official immigrant status and exemption for those experiencing major hardship, e.g. asylum seekers and prisoners. The right to health care was also extended to those in Italy illegally (*stranieri temporaneamente presenti* – STP, or “temporarily present foreign nationals”), guaranteeing them access not only to emergency services but also to essential and continuing health care and preventive medicine programs. Thus a strategy of inclusion was enacted, putting Italy in the vanguard of immigrant destination countries.

## THE ROLE OF LOCAL ADMINISTRATIONS

For EU citizens on short-term stays in Italy health care coverage is guaranteed by the *Tessera Europea di Assicurazione Malattia* (TEAM), or European Health Insurance Card, issued by one’s country of origin; those on longer-term stays can enroll in the SSN

or purchase private insurance. However, some EU citizens – for example, those on long-term stays without regular work, those who do not have a TEAM card or who have not become legal residents – are still left without adequate health care coverage. In practice, such individuals have access only to emergency services. Almost all of the country’s administrative regions have regulated the access of such individuals to health care services, matching it to that of STPs through the “non-enrolled European national” (ENI) code, which guarantees universal coverage in keeping with the Italian Constitution.

## INCONSISTENT APPLICATION OF THE LAW

It is crucial that the inclusive approach taken by legislators be coupled with a similarly constructive stance by local administrations, which have over time become the real protagonists behind the social and health care policies for foreign nationals in Italy, since they are the ones that actually implement said policies. However, it is precisely here that we have seen worrisome arbitrariness and discontinuity in terms of the law’s application, depending on the direction of national and local political winds. Indeed, Italy’s regional health care systems are operating in highly dissimilar ways, leading to a progressive divergence of the 21 systems, which often deviate, particularly with respect to vulnerable groups such as immigrants, from the minimal health care standards and principle of equity that underlie the SSN. In order to prevent this, on 20 December 2012 a formal agreement was enacted during a session of the *Conferenza Stato-Regioni e Province autonome* that, while not actually a new law, mandates how existing legislation must be interpreted, including important changes such as the possibility for immigrants without a permit of stay to enroll their children in the SSN (see *Gazzetta Ufficiale* no. 32 of 7 February 2013). Nearly two years after it was approved, this agreement has yet to be applied in a uniform and widespread manner.

To learn more:  
[www.simmweb.it](http://www.simmweb.it) [www.saluteinternazionale.info](http://www.saluteinternazionale.info)



### **THE ROUTES OF AFRICAN MIGRANTS THAT LEAD TO... AFRICA**

The routes traveled by African migrants do not lead to the wealthy countries of Europe, the Middle East or North America alone. Frequently these individuals choose to cross their own countries' borders, yet remain within the African continent.

According to data from the IOM (International Organization for Migration), seventy percent of West African migrants decide to leave their homes without leaving the actual region. Every year at least 20,000 people from the Great Lakes region and the member states of the Southern African Development Community (SADC) head for South Africa. According to a UN report, in 2013 some 15.3 million African migrants moved within Africa, while 8.9 million migrated to Europe.



# THE FAMILY HEALTH CENTER FOR IMMIGRANTS

The Reggio Emilia Family Health Center provides medical care and support to immigrants who are temporarily present in Reggio Emilia but are not yet in possession of the necessary permits, or are in Italy illegally. Here, they have access to general health care and pediatric, OB/GYN and dentistry services.

TEXT BY / ANDREA FORACCHIA / VOLUNTEER DOCTOR AT THE FAMILY HEALTH CENTER FOR IMMIGRANTS

## A PLACE WHERE ILLEGAL IMMIGRANTS RECEIVE SUPPORT AND CARE

The Family Health Center for Immigrants (CSFS), founded in Reggio Emilia in 1998, is a place set up by the local health care unit (AUSL) in order to provide health care to illegal immigrants. Working in cooperation with Caritas, the Center's aim is to ensure that **foreign nationals temporarily present** in the Province of Reggio Emilia who are illegal or not yet in possession of the necessary permits, and who are without socio-medical coverage, have access to physical and psychological health care and services for prevention and infectious diseases. CSFS has also broadened its objectives to include assistance and support for individuals who do have a permit of stay, but who – for a variety of reasons – have poor proficiency in Italian or insufficient familiarity with the network of services available, and therefore need guidance and support in order to access them.

The target population, therefore, consists of immigrants who are either undocumented and/or illegal, either because of problems with or lack of a permit of stay or because they are to all intents and purposes illegal – that is, legal in another Italian province, but living temporarily in Reggio Emilia for work or other reasons; or in possession of the appropriate permits, but not enrolled in the National Health Service either by choice, or because they do not know their rights, or due to bureaucratic problems such as legal appeals, unemployment or because they are waiting to be sentenced. Most of the immigrants who use the Center's services come from China, Eastern Europe and Nigeria.

## SERVICES AND SPECIFIC HEALTH CARE FACILITIES

Out-patient services are provided by a general practitioner, a pediatrician, an obstetrician and a gynecologist. Three weekly out-patient visits with a dentist are also offered. In addition to these general health care services, there are also special-purpose services such as:

- Pediatric out-patient care
- “Eva Luna”, out-patient care for indoor and outdoor female sex workers
- TB out-patient care

- Nursing out-patient care
- Obstetric out-patient care
- Out-patient care for care-givers for the elderly.

## HEALTH CARE AND INTERCULTURAL STAFF

The staff of CSFS are health care employees from the local health care unit (AUSL) who have specifically requested to take part in this project and provide their services on a voluntary basis during working hours. They have been trained in the areas of intercultural relations and transcultural medicine, and continue their professional development over time. Another distinguishing feature of the services provided by CSFS since its inception is the presence of a team of cultural mediation professionals, who are on hand to help patients from Arabic-speaking countries, Albania, China, India, Pakistan, Nigeria, Ukraine and Romania.

The collaboration with Caritas, which is governed by a renewable annual agreement that provides for a significant financial contribution by the local health care unit (AUSL) in support of the out-patient services, in particular the dental ones, is highly effective thanks to a shared computerized medical records system and the frequent passage of users from one structure to the other that enables them to make the best possible use of the services provided.

## THE CENTER'S NUMBERS

Every year some 2,500 to 3,000 users access the services at the local health care unit (AUSL) and another 1,000 at the Caritas facility; altogether some 11,000 medical examinations are carried out (8,500 in the AUSL and 2,500 in Caritas). Thirty percent of these are related to OB/GYN needs, with around 150 pregnancies being overseen yearly as well as preventive services, contraception and abortions. Another 10% of examinations are for infectious diseases, while 6% are for pediatric check-ups. Finally, examinations for respiratory problems, for digestive system problems, and for problems of the circulatory system each account for 5%-6% of the examinations carried out.

## THE IMPORTANCE OF OPERATIONAL RESEARCH

Below is the paper that was published in *The Lancet Global Health* in June 2014, following the workshop on “*Intervention tools and strategies to improve health programmes: The role of operational research in low and middle income countries*” held in Brussels on 4 March 2014. Dr. Giovanni Putoto of Doctors with Africa CUAMM was one of the paper's co-authors.

TEXT BY / PAOLA BARBAN / DOCTORS WITH AFRICA CUAMM

On 4 March 2014 a workshop entitled “*Intervention tools and strategies to improve health programmes: The role of operational research in low and middle income countries*” was held in Brussels. Organized by the Science and Technology Options Assessment (STOA), an organ of the European Parliament, the workshop featured the participation of various experts in the field of operational research, including Dr. Giovanni Putoto, who represented Doctors with Africa CUAMM.

A paper based on the findings of the workshop was subsequently published in *The Lancet Global Health*. It highlighted the need for the European Union to boost its commitment to, and support for, operational research, recommending that this type of research be embedded into national programs and health systems in order to improve health strategies and care in low and middle income countries. In accordance with the workshop's findings, Doctors with Africa CUAMM is working to strengthen the operational research component of its own health programs in Africa, to the

end of improving the health of African peoples and the performance of the continent's health care systems. One concrete result of this commitment is a recent collection<sup>1</sup> of scientific articles published in medical journals and based on the clinical and epidemiological research that CUAMM has conducted in the hospital wards and rural districts where it is active.

Thanks to its own fieldwork, Doctors with Africa CUAMM recognizes the importance of carrying out research in the area of universal health coverage as well, in order to expand health care coverage throughout Africa. The scientific evidence generated through such research is essential for understanding how to improve coverage for existing interventions, as well as how to introduce new ones; the findings must then be translated into policy choices and best practices. Below is the article, authored by a group of experts from several institutions, non-governmental organizations and research centers, that was published in *The Lancet Global Health* in June 2014 (vol. 2).

### Calling on Europe to support operational research in low-income and middle-income countries

TEXT BY / GIANLUCA QUAGLIO<sup>a</sup>, ANDY RAMSAY<sup>b,c</sup>, ANTHONY D HARRIES<sup>d,e</sup>, THEODOROS KARAPIPERIS<sup>a</sup>, GIOVANNI PUTOTO<sup>f</sup>, CHRIS DYE<sup>g</sup>, OLE F OLESEN<sup>h</sup>, GÖRAN TOMSON<sup>i</sup>, RONY ZACHARIAH<sup>j,k</sup>

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Operational research in public health is the investigation of strategies, interventions, instruments, or knowledge that can enhance the quality, coverage, effectiveness, or performance of health systems, health services, or disease control programmes<sup>1</sup>. By showing what works and what does not in various contexts, operational research can provide evidence to help policy makers to adapt health interventions and services for maximum public health benefit<sup>2</sup>.

During a recent workshop organised by the Science and Technology Options Assessment body (STOA) of the European Parliament, experts in the field of operational research concluded that the European Union (EU) should increase its support for this form of

research. STOA, which provides independent assessments of scientific and technological options in various sectors including the life sciences, organised the workshop in collaboration with Médecins Sans Frontières, the International Union Against Tuberculosis and Lung Disease, and WHO/TDR.

The participants discussed several overarching themes, concluding that research is too often separate from implementation. A crucial gap remains between the development of efficacious health interventions and their optimum delivery in real-life settings. This gap is particularly true in many low-income and middle-income countries (LMICs). For example, two-thirds of childhood

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1 Doctors with Africa CUAMM, Field research: Articles, posters and scientific

abstracts from CUAMM's health care cooperation activities in Africa, 2003-2013, February 2014.

deaths are potentially avoidable with known technologies that are implemented to scale<sup>3</sup>. Similarly, results of clinical trials have shown major benefits of parenteral artesunate compared with quinine to treat malaria, but quinine remains the standard treatment in most malaria-endemic countries<sup>4</sup>. Operational research could show how to introduce and scale up such interventions, which could have a major effect on Global Health<sup>5</sup>.

Many LMICs are rich in data, but have insufficient information. Massive amounts of routine data are collected within public health systems such as by ministries of health (MOH) and non-governmental organisations (NGOs), but are underused, reducing the potential effect of research on policy and practice. Compounding the problem, most data collected at national level are of little use at the point of care; research instruments to assess equity need to be easily manageable at district level to prompt effective actions<sup>6</sup>. The World Health Report 2013 by WHO<sup>7</sup> recommended that all countries should become producers as well as consumers of research, and that research capacity should extend beyond academic centres to public health programmes-close to the supply and demand for health services.

In this context, the Structured Operational Research and Training Initiative (SORT IT), a global partnership led by the WHO/TDR, could serve as a global springboard for country-level capacity building. SORT IT programmes support countries to undertake operational research in accordance with their own priorities, develop adequate and sustainable operational research capacity in public health programmes, and create an organisational culture of policy and practice being informed by operational research, leading to improved programme performance<sup>8</sup>.

The initiative teaches the practical skills needed to undertake and publish operational research<sup>9</sup>. SORT IT holds training programmes of 10-12 months with clear targets. By January, 2014, 18 programmes had been run, enrolling 212 participants from 60 countries, mainly in Africa and Asia. Of the first eight completed courses, 89% of 93 enrolled participants successfully completed these courses and 93% of 96 submitted papers were published within 18 months of completion. Of published papers, 74% were reported to have had an effect on policy and practice. Moreover, the average cost per publication was only € 6,800. Although the comparison is not completely appropriate because of the potential greater value of long-term basic scientific research, the average cost of EU-funded research is € 140,000-220,000 per publication<sup>10</sup>.

Researchers and experts recognised that very little funding is available for operational research within health programmes and they discussed some possible solutions. Embedding research into

national programmes and health systems would be one way of ensuring cost-efficiency. In this way, the traditional call for funding applications would need to be complemented with integrated funding made available within the programme structure, which would encourage MOHs and NGOs in LMICs to embrace operational research more fully<sup>11</sup>. Through NGOs, settings often excluded from research activities, such as those in conflict and disaster, could also benefit<sup>12</sup>. Although international institutions such as the Global Fund to Fight AIDS, Tuberculosis and Malaria allow a sizeable proportion of country grants to be invested in operational research, absorption of such funds has been poor because of the absence of operational research capacity in-country. The SORT IT model is one way to maximise the use of such funding opportunities.

Arising from these issues, identified by the European Parliament event, was the contribution that the EU could make to operational research. As the world's largest aid donor, the EU is well positioned to support international research collaboration, which works as a type of science diplomacy. Until now, EU investment in research has been directed towards innovation, an essential part of the EU Framework Programmes mission. However, knowledge of how to implement new findings for maximum public health benefit is too often insufficient and should be enhanced by complementary EU actions for social innovations that enable operational research. The European and Developing Countries Clinical Trials Partnership (EDCTP), which is part of the EU Framework Programmes, plays an important part in supporting clinical research and capacity building in African countries. However, although the new extended remit of EDCTP includes elements of implementation research, the main focus is on product development, and a necessary continuum would be to support operational research so that the results of EDCTP trials can be effectively applied.

In LMICs, the EU could effectively boost operational research, which could in turn connect organisations that have technical skills in operational research with national public health programmes and strengthen capacity building through north-to-south and south-to-south partnerships. Operational research fellows could be key to building a critical mass of researchers in the public sector who could then be retained. As part of this, the European Commission should establish a clear strategy for operational research, develop a common policy, and increase coordination between different Directorates-General (Research, Development). The EU is one of the world's most prolific funders of both research and development cooperation, but only very few actions relate specifically to operational research in LMICs. There is ample opportunity to use the available financial and political power to better meet these ends.

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# DOCTORS WITH AFRICA CUAMM

Established in 1950, Doctors with Africa CUAMM was the first NGO in the healthcare field to receive recognition in Italy (pursuant to the Cooperation law of 1972) and is the largest Italian organization for the promotion and safeguard of the health of the African populations.

It implements long-term development projects, intervening with the same approach in emergency situations, with a view to ensuring quality services that are accessible to all.

## HISTORY

In its **60** years' history:

- **1,522** people have departed to work on projects: 411 of these departed on more than one occasion. The total number of departures was therefore 2,418;
- **4,758** years of service have been carried out, with a mean of 3 years per expatriate person;
- **1,034** students have been accommodated at the college;
- **481** doctors have departed from the Veneto region in almost 63 years;
- **216** hospitals have been served;
- **41** countries have benefited from intervention;
- **157** key programmes have been carried out in cooperation with the Italian Foreign Ministry and various international agencies.

## IN AFRICA

Today we are in Angola, Ethiopia, Mozambique, Sierra Leone, Southern Sudan, Tanzania, Uganda with:

- **168 providers:** 111 doctors, 18 paramedics, 28 administrative and logistics staff
- **38 key** cooperation projects and about a hundred minor support interventions, through which the organization assists:
  - 17 hospitals
  - 26 districts (for public healthcare activities, mother-child care, training and in the fight against AIDS, tuberculosis and malaria)
  - 5 nursing schools
  - 2 universities (in Mozambique and Ethiopia).

## IN EUROPE

Doctors with Africa CUAMM has long been active in Europe as well, carrying out projects to raise awareness and educate people on the issues of international health cooperation and equity. In particular, CUAMM works with universities, institutions and other NGOs to bring about a society – both Italian and European – that understands the value of health as both a fundamental human right and an essential component for human development.

## NOTICE TO READERS

### Support and take part in our commitment to Africa, in one of the following ways:

- **Post office current account** no. 17101353 under the name of Doctors with Africa CUAMM
- **Bank transfer** IBAN IT 91 H 05018 12101 000000107890 at the Banca Popolare Etica Padua
- **Credit card** call 0039.049.8751279
- **Online** [www.mediciconlafrica.org](http://www.mediciconlafrica.org)

Doctors with Africa CUAMM is a not-for-profit NGO. All donations are therefore tax deductible. They can be indicated for this purpose in the annual tax return statement, attaching the receipt for the donation made.

**HEALTH AND DEVELOPMENT** offers studies, research work and documentation which are unique to the Italian editorial world. Our publication needs the support of all readers and friends of Doctors with Africa CUAMM.



## NEEDY AFRICA

### EVERY YEAR IN SUB-SAHARAN AFRICA:

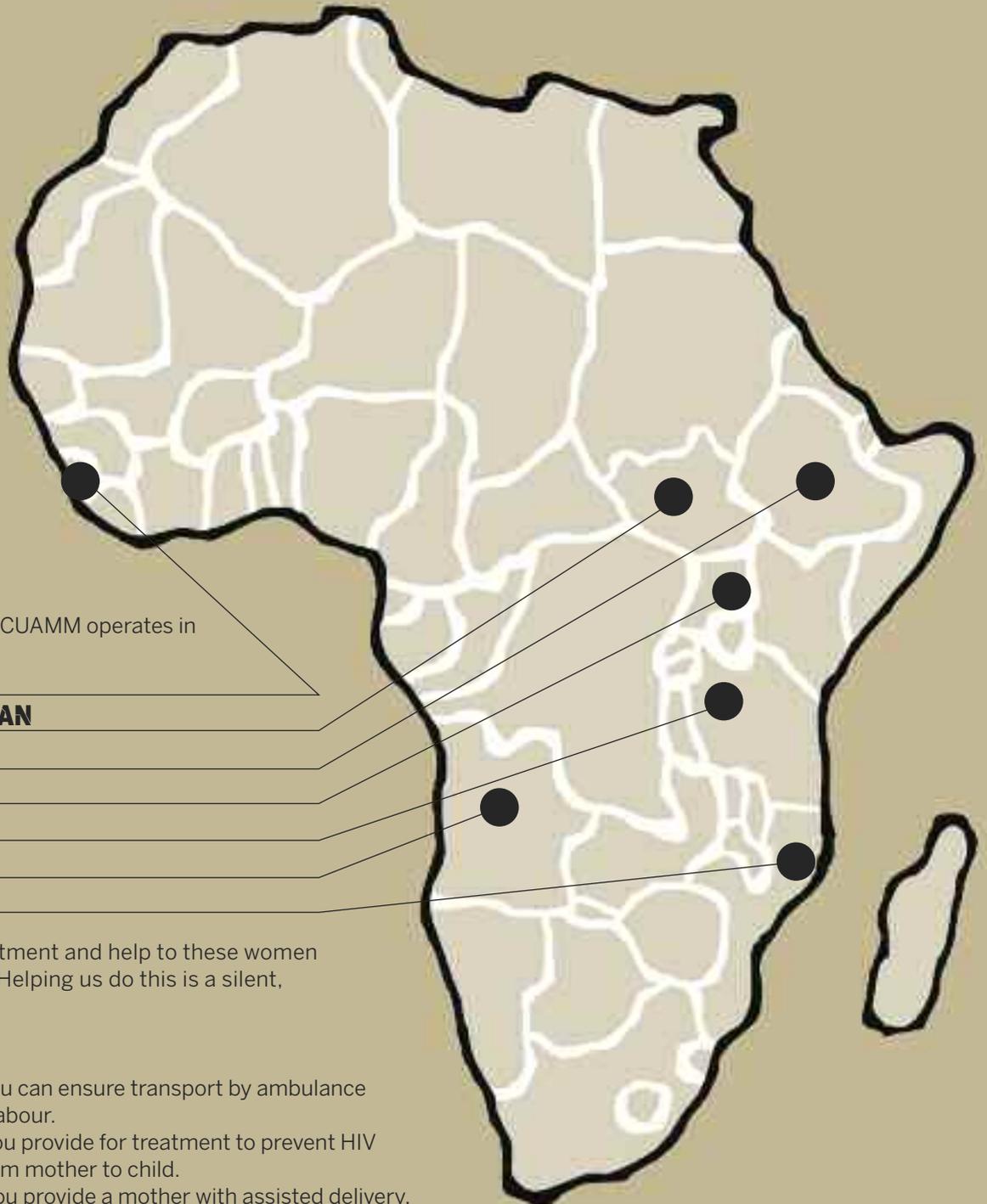
- 4.5 million children die before reaching five years of age, for preventable diseases that can be treated at low cost;
- 1.2 million newborn children die in the first month of life through lack of treatment;
- 265 thousand women die from pregnancy- and delivery-related problems.

Doctors with Africa CUAMM operates in

**SIERRA LEONE**  
**SOUTHERN SUDAN**  
**ETHIOPIA**  
**UGANDA**  
**TANZANIA**  
**ANGOLA**  
**MOZAMBIQUE**

where it offers treatment and help to these women and their children. Helping us do this is a silent, forgotten war.

- With 15 euros you can ensure transport by ambulance for a woman in labour.
- With 25 euros you provide for treatment to prevent HIV transmission from mother to child.
- With 40 euros you provide a mother with assisted delivery.
- With 80 euros you fund a week's training course for a midwife.





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