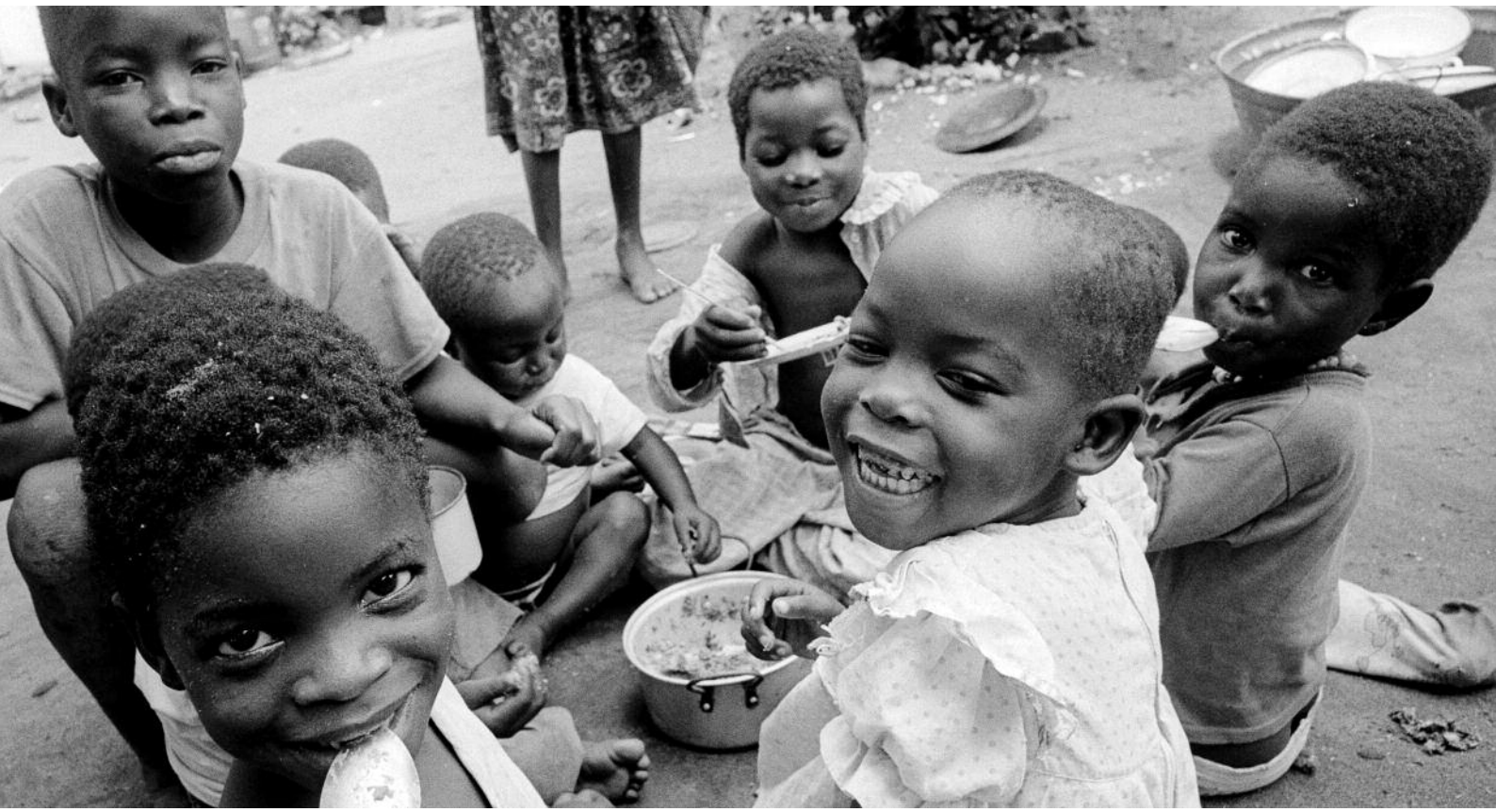
DOCTORS WITH AFRICA CUAMM



STRATEGIC PLAN 2008-2015

STRENGTHENING AFRICAN HEALTH SYSTEMS

THE CONTRIBUTION OF DOCTORS WITH AFRICA CUAMM TO THE REALIZATION OF THE UNIVERSAL RIGHT TO HEALTH WITHIN THE MILLENNIUM AGENDA

DOCTORS WITH AFRICA CUAMM

Summary

Doctors with Africa Cuamm reaffirms its commitment to the mission, principles, and values, that, for more than fifty years, inspired its work, in Italy and in Africa.

To ensure the effectiveness of our work, in 2006 we started a complex process of analysis of the global environment and of our programs, activities, managerial procedures and external relations.

This fascinating but difficult process lasted more than a year.

All our personnel, the organization's members, supporting groups, other individuals sharing our passion for human rights and involved in promoting the universal right to health, participated and contributed.

The Strategic Plan 2008-2015, approved by the Administration Board on October 1st 2007, is the result of this process.

It embraces the spirit and adopts the timeframe of the Millennium Agenda, with its milestones in fighting the most repugnant forms of poverty, such as the preventable deaths, every year, of more than 10,000,000 children and 500,000 pregnant women and the ravages of endemic and epidemic diseases like HIV/AIDS, Malaria and Tuberculosis.

Our mission won't be accomplished by 2015. The Millennium Development Goals (MDGs) represent an important, but still intermediate, goal in the long and difficult path towards a global development based on universal human rights.

Furthermore, the gains in health so far achieved in Africa are still far from the objectives internationally agreed. Without rapid and significant changes in funding levels and modalities, in internal policies and international relations, MDGS will not be achieved in Africa.

This Strategic Plan goes through the fundamental steps of our history and acknowledges the constant struggle to be faithful to our mission and our founders' spirit in a rapidly changing environment.

Our history reveals ability of seeing things in advance and coming up with innovations. This makes us confident in facing today's challenges.

> A first substantial innovation of this Plan is the shift from a project approach (mainly due to financing opportunities) to a country-based strategic planning.

> Other important issues dealt with are the need for a new managerial culture and the search for a greater coherence between planning, advocacy, lobbying and fund raising.

> All our planning, managerial, and communication activities will be based on human rights and scientific evidence and oriented towards the achievement of measurable results.

> Our fundamental strategic objective is the gradual transformation of our organization, through a deep change in our being, doing and knowing, in a center of reference for the strengthening of African health systems.

> Our traditional activities of support to district health systems and training will be strengthened by the territorial concentration of our interventions focused on the four main components of health systems: governance, management, equitable financing, and technical know how.

> Community and family health activities will be an integral part of our programs from the initial phase of data collection throughout the monitoring and evaluation process. They will also be part of our operational research, an important component of all our programs, as already stipulated in our 2005 Guidelines.

> Doctors with Africa Cuamm is committed to support National Health Systems and contribute to their equity, quality, universal accessibility, and sustainability, all needed to ensure the universal right to health.

> Gender equality, economic opportunities, education, food security, environmental hygiene and access to safe water are non-medical factors with a strong impact on the right to health.

> This Plan envisages strategic partnerships with organizations sharing our values and competent in all these health-related fields.

- Strategic partnerships and alliances will not be limited to field activities. They will include lobby, advocacy and management activities requiring economies of scale.
- In line with our choice of "being with Africa" we will expand our presence, from the current seven, to three more countries in West Africa.
- In addition, given the huge challenges posed by rapid urbanization, we will start working with poor communities in urban slums
- The strengthening and expansion of our activities require improved communication and fund raising strategies together with improved management of human resources.
- Three-year operational plans and annual work-plans for headquarters and country offices will be based on this Strategic Plan.

Our objectives are ambitious. But they are consistent with our mission and history and respond to today's opportunities and challenges.

This Plan is a very demanding tool requiring unity of effort and great collaboration.

The worthiness of our cause inspires and encourage us.

We would like to dedicate this plan to all the individuals, women and men, who spent their life faithful to our values and who will continue to inspire the work of Doctors with Africa Cuamm.

Introduction

In September 2000, the Governments and Heads of State of 189 countries committed themselves to achieve, by 2015, an ambitious human development program[1] articulated in eight ambitious objectives (Millennium Development Goals, MDGs)[2].

These objectives are the milestones guiding the collective effort against the extreme manifestations of poverty.

In addition to the financial resources promised by governments, those provided by Foundations and big private donors are more and more consistent.

Many philanthropic Foundations have budgets bigger than those of recipient countries, many United Nations (UN) Agencies and some donor countries.

There is a vast consensus, among international public health experts, on a set of preventive and curative measures that, if universally available, could rapidly reduce maternal and child morbidity and mortality among the poor and stop the epidemics that fester on poverty and lead to it.

In spite of their increase in recent years, the funds for health cooperation, together with those invested in health by recipient countries, are still far below the level considered sufficient to guarantee universal access to essential health services to all.

In addition, most funds coming from institutional donors and big private donors, go to vertical programs, focused on specific diseases.

This further weakens the fragile health systems of poor countries, with negative consequences for the most vulnerable groups of the population.

For these reasons (according to the most authoritative international observers) the health related MDGs will not be achieved, by many Sub-Saharan African countries, at the current levels of investment and with the current policies.

Doctors with Africa Cuamm strongly requests that the investments in health in Sub-Saharan African countries be consistent with the objectives agreed in the Millennium Agenda and that the strategies to achieve them be reviewed and reoriented towards strengthening health systems and investing in human resources.

This has always been the strategy of choice of Doctors with Africa Cuamm: “systemic” interventions on Health Units and their territory with special emphasis on primary care and human resource training.

In this document, we state our vision, values, and strategies, and our contribution to the world movement in support of the Millennium Development Agenda in terms of action and reflection.

To adequately face future challenges and opportunities, Doctors with Africa Cuamm intends to promote and carry out a process of internal and external changes.

This will strengthen our identity and commitment to our values and mission.

To achieve our goals, we are committed to:

1. **better specify the nature of our programs and activities with greater attention to results monitoring and evaluation and to operational research;**
2. **rationalize our organizational structures to increase their efficiency;**
3. **become a *learning organization* able of generating and spreading new knowledge and using the knowledge produced by others;**
4. **adopt an organizational culture oriented towards result-based management;**
5. **build strategic partnerships in the framework of the Millennium Development Goals.**

1 UN Millennium Declaration, September 18th 2000, New York.

2 The Millennium Development Goals are: eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce children mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, develop a global partnership for development.

Values, mission, strategies

1. Context analysis

The political, cultural, social, economic and technological events of the last 20 years deeply changed the international context.

More and more subjects, with different characteristics, objectives, policies, and operation modalities, appear and interact in this rapidly changing and complex scenario.

The world is changing rapidly and so is the so called "aid system".

The new world order, created by the fall of the Berlin wall and the disintegration of the Soviet Union is still dominated by the economic and political power of the United States.

The recent enlargement of the European Union (UE) to 27 countries has increased the international weight of this relatively new actor. New Asian powers, China and India *in primis*, are emerging thanks to an economic growth close to 10% a year. They are extending their spheres of influence in Africa with the aim, among others, of accessing energy sources and raw materials.

In this new international equilibrium, the concept of security has also changed. The attack to the Twin Towers, on September 11th 2001, has exacerbated the difficult cohabitation of different cultures and religions and brought the problems of terrorism and security to the core of international relations.

Globalization, accelerated trade exchanges and the circulation of knowledge, facilitate scientific and technologic progress.

Globalization is still a very asymmetric process.

When it comes to benefits and risks, it works well for some and badly for others.

A clear example comes from pharmaceutical research: of the 1,223 new products developed between 1975 and 1996, only 11 relate to diseases affecting the poor.

International migration is unstoppable. It is not just a matter of brain drain. Huge numbers of people move in search of a better life. About 200 million migrants, half of them moving within poor countries, send home remittances estimated at more than twice the value of the Official Development Aid (ODA).

The speed and depth of change also reached rural areas, even in the poorest countries.

Human development and economic indicators show that changes have not always led to improvements in the quality of life and in the health status of the poor.

The following few data, from the *World Health Report* 2006, published by the World Health Organization (WHO), are significant.

Sub-Saharan Africa has about 10% of the world population and 24% of the global disease burden; it has about 2.8% of the health care manpower and accounts for about 1% of the world health expenditure.

In 1985, 16% of the world's poor lived in Africa, in 1998, 31%.

It is not surprising that the average life expectancy in Africa is 47 years (it was 45 in 1970). Every year 273,000 African women die during pregnancy, delivery or puerperium and 3,500,000 African children die from easily preventable and curable diseases like Tuberculosis, malaria, acute respiratory infections and diarrhea. Sub-Saharan Africa also has the highest number of people infected with HIV and dying from AIDS.

African health systems, weak and ineffective, operate within state structures equally weak and ineffective. In extremely poor countries, highly vulnerable to natural disasters, they lack the resources to ensure universal access to quality services, routinely available in other areas of the world.

Health expenditure in rich countries is about US$ 2,000 per person per year, while in Sub-Saharan countries is about US$ 37 per person per year (but in half of them is less than US$ 15 per person per year).

This is insufficient to provide basic services to the whole population. In addition, it is only partly covered by governments and donors. The rest – in increasing proportions – is directly paid by citizens.

In Burkina Faso, Burundi, Ethiopia, Nigeria, Sudan, and Uganda more than two thirds of health expendi-

ture is paid by users. This is only one of the effects of "structural adjustment" programs imposed by the World Bank and the International Monetary Fund to poor and indebted countries, forcing them to drastically cut public spending, including education and health.

The effects of these policies are clear. Health systems have been turned into an uncontrolled and chaotic market. Drug shops mushroomed in the absence of regulation and controls: inadequate treatments, unwanted side effects and decreasing effectiveness of drugs are unavoidable consequences.

User fees are the most common source of health financing in Africa. They are the most inequitable form of payment for health services, since:

- the poor and the sick, who are in greatest need, are those who pay more, in proportion with their means;
- the poor become poorer, as they are forced, by catastrophic health events, to sell the little they have (like domestic animals and land) or to forego something essential like their children's education.

Equitable financing of health systems and accessibility of services are among the main challenges faced by those involved in public health, development and human rights.

WHO states that the fundamental tasks of health systems are improving population's health status by guaranteeing universal access to services through fair financing. This means that *"the cost to every family of financing a health system must be distributed according to how much it can pay, and not on the basis of risk disease; a fair financial system must protect everybody from a financial point of view"* (*World Health Report 2000*).

To redress the current process of economic globalization, making the rich richer and the poor poorer, a strong and organized response leading to the "globalization of solidarity" is needed.

Health systems of poor countries have serious problems linked to human resources and suffer from an increasing migration of qualified health personnel from rural to urban areas, from the public to the private sector and to foreign countries.

Their Health Management Information Systems (HMIS) supply few data, incomplete, late and often unreliable. The absence of functioning vital statistics registration makes things worse.

Over the years, international aid has given different answers to the needs of African health systems and African countries.

The international aid system engaged in fighting poverty and promoting human development, has become more and more a complex. In the '40s, bilateral donors were less than a dozen. Today they are more than 50. There are more than 15 UN Agencies acting as donors as well as implementers, the financial institutions born from the post-war agreements of Bretton Woods (World Bank, International Monetary Fund), at least 40 bilateral cooperation agencies (many from the 22 DAC[3] countries), the European Union, about 20 Global Health Initiatives (such as the *Global Fund against HIV/AIDS, TB and malaria,* and *PEPFAR – the President's Emergency Plan for AIDS Relief*), regional and national initiatives (such as *NEPAD – New Partnership for Africa's development, UK Commission for Africa, Poverty Reduction Policy*), philanthropic foundations (*Bill and Melinda's Gates*, *Clinton's*, *Rockefeller's*) and a large number of NGOs, big and small, with very different ethics, styles, professionalism, and efficiency.

To increase the complexity of the system, donors choose different approaches, financing specific projects, supporting national budgets or specific sectors (health, education, transport, etc.).

Often, the official acceptance of internationally agreed principles of "*good donorship*" is contradicted by macro-economic policies negatively affecting poor countries.

Inefficiency and mismanagement of aid make things worse.

The European Union (EU) is the most important actor in development because of its contribution to policy formulation and because of the amount of funds it provides.

Beside the European Union's, each member state has its own bilateral development policy.

Italy's cooperation is of marginal importance and instrumental to her foreign policy. In 2006, with 0.20% of GDP allocated to development aid, Italy was at the 19th place out of 22 DAC countries.

The Italian Parliament is currently discussing a bill on a new cooperation policy, including the establishment of a Development Aid Agency.[4]

For the first time in history, the fight against poverty, meaning exclusion and marginalization, not only financial deprivation, is the official common goal of all nations.

Governments promised to invest resources, undertake reforms, and measure progress to achieve the MDGs by 2015.

3 *Development Aid Committee - OECD (Organization for Cooperation and Economic Development).*

4 On April 5, 2007 the Cabinet approved a bill reforming the Law n. 49, 1987, regulating Italian cooperation with developing countries.

2. The history of Doctors with Africa Cuamm

2.1 FROM THE ORIGINS TO THE YEAR 2000

Doctors with Africa Cuamm was born 57 years ago starting its activities in Padova in 1950, 21 years before the first Italian law on development cooperation, approved in 1971. It witnessed all the national and international social, political and religious, events of the second half of the XX Century.

In particular, the decolonization and independence processes of African countries, the Second Vatican Council, the movement that led to the Alma Ata Declaration had a direct impact on the organization's strategies, choices, and style. While remaining faithful to its founding principles, Doctors with Africa Cuamm evolved and changed.

Its long presence in African Countries, sometimes in difficult and critical situations, taught the organization how to adapt to local situations, to understand and interact, credibly, with populations and authorities.

At the same time the organization closely followed and analyzed events and developments in rich countries to understand and interprete them for the benefit of the poor.

Inspired by the Evangelical exhortation *"euntes curate infirmos"*, (*go and cure the ill*) Doctors with Africa Cuamm started its activity as a University College initiated by Professor Francesco Canova, a pioneering missionary doctor and Monsignor Girolamo Bortignon, then Bishop of Padova.

The College was established to host and train medical students, from Italy and from abroad, intending to spend a period of their professional life in missionary hospitals in poor countries.

In the '50s and '60s, Doctors with Africa Cuamm started to recruit and send medical doctors to missionary hospitals in different countries, still under colonial rule, in Africa, Asia, Latin America and the Middle East.

Later on, as cooperation mechanisms became more articulated and complex, the profile of the "*Cuamm doctor*" went through deep changes. From the first charismatic doctors working in mission hospitals, great clinicians and teachers, like Francesco Canova, Anacleto Dal Lago and Giovanni Baruffa, to today's doctors trained in health policy and management.

From the end of the '60s through the '70s, the organization went through a deep, critical analysis of its identity, goals, and activities, and of the role of a "*mission doctor*".

In 1968, at the congress of Nyeri in Kenya, it recognized the need to give mission hospitals a clearer and more integrated role within National Health Systems, an efficient and clear administration. It also saw the opportunity of adding basic care and prevention to the hospital activities.

Activities were no longer left to individual initiatives. They became part of "Projects" formulated and agreed with local communities and authorities to promote the development of the health system and improve the population health status.

This was a fundamental shift from an approach based to mere assistance to one geared towards long term development.

In the following years the organization analyzed the issues linked to closer links with local health systems and to the accessibility of mission hospitals to the poor and disadvantaged, especially women and children.

A more structured discussion developed on cooperation projects, objectives to be achieved, resources needed to achieve them.

On this issue, Prof. Canova had the far sighted idea of creating, within the Italian Church, a "*Foundation for Mission Hospitals*" (Opera Ospedali Missionari), with the aim of financing these institutions. The idea was presented to *Propaganda Fide* in 1958, unfortunately, without success.

In 1972 Doctors with Africa Cuamm was recognized by the Italian Ministry of Foreign Affairs as a qualified organization for cooperation with developing countries.

This recognition allowed access to government funds and implement programs supported by bilateral agreements between the Italian government and countries like Mozambique, Tanzania and Uganda.
Doctors with Africa Cuamm decided to work more closely with the governments of the countries where it was working, on the basis of "*Country Programs*".
This decision did not imply abandoning mission institutions. On the contrary, it contributed to their integration in the National Health Plans, avoiding the risk of their isolation and ensuring wider availability and accessibility of services for the whole of the local populations.
The organization's leading idea was, and still is, "*development*" in its widest meaning and various aspects: overall, equitable development of the country, support to the poorest areas, training of local cadres, promotion of basic and integrated health services.
In 1975, based on the experience gained, Doctors with Africa Cuamm developed a milestone document in its history: "*Intervention Criteria in Health Cooperation*".
This document contains the principles that inspired the Alma Ata Declaration, issued three years later.
The ideas shaped at the end of the '70s are still fundamental for the understanding of health and the formulation of health policies.
After a long period of experiences, analyses and reflections, some basic principles were stated and accepted. They confirmed health as a universal and fundamental human right, indicated as a government responsibility ensuring equitable and accessible health services, underlined the importance of prevention and primary care, and identified poverty as the main cause of morbidity and mortality.
In the following years, the number and size of interventions of Doctors with Africa Cuamm, mainly funded by the Italian Ministry of Foreign Affairs, increased steadily.
Between the second half of the '80s and the beginning of the '90s, the Organization's activities shrank because of the crisis of the Italian Cooperation, with a drastic reduction of public funds for development aid, and increasing problems in developing countries, under the grip of structural adjustment policies that particularly hit the health sector.
It became necessary to review objectives, strategies, and project sustainability. The search for new sources of funds became a crucial issue.
The Organization increased its financing flows from the private sector and from institutions like the European Union and the Italian Episcopal Conference, more and more engaged in the fight against poverty.
In this period of financial hardships, the Board of Governors decided to invest more in the "image" of the Organization and in its external relations.
It was decided to add "*Doctors with Africa*" to the original name Cuamm and to create a new logo. In 2000, the NGO celebrated its Fiftieth anniversary.
It was a symbolic and important chance to reflect and to assess activities, organizational structures and management.
The very low level of the Italian government funding for development aid (it reached its lowest of 0.13% of GDP in 2002), the complexity of international cooperation mechanisms, the need for a rigorous training and selection of personnel, require greater involvement in research, better planning, increased awareness and systematic documentation.

2.2 GUIDELINES. THE PATH FROM 2000 TO THE PRESENT

2.2.1 The 2000 Policy Document

Doctors with Africa Cuamm, over more than 50 years, established a long-term presence and strong links with several countries in Sub-Saharan Africa working in small dispensaries/maternity units, diocesan and government hospitals, at district and regional levels, and in universities.
A *Policy Document* published in 2000, identified the priorities for the organization: health systems accessibility and equitable financing, public-private partnership, training of Human Resources for Health (HRH), fight against major diseases like AIDS, Tuberculosis and Malaria.
To promote greater accessibility and equitable financing of health systems the Organization main actions were twofold:

- to guarantee long-term support to hospitals and public health services by contributing to cover recurrent costs and supporting the development of local human resources.
- To promote equitable financing mechanisms based on solidarity and risk pooling.

In addition, the Document suggested the promotion of *contracting-out* arrangements whereby Private Not For Profit (PNFP) health units receive government funds to carry out public health services and are accountable for activities and results.
This form of collaboration ensures a greater utilization

of PNFP units while maintaining their nature of private services of public interest by keeping user fees low.
Another important point is the development of local human resources with high levels of technical and managerial competencies needed to strengthen health systems and increase their sustainability.
The following operational guidelines stem from these ideas.

2.2.2 The 2005 Planning guidelines

The *2005 "Planning Guidelines"* were meant to help the transformation into activities of the priorities indicated in the Policy Document. The first priority was to establish, in each country, a strong and lasting "*conceptual framework*" for our interventions. This allowed and will allow the structured introduction and implementation of integrated projects (training, Mother and Child Health -MCH-, disability, etc.) or vertical interventions (HIV/AIDS, Tuberculosis, Malaria, etc.).
Doctors with Africa Cuamm is not an emergency organization. Along the years, however, many of the areas where it worked were ravaged by war or other humanitarian crises. In these situations the organization maintained its presence, relieved the suffering of people in the acute phase and started reconstruction and development programs as soon as the situation allowed it.
Special emphasis is placed on monitoring and evaluation criteria for measuring equity, accessibility, effectiveness, efficiency and quality.
This sort of documentation is essential not only for planning and control but, also, for communication and relations with donors.

2.2.3 A few data

So far, Doctors with Africa Cuamm:
> hosted and trained 270 students from 35 countries of the southern hemisphere;
> sent to developing countries 1,250 doctors and 300 nurses and health technicians;
> implemented 150 programs with the support of Italian Ministry of Foreign Affairs, the European Union, and other International Agencies;
> worked in 34 countries in Asia, Latin America, the Middle East and, especially, Africa

Currently, Doctors with Africa Cuamm:
> is present in Angola, Ethiopia, Kenya, Mozambique, Tanzania, Sudan and Uganda;
> employs 92 professionals of which: 61 doctors, 15 paramedics, 16 technicians and administrators;
> implements 56 health cooperation projects and about 100 micro-realizations supporting:
  - 17 hospitals;
  - 25 districts (with activities ranging from training to general public health, mother and child heath, control HIV/AIDS, TB, and Malaria);
  - 3 physiotherapy centers;
  - 4 nursing schools;
  - 3 Universities (in Ethiopia, Mozambique and Uganda).

3. Mission and values

3.1 THE MISSION

The mission of Doctors with Africa Cuamm's stems from the evangelical exhortation *"euntes curate infirmos"* adopted by the founder Francesco Canova in 1950. With time, it was articulated in different ways in successive editions of the Organization's Statute, in 1971, 1984 and 2003.

In 2006, the mission has been phrased as follows:
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. It works with a long-term developmental perspective.
To this end, in Italy and in Africa, it is engaged in training, research, dissemination of scientific knowledge, and ensuring the universal fulfillment of the fundamental human right to health.

This mission is translated in two fundamental objectives:

1. **to improve the health status of African people.**
2. **To promote a positive attitude and solidarity towards Africa.**

The principle inspiring our action is that health is not a consumer good but a universal human right, hence, the access to health services cannot be a privilege.
Equally important is the second objective: the duty of promoting, in western institutions and public opinion, interest and commitment to a better future for Africa.

3.2 VALUES

The reference values of the organization's mission, its activities are:

- **christian inspiration and link to the Church**: the reference to Christian values and to the Gospel is explicit.
- **Commitment to Africa**: the organization works exclusively in Africa, with African people and maximizes the value of local resources. The expression "*with Africa*" underlines the ideas of sharing, participation, exchange, and common effort. We work in a limited number of countries where we emphasize not only the needs and the problems but, also, local values and potentials, with a long-term developmental perspective.
- **Experience**: Doctors with Africa Cuamm is proud of more than 50 years of uninterrupted work with developing countries.
- **Specific and exclusive competence** in the health field.
- **Discretion**: we think that those in need and not those who help deserve visibility and public attention.

Our guiding principles engage us, in the spirit of the Gospel, to work for international solidarity, justice and peace, with a style characterized by sharing and based on respect and dialogue.
In line with our principles, we employ qualified and strongly motivated people, able of establishing a true relationship of collaboration and dialogue.
The spirit of the Gospel expresses the core of our mission: to help the poorest by providing quality services accessible to everybody, with discretion and humility.
Doctors with Africa Cuamm also employs non-Christians as long as they agree on its intervention criteria and share values like dialogue, cooperation, voluntary service, friendship among peoples, defense of human rights, respect for life, personal sacrifice, commitment for the poor, and spirit of service.

4. Vision for the future: Doctors with Africa Cuamm and the Millennium Development Goals

Our commitment to health, based on the evangelical exhortation to cure the ill, was strengthened, during the last decades, by the growing awareness about human rights.

This commitment is also engaged by the challenge of the Millennium Agenda that makes health one of the pillars in the fight against poverty.

A society based on individual freedom and collective responsibility, a model of economic development providing for the protection of the weak and of the environment are part of a virtuous circle where education and health are essential elements for individual and global development.

In today's globalized world inequalities in health, measured by life expectancy, maternal and child mortality, are morally, economically, and politically unacceptable.

The debate on the feasibility of improving the health status in poor countries, before they achieved higher economic levels, takes away momentum from going to scale with a mix of medical technologies, relatively simple and able of saving millions of people if delivered not to single individuals but to entire populations.

The majority of the 500,000 mothers dying every year would survive if correctly assisted by a trained midwife during pregnancy and delivery and if, in case of complications, essential obstetric care were available.

More than 10 million children die every year mostly of preventable and curable diseases such as diarrhea, respiratory infections, and malaria. HIV/AIDS is responsible for less than 5% of children's deaths. Most of the times, malnutrition, a contributing factor in half of children's deaths, is not due to lack of food but to repeated infections and inadequate nutritional practices.

Doctors with Africa Cuamm is not interested in a sterile debate on the primacy of economy versus the need to invest in health and education.

We prefer acting at two levels:

- in Africa, we are determined to prove that experience, knowledge, and the tools to improve the health of the poor in a rapid, sustainable and measurable way, are available.
- At the international level, we want to promote the idea that security for the rich will be possible only if there is development for the poor. Peace and justice are inseparable, universal, and achievable.

For the first time in history, the fight against poverty has officially become the common goal of all nations that promised to invest resources, introduce reforms, measure and report progress and achieve the eight MDGs by 2015.

Particularly relevant to Doctors with Africa Cuamm are the MDGs related to malnutrition, maternal and child mortality, and disease control.

Our focus on public health goals doesn't mean that we neglect the other ones. Fighting poverty and discrimination against women, promoting a more efficient and effective use of financial resources for development, pursuing universal education, are all essential elements for the achievement of better health.

Most public health experts agree on the effective preventive and curative technologies that, if universally available and correctly utilized, will improve the epidemiological profile and the life expectancy of the poorest populations.

Furthermore, we know that the cost of a lifesaving health services package is around US$ 38 per person per year. This means that rich countries should invest around US$ 20 per person per year for poor countries until their national resources will enable them to cover these costs.

Although not a negligible amount of money, this is certainly sustainable considering that the world economy continues to generate wealth at rates and levels never seen before. In addition, improvements in health are, probably, the quickest and most con-

venient way out of the poverty trap in which billions of people are caught.

4.1. THE ROLE OF DOCTORS WITH AFRICA CUAMM IN AFRICA

For more than fifty years Doctors with Africa Cuamm worked with hospitals. It rehabilitated, equipped, and managed them to improve quality, efficiency, and accessibility of their services. It supported curative, preventive, and rehabilitative services and trained health professionals in Italy and in Africa. Recently, it engaged in activities financed by the Global Fund against Tuberculosis, AIDS and Malaria.

In the coming years, we intend to use our experience to prove that, by delivering an adequate mix of effective services at hospital, peripheral unit, and community/family levels, it is possible to achieve and measure a positive impact on people's health.

4.2. HOSPITALS

4.2.1. Technical component

Efficient, equitable and accessible hospitals are an essential element of any health system. We are committed to strengthen the hospital technical components, particularly those services that cannot be delivered at lower levels and have a direct impact on public health. The focus will be on maternal and child health, disability treatment, promotive and preventive activities.

The correct and timely execution of caesarean sections and the adequate treatment of HIV/AIDS are important indicators of a hospital technical ability to carry out its institutional functions.

Many efforts to reduce maternal mortality failed because of inadequate investments in hospitals. Hospitals must, also, be able of preventing and correcting vescico-vaginal fistulae, tragic consequences of lack of assistance during delivery and condemning thousands of women to total marginalization. These pathologies, together with female genital mutilations, are dramatic examples of the unacceptable discrimination against women and young girls.

4.2.2. Hospital management

Efficient and effective hospital management is one of our main objectives, since managerial incompetence compromises service quality and accessibility.

Human and financial resources, equipment, buildings, drugs, and any other input in health service production must be used efficiently and effectively to maximize results and contain costs.

The hospital, district or regional, is comparable to a small to medium size business enterprise and should be managed by a professional manager. This professional profile still very rare in the countries where we work.

Support, development, and training of hospital managers will be one of our priorities in the forthcoming years.

4.2.3. Hospital financing

Hospital services are more expensive than those produced at lower level health units. They should be limited to those that cannot be provided more cheaply, at lower levels. The majority of African hospitals is underfunded, unable to deliver quality services and underutilized.

This vicious circle is made worse by the introduction of user fees that make the hospital even less accessible and inequitable, as they affect the poor when they are more in need.

The Global Health Initiatives (GHI) often exacerbate inequities introducing perverse incentives and distortions. Drugs for specific pathologies, provided by global initiatives, are often free while other equally or more important therapies are available only in private drugstores at high prices.

It is important to document these distortions and propose corrective actions.

It is necessary to promote and support new and equitable health financing mechanisms, based on solidarity and risk pooling, like health insurance plans, community financing schemes, etc.

The institution of a global fund or a global insurance to finance public and PNFP health units are important initiatives deserving to be developed and realized.

In the short term, Doctors with Africa Cuamm will cooperate with existing insurance schemes covering the costs of catastrophic health events.

4.2.4. The Hospital Executive Board

Like any enterprise, the hospital needs a competent and well functioning governing body. This must ensure that the owner, staff, and patients' interests are kept in the right balance and harmoniously respected.

Hospital good governance is often overlooked. Consequently, serious distortions occur, especially in the respect of patient's rights. Patients are denied the possibility to influence strategic choices relevant to their life.

Doctors with Africa Cuamm believes that good governance requires the active participation of people's representatives in supervising institutions of public interest and wants to invest in building the capacity of hospital governing boards.
The above elements are essential for hospitals to fulfill their role. They require, financial investments and human resources, effort in, monitoring, evaluation, analysis and research.
Maternal mortality ratio is, arguably, the most powerful indicator of the effectiveness of a health system and, in particular, of the ability of hospitals to play their public health role.

4.3. PERIPHERAL HEALTH UNITS

Peripheral units, supplying a mix of quality services within a well identified geographical area, with precise responsibilities and measurable objectives, are the second important element of health systems.
In many peripheral units services are poor for several reasons: insufficient qualified staff, lack of drugs, little supervision.
The four basic elements of good performance (governance, management, financing, and technical skills) need the support of a district referral institution.
The majority of interventions to prevent or treat the most common causes of morbidity and mortality can be performed, at low cost, by peripheral health units close to the population.
For this reason Doctors with Africa Cuamm considers a priority to support district networks of peripheral health units.
Vaccination coverage and the number of outpatients visits per person per year are good indicators of the functioning of peripheral units.
In the forthcoming years we want to measure the trend in infant and child mortality. This should provide strong motivation for a renewed effort to revitalize peripheral health networks and constitute an indicator of the degree of success of our interventions.

4.4 FAMILIES

Families, within their communities and with their culture, are the main actors and the best allies in the struggle for better health.
Poverty is heavily influences lifestyles and health status of individuals and families.
It is essential to provide families with the resources needed to adopt lifestyles conducive for better health, like hands washing, drinking safe water, using clean toilets, breastfeeding, not smoking, drinking alcohol with moderation, avoiding risky sexual behavior, sleeping under a treated mosquito net. All this affects individual and public health.
Health systems alone won't be able to achieve the MDGs. What is also needed is a significant investments at family and community levels to promote healthy lifestyles and to provide safe water, soap, treated mosquito nets, DDT for internal residual spraying, and other goods needed for a healthy life.
Efficient and reliable births and deaths registration is another important public good. In many poor countries this does not exist or is unreliable. It should be quickly introduced so that everybody, authorities and citizens, can have a picture of the current situation, assess the success of health initiatives and act consequently.
One of the main obstacles to develop a strong initiative supporting families is the lack of relevant experiences on a large scale and the lack of personnel trained for such a task.
This challenge requires a new way of approaching local communities: a "*rights based approach*" with innovative measures aimed at enabling and empowering families to fully develop their potentialities.
In particular, we must train and recruit semi-professional operators not to take away workers from hospitals.
The poor and disadvantaged, particularly women, children, and people with disabilities are our priority groups. This choice, at the foundations of the organization, is fully in line the objectives of the Millennium Agenda.

4.5 DOCTORS WITH AFRICA CUAMM AND HEALTH POLICIES

Health policies are often influenced by factors not related to the needs and rights of women, children, and people with disabilities.
With the advent of rich foundations and global funds, policy making became even more complex because of the fear of losing financial support, even when funding conditions or country's absorption capacities are not ideal.
There is often contradiction between the official commitment to achieve the MDGs and the adoption of macro-economic policies enforcing budget ceilings for social sectors. These ceilings are always lower than those needed to supply the health services required to improve the health status of the poor. Doctors with Africa Cuamm wants to participate in this important debate involving donors, international agencies and African governments.

Our experience and knowledge, our values, and our commitment require that we participate in the policy making process at all levels.
Our fieldwork provides valuable insights on successes and failures.
To make the best use of our experiences, we must analyze them and share our knowledge with policy makers, nationally and internationally, through wide-ranging lobby and advocacy.
Our participation in alliances and partnerships at national, European, and global levels is of the utmost importance.

4.6 THE CHALLENGE OF HUMAN RESOURCES FOR HEALTH (HRH)

We are fully aware of the complexities and obstacles between our vision and its realization. The scarcity of well trained HRH, their maldistribution and misuse, are an extremely serious problem requiring urgent attention.
Maldistribution of HRH, concentrated in urban areas and in hospitals is well known and documented.
In recent years this problem has been made worse by the migration of trained health professionals from poor countries to less poor countries, and then to Europe and North America.
Among those who remain, many combine an often symbolic presence in the public sector with a full-time and lucrative job in the private one.
Many of the best professionals are employed by international cooperation agencies and NGOs. Today everybody expects allowances to carry out duties that, even if part of their job, are performed within specific projects.
Only meetings where sitting allowances are paid are attended.
Many health workers spend a good part of their working time in training courses, not always relevant or effective, but financially attractive.
All this negatively affects people needing health services and discredits health professionals.
Doctors with Africa Cuamm has always been committed to human resource development and intends to work towards new and better human resources management policies and programs.

4.7 NON-MEDICAL DETERMINANTS OF HEALTH

Doctors with Africa Cuamm only works within the health sector.
When looking for a measurable impact of our activities, we cannot ignore the fundamental importance of other determinants of health that are outside the health sector.
Therefore, we plan to establish programmatic alliances with partners competent and experienced in other sectors, like:

- water and sanitation;
- agriculture, food security and nutrition;
- micro-financing, income generating activities, and social security schemes;
- information, Education and Communication.

The integration and synergy of activities in all these sectors will allow the improvement of health indicators in the intervention areas.

4.8 THE APPROACH OF DOCTORS WITH AFRICA CUAMM

The primary responsibility to guarantee the right to health to their citizens rests with the African Governments and Civil Society, although supported by international solidarity.
The proliferation of actors and the fragmentation of activities in the cooperation field (and especially in the health sector) often overwhelm the fragile administrative structures of recipient countries.
In this complex scenario, Doctors with Africa Cuamm supports African National Health Systems as a facilitator and, when needed, as a temporary substitute.
We look at the sustainability of the interventions needed to achieve the MDGs at national, local and international level.
It will be possible to scale down the donors' contribution only when the economy of African countries will be able to meet the costs to provide universal quality health services.
Doctors with Africa Cuamm, convinced that health is a fundamental human right, is committed to the universal delivery of the package of interventions known to be effective for the achievement of the health related MDGs.
Therefore, we will continue, with great flexibility, to rehabilitate health units, supply equipment and drugs, provide funds, train and provide human resources.
All this, not as a series of stand alone projects, but within a clear frame to help African governments and communities to reach the health related MDGs.

5. 2008-2015 Objectives and strategic projects

5.1 MAIN OBJECTIVE

Doctors with Africa Cuamm intends to become a reference center for the strengthening of African health systems.

Today the main challenge is to provide evidence to the international community that effective, efficient and accessible health systems are necessary to achieve significant health improvements in Africa and that it is right, urgent and strategically important to work in this direction.

5.2 STRATEGIC OBJECTIVES IN ITALY AND AFRICA

To achieve its main objective, Doctors with Africa Cuamm has to work in several interrelated directions. Therefore it intends:

> **to strengthen its identity inside and outside the organization.**

We want to serve African people and our civil society with our approach based on the protection of the right to health as a fundamental pillar of development.

In rich countries, we must stress that the experience, the knowledge and the means to improve, rapidly and sustainably, the health status of the poor are available and must be put to use.

In this perspective, it is important to promote awareness and understanding of development and health issues, inside and outside the organization.

This requires knowledge, financial and human resources.

> **To shape our program activities along the lines of the MDGs, especially those related to health, testing new approaches to improve the health status of African people.**

In September 2000, 189 countries, rich and poor, industrialized and not, committed themselves to increase resources, review policies and join in a partnership to keep the promises of the Millennium Agenda, by 2015.

Doctors with Africa Cuamm wants to take up this challenge with its own approach to African health problems, characterized by long term commitment in collaboration and coordination with government and non government actors.

The organization also wants to build partnerships nationally and internationally, to create synergies and expand the scope of its interventions.

> **To become an internationally respected center of knowledge, research, documentation and scientific dissemination on African health.**

We will increase our investment in monitoring, evaluation, operational research, documentation and dissemination of knowledge and understanding.

5.3 OPERATIONAL OBJECTIVES

We want to build on our experience to improve African health systems in terms of, effectiveness, efficiency and accessibility, and to provide high quality training in Italy and Africa.

This will prove that, with a comprehensive approach, providing a combination of services at hospital, peripheral health units, community and family levels, African health systems can significantly contribute to improve the population health status.

To obtain measurable results, Doctors with Africa Cuamm wants to achieve the following operational objectives:

> **to establish a long term presence with relevant programs, in rural and urban areas, in at least ten African countries, by expanding its action to at least three West African countries.**

> **To build programmatic partnerships with other NGOs and International Organizations for inte-**

grated programs in the fields of health care, education, water and sanitation, food security, agriculture, and micro-credit, in at least three African countries, achieving a measurable health impact.

> To participate in building a national and international consensus, on the urgent need of strengthening African health systems in terms of effectiveness, efficiency, equity, and accessibility.

> To influence, through lobbying and strategic alliances, policy decisions on international cooperation, at the level of the European Union, the African Union and the Italian government.[5]

> To strengthen our training activities by instituting a Master Course on African Health Systems in collaboration with leading academic institutions.

> To improve our organizational management through modern, transparent, collaborative, and efficient procedures, to increase accountability at all levels to be awarded international quality certification.

> To make the transparent and professional management of human resources the cornerstone of our organization.

> To increase financial resources by at least 15% per year.

5 Focusing on the creation modalities of a Cooperation Agency.

6. Crosscutting strategies

Our objectives are analyzed considering the crosscutting strategies needed for their achievement. Some of the concepts below will be further discussed in the Section on "Sector Strategies".

6.1 STRATEGIES TO STRENGTHEN OUR IDENTITY

To strengthen the organization's identity, internally and externally, for a deeper awareness of its inspiring values, we intend:

- to enhance unity and coherence among the various headquarters sections, with clear and shared procedures and a better and transparent circulation of information.
- To enhance unity and coherence of thought and action between headquarters and country offices.
- To increase and improve our investments in human resources at headquarters and in country offices.
- To enhance the involvement of volunteers, associate members, supporting groups and all those who participate in the life of the organization.
- To enhance our activities of public education information and communication on important African issues.

6.2 STRATEGIES TO ADVANCE OUR KNOWLEDGE

To be a reference center of knowledge on development and health in Africa we want:

- to adopt a knowledge management system ensuring the continuous production, flow and fruition of critical analysis and understanding within the organization at all levels, at headquarters and in country offices.
- To adopt a result oriented culture based on continuous monitoring of our activities, critical analysis of their effectiveness and wide circulation and discussion of the findings.
- To expand and improve our activities of operational research ensuring wide circulation of findings through publications on health issues in Africa.
- To work with universities, research centers, national and international organizations, to produce and circulate new knowledge.
- To become a reference center for scientific documentation and dissemination.
- To promote greater attention on important African development and health issues.
- To contribute to the awareness that improving health in Africa means not only fulfilling a fundamental human right of African people but, also, giving an important contribution to global security.

6.3 STRATEGIES TO ENHANCE OUR ACTION

Doctors with Africa Cuamm, to face today's challenges and contribute to the fulfillment of the Millennium Agenda, intends:

internally:

- to match our spirit of service, solidarity and dedication with high professionalism and competence.
- To employ professionals able of responding to the new needs and challenges.
- To establish a permanent pool of professionals giving to the organization continuity and spirit of innovation.
- To enhance our talent management with a careful mix of young and experienced professionals.
- To introduce and systematically use sound systems of performance management and career development for all cadres of our personnel, African and Italian, at headquarters and in country offices.
- To increase the number of our supporting members and groups at all levels of civil society.

externally:

- to explore and test new initiatives to help families and communities to promote and maintain good health.

- To focus our attention on the most vulnerable and disadvantaged groups: women, children and people with disabilities.
- To strengthen our integrated approach (hospitals, peripheral units, communities and families) demonstrating that effectiveness, quality and equity are mandatory and achievable.
- To strengthen hospitals and peripheral units' management, governance, and financing.
- To enhance integration and coordination between government and Private Not For Profit institutions.
- To become an active part of the health systems in the countries where we work.
- To expand our presence to francophone African countries.
- To be an advocate, nationally and internationally, of Africa's health interest and influence political decisions on development cooperation.
- To build partnerships with NGOs and international organizations to implement integrated activities in the fields of health, education, water and sanitation, agriculture, food security and nutrition, micro-credit, economic opportunities, social security schemes.

7. Sector strategies: the countries

Currently, Doctors with Africa Cuamm works in seven countries: Angola, Ethiopia, Kenya, Mozambique, Sudan, Tanzania, and Uganda.

In some of these countries, the first projects started at the end of the '50s, often responding to requests from local churches. Activities continued over the years in the same countries, in the initial and in different areas.

The changes of the aid system and policies, coupled with the rapid transformations of African countries, require clear entry as well as exit strategies when starting new activities or entering a new country.

Being "*with Africa*" suggests the opportunity to expand our attention to countries where we are not yet present.

This may or may not lead to our presence in a "new" country. It may also be limited to studying and understanding issues and situations in countries where we don't work.

This will give us a better overall understanding of Africa and will be a cultural enrichment.

Furthermore, this knowledge will be useful if and when we decide to start working in new countries.

7.1 ENTRY CRITERIA

Our overall goal, stemming from the evangelical exhortation "*go and cure the ill*" is the satisfaction of the universal right to health.

Our main strategy is geared at the development of effective, equitable and efficient health systems.

We will engage in acute emergencies, should they occur in countries where we work, applying the following entry criteria for countries in transition.

We will set up a database with continuously updated economic, social and health data of different African countries. To do this, we will use the most reliable and internationally trusted sources.

From this database, we will get the information needed when pondering the decision intervene in a country.

Entry criteria will be verified when preparing to intervene in new countries to define the objectives of the intervention, its possible duration, the needed human, technical, and financial resources, organizational and logistic support.

On the basis of our mission and values, the decision to intervene in a given area will be guided by the following criteria:

- the needs of each priority group: women, children, and people with disabilities.
- The contexts in which these needs occur, in rural, underserved areas as well as in urban, degraded and overcrowded ones.
- The risk and vulnerability to epidemics and natural disasters.
- The potential for mobilizing financial resources.
- The opportunities for partnerships.
- The potential positive effects on population's health of our intervention.
- The presence of minimum security conditions for our personnel.

7.2 DISENGAGEMENT CRITERIA

Disengagement criteria are as necessary as entry ones.

Clear disengagement criteria, shared with our partners, contribute to the sustainability of results.

Reasons to review a strategy and consider the opportunity to leave a country may be represented by:

- the achievement of the planned objectives.
- The coming to an end of the conditions specified in the entry criteria.
- Significant changes in government priorities and policies.

7.3 STRATEGIC AND OPERATIONAL CONSIDERATIONS

Given the enormity of health needs in Africa, we intend to find the resources to work in at least ten countries, including the seven where we are already present, to reach at least 5 million people by 2015.

In light of the general principles outlined above and with special attention to women, children, and people with disabilities, the following strategic considerations are important:

- we must strengthen our presence in the seven countries where we currently work. We will extend our presence to new geographical areas through partnerships and in synergy with other organizations. We will implement innovative strategies, always considering the essential and complementary levels: hospitals, lower level health units, families and communities.
- Given the degrading conditions of life in many overcrowded urban slums, we will study the possibility to intervene in slums of Nairobi, Luanda and/or other towns.
- We will improve our preparedness to epidemics or natural disasters in the areas where we already work.
- In line with our will of being *"with Africa"* we will expand our presence to at least three west African countries.
- For a greater impact on health and in line with the MDGs, we will operate in partnership with other organizations to improve: safe water supply, nutritional status, education, gender equity, and economic conditions in the areas where we work.
- In line with our strategic objectives, three-year and one-year operational country-plans, will describe objectives, activities, needed and available resources, implementation methodology and timeframe, and context evaluation of the intervention areas.

ANNEX I

The internal organization sector strategies

8. Management

The continuous and rapid transformations of international cooperation require a deep, all embracing change of our organizational culture, structure and management.

8.1. STRATEGIC OBJECTIVE

To turn Doctors with Africa Cuamm into an organization based on result oriented management.

The first step is a deep cultural change turning the organization from one functioning on specific projects accountability to one functioning on whole embracing, cross cutting, result oriented accountability, at headquarters and country levels.

8.2. STRATEGIES

To guarantee the success of this change, all those who work with the organization must understand and share the principles of result oriented management.

All our working procedures, at headquarters and in country offices, must be shared, harmonious, and transparent to optimize time and resources.

8.3. PRESENT SITUATION

The Administration Office is currently running many managerial tasks not related to the organization activities. It carries out administrative work for the *Saint Francis Foundation* (an Institution of the Dioceses of Padova of which Doctors with Africa Cuamm is part). In addition, it takes care of the management of the College, a commercial activity of the Foundation.

Several of the tasks mentioned above are cross cutting and it is difficult to disentangle them.

Up to not long ago, although with some difficulties, this complex managerial set up, evolved over time, has satisfied the organizational and administrative needs.

The increased number of partners and the diversification of donors of Doctors with Africa Cuamm, call for an urgent reorganization and strengthening in terms of managerial setup, logistics, computer networking and staff.

The external audits required by institutional donors, with their tough requirements, provided useful, opportunities to test the organization's managerial capacity and identify the areas requiring improvement and change.

The current organizational and managerial setup guarantees the correct use of the resources received but must be significantly improved as for standardization of procedures, control mechanisms and transparency.

Significant changes and improvements are needed, at all levels, to transform Doctors with Africa Cuamm into a modern and efficient organization.

8.4. THE OVERALL RE-ORGANIZATION

To achieve our strategic objective we have to invest heavily in building our capacity. The cost of this must be identified and the needed resources found. Therefore we need to:

- substantially improve the management of space at our headquarters to allow wide and comfortable office space for everybody.
- Adequately equip all of sections (especially when it comes to electronic tools and information technology).
- Improve and update knowledge, skills and competencies of all our personnel through a two-year training program based on assessed training needs followed by thoroughly planned, regular and frequent updates.
- Make sure that all the Heads of Section are proficient in spoken and written English by providing adequate training to those who need it.

8.5. PLANNED INTERVENTIONS AT OUR HEADQUARTERS

The Administration Section has crosscutting functions and is in charge of the overall management.

The Head of the Administration Section delegates operational tasks to the heads of the other sections (Human Resource Management, Projects and Accounting).
Each head of section must receive a clear mandate indicating responsibilities, scope of action and levels of answerability.
This will make the overall management more transparent and functional.
The organizational setup will emerge from the procedures of each Section.
These will be regularly monitored and updated when needed.
General financial control and accountability functions will be separated from those related to contractual commitments with specific donors.
The financial accountability of all the projects and the general one will be integrated using reliable software compatible with the current needs.
For several years the financial report of the Organization has been annually certified by one of the most reputed auditing firms.
We want it to be more thorough and give more meaningful information on our financial situation.
Working with international donors requires that we improve our procurement procedures.
We adopted the European Union procurement guidelines and already acquired some experience with them.

8.6. PLANNED INTERVENTIONS IN OUR COUNTRY OFFICES

An overall managerial improvement is necessary in all our country offices.
In the countries where the Organization owns buildings and equipment, we will ensure regular monitoring and maintenance to preserve and, if possible, increase the value of our investments.
In the countries where we want to strengthen our presence we will assess the opportunity to buy our office premises.
In particular, we will hire professional accountants and administrators to relieve the workload of the Country Representatives and to achieve the reporting standards currently required.
We have already started a thorough assessment of the financial reporting systems and the procurement procedures of our Country Offices with the aim of obtaining positive external financial audits.
Headquarters will carry out thorough financial and procurement audits in all our Country Offices once a year.

8.7 AUDITING

The strengthening and modernization of Doctors with Africa Cuamm will be ensured by a regular and thorough auditing of financial, procurement and other managerial procedures with reporting made directly to the Director.

8.8 RISK ASSESSMENT

Assessing the risks associated with our interventions requires specific know-how and expertise.
Up until now, the size and nature of our operations allowed Management to asses the financial and operational risks on the basis of previous experiences.
In this respect, we will acquire the solid expertise needed to protect the organization at all levels and ensure responsible and transparent choices.

8.9. QUALITY

Adequate and transparent working procedures regularly and frequently monitored and evaluated, will allow us to achieve the international quality standards currently required.

8.10. EMPLOYEES AND COLLABORATORS

For several years, since the organization is a branch of the Foundation "*Opera di San Francesco Saverio*" of the Padova Diocese, Doctors with Africa Cuamm adopted, for its Headquarters personnel, the standard contractual rules of the AGIDAE[6] National Contract.
For those employed in our projects and for other contracted personnel, in Africa, we adhere to the Frame Agreement signed in 2004 between the Association of Italian NGOs and the Labor Unions.
We have internal regulations and related forms integrated in the national contracts that we adopted.
We will continue to adhere to national agreements on contractual relations with employees and collaborators.
We must identify clear indicators of professionalism, skills and competence of our personnel and set up clear procedures to monitor and assess them.
This will allow adequate recognition of merit in terms of professional advancement and pay raises.
In the previous paragraphs, capacity building, education and training needs have been emphasized.
As part of our organizational re-engineering and in line with recommendations of international auditors', we will provide each employee with an articulated job description defining duties, autonomy and hierarchical relations.

6 Associazione Gestori Istituti Dipendenti dell'Autorità Ecclesiastica: an organization supporting the management of Church owned or related institutions.

9. Human resources

Human resources are our most precious asset.
We will continue to request, from those with us, the most important commitment: to match the basic values of Doctors with Africa Cuamm, such as the spirit of service, solidarity, and gratuity, with the highest professional standards.
The professional profile of our collaborators is linked to our overall strategy and to the strategic objectives set in each country.
We must work out a new recruitment strategy expanded to professional fields outside our traditional one, like management, governance and financing.
Considering the increasing complexity of international health cooperation and the global lack of health professionals, we must count on a limited, but significant, number of experts who will spend their entire working career within the organization.
For short term assignments and consultancies, we have to maximize the expertise of our former collaborators, now back to their permanent job in Italy. To this aim, we will set up a detailed and updated database.
We will keep to employ, for mid or long term tasks, experts and volunteers who, at the end of their work in Africa, will go back to their former occupations in Italy.
Through a series of collaboration agreements with universities and other relevant institutions, we intend to identify a pool of experts for highly specialized but short-term tasks.
Given the global scarcity of qualified and competent professionals, we intend to improve our ability to promote the professional development of all those who worked, work and will work with us.
We will pay particular attention to harmonize their family needs with their human and professional aspirations.
Not to loose their contribution, we will strengthen our relationship with those who worked with us in the past.
So far, the great majority of our collaborators were Italian. This will change and we will have to turn more and more often to international recruitment, including African professionals.
Doing this, we will carefully consider the consequences of our choices for the countries where we work and will endeavor not to worsen their already critical situation when it comes to human resources for health.
This decision has important operational implications, like the communication language used within the organization.
Even more important are the cultural changes needed by the shift to international recruitment.

9.1. PROFESSIONAL ROLES IDENTIFICATION CRITERIA

Aiming at priorities:

Hospital:

> technical component (specialists, midwives, nurses, technicians) to ensure primary care, mainly in the maternal and child sectors and in HIV/AIDS treatment.
> Hospital management and administration (health managers, administrators, logisticians for procurement and maintenance, human resources experts, health economists).

Territory:

> peripheral network management (public health specialists, health technicians);

Community/family:

> promotion of healthy lifestyles and improvement of family environment (community and public health experts, experts in social sciences, anthropologists);

Capacity building:

> professionals in various fields with education expertise at all levels;

Support to health policies:

> technical assistance (experts in health policy making and analysis).

9.2. RECRUITMENT AND SELECTION STRATEGIES

9.2.1. Recruitment of young professionals

Young professionals are a vital resource for the future of our organization.
We intend to invest heavily on them.
We will create a pool of competent professionals able to act as "agents of change" to promote the right to health.

Objectives:

> to create a group of young professionals committed to the Organization's values, with different technical profiles and adequately plan their continuous professional development and career path.

Actions:

> to improve the selection process and invest in people with the needed professional requirements and committed to the organization principles and values;
> to update continuously our training course for professionals at their first cooperation experience;
> to re-introduce on-the-job field training facilitated by a senior professional cadre with subsequent employment into a project and, when relevant, enrolment into further training, for professional growth;
> to earmark adequate funds to these activities.

9.2.2. Recruiting personnel with previous cooperation experience

Experienced professionals are the majority of our staff. Investing in their continuous professional development and retention is vital for the organization.

Objective:

> to create a permanent pool of experts for top managerial and strategic functions at headquarters and in country offices.

These cadres will be recruited inside and outside the current human resource pool of the organization.

Inside, the recruitment will take place among those who already worked with us, the trainers in our various courses, active members of the organization and members of our supporting groups.

Actions:

> to verify availability for field work among those who worked with us in the last ten years, our active members and our trainers;
> to select, among the immediately available, those with the characteristics needed for our forthcoming interventions;
> to identify specific training paths for those available but without the required competences. Adequate financial resources must be earmarked to this end;
> to enhance our motivation strategies;
> to calculate the financial needs for these actions on a three-year basis.

Outside the organization, recruitment and selection will concern professionals with relevant experience, in Italy or abroad, with NGOs, and international agencies.

Actions:

> to employ, in collaboration with our Country Offices, professionals already working in the field;
> to advertise vacant positions in international and national web-sites, magazines, etc.;
> to create a network of Universities and other relevant institutions where we will regularly advertise our activities;
> to translate all our important documents in English, French and Portuguese to allow a wide dissemination;
> to set up an adequate, articulated and transparent selection and recruitment process;
> to set up an induction and training process stressing the values of the Organization;
> to make sure that all our personnel is fluent in spoken and written English and in the main language spoken in the country where they work (French, Kiswahili or Portuguese).

9.3. ADDING VALUE TO OUR HUMAN RESOURCES

During the years most of our collaborators displayed not only high levels of competence but, also, extraordinary dedication, passion, and commitment tour values and mission.
We intend to make this a distinctive trait of our organizational culture.

Objective:

> to ensure the continuous development of our human capital, in line with our values.

Actions:

> to make sure that each position within the organization is occupied by the right person;
> to reinforce our organizational culture through shared information, debates, and other events. Coherence with organizational culture shall be one of the elements of performance evaluation;

> to outline and promote, for all cadres, a continuous professional and career development path;
> to elaborate, for all cadres, a clear salary scale including appropriate incentives;
> to elaborate and adopt, for all cadres, at Headquarters and in Country Offices, a thorough performance management process.

9.4. CONTINUING EDUCATION AND TRAINING

Continuing education and training are essential for individuals and organizations.
For many years we have been running various training courses (a pre-employment and several higher level ones).
We also organize frequent national and international conferences and debates on development issues.
We will consolidate and expand our activities in this field.

Objectives:
Through our training and cultural activities we intend:
> to promote continuous professional development for all our cadres;
> to identify, recruit and select new candidates among the best performers in our pre-employment and other courses;
> to disseminate scientific knowledge on African health issues as part of the international development knowledge network;
> to gain recognition in the national and international academic and scientific fields.

Actions:
> to make sure that our internal training activities are in line with the training needs of our personnel and our strategic objectives;
> to make sure that our current collaborations with various Universities, in Italy and abroad, become formal and fruitful partnerships;
> to make sure that these partnerships contribute to the continuous development of our cadres and produce operational synergies;
> to promote greater awareness about African health and development issues in Universities and other cultural institutions in Italy and abroad.

9.5. A GROUP OF EXPERTS

The implementation of our strategic plan requires the work of a permanent group of experts at Headquarters and in Country Offices.

Objective:
> to employ, full time, a group of experts in Public Health and Public Health Services Management.

Actions:
To describe the professional profile of two types of experts:
> experts in health services management: with expertise in planning and management of human, financial and material resources in the health sector;
> experts in public health: with expertise in epidemiology, research and evaluation;
> to guarantee the presence, in each country, of a specialist in health services management and one in public health;
> to recruit experts within the organization;
> in the initial phase, for lack of professionals with the needed profile, a suitable training path may be necessary;
> to define the experts' roles within the organizational structure;
> to work out contracts allowing mobility and flexibility, including a set of adequate incentives and benefits.

9.6. AFRICAN PERSONNEL

Investing in African health professionals is an effective contribution to the development of African Health Systems.

Objective:
> to contribute to African personnel's development promoting its retention within African Health Systems.

Actions:
> to contribute to the formulation of policies promoting national human resources retention within Africa Health Sectors;
> to contribute to formal training at different levels (from nursing schools to universities) and on the job training within projects supporting local national systems;
> to build partnership with NGOs and international agencies to identify and implement policies of human resources production and retention.

10. Communication, lobby and advocacy

Doctors with Africa Cuamm style is characterized by discretion, away from excessive media attention.
This style doesn't exempt from taking a clear and strong position on issues concerning the universal right to health.
To promote effectively the right to health, a high degree of visibility is important.
Our technical activities must be complemented by systematic communication, lobby and advocacy.
For us, communication is not mere publicity to our activities, but a proposal of change towards a society that doesn't just acknowledge but also realizes the right to health.
In line with our idea of "*service*", we always presented our field personnel not as main actors but discrete facilitators and, when necessary, temporary substitutes.
We avoid the false image of "heroic" field staff as well as the despicable commercialization of pain.
Our organization's image must communicate our engagement in the global fight against poverty side by side with African governments.

1. GLOBAL COMMUNICATION STRATEGIES

Doctors with Africa Cuamm will implement effective communication strategies documenting its participation to the global movement for the respect of human rights in general and of the right to health in particular.

1.1. Internal Communication

We want all our personnel to have timely, accurate and complete information on our activities. This will encourage frank discussions and participation in decision making.
The following communication means and documents will be used:

General communication:
> Internet site;
> Intranet site;
> journals and other publications;
> annual reports, strategic plans, operational plans, work plans, monitoring and evaluation reports, operational research reports;
> timetable of our main activities.

Communication within the Headquarters:
> Administration Board meetings;
> Management Team meetings (Director and Heads of Sections);
> section meetings;
> general meetings.

Communication within Country Offices:
> Management Team (Country representative and members);
> annual general meetings (all our professionals in a given country).

Communication between Headquarters and Country Offices:
> annual Country Representatives meeting at headquarters;
> Dissemination of Management Team meetings minutes;
> visits from Country Offices to Headquarters;
> visits from Headquarters to Country Offices.

All this shall ensure the timely, accurate, complete and transparent circulation of information. Through it, all staff members should have a clear understanding of what is being done, by whom, where, when, how, with what resources and why.

1.2. The Supporting Groups

Hundreds of Italian professionals worked with us in the field then came back to Italy.
Many of them became members of our Assembly, an important organ of the Organization.
Many also created Supporting Groups made of

people interested in our activities and contributing to them in various ways, including financial contributions.
We must provide these Groups with adequate information on our activities and technical support, so that they can fully develop their potential.
To this aim we plan:
> to strengthen the sense of belonging of the Groups while respecting their autonomy.
> To ensure the coordination and integration of the Groups activities with those of the Organization.

We will support the creation of new Supporting Groups so that all those who work with us, when they go back to their communities, become our ambassadors within them.

1.3. External communication

We will make a significant investment in communication, in Africa and in Italy, for the achievement of our strategic objectives.
Our communication strategy will strengthen our identity, disseminate knowledge and inform on our activities. It will be addressed to the following subjects.

1.3.1. Italian institutions

The main targets of our communication activities are national institutions, local authorities, political and advocacy groups.
We intend to achieve the following objectives:
> to create consensus on the importance of development cooperation and for a greater Italian engagement in it;
> to promote a cooperation culture based on all embracing, long term development policies rather than on emergency, fragmented and not evaluated interventions;
> to promote greater attention to and sensibility for the African continent;
> to advocate for the respect, by the Italian Government, of its international commitments like its adhesion to the Millennium Agenda and the promise to channel 0.7% of GDP to development aid;
> to advocate for a greater coherence between development goals and sector policies (like international trade, environmental protection, migration etc.);
> to contribute to the ongoing formulation of a new law on development cooperation;
> to underline the importance of involving in this process the civil society (NGOs, Universities, Local Governments, etc.).

1.3.2. International and European Institutions

The sustainability of development objectives must be considered globally.
The commitment of the international community to ensure the right to health is necessary in view of developing global health policies.
To this aim we intend:
> to contribute to the choice of priorities and functioning mechanisms of the main donors on the basis of our more than 50 years of experience in Africa;
> to promote coherence and coordination between development goals and national policies;
> to promote, in all the international institutions, cooperation mechanisms ensuring transparency, monitoring, and effectiveness of programs;
> to advocate for the sustainable establishment of a global system of social protection.

1.3.3. African Institutions

African Governments and civil societies, with the support of the international community, have the primary responsibility of guaranteeing the right to health to their citizens.
We intend to participate, with African Governments and the African Union, in formulating health policies geared towards the achievement of equitable and measurable health goals in Africa.
To do this we intend:
> to stress the key-role of better health in the fight against poverty;
> to influence national health policies on the basis of our experience shared with the competent authorities.

1.3.4. Individuals and groups

The involvement of civil society, in Italy and Europe, is necessary to put pressure on decision makers for the realization of the right to health.
To create greater awareness and participation, we want:
> to promote wider and better information, at global level, on the right to health in Africa;
> to promote debate and exchange of ideas to create a global movement for the right to health;
> to promote inter-cultural debates on development to establish relationships based on common interests, reciprocal exchange, solidarity, justice and peace.

1.3.5. The Health community

We intend to circulate information, promote debates, and stimulate change within the health community with the following objectives:

> to increase awareness, knowledge and understanding on issues related to the right to health;
> to promote the introduction, in the Faculties of Medicine curricula, of elective courses on global health and health equity;
> to promote greater collaboration between Universities and international health cooperation organizations;
> to increase interest and commitment for the elaboration and implementation of equitable and effective global health policies.

1.3.6. Business enterprises and foundations

Business enterprises and private foundations have considerable influence on policy formulation and implementation.

We intend to influence them with the following actions:

> to increase information and awareness on the right to health and the need of equitable and effective health policies at global level;
> to promote a greater involvement of business enterprises and private foundations in development cooperation.

1.3.7. The Media

Given the impact of media on public opinion and policy making, we intend to do the following:

> to stimulate greater and constant attention, by newspapers, televisions, and radios, on development in general and health development in particular;
> to promote a more accurate and documented knowledge of Africa, its problems and richness;
> to promote a greater involvement in development cooperation of the mass media.

1.3.8. The Catholic community

We intend to increase the awareness of the Catholic communities, in Italy and in Europe on the issues linked to our mission.

In particular we want:

> to contribute to the role played by the Catholic Church in promoting African development;
> to stimulate commitment to the realization of the right to health through equitable and effective health policies;
> to participate in the debate on Catholic health services management in Africa.

1.3.9. The third sector

We want to strengthen our links and collaboration with other development organizations, in Italy and Europe (Focsiv, Italian NGOs Association, Medicus Mundi International, etc.), stimulating debates and cultural growth for a coordinated advocacy at political level.

To achieve this, we intend:

> to collaborate in priorities setting and health planning in Africa;
> to promote networking and the creation of partnerships to increase the impact of our work;
> to increase, through partnerships and collaboration, the weight of our advocacy nationally and internationally.

1.3.10. Local communities

To achieve the MDGs it is important to support local communities.

Poor, marginalized and not adequately informed, they, often, don't have sufficient awareness of their rights. Neither are they involved in the strategic choices heavily impacting on their lives.

In this respect we intend:

> to promote an active role of community representatives in health policy making and implementation;
> to increase information and awareness of the communities we work with, promoting their structured participation in health services management and supervision at hospital and lower levels;
> to increase awareness and participation of families, empowering them to interact effectively with the authorities.

2. THE TOOLS

To promote uniformity of action and wide sharing of values and goals, inside and outside the organization, we will develop communication strategies and actions to achieve the following:

> *brand positioning*: we must solve the problems linked to the shift from our old brand "Cuamm" to the new one, "Doctors with Africa-Cuamm", in al the operational languages we use.
> *Basic brand dissemination strategy, in Italy and Africa*: the dissemination of our brand must take place in all our communications (headed letters,

envelopes, documents, dossier or project presentations).
- *Publications*: our publications must support our strategic objectives and reflect our mission, values and style.
- *Videos and DVD*s: we must add other ways of communication and other forms of expression like videos and DVDs.
- *WEB/Internet*: given its enormous potential, we must use the web for all our communication and fund raising activities. We must improve our website (www.doctorswithafrica.org), make it more dynamic and continuously updated.
- *Advertising*: this must be of excellent quality. Based on our values, it must illustrate our history as well as our original contribution.
- *Cultural Events*: they must strengthen our sense of belonging, display our specificity and prove our ability to link Africa and the West in a fruitful exchange of experiences and ideas.
- *Relationship with the Media*: in Italy and in Africa, we must increase our work with the media (press agencies, journals and newspapers, television, radio, internet) and make it more systematic and effective.

In each field of work we have:
- to plan communication activities, at different levels, assessing needs and opportunities;
- to support Country Offices to plan and monitor implementation;
- To ensure coordination of all actors, at all levels, to ensure the greatest synergy among all activities;
- To report fully on the progress made, the obstacles met and the support needed.

Two levels of involvement deserve particular attention since they illustrate our new approach:
- all those participating in the formulation and implementation of this plan are important actors in a communication work allowing to put the MDGs at the first place in political and health action plans;
- human resources involved in projects and the concerned communities will be able of making their voice heard, thus leading to real change.

11. Fund raising

For each “right” there is a “right bearer” (who should enjoy his/her right) and a “duty bearer” (responsible for the respect of that right).

There is consensus that the responsibility for providing the financial resources needed to ensure the right to health rests with local communities, governments and the international community.

Fund raising is essential to promote the respect of the right to health.

We propose the possibility to accomplish this duty to national and international institutions, to the civil society, business enterprises, private foundations and private citizens.

On the basis of studies costing the production and delivery of health services in Africa, we estimate that, to implement this Strategic Plan, our organization needs to increment its financial income of about 15% per year, to achieve 30 million Euros by 2015.

We consider this realistic and achievable for the following reasons.

The funds channeled to development aid will increase in the next eight years due to greater public pressure to achieve the MDGs, especially in Africa, where progress is slower.

The big Foundations, especially in North America, and the Global Health Initiatives, can mobilize increasing resources.

The professional standards requested today to organizations like our one imply investments in quality that would not make sense with activities worth less than 25 million Euros.

Finally, it is important that adequate amounts of money are channeled to organizations, like our one, having a long term, systemic approach, rather than a vertical one.

1. STRATEGY

Moving from the current financial situation to the desired one, requires all the changes described in this document.

In particular:

- *partnerships*: we are committed to work with other national and international organizations sharing our values and professionally qualified.
- *Results*: donors have the right to know what was done with their money. We have the duty to achieve the planned results, document our actions and disseminate our reports. We must also describe and explain possible failures.
- *Catalytic role*: we must support the implementation of local and national programs resulting in quality services, capacity building, and empowerment.
- *MDGs*: our supporters must be aware that helping us means to participate in the achievement of the MDGs.
- *Specific role and professionalism*: we will maintain our identity and specificity while working within the framework of the the MDGs, with a facilitators’ role, a passion for results, and a partnership culture.
- *Responsibility of mobilizing resources*: needed to promote the right to health, this will be part of the job description of all the organization’s staff.
- *Groups*: the Supporting Groups are precious for spreading our ideas and fund raising. We will provide them with the support they need.

In 2006 our income was about 8 million Euros. We intend to achieve 30 million Euros by 2015. Of this amount, not more than 20% will be used for management, administration and training. The remaining 80% will be used in the countries where we work.

Several international agencies, funds, and foundations have adopted decentralized funding strategies. Considering this, we think that about one third of the funds we want to collect by 2015, that is, about 10 million Euros, shall be raised by our Country Offices with the support of the Headquarters.

Of the remaining 20 million Euros, 60% shall come from the Italian government and the European Union (about 12 million Euros).

The remaining 8 million Euros shall be collected from foundations, business enterprises and individuals, in Italy and abroad.

The funds raised from private sources are particularly important as they are not tied to political or other considerations like those from institutional sources. As such, they allow us more freedom of action in the choice of interventions and countries.

2 INSTITUTIONAL FINANCIAL MARKET: PUBLIC AID TO INTERNATIONAL HEALTH COOPERATION

In recent years there has been renewed interest in health cooperation, with increasing funds channeled to the health sector.

Official Development Assistance (ODA) funds to the health sector grew from US$ 2.2 billion in 1990 to US$ 14 billion 2005. This is 13% of the whole ODA funds in 2005 (WB, 2007).

New donors, like Global Funds, Global Health Initiatives (GAVI, GAIN, etc.) and big private foundations (Bill and Melinda Gates, Clinton, Soros, etc.) act, side by side, with the traditional, bilateral and multilateral donors.

Africa is receiving increasing attention and funds. Europe, through the portfolio managed by Commission for Development, is, today, the biggest donor to Africa (European Commission for Development, 2006).

For the period 2008-2013, the European Commission has budgeted, through the 10th European Development Fund, 22.7 billion Euros for investments in social sectors in Africa (including health).

In the last G8 meeting, held in Heiligendamm, Germany, from June 6th to June 8th 2007, industrialized countries reasserted their commitment to double aid to Sub-Saharan Africa by 2010.

The major donors agree on the need to better coordinate the use of aid funds. Aid must be aligned with the priorities of recipient countries, better coordinated and show evidence of its effectiveness (OCSE, 2005).

More and more donors disburse their funds as General Budget Support, Sector Wide Approaches, and supporting Poverty Reduction Strategic Papers.

Health policies recognize the central role of health systems and the crucial importance of human resources for health (WHO, 2007; DFID, 2007; GAVI, 2007).

Looking at these positive developments, however, there are old and new challenges in the institutional fund raising market:

- after falling in early 2000, current aid to Sub-Saharan Africa has since remained at about the same level as it was in 1990s;
- funds continue to be unreliable and not steady;
- priority has been given only to the principal programmes to control illnesses such as HIV/Aids, Tuberculosis, Malaria and other illnesses which can be controlled through vaccination;
- the worrying lack of funds available to support health systems and for primary care which runs counter to declared strategies and policies;
- the difficulty of the new international aid organisations (CBS, SWAP, PRSP) to produce important and sustainable results at the district level.

Another factor to keep in mind is the national and international multiplication of NGOs that offer themselves as agencies, able to implement health programmes and financed by the international fund-gathering market. In this case, access to funding from the institutional market is linked: to the ability to satisfy the technical and organizational requirements linked by predefined standards; to present technically valid and innovative programme proposal; and to work in partnership with other organizations.

Italian Cooperation for Development deserves a separate comment. After years of financial regression and political disinterest in cooperation, the last document regarding economic-financial programming has shown clear signs of a coming u-turn. More specifically, the document states that in order to honour its international commitments, the Italian government has drawn up a sort of road map setting out proposed increases in State Aid for development as follows: 0.33% in 2008 (estimated as around a total of 4.7 billion), 0.42% in 2009 (estimated at around a total of 6.1 billion), rising to 0.51% in 2010 (estimated at around a total of 7.5 billion).

However, within this funding, priority must be given to Africa where, at the Gleneagles conference, Italy made a commitment to double the aid it provided (DPEF, 2007).

Despite this development, which should be kept under close observation, it is still unclear how long it is going to take to pass the laws that will give Italy a development agency that can function as an efficient tool for carrying out policies effectively.

Furthermore, it is still not clear what criteria will be used to allocate resources and what the level of im-

portance given to the cooperation sector in the field of health will be.

2.1. How does Doctors with Africa Cuamm intend to act within this market?

To obtain financial resources adequate to its plans, Doctors with Africa Cuamm must have the following documents for each Country where it works:

> a Strategic Country Plan.
> A three-year Country Plan with detailed Financial Plan.
> A one-year Country Plan with analytical Financial Plan.

The three-year planning will illustrate all the interventions that will be proposed to the main institutional donors, particularly to the European Commission and the Italian Government, at central and country level.

This mid-term planning approach should allow the timely integration of our activities within donors priorities. It should also avoid having to run after specific and fragmented projects tendered out.

3. BUSINESS, BUSINESS FOUNDATIONS AND BANK FOUNDATIONS

The basic values of corporate responsibility are illustrated in the *2001 European Commission Green Book* and receive increasing attention by business enterprises.

Numerous studies suggest that the financial performance of business enterprises is strongly linked to the degree of corporate responsibility shown by them and perceived by their stakeholders, including the general public.

Governance issues and involvement in social causes, positively affect their financial performance and competitiveness of business enterprises.

Available data refer only to the tax-deductible payments (and not to those that come from organisations in the non profit sector) made by Italian firms. In 2001, these payments amounted to 266 million Euro. [Font: Research IRS, Institution for the Social Research]

In Italy, business foundations are a recent but growing phenomenon. Corporate philanthropy is becoming part of the culture of big business enterprises.

Bank foundations are particularly important. At the end of 2004 they managed a total of about 88 billion Euros.

Bank foundations, in 2004, donated about 1.274 billion Euros [Font: X° Annual report ACRI].

To be effective in this environment, we need:

> a constant, systematic and accurate market analysis.
> a rational optimization of the existing relationships.
> a strong corporate program using the main forms of fund raising:
  - *partnership;*
  - *cause-related marketing;*
  - *grant giving;*
  - *joint fund raising;*
  - *licensing;*
  - *sponsorship;*
  - *membership.*

The effectiveness of our fundraising, especially in its initial phase and for several years to come, will depend heavily on the involvement of all our members.

To do this, as part of our communication strategies, we need a lively and engaging dialogue with all our stakeholders.

We must be able of communicating the goodness of our cause, raise interest and stimulate participation.

Ensuring the universal enjoyment of the right to health must become a project shared by our entire society.

Fund raising is not just a tool to obtain financial resources but a strategy to create a chain of social relationships based on shared values.

3.1. The market of private citizens

This is a market in expansion as suggested by several studies on trends for the next decades. The donations from private citizens amount to 4.8 billion euro [Font: Sole 24 ore, 07/12/24].

Bequests represent 30% and cash 70% of the total annual donations.

An IRS study, from which come these data, forecasts that, in 2020, private citizens donations will reach about 8 billion Euros [Font: “The social and health fund raising” A. Masacci, P.L. Sacco, Meltemi, 2006].

Others (Consodata) estimate current donations to come from 29 million people, equal to 62.7% of the whole Italian population over twenty years of age.

Finally, another study (IREF) found that every year spontaneous donors decrease while those influenced by awareness campaigns increase.

Fund raising strategies must be diversified and addressed to different targets.

Our main fund raising strategies, used in different ways for different targets, will be:

> *mailing*
> *membership policies*
> *cultural events*
> *merchandising*
> *internet site*

The strategy plan suggests increasing specialisation in fund raising efforts directed at the diverse markets and should be presented as a model for achieving sustainable and global growth.
The current trend in Italy is to seek to broaden the overall panorama of methods used for fund raising for all social reasons, but especially in the area of international health provision, these different initiatives will be used at all levels, in order to find the funds required to carry out our mission.

ANNEX II
Country strategic programs

Angola

Angola, with its immense natural resources, is potentially one of the richest states in the world.
Despite this wealth, 70% of the population still live on less than two dollars per day. Until 2002, the year when the peace agreement was signed, the country had been locked in continuous Civil War for 40 years.
The infrastructure of the health service has been severely damaged by the long conflict and reconstruction is going slowly and is faced with many problems. The health system was decentralized in 2001 as part of a vast government reform.
The Angolan government invests 4.1% of the public spending in the health system which is low when compared with the average rate of investment in health (9.24%) practised by other countries in the Sub-Saharan region (WHO 2005).

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

Doctors with Africa Cuamm has been active in Angola since 1997. It is currently active in the province of Uige and of Cunene and in Luanda. Since 2004, it has been collaborating with the central authorities of the Health Ministry and with the United Nations Development Programme to support the national TB programme, and has become the main recipient of Global Fund aid to Angola (2005).

STRATEGIC TARGETS FOR 2015

In line with Millennium Development Objectives 4, 5 and 6, Doctors with Africa Cuamm is seeking:

1. contribute to improving the health of the poorer sections of the population by reinforcing local or district health systems; in particular it proposes to contribute to reducing maternal and infant mortality in the rural areas of the country:
   - Municipality of Damba and Maquela, Uige Province (in the North of the country).
   - Municipality of Chiulo, Cunene Province (in the South of the country).

   In particular it intends to develop the hospital at Chiulo and make it a centre for clinic referrals and for training obstetricians and hospital managers; and also to make it a place for trying out new models for public and private non profit funding integration models and for funding at the community level.
2. Support national programmes which aim to reduce the endemic diseases (HIV, TB, Malaria) without ignoring the “neglected diseases”.
   In particular:
   - consolidate the partnership with the Ministry of Health in its role as leading NGO in the field of tuberculosis prevention and cure;
   - promote experimentation of new organizational models such as the adoption of the Dots at the community level and horizontal integration of TB services in the districts (as regards the supply of medicines, training, communication system, etc.);
   - verify the effectiveness and transferability of

such operations through evaluation and on-going research.

3. Support the country's strategies for improving the production, distribution, competencies and motivation of health service personnel at the rural level by promoting the training centre at Uige.
4. Actively contribute to the development of new strategies for the provision of health services in the urban area of Luanda.
5. Reinforce the local information system in order to monitor and evaluate health services and the system.

HUMAN RESOURCES REQUIRED IN ORDER TO ACHIEVE OBJECTIVES

Angola is one of the Sub-Saharan countries where the crisis of local human resources in the health sector is clearest. Therefore each programme has been designed so as to employ a sufficient number and mix of expatriate health personnel each time, in order to meet the objectives decided on with the local partner.
To avoid harming the Angolan Health system, a list showing how local health personnel are employed will be drawn up, checked and published every year.
It has been suggested that human resources should include 1 or 2 experts in hospital management; doctors and nurses for the clinic functions; administrators and logistics experts.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

In order to be able to operate best in the areas of intervention identified it has been estimated that about 30 million Euro will be required for the period 2008-2015, of which 40% should be found in loco, while the remaining 60% should come from the main offices /organisation /headquarters?

PARTNERSHIP ACTIVITIES

It would be helpful if there were to be official recognition on the part of CEAST, Conferenza Episcopale di Angola e Sao Tomè (Episcopal Conference of Angola and Sao Tomè) of the Doctors with Africa Cuamm which is a Catholic international organization operating in the country.
At the diocesan level, there is a need to stipulate specific agreements, or delegate responsibilities, regarding the management of the diocesan structures in Damba (Uige province) and Chiulo (Cunene province).
Other important alliances are those with international and national NGOs, who already operate in the country and have similar missions and targets even though they may not necessarily be operating in the health sector.

COMUNICATION ACTIVITIES, FUND RAISING, LOBBYING AND ADVOCACY

Given the strategy presented here, and in order to stimulate the necessary changes to reach MDGs, it is crucial that lobbying and advocacy activities be promoted at the level of the local Health Ministry, in synergy with the most important public and private actors in the Angolan[7] context and within national programmes such as that for Tuberculosis.
At the level of international donors we propose developing fund raising activities based on result based management.

7 International agencies, UN, bilateral cooperation, government authorities, the Catholic Church and religious organizations.

Ethiopia

Ethiopia is country with key geopolitical importance both within the whole continent of Africa and, especially, in the Horn of Africa. In 1993, the Federal Government launched a National Health policy based on the democratization and decentralization of the health system.
A programme, based on 5-year periods, was started in 1993 in order to develop the health sector along these lines.

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

Doctors with Africa Cuamm has been present in the country since 1985, when the first doctor was sent to the hospital of Gambo. Today, we are well established in the Oromia region.

STRATEGIC TARGETS FOR 2015

In line with the development targets of Millennium 4, 5 and 6, Doctors with Africa Cuamm proposes to:

1. contribute to improving health among poorer sections of the population by supporting the local district Health Service; in particular it proposes working to reduce maternal and infant mortality in the rural areas of the country:
   - South West Showa Zone, province of Wolisso, Oromia region.
     We intend to improve the St. Luke Hospital in Wolisso to make it into an excellent clinical centre for training obstetricians and hospital managers.
     We also intend to guarantee continuity in rehabilitation services for mobility with the aim of reducing the impact of disabilities due to congenital and acquired malformation in children below the age of five. Building on the hospital's experience (where there is private non profit – public collaboration); we intend to set up local projects, for health and other reasons, working with other NGOs who operate in other sectors (water, hygiene, micro credit and community projects).
2. Promote and encourage, within the community, the capacities required to recognise problems regarding health and to identify suitable solutions.
3. Support activities seeking to reduce the incidence of endemic diseases (HIV, TB, Malaria) and also the neglected diseases.
4. Reinforce the local information networks and systems used to monitor and evaluate health services.
5. Strengthen the role of the "Catholic Medical Bureau" in the Ethiopian Secretariat of the Catholic Church in order to develop the way in which diocesan health structures are organised and managed and encourage greater integration between public and private non profit organisations. St. Luke Hospital in Wolisso offers an example of good management of public-private partnership and is the best practice example which could be reproduced at the Ethiopian Catholic Secretariat. Furthermore, we propose the introduction of capacity building activities for local health staff at the Catholic Medical Bureau, capitalizing on the

experiences of Doctors with Africa Cuamm in this sector in Uganda. Within the wider field of activities in support of the Catholic Health Bureau of the Ethiopian Catholic Church, where there are the required technical, administrative and financial conditions, other technical and financial support activities could be considered which focus on specific health structures. In this case it would be possible to add further, complementary activities, for example: support for St. Mary Hospital at Dubbo (Soddo Hosanna Dioceses) and the Burat-Geto Clinic (Emdibir Dioceses).

HUMAN RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

The most important challenge will be that of managing, over time, to replace the expatriate staff with qualified local staff. It has been calculated that the human resources needed should include 1 or 2 hospital management experts; doctors and nurses for clinical activities; administrative and logistics personnel. There must also be some guarantee of support for orthopaedics and physiotherapy services.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

We estimate that 15 million Euro will be required for the period 2008-2015, of which 50% should be obtained in loco while the remaining 50% should come from headquarters.

PARTNERSHIP ACTIVITIES

Ethiopia is one of the most important examples of planning partnerships, set up in conjunction with other NGOs, in order to undertake integrated support projects in the area even though they are not directly concerned with health. In 2007, one such partnership was started up with two NGOs, Cefa and Lvia, in order to carry out integrated actions in the South West Showa area.

Cefa and Lvia work in sectors (water and hygiene, agricultural and earnings generating activities – Igas) that are complementary to the health sector where Doctors with Africa Cuamm are. This partnership will create important synergies which will help us in our work in the area and improve the situation of the population overall.

In the Wolisso district, partnerships will be explored in order to capitalize on all the varied competencies and experiences present, to share results with other international agencies and institutions operating in the geographical area in question, amongst which are UNICEF and UNFPA. The existing partnership with the Italian Ministry of Foreign Affairs will be reinforced in the hope of being able to contribute to drawing up a country-wide plan on the lines of one that the Utl in loco is currently trying out.

COMUNICATION ACTIVITIES, FUND RAISING, LOBBYING AND ADVOCACY

In the Addis Adeba coordination centre there is a need to improve the local activities of lobbying, advocacy and fund raising. In particular, considering that the office of the United Nations in Africa and of the African Union are in the Ethiopian capital, lobbying, advocacy and fund raising activities should be organised systematically throughout the organization. The country's management team intends to develop suitable communication strategies for divulging information: data, experiences and best practices (for bilateral support organizations and agencies, such as WHO and UNICEF, international NGOs, Italian Cooperation, local dioceses and Catholic health institutions), in order to improve local visibility, support, lobbying and fund raising. Among all the various communication strategies and methods that could be used, those to be encouraged most are annual reports, country information files and brochures and the results of operational research.

Mozambique

In 1992, in Rome, after 16 years of civil war and 26 of negotiations, an agreement was signed between the representatives of the Mozambique Government and the Rebels and Mozambique officially entered a period of peace. Today there is a multiparty democracy. Mozambique has shown clear improvements with respect to the dramatic post-war conditions in the country, thanks in part to the successful implementation of the First poverty reduction plan (Parpa I, 2001). The most recent human development indicator, the Undp (2006) puts Mozambique 168th out of the 177 countries analyzed.

As regards in the situation of the health sector in the country, a primary services health system modelled on the Primary Health Care model suggested by the WHO was introduced in the late 1970s. For the first time the poorer groups among the population had access to the health system, to health care.

Despite this however, there is worrying data today from the Mozambique Health Service system particularly regarding access to health care.

Currently 12.8% of the State public spending goes to the health sector.

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

The first volunteers, members of Doctors with Africa Cuamm went to Africa in 1978, in the period when the colonial health system based on inequality was being changed into one based on principles of equality and free access.

In 2002, after in depth analysis of whether to remain there or leave the country, a new phase has started up with many new projects launched within the provinces of Sofala and Nampula. Apart from one project set up in collaboration with the Faculty of Medicine at the Catholic University of Mozambique at Beira, all these projects have been developed within the public health service.

STRATEGIC ROLE AND OBJECTIVES FOR 2015

Doctors with Africa Cuamm intends to guarantee the right to health care, by organising support for some sectors of the national health system in Mozambique so as to contribute to achieving the Millennium objectives.

We intend to:

1. contribute to improving the health of poorer groups among the population by reinforcing the district health service and system (hospitals, health centres, community health); in particular we aim to contribute to reducing maternal and infant mortality in these rural areas:
   - Sofala Province (city and district Beira).
   - Napula Province (districts of Moma, Angosche and Mongovolas).
2. Support activities and interventions that aim to increase access to primary care and improve nutrition among women and children in rural areas.
3. Promote and encourage, within the community,

the capacities required to recognise problems regarding health and to identify suitable solutions.
4. Support interventions which focus on reducing endemic diseases (AIDS, TB, Malaria) and neglected diseases.
5. Support local strategies that aim to improve production, distribution, competencies and motivations of the medical health staff (University Medical School of Beira).
6. Improve the Central Hospital of Beira and make it a centre for referrals for clinical help, training and research for the northern areas of the country.
7. Improve the local information systems used to monitor and evaluate health services.

HUMAN RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

Mozambique is one of the African Sub-Saharan countries with the worst crises of human resources in the health system. Therefore, each programme is expected to employ suitable expatriate professional health operators, enough, in numbers and competencies, to meet the objectives have been set in conjunction with the local partner.

In order to avoid damaging the Mozambican health system, each year a list will be drawn up and published of those employed in the local health service. Currently, the most pressing problem is the disproportionately large number of projects and their management or organisational support.

The human resources must include: 1 or 2 hospital management experts; 1 or 2 public health experts; doctors with experience both in surgery and in medicine; administrators and logistics experts.

We believe it is important to continue to recruit both health staff and non health staff whether they be foreigners or not in loco, but without eliminating the role of headquarters, and to guarantee adequate and sufficient training and up-dating for all.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

The budget forecast is around 20 million Euro, one third of which should be found in loco.

PARTNERSHIP ACTIVITIES

Considering the situation it would appear crucial to increase both collaboration in loco and partnerships with agencies and NGOs which, on the one hand, will increase the weight and quality of the programmes to be implemented and, on the other, permits multi-sectorial approaches.

The partnership with Celim of Milan, with the Clinton Foundation and the local NGO Aro Moçambique will continue. Offers to work with the following local NGOs will be evaluated: Adpp (regarding HIV/women/children); the Malaria Consortium - working in the context of community education; Save the Children and the Elizabeth Glazer Foundation regarding HIV and paediatrics.

Our presence in the University and the Hospital in Beira will continue to benefit from agreements drawn up between the Veneto Region/Sofala Province as does the collaboration with the Health Authority (USL) and University of Padua. There is a need to create new partnerships with other agencies, foundations and universities in particular, to help in research and training.

Doctors with Africa Cuamm is a member of both the GNGO, coordinating group of most of the NGOs active in Mozambique, and the Naima+, a network of international NGOs which work together in the health sector (especially around HIV/Aids). If we were registered as a Mozambique NGO would make partnership easier both in different sectors and for the different activities.

COMUNICATION, FUND RAISING, LOBBYING AND ADVOCACY ACTIVITIES

In order to disseminate more information about activities there is a felt need for better organisation of the way data and other information are collected and held. Reporting on activities requires that there should be an archive/library in each office and headquarters, with updated documentation on the country, about topics and health programmes and about the organization and its projects.

There should be an annual report on all activities of each project, which should be sent to local and national counterparts, given to the Doctors with Africa Cuamm team in Mozambique and sent to the main office /headquarters. The country's Management Team (Mt) has a particularly important role to play in improving internal levels of communication, and distribution of reports from other towns / countries and from local and national headquarters will encourage up-dating, better sharing of both information and objectives.

Fund raising in loco will continue and there will be a serious attempt to obtain access to funds managed by Misau (Ministry of Health) which has been set aside for projects proposed by NGOs. Were Doctors with Africa Cuamm to be registered as a Mozambican NGO, this would help in fund raising.

Sudan

Sudan is the largest country in Africa and one of the richest in oil which is found mainly in the south of the country. But the health indicators and the human development index show it to be one of the poorest countries in the world. It is politically divided between North and South. Because of the long years of war, the South now has almost no type of infrastructure left intact and a serious shortage, if not total absence, of local medical and paramedical staff.

The 9th of January 2005, the comprehensive Peace Agreement was signed, ending twenty years of Civil War. The agreement provided for a period of transition at the end of which, in 2011, there would be a referendum, monitored by the international community, to establish whether the South should be independent or united with the North.

In the South of the country, where Doctors with Africa Cuamm is now active, the political-institutional reality is still unstable and fragmented. In the health sector, the few existing structures, principally primary care health centres directed by religious organizations, are not able to deal with the huge demand for care from the population.

Furthermore, Health Service structures are still very weak and there is a lack of any real programme for intervention and reconstruction of the Health Service. Notwithstanding the adoption of strongly decentralised health policies there has, so far, been no real definite decisions taken about who is responsible, the Central Government or the Federal States, for providing which competencies.

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

Doctors with Africa Cuamm have been operating in South Sudan since October 2006 thanks to funding from the Italian Government Civil Protection Department, which has made it possible to start up a support project for reopening Yirol Hospital, in Yirol County, in Lakes State.

STRATEGIC ROLE AND OBJECTIVES FOR 2015

In line with the development objectives of Millennium 4, 5 and 6, Doctors with Africa Cuamm proposes to:

1. contribute to improving health among poorer sections of the population by supporting the local district Health Service, in particular it proposes working to reduce maternal and infant mortality in the rural areas of the county:
   - *Yirol County.*
2. Support activities and interventions that aim to increase access to primary care and improve nutrition among women and children in rural areas.
3. Support activities seeking to reduce the incidence of endemic diseases (HIV, TB, Malaria) and also the neglected diseases.
4. Support local strategies that aim to improve production, distribution, competencies and motivations of the medical health staff.
5. Improve the local information systems used to monitor and evaluate health services. We will concentrate our activities in the Yirol County, supporting the Hospital and its management, with the

aim of reinforcing the Health Services in the area. We will progressively extend our field of interventions to at least at two other counties so long as conditions of peace and stability can be maintained. We will set up an office to co-ordinate activities at a country-wide level.

HUMAN RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

In order to achieve any of the objectives for South Sudan, human resources must be provided which include both international and local professionals and experts in hospital, clinic and public health management. There is also a need for administrators and persons specialised in provisioning and procurement.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

The budget forecast is for around 16 million Euro by 2015.

PARTNERSHIP ACTIVITIES

It is very important here to work in a multi-sector manner in partnership with experts with different capacities, training and experience. For this reason, Doctors with Africa Cuamm proposes exploring the possibilities of partnerships with other international or local NGOs and to set up joint projects to support the National Health Service, to integrate its members and to train health workers.

COMUNICATION, FUND RAISING, LOBBYING AND ADVOCACY ACTIVITIES

Doctors with Africa Cuamm proposes to help publicise results and lessons learned from experience both inside and outside the country.

It will compile periodic reports, evaluations of activities and publish the results of applied research that will be used at national and international level for advocacy and lobbying activities.

Tanzania

Tanzania was founded in 1964 from the union between Tanganyika (independent since1961) and Zanzibar (independent since 1963). Although it is in a highly instable area it has managed to maintain a high level of internal cohesion and political[8] stability. Notwithstanding a recent improvements in some indicators, the "Poverty and Human Development Report 2005" has highlighted Tanzania's difficulties in achieving MGDs within the foreseen times. This report, published in 2006 by Undp, puts the country 162nd out of the 177 cases analyzed.

The country is heavily dependent on foreign aid. In 2001, having reached "completion point", it was able to benefit from HIPC[9] (High Indebted Poor Countries Initiative) and its debt with the International Monetary Fund was cancelled. The latest health sector reforms were introduced in 1996 and, together with those launched by local government (districts), have resulted in the introduction of user fees and in a reduction in government subsidies to non profit organisations and structures.

Since 1998, Tanzania has decided to use international aid in the health sector according to the Sector Wide Approach (SWAp) formula where partners are encouraged to finance the total Action Plan of the sector rather than just specific projects.

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

Doctors with Africa Cuamm has been active in Tanzania since 1968. Initially it worked within missionary and diocesan health structures but, since 1977, it has been supporting the Government health structures as part of action supported by Italian Cooperation. Since 2002, we have worked with health cooperation projects in many regions: Dar es Salaam, Pwani (in Mkuranga and Rufiji districts), Iringa (in Iringa Rurale, Mafinga, Ludewa, Njombe and Makete districts) and in Morogoro (Kilosa district). These are contiguous areas but are very different from the both the geographical and social point of view, however, the areas do have very similar health and management problems, for example: insufficient access to health care services, HIV/AIDS, TB, Malaria, high morbidity and maternal-infant mortality.

STRATEGIC OBJECTIVES FOR 2015

In line with the development objectives of Millennium 4, 5 and 6, Doctors with Africa Cuamm proposes to:

1. contribute to improving health among poorer sections of the population by supporting the local district health service. In particular it proposes working to reduce maternal and infant mortality in the seven districts of the regions of Iringa: Iringa Rural, Iringa Muncipal, Kilolo, Mufindi, Njombe, Ludewa and Makete.
2. Support activities and interventions that aim to increase access to primary care and improve nutrition among women and children in rural areas.
3. Support national programmes that focus on reducing endemic diseases (HIV, TB, Malaria) without omitting the neglected diseases.

8 The CCM (Chama Cha Mapinduzi, the Revolutionary Party) was created in 1967 and has been in power since then. Initially it was the only party, but although other parties have been recognised since 1995, it has continued in power as it is the strongest and most popular party in the country.

9 The "HIPC Initiative" (Heavy Indebted Poor Countries) was adopted in 1966 at the G7 meeting in Lyon, as an attempt to render the foreign debts of poorer countries more sustainable at least in the medium-long term.

4. Promote quality in both health services and research at different stages of the health system reinforcing Primary Heath Care in Iringa.
5. Contribute to upgrading the District Hospital of the Mikumi Health Service to make it top level and equip it to become a centre for referrals for maternal-infant health care.
6. Support integration between the public health service and the private non profit sector.
7. Offer our services as support agent for implementing strategies elaborated with the health authorities for the different levels of the district health service (hospitals, health centres, community).
8. Offer our services as support agent within national policies, for management of the health structures from the point of view of governance, of management, and of clinical and financial systems.

HUMAN RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

In order to achieve any of the objectives for South Sudan, human resources must be provided which include both international and local professionals and experts in hospital, clinic and public health management. There is also a need for administrators and personnel specialised in provisioning and procurement.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

We have estimated that by 1915, 18 million Euro will have been necessary in order to continue and reinforce our activities in Tanzania. We estimate that 8 million Euro could be provided locally while another 10 million should come from headquarters.

PARTNERSHP ACTIVITIES

Doctors with Africa Cuamm proposes to seek out partnerships with other organizations in order to set up integrated support projects in the districts, particularly in areas which are not strictly concerned with technical and health problems. In 2007, one such partnership was started up with two NGOs, Cefa and Lvia, in order to carry out integrated actions in the Iriga region and, in the long term, in the Dodoma region too. Both Cefa and Lvia work in sectors (water and hygiene, agricultural and earnings generating activities – Igas) that are complementary to the health sector where Doctors with Africa Cuamm is.
We intend firstly to intensify collaboration with the Italian Ministry of Foreign Affairs (MAAEE) and to start collaborating with major international agencies (UNICEF and WHO), not only in order to obtain funding but also as regards exchanges of experience, best practices and technical support. Partnerships with Family Health International (Fhi), the Clinton Foundation and UsAid will be sought with regard to management and aid for specific questions relating to HIV/AIDS.
Should there be another opportunity to work with the Istituto Spallanzani interventions should be made in areas where we are already active and set up on the basis of the mission of each of the two organizations. Collaboration with the dioceses will be redefined on the basis of the annual budget for each hospital.

COMUNICATION, FUND RAISING, LOBBYING AND ADVOCACY ACTIVITIES

- Promote a strategy of divulgation of results and lessons learned, both inside and outside the country, through periodical reports, evaluating activities and making applied research results public.
- Reformulate the financial strategy for hospitals, taking into account annual agreements and counterparts' support. In this area communication strategies must be made more effective in order to help support groups and foundations become more aware of the issues.

Uganda

Uganda is a democratic republic. Over the past ten years the country has been subject to extraordinary changes in all sectors: financial, political, and cultural. Decentralized administration, internal peace and development of modern politics in favour of foreign capital investment and industrial development are key elements of its current national policies. The targets and national health strategies of Uganda were defined in the second strategic Plan of the Health Sector (HSSP II 2005-2010) and in the Plan for Poverty Reduction.

HISTORY AND ACTIVITIES OF DOCTORS WITH AFRICA CUAMM IN THE COUNTRY

Doctors with Africa Cuamm has been operating in Uganda since 1959. Over this long period it has set up a vast range of initiatives in the health sector, for example: supporting public hospitals, missionary and health services, collaboration with central and peripheral health systems and promotion of training programs for the health personnel. Today we are active in four regions (West Nile, Central Region, Karamoja, Lango) and in the Uganda Martyrs University of Nkozi.

STRATEGIC TARGETS FOR 2015

In line with the development targets of Millennium 4, 5 and 6, Doctors with Africa Cuamm proposes to:

1. contribute to improving health among poorer sections of the population by supporting the local district health service (hospitals, health care, community). In particular we propose working to reduce maternal and infant mortality in the following regions.
   - West Nile.
   - Lango and Teso.
   - Region Central.
   - Karamoja.
2. Support activities and interventions that aim to increase access to primary care and improve nutrition among women and children in rural areas.
3. Promote and encourage, within the community, the capacities required to recognise problems regarding health and to identify suitable solutions.
4. Support national programmes that focus on reducing endemic diseases (HIV, TB, Malaria) without omitting the neglected diseases.
5. Promote quality performances in the health services, especially hospital services, and reinforce teaching, research and academic partnership activities in the Faculty of Health Sciences at the Catholic University of the Uganda Martyrs (UMU).
6. Support the coordination activities of the Catholic Bureau in the area of integration between public and non profit private.
7. Reinforce the local information systems for monitoring and evaluating health services.

WEST NILE

The current activities of Doctors with Africa Cuamm, will continue until 2010, and concentrate on supporting the district and diocesan health structures of Arua and Nebbi.

During 2008, Doctors with Africa Cuamm will support primary eye care interventions and initiatives aimed to

help disabled people in the community, in health structures and in schools.
The activities will be carried out in such a way as to encourage increased commitment and responsibility taking on the part of our Ugandan partner, so that they can carry on, manage, the activities in the future.

LANGO AND TESO

North Uganda has been torn by decades of Civil War. The normalisation policies being promoted in the area all highlight see the Lango and Teso regions as high priority areas for reconstruction and development interventions in health care because of their enormous health needs.

CENTRAL REGION

The activities of Doctors with Africa Cuamm in the Central Region are still directed towards completing and reinforcing administrative competencies at Naggalama Hospital and of collaborating with the national and international partner network, in particular with those involved in the struggle against AIDS.

KARAMOJA

The Karamoja districts have the lowest health and development scores not only for Uganda but also for the whole of east Africa, both because of the extreme poverty in the region and the unsafe, unstable, political and social situation. For these reasons the region is at the centre of the national development priority programmes. We consider it would be good strategy to strengthen and consolidate our long-running collaboration with diocesan health structures, with particular attention paid to Matany Hospital, its clinical services, its role both as coordinator in the sub-district and as promoter of community medicine, and its Nursing School.

HUMAN RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

Human resources must be provided which include both international and local professionals and experts in hospital, clinic and public health management, doctors for clinical and medical activities, administrators and personnel specialised in logistics.
It is hoped that this process will also optimize the relationship between the expatriate and local personnel through continuation of a policy of investing in local human resources, in order to train professionals who will be both able and motivated to continue activities thus ensuring the continuity and sustainability of interventions.

FINANCIAL RESOURCES REQUIRED TO ACHIEVE OBJECTIVES

We estimate that 25 million Euro will be required for the period 2008-2015 if objectives are to be met. Of this, 40% should be obtained in loco while the remaining 60% should come from headquarters.

PARTNERSHIP ACTIVITIES

Partnerships are seen as key factors for success in implementing wider-reaching initiatives that will have greater impact and visibility. During the period 2008-2015 current and traditional partnerships will be strengthened and new ones set up. The following partnerships will be reinforced:

- partnership for obtaining financial support: UNICEF, UE, Japanese Embassy, USAID, WHO, Mildmay Clinic.
- Partnership for development initiatives: AVSI, COOPI, ISP, Malaria Consortium, UMU (Uganda Martyrs University), and Local NGOs.
- Project partnership: diocesan health structures PNFP (private not for profit), districts, HSD (Health Sub-district), government structures, communities.
- Partnerships to reinforce the role of NGOs in national strategy and policy: government ministries, local and district authorities, WHO, UNICEF, OCHA/UNDP UCMB (Uganda Catholic Medical Bureau), UMU (Uganda Martyrs University), development alliances, GFI (Global Found Initiative).

COMUNICATION, FUND RAISING, LOBBYING AND ADVOCACY ACTIVITIES

In order to achieve objectives lobbying, advocacy and fund raising activities in general must be improved and developed coherently and transversally. The adoption of English as the only language of communication, internal and external, will facilitate many activities: communication in loco, event organization, public relations promotion and contact with the media. It will also be helpful in fulfilling one of the aims of Doctors with Africa Cuamm - to act as a channel for passing on, disseminating information - as it will encourage production of periodical reports, evaluations of activities and reports on applied research which can be published both at national and international levels in order to encourage comparison and exchange, sharing and learning from others.