



REALMEDICINEFOUNDATION.ORG

# **Liberating Human Potential**

AFRICA • AMERICAS • ASIA • EUROPE

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# HISTORY AND MISSION

**Real Medicine Foundation** was founded in May 2005 inspired by lessons we learned after working for months in the Asian Tsunami relief efforts. Real Medicine Foundation provides humanitarian support and development to people living in disaster and poverty stricken areas, and continues to help communities long after the world's spotlight has faded. We believe that 'real' medicine is focused on the person as a whole by providing medical/physical, emotional, economic and social support.

We listen, learn, and support the long term whole health of communities most in need, and commit to projects where we will make lasting change. We believe in the human ability to transform — that the people in developing and disaster stricken areas are most capable of creating solutions to their unique challenges. We employ, train and educate locals, producing innovative solutions and strong communities that sustain and grow (health care) capacity, enlisting cutting edge technology and modern best practices. We ignite the potential of the people we are supporting — turning aid into empowerment and victims into leaders.

RMF's first years after inception were characterized by emergency responses to the succession of natural disasters in 2005 and 2006. It was our experience gained in the field that laid the foundation for what drives the organization today and that gave birth to our flexible and sustainable in-country strategies.

Based on today's best practice Modern Medicine, RMF utilizes a Comprehensive Integrative Health Care Model. Once survival and immediate health care needs are addressed, we establish mobile and stationary health clinics employing regional medical doctors, other healthcare professionals and supporting staff, and tailoring them to local needs. Using these clinics as hubs, we implement additional modules of care that address the priority needs of the region being served. Programs such as Maternal Child Healthcare, Malnutrition Eradication, HIV/AIDS Care, Malaria Treatment and Prevention, mHealth, and Vocational Training and Livelihood projects are introduced to build on the existing infrastructure already in place. These programs, addressing some of the developing world's most important issues, are part of RMF's commitment to treating the whole person. By staying for the longer term and by working with local staff and resources, we ensure long term sustainability, local ownership, and capacity building. Since 2009, responding to needs presented to us, RMF has developed and implemented strategies for access to secondary and tertiary care, i.e. support and upgrade of hospitals and training of medical personnel, to build health care capacity and to strengthen health systems on a larger scale. At home in the US, RMF conducts healthcare and education outreach programs in South Los Angeles.

Real Medicine Foundation's vision is to move beyond traditional humanitarian aid programs by creating long-term solutions to health care and poverty related issues. By empowering people and providing them with the necessary resources, we pave the way for communities to become strong and self-sufficient. In just nine years, Real Medicine Foundation has worked in 18 countries on 4 continents, with active projects in 14 countries, and has aligned with governments, international agencies, including the UN, to reach those most in need. In 2011, RMF was granted United Nations Special Consultative Status and PVO Status with USAID. In 2014, RMF was made official Implementing Partners by UNHCR in Uganda for a large Refugee Healthcare Program at the Kiryandongo Refugee Settlement, and by UNICEF in South Sudan for a Malnutrition Treatment, Prevention and Outreach Program in Jonglei State. Real Medicine Foundation is a US-based non-profit public charity, headquartered in Los Angeles, California, with branches in the UK and Germany, and with offices and partners all over the world.



Refugee children enjoying a RMF sponsored circus performance in Uganda

# YEAR IN REVIEW

## Dr. Martina C. Fuchs, Founder and CEO

### Paradigm Shift.

Looking back on 2014, I proudly see RMF's body of work and impact around the world increasing. We have expanded existing programs and started new initiatives and new partnerships such as being implementing partners for UNHCR in Uganda and for UNICEF in South Sudan, and we have welcomed many new team members to our growing RMF family. RMF's specific approach works and is gaining momentum: Liberating Human Potential. Empowering Local Leadership and Encouraging Local Ownership. We have continued to create new and innovative models and solutions and to build solid capacity in the communities we are serving. I also see that our approach is part of an urgently needed paradigm shift in humanitarian aid and development and has to happen on a much larger scale.

Here are just some of the current global facts:

Despite billions of dollars of investment in aid, global poverty is getting worse, now at 3.5 billion people, nearly half the world's population, with around 500 million more people added to the ranks of the extremely poor since 1981. The Millennium Campaign uses a poverty line of \$1.25/day. But in many countries this is not adequate for human existence, let alone for human dignity. In India, children living just above this line still have a 60% chance of being malnourished. 100 million children are estimated to be underweight in developing countries, with serious consequences for their growth and development. 800 women die every day from preventable causes related to pregnancy and childbirth; 99% of these deaths occur in developing countries. If people are to achieve normal life expectancy, the current poverty line has to be tripled, a minimum of \$3.70/day.



Building capacity in the countries and eventually, self-sustainability without dependency – has that really been the purpose of humanitarian work on a large scale? Or is it actually much more self-serving, keeping a lot of people in their jobs and in business? Fact is that the wealth ratio between the richest and poorest countries keeps growing. In 1973 the gap was 44:1. Today it is nearly 80:1. Inequality has reached such extremes that now the richest 67 people in the world have more wealth than the poorest 3.5 billion.

International development is failing because it fundamentally misses the point about poverty. It assumes that poverty is a natural phenomenon, a problem that exists out there. This view lends itself to technocratic interventions led by 'experts' in development 'science'. On a more popular level this approach manifests as quick-fix fads like merry-go-round water pumps, deworming campaigns, microfinance and laptops for children – projects that avoid thinking about the political context of impoverishment. It allows people to feel they are fixing the problem of poverty without ever having to confront power, or challenge the tenets of the prevailing economic order.

The present crisis presents a monumental opportunity to allow development as we know it to wither away and leave space for the evolution of a new approach: an approach framed not in terms of charity but in terms of justice, and focused not on symptoms but on systems. And in the frame of this systems change values have to be reevaluated. Are we really treating each other as a global human family, with respect, dignity and compassion for each other? Are we allowing each other equal access to the resources on this planet, acknowledging that every single human being is valuable and deserves to live a life of dignity?

Here at RMF we firmly believe with Nelson Mandela, "It always seems impossible until it is done". In this spirit: We believe that a paradigm shift is possible in our lifetimes. And we will not rest until it is achieved.

There is little we cannot do if we do it together.

Sincerely,



# INDIA

## INITIATIVES ■ Malnutrition Eradication & Treatment ■ mHealth ■ Digital Green Video Partnership

**66 Local Staff across 600 villages**

**64,305 Village & Family Nutritional Training Sessions held in 2014**

**196,376 Individuals counseled at special Family Sessions on Malnutrition Prevention and Treatment in 2014**

**36,230 Children's condition improved directly since program began because of RMF's intervention**

**3,224 Children received Lifesaving Treatment since launch of program**



RMF CNE conducting Malnutrition Education Outreach Session

### Malnutrition Eradication & Treatment

RMF's Childhood Malnutrition Eradication Initiative has the largest field presence of any NGO working in malnutrition in the region, a result of strong partnerships with government, NGOs, businesses, and most importantly, local communities. Into its fifth year, our program continues to go strong. Our team of 60 Community Nutrition Educators (CNEs) and 6 District Coordinators are covering enormous ground every week across 5 districts and 600 villages in Madhya Pradesh. According to the Government of Madhya Pradesh, RMF's target districts of Jhabua, Alirajpur, Barwani, Khargone and Khandwa face Global Acute Malnutrition rates exceeding 30%, or more than twice the rates the WHO would classify as critical in emergency settings. Our strategy continues to be closing the gap between the resources available and the families who need them by focusing on the basics of malnutrition awareness, identification, treatment, and prevention and inserting simple, but innovative technologies and practices.

#### **2014 Update:**

During 2014, RMF in India continued to work with communities and also worked towards positioning our program for scale. In addition to the local partnerships built over the past 4 years, RMF's work was also recognized internationally, and in June 2013 was accepted into the World Bank's 2013 Development Marketplace as an innovative social program. With this award, RMF is positioned for scale in other districts of Madhya Pradesh and other states in India, having received specific interest to implement our program in the State of Bihar.

### **mHealth – Utilizing Technology to Make our Program More Effective and Adaptable**



CNE measuring the MUAC of a child

Since July 2011, RMF's CNEs have collected data on recovery rates, referrals, and demographics of over 8,000 children in our target communities. Armed with this information, RMF is currently in the process of analyzing trends from the data in order to gain a better understanding of malnutrition in Madhya Pradesh. Once completed, relationships between gender and age and malnutrition, success of referrals and NRC treatments' impact on recovery rate, relapse rates, mortality, and length of recovery will be available. In addition to this comprehensive study of the data, RMF's CNEs continue to use CommCare daily to aid in referrals, counseling, and child tracking.

RMF's database of over 8,000 children suffering from acute malnutrition is one of the most comprehensive efforts to track children suffering from acute malnutrition in Madhya Pradesh. Data analysis of this information will provide valuable insights into malnutrition in Madhya Pradesh, and India, and play a crucial role in developing strategies for RMF's plans to scale and target larger populations.

# INDIA

## INITIATIVES ■ Malnutrition Eradication & Treatment ■ mHealth ■ Digital Green Video Partnership

### Summary of accomplishments over the past year:

- 9,869 children with SAM (Severe Acute Malnutrition) identified and families counseled; 15,250 since the program began in 2010.
- 19,387 children with MAM (Moderate Acute Malnutrition) identified and families counseled; 36,174 since the program began in 2010
- Overall improvement in 36,230 identified children since 2010.
- 554 children received lifesaving treatment at Nutritional Rehabilitation Centers in 2014 (NRCs); 3,224 since our program began in 2010.
- 7,990 village nutrition training sessions conducted in 2014, with over 103,056 people in attendance. 550,542 individuals from rural villages have received training on malnutrition awareness and prevention by attending family and community counseling sessions in their villages since 2010.
- 205,763 family counseling sessions and 18,971 community counseling sessions conducted on topics such as nutrition, public health services, breastfeeding, hygiene and sanitation, food groups, management of diarrhea and safe drinking water.

### Laxraj

In January 2014, Laxraj, a 21-month-old boy from Village Jamli, District Khargone, was identified with SAM and a 11.4cm MUAC by RMF CNE Ranjeeta Rathore. He didn't attend the Anganwadi Centre regularly, thus, he did not get supplementary nutrition. After being identified as SAM, CNE Ranjeeta discussed Laxraj's status with an Anganwadi worker and they decided to meet with his family. They informed Laxraj's parents about the causes and consequences of malnutrition and referred him to a NRC at Khargone District Headquarters. Laxraj was admitted and stayed there for 14 complete treatment days.

Following treatment at the Nutrition Rehabilitation Centre, Ranjeeta and the Anganwadi worker visited Laxraj and observed changes in the child. Not only were his MUAC measurements showing signs of improvement, but his weight had also gone up to 6.89kg from 6.465kg. Though Laxraj's health status had improved, he wasn't out of danger yet. His condition started deteriorating when Laxraj's family moved away from his grandparents' home and his mother started working in the fields as a laborer. On February 10, RMF CNE Ranjeeta went for a follow up and found Laxraj's MUAC at 11.6cm. She asked his mother about her feeding practices, and found that, although she was breastfeeding, he was not receiving any complementary foods, such as semi-solid foods of rice or lentils, appropriate for his age and necessary for his growth. Ranjeeta counseled his mother on complementary feeding and continuous breastfeeding.



Laxraj having his MUAC measured



Laxraj and his mother at the Anganwadi Centre

In March, Ranjeeta visited again on *Suposhan Abhiyan*, the Village Health and Nutrition Day, and took a MUAC measurement which was 11.7cm. She counseled his mother again. Subsequently, Ranjeeta conducted follow up in April and May 2014, she found his MUAC was improving, moving to 11.9cm in April and 12.1cm in May. In June, when Ranjeeta went for a follow up, she found that Laxraj was suffering from diarrhea. Ranjeeta, with support from a local ASHA, provided ORS and Zinc tablets to his mother and counseled her on prevention and management of diarrhea. This time Laxraj's MUAC was 12cm. In the next follow up visit on July 14, Ranjeeta found that the child wasn't going to the Anganwadi Centre regularly since his mother had to attend to her daily field work during the daytime.

CNE Ranjeeta and an Anganwadi worker then met with Laxraj's grandmother and asked her to support her grandson in his recovery from malnutrition. After a long discussion she was willing to look after him during the daytime. After resolving some interpersonal issues between the mother and grandmother, Ranjita started conducting regular follow up visits of the child. Through close

monitoring that the CNE conducted in August and September, she found that Laxraj's MUAC had gone up to 12.6cm.

At this stage, the CNE counseled Laxraj's mother about family planning. She also reiterated the importance of supplementary nutrition, hygiene and sanitation, public health facilities, balanced diet, etc. Finally, Laxraj's family started adopting healthy behaviors and always followed health workers' guidelines. In the last visit Ranjeeta undertook in October 2014, Laxraj's MUAC was 12.7cm; he had fully recovered from malnutrition. 6

# INDIA

## INITIATIVES ■ Malnutrition Eradication & Treatment ■ mHealth ■ Digital Green Video Partnership

### Prateek and Savan

On April 4, RMF's Khargone DC, Auntim Gupta, alerted the RMF team about a severe case of malnutrition in Galtar village of Jirnia block, Khargone. RMF's CNE, Neelofar Mirza, had been working with a family of four for months, and both parents refused to take the children to a hospital for care; both due to constraints at home but also, more alarmingly, because they did not trust the care provided by the government system.

Both of the children, Prateek (5 years, 11 months old) and Savan (34 months) were suffering from SAM and an undiagnosed respiratory tract infection. Their parents were aware of the gravity of the situation, and had consulted many of the local medical practitioners, including a traditional healer and an unlicensed medical provider. They had spent significant money trying to improve their children's conditions. The medical practitioner had given the children vitamin supplements, and the traditional healer had performed a ceremony sacrificing livestock in an attempt to cure the children. Clearly, the family was willing to work towards the improvement of the children, but not willing to travel the two hours to Khargone to spend 14 days in the NRC, a story RMF's CNEs are very familiar with.

Auntim did not let this matter rest, however. Together with senior staff, Auntim met with the Chief Medical and Health Officer (CMHO) of the district to mobilize government health staff. After sharing photos and the details of the children, the CMHO dispatched a local help supervisor and ambulance to Galtar to meet the family. The RMF team was not far behind.

Upon arriving in the village, the magnitude of the children's malnutrition became apparent. With a MUAC of 7.0 and weighing just 5.48 kg, Savan was one of the most severe cases of SAM ever identified by RMF CNEs. His brother, also SAM with a MUAC of 10.7, was suffering from SAM for a second time. When speaking to the parents about Prateek, it became clear why they refused to go to the NRC: on every trip to the district hospital, the family had been mistreated, ignored, or even chastised, and they did not want to return to a facility that not only failed to treat their son, but also cost them time, comfort, and took them away from their support structure.



Savan recovered



Prateek upon admission

After sitting with the family, Neelofar made progress. Prateek had been one of her first referrals, and now, armed with 3 years of experience, she was able to confidently address all of the families concerns. Auntim, now familiar with the entire district health setup and all of the hospital staff, assured the family that their previous experience was an anomaly. After several hours of counseling, the family reluctantly agreed to go to the NRC.

Once in the Khargone District Hospital, the staff of the new NRC immediately rose to the occasion. The new pediatrician immediately visited the family and calmly diagnosed both children, attributing their severe malnutrition to TB, one of the more common malnutrition co-infections. He counseled the family, informing them of the duration of the treatment required, the protocol they needed to follow to treat the TB, the side effects, and a detailed explanation of every treatment the NRC was providing. Although this seems basic, overburdened health staff often does not have the time to provide this standard of care. In addition, Auntim and Neelofar worked out a schedule to visit the family twice a day to provide psychosocial support, address their concerns, shop for them in the local market, or communicate updates back to their family in their village.

Two weeks later, both children were stabilized and discharged from the NRC after achieving their target weight gain. Once back in their homes, the children were regularly visited by the Anganwadi worker to monitor their weight gain and report any problems to RMF and the local government health staff. The family is adhering to their TB treatment and, although they have a long way to go, both children are on the road to healthy lives.

# INDIA

## INITIATIVES ■ Malnutrition Eradication & Treatment ■ mHealth ■ Digital Green Video Partnership

**15 Local Staff across 100 Villages**

**40 Videos produced in Local Languages on Nutrition and Health Related Topics**

**3,587 Screenings conducted in 100 Villages**

**12,478 Households reached with Video Screenings**

**6,667 Adoptions from Video Content among 5,131 Unique Viewers; Total Adoption Rate of 60.7%**



RMF CNE speaking at a Family Counseling Session

### Video Screenings and Adoptions of Practices

Reaching poor communities with health education is one of our biggest challenges. Often, the families have very low literacy, and even less when it comes to health and nutrition knowledge. Although there are many resources available to prevent malnutrition in India, one of the largest challenges our team faces is helping people access these services.

In 2010, RMF started a massive campaign to help educate communities using our Community Nutrition Educators (CNEs) to reach individuals with interpersonal communication and intensive family counseling in their homes. We also developed low literacy tools, such as illustrated flipbooks and mobile phone counseling applications, to help increase the efficacy of our messages, and beginning in 2013, we began piloting films as an additional educational tool.

In October 2013, the RMF team started to include movies into our outreach work. We partnered with Digital Green (DG), an Indian based non-profit that specializes in the production, screening, and dissemination of films in the community, and started filming locally specific movies about malnutrition, its causes, treatment, and how to prevent it. In late 2013, RMF's team in Khandwa had produced 12 videos on topics such as: Severe Acute Malnutrition (SAM), Moderate Acute Malnutrition (MAM), services available to treat malnourished children, and best practices to prevent malnutrition and promote healthy growth such as proper Infant and Young Child Feeding Practices (IYCF), sanitation and hygiene, and immunizations.

Using a small projector, roughly the size of a Smartphone, our CNEs began screening these movies in 50 different villages. RMF uses three types of screenings: smaller "cluster" screenings with mothers' groups and individual families in their homes, larger "community" screenings in the evening that include the fathers of the children, and "sector" level screenings to introduce our concept to government workers. Each of these videos is scripted by RMF's CNEs in the local languages of the area, Kurku and Nimari, and filmed with local community members and the CNEs themselves.

Once the movies are produced and screened, RMF collects information on how effective our message is by tracking adoptions of behaviors outlined in each film, such as bringing a SAM child to a treatment facility or timely initiation of breastfeeding. Details of these adoptions, the number of screenings, and the number of attendees are entered into DG's COCO (Connect Online/Connect Offline) server that helps track the number of videos produced, screened, the total audience, and which audience member has adopted practices from each video.

With this technology, we can target our messages very effectively, and also adapt the messages that are more difficult for communities to understand. In May 2014, a secondary training was held on dissemination and adoption verification to reinforce proper video screening and behavior change messaging as well as introduce new formats for knowledge recall adoption verification. Since the introduction of these tools, RMF has seen the adoption rate quadruple in our target areas, with over 30% of viewers practicing promoted behaviors either through direct practice or through increased awareness.



Mother and child beneficiaries of program

# INDIA

## INITIATIVES ■ Malnutrition Eradication & Treatment ■ mHealth ■ Digital Green Video Partnership

### 2014 Update:

Over the course of 12 months from October 2013 through September 2014, RMF:

- Produced 40 videos on topics ranging from malnutrition and treatment, available government services under the Integrated Child Development Services (ICDS) and National Rural Health Mission (NRHM), sanitation and hygiene, and appropriate Infant and Young Child Feeding Practices (IYCF).
- Conducted 3,587 total disseminations across 100 target villages with 12,478 viewers attending these disseminations.
- Recorded 6,667 total adoptions from video content among 5,131 unique viewers with a total cumulative adoption rate of 60.7%.

### Case Study

Vijay, a farmer, lives in Maidarani village with his family, including a child of 18 months. Maidarani, a small village with a population of approximately 500 people, comes under tribal block Khalwa which is located at a distance of 60 kilometers from District Headquarters. The people of this village belong to the Korku tribe.

Savitri, one of RMF India's CNEs, was on her routine field visit in her area and was supposed to screen a community oriented behavior change video on "Hygiene and Sanitation" at this village of Maidarani. Following her micro plan, she pulled together 4-5 households as audience for the activity. Before she screened the video, she set the tone and initiated a discussion around problems that villagers face with respect to hygiene, sanitation and safe drinking water and its storage. After having screened the video successfully, our CNE facilitated a follow-up discussion with the group of men and women present there. Vijay was also part of the audience. He watched the video and went back home. He discussed the content and messages received from the video with his wife. They decided to make arrangements for keeping their drinking water safe. They also got a stand put up for keeping their drinking water vessels safe and clean.



Vijay, Ritu and their son

After a fortnight, Savitri, our CNE, went back to the village to track adoptions related to the video she had screened. Savitri also met Vijay and wanted to understand if there was an impact of the video messages that were delivered. During their interaction, Vijay observed that, "these videos are creating a greater awareness on Hygiene and Sanitation to our community as people here are not much aware about these issues."

Vijay watched the video on "Hygiene and Sanitation" and understood that storage of water for safe drinking was one of the important aspects of maintaining hygiene. Immediately, he built a two feet high platform to keep the drinking water brass pots/vessels at his home.

Ritu, Vijay's wife was finding a huge difference in the quality of drinking water after a safe platform was constructed for keeping the vessels. Now, because the platform was high, they could maintain required cleanliness there. Children, too, were not able to reach the place and put their unclean hands into the pot for fetching water. Ritu understands that this practice would protect the entire family from water contamination. The couple feels that they are very lucky to get this piece of information through videos as their son was growing, looking at their son Krishna, who is 18 months old.



Clean Water Stand set up by Vijay in his home

# INDIA

## INITIATIVES ■ Adolescent Girls Outreach Program

### Focusing on Adolescent Girls in Madhya Pradesh

#### Adolescent Girls Outreach Program

RMF's outreach workers (Community Nutrition Educators, CNEs) for our Malnutrition Program cover 600 villages and counsel pregnant and lactating women on their diet and care in addition to the mothers and families of malnourished children. The counseling of adolescent girls however remains a critical gap in the community, both in general reproductive health as well as nutrition.

Since malnutrition in Madhya Pradesh (MP) does not exist in a vacuum, RMF's team in India in 2012 started thinking of new ways to reach these girls. After discussion with the UNICEF District Coordinator in Khargone, RMF devised a way to expand our intervention and decided to design a workshop for adolescent girls. In India, "adolescence" is not a homogenous category – as there are school going adolescent girls as well as those who have dropped out to work at home or in the community, or to get married. Girls in rural India are given little information about the physical, emotional, and social changes that go along with puberty and adolescence, yet proper education and guidance during this developmental phase has critical implications that affect individuals, families and entire communities; RMF has developed a series of workshops to empower adolescent Indian girls and turn them into community leaders, breaking the cycle of poverty and establishing a model for women's rights in India. In our pilot workshop, we decided to work with the girls in the middle schools and high schools in the villages in MP we are working in.



Adolescent Girls gathered for Education and Outreach session

#### **2014 Update:**

In an effort to launch this program on a wider scale, RMF turned to the crowdfunding platform Catapult, which focuses on projects for girls' and women's rights and development. "Reaching out to educating adolescent girls is one of the first steps to ensure safe motherhood and improved and better childhood. Through the Catapult interventions, we aim to empower adolescent girls keeping in mind their physical, emotional and social transition from adolescents to accepting the challenges of being healthy mothers." RMF's proposal was successfully funded in August, surpassing our goal of \$19,416 by \$1,000, which will be used to cover operational expenses. In anticipation of the official project launch in early in 2015, RMF Director of Programs, India, Prabhakar Sinha, briefed senior management staff and coordinators at the district level on the mandate and design of



RMF CNE speaking to a gathering of Adolescent Girls

the project. District Coordinators (DCs) have been tasked with gathering additional data from India's Tribal Welfare Department and Education Department to confirm the exact number of schools and girls the program will target and how many trainers will be required to complete the education sessions. The RMF India has started to conduct Training of Trainers (TOTs) sessions; to develop, finalize and produce BCC materials; and to implement the monitoring and MIS system. So far, the feedback has been extremely positive among the DCs and CNEs:

"Following the sequence of life-cycle approach, adolescents' sensitization on their own health is much more important than reaching out to pregnant & lactating women. This is a group that faces vulnerabilities of malnutrition, anemia, hygiene and sanitation, that can drag them through their entire reproductive life-span and thereafter." Deepmala Cholkar, DC, Khandwa

"Educating adolescent girls is like empowering future mothers." Savitri Kajle, Community Nutrition Educator, Khandwa

"I am quite excited to take the project for a roll-out. In this tribal region, looking at the vulnerability of women in general, this is a special intervention". Rakesh Dhole, Project Manager, RMF India

"Nice to be part of such a futuristically appropriate program that would prepare adolescent girls for accepting the challenges of motherhood and would deal with the myths and misconceptions of their minds." Radha Chouhan, District Coordinator, Barwani

# PAKISTAN

## INITIATIVES ■ Primary and Secondary Health Care ■ Maternal Child Health Care ■ MNCH Research Studies

**11,857 Patients treated at Nowshera MCH Center**

**Ultrasound and Pathology laboratory**

**2,500 Individuals reached with Food Drive for IDPs**

**MCH Study launched in Balochistan**



RMF's new MCH Center in Nowshera, Pakistan

### Background

RMF opened its offices in Pakistan in response to the devastating 2005 earthquake that killed more than 80,000 people in Northern Pakistan and left millions in this remote Himalayan valley with no access to shelter, food and healthcare. For the next 6 years, the RMF primary health clinic in Talhatta remained the only source of quality healthcare for 150,000 people in the area from 6-7 Union Councils in District Balakot. With an average OPD of 200 patients per day, our Lady Health Visitors (LHVs) remained the only source of reproductive healthcare for the women of this area until the government of Khyber Pakhtunkhwa was able to rehabilitate and revitalize its health facilities.

In July 2010, the flooding of the Indus River Basin at an unprecedented scale inundated nearly one-fifth of Pakistan's total land area, directly affecting 20 million people mostly by destruction of property, infrastructure and livelihood. RMF's response to the floods was focused in KPK and Sindh, the latter involving an Outreach Mobile Health Unit that accessed nearly 6,000 men, women and children in remote parts of Tehsil Dadu with primary health care and clean drinking water. RMF's intervention in the province of KPK was extensive; with funding from Google Inc. and APPNA our intervention began with relief work in form of 12 free emergency medical camps in the immediate aftermath of the floods which provided healthcare to more than 20,000 men, women and children. With the immediate crisis under control, the KPK Health Department was then and still is faced with a new crisis of Internally Displaced Persons (IDPs) who are made refugees in their own country, driven out of their homes due to the ongoing Taliban militancy in the northern tribal areas of Pakistan. IDPs have sought refuge in surrounding districts including District Nowshera where their health needs are met by a cluster of CSOs and NGOs under the umbrella of the WHO.

### MCH Health Center in District Nowshera, Province KPK

Nowshera has a population of 310,899 IDPs housed in host communities and Jalazoi Camp which is the largest IDP camp in Pakistan with a population of 75,595 (Jalazoi Camp Profile September 2013). Nowshera (also locally known as "Naw" "khaar") is one of the most historical and important districts of Khyber Pakhtunkhwa (KPK). It is bordered to the West by Peshawar, to the Northwest by Charsadda and Mardan, to the East by Swabi and to the Southeast by Attock Districts. With a total area of 1,748 square km, it is divided into two Tehsils (Pabbi and Nowshera) and 47 Union Councils.

The health department of District Nowshera which has an infrastructure designed to serve a population of 1.4 million, is now overwhelmed with an increased population of nearly 1.9 million. This added pressure has been eased by a cluster of NGOs under the umbrella of the WHO. Having successfully provided primary healthcare services in District Charsadda for three years from 2010 to 2013 in the Union Councils of Gulbella and Agra that provided quality healthcare to 41,529 disaster affected poor and vulnerable men, women and children, RMF was invited by the WHO cluster to join hands in addressing the health needs of internally displaced persons in the refugee camps and host communities in any of the above mentioned host districts of KPK. RMF is now a member of this cluster and plays a key role in addressing the gap in MCH care for the women and children of the IDP community.



Brother and sister at the health center pharmacy

### Program Structure

On October 1<sup>st</sup>, 2013, Real Medicine Foundation leased a site in Union Council Taru Jabba. The space available proved to be insufficient for the proposed MCH center. With funds from generous philanthropists from London the existing building was expanded to increase the rooms and utility area. With the construction complete within 5 weeks, the center opened its doors in the last week of November 2013. By January 2014, a Micro-lab, a machine to carry out routine pathological investigations in the field was introduced, making our center the first of its kind to provide 11

# PAKISTAN

## INITIATIVES ■ Primary and Secondary Health Care ■ Maternal Child Health Care ■ MNCH Research Studies

in-house pathology investigations, taking the quality of services to a higher level. The goal of our center is to improve the health of the IDP women and children, living in Union Council Taru Jabba as well as the surrounding areas, thereby contributing to the KPK Government’s mandate to address the immediate needs of this vulnerable group with their repatriation to their homes being the ultimate goal.

In 2014, 11,857 patients were diagnosed and treated at RMF’s Nowshera Health Center for a variety of medical conditions. In this reporting period, 1,847 women came for antenatal and postnatal visits respectively. A total of 4,350 women visited the center for gynecological problems. The pathology lab became operational in January 2014 and conducted a total of 1,976 routine investigative tests.



Lady Health Care Workers attend to women



Equipped pharmacy and testing lab



Doctor and pediatric patient

### Ultrasound donation to Nowshera MCH Center

With an average of 250-300 women seeking antenatal care at our health center per month, the need for ultrasound was imperative. A fundraising call was made to our supporters worldwide, and it is with great pleasure to say that we have met our goal. Mr Anwar Khan, a UK-based philanthropist networked on behalf of RMF and raised the requisite amount to purchase an ultrasound machine. Following the protocols of procurement and quality, the said machinery was purchased and installed in RMF’s MCH Center in November 2014, making our health center the only health facility to offer ultrasound facilities within the NGO/CSO implemented health facilities in Tehsil Pabbi of District Nowshera for the IDPs and surrounding host communities. The local THQ hospital in Nowshera has an ultrasound facility but it is plagued with long queues and complaints of long ‘out-of-order’ periods for lack of maintenance. Similar facilities are found in the private sector but at a substantial fee.

We formally inaugurated our ultrasound facilities, the first of its kind within the area, in December 2014. Our LHV has an additional qualification as a Medical Sonographer and began seeing patients immediately. The introduction of ultrasound at our MCH Center has been shared with the WHO Health Cluster members as well as with the surrounding health care facilities, both in the private and public sector. Housed in the LHV office within the center, the only setback of this facility is that the use is limited to the times when electricity supply is available, which often is only half the day. Frequent load-shedding of electrical power to the center is a common occurrence as it is across the country as Pakistan is facing a serious energy crisis.

### Bannu IDP Food Initiative

#### Background

Waziristan, a mountainous region of northeast Pakistan is one of the thirteen semi-autonomous Federally Administered Tribal Areas (FATA) governed by Pakistan’s Federal Government through a special set of laws. It is divided into North and South Waziristan. Geographically, Waziristan’s southern border lies with District Bannu, Tank, Lakki Marwat and Dera Ismail Khan in KPK while its northern border is the porous line of boundary with Afghanistan. For the past decade, Waziristan has been in the global focus for Taliban militant activities and targeted drone attacks. South Waziristan was rid of Taliban by a military operation in 2009 leading to North Waziristan becoming the cloistered seat of the Taliban.

After months of unsuccessful peace talks, the Pakistan Army launched an offensive in North Waziristan titled Zarb-e-Azb on June 15<sup>th</sup>, 2014 that has led to the displacement of 92,702 families (over 800,000 persons) in just one month. According to the FATA Disaster Management Authority (FDMA), nearly 74% of these IDPs are women and children and the majority of these families are residing in Bannu District with some moving to Dera Ismail Khan and Tank and Kohat Districts.



Preparing the food in Bannu

# PAKISTAN

## INITIATIVES ■ Primary and Secondary Health Care ■ Maternal Child Health Care ■ MNCH Research Studies

According to OCHA (United Nations Office for the Coordination of Humanitarian Affairs), most of the IDPs are living with friends and families, many having opened their ‘hujra’ doors to these families. This also means that the house rents have shot up, further adding to the woes of the IDPs. The government established a refugee camp in Bannu that has attracted only 28 families due to its inadequate facilities and security.

Our needs assessment team determined that although food rations were welcome, many IDPs had no cooking utensils as most had to flee for their lives without their possessions. In the month of Ramadhan, their immediate need was cooked food for the two times of eating, i.e. Sehri and Iftar. With generous Zakat donations by Muslim brethren in Pakistan and the UK, RMF launched the “RMF Iftar Dastarkhawan” on the 10<sup>th</sup> of July 2014. A local philanthropist, Mr Ismail Khan, generously opened his residence (called ‘Hujra’ in local language) as the premises of this food initiative. In the first six days from July 10-15, we provided chicken rice pilau, dates and juice to a total of 690 IDPs (approximately 115 persons per day).



Men, Women and Children served



Sit down community meal



Long lines on the first day of RMF's food initiative

During that week, we learned that most of the IDPs we saw were men and boys, as the cultural norm dictated that women and girls were to stay out of the public space. This meant that most women and children, especially girls, were not being accessed and thus did not receive food. As per this very strict, patriarchal culture, the practice that men and boys eat first and leftovers are for the women and girls was also exhibited by the fact that after the dastarkhawan the attendees would ask for packets to take home to their families, a fact beyond our budget. Therefore, we decided not to serve the food on site and instead distribute the cooked food in packages to families sufficient for an average of 5-6 persons. Hence the remaining days of Ramadhan, July 16-29, 2014, we distributed the same food menu in packages to an average of 25-30 families per day. The total number of people served with cooked food under our Food Initiative for IDPs in Bannu has been approximately 2,500 over a period of 20 days at an average of 125 persons per day. Of these, 74% (1,850) were women and children (15 years and younger) and the remaining 650 were men.



Children in the second week of food initiative



Girls and boys gathered



A family with supplies



Children in the third week of food initiative



More children from third week



Sisters gather during the last week

# PAKISTAN

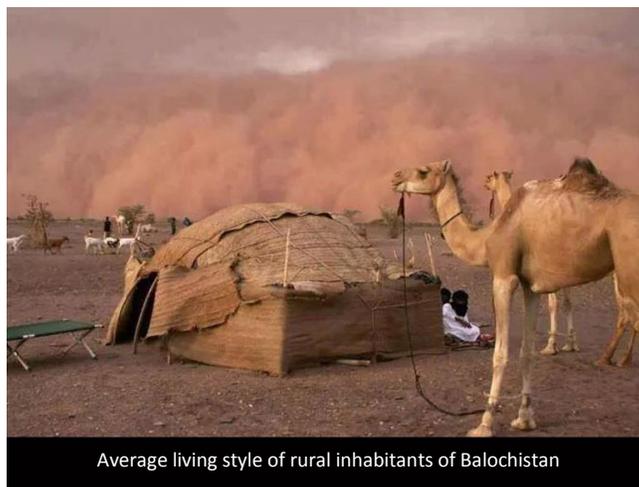
## INITIATIVES ■ Primary and Secondary Health Care ■ Maternal Child Health Care ■ MNCH Research Studies

### Mother, Neonatal and Child Health (MNCH) Research Projects

#### Background

With a maternal mortality rate of 297/100,000 live births; Pakistan is one of the six countries estimated to contribute to half of all maternal deaths worldwide. In 2011, RMF Pakistan became the implementing partners for the School of Public Health, University of Alberta, Canada to research and identify innovative, contextually specific solutions to the many problems the poor and marginalized Pakistani women face. The aim of our research findings is to provide empirical evidence for the formulation of maternal health policies and health care system practices in Pakistan.

Two qualitative studies on Gender, Class and Social Exclusion were launched in three districts of Punjab in 2011. The aim of the first research study in District Chakwal, funded by the Canadian Institute of Health Research (CIHR) was to explore the role of class and gender inequities on the design and delivery of maternal health services in Pakistan and is still underway. The second research project in Districts Jhelum and Layyah, funded by the Research Advocacy Fund (RAF), aimed to evaluate if Community Midwives are fulfilling the government objective of improving access to the full scope of skilled maternity care for poor, disadvantaged and marginalized women came to a successful end in December 2013.



Average living style of rural inhabitants of Balochistan

A new research study has been launched in the districts of Quetta, Gawadar and Kech in the Province of Balochistan.

#### 2014 Update:

##### Update on previous studies

Our RAF funded research study conducted in Districts Jhelum and Layyah of Punjab Province titled “*Are Community Midwives Addressing the Inequities in Access to Skilled Birth Attendance in Punjab, Pakistan? Gender, Class and Social Exclusion*” has been published and is available on the RMF as well as the RAF website. Policy recommendations were made based on the research findings and shared extensively with key stakeholders at both national and international levels which led to extensive discussions on different platforms. Academic papers on the research findings for publication in relevant literary journals are in the pipeline.

The research study titled “*Addressing Disparities in Maternal Health Care Services in Punjab: Poverty, Gender and Social Exclusion*”, funded by the Canadian Institute of Health Research (CIHR) and conducted in District Chakwal of Punjab Province has come to a successful end. Data collection for Module III was carried out over 5 months from May-September 2014 and the subsequent transcription over the last three months of the year. Currently analysis and initial write-up of the research findings are being carried out by the investigating team in the University of Alberta.

##### New research study

A project operations research titled “*Evaluating the Improving Mother and Newborn Health initiative: Are Community Midwives Increasing Quality Essential Newborn and Maternal Care in Quetta, Gawadar, and Kech Districts in Balochistan and are they doing so in a Financially Self-sustaining Manner?*”, conducted within an IMAN (Improving Mother and Newborn Health) initiative, a USAID funded project implemented by Mercy Corps in the districts of Quetta, Gawadar and Kech in Balochistan Province was awarded to the University of Alberta in early 2014 and is being implemented in Pakistan by RMF.



Arid desert turns into Indian Ocean

#### Background

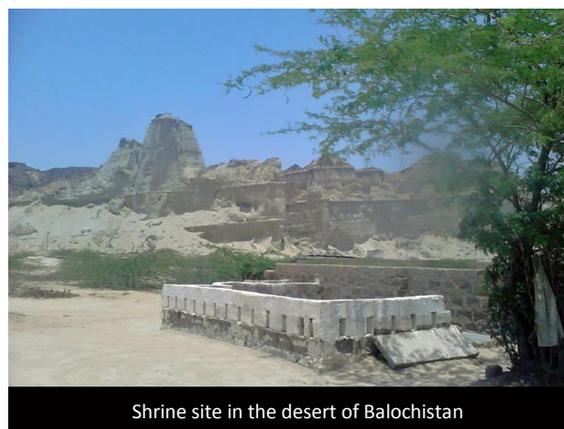
The Balochistan Province of Pakistan constitutes 44% of the country’s territory with only 5% of the nation’s population, and thus experiences unique problems of health services delivery; it also boasts some of the highest statistics of MMR and IMR. The government health department has attempted to address this problem with a new cadre of grassroots level health providers called Community Midwives (CMWs). However, recent research shows that these CMWs have largely failed to establish midwifery practice and attract patients. A number of reasons have been identified for this failure which include, but are not limited to: 1) community, in particular women’s, lack of trust in CMWs’ capacity to conduct

# PAKISTAN

## INITIATIVES ■ Primary and Secondary Health Care ■ Maternal Child Health Care ■ MNCH Research Studies

safe births; 2) the CMWs' lack of interest in pursuing midwifery practice, partly because they are unable to meet its professional demands in terms of time and resources. For example, the young CMWs cannot travel to patients' homes without a chaperone, a woman during daytime and at least two additional men during night visits; 3) the CMWs' lack of business skills necessary to establish a private practice; and 4) the CMWs' lack of financial resources that are essential for development of a practice infrastructure and logistics (Mumtaz et al, 2013).

**Intervention:** To address some of these issues, a USAID funded initiative called "Improving Mother and Newborn Health" (IMAN) has been implemented in Quetta, Gwadar, and Kech Districts of Balochistan by Mercy Corps. The IMAN initiative seeks to increase use of quality essential maternal and newborn care through private sector community midwives (strategic objective) through increased availability of quality maternal and newborn care in communities (IR1); improve knowledge and demand for essential maternal and newborn care (IR2); improve access to emergency transport in remote communities (IR3); and improve the policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research (IR4).



Shrine site in the desert of Balochistan

These objectives will be achieved by enabling the CMWs to establish self-sustaining private practices through provision of business skills and small loans from a micro-finance institute. CMWs will also liaise with LHWs to undertake an awareness building campaign using cellular phone SMS technology and through existing women's support groups. To increase access to emergency transport services, the CMWs will work with their communities to establish a revolving transport fund called the Mamta Fund.

**Operation Research Aims:** The proposed research aims to investigate whether the CMWs in the IMAN initiative are providing the essential maternal and newborn health care to women and children living in remote Balochistan districts of Quetta, Gwadar, and Kech Districts in a financially self-sustaining manner. Specifically the research will investigate: (1) whether the IMAN initiative is having an impact on CMW service uptake; (2) whether the IMAN initiative will enable the CMWs to develop financially self-sustainable practices; and (3) what is the level of quality of care the CMWs are providing?



Small desert town in Balochistan

**Research Methodology:** Data will be collected in three interlinked modules over a 42-month period.

**Module 1** will consist of a pre-post survey. Proportions of births attended by CMWs in the three IMAN initiative districts will be assessed at baseline (2013) and three-year levels (2016) to determine if CMWs' coverage of provision of essential maternity care has improved. This coverage will include intermittent preventative treatment during pregnancy, clean cord cutting, active management of third stage of labor, post-partum visit for the mother, thermal care (immediate drying and wrapping), immediate breastfeeding of newborns, and patient satisfaction levels with their maternity care provider.

**Module 2** will explore if the IMAN initiative has enabled the CMWs to establish self-sustaining practices. Organizational, social, and financial challenges faced by CMWs in establishing and running their practices and attracting new clientele will also be explored in two randomly selected IMAN districts of Quetta and Gwader. A quantitative financial tool will be used to assess the direct and indirect monetary costs as well as opportunity costs and benefits. The size, sustainability and effectiveness of the Mamta Fund will also be assessed.

**Module 3** will explore the quality of care provided by CMWs in Quetta and Gwader. In-depth interviews with CMWs, women of child-bearing age, mothers-in-law, older women, and other community members will be conducted. CMW patient-provider interactions during antenatal visits and childbirth will be observed to document CMWs' quality of care.

**Progress Report:** Module 1 has been completed successfully in all three districts. The baseline survey tools in the local dialects were pre-tested in May 2014 and then data was collected over the next 8-10 weeks. After another two months of data analysis and report writing by the University of Alberta investigating academics, the baseline survey was shared with Mercy Corps. Module 2 is expected to be launched soon.

# PHILIPPINES

## INITIATIVES ■ Disaster relief

### Typhoon Haiyan/Yolanda relief

**2 shipments of disaster relief supplies:  
40 foot container of medical supplies  
2 pallets of WHO medical kits**

### Emergency Supply Delivery/Typhoon relief

#### Background

**Typhoon Haiyan**, known as **Typhoon Yolanda** in the Philippines, was an exceptionally powerful tropical cyclone that devastated portions of Southeast Asia, particularly the Philippines, in early November 2013. The deadliest Philippine typhoon on record, it killed at least 6,000 people in the Philippines alone. The Hong Kong Observatory put the storm's maximum ten-minute sustained winds at 260 km/h (160 mph) prior to landfall in the central Philippines. At 1800 UTC, the JTWC (Joint Typhoon Warning Center) estimated the system's one-minute sustained winds to 315 km/h (196 mph), unofficially making Haiyan the fourth most intense tropical cyclone ever observed. Several hours later, the eye of the cyclone made its first landfall in the Philippines at Guiuan, Eastern Samar, without any change in intensity. The typhoon made four additional landfalls as it traversed the Visayas: Daanbantayan, Bantayan Island, Concepcion, and Busuanga Island. It caused catastrophic destruction in the Visayas. According to UN officials, about 11 million people have been affected and many have been left homeless.

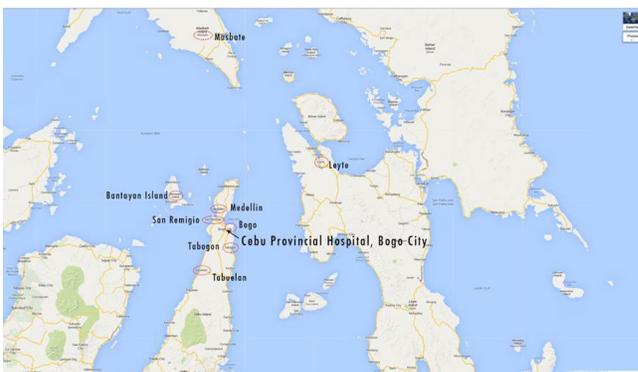
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#### 2014 Update:

Following Typhoon Haiyan/Yolanda's center path of destruction, RMF focused relief efforts on the support of three hospitals in the Visayas: Cebu Provincial Hospital-Bogo City, Bantayan District Hospital and Daanbantayan District Hospital, urgently in need even before Typhoon Haiyan/Yolanda devastated large parts of the islands in early November 2013, and even more critical following the disaster. These health centers function more as Primary Healthcare Facilities than as hospitals and serve a total population of 406,482 (2011) with only 85 available beds.



Families waiting for emergency supplies to be delivered in Visayas



Visayas, Philippines - Focus of RMF Disaster relief



Severely damaged house post-Cyclone Haiyan

#### Cebu Provincial Hospital-Bogo City

The Cebu Provincial Hospital-Bogo City (CPH-BC), formerly known as Severo Verallo Memorial District Hospital, is located about 1km from the heart of Bogo City. A 50-bed facility with an organic physician who specializes in pediatrics, it also has nine outsourced physicians trained in obstetrics/gynecology, internal medicine, family medicine, and general surgery. In addition, it has a dental clinic, managed by a dentist and a dental aide. The hospital has 10 beds for the male ward, 10 for the female ward, 10 for the pediatric ward, 10 for obstetrics/gynecology 7 private rooms, and 3 for the NICU with only one functional incubator. It has one operating room, a lab and an x-ray machine. The residents of three main catchment municipalities: Bogo, Medellin and San Remigio are all served by this facility; it also caters to patients coming from the towns of Bantayan Island, Daanbantayan, Tabogon, Tabuelan, and from neighboring provinces such as Masbate and Leyte.

# PHILIPPINES

## INITIATIVES ■ Disaster relief

For years, the number of patients has ballooned dramatically. Patients from rural health units of the catchment vicinities and from primary hospitals such as Daanbantayan District Hospital and Bantayan District Hospital are referred to Bogo City Hospital for immediate clinical attention and critical cases; complicated obstetric cases, cardiopulmonary disorders, severe dehydration. These patients often take several hours travel time by public transport to reach the hospital. Bogo City Hospital refers critical patients to tertiary hospitals in Cebu City for intensive care, diagnostic work-ups, and specialty consultation, elective and specialized emergency surgeries. This transport can take up to 4 hours. Trained physicians are not available 24/7 at the hospital. As of December 2013, the occupancy has been consistently over 200%; 2 or 3 patients sharing one bed; many only find space on the hospital floors.



Patients sharing beds on the floors of Cebu Provincial Hospital-Bogo City



Crowded Female Ward at Cebu Provincial Hospital-Bogo City

### Daanbantayan District Hospital

Daanbantayan District Hospital is a 10-bed primary care facility, situated at Barangay Pajo, 35km from Bogo City Hospital. It caters to patients from Carnaza Island, Malapascua Island, and the population of Medellin. The hospital has a 5-bed children's ward, 5-bed medical ward, 1-bed labor room and 3-bed OB-room. Daanbantayan District Hospital has only one physician being able to handle OB/Gyn and minor surgeries, the other two physicians are contractual or outsourced and both general practitioners. When we visited this hospital in November 2013, we were told that up to 28 women deliver per day, sharing the 1-bed labor room and 3-bed OB-room. There has been a tremendous increase in the bed occupancy rate of Daanbantayan District Hospital, consistently over 200%, with 2 or 3 patients sharing one bed; many only find space on the hospital floors.



Daanbantayan District Hospital



Pediatric Ward patients at Daanbantayan District Hospital

# PHILIPPINES

## INITIATIVES ■ Disaster relief

### Bantayan District Hospital

Bantayan District Hospital is a 25-bed facility, and the only hospital catering to the health needs of the people in the three municipalities comprising Bantayan Island: Santa Fe (25,528 pop), Bantayan (73,753), and Madridejos (33,089). It is accessible by land transportation and several hours' navigation by sea from the islets surrounding the three municipalities.



Bantayan District Hospital post-Typhoon Haiyan/Yolanda



Damaged roof at the Pharmacy

### First Relief Shipment

On January 27<sup>th</sup>, 2014 Real Medicine Foundation received and distributed two pallets worth of World Health Organization (WHO) medical kits, generously donated by International Relief & Development (IRD) as part of our ongoing Typhoon Haiyan/Yolanda relief efforts. These WHO kits contain a large assortment of emergency medicine and supplies (i.e. general and local anesthetics, analgesics, antipyretics, antibiotics, antifungals, anti-inflammatory and anti-rheumatic drugs, anti-allergic and drugs used in anaphylaxis) that are very useful for clinics and hospitals, especially in the wake of an emergency.

### Second Relief Shipment

On February 26<sup>th</sup>, 2014 RMF received and distributed a 40 foot container load of medical supplies, a second major relief shipment, provided by IRD, as part of our continued Typhoon Haiyan/Yolanda relief efforts. The container held a substantial assortment of general medical supplies (dressings, surgical kits, IV supplies, protective wear, gowns, catheters, etc.). RMF was again able to use the Bogo Sports Complex as a staging area to hold and divide up medical supplies among the three hospital stakeholders in the typhoon-affected areas of the Visayas: Cebu Provincial Hospital-Bogo City, Bantayan District Hospital and Daanbantayan District Hospital. These hospitals had all been overwhelmed with the significant increase in patients and dwindling supplies since Typhoon Haiyan/Yolanda struck.



Unloading 2<sup>nd</sup> emergency relief shipment



RMF staff and medical volunteers with supplies



Medicine and supplies being used

# SRI LANKA

**INITIATIVES** ■ Primary Health Care ■ Long Term Medical Support for Children ■ Preschool and Student Support

**Healthcare for more than 4,000 Post-Tsunami**

**2,541 Patients treated**

**Long term medical support for 6 Children**

**36 Preschool Children and Students supported**

**Background**

Sri Lanka marks the birthplace of Real Medicine Foundation, the place where the first promise was made and the concept of “Friends Helping Friends Helping Friends” was born. More than nine years after the Indian Ocean Tsunami of December 2004, rural villages in Southern Sri Lanka still face challenges of coping with poverty, infectious disease outbreaks, and psychological trauma.

After completing Real Medicine’s immediate tsunami relief efforts at the Mawella Camp Clinic, a second clinic was opened in Yayawatta in October 2006. Now in its eighth year, this clinic remains fully active and continues to grow. Initially established to serve one community of 400 that had been displaced through the tsunami, the Real Medicine Yayawatta Primary Health Care Clinic now continues to provide free health care access to over 4,000 people in five impoverished villages in the Hambantota District of Southern Sri Lanka.



RMF’s Dr. Chamal with patients at the RMF Clinic in Yayawatta

**Yayawatta Primary Health Care Clinic**

**2014 Update:**

The beneficiaries of RMF’s Clinic in Yayawatta include the populations of Seenimodara, Kadurupokuna, Moreketi-Ara and Palapotha. Having access to free healthcare is especially important for young mothers, children, and the elderly in the community. Using our clinic activities as a hub, we provide regular medical camps and healthcare outreach programs to preschools, schools and communities in the surrounding areas. Patients with more serious conditions are referred to the local District Hospital in Tangalle and then seen regularly for follow up treatment by RMF’s physician and clinic team.

In 2014 our Yayawatta Clinic was open for 10 days every month, seeing about 25 patients per day and an average 650 patients per quarter. The first Thursday of each month is set aside for health education programs for mothers and expectant mothers, administered by government nursing officers and hosted by RMF’s clinic staff.



Some of the younger patients at the clinic



Newborn at RMF’s Yayawatta Clinic



Medicine and supplies at Yayawatta



Busy waiting room during clinic hours

Our family planning program for women continues to be very effective with administration of Depo-Provera to an average of 6 women per month as well as provision of oral contraceptives, giving women a choice. The diseases we see most frequently are respiratory tract infections, viral fevers, gastrointestinal tract infections, heart disease, hypertensive disorders, skin diseases and different forms of arthritis.

# SRI LANKA

## INITIATIVES ■ Primary Health Care ■ Long Term Medical Support for Children ■ Preschool and Student Support

### Long Term Medical Care of Children

#### Background

In early 2005, shortly after the Indian Ocean Tsunami devastated large parts of Sri Lanka, Dr. Martina Fuchs met Madumekala, a young girl suffering from panhypopituitarism. At age 11, Madumekala was the height of a three year old child. In an unsupported gesture of compassion, Dr. Fuchs chose to fund Madu's treatment for growth hormone therapy and initiated the supervision of this treatment through Ruhuna Medical College, Galle. While over the next three years, as RMF expanded this program to care for 6 more children suffering from long term health conditions, it was impossible to predict that this one act of compassion would initiate a country wide program to identify and treat over 120 more children suffering from human growth hormone deficiencies.

#### 2014 Update:

Our five patients have continued with their growth hormone treatment; they are growing in height and are maintaining healthy weight gains. Our patients and their caregivers also regularly consult with Prof. Sujeewa Amarasena, the Head of Pediatrics at Karapitiya Teaching Hospital, to discuss their progress and to add supporting treatment, such as sex hormones. Tharindu, our sixth long term patient, who had lost his mother in the tsunami, is being treated for familial hyperlipidemia with lipid lowering medication. We also provide nutritious food for these six patients and their families every month.



Madumekala with her food parcel



Fazeer with his food parcel



Gayan with his food parcel

### Preschool and Student Support

#### Minhath Preschool, Dickwella

The Minhath Preschool was constructed by RMF in 2006 as the first ever preschool for the children of the Tamil/Muslim minority community in Dickwella, Sri Lanka, a region hit hard by the Indian Ocean Tsunami. Based on the Montessori Education Model, in 2014, 36 children benefited from the preschool classes that include academics, art classes, performance events, and sports activities. This educational basis allows these children the chance of an advanced education that they were excluded from before. Lessons are taught in three languages: Tamil, English and Sinhala. RMF supported the salaries of the teachers and some of the school costs throughout the year. Some of the field trips taken with the children include trips to the capital of Sri Lanka, Colombo, to the zoo, to Galle harbor and to swimming pools.



Preschool students selling fruits at market day



Students learning about gardening



Field trip to Colombo

# SRI LANKA

**INITIATIVES** ■ Primary Health Care ■ Long Term Medical Support for Children ■ Preschool and Student Support



Students learning how to pot a plant



On a field trip to a river



Heading out with the teacher

## Palathuduwa Preschool

In February of 2010, RMF moved our preschool support from the Tangalle Children’s Relay Preschool to its new location, in the Village of Palathuduwa, 2 km inland from Tangalle. In 2014 we supported the staff salaries and some of the costs of supporting the 15 children of primarily lower income farmers and laborers including bus fares to and from school. The objectives of this program are: Educate children on basic English knowledge, modern communication technologies, health awareness and proper sanitation; Environmental awareness, integrating eco-awareness and outdoor activities into their routines; Natural disaster awareness and environmental pollution, including small skills they can utilize to help preserve their surroundings; Provide students with diversity education about cultural and ethnic diversity, and with at least one nutritious meal a day. Palathuduwa teachers organized the annual children’s fair for the children, parents and community to participate in. The children wore traditional clothing and selected items to sell at the market; learning about buying, selling and how to save money. Sports and physical activities are also a key part of the Palathuduwa Preschool’s program with many games played using the equipment in the school yard.



Palathuduwa students performing



Children’s Fair/Market Day held at the school



Playing catch with a ball



Balancing game using tires



Performing Traditional Ceremonies



Climbing pyramid in the courtyard

# SOUTH SUDAN

## INITIATIVES ■ RMF - UNICEF Malnutrition Treatment, Prevention and Outreach Program, Jonglei State

Serving population of 240,000; 4 Counties and 12 Payams in Jonglei State targeted

45,467 Children to be monitored; 7,214 SAM Cases targeted



Emergency Medical Tent in Korwai, Ayod County

### RMF-UNICEF Malnutrition Treatment, Prevention, Outreach

#### Background

In December 2014, RMF South Sudan entered into a new partnership with UNICEF and the South Sudan Ministry of Health to bring our expertise in Malnutrition Treatment, Education and Outreach to one of the hardest hit areas of South Sudan, Jonglei State. This new initiative is designed to ensure that all children with Severe Acute Malnutrition (SAM) are reached with a package of integrated nutrition services in the counties of Jonglei State assigned to RMF by UNICEF: Ayod, Fangak, Nyirol, and Pibor; launch will be in January, with activities rolling out in February 2015.

Counties	Ayod	Fangak	Nyirol	Pibor
Payams	Kuach-deng Korwai Mogok Magok / Haat IDPs	Phom / Barbuoi Phom IDPs Paquer New Fangak	Pulturuk Pulturuk IDPs Chuil Chuil IDPs	Kiziongora Marow (Maruwo) Miwono (Meoun)

The nutrition interventions will be coordinated through the Nutrition Cluster and with other relevant clusters including Health and WASH, and will be implemented with financial and supply/logistics support from UNICEF, WFP and the WHO. RMF's work will serve a total population at 240,000, reaching more than 45,000 children and benefitting an estimated 7,214 SAM Children (6-59 months of age) and at least 60% of Pregnant & Lactating Women (including IDPs and host communities) in each targeted county. The proposed strategy for nutrition in Jonglei State is designed to ensure the provision of lifesaving nutrition services for acutely malnourished children, and pregnant and lactating women to prevent poor nutritional outcomes, including promotion of optimal infant feeding practices, proper hygiene/sanitation and improved maternal nutrition; micronutrient supplementation and nutrition education on locally available foods; setting up of a robust reporting and information system and monitoring mechanism; and an establishment of a surveillance system, with an emphasis on capacity development of health care providers for all target areas.



Korwai Payam, Ayod Country



Basic medicines available at local PHCC



UN helicopter delivered RMF Team

This program has three main components: *Community Outreach* - Community Outreach Workers trained in the identification of acutely malnourished children using MUAC will be responsible for referring clients to nutrition centers. *Outpatient Therapeutic Program* - Children with severe acute malnutrition (SAM) without complications will be treated with ready-to-use therapeutic foods (RUTF) and symptomatic outpatient medications in the nutrition centers in the target areas by RMF doctors, nurses and nutritional experts; there will be 8 of OTPs. *Stabilization Center* - Children without appetite and with complications will be treated as inpatients at RMF-managed Stabilization Centers until they are stable and ready for discharge. RMF will establish 1 SC in Fangak County (Mareng Payam) and 1 SC in Ayod County in order to save the lives of children with complications and will ensure they are treated in the Stabilization Centers as per the national and international protocols.

# SOUTH SUDAN

## INITIATIVES ■ Health Care Capacity Building and Training ■ Diploma Level Training of Nurses and Midwives

**First ever accredited College of Nursing and Midwifery in South Sudan**

**136 Nursing & Midwifery Students enrolled**

**2<sup>nd</sup> Class of 23 Nurses and 22 Midwives graduated in December 2014**



Nursing Students in training at Juba Teaching Hospital

### Background

South Sudan's maternal mortality remains the highest in the world, at 2,054 deaths per 100,000 live births according to the 2006 South Sudan Household Survey. Some of the major reasons for the high levels of maternal mortality in South Sudan are women's lack of access to appropriate reproductive health care, poor health infrastructure, inadequate medical supplies, and insufficient human resources in the existing health facilities. The WHO recommends that a skilled attendant be present at every birth since midwives can prevent up to 90% of maternal deaths where they are authorized to practice their competencies and play a full role during pregnancy, childbirth and after birth.

Since the signing of the Comprehensive Peace Agreement (CPA), South Sudan has struggled to provide efficient and quality reproductive health care to its population, with less than 10% of deliveries occurring in the presence of a nurse, midwife or doctor. There is a serious shortage of skilled birth attendants, in particular qualified midwives, in South Sudan, a country with a population of 9.86 million. The Ministry of Health estimates that it will take close to 66 years for South Sudan to establish a professional and sustained capacity to address the maternal mortality issues in the country.

### Juba College of Nursing & Midwifery (JCONAM)

Real Medicine Foundation, in collaboration with the Ministry of Health of South Sudan, UNFPA, UNICEF, UNDP, WHO, St. Mary's Hospital Juba Link, Isle of Wight, CIDA, and the Japanese International Cooperation Agency (JICA), and in partnership with and with financial support from World Children's Fund, has established South Sudan's first ever accredited College of Nursing and Midwifery. The consortium aims to provide a scalable working model for this college that offers a 3 year diploma for Registered Nursing and Midwifery and is envisioned to be extended to other strategic locations in South Sudan. This graduated level of nurses and midwives aims at filling the gap of professional skilled care services, destroyed as a result of the more than two decades of civil strife and war.

During their training, the students serve as staff in the outlying primary health care clinics and units in Munuki, Nyakuron, Kator and Malakia as well as Juba Teaching Hospital. The immediate population in Juba and surrounding areas, estimated at 500,000 are direct and immediate beneficiaries of this newly qualified health care staff. Upon graduation, nurses and midwives return to their home states to work for at least two years to serve the population of South Sudan. The college accepts applicants from all 10 states to optimize the distribution of newly qualified health care personnel.



Nursing Tutor Justina, instructing students

The 2010 intake admitted 36 students (18 nursing and 18 midwifery students). 30 of those students progressed into their final year and graduated in August 2013. A second class of 61 students started training in January 2012 and 45 (23 nurses and 22 midwives) progressed into their final year, completed the course and graduated in December 2014. 54 students were admitted at the beginning of 2013 and 40 progressed to second year. A first year class of 54 students started classes in June 2014 and by the end of this reporting quarter the class had 51 students. The graduated students have been deployed to their respective state hospitals, county hospitals and primary health care centers to bridge the gap between demand for skilled services and available service providers.

# SOUTH SUDAN

## INITIATIVES ■ Health Care Capacity Building and Training ■ Diploma Level Training of Nurses and Midwives

### 2014 Update:

The civil conflict in Juba that erupted on December 15<sup>th</sup>, 2013 and later spilled over to other states in South Sudan made it difficult for the JCONAM staff and students to return to their various homes and many of the students were stranded on campus or within Juba. The deteriorated security situation in parts of Jonglei, Unity and Upper Nile States caused some students not to report back to the College, and it has been very difficult tracing them due to poor communication networks in these states. The visit by RMF CEO Dr. Martina Fuchs during that critical moment when most partners left the country due to the deteriorating security situation generated hope and confidence among the college staff and the students.

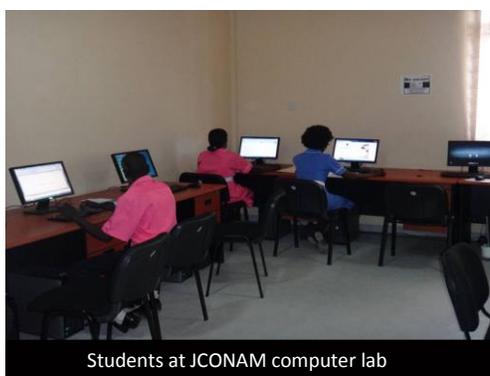


Nursing and Midwifery students on JCONAM campus

- Following the student selection for the 2014 intake in early December 2013, the final list of the successful students couldn't be circulated to all of South Sudan's states in time due to the fighting in some parts of the country; because of this delay in processes, the next class of year one students reported in early June 2014.
- We continued our support to the National Ministry of Health and project partners in the coordination and implementation of JCONAM project activities, in line with the approved Annual College Work Plan. We also continued facilitation of inter-linkages with UNFPA, MOH, IMC and other stakeholders, ensuring quality assurance in the implementation of nursing and midwifery curricula in the diploma program.
- Coordination of RMF activities and participation in meetings/workshops with UN agencies and NGOs supporting JCONAM and other National Health Training Institutes.
- Sponsorship of first, second and third year nursing and midwifery students at the Juba College of Nursing and Midwifery through provision of uniforms, skills laboratory equipment, clinical training equipment, books, stationery and Information Technology (IT) equipment.
- JCONAM students continue to get good support and mentorship from JTH staff and college tutors while in clinical practice following the formation of a joint JCONAM-JTH committee, which enhances the relationship between JCONAM and Juba Teaching Hospital administration.
- Stakeholders in nursing and midwifery education and services are undertaking the development of a bridge course for Community/Enrolled Midwives for acceptance into diploma training to complete the course in less than 3 years.
- With the inclusion of the second year midwifery students on the maternity ward delivery roster, the students are able to conduct/participate in 10-20 supervised deliveries per day. These numbers will increase as the College looks into expanding the number of practice sites in the near future.
- Continued to pay the salary for one highly experienced and qualified National Tutor and hired a second RMF supported National Clinical Instructor in August 2014.
- The third year midwifery students trained on Respectful Maternity Care (RMC) in 2013 continued to practice and disseminate the basic concepts of RMC to other students and maternity staff, improving patient outcome.
- Developed Respectful Maternity Care (RMC) supervisory checklist to be used in maternity unit of Juba Teaching Hospital and neighboring PHCCs within Juba city.
- Additional monetary and emotional support for two JCONAM students who were badly affected by the fighting in Malakal and Balliet.
- Provision of new computers and computer accessories, enabling the tutors to connect to LCD projectors during classroom lectures.
- Created and expanded student database for easier monitoring and follow up.



Nursing students in front of JCONAM classroom



Students at JCONAM computer lab



Midwifery student administering IUD

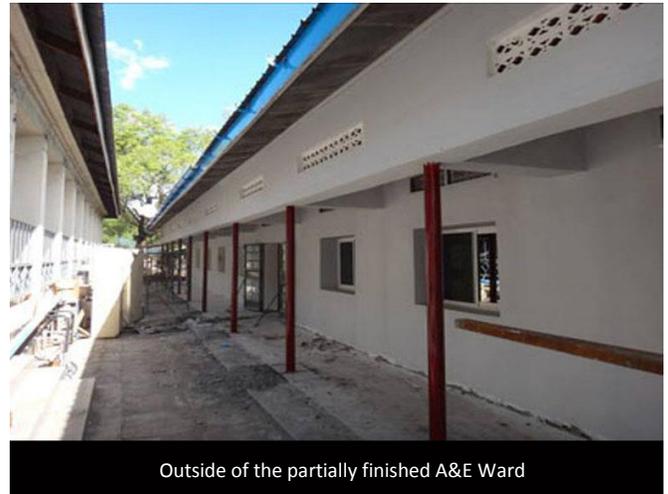
# SOUTH SUDAN

**INITIATIVES** ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery

**Renovation and Upgrade of Pediatric Wards and Accident & Emergency Department**

**Large shipment of Emergency Medical Supplies delivered to Juba Teaching Hospital**

**Waste removal and management program**



Outside of the partially finished A&E Ward

## Juba Teaching Hospital

### Background

Juba Teaching Hospital (JTH), a 580-bed facility and the only national referral hospital in the whole country of South Sudan, is located in its capital, Juba City, Central Equatoria State. With an estimated population of 9.86 million based on annual population growth of 3% from a population census conducted in 2008 and lack of proper functioning primary health care facilities upcountry, many South Sudanese have nowhere to go to but this national referral hospital which has been overwhelmed due to continuously increasing demand even before the recent civil conflict that erupted in mid-December 2013. Military and police hospitals, if any, are non-functional country wide, forcing soldiers and officers to share the limited facilities with civilians. JTH's departments and services include: Pediatrics, Internal Medicine, General Surgery, Obstetrics/Gynecology, Ophthalmology, Mental Health, Physiotherapy, ENT, Diagnostic Services: Laboratory, Radiology; Finance/Administration/Statistical Units. JTH was established in 1927, in structures that previously served as army barracks, and most of its infrastructure is now dilapidated requiring upgrades and renovations to create an environment conducive to healing for patients and their community, and the healthcare professionals serving them. The hospital is directly funded by the National Government through the National Ministry of Health and supported by RMF, UN agencies and other local and international NGOs.

RMF has worked in close cooperation with South Sudan's National Ministry of Health (MOH) and with Juba Teaching Hospital (JTH) for several years. In a Health Systems Strengthening project at Juba Teaching Hospital, RMF, with support from Medical Mission International, has started to upgrade infrastructure at JTH in spring of 2013, beginning with the wards of the Pediatric Department, as well as to support procurement of furniture, medical equipment, and supplies for the Pediatric Department. Milestones achieved include the full renovation of Pediatric Wards 5 and 7 (total bed capacity of 120 beds), development of guidelines and policies and provision of supplies for the maintenance of the renovated Pediatric Wards; recruitment of additional staff; removal and disposal of large amounts of regular and medical waste and design and initiation of a waste disposal management program; training of nursing staff in charge in various departments on the importance of infection control and waste segregation in the wards/outpatient departments; procurement of protective gears; facilitation of and regular monitoring and supportive supervision of the JTH healthcare workers on policy guidelines; support of high speed WIFI internet services for JTH Resource Centre providing internet access to doctors and nurses at the hospital; assessment for improving water and sanitation situation at JTH; and training programs on Respectful Maternity Care and Respectful Health Care.

Respectful Maternity Care and Respectful Health Care.

South Sudan's Minister of Health, H.E. Dr. Riek Gai Kok personally visited the newly renovated Pediatric Wards and acknowledged RMF's work for JTH. The renovation of the Pediatric Wards has reduced re-infection rates among children on admission and also improved working conditions for healthcare professionals and Juba College of Nursing and Midwifery students who are on their clinical rotations, and, above all, increased the quality of care patients receive and started to increase the number of patients coming for medical treatment.



MOH Dr. Riak Gai Kok with RMF team and JTH staff

### Accident & Emergency Department

The improvement of the *Accident and Emergency Department* at Juba Teaching Hospital was initiated in mid-February 2014 when Dr. Martina Fuchs visited Juba with a pledge from a generous private RMF donor during that critical moment for the nation, and had a series of meetings with the National Minister of Health and his team, and with Juba Teaching Hospital leadership. During these meetings, the

# SOUTH SUDAN

## INITIATIVES ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery



Newly completed Waiting Area at A&E Department



Interior of one of the four newly finished A&E Department Blocks

Minister of Health, H.E. Dr. Riek Gai Kok, committed to matching the pledge from RMF's donor, Pamela Omidyar. The project is aimed at improving the conditions at the current *Accident and Emergency Department*, creating a welcoming and healing facility for all South Sudanese and foreigners residing in the country, and supporting peace from within through provision of better healthcare services, with a strong focus on respectful care.

The Ministry of Health and Juba Teaching Hospital's leadership took the lead in the preparation and procurement process for the project, making sure that there would be no interruption of services for the patients, and work on the four blocks of the *Accident and Emergency Department* officially started in July 2014 when H.E. Dr. Riek Gai Kok and Undersecretary Dr. Makur Matur Kariom visited the site on July 8<sup>th</sup> to kick-off of the project, following the inauguration of the South Sudan Reference Laboratory by President Salva Kiir.

The contracted construction company, Pan Koung Ltd, contributed additional improvement work beyond the work stipulated in our agreement, as a sign of commitment towards their new country. As of September 2014, work on tiles, operation theaters, plastering, electrification, plumbing, replacement of ceiling boards, doors and windows had been successfully completed while painting both interior and exterior was ongoing and awaiting the final coat. Progress of the work was evaluated in September 2014 by engineers from the Ministries of Health, Housing and Physical Infrastructure, the Juba Teaching Hospital Administration and the RMF team. The Ministry of Health then entered into a legal agreement for the work on the fourth block (formerly the medical unit of the A&E Department) and the operating theatres, the MOH's contribution to this project.

By the end of 2014, the improvement work on all four blocks of the *Accident and Emergency Department* was close to completion. The MOH through its leadership promised to furnish the entire department so as to provide quality and modern services to its population. By mid-December 2014, the MOH procured and delivered some furniture for the waiting area. Due to demand, the MOH opened up one of the blocks housing A&E pharmacy, X-ray/ultrasound, some consultation rooms and the reception for use while the other three blocks were still locked awaiting furnishing. The official inauguration is expected in early 2015.

### Juba Teaching Hospital 2014 Updates:

- Continued implementation of RMF's annual work plan guided by our MOU with the National Ministry of Health.
- RMF's ongoing renovation of the *Accident and Emergency Department* has changed the face of the hospital and the community feels it is a sign of unity and a safe and much better place to get healthcare services and to heal.
- RMF completed the renovation of Pediatric ward 5 surgical unit, including painting the interior, replacement of ceiling boards, electrification and plumbing work, making the environment much more favorable for the patients, their visitors, and the healthcare professionals. Procured furniture, including chairs, and cupboards for emergency drugs and patient files, to Pediatric ward 5 surgical and medical units.
- The renovated and upgraded Pediatric and Special Wing inpatient wards coupled with provision of adequate cleaning materials continued to reduce nosocomial and re-infection rates among inpatients and also improved working conditions for healthcare professionals and JCONAM students on their clinical rotations. Above all, it has increased the quality of care patients receive and thus the number of patients coming for medical treatment continued to increase.
- Continued rehabilitating the equipment set at Juba Teaching Hospital with focus on the Pediatric Department.
- Continued maintenance and repairs, where needed, of already upgraded/renovated Pediatric wards.
- Removed and funded replacement of the ceiling boards at JTHRC where the RMF coordination offices were also situated.
- Continued provision of basic medical supplies, pharmaceuticals, disposables, and equipment for JTH especially for the Pediatric Department supplementing those provided by the Ministry of Health.

# SOUTH SUDAN

## INITIATIVES ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery



Baby at the renovated Pediatric Ward



Highly frequented Pediatric Ward



Pediatric Ward

- Organized on-site clinical training, beginning with general equipment usage and Respectful Maternity Care.
- Supported South Sudan Ebola Preparedness and Response Plans.
- Continued to work closely with JTH administration and public health officers to ensure proper implementation of waste management policy guidelines and regular waste removal; facilitated and performed regular monitoring and supportive supervision of the JTH healthcare workers and janitors on implementation of waste management policy guidelines.
- Monthly provision of adequate cleaning materials to Pediatric Department and Special Wing, ensuring proper cleaning and hygiene maintenance in the wards and their surroundings.
- RMF's support helped to preserve and to keep JTH premises and the surrounding areas clean and safe through regular removal of the waste which previously had posed a threat to the healthcare workers, patients, surrounding community and the environment.
- The working conditions of the hospital's janitorial workers stayed improved through implementation of the waste management policy, developed with the support of RMF staff.
- Hired additional cleaners stationed at Pediatric ward 5 surgical unit to increase the workforce to ensure proper cleaning and maintenance of the renovated ward.
- Monitored and evaluated the impact of RMF's Respectful Maternity Care (RMC) project through continued supervision guided by RMF's RMC supervisory checklist, and conducted follow up trainings.
- Developed structure and manuals for Respectful Health Care (RHC) Training to be rolled out for staff at JTH A&E Department in early 2015, and eventually for all staff at JTH, and at healthcare facilities in Juba County.
- Improved, furnished and equipped the new office space on Juba Teaching Hospital grounds allocated for the RMF South Sudan team, easing coordination significantly.
- Continued provision of high speed WIFI internet services for Juba Teaching Hospital Resource Centre to healthcare staff at the hospital, facilitating research and improving continuous medical education.
- Collected and analyzed Pediatric disease burden for years 2012- 2013. The Pediatric disease statistics report has helped the healthcare professionals to adjust their intervention strategy toward the most frequent causes of mortality in under 5's, this will in turn improve services offered to the community.



New floors at the Pediatric Ward



Waste Removal at JTH site



# SOUTH SUDAN

## **INITIATIVES** ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery

### **Emergency Shipment of Supplies from Uganda to Juba Teaching Hospital**

Based on RMF's partnership with the Ministry of Health and Juba Teaching Hospital for the past several years, we were made aware of the desperate situation at JTH in December 2013 due to the violent conflict that broke out in Juba and across South Sudan in mid-December. JTH was inundated with patients, severely wounded and seriously ill, civilians and military personnel, and running desperately low on urgently needed medical supplies, medicines, and equipment to do its life-saving work at this time of crisis. Since many people arrived with severe wounds, there were also urgent requests to donate blood. In addition to patients, many others, especially women and children, were seeking shelter at JTH.



856 boxes of supplies purchased in Uganda for shipment to Juba



RMF truck delivery at the South Sudan border customs check

With the generous support of Humanity United, Pam and Pierre Omidyar, and Michael Wilson and The Maya Foundation, and in close collaboration with the Director General of Juba Teaching Hospital and the Ministry of Health, RMF Uganda and South Sudan team members worked with Joint Medical Store in Kampala to procure critically needed supplies to be shipped to JTH in the course of late December 2013/early January 2014. A total of 856 boxes of medicines, medical supplies and equipment were packed, more than 13,000 pounds in urgently needed supplies for Juba Teaching Hospital. Because of the amount and weight of the consignment, the supplies were transported by road. A friend of RMF's team, a lab technician who works for JTH and also as Managing Director of Medicare Company, a firm experienced in transporting laboratory equipment, pharmaceuticals and medical goods, offered to transport the goods from Kampala to Juba – the only truck willing to cross the border at that time.

The arrival of our shipment at JTH on January 10, 2014 saved and stabilized the emergency situation at this critical moment. JTH had been seriously lacking blood, and because of our consignment, desperately needed blood transfusions were now possible. We provided 1,000 blood giving sets, 1,500 blood bags, blood grouping reagents Anti A Serum, Anti B Serum, and Anti D Serum, IV sets, drip stands, IV cannulae, syringes. A major blood drive was initiated for the next day, January 11. The radiology department was able to resume performing X-ray services after receiving 3,500 X-ray films in different sizes, X-ray developer and fixer from us. And this was just a small portion of the total shipment. Other teaching hospitals in South Sudan, in Malakal and Wau, shared into the provided medicines and supplies as well, following requests from the National Ministry of Health.



JTH Director General welcomes RMF Team and supplies



JTH Lab technician eagerly helps distribute the supplies

# SOUTH SUDAN

## INITIATIVES ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery

### Second Shipment of Pharmaceuticals and Medical Supplies to Juba Teaching Hospital

Direct Relief International (DRI) and RMF have previously worked together in several other countries, such as Pakistan, Sri Lanka, Peru and Haiti, and entered into a partnership in South Sudan in August 2014. In November 2014, DRI provided an air shipment of Pharmaceuticals and Medical Supplies valued at more than \$470,000 to Juba Teaching Hospital. Prior to the shipment, RMF, in collaboration with the leadership at Juba Teaching Hospital and the National Ministry of Health, obtained tax exemptions from the Ministry of Finance and Economic Planning and prepared for distribution and storage for the donated medical items. RMF cleared all handling charges, and all items arrived at Juba Teaching Hospital in very good shape without any damage, anticipated to make a significant difference for JTH operations for several months to come.



One of 2 pallets of medical supplies donated by DRI



Unloading the DRI supplies at JTH



Checking the packing lists and content

### Internal Displaced People (IDPs) in Nimule, Magwi County, Eastern Equatoria State

Following the outbreak of the conflict in Juba in mid-December 2013 which quickly escalated into other states, hundreds of thousands of South Sudanese were forced to flee their homes. Many people from Juba and Greater Bor County moved to Nimule at the South Sudan-Uganda border. Many of the displaced people crossed as refugees to Uganda, others remained in Nimule as IDPs. When RMF visited one of the sites in Nimule, the IDP camp at Hai Kanisa Church, in late February 2014, the population of IDPs in the area was more than 40,000 and increasing daily. We found almost exclusively women and children, in 115°F, without shelter or shade. They didn't even have enough mats for their children to sleep on. It had started to rain at night, and they tried to squeeze into a nearby container to find shelter. The mothers didn't have enough food for themselves and their children, and reported that many of the children had been getting sick. Their stories were desperate and sad. *"They came kill everyone, burnt down houses; they did not spare even my old mother."* Many visitors had come by and taken photos, but none of them had returned. Many of the women were desperate and very angry. We decided to mobilize resources, and locally purchased and delivered posho, beans, cooking oil and papyrus mats to the group Hai Kanisa Church. Their joy was incredible and humbling. They started to pray and thank God that he made our gift happen for them. The most touching transformation was that of one very outspoken, angry, older woman. Her smile and gratitude was beyond words. She expressed that our coming back made her believe in God again.



IDPs at Hai Kanisa Church



RMF team buying supplies



Giving supplies to the IDPs

# SOUTH SUDAN

## INITIATIVES ■ Juba Teaching Hospital ■ Health Systems Strengthening ■ Emergency Medical Supply Delivery

### Support of Nimule Hospital, Nimule, Magwi County, Eastern Equatoria State

Nimule Hospital started in the early 1970s as a clinic and was upgraded to a hospital in 1983. Interventions are in healthcare, nutrition and HIV/AIDS. The bed capacity is 174 beds, very small considering it serves the entire population of Magwi County (287,000 people), patients from Uganda, and other neighboring counties in Central Equatoria State. Following the outbreak of the conflict in mid-December 2013, the hospital serves the more than 50,000 South Sudanese IDPs relocated to Nimule in addition. Nimule Hospital departments and services include: OPD; MCH, ART, TB, and Sleeping sickness programs; OR, Pediatrics, Maternity Department; one ambulance for referral cases. RMF South Sudan was asked to support Nimule Hospital, and together with RMF CEO Dr. Martina Fuchs, the team visited the hospital, met with Medical Director, Dr. David Nyuma and his team, identified gaps and discussed the possibility of collaboration in providing quality healthcare for the population. As a gift, the team brought 150 pairs of beddings. The provision of beddings to Nimule Hospital helped to reduce re-infection rates among inpatients since the hospital now has adequate numbers of beddings for its patients.



Nimule Hospital



Maternity ward



RMF team brings gifts to Nimule Hospital

### South Sudanese Refugees in Adjumani District, Uganda

Following the visit of Nimule Hospital and of IDP camps at the South Sudan border, Dr. Martina Fuchs and the leadership of the RMF South Sudan team and the RMF Uganda team, carried out needs assessments of South Sudanese refugees in Adjumani District, Uganda. Our visit to South Sudanese refugee camps in Adjumani generated joy, hope and unity among the refugees since the RMF South Sudan team is led by South Sudanese nationals and had been the first to listen to them. We met with the Settlement Commander at the Office of the Prime Minister's Refugee Desk in Pakele, and then visited the reception centre in Nyumazi and two of the five refugee camps in the area, Nyumazi 1 and Ayuilo, each of them with more than 20,000 refugees from South Sudan, mainly Jonglei and Unity States. More than 65% of refugees registered there were school age children, many of them unaccompanied minors. It was projected that the number of refugees in West Nile would continue to rise, to 70,000 or more. 40,000 refugees from West Nile alone are expected to move on to Kiryandongo Refugee Camp, where RMF has been working since 2008.



Reception center in Nyumazi



RMF South Sudan and Uganda team leaders



Refugee children, many unaccompanied minors

The situation in the camps was very poor: Lack of Health Care, especially maternal child healthcare; Inadequate Clean Water supplies; Lack of Schools: There are no schools in the camps and thousands of children, the majority of them traumatized, just roam around; Inadequate food for the number of refugees; a large percentage of children already arrived malnourished; Inadequate Shelter: Refugees are given one plastic sheet to erect a shelter; Poor hygiene and sanitation. From interviews with refugees, over 90% of them were only able to arrive in Uganda with the clothes on their back and no other supplies.

# SOUTH SUDAN

## INITIATIVES ■ Respectful Maternity Care Trainings ■ Respectful Health Care Trainings

Adapted existing RMF program to be relevant to all healthcare specialties through Respectful Health Care Program (RHC)

Advanced training for Master Trainers held

Trained first cohort of Nurses, Midwives, and Doctors in RHC at Juba Teaching Hospital



First group of RHC trained Health Workers

### Respectful Maternity Care and Respectful Health Care Training

#### Background

According to the Southern Sudan Household Health Survey (SHHS) 2006, South Sudan is known to bear the highest maternal mortality ratio in the world at 2,054 per 100,000 live births, with only 10% of deliveries attended by skilled birth attendants and about 14% of deliveries occurring in a recognized health facility. These numbers can be attributed to many issues: poor access to quality reproductive health services, including family planning, limited access to skilled birth attendants, poor access to emergency obstetric and neonatal care, and inadequate equipment and medication. Infrastructure complexities involving lack of transportation to facilities, economic factors, certain cultural beliefs and a lack of knowledge about the benefits of facility-based birth and antenatal care also contribute to these overwhelming numbers. Quality health service delivery of all kinds is challenging to say the least under these conditions, and RMF now has two programs focused on hospital staff training: one focused on Maternal Health and the second on more General Health Care delivery.

#### Respectful Maternity Care (RMC) Program

Maternity experts and global stakeholders have recently turned attention towards the presence of disrespect and abuse (D&A) by staff as a deterrent to women seeking potentially lifesaving maternity services in facilities. Literature indicates that there is a *strong correlation between how respectfully a woman is treated when receiving antenatal care and giving birth with how likely she is to utilize these services in the future*. Negative experiences and perceptions of providers and health facilities also can spread across communities and deter large numbers of women from seeking care. D&A exists on a continuum ranging from shaming or neglecting women when they are at their most vulnerable to slapping and shouting at them and their families. These behaviors can partly be attributed to the stress and burnout among staff that routinely work without the medications, supplies, and human resources they need to effectively save lives. Many have also been incorrectly taught to treat women poorly as part of their training, or because of a lack of exposure to humanized and family-centered care.

#### Respectful Health Care (RHC) Program

The concepts from the RMC program obviously transcend maternity care and are also relevant in all aspects of health service delivery. RMF took the core concepts that were successful in previous implementations of Respectful Maternity Care trainings and adapted them to be viable for training any specialty of healthcare, creating our Respectful Health Care (RHC) program.

The goal is to have respect, compassion, privacy, confidentiality, evidence-based practice, stress reduction among staff, and a positive work environment as core values of all programs. We train, educate and employ locals, producing innovative solutions and co-creating strong communities that sustain and grow (healthcare) capacity. By empowering the people we are trying to help, we discover visionaries and partners who are best able to



Respectful Care Training Session

# SOUTH SUDAN

## INITIATIVES ■ Respectful Maternity Care Trainings ■ Respectful Health Care Trainings

solve their problems. This mechanism of building **community resilience** is a cornerstone of RMF’s vision. The program itself is the first to operationalize the teaching of Compassion and Respect to health care workers rather than just document and define the problem of Disrespect & Abuse in facilities.

### RMC and RHC Training and Updates

What makes RMF’s RMC and RHC training approach unique is that this program is based on our concepts of “Friends helping Friends helping Friends” and “Liberating Human Potential”: Treating each other and the people we are supporting around the world with the respect and dignity you give to friends; we listen, learn and partner with the local populations, and empower local leadership.

What this means is that the program brings a **solution-oriented** approach to the community and facilitates them to create a sustainable and independent response to challenges rather than dictating a preordained set of solutions from outside the community.

RMF’s RHC Program involves 4 main concepts:

- *RMF Concept of “Friends Helping Friends Helping Friends”:* Welcoming patients and their families, creating rapport and trust, concepts of body language and respectful communication
- *RMF Concept of “Building Trust”:* Assessing the Patient, Informed Consent, Privacy, Confidentiality, Human Rights
- *RMF Concept of “Compassionate Care”:* Evidence-Based Care, Collaborative Practice
- *RMF Concept of “Liberating Human Potential”:* Work Relationships, Accountability, Stress and Burnout Reduction

More specifically RHC Training involves:

- Treating patients and colleagues the way you treat friends
- Letting people have an opinion and choice in decision-making
- Partnering with patients and colleagues to create better outcomes
- Making people feel welcome in health facilities

### First RHC Training at Juba Teaching Hospital

The methods and materials for these trainings were created in late 2014 and the first RHC training was held at Juba Teaching Hospital in February, 2015. The first round of training consisted of 14 staff members that are doctors, midwives, or nurses from maternity, antenatal, and pediatric wards at Juba Teaching Hospital. The second training session took place in March after the second set of tablets necessary for the trainings were transported from Uganda to Juba by RMF staff. That training targeted department heads and nutrition/famine relief staff.

We feel these trainings not only improve the quality of care patients receive, but also establishes a positive work environment that ensures good outcomes not only in our programs, but also sets the standard for maintaining an infrastructure with accountability, sustainability, and independence for entire communities. This aspect of our training programs has been met with excellent feedback and very positive outcomes.



Dr. Hassan and Senior Midwife Regina Akur in a RHC Training at JTH



JTH Medical Staff attends RHC Training



RMF Director Global Programs, Cindy Stein, leads RHC Training

# UGANDA

**INITIATIVES** ■ Refugee Support ■ Health Center ■ Education and School Support ■ Vocational Training Center

**More than 46,960 Patients treated**  
**4,393 Refugee School Children supported**  
**Vocational Training Institute with 102**  
**Tailoring and Hairdressing Students**



Patients at Panyadoli Hills Health Center II, Kiryandongo

## Background

The Kiryandongo Refugee Settlement in Bweyale, Uganda is a UNHCR managed refugee settlement that provides shelter, land and support for more than 55,000, comprised of Ugandan IDPs and refugees from Kenya, Congo, Rwanda, Burundi and South/Sudan. RMF has partnered with UNHCR and the Ugandan Office of the Prime Minister (OPM) in supporting Kiryandongo and the greater surrounding community of Bweyale (an additional 30,000 residents) with health care, education and vocational training since 2008. We saw an influx of 10,000 Ugandan IDPs in October 2010 and another 15,000 joined the camp at the end of May 2011. By the end of December 2013, thousands of South Sudanese refugees started arriving in Kiryandongo, fleeing the conflict in their country that started in mid-December. By the end of December 2014, we had 35,073 new refugees from South Sudan, with over 100 new arrivals every day; some are coming from other refugee camps to settle in Kiryandongo.

The 75-bed Panyadoli Health Center III, located in the middle of the Kiryandongo Refugee Settlement, has been consistently supplied with medicine, medical supplies and operational support by RMF since early 2009. In collaboration with the UNHCR and the OPM and with the support of World Children’s Fund, RMF, on an as-needed basis, periodically repaints, provides mosquito nets, beds and mattresses, and keeps critical medical inventories supplied and in stock. RMF cleaning staff also regularly cleans the patient wards and grounds of the clinic compound to ensure hygiene and low mosquito and other infestations near the buildings.

## UNHCR Implementing Partner for Healthcare

In July 2014, Real Medicine Foundation signed a tripartite agreement with the Office of the United Nations High Commissioner for Refugees (UNHCR) and the Government of Uganda to take over as official UNHCR Implementing Partner for Healthcare through the three established health centers at Kiryandongo Refugee Settlement, namely Panyadoli Health Centre III, Panyadoli Hills Health Centre II, and the Reception Centre Clinic, as well as through large community outreach programs. Acting as official Implementing Partner of UNHCR at Kiryandongo, we are now able to expand our already existing support of health programs and address two goals of emergency operations and care and maintenance of the originally targeted 24,722 (20,269 new caseload and 4,453 old caseload) refugees and asylum seekers in Kiryandongo Refugee Settlement through the delivery of quality and sustainable healthcare services. Beneficiaries of the healthcare services are also Uganda nationals; the host community comprises more than 74,220 people. By the end of December 2014, the project had already grown to benefit 35,664 refugees (as per UNHCR).

In addition, RMF continued to provide medicine and medical supplies to Panyadoli Health Center III; payment of staff salaries for six individuals, and other operational support. In the course of the past few years, through RMF/WCF's support, the Panyadoli Health Center has become a reliable source of health care within the community, handling a wide variety of issues including maternal and child healthcare, malaria, malnutrition, and HIV/AIDS. Patients requiring advanced care can now be treated at Panyadoli Health Centre III as well as with the new RMF/UNHCR/OPM partnership additional medical and human resources are now employed. Patients continue to come from all different parts of Kiryandongo with some patients even leaving Kiryandongo Main Hospital to come to Panyadoli Health Centre because of better availability of medications and supplies and higher level medical treatment. With the huge influx of new refugees to Kiryandongo in 2014, mostly from South Sudan, more than 46,966 patients were treated at Panyadoli Health Centre III compared to 23,400 in 2013. In addition to the continuous medical support, RMF has also has maintained the solar powered water pumps, pipes, and taps that supply all the clinic buildings and that we had installed in previous years.



RMF Deputy Country Director reviews patient records

# UGANDA

## INITIATIVES ■ Refugee Support ■ Health Center ■ Education and School Support ■ Vocational Training Center

### 2014 Update:

RMF's partnership with UNHCR has already generated significant impact at Kiryandongo Refugee Settlement, initiating an overall improvement in the quality of life at the settlement in addition to considerable improvement of health indicators. The increase in number of staff in all health facilities has added tremendous value to health services. New medical and non-medical staff was recruited under the collaboration of RMF, the Government of Uganda, and UNHCR, including Program Officer, Medical Doctor; Finance and Administrative Officer, Clinical Officers, HIV/AIDS Counselor, Nurses, Midwives, Lab Technician, Lab Assistants, Data Clerks, Guards, Ward Cleaners and Compound Cleaners, and Drivers. The establishment of a health clinic at the Reception Centre has reduced overcrowding at Panyadoli Health Centres II and III, changing health seeking behaviour positively among the refugees.



RMF Medical Staff



Medical Outreach training



Grandmother and child wait in line to be seen

In RMF's role as an Implementing Partner for UNHCR and expanding our current health programs in Kiryandongo, various capacity building activities were undertaken, mostly planned under the direct guidance of UNHCR and carried out by RMF. RMF made considerable efforts to fast track implementation of these trainings. Training of the community health promoters (VHTs) on disease surveillance and prevention came in handy at a time when there are outbreaks of epidemics in such as Ebola in West Africa. As a result one of the VHTs trained was able to detect a suspected case of polio in Magamaga. HIV/AIDS Voluntary Counseling and Testing (VCT) were provided in the Panyadoli Health Center III by RMF staff. ART clinics have been conducted, condoms distributed and opportunistic infections properly managed. Communities have been sensitized on prevention, care and guarding against discrimination and the risk of engaging in risky lifestyles that lead to the spread of HIV/AIDS. Availability of skilled midwives has increased ANC services and institutional deliveries at both health facilities. RMF took an integrated outreach approach with services covering immunization, HCT, ANC, deworming, condom distribution, health education including vital information on issues like gender based violence. The community health promoters were trained on disease surveillance and prevention and their roles, and sensitization campaigns were conducted with topics including chicken pox, Ebola, and jigger prevention/response.

- 100% access to primary health care
- 41,702 patient consultations during the year at all UNHCR supported clinics
- 11 staff trainings on HIS; 29 staff trainings on UNHCR CoC
- 50 VHTs trained on disease surveillance and outbreaks
- 45 routine trainings of health workers on SOPs
- 0.09% crude mortality rate
- 0.0% under five mortality
- 95% measles coverage
- 1:42 clinician/patient ratio per day
- 1.7 health facility utilization rate
- 22% bed occupancy rate
- 61.8% hospitalization rate
- 26% vaccine coverage rate
- 88.2% postnatal Vitamin A distribution
- 8 routine immunization programmes established and maintained

Because of the improved health care services, the community is less sick and thus can engage in more productive activities, especially farming. A number of families are producing food, vegetables to supplement the food rations provided by WFP (World Food Programme).

# UGANDA

## INITIATIVES ■ Refugee Support ■ Health Center ■ Education and School Support ■ Vocational Training Center

### Kiryandongo Refugee Children Education and School Support

#### Background

When the Kenyan refugees arrived at the Kiryandongo Refugee Settlement in 2008, there was very little support in terms of school fees for their children, and there was no provision for a nursery school at the settlement. RMF stepped forward in collaboration with the UNHCR and Ugandan Office of the Prime Minister and with support from WCF to establish a school support program to cover fees and supplies for Nursery, Primary and Secondary School children of the Kenyan refugee community at Kiryandongo. In the subsequent years, students from South/ Sudan, Congo, Burundi and Rwanda have been accepted into our program as well. RMF pays a portion of the tuition fees, school uniforms, school supplies, and examination fees for the students of parents unable to afford the fees. We also covered the cost and travel expenses for the final examination tests for the senior high school students and continued to provide funding for the annual registration of candidates in Senior Level Four and Senior Level Six that are in our sponsorship program and facilitated candidates taking their national exams in the city of Masindi.



Dr. Martina Fuchs and some of the children supported

#### 2014 Update:

Dr. Martina Fuchs visited all Kiryandongo Resettlement schools supported by RMF as well as the Vocational Training institute during her visit in March 2014 and conducted a needs assessment together with the RMF Uganda team. In the schools Dr. Fuchs met with the teachers to get updated on accomplishments and needs, and interacted with students from South Sudan, refugees that had just arrived, most of them minors; they shared their harrowing stories about their experiences in South Sudan since December 2013, a sad majority of them having seen family members killed in front of their eyes. A total of 4,393 school children were supported by RMF by the fourth quarter of 2014; this number is significantly higher than last year's support of 1,286 students, mostly due to the recent influx of South Sudanese refugees.

### Kiryandongo: Panyadoli Vocational Training Institute

#### Background

In April 2011, RMF initiated a Vocational Training Program at the Kiryandongo Refugee Settlement after being presented by the refugee community with issues surrounding the lack of skills and vocational training for students graduating from the settlement high school. After researching which skills and programs might provide the quickest income earning opportunities for the students and the most economic investment requirements for RMF, and with the feedback from the community, we narrowed the programs down to two: Hairdressing/Beauty and Tailoring Training. With the generous support of WCF, we renovated a disused building in the camp, purchased tailoring and hairdressing supplies, and funded the salaries of four vocational tutors.

This program is part of the economic component of RMF's overall humanitarian vision, the 'focus on the person as a whole'. The longer-term vision for this vocational training center is to be one of several models for income generating opportunities for the populations we are supporting around the world so they eventually can be self-sufficient again.

#### 2014 Update:

RMF completed its fourth year of vocational training classes in 2014, covering both theory and hands-on techniques for hairdressing and tailoring. Our Vocational Training Institute has had five graduation ceremonies since 2011 and graduated a total of 102 students in 2014 alone. The Vocational Centers are continuing to generate some income for the school by tailoring garments, i.e. uniforms for the nurses at RMF's Panyadoli Health Center III, and by offering hairdressing services to the refugee population at Kiryandongo and its surrounding communities. RMF/WCF's support in running the Vocational Training Institute has helped empower Panyadoli youth with livelihood skills, which has promoted self-reliance among the entire youth community. A number of individuals who have completed training at the vocational institute now own shops in different trading centers and others are employed in shops in the region.



RMF Vocational Hairdressing and Beauty Therapy Students

# UGANDA

**INITIATIVES** ■ Refugee Support ■ Health Center ■ Education and School Support ■ Vocational Training Center

## RMF and JICA Partnership



JICA and GOSS visitors to Kiryandongo w/ RMF Country Director

RMF also began a new partnership in Uganda with JICA, the Japan International Cooperation Agency (RMF already has a partnership with JICA in South Sudan), with JICA funding materials and providing staffing costs for a large intake of students for a 3-month intensive vocational training program at Panyadoli Vocational Training Institute, Kiryandongo Refugee Settlement.

This new intake included the following:

45 tailoring and garment cutting students, 19 carpentry and joinery students, 20 bricklaying and concrete students, and 37 hairdressing and beauty therapy students. RMF management in Uganda received 350 applicants for the above mentioned different courses in December and narrowed down the admission to 121 students.



Vocational Training: Brickmaking and Bricklaying



Vocational Training: Carpentry



Vocational Training: Hairdressing and Braiding

## Tailoring Shop Program

The goal of RMF's Tailoring Shop Program is to set up sustainable, market-based business opportunities for the refugee and IDP graduates of our Panyadoli Vocational Training Institute (PVTI) Tailoring Program. Supported by Frost Family Foundation, we started this program in 2013 with the sponsorship of 10 RMF Tailoring Training graduates to set up their own Tailoring Shop businesses with the purchase of sewing machine, fabrics, threads and other equipment. In order to be approved for the program tailoring students are expected to give 10% of their profits back to PVTI. RMF purchased a sewing machine, enough fabric for several months, threads, needles, and enough tables and chairs to set up new shop locations for each of the 10 selected.



Tailoring Training Class



Tailoring Training Workshop

# UGANDA

## **INITIATIVES** ■ Refugee Support ■ Health Center ■ Education and School Support ■ Vocational Training Center

RMF also paid the monthly shop space rent for one year to help the tailors become profitable and save enough money to continue their businesses in a sustainable fashion without further donations. After a 3-month grace period, they were also expected to give 10% of their profits back to PVTI; these funds were to be used to procure supplies for the next round of vocational training students.

In response to concerns by the members of our Tailoring Shop Business Program, a training was conducted for the 10 sponsored tailors, covering business management, business planning, marketing management, record keeping, customer care, and creativity in business by Adolph Byamungu, one of RMF's vocational instructors, who has business background attained as a businessman in his home country, DR Congo.

The ten tailors sponsored by RMF are doing well; six of them are very successful. These six remained in their immediate locality and marketed themselves effectively and are consistently making a profit. Several of them had mentioned the lack of business and customer service training received in the regular vocational training program, so we followed up with another secondary training for all that were interested and incorporated this training into the regular curriculum.

### **2014 Update – Success Stories**

#### **Pauline Anyango**



Pauline Anyango in her shop

Pauline's business has been improving steadily by the end of 2014, despite her having had some difficulties in the beginning. When she had just started, she did not have the business skills or customer care language she needed to be successful, but she received business education from RMF along the way when it became apparent to us that all of the 10 tailors would benefit.

Her business and customer service skills improved greatly after our follow-up training and now Pauline makes a profit of about UGX 110,000/= per month on average, sometimes much more. Part of her profit per month she uses for her personal needs and the rest to expand her capital. She is joyful and thanks RMF for supporting her and making a huge difference in her life. She feels that from the time she joined Panyadoli Vocational Training Institute, she has become a different person, and she vows to progress and to commit to her tailoring business for life.

#### **Auma Santa**

Auma Santa was one of the first graduates of RMF's Panyadoli Vocational Training Institute, and she also went on to take further design courses on her own volition. She is now making a name for herself as both, a tailor and designer.

Auma Santa set up a successful and profitable shop with machines and capital from RMF. She designs bed sheets, bed lines, and curtains, and also serves on the Bweyale Town Council. In addition, she took on other tailors to work for her in her shop.

She markets her products as far north as the border to South Sudan. On average she earns UGX 200,000/= in profit per month. In the months when she travels to the border frequently, she earns as much as UGX 500,000/=. She feels that without RMF, her talent and gifts would not have been realized.



Auma Santa in her shop

# UGANDA

## **INITIATIVES** ■ Boarding School and Orphanage Support ■ Construction of New School Buildings

**Full operational support of school programs and more than 400 students**

**New Construction Project completed with 4 new buildings**

**New Classrooms add space for students**

**New Dormitories for 180 boarding students**



Botany and Gardening Classes at Mama Kevina

### World Children's Fund Mama Kevina School, Tororo

#### **Background**

The World Children's Fund Mama Kevina Comprehensive Secondary School is both an orphanage and a boarding school that provides education and care for orphans, and poor and vulnerable children in Eastern Uganda. The boarding school caters to both orphans and some local paying students and is located just a few kilometers outside of the town of Tororo in Eastern Uganda, about 200 kilometers from the capital, Kampala. Mama Kevina School was opened in 2006 with international financial support, and with the goal of providing both secondary education and vocational training. The student population is from Northern and Eastern Uganda where many children have been affected by ongoing wars, floods and HIV/AIDS. Many of the students' parents were killed by rebels or AIDS which left many of the children as orphans; several boys had been forced to be child soldiers. Enrolled at the school are students ranging in age from 11 to 24, who attend secondary grades 1 to secondary 4.

#### **2014 Update:**

Continuing in 2014, the World Children's Fund (WCF) and RMF provided financial support to the school's monthly operational funding needs. This funding is being used to cover the school's various operational expenses, enabling it to significantly raise the level of academics and support for the students and orphans, and also facilitating the school to attract more paying students. In 2014, the overall academic performance at WCF Mama Kevina School was stellar as a result of all the support staff and students received. The school was ranked third in all of Tororo District based on the senior four national examination results, which were released in February. RMF's work in 2014 included:

- Support of the school administration in payment of staff salaries and the daily running of school programs;
- Supply of school text books, laboratory and chemistry equipment for science practices;
- Supply of computers to equip students and staff with computer skills and knowledge;
- Provision of nutritious food for the students of WCF Mama Kevina School, including all the meals in a day, and support of the school gardening project so that the school can produce its own food. The students are much healthier than in the past receiving a balanced diet.
- The school has also been developing an eucalyptus forest that will be a source of firewood in the future.
- Procurement of medicines and medical supplies for the school clinic and payment of the clinic staff's salaries so that the school nurses and medical officer can treat the children within school premises and educate them on good health behaviors. Since RMF's involvement, morbidity, i.e. cases of malaria among school staff and students, has been significantly reduced.
- Providing the students with the tools for extra-curricular activities to participate in the regional games and sports to enhance the performance of the students and the standing of the school in the region;
- Facilitated students to participate in inter-schools athletics and football competition; WCF Mama Kevina school students secured the 12<sup>th</sup> position out of 18 schools that participated.
- Held an inter-house Music, Dance and Drama festival. This part of school co-curricular activities promotes the talent development of the children. It is an activity the students eagerly await because every student, teacher and support staff gets involved in one way or another. It is both fun and educational for the students; the theme for this past year was: Malaria – Prevention and Treatment.
- The school hosted 6 student teachers on internship. This is a manifestation that the school is building a positive image since it can be taken as a choice of internship for university students studying to become teachers.
- Support of the local youths in the surrounding poor areas.
- 84 candidates sat for their Uganda Certificate of Education (UCE). Results are expected in February 2015.
- Inauguration celebration of new building construction in May with visiting representatives of WCF and RMF.

# UGANDA

## INITIATIVES ■ Boarding School and Orphanage Support ■ Construction of New School Buildings

### Construction Project Completed

Starting in December of 2013, a new WCF supported construction project proceeded in 2014 that included a major upgrade of the campus infrastructure with four new buildings: Classrooms, Multipurpose Dining Hall, Girls' Dormitories, and Boys' Dormitories. These new buildings will significantly increase the school's capacity and thus the possibility to accept a greater number of paying students to help subsidize the support of the orphans. Our long-term goal is to guide WCF Mama Kevina School towards self-sufficiency and to establish a school model that can be replicated.

Dr. Martina Fuchs and WCF visited the school in May 2014 and performed a full construction audit, and met with all staff and students. While construction progress had been slow leading up to their visit, construction was accelerated and was completed by the end of the fourth quarter. As of the end of 2014 the construction project is complete and all buildings are in full use by the school and students. These buildings add another 1,717 square meters (18,482 square feet) of new building space to the school's buildings.

**Girls' Dormitories:** Have a capacity of housing 90 girls, each girl sleeping on her own bed. The beds are arranged in two columns of 5ft apart from each other and rows of about 3ft from each bed. These dormitories cover a space of 203 square meters. They are evenly partitioned into 3 rooms and each room covers a dimension of 68 square meters. Each room accommodates 10 bunk beds and each bunk bed has 3 beds. This means that each room accommodates 30 occupants multiplied by three bringing the number to 90 occupants. The matron also sleeps in the dormitory with the girls so that she is always available in case of any emergency as well as giving guidance to the girls. A five stall bathroom with a curtain well is attached to the dormitories at the back.

**Boys' Dormitories:** House 105 boys with a reserved space of accommodating 8 patients (in the sick bay): This structure covers a total space of 272 square meters. It has 4 partitioned rooms with two rooms evenly partitioned to accommodate 11 bunk beds and each bunk bed with 3 beds. In short these two rooms house 66 boys. The bigger room in the corner accommodates 13 bunk beds with 3 beds each, hosting 39 boys. This brings the total number to 105 boys in the whole block.

**Multipurpose Hall:** Covers an area of 36m x 12m. It serves as examination hall, assembly hall, entertainment hall, debating hall, and as hall for other general functions.

**Classroom/Administration Block:** This block is planned to be a two-story building; the ground floor was established with the funding made available for this phase of construction. The ground floor covers an area of 810m<sup>2</sup>. It has 7 classrooms and each classroom has a seating capacity for 56 students. This building also contains the Head Teacher's office, Staff Room, Bursar's/Secretary's Office and 2 storage rooms for learning and cleaning materials.

This construction has changed the face of the World Children's Fund Mama Kevina School and the entire village of Agururu and the city of Tororo where the school is located. The construction company also hired many local people who have enriched their families through the wages they were getting and resulted in much community support of the school. World Children's Fund Mama Kevina School and its administration, the village of Agururu, and the city of Tororo are all deeply thankful for the upgrades made possible with this construction. This construction changed the face, influence and impact of the school and of the entire city of Tororo forever.

WCF Mama Kevina School's new buildings were officially inaugurated in May 2014 by visiting representatives from WCF and RMF CEO Dr. Martina Fuchs. A tour of the newly constructed buildings and a celebration including dancing, singing, and speeches were held for the visitors.



Construction begins in late 2013



Putting up the roof rafters in Multipurpose Hall



Plastering the outside of new Classroom Block

# UGANDA

## **INITIATIVES** ■ Boarding School and Orphanage Support ■ Construction of New School Buildings



The new Multipurpose Dining Hall



New larger and brighter Classrooms



The new Classroom & Administration buildings



New Boys' Dormitories building



World Children's Fund and RMF Inauguration of new buildings



New Girls' Dormitories building

# UGANDA

## INITIATIVES ■ Sports Academy

**Sports Academy for Children and Youths**  
**Provision of supervision, equipment, food and medical care**  
**Sponsored sports camps and tournaments**

### Buwate Sports Academy

#### **Background**

In early 2013, RMF, in cooperation with Italy's Associazione Devoti Madre Teresa Per I Bambini, started funding support of the Buwate Sports Academy. Buwate Sports Academy is a supervised sports club and activity group for children living in and around Buwate Village, Kira Town, Kampala District. The Sports Academy seeks to develop the youth advancement component of our humanitarian work through games, sports training, vocational training and other educational opportunities. One of the major functions of this project is that of a safe haven for the youths of Buwate and Kireka that we are targeting, most of them from slum areas and desperately poor. The food we are providing is often the only food the children and youths are receiving in a given day. By providing the opportunity to be physically active and play, the youths are practicing their sports skills and are supervised and safe during that time. During their gathering, the youths are also receiving more general counseling and guidance. We have seen significant improvement of sports skills as well as the morale of all camp youths and staff. The standard of living of the youths and community members of Buwate and Kireka have improved due to the goods we were able to provide. In the later part of 2013, we started looking into acquiring land to establish buildings to house an on-site clinic as well as space for a vocational training center.



RMF CEO, Dr. Martina Fuchs, visiting the Buwate Sports Academy

#### **2014 Update:**

- Exercise books were purchased and distributed to orphaned and vulnerable children reporting to their first term in February; our children are stress free from worrying about buying books and stationery. These are very poor children whose parents often cannot afford school supplies, which means a child has to leave school to do small jobs to earn income to be able to buy books and supplies, losing valuable time that should be spent studying. This help with supply purchases has greatly improved the academic performance of the children.
- RMF recruited a full-time staff member (Christine Hilda Kasabira) at Buwate to oversee our work, promote professionalism and share our values.
- Food and charcoal was purchased and one afternoon meal provided for all Sports Academy children and youths every day.
- Children and youths were treated free of cost at a nearby clinic, providing comprehensive healthcare services, and contributing to better overall health and injury management. Medical bills for the children and youths were paid as needed, and first aid kits were distributed. Sensitization of the community on HIV/AIDS took place through regular outreach and education activities.
- Buwate Sports Academy continues to have girls enrolled as well, who are playing football in our community.
- Equipment, including more than 30 balls, 15 pairs of soccer shoes and goalkeeper gloves, was purchased, doubling the children's efforts in winning and improving their self-esteem.
- 26 more children were added on the list of sponsored children.
- 4 boys and 1 girl were given scholarships to affluent schools in Kampala.
- Dr. Martina Fuchs and representatives from MTCF visited the academy; Dr. Fuchs inspired students with her speech, love and compassion.
- MOU between RMF and St. Michael Church of Uganda-Buwate was signed.
- The Sports Academy conducted the Peace Day United Nations Global Peace Games for children and youth, hosted at Katwe playground. Students were taught important human values including: respect for all life, non-violence, understanding through listening, preserving the planet and sharing with others.



Boys from Buwate Sports Academy at the Kireka Academy Fields

# UGANDA

## INITIATIVES ■ Sports Academy

- Students were transported to compete with students outside of Buwate, exposing the children to the difficulties other sports academies face, resulting in appreciation for the services Buwate Sports Academy is able to provide.
- Transported children to and participated in the Amis under 17 Tournament and came in 2<sup>nd</sup> place overall.
- Kabarinda Madina, a widow in Buwate with 4 grandchildren, received assistance with the children’s school fees and medical needs.
- The Sports Academy children participated in a tournament in Kampala at the Wampewo Sports Academy, on Easter Monday. Buwate was proud to win the match.
- Buwate Academy Girls’ football team traveled to play the Gayaza High School (Gayaza High School is one of the most powerful schools in Uganda). The game ended in a draw 2-2. It was hosted at the Gayaza High School field and attracted many spectators.
- Buwate Academy Boys’ team traveled to play the Kira Young Stars at the Kira Field. Buwate won by 2-1.
- Buwate Academy Boys’ team traveled to play the Kireka Boys. This was hosted at Kireka and it ended tied at 0-0.
- The Independence Program, a children’s talent exhibition in sports, was held on the 9<sup>th</sup> of October 2014 at the Gayaza Primary School sports fields. Buwate Sports Academy was part of this talent exhibition, and our children did very well in games including boys’ and girls’ football and netball. Our children gained the exposure to and interacted with the children from high-income households at this expensive private school.
- On the 18<sup>th</sup> of December 2014, we traveled for a competition program for the under-twelve age bracket at Kireka playground. This was a difficult but friendly game; the children exhibited the skills they have acquired with us so far and at the end of the match we managed to win the game with a 4-1 score.
- The Academy conducted a gender balance holiday program whereby the academy boys played vs the academy girls for a large audience.
- We are delighted that two of our sponsored children from the top of the class graduated to primary level and six children sat for their primary leaving examination. One student also sat for the Uganda Certificate Examination.
- Held a friendly holiday match at Buwate with locals and inspired many to want to join Buwate Sports Academy.
- We also organized a Christmas Cup Holiday Program on the 16<sup>th</sup> of December 2014. Although this program had a high percentage of grown-ups (older than 17), the children from the Sports Academy also showed off their skills and what they had learned from their coaches. Many of the teams were amazed and challenged by how well the children played, and admired the great coordination and unity they had during the matches.
- Celebration of International Women’s Day in Buwate, accompanied by a meal and women/girls soccer game sponsored by RMF.
- Conducted meetings with women in Buwate to brainstorm startup income generating ideas using two donated sewing machines.
- The “Women Empowerment Program”, took place in Namasuba on the 30<sup>th</sup> of December 2014. The Buwate Girls’ team played against the Namasuba Girls’ united team and the match ended with a 2-1 win in favor of Buwate.



Buwate and Gayaza teams together



Buwate children performing for visitors



Buwate Girls team at Namasuuba fields



New shirts and soccer balls



Buwate team participating in tournament



Younger beneficiaries

# KENYA

## INITIATIVES ■ Health Systems Strengthening ■ Upgrade, Renovation, Support - Lodwar District Hospital, Turkana

**Lodwar District Hospital – The only referral hospital for over 1,000,000 people in Turkana**

**95,288 Patients treated in 2014**

**29,758 Pediatric Patients treated**



Pediatric Ward at Lodwar District Hospital

### Lodwar District Hospital, Turkana

#### Background

When RMF's CEO Dr. Martina Fuchs visited Turkana during the severe drought in September 2009, she realized that RMF's work in setting up health clinics for the drought victims would not suffice over the longer term – many of the more seriously ill patients needed advanced care at a secondary and tertiary care referral hospital. Lodwar District Hospital (LDH) is the only functional government regional referral hospital for all of Turkana region, spanning a population of over 1,000,000. This is where the vast majority of the Turkana and other populations of Northwestern Kenya as well as people from across the borders to Uganda and South Sudan seek help when they need more advanced care requiring medical equipment and specialized skills that cannot be provided at dispensaries, health centers, or private health clinics. Lodwar District Hospital had been struggling for years with wards in need of major repair, and medicines and medical supplies that come in with great irregularity from the government health supplies department in Nairobi. The situation had become so dire that patients were often requested to purchase disposables and medicines themselves in Lodwar town because the hospital could not provide them. Dr. Fuchs realized back in 2009 that referral care could only be improved for the Turkana people if the hospital would receive additional support to supplement supplies, upgrade the infrastructure and equipment, and conduct on-the-job training for the healthcare and biotechnical staff.

With generous support from MMI, we started our support of Lodwar District Hospital in February 2011 with upgrades and renovations of its infrastructure, and operational support such as provision of medicines, medical and emergency supplies, medical equipment, and advanced trainings of staff. Within less than a year and as a result of the improved infrastructure and availability of essential drugs and equipment, LDH had been approved by the Nursing Council of Kenya as a "Training Institution" and an internship center for clinical and medical officers, as well as a County Referral Hospital, and was acknowledged as the best pediatric facility in the area. We saw an amazing transformation in the quality of healthcare provided and in the attitudes and energy of staff and patients, and since then, we have been regularly recognized within the Kenyan Ministry of Health for our improvements to the hospital.

After successful infrastructure repairs to the entire Inpatient Unit at LDH in 2013, we embarked on ensuring the wards were provided with the emergency medical equipment and supplies necessary for a fully functioning hospital. For years, Lodwar District Hospital survived on very little emergency equipment, with wards having to share equipment across departments and frequently not having it available when most needed. Prior to 2013, the entire hospital had only two functioning oxygen concentrators, one suction machine, and one nebulizer (all provided by RMF). There were also very few working stretchers, wheel chairs and weighing scales. In order to bring LDH up to the standards of a functioning and efficient emergency/referral hospital and to motivate staff to provide the best and most immediate care, we decided to purchase for each ward its own independent equipment. By the end of 2013 we had equipped the entire Inpatient Unit including the Pediatric, Male, Female, Maternity wards, the Operating Theatre and the Casualty/Outpatient departments fully and independently with their own emergency equipment.

#### 2014 Update:

In 2014, we continued the prior year's work of purchasing the equipment needed for each ward. Focusing on the hospital needs, it was agreed that the departments supported would be Physiotherapy/Orthopedics, Dental, MCH and the Maternity ward. The equipment at these departments was either not available or worn out and the staff was not able to perform properly. During the course of 2014, the Pediatric ward has continued to record low mortality numbers for the fourth year in a row with our regular resupplies of medical and emergency supplies, thus enabling the wards to maintain the tendency our work had initiated in 2011: very low mortality numbers yet recording high and increasing numbers of patient visits.

# KENYA

## INITIATIVES ■ Health Systems Strengthening ■ Upgrade, Renovation, Support - Lodwar District Hospital, Turkana

### Achievements in 2014 include:

- RMF activities at the hospital continue to be recognized and greatly appreciated by the Ministry of Health.
- Lodwar District Hospital registered another large increase in the number of patients treated from 77,286 in 2013 to **95,288** in 2014, of which **29,758** were pediatric patients.
- The newly equipped and maintained Occupational Therapy Department recorded **1,506** patient visits up from 1,321 patient visits in 2013.
- Pediatric ward patients continued to receive free high quality medical services including free medicines and medical supplies, and treatment for the fourth year running.
- Patients' stay at the hospital continued to reduce. With the availability of emergency drugs, patients are treated and discharged faster than before. This has been a trend that has been maintained by RMF since we first began partnering with the hospital in 2011.
- RMF continued to ensure that the supply of essential and emergency drugs at the Pediatric ward and non-pharmaceuticals for the entire hospital was consistently maintained.
- With respect to new equipment for the hospital, RMF began 2014 by purchasing equipment for the Physiotherapy department, including a static exercise bicycle, infrared body massagers, plaster power saws, hand exercisers, orthopedic weights, chest expanders, exercise balls, hydro collator pack heaters, leg elevators, jig saws, ankle and knee braces. Having this new equipment has greatly motivated the physiotherapy staff to provide quality treatment to their patients that they were never able to receive on this level before.
- For the Dental department, we provided a large supply of urgently needed equipment, including forceps, incisors, premolars, surgical scissors, dental needles, cryer dental elevators, straight elevators, curved elevators, dental mirrors, periodontal probes, and syringes. Most of the equipment at the Dental department was very old, rusty and outdated, or totally lacking, making effective service delivery very hard. With this new equipment, it is now possible to attend to most of the visiting dental patients.
- RMF also added the Maternal and Child Health and Maternity Wards to its support portfolio in this past year, procuring weighing scales for both, mothers and children, delivery kits, disposable specula, stethoscopes, digital BP machines, sponge holding forceps, scissors, and MVA sets.
- The Maternity ward received a Doppler, stretchers, dirty linen carriers, medicine trolleys, delivery couches, BP machines, stethoscopes, weighing scales, examination couches, and delivery kits.
- Male, Female, Maternity, Pediatric, and Casualty/Outpatient departments/wards as well as the Operating Theatres all received any additional emergency equipment they needed considering the rising patient numbers, adding to the equipment we had procured in 2013, which included nebulizers, oxygen concentrators, oxygen flow meters, suction machines, stretchers, patient weighing scales and wheel chairs. All departments also received glucometer + strips; this had been a challenge for diabetic patients coming to LDH as these items had not been available.
- In addition to buying more equipment, RMF also always ensures that the equipment being used at the hospital is well maintained and serviced. More than 90 pieces of equipment were repaired and serviced in the course of 2014.
- In alignment with RMF's goal to have a clean and hygienic hospital, we continued to purchase disinfectants such as hydrogen peroxide, Lysol and Cidex throughout the year. These disinfectants have been used to disinfect hospital equipment parts to support prevention of nosocomial infections.
- RMF also continued to ensure that waste disposal and management is done the correct way. Red, black and yellow disposal bags were purchased with color coding for the hazard level of waste, enabling the hospital to manage and dispose of waste in the right places.



Mothers and Children at Lodwar District Hospital



Nurse at Lodwar District Hospital

# KENYA

## INITIATIVES ■ Health Systems Strengthening ■ Upgrade, Renovation, Support - Lodwar District Hospital, Turkana

### Asibitar Nakel



Asibitar on admission

Asibitar is the third born in a family with three children; her siblings are all alive and well. Her father is a herdsman and her mother does small scale business of weaving baskets. Asibitar was admitted to Lodwar District Hospital with complaints of diarrhea, vomiting, cough and fever for a continuous period of two days. Her mother had attended the antenatal clinic at our Lodwar Clinic. Asibitar was immunized with Tetanus Toxoid vaccine, and her HIV test was positive. She had been delivered at Lodwar District Hospital with no complications and had received expanded program immunization as per schedule and she has attained developmental milestones relatively well. She was diagnosed with tuberculosis and anemia and was started on anti-TB treatment for two

months: Isoniazid, Rifampicin, Pyrazinamide, Ethambutol; then Isoniazid and Ethambutol for four months. She was eventually discharged after a substantial recovery to be followed up at the Tuberculosis Clinic. Her mother was so happy about the progress of her child because of the treatment she had received. She said the recurrent illness of her baby had interfered with her business and eroded the little income for the family. She is very grateful for the support received: *'I thank RMF so much for helping us out by offering our children drugs. I had lost hope with Asibitar and I thought my child would not survive. Through your help and generous donation, my child has survived and is progressing on well. May God bless you for your continued support and do not give up on us.'*



Asibitar on the day of discharge

### Dennis Nang'odia



Dennis on admission

Dennis is the third born in a family with four children, all alive and well, one girl and three boys. The father is a herdsman and the mother does small scale business of making brooms. Dennis was admitted through a referral from the Lokichar Health Center (89km from Lodwar town) with complaints of diarrhea, vomiting, coughing and fever for a period of one month. He had been treated at the clinic with no improvement and was referred to LDH for a chest X-ray. Dennis's mother attended antenatal clinic at Lokichar clinic; she was immunized with Tetanus Toxoid vaccine, HIV test was positive. Dennis was delivered at Lokichar Hospital without complications and had received expanded program immunizations as per schedule and has attained developmental milestones relatively well.

Dennis was diagnosed with tuberculosis, anemia, moderate acute malnutrition, and HIV+. Dennis did not respond to the initial treatment, and was started on combined anti-TB treatment for two months, then Isoniazid and Ethambutol for four months. He was discharged after 3 weeks and followed up at the Tuberculosis Clinic.

Dennis was also put on F-100 for 8 days and alternatively started on ready-to-use supplementary food. On discharge he was given supplementary food and referred back to Lokichar for nutrition support; we recommended that he would be taken back every 2 weeks for status assessment. The mother was very happy with the progress of her child and for the treatment he received and was very grateful for the support.



Dennis on the day of discharge

# KENYA

## INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics

**Target population of more than 106,100 reached**

**20,229 patients treated at Health Clinic and Mobile Outreach Clinics in remote areas**

**26,817 Cases managed**

**1,236 Immunizations given**



Patients from Nariamao Village waiting to be seen

### Lodwar Healthcare Clinic and Mobile Clinic Outreach

#### Background

The September 7<sup>th</sup>, 2009 NY Times article by Jeffrey Gettleman, which highlighted the life threatening impact of the drought in Northern Kenya, called to action Real Medicine Foundation to coordinate a supply chain for water and food aid, and medical support to the region. We were able to provide a 4-week supply of food and water to 4,500 persons in severely drought affected regions of Turkana, Kenya where it had not rained in four years. RMF's Turkana documentary: [www.YouTube.com/RealMedFoundation](http://www.YouTube.com/RealMedFoundation).

In December of 2009, RMF started a longer term partnership with Share International supporting the only clinic in Lodwar, Turkana's capital and the largest town in Northwestern Kenya, with a population of almost 50,000 as well as expanding medical outreach programs and mobile clinics, and food and water aid where needed. Funding from Medical Mission International (MMI) made it possible to significantly enlarge this program at the beginning of 2010. Now entering into the 6<sup>th</sup> year of this program we are continuing to provide much needed health care and mobile outreach to communities not traditionally served by the health care system in Kenya.

Our medical services now reach a target population of over 106,100 people in some of the most remote regions of Turkana, including the Villages of Nabuin, Chokchok, Nadapal, Nayanae, Elelea, Kaitese, Nayuu, Nakabaran, Kanamkemer, Nawoitong, Lomopus, Nakoriongora, Kangikukus, Napetet, Nakwamekwi; the Kerio Region, including Lokori, Kalokol, Lokichar, Katilu, Kerio, Kalokutanyang, Kimabur, Lochwaa, Nakepokan, Nakoret, Kaikir, Kapua, Lolupe, Lokichogio, Lomuriae, Lorengelup, and Lodwar Town. The nomadic nature of the Turkana tribe causes the population of the villages we are serving to migrate approximately every four months and to be a new group of villagers about every four months; therefore we are providing service to more than the estimated population of persons living in each village at one time.

#### 2014 Update:

The continued quality and regularity of medicines and medical supplies provided by RMF this past year has allowed the health clinic and mobile outreach clinics to be conducted and maintain a high level of service. Our clinic staff serves all villagers who come for treatment, but we see an especially high number of children and pregnant women. An average of eight mobile clinics has been conducted each month, reaching the most remote regions of Turkana, with the target population being able to access our services now at more than 106,100 people. The mobile clinics saw an average of almost 1,000 patients per month, and at our permanent clinic over 715 patients per month were treated.

- **20,229** were treated and **26,817 cases** managed during 2014, another significant increase compared to 2013. These numbers were higher because of many factors, including focus on service delivery to even more distant rural villages, word-of-mouth marketing among the villagers, informing each other about the provision of and access to medical care, and continued availability of medicines and medical supplies.
- **137** outreach clinics conducted by the mobile clinic team.



Father and daughter at the Lodwar Clinic

# KENYA

## INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics

- 52 home visits conducted, in the rural villages and within and around Lodwar Town to patients not able to come to the Lodwar Clinic.
- Ambulance services have remained available continuously, the mobile clinic vehicle was serviced on a regular basis and at any time mechanical problems would arise, and was thus kept in very good condition.
- Public health teaching continued to be conducted at the beginning of every clinic day for the patients who arrive early and individual teaching on specific cases in the course of treatment.
- 5,826 laboratory tests were conducted in 2014, with 3,724 tests showing positive results. Many patients tested positive for malaria.
- We made 53 referrals mostly collecting patients who were very sick from rural villages and transporting them to our Clinic in Lodwar and to Lodwar District Hospital.
- The program continued to meet the cost of medical fees for some patients whom we referred for treatment of more complex medical conditions to other secondary and tertiary health facilities.
- Construction of an extension to the Lodwar Clinic to serve as Maternal Child Health Clinic and Medicine Storage at the beginning of 2015. Activities now include patient consultation and observation, pharmacy for storage/dispensing, laboratory, patients' waiting bay, wound dressing, store for drugs/records/nutrition commodities/outreach equipment; maternal and child health clinic, injection room; office for staff; large fridge for vaccines and nutrition for malnourished patients.



Patients waiting for Mobile Medical Outreach Clinic



Patients examined during Medical Outreach Clinic

### Vaccinations

Vaccination against childhood diseases is a vital activity during our medical outreaches. Many of the diseases that occur in Turkana land are preventable, and it has been the effort of every stakeholder engaging in medical care to make sure that children within our program catchment are immunized in order to save their lives. There are reports now of cases of measles and polio in Turkana land. Our program has increased efforts to make sure children within our catchment have immunization against various childhood diseases. We also target expectant mothers to receive tetanus vaccine. In November we have been engaging in educating rural villages on the importance of bringing children for immunization. We also emphasize and educate on diseases that occur due to lack of immunization. The message was received positively and elders in various villages were given the task of making sure mothers bring their children for immunization during medical outreach days.



Baby receiving vaccination during outreach



Infant immunized during medical outreach



Expectant mother receives immunization education

# KENYA

## INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics



School children receiving health education on HIV/AIDS

### School Health Program

Our teams provide intensive public health education as part of the local school health program. We visited several schools and offered health education on various topics that included good hygiene practices, HIV/AIDS, and deworming of school children. Moreover, we were able to screen the sick children and give them the necessary treatment. We have made this service a part of the routine outreach clinics in the rural villages. Rural villages with schools really benefit from such programs. Some members from our health team teach and treat at the school while the rest see the other patients in the village. Sometimes if there is no space in the school building, the children are treated outside the school building as part of the medical outreach but separate from the routine evaluation of all the villagers. It has been fun and interesting to work with the children.

### Mrs. Aleper

It was on a hot afternoon while conducting a medical outreach clinic in Nakoriongora Village that a middle-aged man arrived, sweating profusely after a long run. He spoke to the health team and explained that his wife was severely sick and needed help immediately. He had run ten kilometres to the site where we were conducting our medical outreach clinic. Without hesitation we took the necessary medication and part of the team went to rescue the patient. We found the patient, a 25-year-old woman and her baby lying down in the hot sun. Her husband had left her in the sun with the baby after struggling to take her into the shade but unable since he was also sick with malaria. It was a very emotional experience for our health team, one member of the team narrated how she found herself tearful after seeing the situation of the patient in the hot sun with her baby. The patient was moved to the shade and given medication and water with difficulty. After the initial medication, the patient was taken to Lodwar Hospital for further treatment where she was diagnosed with severe malaria and amoebiasis. She was treated immediately and discharged four days later in much better condition.



Mrs. Aleper found by our health team in the hot sun with her baby



Clinics are far away causing situations like this



Mrs. Aleper receives malaria treatment



Mrs. Aleper takes medicine and water

# KENYA

## INITIATIVES ■ Community Hospital ■ Ambulance Service ■ Safe Motherhood ■ Livelihood Programs

**31,100 Patients treated**

**415 Babies safely delivered**

**7,574 Children attended Child Welfare Clinic for vaccinations and monitoring**

**1,100 HIV/AIDS patients enrolled in HIV Care**



Mothers and children waiting to be seen at Lwala Community Hospital

### Lwala Community Hospital

The Lwala Community Hospital serves the population of North Kamagambo in Migori County, Kenya. Poor physical infrastructure, including impassable roads during the rainy season, lack of electricity and lack of reliable drinking water, have helped to create a critical healthcare challenge. Malaria, intestinal disorders, tuberculosis, pregnancy complications, HIV/AIDS (rates are 16-20%, triple the national average) and other diseases contribute to a significant infant, child and adult mortality rate. Out of every 1,000 births, 95 babies will die before their 1<sup>st</sup> birthday. Life expectancy in the region hovers just above 40 years.

#### Background

The Lwala Community Health Center was founded by the Ochieng' siblings in memory of their parents who died of AIDS to meet the holistic health needs of all members of the Lwala community, including its poorest. Real Medicine Foundation started our partnership with Lwala in 2007 with additional support from World Children's Fund in 2008. Prior to the establishment of the health center, there was no immediate access to primary health care or HIV/AIDS testing and care. For this reason, the Lwala health initiative has focused on primary care for children, access to medicines (particularly vaccines and antimalarials), HIV testing and care, public health outreach and safe maternity services. Primary beneficiaries are children, pregnant women, HIV infected persons and the elderly. The health center was upgraded to a community hospital in the course of 2011 and has continued its infrastructure expansion and improvement in 2012, and again in 2014. Other programs include Emergency Ambulance Services, Maternal and Child Health Outreach Programs, Education, Economic Development and Livelihood programs. Based on the populations of school aged children and the number of families related to the 13 primary schools in the Lwala area, there are over 30,000 people who are able to access health care at the Lwala Community Hospital by foot or short motorcycle transport. Many other patients walk hours, sometimes days to access safe health care.

#### 2014 Update:

- Launch of the "Thrive thru 5" program in 2014, an effort to reduce under-5 mortality by 50% by the end of 2016. 2,806 children from 1,791 families are now receiving services on a monthly basis from Community Health Workers. The number of under-5 deaths has been gradually decreasing during 2014. The monthly average of the first six months compared to the last six months of 2014 decreased from 9.2 to 3.5.
- Started monthly nutrition trainings for parents of severely malnourished children.
- Community outreaches added to a cumulative total of almost 6,000 individuals reached in 2014, attracting many parents, typically mothers, to discuss issues around family planning options and methods.
- Hospital statistics for 2014 include:
  - 31,110 patient visits (average 2,593/month)
  - 415 babies delivered (average 35/month)
  - 7,575 HIV patient visits (average 631/month)
  - 663 long-term family planning methods dispersed (55 average/month)



Pharmacy at Lwala Community Hospital

# KENYA

## INITIATIVES ■ Community Hospital ■ Ambulance Service ■ Safe Motherhood ■ Livelihood Programs

- Lower delivery rates seen in 2014 than in 2013 seem to correlate closely with the update of family planning in 2013 and 2014.
- Groundbreaking for the expansion of Lwala Community Hospital in October 2014.
- A quality improvement plan was put in place, including improving quality of care and staff communication, and decreasing patient wait time.
- 100 patient interviews were conducted to assess patient satisfaction (most frequent complaint was patient wait time; most frequent praise was better treatment and emergency care).
- Preparation for and start of electronic medical record (EMR) implementation; as of December 2014, 400 patient records have been entered.
- Continued integration of health education into education program activities, including a WASH training and a large WASH promotion for students in the area. A WASH training was held with over 100 participants prior to the 4<sup>th</sup> Annual WASH Tournament in August. The tournament hosted over 800 players and fans; the various booths (on WASH, Thrive Thru 5, family planning, and general health and healthcare) attracted approximately 600 visitors.
- To meet high targets set for reaching students with sexual and reproductive health education and services during school breaks, the Education Team held 3 days of holiday break activities and engaged 474 students. Activities included health sessions on HIV/AIDS, sexually transmitted infections, sexuality and WASH, sports and dancing events, and career development sessions.
- The number of Youth Peer Provider (YPP) referrals for sexual and reproductive health services reached an average of 179/month in Q4.
- Implementation started on Youth Peer Provider (YPP) year 2 activities. Key activities include continuation of YPP-led school clubs, peer-to-peer sexual and reproductive health education, parent and community sensitization, and condom distribution to youth. 13 out of school Youth Peer Providers (YPPs) and 73 CHWs are actively generating demand for family planning services and distributing condoms in the community.
- In November, 86 out-of-school girls graduated from the mentoring program and were linked to a team at LCA to receive livelihood training (tailoring, improved farming, soap-making).
- The ratio of girls to boys sitting for the KCPE (Kenya Certificate of Primary Education) exam in class 8 has increased every year since LCA's girls' education program began. The girl: boy ratio in primary school completion has improved from 37:63 in 2009 to 45:55 in 2014.
- Construction of a youth friendly corner in September; the corner will provide a safe space for youth to meet and learn, FP services and counseling, education and information on SRH, HTC (HIV testing and counseling) services, and STI services. It will also act as a meeting point for the youth health club and possibly a support group for HIV+ youth.
- Increased economic opportunities to promote self-reliance and sustained livelihoods for the people of North Kamagambo through KIVA microloans, Development in Gardening (DIG), agricultural programs and the New Vision Sewing Cooperative.
- The number of KIVA borrowers increased from 30 in October to 57 in November.
- New Vision Sewing Cooperative completed several international orders as well as pad kits and uniforms to be distributed to class 6-8 girls at 13 partner schools.
- Through the Development in Gardening agricultural program, five school gardens have been established in collaboration with school faculty and students. Students at these schools are taking the skills they are learning and starting gardens at their homes. 35-45 students from each school were selected to receive seed packets for their home gardens.
- RMF's CEO Dr. Martina Fuchs and a team from WCF visited Lwala in May 2014.



School Garden



Dr. Martina Fuchs with several of her namesakes



Tailor sewing menstrual pads

# KENYA

## INITIATIVES ■ Community Hospital ■ Ambulance Service ■ Safe Motherhood ■ Livelihood Programs

### Success Stories

**Elizabeth Achieng Omiti**, 52, and a widow since 2000, takes care of five of her grandchildren. A member of the Rang’ala self-help farmer group in North Kamagambo, she receives training on sustainable farming practices and farming as a business. Training topics are crop enterprise selection, farm management, marketing, financial management, group savings/loans, farm profitability, record keeping, value addition of farm products, and long term garden sustainability practices. Participants choose an area of improvement for their own farms that fall in one these topic areas. Elizabeth picked bulb onion growing and developed a bulb onion nursery on her farm in July 2014. She took good care of her nursery until September when it was ready for transplanting. She was then trained on how to transplant bulb onions, and transplanted them into two small plots and worked hard to nurture her bulb onion farm alongside other vegetables in her farm by weeding, fertilizing, and watering when needed.



Elizabeth Achieng Omiti in her garden

Elizabeth made Ksh 17,300 (\$194) from her plot of bulb onions in November: “I would have not been able to make this money if I had planted sugarcane or maize. I now get money daily from the sale of vegetables, and I never go without necessities, like soap, as I did before.” She plans to use her newly-earned money to renovate her house so she and her grandchildren have a safe place to live. Elizabeth does not know how to write well but is assisted by her grandchildren to keep proper records of all her farm expenses and income. She is also able to feed her grandchildren from a variety of vegetables from her own farm. Within the Rang’ala self-help group, Elizabeth is a role model to her fellow group members.



Cellestine Adhiambo

**Cellestine Adhiambo**, 18, smiles, “I would like to be a nurse, and work at the hospital in Lwala.” Her dreams for her future point to her resiliency and hard work, as she recently re-entered school after having dropped out for 6 months. When she was in Class 8 at Lwala Primary School, Cellestine became pregnant and stopped attending school once she gave birth to her baby girl, Francis Marion.

Cellestine is the 4<sup>th</sup> of five siblings; her parents are subsistence farmers. After giving birth, Cellestine dropped out of school to take care of her newborn child. Then, through her visits to the Lwala Community Hospital for her delivery and well-child visits, she heard from staff and other teen mothers about a group of out-of-school girls meeting together in a mentoring group called Salama Pamoja. Curious, Cellestine attended her first mentoring session in May 2013 and remains in the group to this day. She says, “In Salama Pamoja, I learned how to protect myself and I learned about reproduction. The mentors are always teaching us about how we can be courageous; if we get challenges in our life, we can know how to solve them. As girls, you can know many things as you go to school.” When she first joined Salama Pamoja, Cellestine was trained in LCA’s agricultural program and learned farming techniques to learn to grow vegetables to sell in the local market. The female mentors have also created a safe space for her to talk openly if she is experiencing difficulties. They also reached out to her parents and encouraged them to send her back to school. Cellestine re-enrolled in school and is now in Form 1 at Tuk Jowi

Secondary School. She hopes to be a role model for her younger sister and that someday Francis Marion will attend secondary school as well.

Cellestine is demonstrating that Salama Pamoja is effectively empowering girls to continue with their education, gain knowledge about sexual and reproductive health, and make wise choices that will protect them from the risk of violence and infection. She is also actively recruiting other girls to join the mentoring group, “Nothing comes without working. I am always telling girls who have dropped out about the club in Lwala that is called Salama Pamoja. Some of them have come with me and two of these girls have now gone back to school.”



Stesline Achieng'

**Stesline Achieng'**, 14, attends class 7 at Andingo Primary School. She is a member of the Andingo Health Club, where students learn about diseases, hygiene, and sexual and reproductive health and receive training on how to plant, grow and sell vegetables. “This is the first time I have learned about how diseases are contracted. I know that washing my hands and staying clean can prevent cholera and typhoid. I also know that girls can get HIV, STIs, and even become pregnant at a young age if they are not knowledgeable. All of these things might cause you to drop out of school.” Stesline was one of the recipients of a pad kit this past July, and is incredibly happy. Before being given the pads, she was using pieces of old clothes during menstruation and appreciates the fact that these pads are reusable: “Before, I was not coming to school during my period, but now I am. Now, I can improve my marks because I don’t miss lessons.” Stesline has done remarkably well in school this year, and is ranked second out of 40 students in her class. She dreams of attending Limuru Girls School, a highly-ranked national school in Kenya, and becoming a lawyer. Asked about life as a young woman in the community, she says, “I am very proud of being a girl here because we receive pads, uniforms, education and mentorship that help us to be happy and successful.”

# MOZAMBIQUE

## INITIATIVES ■ Mobile Clinic Project

30,363 Patient consultations and treatments

Target population: 10 districts in Zambézia Province, 2.5 million people

978 HIV Patients identified and treated

578 HIV Patients receiving ART

49 Children under ART

1,512 Patients receiving CTZ prophylaxis

2,159 Pregnant Women registered with ANC



Mothers line up with their Children for Vaccination Outreach Clinic

### Mobile Health Clinic Outreach

#### Background

RMF's Mobile Clinic in Mozambique was initiated as a model of health care provision, conceptualized to reach remote and rural communities with extremely limited prior access to health care. Since its inception in 2008 our Mobile Clinic has been hugely successful and has been delivering high impact health care in some of the most difficult to reach regions of Mozambique. The clinic, a collaboration between RMF, Vanderbilt University's Friends in Global Health (FGH) and Medical Mission International, is currently deployed in one of the most populous provinces of Mozambique, Zambézia Province, located in the central coastal region with a population of almost four million. The Mobile Clinic vehicle, custom built on a mid-sized truck frame, operates as a 'mini-health clinic on wheels' and provides an extremely versatile and flexible platform for providing health care services, education and counseling.



Weighing baby at health facility

Addressed are all the most common health problems observed within the targeted region, such as Malaria, Malnutrition, Diarrhea, HIV/AIDS and Tuberculosis. The main services provided through our Mobile Clinic include general clinic consultations (adults and children); antenatal clinics, family planning, HIV counseling and testing for pregnant women, and PMTCT for HIV+ women; immunization for children and pregnant women as per the National Program schedule; nutritional monitoring and supplementation for children and adults; counseling for prevention of cervical and breast cancer and referral of suspected cases for follow-up; health counseling and testing (HCT), including distribution of male and female condoms; positive prevention packages for HIV+ patients; rapid testing for malaria, HIV and syphilis; TB services, including TB screening, TB treatment and follow-up; HIV services, including follow-up and point-of-care lab control, CTZ prophylaxis and initiation of ART; first aid for medical emergencies; collection of blood and other biological samples for lab tests and transport to laboratory; transport of sputum samples for TB smears, collected by DOTS-C volunteers and Mobile Clinic staff; support of DPS-Z in health-related celebrations and events; public education regarding the importance of adherence to ARV treatment, proper use of condoms and malaria prevention.

The target population includes 10 districts (Alto Molócuè, Chinde, Gilé, Ile, Inhassunge, Maganja da Costa, Morrumbala, Mopeia, Namacurra, and Pebane), comprising approximately 2,500,000 people. Starting in 2012, a revised strategy was implemented for the increased and enhanced utilization of the Mobile Clinic, integrating it within the CDC/PEPFAR-supported HIV care and treatment services supported through Vanderbilt University/FGH. RMF funding, together with CDC/PEPFAR support for the Mobile Clinic operating in Namacurra District, has allowed our teams to deliver quality HIV/AIDS care and treatment services to the populations in four extremely isolated sites in 2014. The direct target population for the Mobile Clinic in 2014 included the communities of Furquia and Mbawa in Namacurra District and the health staff supporting the implementation of services in those MOH health facilities.

# MOZAMBIQUE

## INITIATIVES ■ Mobile Clinic Project

### 2014 Update:

The Mobile Clinic team continued to strengthen the technical and logistical capacities of local personnel through clinical mentoring activities and on-the-job training. In addition to daily lectures given on disease prevention, community members benefit from health counseling and testing in screening rooms where, on a voluntary basis, individuals can be screened for malaria, TB, STIs, HIV. Malaria prevention, diagnostics and treatment were prioritized (malaria cases increase during rainy season). HIV testing is also implemented in the vaccination sector following the recommended strategy of testing at every entrance to the health units. In addition, the Mobile Clinic team provides management support and aids in medication (ARVs, cotrimoxazole, isoniazid, ferrous salt, mebendazole) and blood sample transport.

Reinforcement of the community clinical linkages was maintained through continuous coordination with the existing Health Councils (Conselhos de Saude) in the targeted communities with several monthly meetings held among Health Councils and health facility staff, each averaging 50 participants, including Traditional Birth Attendants, Community Leaders, DOTS Volunteers, Health Councils Volunteers, APES, Religious Leaders and Health Technicians.

In 2013, the Ministry of Health of Mozambique had officially integrated the RMF Mobile Clinic in Namacurra into the strategy to support implementation of the very ambitious national ART acceleration plan. Since then, implementation of the “Option B+” strategy and World Health Organization guidelines to initiate ART to all children under 5 years of age determined the focus and direction of the Mobile Clinic in Namacurra District.

### The following services are included in the support package that the Mobile Clinic provided (with funding support from PEPFAR):

- HIV services, including monitoring and quality control at the point of service delivery, prophylaxis with cotrimoxazole (CTZ) and initiation of ART.
- Health counseling and testing (ATS), including distribution of male and female condoms.
- HIV counseling and testing for pregnant women and PMTCT (prevention of mother-to-child transmission) services for HIV+ women.
- Positive prevention package for HIV+ patients.
- TB services, including screening, treatment and follow-up.
- Collection of blood and other biological samples for analysis and transport to the laboratory.
- Transport of TB sputum smears samples, collected by C-DOTS volunteers and Mobile Clinic staff.
- General clinical consultations (adults and children).
- Rapid testing for malaria, HIV and syphilis.
- Basic First Aid for medical emergencies.
- Referral of patients to health facilities according to clinical needs.
- Evaluation and nutritional supplementation for children and adults.
- Support for DPS-Z (Direcção Provincial de Saúde da Zambézia) in health-related events.

### Technical support provided by the Mobile Clinic team included:

- Reinforcement of diagnostic and clinical management of TB (pediatric)
- Screening/assessment of malnutrition
- Creation of GAACs (Grupos de Apoio a Adesão Comunitária)
- Refresher sessions for PCR sample collection, registration and sample transport
- Clinical mentoring
- Data registration and clinical patient record data collection
- Clinical patient record organization
- Pharmacy inventory
- Update and organization of individual patient forms for receiving ARVs (FILAS)
- Update of lost-to-follow-up in the database and lists for active case finding



Nurse preparing medication



Vaccination administered to an infant

# MOZAMBIQUE

## INITIATIVES ■ Mobile Clinic Project

- Refresher sessions on clinical protocols and MOH HIV/AIDS clinical orientations
- Distribution of job aids and algorithms

### Health care services and ART:

- 978 new HIV patients were enrolled in clinical care in 2014.
- From 1,066 HIV-positive persons receiving care during the year eligible for CTZ prophylaxis 1,006 received CTZ prophylaxis
- 870 individuals with advanced HIV infection were newly enrolled on ART; 799 adults ( $\geq 15$  years), 71 children (0-14 years old)
- New care patients who were screened for STIs at the last visit during the reporting period: 863

### Provision of Prenatal & PMTCT services (universal ART) for pregnant and lactating women:

- In the period under review, 2,159 pregnant women were registered at ANC service in the two health units, 1,145 in Furquia and 1,014 in Mbawa; 1,969 pregnant women received HIV counseling and testing with 274 positive results (14%). Due to Option B+, 261 HIV+ pregnant women received ART during this period (95.2%). Efforts to strengthen ART adherence counseling and follow-up of female patients' children in the CCR are ongoing.
- Partner testing continues being reinforced through "palestras" (lectures) in the health facilities and communities for men to accompany their pregnant partners. During the period, 655 partners of pregnant women were tested, 116 being diagnosed HIV+ and referred for ART care and treatment.
- Health facilities supported by the Mobile Clinic now count on mother to mother support groups to improve adherence. Currently women meet once per month to share experiences and receive orientation from the MCH nurse and trained TBAs. After the meeting, HIV+ women join the larger group to participate in the demonstration of nutritional food preparation for children.
- Provision of health care services and early HIV diagnosis in infants born to HIV+ women
- 278 children were enrolled in the Child-At-Risk Clinic (CCR)
- 263 pediatric patients benefited from virological testing with 35 positive results reported.
- Rapid testing was offered to 113 children, 8 were positive.

### Voluntary Counseling and Testing – Children:

- 277 children were counseled and tested with 73 HIV+ results, 64 of them initiated ART

### Diagnostic services for TB care and treatment:

- 70 patients were enrolled into TB care and treatment. All underwent counseling and testing for HIV, with 43 positive results.



Mobile Clinic in the field

# NIGERIA

## INITIATIVES ■ Primary Health Care

Access to healthcare for over 154,000 in one of the most remote areas of Nigeria

More than 34,800 patients treated

Lab and Dental services

### Gure Model Healthcare Center, Baruteen LGA

#### Background

Nigeria's child mortality rate of 117 per 1,000 for 2013, while improving over the past few years, is still ranked among the 10 countries showing the highest child mortality rates of all 191 countries tracked by the World Health Organization. Nigeria's maternal mortality rate also improved but still stands at a high 560 per 100,000, also among the highest rates in the world. Real Medicine Foundation, supported by World Children's Fund, has partnered with the Kwara State Ministry of Health, the Nigerian Youth Service Corps and the Gure Gwassoro Ward Development Committee to support the previously abandoned Gure Model Health Center. Situated near the Nigeria/Benin Republic border, this health center is the only access to healthcare for a population of over 154,000 in the Baruteen Local Government Area and its surrounding towns. Patients continue to cross the border from the Benin Republic to seek treatment here.

The Nigerian Youth Service Corps (NYSC) was created in a bid to reconstruct, reconcile and rebuild the country after the Nigerian Civil War. As a developing country, Nigeria is plagued with poverty, mass illiteracy, acute shortage of high skilled manpower (coupled with highly uneven distribution of the skilled people that are available), inadequate socioeconomic infrastructural facilities, housing, water and sewage facilities, roads, healthcare services, and effective communication systems. The NYSC is responsible for deploying graduating professionals, including physicians, to Nigeria's remote regions for their final year of service to their country. As a result of our support at the Gure Health Center, the NYSC along with the Kwara State Ministry of Health partnered with RMF to leverage their network of emerging medical staff and their connectivity to other remote health care clinics within Kwara State in need of support.

#### 2014 Update:

RMF's provision of medicine and supplies to the Gure Model Healthcare Center has continued to enable high quality medical services, rising patient treatment numbers again in 2014. Weekly immunizations are consistently provided, and regular maternal and child health and hygiene clinics are held for new mothers, with continued high attendance. We also provide regular supplies of laboratory reagents to conduct basic laboratory tests, thus facilitating more inclusive, comprehensive health care delivery versus the previously necessary referral to the state hospital in Ilorin. We also maintained our focus on good relationships between the community and all involved parties and stakeholders. Word of the high quality medical services provided and the dependable stocks of medicines and medical supplies at the health center continued to spread through the entire surrounding community and we are now averaging 2,900 patients per month; 34,825 patients for the year 2014.

Services provided include:

- Primary Healthcare, Family Healthcare, Maternal and Child Healthcare
- Weekly Immunizations for newborns and infants
- Malaria treatment
- HIV/AIDS support
- Management of systemic diseases such as Hypertension and Diabetes
- Community Outreach and Training
- Dispensary for Medicines
- Laboratory Facilities
- Dental care



Mother and child waiting to see the doctor at RMF Nigeria Clinic



Nurse attending to new patient



Pediatric patient and father

# HAITI

## INITIATIVES ■ Disaster Relief ■ Surgical Support Program ■ Long Term Health Care Capacity Building

### Orthopedic Surgical Support Program

#### Hospital Equipment and Supply Support

##### Background

In the aftermath of the January 12, 2010 earthquake, in addition to tackling some of the immediate relief needs, RMF moved forward with a comprehensive long-term strategy for sustainable health services development in Haiti to help rebuild its shattered public health system. Our work during the initial weeks was focused on the provision of medical staffing, medicines and medical supplies and strategic coordination to help meet the surging needs of the health crisis on the ground.

For all of 2010 and much of 2011, RMF provided free clinic services at Hôpital Lambert Santé Chirurgicale in Pétion-Ville, a facility which since the January 2010 earthquake had never stopped providing much needed care to public patients. Pétion-Ville and the surrounding communes were home to more than 100,000 displaced persons, living in tent communities. This free clinic continued to offer quality healthcare to patients in need of primary, secondary and even tertiary care. We were able to provide for more than 1,800 consultations and 450 surgeries over this time frame.

Five years have passed since most of Haiti's infrastructure was devastated, and while much progress has been made in rebuilding efforts, there is still much work to be done. Social and healthcare status remain dire and worsening because of the now dwindling presence of NGO-run Primary Healthcare Clinics all around the areas of the country most affected by the 2010 earthquake, and even more so in Port-au-Prince.

While a very positive initiative, having given more people access to basic care, sadly the effort remained disorganized and unstructured and did not define a clear and continuous pathway for the patients in search of diagnosis and treatment; secondary and tertiary care continues to be desperately lacking. Never losing sight of our main objective to increase overall access to quality secondary and tertiary care for the entire Haitian population, RMF has kept that vision alive through our partnership with two local Haitian private healthcare institutions, sharing our philosophy, but also by actively researching funding towards much larger partnerships.

##### Orthopedic Surgical Support Program

RMF continued our Surgical Support Program in Haiti that we had started in 2012, providing complex surgeries and longer term follow up treatment for children and adults suffering from chronic or acquired orthopedic conditions, often extremely severe, ranging from congenital deformities to posttraumatic impairments, in many cases caused by the January 2010 earthquake. Over the past three years, generously supported by Child Survival Fund, Real Medicine Foundation has been able to provide specialized orthopedic care and follow up treatment for 50 children and adults who were desperate for treatment of their posttraumatic or congenital ailment, preventing them from thriving or taking care of responsibilities and their families' needs.

Most of our child patients were selected at a facility, St. Vincent's School/Hospital, that cares for children with cerebral palsy, orthopedic, congenital, and trauma related deformities. St Vincent's was once the only recourse for these children, providing schooling, ambulatory clinic and surgeries but was destroyed in the 2010 earthquake. It is currently operating with only outpatient services and no surgical capacity for the foreseeable future. These young children and young adults came to St. Vincent's from the metropolitan area of Haïti's capital Port-au-Prince as well as the remote provincial towns located in the far southern and northern departments of the country.

##### 2014 Update:

Our dedicated surgical team of two orthopedic & trauma surgeons and one anesthesiologist, have to date performed 50 specialized orthopedic procedures at the Lambert Santé Chirurgicale in Pétion-Ville, making it possible for these little patients to regain capacity to walk, to do so proudly, free from society's discrimination for their visible and incapacitating conditions. Real Medicine Foundation has been able to continue providing these complex surgical services as well as the multifaceted follow up care for these patients through generous funding by CSF, with an additional ten patients added to our program in 2014.



Manoach, an orthopedic surgical patient of RMF Haiti

# HAITI

## INITIATIVES ■ Disaster Relief ■ Surgical Support Program ■ Long Term Health Care Capacity Building

The third edition of RMF’s orthopedic surgical program was completed in December 2014 and again benefited children, teenagers and young adults who were incapable of enjoying a normal childhood or starting a meaningful young professional life. This year once more, in view of the severe conditions encountered in our outpatient services, we concentrated our efforts on patients with major deformities, focusing on improving their functionality and subsequently their overall aspects, our main desired outcome remaining to optimize their chances to thrive as active members of their communities.

We again had three young patients with very severe forms of Blount’s disease, a deformity of the lower limbs that is a common condition afflicting a specific ethnic group in Haiti, which also includes increased weight and specific morphologic features as well as moderate to severe progressive medial leg bowing and tibial bone changes: Samaelle Joseph, 10 years old, Nancy Samedi, 6, and Edouard Julien, 14; the latter patient returning for a second surgery to complete his treatment, started in 2013.

Five other patients were treated for lower limb deviations resulting mostly from complications from incorrect fracture treatment at other facilities: Hormia Massenet (3 years old), Anne-Christelle Guillaume, 10, Junior Janvier, 13, Cadeus Boileau, 13, and Rosebert Stevenson, 14.

### Success Stories

**Manoach Loudort** is a 6 year old boy, for whom we had previously done a corrective tibia osteotomy in 2013 for his post-traumatic left tibia injury and a temporary growth arrest on the medial side of his femoral growth cartilage at age 4. In 2014, when we noted recurrent bowing, following the first procedure, we had to perform another procedure, a more aggressive osteotomy correction, in view of lessened but still ongoing deformity 6 months later. Upon the last follow-up, 4 months after his last surgery, his recurring condition appears to have finally been halted.



Manoach before his first surgery

Before and after x-rays



After 1<sup>st</sup> surgery (probable overstimulation of his growth cartilage)

Knee stapling to arrest medial growth

# HAITI

## INITIATIVES ■ Disaster Relief ■ Surgical Support Program ■ Long Term Health Care Capacity Building



1 year after surgery (1<sup>st</sup> & 2<sup>nd</sup> round)

Final results 3 months after 2<sup>nd</sup> corrective osteotomy

**Pédaline Louis** is 13 years old now, and was first treated during our second surgical program in 2013 for a severe bilateral bow leg deformity caused by rickets. She was able to see her life drastically changed following just the first surgery on her right leg that year and then benefited from the same surgery to re-align her left lower limb in 2014 to finally match her new appearance and functionality.



Pédaline before her first surgery

Before and after x-rays

3 months after 1<sup>st</sup> surgery, x-rays show full bone healing



Pédaline 6 months + after her 1<sup>st</sup> surgery, ambulatory before her 2<sup>nd</sup> surgery with a new look, and after her last surgery with cast

The journey of **Shirley Etienne** is a reminder of the impact of this orthopedic surgical program and an example of what could be done with the right funding towards the right project: This young girl came into our care more than a year after she was injured during the 2010 earthquake. She had suffered from a closed distal femur growth plate fracture, which in the midst of all the emergencies in the aftermath of the catastrophe failed to receive proper care. The turmoil following this catastrophe prevented her to later access any facility and resulted, as these injuries do more often than not, in progressive deviation and shortening of her left lower limb due to partial growth plate arrest.

# HAITI

## INITIATIVES ■ Disaster Relief ■ Surgical Support Program ■ Long Term Health Care Capacity Building

After a successful procedure in 2012, aiming to restore a more anatomical alignment of her knee joint with an external fixation device, we managed to restore also more than adequate knee mobility with an intensive physical therapy regimen. In 2013, we were able to complete her surgical treatment course by addressing the more than 2 inches of leg discrepancy she had remaining from her quake-related injury. Through an escalator technique, we lengthened her thigh bone to recuperate the difference and provide her with an equal limb to the non-affected side.



Shirley turned 13 in 2014, after her 3<sup>rd</sup> surgery, and is now a young girl with a much more cheerful outlook on life, looking forward to all the usual activities other teenagers like her are engaging in. She is not afraid any longer to show her legs and is not ashamed anymore of her appearance and gait. As she continues to strengthen her lower limbs with physical therapy, she has already recuperated almost all of her previous, pre-earthquake range of motion and is looking forward to so much and is so grateful for her care, as so eloquently put by her own words in a text message she sent:

*“Bonjou doktè mwen te wè mesaj ou te voye-a pou te mandem vini lan randevou, mwen pat kapab a koz pwoblem ki te gen la peyi-a. Mwen pa pimal e mwen te vle diw m’tap vinn wèw, men fòm ta pote yon sipriz pou ou... Mèsi anpil pou operasyon yo, mwen kontan ampil... si se pat ou men mwem pa tap ka mache byen, mwen tap domaje nan pye e mwen tap wont ale tout kote... Mèsi anpil ankò doktè, salye doktè Olivier ak doktè Beauvoir pou mwen...”* which translated to English means:

*“Good morning Doctor, I had seen the text you had sent to me asking me to come for follow-up but I could not come because of the ongoing problems in the streets. I am going to come but I have to bring a surprise for you. Thank you very much for the surgeries. I am very happy. If it wasn’t for you, I would have remained damaged and would not be able to walk or go anywhere I need or have to... Thanks a lot again, please say hi to Doctor Ollivier and Dr Beauvoir for me.”*

This provides a glimpse of how this surgical program or better yet, the type of quality and continuity of care we are aiming for, has impacted Shirley’s life, and could impact the life of hundreds, thousands of kids like her.

### CDTI Hospital project – Centre Hospitalier du Sacré-Cœur, Hôpital CDTI

The stories of these children are examples of RMF’s interest and overall philosophy to promote and provide sustainable healthcare, which has been paramount in our efforts to implement a public/private partnership healthcare facility in Haiti available to all patients regardless of their ability to pay, RMF’s CDTI Hospital project (Centre Hospitalier du Sacré-Cœur, Hôpital CDTI). This project has been developed to become a flagship hospital, offering greater access to quality and continuity of care in a facility dedicated first and foremost to serve the patients through a sustainable model developed in a modern and integrated healthcare facility, capable of generating the required income for operational and expansion costs through both private and subsidized revenues. This flagship facility, as it is envisioned, has the potential to become a game changer in the Haitian healthcare system, improving access to quality secondary and tertiary care for the Haitian population and its visitors in an ever developing climate.



CDTI Hospital

# PERU

## INITIATIVES ■ Primary Health Care ■ Medical and Dental Outreach

**Serving 30,000 in San Clemente; 125,000 reached in Province of Pisco**

**11,741 patients treated**

**Ultrasound, Dental and advanced Lab services**



Nurse attending to patient at the RMF's Policlínico Peruano Americano

### Policlínico Peruano Americano in San Clemente, Pisco

#### Background

On August 15, 2007 a magnitude-8 earthquake struck just off the coast of central Perú, with more than 1,000 killed, 3,000 injured and more than 58,000 homes destroyed. The areas most affected were Pisco, Ica, Chincha, Cañete, and Huancavelica. After initially supporting the Children's Hospital in Lima which experienced a substantial influx of patients from the earthquake affected areas, helping other NGOs with aid and food distribution during the first days after the earthquake, and running a temporary health clinic to offer primary healthcare services until an appropriate permanent location was found, RMF Perú opened the doors to the "Policlínico Peruano Americano" in its permanent location of San Clemente, the poorest district in Pisco, in December of 2007. The clinic's target population is San Clemente (population of 30,000), but because of its excellent reputation of delivering high quality medical services, it also receives many patients from other areas of the province of Pisco (population of 125,000).

RMF's Policlínico Peruano Americano was originally located in an earthquake safe residential building with several examination rooms, a large waiting area, laboratory, and ultrasound equipment. During our first year we also treated over 3,000 children through a school nurse program. From the start, we held weekly educational health workshops both inside and outside of the clinic, on topics requested by our patients such as family planning, arthritic pain, hypercholesterolemia, lower back pain, and acute diarrheal disease. In February 2011, upon invitation of the Mayor and the City of San Clemente, RMF's Policlínico moved to a new building with the sponsorship of the local authorities under which RMF Perú continued to provide medical services to those in and around the district of San Clemente. The City of San Clemente provided us with resources such as electricity, water, security guards and cleaning services. This new location was more economic for RMF Perú to rent and manage, and brought us in closer partnership with the local health and political representatives.

The presence of RMF's Policlínico Peruano Americano continues to relieve the strain on the existing health infrastructure where patients didn't have sufficient access to healthcare even before the earthquake. Services provided include general medical services, Pap smear exams, laboratory, EKG services, and dental services 3 times a week. In addition, the philosophies adopted at our clinic are based heavily on education and prevention. Not only are our patients being treated for their illnesses, but they are being educated as to why they are sick and how they may prevent the sickness in the future. Dental outreach campaigns are performed at least once a month to specifically reach seriously underserved patients.



RMF's Annual Christmas Chocolatada Children's Party

#### 2014 Update:

- In May 2014, we came to an agreement with the Municipality of San Clemente in a Municipal Assembly to move into a new, bigger, and more central office space. The new location for our Policlínico Peruano Americano is approximately two blocks from the Municipality, and located in the central square of San Clemente. We moved on May 19<sup>th</sup> and reside in the entire second floor of the building.
- An average of 49 patients per day are treated at our clinic and during our team's medical and dental outreach efforts, representing all ages from newborn to 60+, with an average of 975 patients treated per month.

# PERU

## INITIATIVES ■ Primary Health Care ■ Medical and Dental Outreach

- We held 3 Dental Campaigns, treating a total of 146 patients at the Policlínico Peruano Americano location in February, March and August.
- As it continues to be rare to receive dental patients at our clinic, our dentist and team have been visiting local schools to offer their services in Dental Outreach Campaigns. The dental care team held 8 fluoridation campaigns at different elementary schools in San Clemente with a total of 1,837 children treated. In addition, Oral Hygiene talks were given at schools in San Clemente and at our clinic.
- We held a Health Outreach Campaign in Nazario Palimino, San Clemente in Q1 2014, and carried out several Anemia Screenings and Awareness Campaigns in San Clemente in the course of 2014.
- Echography and ultrasound exams continue to be performed.
- For the fifth consecutive year, a Medical Outreach Mission was conducted for the populations surrounding San Clemente by RMF Perú and the Peruvian American Medical Society (PAMS) on the 19<sup>th</sup>, 20<sup>th</sup> and 21<sup>st</sup> of August. A total of 174 patients were treated, many with histories of diabetes and hypertension. There were also 56 patients who received dental consultations, including dental treatments, extractions, and fluoridation. 4 patients required and received psychological care, and 12 patients were transferred to medical specialists in Chincha for treatment of more complex medical conditions. We also organized art workshops and psychotherapy sessions for several patients following a brief orientation how to improve mental health. The PAMS 2014 Mission contributed the following medical equipment to our Policlínico Peruano Americano: Digital Incubator, 3 Micropipettes, Brand Scilogex; 1 Camera (Neuwar/double mirror).
- We received 150 gifts and cookies for our 2014 “Chocolatada” and held the Chocolatada party on the 21<sup>st</sup> of December in the Municipality Building with a Clown and Santa Claus joining the festivities.



Patients line up for an outreach clinic in Nazario Palimino



Mother and daughter patients at RMF's Policlínico Peruano Americano



RMF's Annual Christmas Chocolatada Children's Party



RMF Perú's Medical Staff seeing a pediatric patient

# UNITED STATES: LOS ANGELES

## INITIATIVES ■ Medical Outreach and Healthcare Education ■ Children’s Programs

At home in Los Angeles, Real Medicine Foundation has initiated outreach programs at several locations in underserved areas in the greater Los Angeles area to provide medical/physical, emotional, social and economic support to children and adults, including training for teachers and caregivers on psychological trauma support for children.

### Florence Western Medical Clinic, South Los Angeles

RMF’s Community Outreach Programs at FWMC have focused on increasing health care access and health education to the South Los Angeles community. FWMC provides care to patients from all economic backgrounds. Services offered are primary healthcare, pediatrics, geriatrics, gastroenterology, diabetes care, podiatry, and physical therapy. The clinic also hosts a variety of specialists committed to meeting the needs of the whole family as well as a full service pharmacy and laboratory. RMF’s outreach programs included physical therapy and healthcare education services as well as non-medical services such as physical fitness and yoga for adults and children, programs for new mothers, assistance to families with children without insurance, arts & crafts and reading programs for children, and much more. Most of the children who participated in our programs are being raised by family members other than their parents, and are at heightened risk for future physical and psychological problems. In consideration of this fact, RMF’s Children’s Programs have been especially focused on teaching the children how to approach and successfully overcome stressful situations within their everyday lives. RMF, in collaboration with Health Net has also provided workshops for adults educating the community of South Los Angeles on the benefits of living a healthy lifestyle. The participants i.e. engage in low-impact exercises; discussions included the risks of smoking, alcohol and drug abuse along with the benefits of healthy eating habits to lower cholesterol levels, risk of diabetes and heart disease. RMF’s programs have also included Annual Holiday Parties and “Back to School” Events. Our daily healthy food and grocery program in cooperation with the Whole Foods Market in Venice, CA, was in place from 2008 through 2013. Generous contributions from donors such as Mizrahi Tefahot Bank Ltd made several of our programs in Los Angeles possible.

In 2012, we added a “Walk For Real” program. Obesity and inactivity are fast becoming the number one threat to the health of many Americans. At the same time, exercise can be dangerous in many of the city’s neighborhoods. RMF believes the best healthcare is preventative and introduced a community walking program offering to help individuals make physical activity a regular part of their lives – while becoming more involved in their neighborhood through a fun, motivational group walk.



Girl at the Florence Western Medical Clinic



Children’s activities at FWMC

### Family Care Center, Downey, South Central Los Angeles

JWCH Institute, Downey Regional Medical Center and AD+ World Health partnered to create the JWCH/DRMC Family Care Center, a Federally Qualified Health Center. Real Medicine Foundation remains one of the first partners of the coalition to help attract funding support and to provide outreach programs. Construction was completed in August and the clinic opened in October 2014. It is run and operated by JWCH Institute, a network of FQHC clinics in Southern California. The clinic began as a satellite of their Norwalk clinic at 20 hours per week. It is expected to get full status as a stand-alone site within 8 months and operate at full time with extended hours. The clinic will additionally be a training site for Family Medicine residents from PIH Health Hospital, Downey. The JWCH/DRMC Family Care Center serves as a primary, preventative and urgent care family clinic in Downey to serve the underserved and underinsured in Southeast Los Angeles County. The local community has been in desperate need of a healthcare home where children and adults can receive the full spectrum of primary and preventative care. With the implementation of the Affordable Care Act, much of our underserved population now has medical coverage but no access to medical care without the addition of more clinics. Clinic services include comprehensive primary care for children and adults; mental health services; prenatal care and education; preventive education on asthma, diabetes, heart disease, HIV, STDs, teen pregnancy, obesity; women, infants & children (WIC) enrollment; urgent care; nutritional and exercise education. Patients are seen regardless of ability to pay.



DMRC Family Care Center

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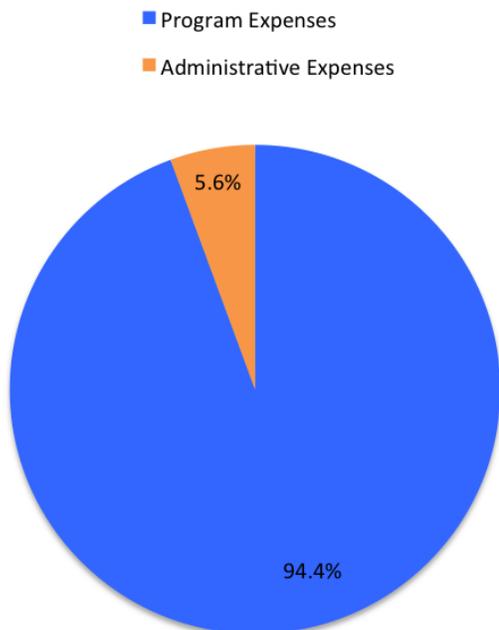
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Stanford University | Center for Innovation in Global Health  
Stanley & Marion Bergman Family Charitable Fund  
Stein Family Philanthropic Fund  
Steven Bochco Productions, Inc.  
Tahoe Associates, LLC  
The Amy L. Sheyer Trust  
The Annenberg Foundation  
The Apple Matching Gifts Program  
The Babaian Family Trust DTD  
The Long Island Community Foundation at Nassau Hall  
The Maya Foundation  
The New York Community Trust  
The Rosenthal Family Foundation  
The Sacherman Fund  
The Salvation Army  
The Surly Goat, West Hollywood, CA  
Tides Foundation  
Tiger Freight Services, Inc.  
TISS | Tata Institute of Social Sciences, India  
Total Contact Management, London, UK  
UBS AG | Employee Giving Program  
UN ECOSOC | United Nations Economic and Social Council  
UNDP | United Nations Development Programme  
UNFPA | United Nations Population Fund  
UNHCR | United Nations High Commissioner of Refugees  
UNICEF | United Nations International Children's Fund  
Union Bank of California, Los Angeles, CA  
University of Alberta, Canada – School of Public Health  
University of Pittsburgh at Bradford, PA  
Vanguard Charitable  
Walmart Foundation  
WHO | World Health Organization  
Whole Foods Markets  
World Bank Development Marketplace | The World Bank  
World Children's Fund  
Windle Trust Uganda  
Zanmi Lasanté, Partners in Health, Haïti

# FINANCIALS

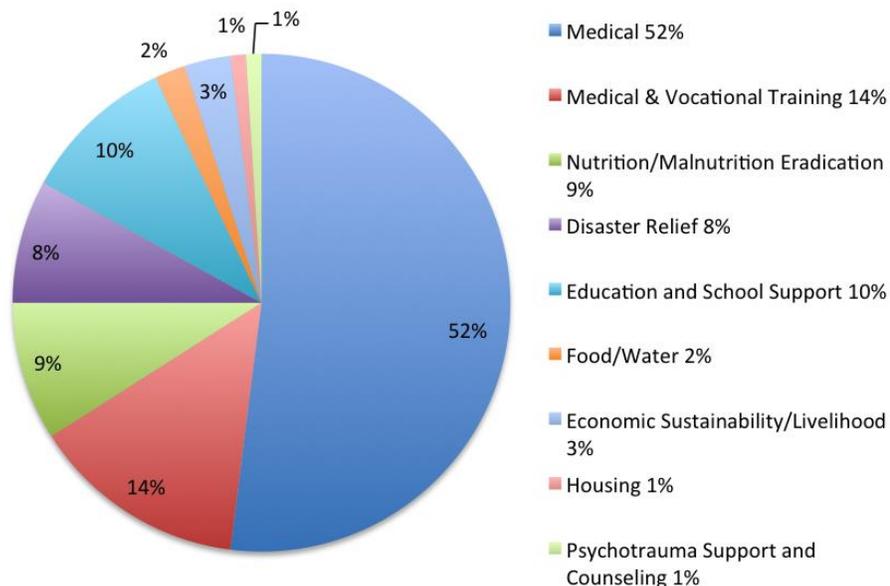
## FISCAL YEAR 2014 (June 2013 - May 2014)

In US \$	Fiscal Year 2013	Fiscal Year 2014
<b>Contributions and Grants to RMF USA*</b>	<b>1,624,321</b>	<b>3,910,162</b>
<b>Expenses*:</b>		
Program Expenses	1,339,562	3,602,916
Administrative Expenses	179,443	192,362
Fundraising	21,244	20,529
<u>In-kind Expenses</u>	<u>55,500</u>	<u>0</u>
<b>Total Expenses</b>	<b>1,595,749</b>	<b>3,815,807</b>
<b>Total Net Assets</b>	<b>206,491</b>	<b>786,415</b>
<b>International Contributions**</b>		
Contributions to RMF Germany (100% used for program expenses)		<b>1,089,080</b>
Contributions to RMF Pakistan (100% used for program expenses)		<b>106,218</b>
Contributions to RMF India (100% used for program expenses)		<b>105,971</b>
Contributions to RMF Uganda (100% used for program expenses)		<b>70,245</b>

### Total Expense Breakdown



### Global Program Expenses by Category



\*Fiscal 2014 IRS Form 990 US Contributions and Grants, and Expenses. Copies of 2014 Form 990 or earlier years may be found on RMF's website or requested from head office in Los Angeles.

\*\* The Fiscal 2014 international figures are set up in accordance with international accounting standards.

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