Doctors with Africa Cuamm

MEDICI CON L'AFRICA CUAMM

Doctors with Africa

Strengthening health systems to build resilient communities in Africa

Strategic Plan 2016–2030

Doctors with Africa Cuamm

Strengthening health systems to build resilient communities in Africa

Strategic Plan 2016–2030

In continuity with Strategic Plan 2008–2015, Doctors with Africa CUAMM presents a new plan to guide its strategy and actions for 2016–2030, towards the achievement of the Sustainable Development Goals.

CONTENTS

Page	No.	Title
06	1	INTRODUCTION
09	2	MISSIONS AND VALUES
10	2.1	Mission
10	2.2	Values
11	3	CONTEXT
12	3.1	Changing poverty in Africa
13	3.2	Changing health systems in Africa
14	3.3	Changing health cooperation in Africa
15	4	VISION AND STRATEGIC OBJECTIVES: STRENGTHENING HEALTH SYSTEMS
17	4.1	Working in a health system centered on people, families, and the community
17	4.2	Working in a health system that values local personnel
17	4.3	Working in a health system that gives substance to primary health care
18	4.4	Working in a health system that aims to improve its performance
18	4.5	Working in a unified health system that supports integrating programs
18	4.6	Working in a pluralistic, inclusive health system that strengthens collaboration between NFP and governmental sectors
19	4.7	Working in a health system that learns from and invests in innovation, assessment, and operational research
20	5	PLANNING
21	5.1	Geographic priorities
21	5.1.1	Entry criteria
21	5.1.2	Exit criteria
22	5.2	Priority issues
22	5.2.1	Maternal reproductive health, Neonatal, child, and adolescent health: an agenda to be completed
22	5.2.2	Nutrition
23	5.2.3	Infectious diseases
24	5.2.4	Noncommunicable diseases and traumas
24	5.2.5	Universal Health Coverage (UHC)
25	5.3	Organizational priorities
25	5.3.1	Improving program quality, implementation, monitoring, evaluation and operational research
27	6	INVESTING IN HUMAN RESOURCES
30	7	STRENGTHEN ACCOUNTABILITY
33	8	COMMUNICATION, TRAINING PUBLIC AWARENESS AND FUNDRAISING
34	8.1	Context
34	8.2	Changes in society, the media, and fundraising
35	8.3	Strategic directions
36	8.4	Areas of action
36	8.4.1	Communicating: a necessity and a calling
38	8.4.2	Education and public awareness in global health and international health cooperation
40	8.4.3	Fundraising

01

Introduction

“I thank you for what you are doing to support the fundamental human right of health for all. Health is not a consumer good but a universal right, so access to health services cannot be a privilege.”

Pope Francis,
in a special audience
for Doctors with Africa
CUAMM, May 7, 2016

Since it was founded in 1950, Doctors with Africa CUAMM has fought for access to health to be guaranteed to all, especially the poorest among us. We consider it our founding duty to commit to working tirelessly until “access to the highest level of health can be guaranteed for all” (Alma Ata Conference, 1978).

Understanding the great value of the dignity of every human being, and the Gospel, which has inspired us since our inception, drive our commitment and connect us to every man and woman of good will.

FRAGILE STATES AND VULNERABLE AREAS

Africa is changing very quickly. The Africa we see today is very different from that of twenty years ago. There are fewer wars and less poverty, more infrastructure, more natural resources, and more communication. The GDP of many African countries is growing, as are their middle class, number of graduates, and skills. Despite many signs of hope and progress, there are still many “fragile” countries here. The United Nations has defined 50 “fragile states,” and 28 of these are in Africa. These are countries that are moving from a situation of absolute emergency to one of development needing to be supported and strengthened. Doctors with Africa CUAMM feels that its purpose is working to support and assist these countries in their process of reconstruction and growth.

SUSTAINABLE DEVELOPMENT GOALS AND STRENGTHENING LOCAL HEALTH SYSTEMS

The *Sustainable Development Goals* (SDGs), which the international community has defined as the pillars of development for coming years, are necessarily broader and more numerous than the eight *Millennium Development Goals* (MDGs). Only a comprehensive approach that pays attention to broader causes can aim for sustainable development.
However, there is a widespread consensus that, particularly in countries with lower incomes, efforts should be concentrated first and foremost on meeting urgent, basic social needs such as health, education, food, and water. This is why health continues to be a central theme (the third goal) in the new SDGs too.
On this point, the post-2015 goals decisively support Universal Health Coverage (UHC) with a view to strengthening the local health system. For epidemiological, technical, and ethical reasons, maternal and child health are still at the core of the health needs on which we focus, with particular attention to malnutrition, tuberculosis (TB), malaria, HIV/AIDS, and chronic and degenerative diseases.

ACCOUNTABILITY, RESULTS, OPERATIONS RESEARCH, INNOVATION

We believe deeply that international cooperation can be a truly important instrument of change. Programs and plans should be managed scientifically and transparently to make sure that benefits reach the poor. Data, scientific evidence, impact measurements, tools, and methods are useful to evaluate the work done. Operational research will be furthered with a structured approach to these ends. We will make every effort to publish and provide the proper evidence for all the results achieved, stimulating discussion and debate. This is why rendering administrative and operational accountability to our beneficiaries, ourselves, and our stakeholders will continue to be the lodestar around which all of our daily efforts revolve.

HUMAN RESOURCES

We rely on a pool of excellent professionals, including health workers and others, well aware that the path to adapt to new challenges is still long. The most serious problem we face is that of quantity.

We need the entire organization to push powerfully to create a well-structured, well-coordinated system that engages first the countries in which we work to recruit and select available local, Italian, and international staff.
It is also important to expand our search to European countries that have relative high availability of health care professionals.
For Italian doctors who are already full staff employees there, are often considerable difficulties with their home institutions, despite the option of obtaining leave from work. We need to work with more synergy and strength

to develop relationships with their institutions; scientifically, we need to develop directions of study that are in line with those of their institutions.

STRATEGIC PARTNERSHIPS

CUAMM needs to further develop partnership work to be effective in a globalized world. We should shape our action and our approach by thinking and acting in partnerships:

→ **Internationally**

→ **Nationally**

The goal is to become a leader in Italy in international health cooperation and avoid falling prey to attitudes of presumption, detachment, and superiority, and instead develop actions and relationships that are appealing and inclusive, making us a respected and listened-to standard setter.

→ In the field (in the countries)

We should become more determined in establishing "local CUAMMs" without losing site of the organization's unity.

→ Scientific research

There are not many organizations specifically focused on health cooperation that have an approach based on working in the field based on scientific evidence and solid, transparent data and results. It is with these few organizations that we should strengthen our relationships and opportunities for public dialogue in order to improve work in the field and influence policy makers.

COMMUNICATION, REPUTATION BUILDING, AND FUNDRAISING

→ Relationships, reputation, and trust

CUAMM's communication, reputation building and fundraising strategies are based on a relational approach that makes our partners and stakeholders central.

The goal of authentic transparent relationships is to create engagement and participation around our organization's defining motivations, goals, style, and operations in the field. This approach lets us strengthen and build on our legacy of trust and reputation, which are the cornerstones of every communication, training, and fundraising effort.

→ Returnees and local areas

Our returned volunteers and local groups forming around them throughout Italy are important strengths to be leveraged. Each returned volunteer is an invaluable resource to activate a local area, tell others about Africa and what we do, and involve friends, communities, institutions, the media, and more.

Work in local areas will be supported by a greater dissemination of our name through multi-pronged, innovative communication tools (such as social media).
Partnerships with student associations, professional groups, universities, specialization schools, and so on, also help us become more deeply rooted and improve our reputation in the local areas.

→ The field

CUAMM's greatest strength in terms of communication is our work in the field. We should aim to convey what we do and present it more effectively. We need to show that we are an organization that can make and demonstrate real change, and though aware of our limits, are motivated to continue our history of committing ourselves as humans and professionals to support the poorest among us, from start to finish.

→ New communication tools

Communication is dramatically changing. Print is being flanked increasingly by digital tools, which we need to use in a broader and more structured way.

→ Fundraising

We have established a fundraising approach over recent years based largely on requesting funding from individual donors for specific works. This approach is consistent with our strategy, attentive to donor relationships, and focused on concrete action in the field. The results have been good, and this strategy should be continued and improved upon. At the same time, we should also diversify sources of fundraising, working harder to engage private donors around programs/campaigns that are broader and flexibly meet the different needs encountered in the field.

→ Africa

We should give special attention to our communications and visibility in the countries where we are active. Specific approaches should be adopted with the goal of properly highlighting results in the field, forwarding good practices to be expanded to other areas and for possible further development and innovation, involving local institutions and international partners.
One starting point could be an annual event to put on in capital cities.

→ International

"International" fundraising is relatively new. We should end the "exploratory" phase and move gradually and decisively to a more organized, structured phase, redistributing and dedicated specific resources (both human and financial ones). One result would be establishing "CUAMM" as legally recognized by most of the countries of interest — the U.S., Canada, and the UK, to name only a few — as well as the African countries where we are active.

02

Mission & values

2.1 Mission
2.2 Values

"We think the identity of an organization is like that of a person — it's not about being always the same, fixed, not growing. It means developing, but keeping our distinct individuality, without changing our genetic heritage, disconnecting from our roots, or losing our original traits, but changing over time, adapting and updating certain attributes and modes of expression, and avoiding becoming lifeless and irrelevant. This is ultimately a major challenge for all institutions. And this is the challenge that Doctors with Africa CUAMM has been taking up for 60 years, and we will plan to keep on doing so in the future."

Don Luigi Mazzucato

2.1 MISSION

Doctors with Africa CUAMM's organizational mission stems from the Evangelical expression "*euntes, curate infirmos*" — "go and care for the sick" — (Mt. 10, 6-8) used by our founder Francesco Canova (1950) in our statutes from 1971, 1984, and 2003.

In 2006, the mission was specifically defined: Doctors with Africa CUAMM was the first NGO working in the international health field to be recognized in Italy and is the largest Italian organization for the promotion and protection of health in Africa.

We work with a long-term development perspective. To this end, in Italy and in Africa, we are engaged in training, research, disseminating scientific knowledge, and ensuring the universal fulfillment of the fundamental human right to health.

This mission translates into two basic objectives:

1. To improve the health status of African people, in the firm conviction that health is not a consumer good, but a universal human right, and that therefore access to health services cannot be a privilege;

2. To promote a positive attitude and solidarity towards Africa — the duty of fostering interest and hope for the future of Africa, and commitment among institutions and public opinion.

2.2 VALUES

The essential values informing our mission and undertakings are:

→ Christian inspiration and a relationship with the Church, as we explicitly draw from Christian values and the Gospel;

→ "with Africa": the organization works exclusively with African populations, engaging local human resources at all levels. The idea of being "with Africa" emphasizes the ideas of sharing, deep participation, exchange, and joint effort, highlighting more than just problems and needs and expressing the values of Africa with a view to long-term development;

→ The value of experience: Doctors with Africa CUAMM draws on over sixty-five years of working to support developing countries;

→ Specific, exclusive expertise in medicine and health;

→ Discretion: the essential idea is that those in need, not those who help, should be the focus of attention.

Doctors with Africa CUAMM is for everyone who believes in values like dialogue, cooperation, volunteerism, exchange between cultures, friendship between the peoples, the defense of human rights, respect for life, willingness to self-sacrifice, the choice to help the poor, the spirit of service, and those who support the organization's action criteria.

03

Context

3.1 Changing poverty in Africa

3.2 Changing health systems in Africa

3.3 Changing health cooperation in Africa

“We should be optimistic and we should feed hope, but knowing the price of optimism, the price of hope. This means having a realistic, clear-eyed, unflinching view of the challenges ahead, the tests to overcome, the efforts to be made, efforts like those you have made so far and plan to keep on making.”

Giorgio Napolitano, November 11, 2010. For the 60th anniversary of Doctors with Africa CUAMM.

It is beyond question that there have been forms of interdependence throughout human history. But it is hard to say whether and how much this has contributed to social progress and the common good of people and our communities.

Today, we see such intense, pervasive forms of globalization that we are left unsettled and concerned that this has been much to the disadvantage of the values of human rights and the central importance of human beings.

Financial crises spawned in the havens of Western finance have a devastating effect, spreading like epidemics through societies and people throughout the world. Economic inequalities between countries are heightened. Social “elevators” are stuck and the most vulnerable groups are pushed to the margins of poverty. The horrors of war and religious fanaticism surge, and with them the cynical use of violence against unprotected people and violence against the icons of history. The mass exodus of millions of people is building, without the prospect of stopping, as they cross all barriers, sometimes with tragic consequences, to escape a future with no work, no freedom, and no hope. European societies, blinded by fear and demagoguery, often prove too selfish and ill-prepared to receive new people who are different and in need. Human-caused climate change, now more than ever, risks compromising environmental sustainability and economic and social progress, today and in the future.

Within these processes of globalization, Africa has become emblematic and a lens for understanding our responsibilities. Addressing the right to health in Africa means going to the root of these issues. It starts with a choice to make our duties central to our understanding of rights, particularly the duties of solidarity and mutual aid on a continent where it is still harder than anywhere else to ensure a decent life to communities.

This responding to duty is our organization, Doctors with Africa CUAMM, first calling. Our original mandate is to be with the people of Africa in the field, in person, committing ourselves to the neediest places, working with local institutions and communities, ensuring access to basic health services and social protection.

This responsibility should not be stuck in a niche — it should spread to new generations and the Italian healthcare world. Africa is both a school for global health and a school of life. It’s a commitment to the future to open this “school” to students’ and young doctors’ enthusiasm and desire to get involved. Solidarity is generational, too. For its part, the health professions can and should offer Africa the wealth of knowledge and professional skills it has in order to find the value of new humanism in social medicine.

Africa’s role in the coming world also involves our country, Italy, and our continent, Europe. Revitalizing international cooperation policies and supporting new development models for Africa is not just a humanitarian and ethical duty (however important). It is also an act of far-sighted intelligence. Current events in Italy and Europe — especially the rise of migration — are far from unrelated to changes taking place in Africa. Africans are our neighbors. Cooperating with Africans means working on writing a common destiny where we can share problems and opportunities, strategies and responsibilities.

We have to understand the changes that Africa is going through to adopt this approach to cooperation, especially in terms of changes in poverty, health systems and international aid.

3.1 CHANGING POVERTY IN AFRICA

Over the last fifteen years, Africa seems to have reversed the downward spiral of war, hunger, and poverty that had marked it as a lost continent: a continent adrift. We are seeing a profound change defined by positive trends in demographic, economic, technological, and social indicators. Life expectancy at birth has improved by an average of almost 10 years. Africa’s population — with 42% under the age of 15 — is the youngest in the world. Its gross domestic product is growing faster than population pressure. Female education has improved, universities are multiplying, and communication technologies are booming. Expectations,

lifestyles and consumption are changing, and there is a palpable desire to be key players in this change.

We are seeing such a paradigm shift from the past that the very definition of Africa has been turned upside down. Now *The Economist* calls it "the hopeful continent."

Nonetheless, this change is far from uniform and durable.

There are still very evident contradictions and differences, especially having to do with poverty. If we look critically and carefully at what it is happening, these processes of change affect not only development but poverty and its manifestations. We can see a new map of poverty forming, between countries and within countries in Africa.

Extreme poverty tends to cluster in "fragile states." This term describes 50 countries, mostly in Africa, where 43% of the world's poor live on less than $1.90 a day. Despite some improvements, just a few of these countries met the targets of the Millennium Development Goals at the end of 2015. Indicators of health and a functioning health system are among the lowest in the world, especially for maternal and child health.

There is a link between poverty and fragility. People and communities often become fragile for interdependent reasons. Primary causes of fragility in chronic conflicts include social injustice, economic disparities, ethnic tensions, and, in extreme cases, the radicalization of religious differences. Climate change, environmental exploitation, pandemics (such as Ebola), and institutional weakness aggravate the fragility of groups, sometimes to the point of collapse with catastrophic results, such as mass migration.
In these areas of extreme poverty, projects that support the resilience of people and communities, including a functioning health system, are urgent and indispensable.

But poverty is not limited to its most extreme forms. Even in African countries less susceptible to external shocks, poverty has not disappeared. Poverty in those countries tends to cluster and become chronic in specific pockets, such as remote border areas, isolated rural areas, and decayed urban neighborhoods.

Here, vulnerable groups, such as women, children, adolescents, the chronically ill, and minorities (such as nomadic people) are hit hardest. This part of the population is living on the margins of the changes underway. Voiceless groups do not take part in decisions and do not have access to resources and basic rights like food, education, and health care.

We need to understand, document, and address the root cases of this new map of poverty in Africa. Social inequality is the interpretive lens through which we can look at fragility and poverty.

3.2 CHANGING HEALTH SYSTEMS IN AFRICA

Health systems in Africa are very heterogeneous. They reflect the level of fragility in the country or area where they are located. The health systems of some countries need to be rebuilt from the foundations — or almost — where coverage is very low, and the primary problem is providing the people basic health services. Other countries have invested heavily in infrastructure expansion and have high coverage rates, even beyond the regional average, but there has been little or no impact on mortality due to inadequate or low quality. This is particularly true for treatment more than prevention.

Generally speaking, the greatest challenges for strengthening African health systems remain the scarcity of human resources (quantity, mix of skills, distribution, and motivation) and inadequate financial resources, especially public ones (due to poor taxing systems, collection capacity, and resource allocation).

There is still a shortage of organized forms of financial sharing of health risk. Rather than serving to mitigate inequalities, in many cases, the health system spreads inequality.

These still unresolved problems are seen in the persistence of major inequality. A dramatic example is in the catastrophic expenses for health services.

Another complicating factor is having pluralistic health systems with a (fragmented) co-existence of governmental, not-for-profit (NFP), and for-profit sectors. With a few rare exceptions, partnerships between governments and not-for-profit sectors are not based on effective, innovative contracting agreements. The for-profit private sector tends to spread in urban areas and operates without control, leading to the commercialization of health services.

New approaches have been evolving in health policies. The emphasis is shifting from the effectiveness of actions to "enabling policies." Positive examples are found in the issue of nutrition and a multisectoral approach gaining ground in governing policies. Continuum of care is no longer limited to child health, and now covers the entire spectrum of reproductive health: maternal, neonatal, child, and adolescent. Because this epidemiological shift is happening, the focus on maternal and child health and infectious diseases is gradually extending to chronic diseases as well (such as diabetes, hypertension, cancer, trauma) and risk factors such as smoking, alcohol, obesity, chronic and acute malnutrition ("double burden"); in terms of program effectiveness, the focus is shifting from coverage of interventions to "effective coverage," which takes on the challenge of providing quality services with a greater focus on patient centrality.

On the issue of equity, measures have started to be less about giving everything to everyone and more about forms of individual and geographic targeting with the goal of reaching the poorest and most disadvantaged people and communities.

The field of innovations seems open and very dynamic, such as adopting financial incentives (e.g., conditional cash transfers, voucher systems, and results-based payments) to support demand and supply-side financial mechanisms; spreading different forms of task shifting, including giving a new role to community health workers and, applying information technology (ICT, m-health, GPS, etc.) to support health promotion, improving health management and operational research.

Looking ahead, it is believed that — with the currently available financial resources, technical skills, and technological support — by 2030, the span of a generation, we will be able to achieve great convergence in terms

of the overall reduction of maternal mortality and infectious diseases, as well as reduce the incidence of chronic diseases.

It is still an open question if and how health policies and interventions will help create this convergence by strengthening health systems, and it should be put to ongoing careful study, evaluation, and research to understand different national features.

3.3 CHANGING HEALTH COOPERATION IN AFRICA

Since 2000, the landscape of international aid for health cooperation has undergone profound changes in terms of volume, key players, and policies.

In volume, it has gone from a little more than $6 billion in 1990 to almost $36 billion in 2014, with contributions tending to plateau in recent years.

A substantial portion of these contributions still came from multilateral and bilateral governmental agencies and international nongovernmental organizations traditionally active in the area. They are now joined by new, influential emerging players, such as global funds, cooperation from emerging countries (BRICS), private foundations, corporations, private fundraising, and new local non-governmental organizations. This increase in aid and expansion of players have helped raise the political and social profile of health cooperation in the international arena and significantly increased resources for the health sector. In the field, it has created original organizational models for treating the ill and community involvement. It has aroused strong interest in worldwide public opinion about Africa's healthcare problems, and has led to new forms of results-based accountability. However, alongside these positive factors, problems that afflict the current structure of international aid for health cooperation should be recognized, such as the overall inadequacy of funding and its essential unpredictability. Aid has also not always been directed to the poorest countries or targeted at the health priorities that countries set. In many instances, focusing only on certain diseases or certain mutually exclusive approaches (e.g., community or hospital-based) has helped to fragment and weaken the health system rather than strengthen it. Commitment to achieving the objectives of the Paris and Accra agendas about the need to strengthen effectiveness and accountability has been largely ignored by a large part of those involved in international health cooperation.

In terms of aid policies, the Millennial Development Goals had the positive effect of providing a conceptual and practical frame of reference, focusing agendas and drawing funds around a series of health goals (numbers 4-5-6), which were well defined and globally accepted. Overall results, compared to 1990 data, show marked decreases in maternal, newborn, and child mortality and substantial improvement in the fight against three pandemics: HIV/AIDS, tuberculosis, and malaria. But, despite the significant process in many sub-Saharan African countries in these areas, it will take many more years to achieve the set targets of coverage, quality, and equity.

Meanwhile, the Sustainable Development Goals are the basis for the new framework for international cooperation for the next 15 years (2016–2030). These goals came out of the process started with the Rio+20 Conference in 2012, along with an intense debate open to contributions from diverse sources of varied scopes, substance, and types.

The new priorities — 17 goals and 169 targets — set in the new agenda pay special attention to the importance of development determinants, including economic, social, environmental, and safety aspects. Differing from the MDGs, set based on goals for individual diseases, the proposed goal for health, the third goal (no. 3) is based on a concept that promotes healthy life and well-being for all ages. The health goal, in its internal sub-sections, identifies a wide spectrum of problems to be addressed, including access to basic quality services, access to safe, effective drugs and vaccines for all, and providing universal health coverage.

This multisectoral approach pays attention to social determinants of health, along with the commitment to building public forms of financial protection for individual health risk. It gives reason to hope that health cooperation's policies and measures will have a more horizontal approach than they have so far. Alongside the opportunities offered on the new horizon of global health, there are still risks and challenges to keep in mind, such as maintaining a high focus on health, as it does not play the same prime role in the SDGs as it did before. We must avoid having the many issues and health problems to address and document lead to a dispersion of action and ultimate ineffectiveness. We need to support the reforms needed to rely on an effective governance of global health that can orient policies and mobilize the resources — national and international, public and private — needed to put the reforms into action.

04

Vision and Strategic Objectives: Strengthening health systems

4.1 Working in a health system centered on people, families and communities

4.2 Working in a health system that values local personnel

4.3 Working in health system that gives substance to primary health care

4.4 Working in a health system that aims to improve its performance

4.5 Working in a unified health system that supports integrating programs

4.6 Working in a pluralistic, inclusive health system that strengthens collaboration between NFP and governmental sectors

4.7 Working in a health system that learns from and invests in innovation, evaluation, and operational research

Strengthening health systems: Doctors with Africa CUAMM's approach

Doctors with Africa CUAMM reaffirms that strengthening health systems is key strategy to meet health needs and fulfill the health rights of poor in Africa.
This strategy has remained constant. It is consistent with the ideals, experience, and evidence based on over sixty years of working in the field in Africa, and the still valid guidelines for Primary Health Care (PHC) set at Alma Ata in 1978.

"Health system" is an elusive concept, as it has more than one definition.

Doctors with Africa CUAMM uses the definition given by the World Health Organization (WHO), which divides it into the following **components and functions**:
→ Governance/Leadership
→ Service delivery
→ Health workforce
→ Medical products and technologies
→ Health care financing
→ Information and research

These factors interact and allow **intermediate health outcomes** to be achieved, including
→ Accessibility
→ Coverage
→ Quality and safety

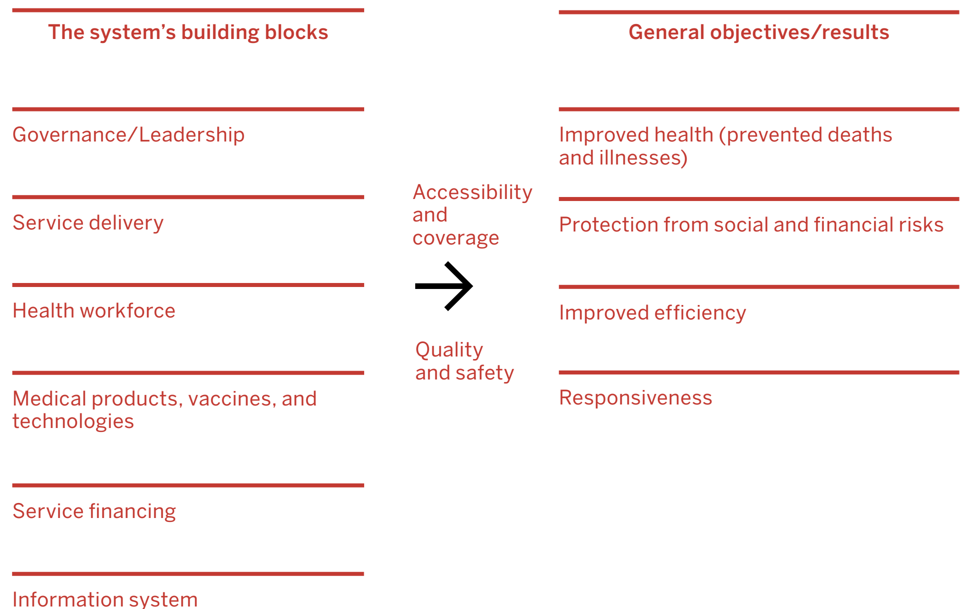
and final health outcomes, such as:

→ Prevented deaths and diseases
→ Social and financial risks protection
→ Adopts improved efficiency
→ System responsiveness

Health processes and outcomes within the health system are in turn affected by **social determinants**, including political, economic, and safety factors of the different settings.

Figure 1

Source: *World Health Organization 2008*



Below is an overview of Doctors with Africa CUAMM's approach to strengthening health systems.

4.1 WORKING IN A HEALTH SYSTEM CENTERED ON PEOPLE, FAMILIES, AND THE COMMUNITY

The health system is based on the good of people and not on its own good. "Good" in this case means health.

The centrality of the patient as a person and families and communities marks the importance of quality relationships and processes inside and outside of the health system.

The experience of illness is reflected in a collection of anxieties, beliefs, and personal perceptions that health personnel needs to understand as a whole. The care process is as important as its outcome.

If correctly applied, factors such as respectful reception, effective communication, direct involvement of the patient throughout the care, providing complete services and information, and continuum of care, can bring major benefits such as cost reduction, patient competence, better treatment adherence, better health, and more satisfaction among patient and health workers.

The centrality of the patient is fundamental for providing unified care management to patients suffering chronic diseases, whether or not infectious. What's more, it is also decisive for getting to family and community behaviors at the root of many health problems, such as smoking, drinking, sedentary lifestyles, obesity, malnutrition, and violence against women. The community can sometimes help identify people and families living in extreme poverty. By knowing families and fostering quality communication and relationships between the communities and health services, we can help guide behavior, support the demand for basic health services, and provide "individual targeting" for financial protection for the poor to strengthen their resilience.

Doctors with Africa CUAMM is committed to adopting an approach centered on patients, families and communities in its projects in Africa, drawing on the contributions of the communities themselves, community agents, health workers, and community-based organizations, and specialized international agencies.

4.2 WORKING IN A HEALTH SYSTEM THAT VALUES LOCAL PERSONNEL

No health objective of the SDGs agenda can be achieved in Africa without dramatic changes to strengthen the health workforce. There are many gaps to be filled. Though there is almost universal recognition of how important community agents are for health promotion and the case management for health problems, there is concern about their performance and stability. There are too many jobs assigned, too high turnover, too little opportunity for professional growth, and unstable government policies about their employment and compensation in the public health system. There are also well-known difficulties for finding qualified health personnel. Though there has been documented progress in different forms of "task shifting," many areas of Africa still have a shortage of doctors, midwives, nurses, and lab and anesthesia technicians, poor distribution of the existing workforce, ineffective forms of retaining and motivating them to stay mid-to-long term in isolated, disadvantaged places ("hard to reach and hard to stay").

These problems have various root causes, including organizational, financial, regulatory, and political ones. Listening closely and emphatically to local health personnel working in the field and studying problems in work and life organization are essential steps to understand the existing gaps and implement solutions with a systemic approach.

Doctors with Africa CUAMM recognizes the crucial importance of human resources in health. We work with health authorities, professional bodies, and specialized agencies in the countries where we are active to: further the development of community workers and their contractual status in the health system; facilitate professional development, personnel retention, and task shifting in remote areas; actively support schools and universities that train qualified health workers (medical and non-medical staff) directed at Primary Health Care. Support the *Global Strategy on Human Resources for Health Workforce 2030* through lobbying, advocacy, and operational research.

4.3 WORKING IN A HEALTH SYSTEM THAT GIVES SUBSTANCE TO PRIMARY HEALTH CARE

The district platform consists of the local hospital (governmental or nonprofit), an peripheral health units network and the community, linked by a network of communications and relationships. This platform has proven the most effective way of delivering essential health services for prevention and treatment.

Many health services for reproductive health disorders, infectious and chronic diseases can be provided at a primary level through the community staff and first level medical staff. In many countries, we have seen that an effective approach for strengthening health systems is a strong network of basic health infrastructure, with qualified staff, supported by an efficient medical product supply and distribution chain.

However, basic health services and community agents by themselves are not enough. Treating obstetric and neonatal emergencies, severe complicated malnutrition, and complications from infectious and chronic diseases require access to quality hospital and surgical care. **The hospital is an essential part of the health system and is part of the structure of Primary Health Care**.

Doctors with Africa CUAMM's essential strategy in the field remains strengthening the internal structure of this health platform, made up of the community, the peripheral health network, and the hospital.

This applies to both fragile and stable health systems. In countries where we work, Doctors with Africa CUAMM seeks to select one or more district platforms in which this strategy will be fully implemented in partnership with institutions, local communities, and others. These district platforms will serve as laboratories, centers of research and innovation for "scaling up" PHC.

4.4 WORKING IN A HEALTH SYSTEM THAT AIMS TO IMPROVE ITS PERFORMANCE

A health system's performance can be defined in a number of ways. One way is to divide the health settings into low, middle and high health systems, depending on the coverage rate of childbirth attended by qualified personnel (Skilled Birth Attendance) and coverage of direct obstetric emergencies (met need for EMOC). These indicators are given as markers for how well the health system works in terms of access and equity services provided, and because they are negatively correlated with maternal and neonatal mortality. They are indirect indicators, or proxies, reflecting the density of workforce and service demand, both factors affecting the performance and quality of the health system. Low health systems have coverage rates below 30%; intermediate ones are between 30% and 60%; and high ones are over 60%. Intervention packages and implementation strategies vary according to the health settings and their features.

Doctors with Africa CUAMM seeks to adapt the intensity of our interventions to the needs of health care settings, giving priority to the most critical situations (low health systems). The more fragile and less resilient the health system, the broader our range of action will be in terms of: physical and functional rehabilitation of health facilities, providing equipment, availability of international and regional human resources, providing assistance to hospital management; and our intervention's duration.

Conversely, as the health system develops from poor performance to medium-high performance, more actions will be more targeted to a few specific parts of the system, and will be more limited in time. This also applies to hospital support. At any rate, all interventions will be based on supporting, rather than replacing, local governance, and will be aimed at intermediate and final health outcomes.

4.5 WORKING IN A UNIFIED HEALTH SYSTEM THAT SUPPORTS INTEGRATING PROGRAMS

Over the last decade, many health cooperation programs have taken "vertical" approaches that have proven to the detriment of the health systems' proper functioning.

This approach was long justified by the need to implement specific, sometimes specialist interventions related to a disease, which due to their complexity and urgency, could not be included in a broader set of health services. This approach has started to change. Because some diseases are correlated — for example, HIV/AIDS and tuberculosis; diabetes and tuberculosis or HIV/AIDS in pregnancy — there has been a push towards the "structural integration" of services, especially on the levels of the community and peripheral health network. Diagnosis, treatment, and follow-up of patients with HIV/AIDS and tuberculosis are starting to be offered in shared structural and procedural settings. Something similar is happening in maternal and child health. Screening for sexually transmitted, infectious, and chronic diseases has become part of prenatal services. This creates integrated platforms of services that involve personnel, information systems, and procurement procedures for medicine and medical products. The lessons is that many of the challenges and opportunities in integrating different programs happen at a decentralized level, often tied to operational aspects — in other words, they have to do with "how" activities are implemented. Here we need to take advantage of all opportunities for the services and procedures offered by the different programs to be integrated within a single health system.

Doctors with Africa CUAMM is increasingly involved in implementing health programs on a regional basis with the goal of improving the treatment of individual diseases and health problems.

Working with local partners, we aim to help strengthen health systems so that these programs can promote integration and synergy, especially in the areas of: community level services and peripheral health network; training and development of local personnel; local information systems to monitor and evaluate projects; and the supply and distribution of primary medical products.

4.6 WORKING IN A PLURALISTIC, INCLUSIVE HEALTH SYSTEM THAT STRENGTHENS COLLABORATION BETWEEN NFP AND GOVERNMENTAL SECTORS

Many health systems in Africa are pluralistic. They involve numerous types of providers of health services. An important role is played by the not-for-profit sector, in which many faith-based health organizations work. They make a substantial and widely appreciated contribution in terms of volume and amount of health services provided to the public. Equally important and appreciated is the spiritual, social, and cultural contribution that religions make to the care of the sick and poor.

Different local histories have shaped the relationship between the governmental and NFP sectors.

Countries with longer traditions of the two sectors working together have developed policies, plans, and programs over time with advanced agreement forms, such as "service agreements" in Tanzania, and "delegated funds" in Uganda. In some countries, like Ethiopia and Sierra Leone, the two sectors are still determining their positions.

The current state of relationships between the two sectors seems to suffer two types of problems.

One critical area is the moral controversy in the health field on issues such as family planning, services for adolescent health, pregnancy in minors, violence against women, and HIV/AIDS prevention. On these complex, controversial issues, there seems to be a lack of mutual agreement among the parties about which services to provide, in what form, and by whom.

This lack of agreement has a negative impact on the public's access and use of essential health services.

The other problem pertains to health policies, particularly forms of contract financing according to which services provided by the NFP sector are reimbursed by the government based on quality standards and containing out-of-pocket expenses. Such policies are often inexistent or lack effectiveness. As a result, in the NFP sector, many essential services that are lifesaving and have a strong social and economic impact — such as cesarean sections — continue to be paid services with obvious negative effects on equity and social justice.

The Universal Health Coverage goal is an opportunity to take to launch inclusive, effective forms of integrating the NFP system and the health system.

In keeping with our tradition of working with governmental and not-for-profit sectors, Doctors with Africa CUAMM is committed to ensuring access to life-saving services in the maternal and child health hospitals where we work; to strengthen relationships between the parties and improve essential health services and implement inclusive policies bound to Universal Health Coverage (see UHC goals for actions).

4.7 WORKING IN A HEALTH SYSTEM THAT LEARNS FROM AND INVESTS IN INNOVATION, EVALUATION, AND OPERATIONAL RESEARCH

A health system improves if it allows for and encourages newness, whether in ideas, strategies, methods, or medical devices. But innovation and technology are not a panacea. They can have unwanted side effects if they are not well managed, such as risks for patient health, deepening inequality, commercial fraud, and financial dependence.

We urgently need to promote "frugal" innovations in technology that address the health problems of the poor. Recent innovations have made a tangible contribution to improving health systems in Africa. For instance, adherence to antiretroviral treatment (ART) has improved thanks to new forms of associations between HIV+ patients, which have provided personalized and user-friendly services.

The use of maternal health services has grown significantly through a mix of incentives supporting demand for the services, such as transportation, involving traditional midwives, and using more culturally appropriate and accepted birthing positions. The use of ambulances for emergencies has been extended and optimized through community forms of insurance, supported by the use of modern communication technologies (m-health, GIS).

New diagnostic and therapeutic devices (such as point-of-care testing) have let diagnostic and therapeutic services for numerous illnesses be decentralized from the hospital to the communities.

New vaccines and medications help to reduce mortality and the incidence of some diseases.

And there have been some examples of transferring to wealthy countries innovations successfully applied in limited resource settings ("inverse innovation" in global health).

Doctors with Africa CUAMM considers essential to take up the challenge of innovation, knowledge, and evidence within health cooperation programs in Africa.

Working with health authorities, professional bodies, and specialized agencies of the countries where we are active, we seek to: invest in innovation, starting from the field and the problems of patients and health workers; match innovation and technology to revising health processes; address how to benefit the poor; subject innovation and program results to rigorous evaluation, using the qualitative and quantitative tools of operational research; work with an open, networked approach involving young researchers, public and private entities, and African and international research centers; and ensure that the evidence influences policies.

05

Planning

5.1 Geographic priorities

5.1.1 Entry criteria

5.1.2 Exit criteria

5.2 Priority issues

5.2.1 Reproductive, maternal, newborn, child, and adolescent health: an agenda to be completed

5.2.2 Nutrition

5.2.3 Infectious diseases

5.2.4 Chronic diseases and traumas

5.2.5 Universal Health Coverage (UHC)

5.3 Organizational priorities

5.3.1 Improve the quality of implementation, monitoring, evaluation, and operational research programs

Maternal, neonatal, child, and adolescent health are still urgent needs in sub-Saharan Africa and one of the primary health objectives set out in the new Sustainable Development Goals.

Planning priorities are broken down into:

→ Geographic priorities:
countries and areas of action (where).

→ Priority issues:
health issues to be addressed with which actions (what).

→ Organizational priorities:
which internal organizational modes to adopt (how).

5.1 GEOGRAPHIC PRIORITIES

In its 2016–2030 plan, Doctors with Africa CUAMM commits to:

→ Further expand its presence in **fragile states** (Sierra Leone, South Sudan, and others) in order **to develop the resilience of the local communities** affected by conflict, epidemics, climate change, and extreme poverty.

→ Ensure **medium- to long-term interventions** in these countries to strengthen the health system: public health measures, access to basic health services, hospital support, medical and non-medical personnel, both international and regional[1].

→ Support health interventions for **nomadic minorities** in cross-border clusters, including the region of Karamoja in Uganda, the South Omo and Somali regions of Ethiopia, and Somalia and Eritrea in the Horn of Africa.

→ Focus health interventions on the **disadvantaged regions** of Angola, Mozambique, Tanzania, and Uganda in order to foster greater economies of scale and greater impact.

→ **Support public health programs** within these regions with a strong community-based orientation, heightening recruitment of qualified African personnel as far as possible.

→ Give **targeted** support to governmental and NFP hospitals in the countries where it operates, **supporting, not replacing** the governance of those facilities.

→ Strengthen health projects to combat poverty in the **decaying outskirts of African cities** in the countries where we operate (in the cities of Luanda, Beira, Kampala, Dar Es Salaam, Addis Ababa, Freetown, and Juba).

→ Take action in **humanitarian catastrophes** in sub-Saharan Africa by fostering continuity between emergencies and development in partnership with specialized agencies and other NGOs.

5.1.1 Entry criteria

The decision to engage in a particular area will be guided by the following criteria based on our mission and values:

→ The extent of need in the priority groups: women, children and the disabled and chronic patients;

→ Potential to mobilize financial resources;

→ Opportunities for planned partnerships with the government and NFP sectors;

→ Our involvement's likelihood of catalyzing additional positive effects on the health of the population;

→ Minimum safety conditions both for our personnel's safety and our ability to operate.

5.1.2 Exit criteria

As we explained our entry criteria, we think it equally important to explain the exit criteria on which our decisions are based.

We consider it invaluable for the sustainability of results to share our strategies with our main stakeholders and partners, including criteria for exiting a country. Significant changes in priorities and policies in the countries where Doctors with Africa CUAMM works are a reason for reconsidering a country strategy, as are having achieved results set in the countries strategic plan, or the disappearance of conditions specified in the entry criteria.

5.2 PRIORITY ISSUES

5.2.1 Reproductive, maternal, newborn, child, and adolescent health: an agenda to be completed[2]

Maternal, neonatal, child, and adolescent health are still urgent issues in sub-Saharan Africa and among the primary health objectives set out in the new Sustainable Development Goals. This is also a priority for Doctors with Africa CUAMM for several reasons.

Despite major progress, maternal and neonatal mortality have not yet been reduced enough to meet the fourth and fifth Millennial Goals for sub-Saharan Africa.

Points of particular concern are the serious issue of adolescent pregnancy, violence against women in all its forms, inadequate progress in reducing neonatal mortality, and high mortality from diarrhea and lung infections for children under 5 years old.

Maternal mortality and access to services for reproductive health and obstetric emergencies are among the key indicators of the level of social inequality between developed and less developed countries and between rich and poor people within a country.

Access to attended births is a proxy of how a health system as a whole is functioning, because it shows that there are basic and advanced quality obstetric services in operation at all times of day, and that there is a consistent availability of a qualified workforce, medicine and equipment (including the option of blood transfusions), transportation and communications that connect families and communities with the peripheral health network and hospitals, following a continuum of care approach.

Actions

→ Implement regional- and district-based national policies and programs that promote reproductive health and especially access to skilled birth attendants and life saving interventions (BEmOC and CEmOC) to reduce maternal (and adolescent), fetal, and neonatal mortality and morbidity ("triple returns").

→ Implement national policies and programs on a regional and district basis that promote access to effective interventions for the prevention and treatment of the most common pediatric diseases in order to improve early child development.

→ Remove or lower financial barriers (such as "user fees") for childbirth assistance and especially obstetric emergencies.

→ Invest in the community, in the peripheral networks and hospitals, to improve the supply and demand of health care through the use of incentives.

→ Support the development of systems for registering population and vital statistics.

→ Monitor the rates of coverage, quality, and equity of health services.

→ Address the issues of adolescent motherhood and violence against women, studying determinants and risk factors and implementing multidisciplinary health and social interventions.

→ Conduct operational research on determinants that prevent women from accessing assisted childbirth; on ambulance usage models and sustainability; use of the GIS system for mapping birth centers and obstetric emergencies; neonatal diseases and good practices in neonatology; obstetric diseases and good obstetric practices (such as cesarean sections); the role of Traditional Birth Attendants and Community Health Workers; applying a system of maternal deaths surveillance and reporting.

→ Support the *Global Strategy for Women's, Children and Adolescents' Health 2016–2030* through lobbying and advocacy.

5.2.2 Nutrition[3]

A major priority in the sustainable development agenda is increasing the focus of ensuring good nutrition in adolescence, during pregnancy, and in early childhood.

The effects of malnutrition on fetuses, infants, and children are well-known and include reduced fetal growth, increase susceptibility to infectious diseases in early life, and chronic ones in later life, and impaired physical and cognitive development in the medium- to long-term. We can add economic damage from lost productivity of the population. Recent financial and food crises have negatively affected access to food, especially by the poorest parts of the population.

Maternal malnutrition contributes to 800,000 deaths each year, and childhood malnutrition is at the root of 3.1 million pediatric deaths under five years of age, nearly half of all deaths in this group.

Acute malnutrition ("wasting," low weight for height) is due to acute shortage of food or diseases, and poses a high risk of death for the child. Many countries in sub-Saharan Africa have a prevalence of wasting over the threshold of 5% and up to over 20% (such as in South Sudan). The prevalence of chronic childhood malnutrition ("stunting," low height for age) is due to a poor or insufficient diet, poor levels of care for a child, and the coexistence of disease. It is found mainly in poor populations and families.

The prevalence of chronic malnutrition in sub-Saharan Africa has declined only a few percentage points from 1990 to 2010; in some cases, it is found in over 30% of the pediatric population. A 40% reduction target has been set for 2025.

Actions

→ Support national policies and programs to combat maternal and child malnutrition.

→ Implement, on a district and regional level, cost-effective public health interventions to prevent and treat acute and chronic malnutrition, with priority given to the first 1,000 days of a child's life, from conception to age two, nutrition during pregnancy, breastfeeding, and baby weaning.

→ Adopt a mix of community- and health-system based strategies according to the setting and the type of barriers.

→ Support the integration of malnutrition services with those of the Maternal

Neonatal and Child Health (MNCH), Integrated Management of Childhood Illness (IMCI), HIV/AIDS and tuberculosis (TB).

→ Promote the involvement and professional development of nutritionists and research centers in the African countries where we work.

→ Apply innovative epidemiological tools (e.g., SLEAC, SQUEAC, S3M) and information technology to better monitor and map results, including coverage, effectiveness, and impact of interventions.

→ Implement operational research. Particular focus for planning nutritional projects is placed on "educational research" needed to analyze the cultural determinants ("nutritional behaviors") that help or hinder good nutritional practices at the family and village levels.

→ Promote partnerships with other specialized agencies in non-health sectors to promote an integrated approach to malnutrition issues: e.g., water and sanitation, homestead food production systems and biofortification of staple crops, education, and women empowerment.

→ Support the Global Nutrition Targets 2025 agenda with lobbying and advocacy to international agencies, governments, civil society, and the professional and business world.

5.2.3 Infectious diseases[4]

Driven by the Millennium Development Goals, the efforts of international cooperation have achieved significant results, especially in recent years in reducing the incidence, mortality, and increasing access to treatment for major infectious diseases, including HIV/AIDS, tuberculosis, and malaria, as well as neglected tropical diseases.

Compared to ten years ago, fewer people in Africa today are infected by these diseases, fewer people die, and more patients are in treatment. Nonetheless, much of the African population continues to suffer disproportionately more than in other continents from preventable premature death and disability caused mostly by major epidemic diseases. Seventy-eight percent of HIV+ patients who do not have access to antiretroviral treatment (ART) are in Africa.

These diseases affect poor people and groups and those at risk of poverty, especially pregnant women, children, adolescents, and adults living in disadvantaged social conditions with difficulties accessing, using, and adhering to prevention, treatment, and follow-up. This is why these diseases are also known as "infectious diseases of poverty."

For an effective response to new, ambitious international objectives and targets (Getting to Zero AIDS, TB and Malaria), we need not only major investment in research and development of new drugs and vaccines; we also urgently need to mobilize resources for the overall strengthening of the health system (as the Ebola epidemic proved about monitoring systems and health and community personnel). Equally indispensable are testing and demonstrating new models and platforms that make sure interventions in the health system are integrated and sustainable. For example, there is a need to integrate disease treatments (such as the incorporation of HIV/AIDS actions in the mother-child services, co-management of HIV/TB patients, the integrated management of patients with TB/diabetes, and combined screening for HIV/AIDS and cervical cancer); between levels of care (community, peripheral health network, hospitals); and among workers (qualified health personnel and community workers).

Actions

→ Support national policies and programs combating HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases (NTD).

→ Implement, on a district and regional level, cost-effective public health interventions to prevent and treat major infectious diseases.

→ Strengthen epidemiological surveillance systems.

→ Adopt a mix of community- and health-system-based strategies according to the setting and the types of barriers affecting access, use, adherence to diagnostic, treatment, and follow-up.

1 Strengthening health system for resilience, IDS, February 2015

2 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. (cfr. *Sustainable Development Goals* 3 targets)

3 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. (cfr. *Sustainable Development Goals* 2 targets)

4 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. (cfr. *Sustainable Development Goals* 3 targets)

→ Support and strengthen the integration of services for preventing and controlling infectious diseases with those for reproductive health (MNCAH) and chronic diseases (NCDs) and the general health system.

→ Implement operational research. Particular emphasis will be on operational research on poverty and social protection (e.g., catastrophic costs borne by TB/HIV patients); co-morbidity (e.g., TB and diabetes, HIV/AIDS and hepatitis); diagnosing and treating TB/MDR (Multidrug Resistance); ARV adherence; adolescents and HIV/AIDS; epidemic control.

→ Support global agendas, including End the AIDS Epidemic by 2030, End TB Strategy 2030, Global Technical Strategy for Malaria 2016–2030, with lobbying and advocacy to international agencies, governments, civil society, and the business and professional world.

5.2.4 Noncommunicable diseases and traumas

Aging processes, urbanization, economic development and the spread of risk factors in Africa are at the root of the dramatic rise in chronic diseases and traumas, especially in urban areas. The impact of Noncommunicable diseases and traumas in terms of premature death and disability join those of maternal and childhood diseases and infectious diseases ("double burden").

There is greater than 20% probability of dying between 30 and 70 years old from chronic diseases in Africa, among the highest in the world.

The problem is profoundly complex. Chronic patients are usually affected by more than one disease (multi-morbidity), including infectious diseases, such as HIV/AIDS. This exposes them to serious, prolonged social and economic consequences, including bearing catastrophic healthcare costs. This form of "hidden inequality" is exasperated by fragmented patient management that follows a care model more focused on individual diseases than on people, difficulty in accessing basic diagnostic tests, essential medicine, competent medical personnel, and the basic lack of any form of protection from financial healthcare risk.

In order to respond more effectively, equitably, and sustainably to chronic diseases, we need multisectoral fiscal policies, integrated prevention programs, psychological and pharmacological intervention packages of proven efficacy, systems for recording vital data, monitoring and surveillance of individual and population risks, and innovative forms of integration and synergy with other health programs.

Innovations also need to be made in the relationships between patients and health workers. Patients suffering from chronic diseases, if empowered by trained health workers, can learn over time to be skilled in self managing risk factors, episodes of illness, and multi-morbidity.

Putting these interventions into effect, informed by the principles and practices of Primary Health Care and continuum of care, is an urgent need and priority for fragile African health systems and for Doctors with Africa CUAMM.

Actions

→ Support policies, plans, and programs for the prevention, care, and treatment of chronic illnesses.

→ Implement, on a district and regional level, cost-effective public health interventions to prevent and treat chronic illnesses and traumas.

→ Strengthen epidemiological surveillance systems of individual and population risk factors.

→ Adopt a mix of people-centered and health-system-based strategies according to the setting and types of barriers affecting access, use, adherence to diagnostic, treatment and follow-up of chronic diseases.

→ Support and strengthen the integration of services for preventing and controlling infectious diseases with those for reproductive health (MNCAH) and infectious diseases and the general health system.

→ Implement operational research. Particular emphasis will be given to epidemiological surveys on risk factors and chronic diseases, social determinants, health system gaps, and technological innovations.

→ Support the Global Action Plan for the Prevention and Control of NCD 2013–2020 agenda, which aims for 25% reduction of chronic diseases by 2025 with lobbying and advocacy to international agencies, governments, civil society, and the professional and business world.

5.2.5 Universal Health Coverage (UHC)

In many African countries, about 50% of health expenditures are borne out of pocket.

Poorer social groups are those who pay the most and have the most concentrated cases of financial catastrophe and impoverishment. Over one hundred million people are affected each year. It has too long been an empty promise to provide even mere access to health services — and hopefully quality — without protection from economic ruin.

UHC means that all people have access, without discrimination, to preventive, treatment, and rehabilitative services as a whole, defined nationally, and to basic, safe, affordable, effective, and quality medicine, with the assurance that using these services does not expose patients to economic hardship, especially in the poorest, most vulnerable groups.

The health system is called upon to ensure not only health gains, but also economic and welfare goals in terms of reducing poverty and improving economic prosperity. Financial protection is based on two factors: expanding forms of insurance-type prepayment (e.g., community, state, private) and the elimination of out-of-pocket payments.

To these ends, each African country needs to decide: a) which services for maternal-childhood, infectious and chronic diseases, considered cost-effective in terms of reducing mortality and poverty, will be part of the insurance package; b) how many and which people will benefit from it at the point of delivery, and c) which costs will be borne by the government.

This raises a number of challenges.

→ The crucial choice for health policy and public ethics will be whether to

expand insurance coverage by acting equally on all three fronts (health services, beneficiaries, and costs) or only developing some of them. These decisions have profound moral implications in terms of distributive equity. It is yet to be seen whether or not there is commitment to including poor people in insurance coverage.

→ The choice will be political, not just technical, in decisions on how many, and which, public financial resources, especially domestic ones, but international ones as well, will be invested to support the costs of essential health services. It is self-evident that these resources are now severely lacking compared to the commitments made by the governments.

→ Another issue for achieving UHC in Africa is involving faith-based health care providers in the nonprofit health sector, as they play an essential role in many fragile health settings. The strengthening of partnerships between these two sectors and the adoption of innovative forms of contracting (performance-based contracting) are testing grounds for both sectors for enacting an inclusive (or divisive) platform for UHC in Africa.

→ Human resources are another critical factor. Countries will need to match their commitment to UHC with their ability to provide quality services, and this depends on the availability of qualified, motivated health personnel. Current problems in the shortage, mix, and distribution of health personnel in Africa invite reconsideration of traditional models of training and use of human resources, and require strongly supporting the development of community health workers.

→ Last but not least, UHC presents considerable difficulties in choosing and applying a system of indicators to monitor desired outcome, such as effective coverage, quality of services, and financial protection. These problems are particularly acute at the decentralized levels (regional, district, and community), where there has long been a lack of simple, effective, quality tools and methods for measuring outcomes for the purposes of planning and evaluation of interventions and policies.

In Africa, UHC will take different paths and follow new forms and models, greatly conditioned by the values, political interests, and economic and social organization of each setting.

Due to all these factors, we should expect different health systems in terms of accessibility and equity.

Doctors with Africa CUAMM firmly believes that UHC should be the unifying policy goal of the SDG agenda in health and is an important step forward for achieving the right to health. If implemented effectively, the gradual application of UHC in Africa could contribute to reducing extreme poverty and social injustice, strengthening the health system, and potentially encouraging new modes of operation. Doctors with Africa CUAMM therefore intends to participate energetically and pro-actively, through a number of actions, in the international debate and in the processes for achieving UHC in the African countries where we are active.

Actions

→ Support the efforts of African health institutions to "guide" UHC development and implementation processes.

→ Strengthen the capacity of local communities and civil society to take an active role in developing, applying, and monitoring UHC.

→ Strengthen the technical capacity of faith-based health providers to negotiate with governments to develop innovative forms of finance contracting (such as performance-based contracting) and to implement forms of community insurance for essential health services not yet covered by the public insurance system (e.g., community-based loan funds for transport of obstetric complications).

→ Promote the development of multi-purpose community health professionals and their classification in the health system. Foster retention of health personnel and task shifting in remote areas. Actively support schools and universities that train qualified health workers oriented to Primary Health Care (medical and non-medical personnel).

→ Measure effective coverage, quality of services, and financial protection in interventions in the field, using appropriate indicators and tracer conditions.

→ Implement operational research for UHC. Particular importance will be given to studying cost-effective interventions that improve health impact on populations living in poverty and fragile conditions.

→ Promote program partnerships with other specialized agencies in the field of international health cooperation in order to improve economies of scale, expertise sharing, technological innovations, and intervention impact.

→ Support the Plan of Action — Health Systems Governance for Universal Health Coverage agenda globally, with lobbying and advocacy to international agencies, governments, civil society, and the professional and business world.

5.3 ORGANIZATIONAL PRIORITIES

5.3.1 Improve the quality of implementation, monitoring, evaluation, and operational research programs

There has been recent tangible improvement in the quality of programs, evaluation, and use of research within Doctors with Africa CUAMM. Nonetheless, to meet the new Sustainable Development Goals, and health goals in general, our programs' quality impact could be enhanced by being increasingly focused on innovation and learning. This will improve internal knowledge based on failures and successes, and help document result accountability for funders and beneficiaries.

The project cycle, starting from drafting the project, operational modes and implementation, should become more consistent and in balance with available human and financial resources.

To achieve this objective, Doctors with Africa CUAMM commits to:

→ Improve the computerization of the processes of designing, producing, reviewing and approving projects, revising and speeding up the system and bringing it closer to the actual process.

→ Strengthen project drafting with a dedicated staff with demonstrated ability to meet expected standards.

→ Improve planning and implementation of actions of each individual project, by strengthening the central control and adopting innovative project management methods.

→ Increase within the organization the circulation of experiences, good practices, and evidence gained in the field.

→ Organize a department for procuring and maintaining medical supplies and support equipment for the projects with dedicated staff using suitable technologies.

→ Develop operational, functional and equipment standards for major critical areas in health (including operating room and anesthesia service, delivery room, neonatal units, laboratory, radiology, ultrasound, water, and energy) with the help of expert consultants on these topics and on labor in Africa. Also with the support of external consultants, we will set construction standards for the main hospital buildings.

→ Strengthen monitoring, evaluation, and operational research with dedicated staff in Italy and Africa.

→ Update guidelines and manuals for assessing health interventions and the use of indicators based on international standards.

→ Include a base line survey, an end line survey, and operational research in every project.

→ Publish at least ten high quality operational research studies and evaluations a year.

→ Enhance the dissemination of evaluations and operational research through our web site, dedicated workshops, scientific publications, and participation in quality conferences.

→ Encourage adopting health innovations through scientific and planning partnerships with universities, research and development centers in Africa and internationally, and through a network of consultants with specific disciplinary knowledge.

06

Investing in human resources

Human resources are Doctors with Africa CUAMM's most valuable assets. We want to protect this asset, grow it, strengthen it, and enrich it.

In keeping with the approach Doctors with Africa CUAMM has always maintained and put into action, we reaffirm that human resources are our most valuable asset. We want to protect this asset, grow it, strengthen it, and enrich it.

To these ends, it is essential to focus greater effort on attracting and retaining human resources who have returned from Africa and are already part of Doctors with Africa CUAMM, but still too often have difficulty finding ways to stay deeply involved.

The sense of belonging should be cultivated with greater care, specifically around the two linchpins of our organization: our values and the health profession.

Attending to the aspect of values involves meetings, events, giving opportunities for reflection and participation, fitting current work and lifestyles and to keep this culture of values "alive."

Over our over sixty years of history, the experiences had and sharing ideals and values have fostered incomparable dedication among our human resources involved in the projects in Africa. Local institutions and the community have always recognized and appreciated this dedication.

The health profession aspect needs to be developed through proactive involvement focused on specific issues of work done in the field. We need to focus on spreading the evidence developed in Africa, good practices, and proven results (as well as failures, as the starting point for innovative analysis and solutions). Available technology should be used in dedicated sections of our website to support communication between returnees, as well as workers in Africa.

Particular attention should be given to young doctors, returning from being JPOs (Junior Project Officer) with a view to keeping our human resources involved. We need to attract them to the research area with opportunities for publishing scientific articles and presenting at conferences on these issues, building research interest in synergy with their universities.

The more we can succeed in keeping human resources involved to the organization, the easier it will be to recruit the professionals needed for projects in Africa from the membership pool.

An important strategy is building relationships with each doctor's institutions (health agencies, hospital directors, and head physicians) in order to make going to Africa easier for professionals who are full staff employees in the Italian health system. These relationships should be more strongly developed with synergy so that the departure of a staff member will be seen as an opportunity for the institution and the local area to gain quality and prestige.

Recruitment of professionals for projects in Africa should be systematically and structurally extended beyond Italy to the rest of Europe and Africa.

We need to push towards a structured framework for recruiting and selecting qualified African personnel, first and foremost in the countries where we work. Some of these countries have more availability of health professionals and our work with national personnel is already active and effective, but the approach still needs to be improved in terms of consistency and structure.

It is important to establish "where" and "how" to focus the process for recruiting health personnel: professional bodies, specialist associations, universities, and workshops organized by CUAMM itself on specific topics that involve local specialists. A network has also developed over the years in the countries where we are active, which can bring good results through direct interpersonal communication. Once selected, national health professionals will become part of our projects in the country and form an international team of European and national professionals.

African health personnel may also be part of projects in the countries neighboring their country of origin. They will be part of the international personnel on par with the European personnel.

This organizational approach may be used for particularly fragile countries in which there is a severe lack of national skilled health personnel available.

Within the recruitment of African health professionals — a particularly difficult issue, to which constant ongoing attention should be paid — there is the risk of taking away qualified from the national health system.

In order to prevent this, Doctors with Africa CUAMM recognizes the principles of the World Health Organization's "Global Code of Practice on the International Recruitment of Health Personnel."

Professional figures to recruit in such areas and the organizational model for personnel in the projects are closely tied to the geographical and issue priorities of the organization's strategic plan.

For fragile countries (with low health systems), professional figures will still be the usual ones both in healthcare and logistics/administration, including gynecologists, obstetricians, pediatricians/neonatologists, surgeons, infectious disease specialists, and public health specialists to ensure an integrated approach between the hospital and local area.

In terms of the community, we will need to significantly involve national personnel that has a deep knowledge of the culture and lifestyles of the local population with whom they can interact using effective language and behaviors.

The organizational model for interventions in fragile states will continue to be the presence in the field of international, European and African human resources for medium-to-long periods; in the absence of qualified national professional health personnel, their role will be one of substitution to strengthen the local national system.

In these settings, young doctors, supported by experienced personnel, can have extraordinary opportunities for personal and professional growth, which is why we should identify operational and financial ways to send young doctors beyond the projects themselves.

For middle and high health systems, professionals should have specific skills in the discipline and act in a role of supporting rather than substituting qualified health personnel in targeted areas of the country's health system.

In these settings, the organizational model will be different and have teams with fewer human resources in the field, but supported by short-term consulting.

Specialist support has been implemented recently and needs to be further developed through partnerships with bodies and institutions specialized in various health fields. The pool of consultants that already works with our organization should be further developed for this purpose.

07

Strengthening accountability

Processes put in place to "make the machine run" are essential for an organization that wants to build its reputation based on results.

The process of change that our organization undertook with the 2008–2015 Strategic Plan has oriented our organizational process towards "result-based management," applying a concept of "managerial and cross-sector" administration to all levels of management, both centrally and at the peripheral level in the countries in Africa where we work.

This led to a major, complex work of organizing and fine-tuning of processes and procedures, which is still underway, and in some cases, is being updated, finalized, and made more efficient and effective in its administrative and management support mechanisms. Though complementary and ancillary, these mechanisms are indispensable for carrying out the organization's work in Italy and in the field. The effects of this long, arduous undertaking can be seen most clearly in our economic/financial management, especially for the projects and our coordination offices in Africa.

The complexity of management has recently been growing in all of our organization's operational areas.

Raising and managing funds (national and international tenders, contribution requests, progress and financial reporting, monitoring, and evaluations) have been strengthened by widening our network of partners, and developing skills to find new funding opportunities outside of Italy.

In coming years, it will remain strategic to continue to invest energies in this area to find resources for our projects and the organization's activities. We should therefore:

→ Keep up to date our mapping and knowledge of the "markets" of international cooperation funding;

→ Improve the skills of project leaders, directors, and country administrators to provide tools up to the standards required by donors at various levels;

→ Provide evidence of results for all interventions, and, for more complex initiatives, provide for "built-in" end evaluation.

Another important management aspect for an organization like ours is managing **national, international and local human resources** (including bargaining, benefits, and security). Because of the specific features of our work, we need a professional for the purpose in the field to achieve the goals set for the health interventions.

Enlarging the recruitment pools beyond national borders, the management of relations with international networks, increased turnover in projects, and the increasing use of local professionals requires specific knowledge of labor law, international taxation, collective bargaining, and safety standards. Our organization must therefore focus on strengthening these capabilities in our headquarters and in the countries by improving service quality and efficiency.

In coming years, further bolstering efforts already in place to make the management planning more functional can be achieved by a gradual but decisive revising of our organizational model, including on the basis of legal provisions in Legislative Decree No. 291/2001 (organization, management, and control model).

This entails reviewing the present staff organization for the management processes adopted thus far and the rapid changes that are still taking place to reorganize roles and functions.

For this purpose, the responsibility levels that inform our daily operations will be further defined and codified, both in the headquarters and in the field. This will lead us to define who makes decisions and in what realms, and how these decisions should be made operational as a result. This increased clarity will let us apply a natural internal **control** process — not just bureaucratic and self-referential — but directed at the overall improvement of management.

We should clarify that our organization has already acquired methods and tools that let us handle regular audits, by governmental authorities and by donors, with no particular difficulty, both in the headquarters and in the coordination offices. Combined with evidence from the results achieved n individual projects, we confirm our serious, ongoing commitment to **accountability**, adopting an accountability process that

is always accurate and transparent, while respecting the principles set and shared with the Link 2007 NGO network.

Though **flexibility** can be difficult to balance with processes and procedures, it needs to be given room in day-to-day operations to respond well to work needs in our headquarters and in Africa, as well as to avoid restricting to overly rigid structures planning, new prospects, and employment opportunities. This does not mean overriding rules; for those in positions of responsibility, it means dialoguing with others, and not fearing change in the face of new rules and more complex stakeholders.

The organizational model will work to the extent that our organization is understood as a unified whole that needs all of the ideas and energy available, in our headquarters and in the field in the countries. No function or role should be perceived as in opposition to an active or passive subject in a decision-making or operational process.

The organizational strategy's success will be determined by the processes to put in place to "make the machine run," essential for an organization that wants to build its reputation based on results.

08

Communication, training, public awareness, and fundraising

8.1 Context

8.2 Social changes in the media and in fundraising

8.3 Strategic directions

8.4 Areas of action

8.4.1 Communicating: a necessity and a calling

8.4.2 Training and public awareness in global health and international health cooperation

8.4.3 Fundraising

"The future depends on how we imagine it and want to build it. Our first objective is to help restore interest and hope in the future of Africa that we believe in".

Don Luigi Mazzucato

8.1 CONTEXT

Doctors with Africa CUAMM is active in an increasingly global, interconnected context. Communication, public awareness and fundraising are affected by this growing globalization and the intense speed and flow of the changes underway. In the next 15 years, in a world with a growing population (8.5 billion in 2030[1]), concentrated in increasingly crowded large cities, demand will grow for water, energy, and food. We will see the growth of the economies of Asia (China and India) and the Global South. Technology and research will play a key role in developing the economies of individual countries, and we will live in a digitally connected world around the clock, where news come in real time. Africa is often looked at exclusively from an economic point of view. A lot of attention is given to GDP growth in Africa, which is increasing at rates near those of Asia (the OECD estimates 5% growth for 2016)[2]. This increase is far and beyond anything in Italy and Europe in general. But Africa is much more — the development of systems of governance, education, health, culture, and there is also the persistence of great inequality. Doctors with Africa CUAMM wants to do its part in giving the public a new view on Africa in Italy and major European and Western countries. We are committed to understanding the changes affecting and challenging Africa and our entire planet. As discussed extensively in the "in the field" planning sections (operations in Africa), CUAMM intends to adhere to the Sustainable Development Goals with a focus on reducing maternal and child mortality (infants and children under 5 years of age), fighting AIDS, tuberculosis and malaria, as well as malnutrition, especially in children under 5 years old. In keeping with Sustainable Development Goals, our organization will seek to inform, raise awareness and mobilize public opinion, both nationally and internationally, around major issues of Global Health, attention to climate change, and the fight against poverty and marginalization, with the goal of reducing inequalities and promote peace and justice.

8.2 SOCIAL CHANGES IN THE MEDIA AND FUNDRAISING

The global economic crisis has had a negative effect on economic development. The gap between the world's rich and poor is widening, bringing the theme of equity back to international and European agendas, both on a social level and in terms of access to health services.

According to the *Commission on Social Determinants of Health*[3] of the World Health Organization, ensuring equitable access to health services requires a multidisciplinary effort that takes into account the current situation, made up of multicultural societies, migration, and demographic, technological and climate changes. Health professionals are on the front line of interacting with society responding to new needs related to demographic and social change (multicultural societies, the new poor, and migrants) and the epidemiological context, with re-emerging diseases (such as tuberculosis) and new diseases (e.g., tropical diseases now found in Italy too due to migration and climate change).

Health professionals need new tools and knowledge in this global, interdependent world. This is why Doctors with Africa CUAMM will continue to promote global health training programs for medical students at Italian and European universities and to offer internships in the field in Africa to help train medical students and young doctors, and increase "brain circulation," which enhances Italian competitiveness in the world.

Communication in the digital age is undergoing extremely rapid changes affecting established categories, such as the concept of news, the role of journalists and editors, the organization of stories, how content and experiences are consumed, and publishing and business systems. The fight to gain an audience and build a consistent, transparent dialogue with public opinion is no longer a once a day occurrence; it happens every minute and on all media, ever less on traditional newspapers and ever more on tools connected to the internet, such as computers, and especially cell phones and tablets. In just a click, the internet brings us into contact with the entire world, including games, videos, photos and messages from friends and relatives, practical information, and interesting facts.

Audiences are increasingly fragmented. People are taking an

active part in communication and want information that truly meets their interests.

Social networks, like Facebook and Twitter, are main sources of news. While Facebook is mainly for other purposes, such as staying in touch with friends and acquaintances, Twitter is used by a more specialized audience to look for recent developments and news, including in information technology. News is increasingly "unbranded" in search engines like Google and social networks are overwhelmingly the gateway to the journalism websites[4].

These changes in society and communication have many effects on us, including motivation for donating. We should emphasize that decisions to donate are still influenced first and foremost by being involved in the organization's causes, knowing people, and trusting in the organization[5]. Italy is still our primary country for fundraising from private individuals, though the situation has dramatically changed recently. There are fewer donors in Italy, and major, international competitors with large investment budgets have come on the scene in Italy and shaken things up. Out of available communication and fundraising channels, the internet will become ever more important for fundraising from private donations. Currently, 39% of Italians already say they are very inclined to use the internet and 57% find it fairly or very easy to use. As crowdfunding platforms grow, fundraising is becoming increasingly global, and the importance of being known even more strategic[6].

8.3 STRATEGIC DIRECTIONS

Doctors with Africa CUAMM believes that communication, reputation, and involvement should prioritize personal contact and direct relationships on all fronts in Italy, Africa and internationally.

This attitude is essential for spreading our values and approach to cooperation, especially in a global, interconnected world where information is ever-more far-reaching, rapid, and accessible. Highlighting and telling about would we do, the results we achieve, and our approach, are strategically essential already and will be increasingly so in the next 15 years.

Communication and public awareness initiatives are connected to fundraising and building roots in the local areas of action, making up a mutually-reinforcing unified whole. We intend to focus on five strategic directions.

→ Trust

Doctors with Africa CUAMM has been helping develop African health systems with integrity, transparency, and passion for over 65 years. We plan to continue to be recognized for the tangible results we achieve in the field and the efficiency we strive for consistently, always seeking innovative solutions, using qualitative and quantitative tools of operational research, and putting our programs to rigorous evaluation. This approach is our true strength and the capital on which to build future relationships; it is what sets us apart and is appreciated by donors, public and private institutions, and local partners. We are committed to continuing in this direction in coming years.

→ Tending relationships

As we strive for a health system centered on people, families, and communities, including in our communication and fundraising, we seek to focus on our relationships, whether with individuals, profit or not-for-profit organizations, institutions, foundations in Italy, Africa, and in the world. Doctors with Africa CUAMM believes that a transparent relationship and shared values of trustworthiness and honesty are the best ways to create strong involvement and active participation in our objectives and actions in the field.
The "network" in Italy of returned participants over the years and volunteers in groups make up the backbone of our activities, just as active volunteers in Africa can speak most credibly to the daily life and challenges of the projects in the countries.
At every level, we will strive to grow forms of participation and involvement, in amount and quality, using flexible models that are responsive to different circumstances and needs. We will fine-tune systems for bringing together and leveraging the experiences and people who care about our values and objectives. Tending relationships and building networks with like sensibilities and motivations are the main ways of

1 Department for Economic and Social Affairs (UN-DESA) of the United Nations. 24th annual estimate of the world population. http:// www.lifegate.it/persone/news/ nuove-stime-popolazione- mondiale

2 "African Economic Outlook 2015" — OECD

3 WHO, Closing the Gap in One Generation. Health Equity through Action on the Social Determinants of Health. WHO, 2008

4 www.datamediahub.it/2015/06/16/digital-news-report-2015

5 "Gli italiani e le donazioni". GfK Eurisco 2014

6 "Gli italiani e le donazioni". GfK Eurisco 2014

building familiarity with CUAMM in a broader public.
This structure allows us to be inclusive, disseminate experiences and actions, and catalyze the energy of those who show interest and concern for these issues. We will focus our annual operational strategy on networks, forms of groups and partnerships, and our diverse stakeholders to achieve focus, attention, and results.

→ **Being global**

Doctors with Africa CUAMM is asked more and more often to present our approach, programs, and results internationally and in the countries where we operate. Within a cooperation system involving a wide variety of traditional and new players and increasingly complex mechanisms, we want to promote partnerships and networking with different players and donors. We also plan to develop our communication in several major languages to give a clear, engaging representation of our organization as a whole, as well as our specific projects and interventions, helping create a direct, recognizable understanding of the settings where we operate. Our web sites, videos, and print media will be produced in English, Spanish, and Portuguese. Though it will be a long process, we will start to put this plan in action by providing content, support, and methods to our locations in Africa.

→ **Positioning**

Doctors with Africa CUAMM seeks to be a standard setter for reliability and integrity in international health cooperation. Similarly to our planning strategy, our communication and reputation strategy will be centered on telling about our work on the furthest outposts of the world, decayed peripheries, and in the "field" hospitals of the disadvantaged regions where we work, focusing particularly on mothers and children.
We intend to strengthen forms of sharing good practices, research, and results achieved by creating opportunities for dialogue with health specialists and civil society. Our positioning is unique and open to engaging everyone, including professionals with already established skills, the most vulnerable groups of the population, and young people to involve them in the change we seek.

→ **Doctors with Africa CUAMM: a "brand"**

The bases for expanding familiarity with Doctors with Africa CUAMM include documenting and recounting results and successful "case histories." Increasing "brand awareness" is not an end unto itself; rather it helps our actions in Africa, building political and institutional relationships nationally and internationally, fundraising and awareness-raising at all levels, from large institutional donors to private individuals, in Italy and around the world. Alongside our well-established methods on which we have built experience, we should thoroughly and efficiently explore the effectiveness and vocabulary to use in new media and tools (especially social networks and campaigns for specific issues).
We will thoroughly explore innovative forms of communication, including audiovisual and social networks, initiating partnerships at a European level as well.

8.4 ACTION AREAS

8.4.1 COMMUNICATION: A NECESSITY AND A CALLING

Doctors with Africa CUAMM aims to plan and foster dialogue with people, families, communities, and institutions that can inspire engagement, help teach about the reality of Africa — not only its problems, but its potential as well — and show the many dimensions of the organization in Italy, Africa, and internationally.
Our communication aims to foster relationships of trust, to disseminate and explain our organization's identity, and convey and amplify our messages and concerns, inviting partnerships and contributions at all levels.

We are now taking on the challenge of the dramatic change touching every form and mode of communication to powerfully develop new potentials. This fascinating undertaking will mean making more room for involvement of our staff in Italy and Africa, and creating increasingly targeted forms of communication as an essential basis for awareness-raising and fundraising.

Touch points for this will include paying attention to quality in the rapid digital environment, engaging endorsers who are important, authoritative supporters, the power of communication based on experience and trust relationships, and the greater internationalization of our communication.

→ **Quality and speed**

Doctors with Africa CUAMM's history and values demand that we give the utmost respect to people and avoid turning their problems and needs into mere spectacle,
and not indulge in pseudo-piety. This means we need accurate sources of news, information, and stories. It also invites us to take up the challenge of digital technology, to adapt our communication to all content types (such as experiences in the field with photos and videos) on new digital and social platforms. Our communication should make the most of this by being ready to meet the challenge of speed, providing a constant flow of simple, up-to-date, and engaging studies and facts, stories and experiences.
We have an invaluable resource in our organization's documentation, gathered over the years in Doctors with Africa CUAMM's archives (which has recently undergone a major securing process). The archive can also be drawn on as part of the flow of regular updates to help us communicate and highlight our specific features, drawing on past experiences to understand the present and build the future.
We can give narratives of the experiences, results, and actions from the furthest outposts, keeping the accounts varied and vibrant, including in lighter, more emotional tones, to cohesively bring together our organization's life, and build on our capital of trust, and sense of being reputable, reliable, and consistent.

→ **Personal accounts and endorsers as "travel companions"**

With each group that goes to the field, the experience of bringing treatment and being doctors in fragile settings have forged relationships and encounters with everyday men and women, and their problems and suffering, as well as their expectations and hopes. We have recently found a way to bring them these experiences to the surface, always with deep respect for these worlds, making our voices heard and expanding our

capacity to be known and understood. Coming together with special friends has let us discover unexpected affinities, perhaps unimagined, such as with Niccolò Ammaniti, Niccolò Fabi, Carlo Mazzacurati, Paolo Rumiz, and many others. These are far from "disposable" endorsers — occasional and fleeting; they are true travel companions.
With the help of our sensitive new friends, we will continue on our path, shedding light on what our organization does, making our stories public, yet personal and profound. Likewise, Doctors with Africa CUAMM works for the voice of Africa be heard, including for its cutting-edge art, culture, music, dance, sports, representing its international excellence.
We seek to forge a stronger, long-lasting deep dialogue with the communities and countries where we work.

→ The contagious power of experience

Firsthand accounts are starting points for engaging in the values, stories, and initiatives, and they gain strength by sharing personal experiences.
When Doctors with Africa CUAMM plans projects, events, and initiatives, we should put the value of the personal experience front and center to unleash the full potential that comes out of real relationships, bonds of trust, and meeting people and communities directly. In a world of information overload, the value of personal experience and interpersonal encounters should be underscored in events, field missions, universities, groups, and in our local areas. With this understanding, we will seek to increase our involvement and presence in traditional media (TV, newspapers, magazines) as well as new media (the internet, social networks), taking a more systematic approach to leveraging the potential of integrating different media platforms. Likewise, we plan to support fundraising by involving different players in a chain of relationships, based on trust, direct encounters, and positive experiences, forging effective, creative forms of communication within different communities.

→ African and international dimensions

In order to make our voice heard in the countries where we work and internationally, Doctors with Africa CUAMM will produce our communications in English, Spanish, and Portuguese, with concise presentations of our organization, projects, and operational research, from a perspective of accountability.
At the same time, we will organize opportunities to present and discuss our programs and have project launch events with institutions, stakeholders, and donors. *Our mission and values will also be expressed in visibility materials from those working in the field*, to make it easier to build our identity and recognizability.

1. Strengthen Doctors with Africa CUAMM's identity to make our "brand" distinctive, recognizable, and credible, nationally and internationally.

2. Develop the use of our website and social networks (Facebook, Twitter, and Instagram) to engage the public around our values and projects, growing our network of friends, supporters, and CUAMM ambassadors, nationally and internationally, and increasing dialogue with our network through social networks to collect and amplify comments, thoughts, and ideas from the community.

3. Promote Doctors with Africa CUAMM's visibility by leveraging local, national, international press offices.

4. Plan communication that is accessible internationally (using English, Spanish, and Portuguese in addition to Italian) and increase international visibility through events abroad and with multilingual standard material.

5. Endorsements: Involve prominent figures around our mission to raise public awareness in Italy and Africa, creating opportunities for public gathering.

6. Make use of the wealth of the stories in our archive to highlight the continuity of CUAMM's roots and core values.

7. Pay close attention both to developing and using products to increase visibility (shirts, backpacks, sweatshirts) to spread the name and message of Doctors with Africa CUAMM in Italy, Africa, and internationally.

8.4.2 TRAINING AND PUBLIC AWARENESS IN GLOBAL HEALTH AND INTERNATIONAL HEALTH COOPERATION

Globalization has accelerated the spread of knowledge, fostering scientific and technological progress and has led to a general improvement in health, though unevenly benefiting different countries and individuals. Global health cooperation means acting practically to reduce inequality with interventions in the field of health cooperation, as well as by supporting a movement for the right to health for all.

This is what Doctors with Africa CUAMM seeks to do in Africa, and Europe, and in Italy. Raising awareness about global health is for everyone in a broad sense.

Talking about global health means understanding the reasons for inequality and equity, the determinants of health, what health cooperation can do, and the connections between the economy, society, environment, and health. These are all core issues for guaranteeing the right to health for all, as recognized by the Universal Declaration of Human Rights (arts. 3 and 25) and the Italian Constitution (art. 32).

For several years, Doctors with Africa CUAMM has organized training opportunities for doctors, nurses, and health workers, addressing key issues for global health, focusing on international health cooperation, essential for a practical commitment to health inequalities.

→ Human capital

In our increasingly globalized world, health workers are called upon to go beyond their roles as doctors, nurses, and midwives to take on increasingly important role as advocates for the right to health for all.

This is why Doctors with Africa CUAMM continues to focus on health professionals, working to raise awareness on the issues of global health and international health cooperation and engaging them in our organization's mission through training in Italy and Europe and practical experiences in the field in Africa.

Doctors with Africa CUAMM also works to create information on health cooperation and global health policies by disseminating scientific content, good practices, and research highlights, improving communication and sharing scientific results. We are also working to consolidate and expand our network of partners who share our health cooperation values by implementing new international projects and initiating new partnerships.

Part of our genetic heritage at Doctors with Africa CUAMM is attention to young people. We seek to raise awareness among them on issues of cooperation and the right to health and engage them in our projects in the field. We offer university training to young people[7], combining theory and practical application, disseminating scientific content and research to create information on health cooperation issues, using a unified, shared communication, experience in the field in limited resource countries, and new partnerships and plans to help contribute to achieving human and professional training in a perspective that goes beyond national boundaries and is inclusive of global changes.

Several training and traineeships in the field are offered to young people; one program is for medical students, organized jointly with the Italian Secretariat of Medical Students (SISM), which provides one month of field experience in the countries where we work in Africa; another project is for interns (Junior Project Officers); and the Midwives Project is for midwives who are still students or recent graduates. These projects all aim to provide traineeships in Africa, where participants can explore different ways of doing medicine and gain new experiences professionally and personally.

Young people also help spread the word about our organization's work in the field through new communication tools, engaging their network of contacts, solidifying our reputation for integrity through relationships of personal trust.

Young health professionals not only expand their interest in the field of health cooperation through traineeships in the field, they also build their educational resume, giving them a competitive edge in the current international market. This is an investment in young people, which Doctors with Africa CUAMM has been making for a decade, and will continue do make in the future, and it is also valuable for Italy as a whole.

Doctors with Africa CUAMM aims to engage everyone, whether young or not, in keeping with their potential. Health professionals with a great deal of experience, advanced skills, "senior" both in their careers and life, have shown the desire to take action to "do their part," even if they haven't had an international health cooperation experience. This human capital is a source of wealth. These are sensitive people with great experience who can pass on unique professional and human abilities to younger generations.

Doctors with Africa CUAMM will launch an initiative called Senior Medical Officer (SMO). The project is aimed at health professionals who want to get involved and donate their skills, which could be useful in Italy and/or in Africa. Contact will be made through active collaborations with different professional bodies. Doctors with Africa CUAMM puts great value in the professional and human backgrounds of these mature health professionals, both for the purposes of health cooperation, and for the dialogue between generations passing values to young people, who need tutors and models to help them grow in personal and professional terms.

→ Operational research, workshops, and scientific publications

Operational research has long been a part of Doctors with Africa CUAMM's strategy, with the goal of thoroughly understanding the contexts in which we work, initiating discussion between specialists on an international level and thereby improving our action in the field.

A primary goal of this approach is disseminating results and discussion within the scientific community, through specific tools, such as the Salute e Sviluppo journal and publishing materials for specific groups (such as the community of maternal and child health professionals). Our goal is to create sharing and to open to academic and scientific worlds, as well as that of cooperation. Taking part in conferences to present research material and

organizing scientific seminars, including in Africa, will help us solidify and expand our working network, establish ourselves as important players in research in particular subject areas, and build planning online.

Doctors with Africa CUAMM focuses its research on maternal, newborn, and child health.

Particular attention will be given to the reproductive health of adolescent girls. Nutrition (nutrition for pregnant women, breastfeeding, acute and chronic child malnutrition, and obesity) will also be a major area of study. Another area of research will be major communicable diseases (HIV/AIDS/TB/malaria, neglected diseases) and comorbidity with chronic illnesses. All areas will be researched from several perspectives, including clinical, epidemiological, health system performance (coverage, quality and equity in services and the community) and impact on health status. Research tools and methods will be both quantitative, including trials, and qualitative.

In the medium term, operational research and the resulting workshops and publications will give Doctors with Africa CUAMM a broader network of academic, institutional, and scientific partners, and will help us improve communication of our research to the health community, students, young doctors, aid workers and returnees, in a framework of strengthening relationships and accountability.

1. Implement training and awareness raising about global health, international cooperation, and health policies for health professionals in Italy and in Europe.

2. Engage health professionals, both young and senior, each according to their strengths, in specific projects, including training, traineeships in the field, and actions in Italy.

3. Produce, collect, and disseminate the contents in scientific and non-specialist areas to support operational research and the results of national and international projects.

7 Thanks to agreements between Doctors with Africa CUAMM and many Italian universities, as well as a specific protocol with the Conference of Italian University Deans and our ongoing collaboration with the Italian Network of Global Health Education.

8.4.3 FUNDRAISING

→ Fundraising in Italy

Over the past seven years, Doctors with Africa CUAMM has kept a basic balance between private and institutional sources of funding, growing the two sources evenly and in parallel. This funding method is consistent with our mission, aiming to increase hope and commitment in institutions and public opinion for the health of African populations.

CUAMM is encouraged in its fundraising not only by financial need; especially for the private funding, we are also aiming to engage people in the mission and values of Doctors with Africa CUAMM. The involvement of private individuals as supporters also legitimizes and strengthens CUAMM's work in the eyes of beneficiaries and institutions.

In the future, keeping the balance between the different sources of funding will be an important challenge that will necessarily lead us to new frontiers and methods of fundraising.

The path we have taken in recent years has led to set more value by our human capital, starting from the more than 1,500 aid workers who have given their service in Africa over the last 65 years. They were joined by people and associations, who share their approach and values, to form a unique network that gives voice and resources to CUAMM's mission through awareness raising and fundraising. Activating this human capital takes local contacts in the area to support and reinforce our projects and dialogue with our headquarters. This local presence has helped solidify our relationship with all our donors, conveying practical action and trust through the active engagement of volunteers in Italy and aid workers in Africa.

Our growth strategy will continue to be guided by being rooted locally, has let us achieve good fundraising results during this period of economic downturn and not take away resources from projects in Africa.

→ Strengthening our network

The network of volunteers currently in Italy is formed primarily through the efforts of those who had experiences in Africa and their contribution will continue to be fundamental in coming years.

Pursuing such an important, difficult mission requires finding new, broader ways of participating in CUAMM's world, engaging larger sections of civil society, and it will mean dialogue and commitment among generations to ensure growth and continuity.

Training projects for students, interns, and midwives in Africa and support missions for aid workers with more professional experience and time are moving in this direction. They offer a chance to expand the network of health professions, who, in addition to their work in the field in Africa, are called upon to be some of CUAMM's main mouthpieces as those involved firsthand in cooperation.

Increasing our "brand" reputation, through the support of endorsers and the use of social networks are also opportunities to engage new groups in the CUAMM network. This is why it is important to find simple, broad forms of engaging and activating our network, which will include different professionals, not only health professionals. It will be crucial to put into action the idea that everyone can give their contribution in different ways to the health of African populations, each based on their own talents and abilities.

Expanding our network will also increase CUAMM groups, which, in a more streamlined, operational form, will continue to be catalysts of local opportunities to raise awareness and boost our reputation among donors, institutions, and civil society. The goal in the next 15 years is to increase the current 28 groups to 100 groups with special focus in the northwest and central south Italy.

To keep our work unified and cohesive, in addition to opportunities for gathering and education, we will make use of a communication tool that can collect the news from the daily lives of the people in our network, a new I 4 Venti bulletin will be the best way to mark and remember the little moments that make life great (such as births, weddings, and graduations that will have their place in our ability to communicate). The CUAMM family, which speaks to and represents our mission throughout Italy, will likewise need to use social networks broadly, as they are a wider new world for highlighting firsthand accounts.

→ Increase of donors

The trust and concrete substance that our aid workers in Africa manage to convey will continue to be the foundation of the relationships we seek to build with our donors. We have sought to encourage a fundraising mindset in our organization and our human capital. We should continue to expand this process to make every aid worker feel a responsible, interested, and sure representative of CUAMM and its projects, both in implementing them and in seeking the financial and human resources needed to make them happen.

Empowering our human capital and growing our reputation through the media in Italy will let us engage a growing number of donors, including individuals, companies, associations, and foundations.

In turn, we will take care to provide our donors attention, sensitivity, commitment, and credibility in our reporting so they can feel an essential part of Doctors with Africa CUAMM and feel involved in promoting our mission in their communities.

To achieve this goal, we should increase opportunities for visiting our projects in Africa (fidelity trips and educational trips), organize visibility opportunities to inspire emulation and boost the use of social networks as direct, rapid communication tools about experiences in Africa to promote them and share them.

This important process will be supported by organizing an information system to collect all the knowledge about the network to make it an asset to be fully exploited. We will increase the number of local events to grow our reputation and make new contacts. This will also be an important organizational undertaking to manage all our relationships with a smooth, personalized approach.

Doctors with Africa CUAMM plans to grow by 10% annually over the next 15 years by putting this plan into effect.

→ Bequests: gifts for the future

Special consideration should be given to bequests, which have a symbolic and ethical value beyond their economic one. Leaving a gift behind after death is a way to keep on being part of life in a wonderful, joyful way. Doctors with Africa CUAMM plans to tell more often about the positive projects done in memory of those who have left us, conveying the full beauty of such a gesture.

It means an intergenerational commitment that can keep making CUAMM's mission vital and effective. We see bequests as a message to those left behind and a final act of care for the poorest and neediest among us. It is a new start, a reminder left to young people to keep going on the path of the right to health for all.

1. Expanding and **leveraging the network** of those engaged in CUAMM's mission in Italy and abroad through diverse forms of direct involvement (JPOs, SMOs, educational trips) and indirect involvement (events and meetings in Italy).

2. **Increase by 10% the number of active supporters** by local engagement and activating communities linked to our network, boosting current modes of relationship building as well as on social networks.

3. Improve our capacity for **building relationships and loyalty** through direct, personal contacts and with tools that keep people actively in touch and "shorten" the distance with Africa (such as the new I 4 Venti bulletin and using social networks).

4. Build a **database** to dynamically collect, edit, and take advantage of our organization's knowledge.

5. Highlight bequests as a way to care for the poor even after death, leaving the community a **powerful message** of hope for the future.

→ International fundraising

International fundraising has been a mainstay of Doctors with Africa CUAMM's strategy in recent years.

New international donors have provided resources that are essential for ongoing programs, in some cases supplementing or replacing traditional donors in cooperation (such as Italian cooperation or the United Nations system). CUAMM realizes that international fundraising has great potential and is a major "incubator" of relationships, helping develop solid connections between the organization — by means of the project — and players in international cooperation.

This relationship and the resulting partnership takes the form of events, workshops, and other opportunities for Doctors with Africa CUAMM to be visible, amplifying our message internationally. We plan to increase presentations of good practices and results in the near future. CUAMM seeks to support this development, understanding that spreading its health cooperation model is an effective, solid way to influence health policies to be more equitable and efficient.

International fundraising priorities have been about giving continuity and support to current programs as well as supporting the growth of inventions with the most while maintaining the identity and approach of Doctors with Africa CUAMM. This is happening in a situation of severe economic crisis and rapid change in which the "cooperation system" has a growing variety of public and private players involved.

In addition to traditional mechanisms of bilateral and multilateral cooperation, new institutional donors and private foundations are new to the table of donors, including those linked both to private individuals, set up for charitable purposes, and to businesses with social responsibility aims. Internationally, Doctors with Africa CUAMM intends to "defend" and promote our approach to strengthening health systems in an active, dynamic way, forming partnerships with new players in health cooperation.

The geographical areas where Doctors with Africa CUAMM will build relationships are mainly: Europe, both in terms of the EU and individual countries (such as Spain, Germany, Switzerland, Denmark, and UK); the United States, especially with private foundations; Canada, currently one of the main bilateral donors in the fight to reduce maternal mortality, and South American countries that have both important missionary organizations and long traditions, and many health professionals interested in cooperation, as these countries are becoming important institutional players (in what is called "South-South cooperation").

Particular attention will also be given to major international hubs, such as Brussels the European Union, New York, and Geneva for the UN, and Addis Ababa for the African Union

Internationally, Doctors with Africa CUAMM commits to:

→ Participate in events and international conferences to present the results of our programs, good practices, and experiences from the field.

→ Create opportunities to present the work of Doctors with Africa CUAMM by putting on events, presentations, workshops and conferences abroad, both in partnership with major players in cooperation (foundations, governments, etc.) and autonomously.

→ Tend ongoing relationship (formal and informal) with all players in international cooperation, promoting networking, knowledge of Doctors with Africa CUAMM, and stimulating commitment to operational projects, staying true to our core values.

→ Facilitate visits by international players both to Doctors with Africa CUAMM projects in the field and in our Padua headquarters, as opportunities to give reports of the work done (for already active donors) and to develop new and innovative programs.

→ Join international networks on specific issues (such as nutrition, maternal-childhood health, HIV/AIDS, and NCDs), posting online documents, good practices, and project results and operational research, actively following online discussions and international newsletters.

→ Explore how to establish CUAMM offices in certain European countries, the U.S. and Canada in support of fundraising and on-site partnerships.

Tied to this presence, we are working to create visibility, technical and scientific materials, project fact sheets, and brochures in English, as well as create our website in Italian, English, Spanish, and Portuguese. We need to increase our ability to convey news, engagement and attract new groups through multilingual social media (Italian, Portuguese, English, and Spanish).

1. Promote **international partnerships** with private and public donors and facilitate relationships with international institutional stakeholders.

2. Focus on **Europe, the United States, and Canada**, including establishing on-site CUAMM offices.

3. Increase our ability to communicate locally through documents, materials, and use of communication channels in **Italian, English, Spanish, and Portuguese**.

Bibliography

→ Context

Speech by the President of the Republic at the opening session of the 10th Conference of Ambassadors of Italy, "Diplomacy for Italy." http://www.quirinale.it/elementi/ Continua.aspx?tipo=Discorso&key=95

Africa: a continent adrift John Marcum, Foreign Affairs, America and the World, 1988/89
https://www.foreignaffairs.com/articles/africa/1989-02-01/africa-continent-adrift

The rising of the south, Human Development Report 2013, UNDP
http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf

African Economic Outlook 2015, Regional Development and Spatial Inclusion

Africa a Hopeful continent, The Economist, 2013
http://www.economist.com/news/special-report/21572377-african-lives-have-already-greatly-improved-over-past-decade-says-oliver-august

OECD (2015), *States of Fragility 2015: Meeting Post-2015 Ambitions*, OECD Publishing, Paris
http://dx.doi.org/10.1787/9789264 227699-en

World Bank harmonized list of fragile situations, FY14
http://siteresources.worldbank.org/EXTLICUS/Resources/511777 1269623894864/Harmonizedlistoff ragilestatesFY14.pdf

Strengthening Health System for resilience, IDS Practice paper in brief, 18, February 2015-09-05

The urban disadvantage. State of the world's mothers, Save the Children, 2015-09-05

Pastoralism, demographics, settlement and service provision in the Horn and East Africa, Humanitarian Policy Group, May 2010, ODI

Health in the post-2015 development agenda: need for a social determinants of health approach
http://www.who.int/social_determinants/advocacy/UN_Platform_FINAL.pdf?ua=1

Global Health Statistics 2015, World Health Organisation

State of inequality: reproductive, maternal, newborn and child health, 2015, World Health Organisation

Progress for children. Beyond average: learning from the MDG, Number 11 2015, UNICEF

Global health 2035: a world converging within a generation, The Lancet Commission Global Health 2035, *Lancet* 2013; 382: 1898–955

Institute for Health Metrics and Evaluation. *Financing Global Health 2014: Shifts in Funding as the MDG Era Closes*. Seattle, WA: IHME, 2015

Biesma R, Brugha R, Harmer A, Walsh A, Spicer N, Walt G. The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. *Health Policy Plan* 2009; 24: 239–52

La cooperazione sanitaria internazionale in La Salute Globale, Maciocco e Santomauro, pp. 229–249, Carocci Faber Editori, 2014

The Millennium Development Goals Report 2015, United Nations 2015-09-05

Transforming our world: the 2030 Agenda for Sustainable Development, https://sustainabledevelopment.un.org/post2015/transformingourworld

Kent Buse and Sarah Hawkes *Health in the sustainable development goals: ready for a paradigm shift?*

Buse and Hawkes Globalization and Health (2015) 11:13 DOI 10.1186/s12992-015-0098-8

Marco Schäferhoff, Christina Schrade and Elina Suzuki Centre on Global Health Security | August 2015 *Analysing Proposals for Reform of the Global Health Architecture*, Research Paper, Chatham House

→ Doctors with Africa CUAMM's Strategy

Criteri di Intervento nei Programmi di Cooperazione in campo sanitario nei PVS, Documenti 1975–1985 2 Cuamm

Declaration of Alma Ata, World Health Organisation, 1978

Africa nel 21 Secolo: Salute Per Tutti? Cuamm, Medici con l'Africa, 2000

Piano Strategico 2008-2015. Rafforzare i Sistemi Sanitari: Il contributo di Medici Con l'Africa Cuamm alla realizzazione del Diritto alla Salute per i Poveri nel contesto dell'agenda del Millennio. Padova 2008

Everybody business: Strengthening Health System to Improve Health Outcome, World Health Organisation, 2007

Putting People First, in Primary Health Care, Now More than Ever, Global Health Report 2008. WHO, Geneva

Tarimo, E. (1991) Towards a healthy district: organizing and managing district health systems based on Primary Health Care; WHO, Geneva

J Rohde et al. 30 years after Alma-Ata: has primary health care worked in countries? *Lancet* 2008; 372: 950–61

Friberg IK et al. (2010) Sub-Saharan Africa's Mothers, Newborns, and Children: How Many Lives Could Be Saved with Targeted Health Interventions? PLoS Med 7: e295. doi:10.1371/journal.pmed.1000295

R Atun et al. Improving responsiveness of health systems to non-communicable diseases *Lancet* 2013; 381: 690–97

A Harries et al. Monitoring treatment outcomes in patients with chronic disease: lessons from tuberculosis and HIV/AIDS care and treatment programmes Tropical Medicine & International Health Volume 20, Issue 7, July 2015, Pages: 961–964

Olivier J, Tsimpo C, Gemignani R, et al. Understanding the roles of faith based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet* 2015; published online July 7.

http://dx.doi.org/10.1016/S0140-6736(15)60251-3

Duff JF, Buckingham WW III. Strengthening of partnerships between the public sector and faith-based groups. *Lancet* 2015; published online July 7. http://dx.doi.org/10.1016/S0140-6736(15)60250-1

Tomkins A et al. Controversies in faith and health care. *Lancet* 2015; published online July 7. http://dx.doi.org/10.1016/S0140-6736(15)60252-5

A Universal Truth: No Health without a Workforce, 2014, Global health Workforce Alliance and World Health Organisation

Technology for Global Health, Lancet Commission, *Lancet* 2012; 380: 507–35

Syed S, Dadwal V, Martin G: Reverse innovation in global health systems: towards global innovation flow. Globalisation and Health 2013, 9: 36.

Research for Universal Health Coverage, World Health Report 2013, World Health Organisation

→ **Priority issues**

Jennifer Bryce, Cesar G Victora, Robert E Black The unfinished agenda in child survival *Lancet* 2013; 382: 1049–59

Count Down to 2015 Fulfilling the Health Agenda for Women and Children *The 2014 Report*

Stenberg K, Axelson H, Sheehan P, et al. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *Lancet* 2013; published online Nov 19. DOI:10.1016/S0140-6736(13)62231-X

Maternal and Child Nutrition Series, *Lancet*, June 6, 2013

International Food Policy Research Institute. 2014. Global Nutrition Report 2014: Actions and Accountability to Accelerate the World's Progress on Nutrition. Washington, DC

The Gap Report 2014, UNAIDS, Defeating AIDS-Advancing Global Health, *Lancet*, June 25, 2015

http://dx.doi.org/10.1016/S0140-6736(15)60658-4

Global Tubercolosis Report, WHO, 2014

WHO's new End TB strategy, *Lancet*, 2015; 385: 1799–801

WHO. World malaria report 2013. Geneva: World Health Organization, 2013

Global Technical Strategy for Malaria 2016-2030, WHO, 2015

Non Communicable Diseases Series, *Lancet*, February 12, 2013

Global status report on non communicable diseases 2014. WHO

Global action plan for the prevention and control of non communicable diseases 2013-2020, WHO, 2013

Atun R Transitioning health systems for multimorbidity, *Lancet*, June 8, 2015 http://dx.doi.org/10.1016/ S0140-6736(14)62254-6

Universal Health Coverage series, *Lancet*, 2012

Tracking universal health coverage: first global monitoring report, WHO and WB, 2015

Monitoring Universal Health Coverage, Collection Review, Plos Medicine, September 2014

Medici con l'Africa Cuamm
via San Francesco, 126
35121 Padova
tel. 049 8751279
cuamm@cuamm.org
www.mediciconlafrica.org

Graphic design:
Heads Collective

Layout:
Publistampa Artigrafiche

Finished printing
in July 2016
by Publistampa Arti Grafiche

Supplemento n. 1 a èAfrica 4/2016
Poste Italiane s.p.a.
Spedizione in Abbonamento Postale
D.L. 353/2003 (convertito
in Legge 27/02/2004 n° 46)
art. 1, comma 1, NE/PD