



# **ANNUAL REPORT 2015**

## **Liberating Human Potential**

AFRICA | AMERICAS | ASIA | EUROPE

**RMF**  
REAL MEDICINE FOUNDATION



## Contents

History & Mission	6
Our Team	8
Our Work	12
India	14
Pakistan	30
Sri Lanka	48
Nepal	52
South Sudan	66
Uganda	82
Kenya	100
Mozambique	118
Nigeria	128
Haiti	132
Perú	138
Los Angeles, California	144
Our Partners	148
Financials	150
Contact Us	152

Real Medicine Foundation Annual Report 2015  
[realmedicinefoundation.org](http://realmedicinefoundation.org)



# History & Mission

Real Medicine Foundation was founded in May 2005, inspired by lessons we learned after working for months in the Indian Ocean 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 focuses on the person as a whole by providing medical/physical, emotional, economic, and social support.

At RMF, 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 own unique challenges. We therefore 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: Liberating Human Potential.

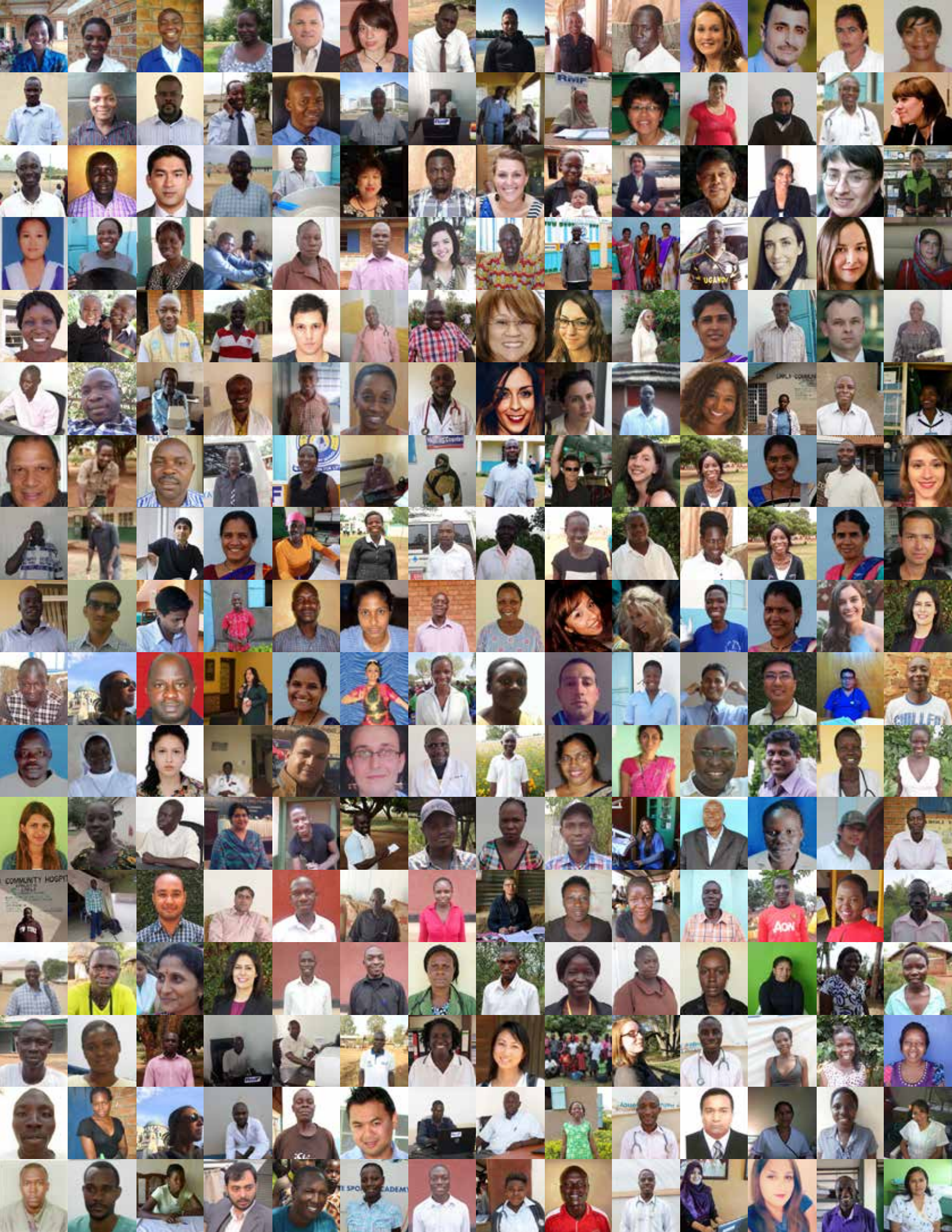
The first years after RMF's inception were characterized by emergency responses to the succession of natural disasters in 2005 and 2006. It was our experience gained in the field that shaped the organization's driving force and gave birth to our flexible, sustainable in-country strategies.

Based on today's best practices in modern medicine, RMF utilizes a Comprehensive Integrative Health Care Model. Once survival and immediate healthcare needs are addressed, we establish mobile and stationary health clinics employing regional medical doctors, other healthcare professionals, and supporting staff, and tailoring our clinics 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 Health Care, 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. the support and upgrade of hospitals and training of medical personnel, to build healthcare 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 ten years, Real Medicine Foundation has worked in 21 countries on 4 continents, with active projects in 17 countries, and has aligned with governments and international agencies, including the UN, to reach those most in need.

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. RMF is in Special Consultative Status with the United Nations Economic and Social Council and in PVO Status with USAID, and is Implementing Partner with UNHCR in Uganda, with WFP in South Sudan, and with UNICEF in South Sudan and Pakistan.



# Our Team

## OUR MISSION: LIBERATING HUMAN POTENTIAL

### Lasting Change

RMF is aligned with governments and international agencies in twenty-one countries on four continents around the world; we partner with and empower local populations, co-creating long-term solutions that are self-sustainable. RMF believes that real medicine focuses on the whole person, reaching beyond medical and physical care to include economic, social, and emotional support as well. From disaster relief to hospital support to vocational training, RMF's adaptive global initiatives are tuned to the country, culture, and needs of the region, and based on our ethics of 'friends helping friends', treating every person with dignity and respect.

### Proven Methods

In eleven years of operation, RMF's services reach a target population of more than 15 million people worldwide. Adaptive, creative, and efficient, RMF makes the most of every dollar donated by employing local, passionate, dedicated teams that combine deep regional wisdom with cutting edge best practices. We are all united by the unique human ability to transform the world around us – the people in developing and disaster stricken areas are most capable of solving their unique challenges. We are at our best when we act as co-creators for a better world. Liberating Human Potential.



## OUR TEAM

**21**  
COUNTRIES

**48**  
ACTIVE  
INITIATIVES

**15+**  
MILLION TARGET  
POPULATION

### Who We Are

Real Medicine Foundation provides humanitarian support to people living in disaster and poverty stricken areas, focusing on the person as a whole by providing medical/physical, emotional, social, and economic support.

We provide immediate disaster and crisis relief and stay in country long after the world's attention has faded, to repair, build, and co-create capacity.



## DISASTER RELIEF

Always striving to be fast, lean, and effective, RMF works hand in hand with local populations to ensure aid goes where it is needed most.



## HOSPITAL AND CLINIC PROJECTS & SUPPORT

Once we understand the main medical needs of a community by close management of select local clinics and hospitals, we bring in other health programs to supplement or expand the health facility's scope, and look into other areas where the community needs support.



## HIV/AIDS PREVENTION & TREATMENT

From mobile testing/diagnosis and education workshops to treatment and referral networks, we continue to focus on creating a HIV/AIDS free generation.



## MOBILE CLINICS

Our Mobile Clinic concept is a flexible model of health care provision for our organization, conceptualized to reach remote and rural communities with no prior access to health care.



## EDUCATION & SCHOOL SUPPORT

In order to break the cycle of poverty, the importance of an education for younger generations is just as vital for the healing of the entire community as treating immediate healthcare needs.



## REFUGEE SUPPORT

Refugees are some of the most vulnerable populations in the world and are usually in need of a myriad of services, in addition to food and healthcare. Our established programs provide healthcare, education, solar-powered water pumps, vocational training and small business support. We also support children's school fees.



## ECONOMIC STABILITY

The economic component of RMF's overall humanitarian vision, the 'focus on the person as a whole', aims to help people escape the cycle of poverty and provide for themselves.



## COMMUNITY SUPPORT

Community Support programs add a social component to the medical/physical, economic and emotional support we provide, initiating creative and fun activities for people in post-disaster areas.



## MALNUTRITION ERADICATION

We aim to prove a holistic, decentralized, community-based approach to malnutrition eradication, empowering communities through health literacy and connecting rural communities with available government health and nutrition services, is ultimately more successful and cost-effective than centralized approaches.



## mHEALTH

Using smart phones, tablets, and central databases we are able to access, track and follow-up on patient cases from virtually anywhere.



## VOCATIONAL TRAINING

The longer-term vision of our vocational training programs is to have several models for income generating opportunities for the populations we are supporting around the world so they eventually can be self-sufficient again.



## MEDICAL SUPPORT OF INDIVIDUAL CHILDREN

We provide long-term medical support and treatment to selected individual children suffering from congenital and other health conditions, coordinating and managing the system that delivers treatment to the children and ensuring patient compliance with the program.



## CAPACITY BUILDING

From training Community Health Workers to do outreach and education in rural villages, to educating diploma level Nurses and Midwives, our capacity building programs are covering many levels of necessary training, aiming for long term solutions in addition to filling the immediate needs.



## HEALTHCARE EDUCATION & OUTREACH

Long term health can be achieved through reaching out to the local populations and educating them with health and social programs tailor made for their local cultures and norms.



## PSYCHOLOGICAL TRAUMA SUPPORT

From trained psychologists to support group facilitation, we work on supporting and healing people affected by disaster after the initial relief efforts move on.



## HEALTH RESEARCH

Partnering with universities' schools of public health we are researching and identifying innovative, contextually specific solutions to the many problems the poor and marginalized, specifically women, experience.

## MALNUTRITION PREVENTION & MANAGEMENT

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. In its sixth year, our program continues to go strong and has had significant impact in these last few years. Our team of up to 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 acute malnutrition rates exceeding 30%, or more than twice the rates the WHO would classify as critical in emergency settings. RMF has been able to significantly reduce these numbers over the last five years. Our strategy continues to close the gap between available resources 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.

### 2015 Update:

The year 2015 was a very important period for RMF India. While it was a year of consolidating our World Bank partnership efforts in health, and malnutrition treatment and prevention, it was also a year marked by new initiatives, including adolescent health, a segment that falls directly within the purview of malnutrition prevention. During 2015, RMF India continued to work with communities and began positioning its program for scale. A qualitative and quantitative study conducted in

2015 indicates that RMF's approach to community outreach reduced Severe Acute Malnutrition (SAM) by 34% and Moderate Acute Malnutrition (MAM) by 14% in target communities: a 48% reduction in acute malnutrition in the region it served. RMF India stands recognized by several Indian and international agencies, including the World Bank, and the governments of Bihar and Madhya Pradesh. RMF is working to formalize its partnership with both governments.

### Summary of accomplishments over the past year:

- Reduced Severe Acute Malnutrition (SAM) by 34% and Moderate Acute Malnutrition (MAM) by 14% in target communities: a 48% reduction in acute malnutrition.
- Reduced the number of households with a malnourished child from 21.2% to 6.6%.
- 3,064 children with SAM successfully referred for lifesaving treatment at Nutritional Rehabilitation Centers.
- 67% of SAM and MAM cases showed sustained improvement.
- 487,889 individuals counseled on sanitation and hygiene, proper feeding practices, and government services they are entitled to since the program began.
- 1,425 households counseled in 2015 at special family sessions on malnutrition prevention and treatment.
- 626 village health and nutrition training sessions conducted.

# India

INITIATIVES: Malnutrition Eradication and Treatment | mHealth | Empowering Adolescent Girls Health

**85,720** Children directly impacted and **3,500+** Children received lifesaving treatment since the program's launch

**487,889** individuals from rural villages received training on malnutrition awareness and prevention

**71,628** households in **600** villages reached

## BENEFICIARY PROFILE: SANDHYA

This is the story of Sandhya, from the village of Badgaon in Barwani district. Badgaon is a tribal village with a population of about 4,100 inhabitants, mostly belonging to Bhil and Bhilala tribes. Most villagers participate in farming or small, casual jobs to support themselves. There are four Anganwadi centers, one middle school, and one Primary Health Center (PHC) in Badgaon. The distance to the closest Nutrition Rehabilitation Center (NRC) is about 8 kilometers from the village of Badgaon. Sandhya is a 21-month-old girl who resides in the village with her 3 older brothers and her parents. The family's financial condition is not good, because Sandhya's father is the only breadwinner, and he supports the family by doing casual work whenever he can get it.

Badgaon village is part of Real Medicine & Nutrition Trust's (RMNT, RMF's India arm) program catchment. Sangita Badole is the area's Community Nutrition Educator (CNE), and often ventures into the village as part of her routine community-household outreach and counseling drive. During one such visit, Sangita was at Sandhya's house conducting her MUAC (mid-upper arm circumference) measurement. The measurement revealed that Sandhya fell in the category of severe malnourishment. This was alarming not only for Sandhya's mother, but also for people in the neighborhood. Sandhya's mother explained that during her pregnancy with Sandhya, she used to vomit profusely, which didn't allow

her to eat or digest much. She added that when Sandhya was born, she was very thin and weak. At the time of her birth, Sandhya only weighed 2 kg. Because of her size and frailty, Sandhya was always sick with ailments like a cough, cold, and diarrhea. After Sandhya reached the age of six months, her complementary feeding didn't start on time, as elders within the family and in the neighborhood believed Sandhya wouldn't be able to digest semi-solid or solid food. In this belief, she wasn't given any complementary food up to 12 months. After 12 months, she started to be given biscuits. In Sandhya's first growing stages, timely initiation of complementary feeding and adequate quality of nutrition was not administered to her, leaving her severely malnourished.

After studying Sandhya's case, CNE Sangita Badole started counseling the parents about seeking referral services of the NRC. Sangita explained all the benefits the family and child would receive through an early referral to the NRC. The family was also informed about the wage loss compensation they would be entitled to if they traveled to the NRC. Sandhya's mother was unconvinced and believed that if she would go and stay at the NRC, three of her children would be left at home unattended. But Sandhya could not be left untreated; because of the severity of her condition, the young girl would die without treatment. Since Sandhya's mother would not go to the NRC, Sangita started counseling the

family on introducing complementary feeding in the right quantities at the right intervals. Sandhya's fight against malnutrition started at home with the introduction of solid and semi solid nutritious food with lots of green and leafy vegetables, pulses, etc. The family also received special counseling on hygiene and sanitation, especially hand-washing before eating, preparing food, and after defecation.

As a result of the special care and support that Sandhya started receiving at home, both the family and CNE Sangita Badole witnessed Sandhya improve. More than anyone else, Sandhya's mother was very happy to see Sandhya transform in both physical and mental terms. The RMF CNE's level of commitment and regular, sincere counseling efforts were able to ensure that Sandhya became a healthy, well-nourished child.



Caption here.



## BENEFICIARY PROFILE: RADHIKA

Radhika is a 10-month-old girl who lives in the village of Nani Barwani, located 5 km from Barwani district headquarters in the West Nimar region of Madhya Pradesh, India. The village, like the entire region, is predominantly tribal and inhabited by Bhil and Bhilala tribes. Nani Barwani has a population of 4,400, and most people there engage in work related to farming and the farming industry. As part of governmental service delivery provisions, there are 3 Anganwadi centers, a primary school, and a health sub-center located in the village. The distance to the nearest Nutrition Rehabilitation Center (located at the district headquarters) is 5 km from the village.

Close to the center of Nani Barwani village, there is a small hamlet called Chetaria, where Radhika's family lives. The family belongs to the Bhilala community. Radhika's family consists of her 26-year-old father, Shiva, her 23-year-old mother, Manju, and her grandmother. The family's economic status is below poverty level. Radhika's parents are daily wage earners whose meager earnings one way or another help meet the household expenses.

Nani Barwani village is under the programmatic coverage of RMNT's (RMF's India branch) health and malnutrition prevention and management

program coverage. RMNT's Community Nutrition Educator (CNE) appointed for the village conducts home visits as part of her programmatic mandate, screening children for malnutrition and managing the treatment of moderately and severely malnourished children with help from government front-line community workers, Anganwadi workers, and others. During one such routine field visit, RMNT's CNE happened to screen Radhika, and it was distressing that her MUAC measurement was found to be at 10.5 indicating that she was a severely malnourished child. Worried, the CNE wanted to find out what had led Radhika's case to be so severe.

Radhika was born at home and weighed 2 kg at birth. Her mother started breastfeeding her a day after Radhika was born, and continued up to a period of 9 months, in addition to also giving her cow's milk. Beyond her 9th month, Radhika was given complementary food, such as biscuits, toast, and finger chips. Radhika's mother was not aware of the right time and method of starting complementary feeding for her child. RMF's CNE was also told that Radhika suffered from recurring episodes of diarrhea. As a result, by the time she was screened, Radhika had reached a state of severe malnutrition and looked thin, pale, and weak.



Caption here.

The CNE shared Radhika's case with the concerned Anganwadi worker, and both reached out to the family with counseling, recommending an immediate referral to the Nutrition Rehabilitation Center for proper care and support for Radhika. The family was made aware of services the NRC would offer, which would also partially offset the wage loss the family was to suffer during their stay at the NRC. Both the CNE and the Anganwadi worker's repeated visits and joint counseling and persuasion helped to ease the family's fear and inhibition in taking Radhika to the NRC. The family also received assurance from these two 'social change agents' that their food and stay at the NRC would be taken care of. Finally, Radhika's father agreed to take her to the NRC.

Radhika was admitted to the Barwani district NRC. On completion of 14 days at the NRC, Radhika's MUAC measurements showed signs of improvement, indicating that she was on the road to recovery. When released from the NRC, Radhika had not fully recovered and had a long way to go, but signs of Radhika getting better day after day were clearly visible, which was recognized by her family and caregivers at the NRC. Radhika's parents were full of gratitude for both the CNE and the Anganwadi worker for saving Radhika's life.

## BENEFICIARY PROFILE: BHARATI

Bharati is a 24-month-old girl who lives in the village of Balkuan. The village has a population of 4,200, and most inhabitants belong to Bhil, Bhilala, or Barela tribes. Balkuan is located in the Barwani District of Madhya Pradesh. The main source of employment in this village is agriculture, which is seasonal and depends largely on rain water. Apart from farming, community members' source of livelihood comes from casual work and daily wages. As part of governmental service delivery provisions, Balkuan has 4 Anganwadi centers, one high school, and a primary health center. The nearest Nutrition Rehabilitation Center (NRC) is 15 km from Balkuan. The village consists of seven clusters, one of which is Ghatiya Baidi. Bharati lives in the Ghatiya Baidi cluster with her 28-year-old father and 25-year-old mother. She has two older sisters. The family is struggling to meet household expenses.

Balkuan is part of RMNT's health and malnutrition program. RMNT's representative Akeela Sheikh is responsible there as RMF's Community Nutrition Educator. During one of her routine visits, Akeela visited Bharati's home and took the child's MUAC measurement. Bharati's MUAC was 11.5 cm and she weighed only 6 kg, revealing that she was severely malnourished. Bharati's parents told Akeela that up to the first 6 months after birth, Bharati was in good health. As the child grew older, the family faced acute poverty and both parents had to go out looking for work, leaving Bharati alone under the care of her sisters. Since the family was unaware of the proper time and methods of introducing complementary foods, the only complementary foods they gave Bharati were biscuits and tea, causing her diarrhea. Bharati needed to be treated at a private nursing establishment for diarrhea.



Caption here.

After reviewing the whole case study of Bharati, CNE Akeela Sheikh, referred the child to ICDS 'Suposhan Abhiyan'. As per the campaign, Bharati was enrolled and given nutritious food 3 to 4 times a day for 12 days. The family was counseled on feeding Bharati with nutritious, homemade foods at the right intervals. As the days of care and support progressed, Bharati started to recover. Her body showed signs of improved health and nourishment. With CNE Akeela's tireless efforts, she achieved wonderful results. With all the hard work that the CNE and Bharati's caregivers had put into her care, Bharati's MUAC measurement had improved to 12 cm.

Malnutrition is caused by ignorance, myths, misconceptions, economic deprivation, and uncaring attitudes toward individual children in multi-sibling settings. The CNE's role is to bridge such gaps.



Caption here.

## COMMUNITY NUTRITION EDUCATORS AS THE CATALYSTS OF CHANGE

### A qualitative and quantitative study conducted in 2015 stated:

20 RMF CNEs were met during this assessment at their field stations. CNEs feel passionate about the work they are doing at the community level and each life saved through their intervention/support counts a lot for them. They admit that their job is tough as not only do they have to work in difficult terrains and brave tough environmental conditions, but they often also have to face hostile attitudes in the community. However, the belief

and confidence that their efforts are saving the lives of children keeps them motivated. The level of knowledge and skills among these CNEs to perform their tasks is appreciable. They are very clear about their roles and responsibilities, and the activities they need to conduct. They are fully aware of the geographical areas that they work in and are quite familiar with the households and other government functionaries including AWWs and ASHAs, and have maintained good working relationships with them in their respective villages.



Caption here.



Caption here.



Caption here.

## VIDEO SCREENINGS AND ADOPTIONS OF PRACTICES

The families in the poor and remote communities we are serving often have very low literacy, and even less when it comes to health and nutrition education and 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, Korku 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.



Caption here.

## ADOLESCENT GIRLS OUTREACH PROGRAM

Adolescents worldwide and more so in developing countries are at greater risk of reproductive health's adverse consequences. Every year adolescents give birth to 15 million infants, and globally, girls aged 15-19 years are twice as likely to die in childbirth as are women in their twenties, while girls younger than age 15 face a risk that is five times greater. More adolescent girls die from pregnancy related causes than from any other causes. This risk is aggravated by their lack of information about reproduction and sexuality, misconceptions and little access to family planning and reproductive health services. What happens in their future depends to a large extent on the decisions taken by adolescents as they enter their reproductive years.

Adolescent girls in India are given little information about the changes that are normal to experience physically, emotionally, and socially when transitioning from childhood to adolescence. Real Medicine and Nutrition Trust, RMF's India branch, has been working in southwestern Madhya Pradesh for more than a decade. Its extensive health outreach programs extend up to household levels. The RMNT outreach model is entirely inclusive in the way that it converges closely with the frontline governmental service providers. In the process of its community interventions, RMNT noticed a gap with respect to specific outreach and health information for adolescent girls. In September 2012, RMNT conducted a workshop with 44 adolescent girls in the community hall in Bhagyapur Village in Khargone district. With help of two books

and a curriculum published by a National Level Government Organization for the Purpose of Adolescent Education, the content of the workshop was created. Giving adolescent girls the opportunity to ask questions, find their voice, and understand their feelings leads to self-confidence they need in order to become powerful women.

Having established a viable, needs-based connection between our CNEs and the school system, RMF uses the following steps to reach out to adolescent girls and provide them with health education. Our research and work with these girls reinforces the need for integrating health education as part of the regular teaching curriculum:

- Train a set of Community Nutrition Educators (CNEs) on life cycle approach
- Identify schools for coverage
- Conduct group-specific survey of adolescent girls in identified schools to ascertain actual numbers to be covered
- Seek formal concurrence of the education department of the Government of Madhya Pradesh for conducting such school-based health education for adolescent girls
- Draw a project roll-out, including session plan as per the number of students per group per school
- Train RMF team on management information systems and reporting
- Roll-out the program, monitor and document.



Caption here.



## 2015 UPDATE

### Results with Funding from Catapult

- 19 CNEs trained on adolescence and other topics for school workshops on life cycle approach
- 497 In-school training sessions conducted at 67 schools across 3 districts
- 131 School teachers sensitized on issues of adolescent health to take up with this age group of students enrolled in their schools
- 1,966 In-school adolescent girls trained (project target 1,500)

### Beneficiaries Speak:

This training is helping our adolescent girls a great deal with knowledge that their books don't cover in regular classes. This has motivated us to converge with the health department to get our adolescent girls' health check-ups conducted. We are coordinating with the health department for such help.

– Ajay Mishra, Principal, Higher Secondary School, Talun, Barwani

We are extending our whole hearted support to your team here. Because we are aware about how important it is for our students to know the basics of health, hygiene and safe sanitary practices. Your teams periodically visit our school, and we try and work with them to educate girl students. However, I would like to suggest that such a curriculum should also include boys' adolescent health and not just girls'.

– Madhusudan Bani, Principal, Haraswad Middle School, Alirajpur

The girls normally do not discuss physical or mental health-related issues with their parents, but such in-school trainings help them in not only understanding larger health subjects but also clear doubts that they might have.

– Mohammad Farooq, Principal, Karpur Government Middle School, Pandhana, Khandwa

We should always boil water, filter it and then drink it. We should keep drinking water in a clean and covered place.

– Deepika Dhankar, Student, Secondary School, Talun, Barwani

This education is much needed for us. Now we can guide other members of our community.

– Aarti Chouhan, Student, Secondary School, Talun, Barwani

We should wash our hands using soap before eating and after defecation.

– Pooja, Student, Secondary School, Talun, Barwani

This training has helped me understand issues around the menstrual cycle. As we set out on our adolescence, there are several changes that occur in us physically and psychologically, and such sessions help us understand these changes well.

– Nabina Vijay, Student, Government School, Karpur, Pandhana, Khandwa

Through these training sessions, I have learnt the benefits of using sanitary napkins and since then I have been using them.

– Shami, Student, Government School, Karpur, Pandhana, Khandwa



Caption here.

Washing hands using soap helps us remove dirt from our hands and that prevents us from illnesses. We should follow this before every meal and after defecation. We have learnt this during a new training that we have received.

– Sangeeta, Student, Haraswad Government School, Alirajpur

We have learnt that health is the only wealth. We have started to follow what we have been taught during the training session.

– Meena Solanki, Student, Haraswad Government School, Alirajpur

This new madam teaches us about what practices can help us stay healthy and free from diseases. We will try and guide others in our community on these good practices.

– Rakhi, Student, Haraswad Government School, Alirajpur

## BACKGROUND

RMF Pakistan began operations of emergency and health service delivery in 2005, responding to the October 8th earthquake that killed more than 80,000 and left millions homeless in the remote Himalayan valley of Northern Pakistan. Using a local NGO as the implementing partner, RMF's first project was a primary health clinic in Union Council Talhatta, District Balakot which was established as the only source of quality healthcare and maternal health services for 150,000 men, women and children. RMF Pakistan was formally registered with the Government of Pakistan as a local not-for-profit charity that allowed us to directly implement on ground.

Our health service delivery wing of operations expanded with the July 2010 massive floods of the Indus River Basin that 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. Intervention in the province of KPK flood situation was extensive; with funding from Google Inc. and APPNA, the interventions ranged from twelve relief emergency medical camps that treated over 20,000 people to static primary health care clinics in Union Council Gulbella and Agra in District Charsadda that treated

more than 200,000 people over a period of 2 years post floods. With rising insecurity and terrorism issues, Pakistan faces a chronic crisis of Internally Displaced Persons (IDPs) whose needs are met by a cluster of CSOs and NGOs under the umbrella of the WHO. RMF is a partner of this cluster and provides an on-going MCH service to IDP women and children in District Nowshera. In October 2015, an earthquake of Richter scale 7.7 hit the northern border of Pakistan and RMF was in the frontline in relief work in terms of provision of tents, blankets and uncooked food rations for the earthquake affected victims in District Swat of Province KPK.

In line with our mission of a long term goal 'to move beyond traditional humanitarian aid programs by creating long-term solutions to health care and poverty related issues', in 2012 RMF added a new wing of operations dedicated to research. By collaborating with academic partners such as University of Alberta, Canada and Columbia University, New York, the aim of our mostly qualitative, social research is to identify innovative, contextually specific solutions to the many problems the poor and marginalized Pakistani women face under the umbrella of sexual reproductive health. Our research findings provide empirical evidence for the formulation of maternal health policies and health care system practices in Pakistan. We have successfully completed three research studies and are currently undertaking two new ones.

# Pakistan

INITIATIVES: Primary & Maternal Child Health Care | MNCH/MHM Research Studies | Earthquake Relief

- 10,965** Patients treated at Nowshera MCH Center
- 2,450** Individuals reached with Food Drive for IDPs
- Earthquake Relief Efforts** in Swat, KPK
- MNCH Study** completed in Balochistan
- MHM Study** launched in Punjab and Balochistan

# PAKISTAN

## MCH HEALTH CENTER IN DISTRICT NOWSHERA, PROVINCE KPK

### Program Structure

In October 2013, RMF leased a site in an easily accessible location in Union Council Taru Jabba, District Nowshera and with philanthropic donations, built the current clinic space consisting of an OPD, minor OT, ultrasound room, pathology lab, pharmacy and an admin room with a large comfortable waiting area. The clinic began operations by the last week of November 2013 and over the next couple of months, equipment and machinery for the pathology lab and ultrasound room was procured using funds raised by our friends from the UK. The RMF MCH clinic is the only primary health care level facility in the area to provide free-of-cost routine pathological investigations and ultrasound services.

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. Morbidity reports are made on a quarterly basis and shared with the WHO data base.

During the year 2015, a total of 10,965 patients were diagnosed and treated at RMF's Nowshera Health Center for a variety of medical conditions. In this reporting period, 2,438 and 433 women came for antenatal and postnatal visits respectively. Over 2,500 women visited the center for gynecological/obstetric problems. Family planning services were sought by only 132 women, indicative of the cultural practices of this region. The pathology lab carried out 1,989 routine investigations such as urine test, pregnancy test, blood complete picture, blood grouping, Vidal test and malaria parasite test. The ultrasound services were offered to 2,190 women.



Caption here.



## IDP RAMADHAN FOOD INITIATIVE

### Program Structure

After our successful Ramadan Food Initiative last year for IDP refugees in Bannu, KPK, RMF Pakistan has decided to make this an annual event. In 2015, the month of Ramadan of the Islamic calendar fell in June-July, the hottest and longest months of the year. With our 19-months presence as a gender sensitive MCH clinic in Union Council Tarru Jabba, we have earned the trust and goodwill of the community which also means that this population leans heavily in our direction for all their problems, inclusive of health-related issues. The month of Ramadhan, especially in the hot summer months, places additional burden on this vulnerable and needy population that lives constantly with food and shelter insecurity.

Hence, the 2015 Ramadhan Food Initiative project was launched for the IDPs in our own Union Council of Tarru Jabba and conducted on the clinic compound. Funding was obtained from Zakat donations by fellow philanthropists in both Pakistan and the UK.

We followed the protocol that we developed in the previous year. To ensure cost-effective, high quality and hygienic food, a cook was hired who planted his cooking utensils in the compound for the full month and came on a daily basis to cook the food right in front of us. Raw food recipe items were purchased by our staff on a daily basis and cooked food was put into hygienic food bags and distributed to families that we had registered in the beginning of the month. The number of bags per family varied according to family size and we were very particular that excess food should not be given since, in the hot months of summer where temperatures exceed 40 degrees centigrade, food gets spoiled within hours of storage.

In the 2015 Ramadhan, the food initiative was carried out for 23 days and an average of 100-110 people received food packages on a daily basis. Therefore a cumulative 2,450 food packages reached more than a 100 families for their Iftar meal.



Caption here.

## IDP RAMADHAN FOOD INITIATIVE

On October 26, 2015, an earthquake of magnitude 7.7 hit the Hindu Kush region at the border of Afghanistan and Pakistan. At a depth of 213 feet below the ground surface, the damage impact of this otherwise powerful earthquake was controlled. However, the main quake was followed by 87 aftershocks, which along with the winter rains and snowfall, triggered off series of landslides in the mountainous regions causing weakly structured houses built on hill slopes to collapse rendering nearly 600,000 people homeless or living in makeshift shelters.

Emergency response by the National Disaster Management Emergency Response teams (NDMA) and Pakistani Army Rapid Response units was the initial face of the rescue operations. Mortality and morbidity figures in the first few days rose to over 300 dead and over 2,000 injured in KPK's key affected areas of Districts Dir, Chitral, Buner, Swat, Shangla and Malakand. However, detailed data of affected populations in terms of shelter, food and health needs was lacking due to the remote nature of this region. With our experience with the 2005 earthquake, we have seen that whole villages can be destroyed and they remain unidentified having fallen through the cracks of the relief services by the active players in the field at that time. Following the logic of identifying areas that have no road access, RMF carried out a 5-day needs assessment survey in two Union Councils of Shagai and Kabal of District Swat on 29th October to 2nd November 2015 during which we identified and registered more than 100 needy families. The common occupations of these people were daily laborers, carpenters, farmhands

and sweepers. Most of their houses were weak mud/stone structures, often built with their own hands, that collapsed at the first tremors. While all of their houses have been destroyed, some people lost their livestock which was being kept indoors to protect from the cold. Their hand-to-mouth existence (average income is 100 USD per month for an average of 7-9 member families) meant that their entire existence collapsed with the rubble.

No formal request was made by the Government for international assistance, a fact attributable to the security concerns related to these previously Taliban infested areas. Hence locally registered NGOs, CSOs and charities were encouraged to take an active role in providing rescue and immediate relief services in assistance to the NDMA and Army relief units.

RMF USA, in collaboration with and funding from Latter-day Saints Charities, Inc (LDS), directed RMF Pakistan, officially a locally registered charity, to launch the 'Swat Earthquake Relief Project' on December 1st 2015 in District Swat. The two project sites were Mohalla Bhakharawan, Union Council (UC) Kabal, Tehsil Matta and Mohalla Akhonbaba, UC Shagai, Tehsil Saidu Shariff, District Swat and the project objectives were:

1. To provide immediate relief of shelter
2. To provide immediate relief of food
3. To provide immediate health care to earthquake victims
4. To assist in rebuilding of destroyed homes in project site Union Councils

## UPDATE ON PROJECT PHASE 1: THE FIRST THREE OBJECTIVES CONSTITUTE THE FIRST PHASE OF THE PROJECT.

The first objective of providing shelter relief was achieved by distribution of 100 winterized tents and blankets to families in need. Distribution was carried in two steps. On 10th December, a distribution ceremony was carried out under the auspices of the local army brigade where 54 families validated by government databases as to not having received any previous assistance of any kind were invited to receive relief goods. The remaining items were distributed over the next 2-3 weeks on a snowball rolling technique by RMF staff based in Swat. Each family was assessed individually as needy and vulnerable.

The second objective was to address food insecurity. Our needs assessment revealed that most families had managed to salvage some of their home furniture, cooking utensils, etc from the rubble of their destroyed homes and therefore were able to cook for themselves using firewood, as was their normal practice. They needed uncooked food rations. RMF developed a Food Ration Package composed of uncooked, non-perishable, dry rations such as flour, rice, cooking oil, lentils, tea, dry milk, sugar, etc, enough to feed a family of 8 people for one month. Procurement was carried out from local vendors and packaged in a deliverable form. The first distribution of 54 food packages was carried out with the distribution of a tents and blankets ceremony. The remaining 46 packages were distributed to carefully selected households

that met our set of criteria such as women headed households, single earner and households with a family size of 5 or more with children under 12 and geriatrics adults. This objective is proposed to distribute food packages to 100 families for 3 months. By the end of December 2015, the target of 100 families for the month has been met.

The third objective of providing quality primary healthcare services to earthquake affected people in Swat was initiated on 21st December 2015. RMF's clinic is located in Mohalla Laloo Bandee, UC Kabal, Tehsil Matta. This site was chosen based on the fact that the nearest health facility is over 20 km away. The two-roomed clinic is providing primary health care (PHC) and maternal and child health care (MCH) via a 5 member clinic staff, composed of a team of male and lady doctor, a medical technician, a pharmacy technician and cleaning/security staff members. As per RMF's protocol of giving employment opportunities to the local community, all the clinic staff is from UC Kabal. As our normal practice, we observe the segregation of genders which is the cultural requirement of KPK and have made provisions for the same in the clinic premises. For quality assurance, the medical supplies are procured from our Peshawar-based vendor who has been supplying us with medicine for RMF's Nowshera Health Clinic project for the last two years. Our daily OPD is an average of 30-35 patients.

# PAKISTAN—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 set up a new wing of operations focused on research only. We became the implementing partners for the School of Public Health, University of Alberta, Canada for two qualitative studies on Gender, Class and Social Exclusion launched in three districts of Punjab in 2011, both of which have been successfully completed.

Our first research project was a 2-year study carried out in Districts Jhelum and Layyah in the province of Punjab, funded by the Research Advocacy Fund (RAF), titled “Are Community Midwives Addressing the Inequities in Access to Skilled Birth Attendance in Punjab, Pakistan? Gender, Class and Social Exclusion” that 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. This came to a successful end in December 2013 and research findings with policy recommendations have been shared extensively with key stakeholders in both the Pakistan Government and policy makers as well as development players from bilateral and multilateral agencies on several different platforms. They have also been published in academic literary journals and are available on the RMF as well as the RAF website.

Our second research began at around the same time in 2011 and was a 4-year study in District Chakwal, funded by the Canadian Institute of Health Research (CIHR) titled “Addressing Disparities in Maternal Health Care services in Punjab: Poverty, Gender and Social Exclusion”, aimed to explore the role of class and gender inequities on the design and delivery of maternal health services in Pakistan. Data collection and analysis of study findings came to successful end in 2014. Findings have been shared with relevant stakeholders at both national and international levels in form of academic publications and conference presentations.



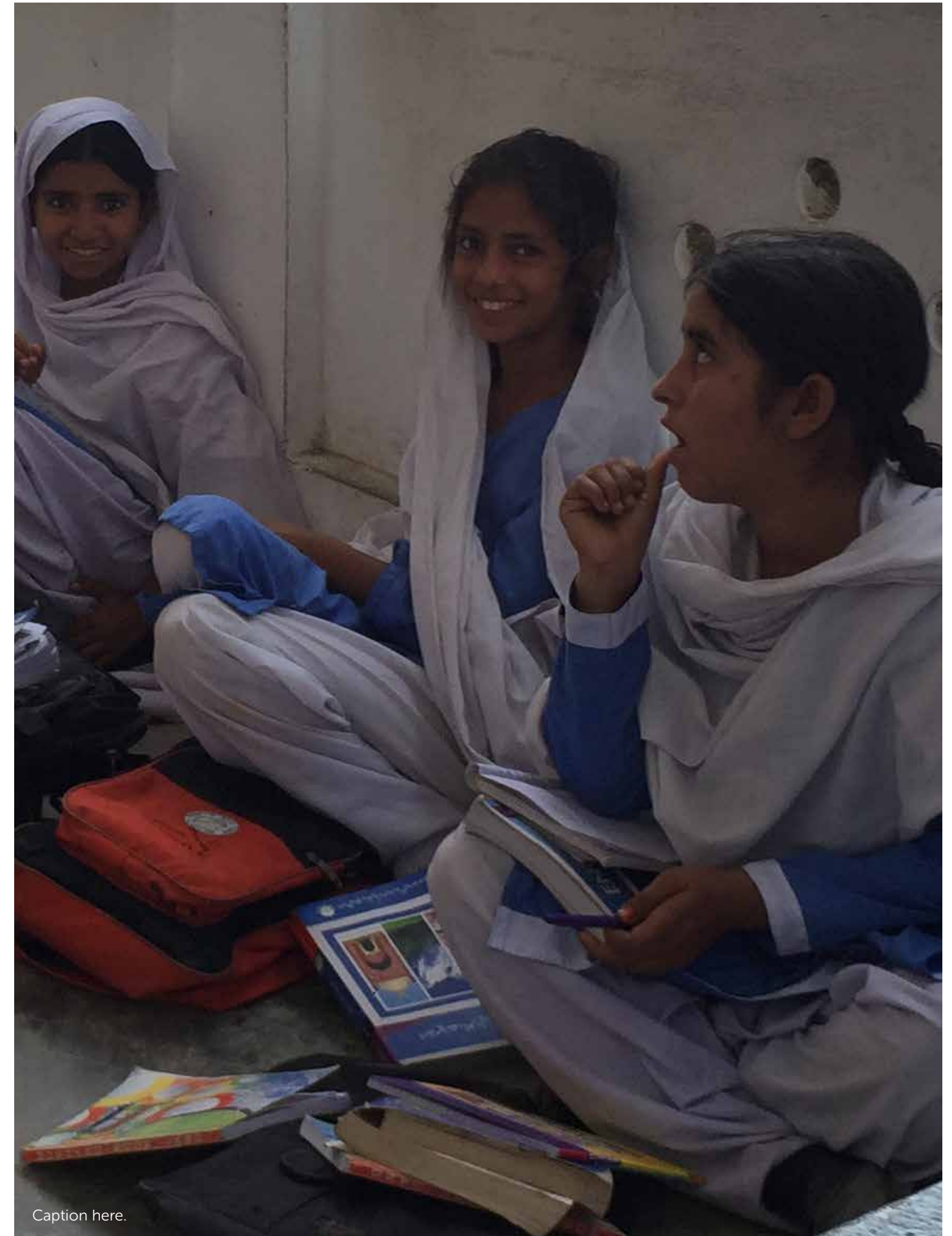
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# PAKISTAN—RESEARCH PROJECTS

## 2015 UPDATE: MERCY CORP PROJECT OPERATION RESEARCH STUDY

In conjunction with the University of Alberta, 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, Gwadar, and Kech Districts in Balochistan and are they doing so in a Financially Self-sustaining Manner?” was launched in Quetta, Gwadar and Kech in Balochistan Province in 2014. This was an operations research protocol within the IMAN (Improving Mother and Newborn Health) initiative, a USAID funded project implemented by Mercy Corps that sought to increase use of quality essential maternal and newborn care through private-sector community midwives. The proposed research aimed to 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? Using a mixed methods approach, data was to be collected in three interlinked modules.

The Modules were completed successfully in all three districts. The baseline survey tools in the local dialects were pre-tested and piloted by May 2014 following which data collection for all three modules was implemented. At the end of the data collection exercise by the end of December 2014, raw data was shared with the University of Alberta investigating academics for analysis and write. The study research findings were shared with Mercy Corps and the study came to a close by mid 2015. Findings have been shared on different conferences and platforms by the University of Alberta and academic publications of the same are in the pipeline.



Caption here.

# PAKISTAN—RESEARCH PROJECTS

## MENSTRUAL HEALTH MANAGEMENT (MHM) STUDY IN PUNJAB

A significant body of research demonstrates the relationship between girls' education and improved population health. Many barriers prevent young women from attending or completing school but one of the most under-researched is menarche. Cultural practices surrounding reproductive health in Pakistan, including menstruation, is the 'culture of silence'. Part of a larger value system that is embedded within the gender order of society, information around menstruation is actively withheld until after the onset of menstruation. The intersections between menarche and education in Pakistan are poorly understood and given that menarche may be jeopardizing young women's schooling and health in Pakistan, research in this arena is the call of the day.

RMF, in collaboration with Columbia University, New York and University of Alberta, Canada, with funding from Grow N Know Inc (G&K), launched a research study in early 2015 to explore the knowledge gap of how the onset of menstruation and puberty influences the Pakistani girl's school-going experiences, including school retention. The outcome of this research is to develop the Pakistan Girl's Puberty Book. This project is an adaptation to Pakistan of similar research studies conducted in Tanzania, Ghana, Ethiopia and Cambodia which also developed context-specific, culturally sensitive country girl's puberty books; all above studies were conducted by the same PI of Columbia University.

The research design of this study is a comparative case study in rural and urban Punjab, aimed at exploring the relationship between the onset of menses and young women's schooling experience. Specific objectives were to collect qualitative data to understand girls' experiences of menarche, explore

cultural values, beliefs and practices surrounding menstruation, and how the lack of water, sanitation and disposal infrastructure may be negatively impacting girls' management of menstruation in schools, and their ability to participate in the classroom. The participatory design will guide the outline of the girl's puberty book. In addition, the descriptive nature of this study will fill gaps in the research literature by providing information on cultural understandings and meanings of menstruation, young women's lived experiences of menstruation and schooling, and the role of menstrual-related stigma in creating feelings of shame in post-pubescent young women in Pakistan.

Data collection methods adopted were ethnographic observation, key informant interviews with adults and participatory group activities with adolescent young women aged 10-19. Participatory approaches were used as our respondents were adolescent girls, which is a particularly sequestered group of the population in Pakistan. Participatory methods allowed for an equalizing and dynamic exchange between researchers and participants, which in turn enables development of a relationship of trust. It further enables collection of sensitive information from young girls using activities such as the writing of menstrual stories, girls' brainstorming on the improvement of WASH facilities in schools; and the development of a proposed puberty curriculum for girls aged 10-14.

The urban setting selected was Dhoke Sayedan in Rawalpindi and the rural field site Nara Mughla village in Chakwal. The target population was between school going girls, young women in vocational training centers and community members.



Caption here.

# PAKISTAN—RESEARCH PROJECTS

## 2015 UPDATE

Having obtained ethics clearance from the Pakistan Board of Ethics, RMF launched the research study after obtaining clearance and NOCs from the Ministries of Health & Education, Punjab Province and then had a series of meetings with all the relevant government district level education departments and TEFTA (Technical Education and Vocational Training Authority).

Data was collected in two phases. Phase I was data from the rural area 'Government Girls' High School' in Mulahal Mughla, District Chakwal over a period of twenty days inclusive of participation observations with nearly 60 girls aged 15-18, 4 informal interviews with teachers and 4 in-depth interviews with key stakeholders within the community. Two girls who had dropped out of the rural school were identified within the community by snowballing technique and interviewed. Key informants included mothers, teachers, school administrators, community health workers and religious leaders. All key informants were women as culturally menstruation is a female domain from which men are excluded. Not only is male involvement considered a taboo, involving men might have created issues that potentially could have terminated the research.

The urban school data was collected from the 'Government Girls' Higher Secondary School' in Morgah, Dhoke Saydan, Rawalpindi inclusive of participation observation with 100 girls of the same age group as above. Eight girls dropped out of

school were identified with the same technique and interviewed.

Phase II was data collection from Vocational Training Schools; the rural center was the 'Government Vocational Institute for Girls' in Mulahal Mughla and data collected from a total of 12 older girls in 'Tailoring' classes and 'Religious Education' classes. Data for the urban vocational training centers was not possible since the students did not fit into our inclusion criteria. So for the urban sample, subjects were selected on a snow balling technique from the community, local beauty parlor training schools and religious schools. In total 10 key informants and 14 in-depth interviews were conducted respectively and 75 hours participation observation notes made. All data were collected in Urdu. Audio data has been transcribed by RMF and shared with Columbia University for analysis and report writing. Data were analyzed using a latent content analysis approach. Using Quirkos, a qualitative data management program, the data was first coded inductively. The codes were then categorized to identify broader themes to abstract deeper meaning and to build an explanation for the findings.

Findings of this research with additional qualitative data collected from a small number of NGOs working in the KPK provinces of Pakistan have initiated the draft of the first outline of the Pakistan Girl's Puberty Book.



Caption here.

# PAKISTAN—RESEARCH PROJECTS

## MENSTRUAL HEALTH MANAGEMENT (MHM) STUDY IN BALOCHISTAN

Towards the end of the MHM research in Punjab, UNICEF commissioned RMF to replicate the study in Balochistan to ensure the book captures the cultural beliefs and values of an additional key province of the country. The PI and research protocols remained identical.

The comparative case study (rural vs. urban) was conducted from September to December 2015 in rural and urban Baluchistan. Urban data were collected from Kuchlak, a neighborhood in Quetta City, District Quetta, and rural data from village Sakuran Goth, Tehsil Hub, in Lasbela District. Both sites were selected by UNICEF, Pakistan. In-school girls were recruited from one high school in each site after obtaining permission from the Provincial Educational Directorate, respective District Education officers and School administration. Out-of-school girls were identified with the help of a local social worker in Kuchlak and a Lady Health Worker in Sakuran Goth, who gathered them in their homes. A total of 177 girls were included in the study.

All data were collected in the local languages, mostly Urdu, but also Pushto and Lassi. The data in Pushto and Lassi was first translated into Urdu. All data was then transcribed in Urdu and then translated and transcribed into English.

### Preliminary Results:

Overall, our data identified five key themes that could broadly be understood as:

1. Menarche was often a traumatic event due to lack of preparedness
2. Knowledge and normalization of pubertal changes was lacking and girls were left to discover from older sisters/mothers/friends
3. Skeptical Acceptance of cultural taboos and restriction surrounding menstruation
4. Information Needs and Concerns regarding menstruation physiology was a common demand
5. Quality of WASH facilities do not meet girls' menstrual hygiene needs as toilets were often dirty, non-functional, with no running water. Often in rural schools, pit latrines were the norm and at a distance from the classrooms. These girls had permission to go home to use toilets, and those who lived further tended to go to their friends' homes. We observed girls freely walking out of the school at all times and not returning for up to an hour at a time. Such behaviors have implications for girls' absences from school during school-hours and its potential impact on their education
6. Characteristics of Girl-Friendly school facilities inclusive of availability of sanitary napkins and resting rooms was another common demand

Findings have been incorporated in the outline of the Puberty Book that is currently underway for consensus by key stakeholders and the government followed by publication and distribution to schools.



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## BACKGROUND

Sri Lanka marks the birthplace of Real Medicine Foundation, the place where our first promise was made and the concept of "Friends Helping Friends Helping Friends" was born. More than eleven 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 our immediate tsunami relief efforts at the Mawella Camp Clinic, RMF opened a second clinic in Yayawatta in October 2006. Now in its ninth year of operation, this clinic remains fully active and continues to grow. Initially established to serve one fishing community of 400 that had been displaced by the tsunami, the Real Medicine Yayawatta Primary Health Care Clinic now continues to provide free health care access to over 4,000 people in 5 impoverished villages in the Hambantota District of Southern Sri Lanka.

# Sri Lanka

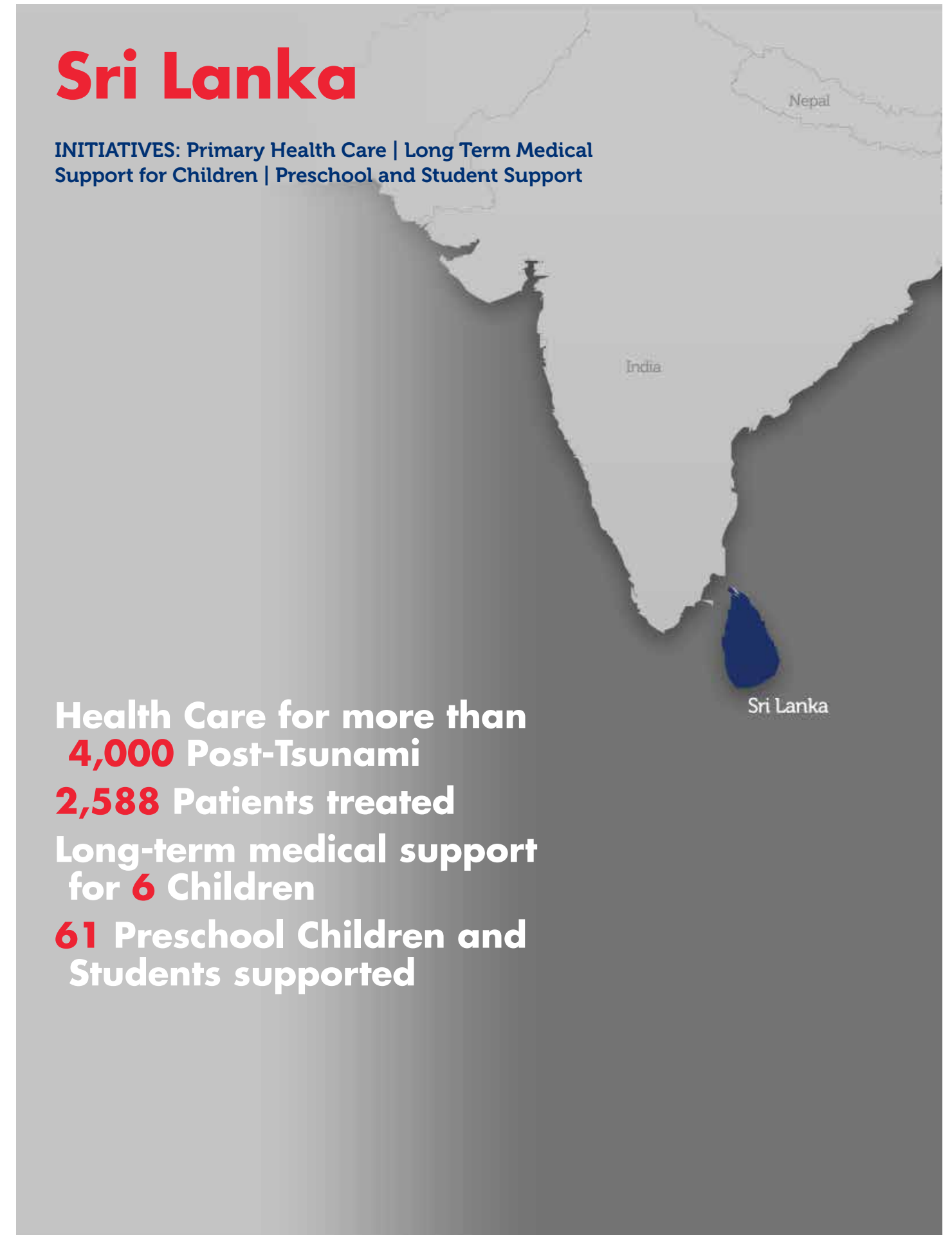
INITIATIVES: Primary Health Care | Long Term Medical Support for Children | Preschool and Student Support

Health Care for more than  
**4,000** Post-Tsunami

**2,588** Patients treated

Long-term medical support  
for **6** Children

**61** Preschool Children and  
Students supported





## YAYAWATTA PRIMARY HEALTH CARE CLINIC

### 2015 Update

The beneficiaries of RMF's clinic in Yayawatta include the populations of Seenimodera, Kadurupokuna, Moreketi-Ara, and Palapotha. Having access to free health care is especially important for young mothers, children, and elderly community members. Using our clinic activities as a hub, RMF provides regular medical camps and healthcare outreach programs to preschools, schools, and the surrounding communities. 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 2015, 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. Another of our woman-centered programs, family planning for women, continues to be very effective, with provision of oral contraceptives to an average of 6 women per month. The diseases seen most frequently at the Real Medicine Yayawatta Primary Health Care Clinic include respiratory tract infections, viral fevers, gastrointestinal tract infections, heart disease, hypertensive disorders, skin diseases, and different forms of arthritis.

### LONG-TERM MEDICAL CARE FOR CHILDREN

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. Over the next three years, RMF expanded this program to care for 6 more children suffering from long-term health conditions, and, to our unexpected joy, we were able to build on this one act of compassion by initiating a country-wide program to identify and treat several hundred more children suffering from human growth hormone deficiencies.

### 2015 Update

In 2015, RMF supported 6 children through this program. 5 of these children have continued with growth hormone treatment, and are growing in height and maintaining healthy weight gains. These children and their caregivers also regularly consult with Professor Sujeewa Amarasena, the Head of Pediatrics at Karapitiya Teaching Hospital, to discuss their progress and add supporting treatment, such as sex hormones. Tharindu, our sixth long-term patient, who lost his mother in the tsunami, is being treated for familial hyperlipidemia with lipid lowering medication. We also provide nutritious food for these 6 children and their families every month.

### PRESCHOOL AND STUDENT SUPPORT MINHATH PRESCHOOL, DICKWELLA

The Minhath Preschool was constructed by RMF in 2006 as the first-ever preschool for children in the Tamil/Muslim minority community of Dickwella, Sri Lanka, a region hit hard by the Indian Ocean Tsunami. The school is based on the Montessori Education Model, and in 2015, 49 children benefited

from preschool classes, including academics, art classes, performance events, and sports activities. Minhath Preschool allows Tamil/Muslim children the chance of an advanced education that they were excluded from before. Lessons are taught in three languages: Tamil, English, and Sinhala. RMF continued to support the teachers' salaries and some of the school's operational costs throughout 2015. Some of the field trips taken with the children include trips to the capital of Sri Lanka, Colombo, as well as the zoo, Galle harbor, and swimming pools.

### 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 2015, we continued to support the school's staff salaries and supported some of the expenses of 12 children from 15 families, primarily lower income farmers and laborers, including bus fares to and from school. The objectives of this program are to educate children on basic English knowledge, modern communication technologies, health awareness, proper sanitation, environmental awareness, outdoor activities, natural disaster awareness, and cultural and ethnic diversity. The school also provides children with at least one nutritious meal a day. In 2015, Palathuduwa teachers organized a concert, an art competition, and an annual children's fair for the children, parents, and community to participate in. The school also celebrated national holidays and the Sri Lankan New Year's festival. Sports and physical activities are also a key part of the Palathuduwa Preschool's program, with many games played using the equipment in the schoolyard.



Caption here.



Caption here.

## BACKGROUND

On April 25, 2015, a 7.8 magnitude earthquake struck central Nepal, killing more than 8,500 people, injuring more than 15,000, and demolishing or damaging the vast majority of structures in central Nepal. RMF sent a team that month to provide immediate relief, assess the population's needs, form local partnerships, and strategize longer-term solutions. Our team was present during several aftershocks and the 7.3 magnitude earthquake that struck the region on May 12, 2015. The second earthquake further traumatized area residents, damaging more structures, killing an additional 200 people, and injuring another 2,500.

### 2015 Update

RMF, with generous support from the Pierre and Pamela Omidyar Fund (Silicon Valley Community Foundation), Michael K. Wilson Trust, Gandhi Foundation, Society of Nepalese in Hawaii, Upaya, Global Giving, and many other generous donors, began our presence in Nepal by (which was followed by initiating several long term rebuilding and rehabilitation initiatives):

- Establishing Metta Kathmandu Earthquake Relief Camp with Global Karuna, serving 500 people per day

- Procuring and delivering emergency supplies such as food, medicine, water filtration systems, solar lighting, and tarps to unreached areas of Sindhupalchuk, Dahding, Chagam, Kavre, and Dolkha
- Forming partnerships with local organizations such as Bibeksheel Nepali, Nepal Children's Organization, Global Karuna, Seven Summits Women, Sushma Koirala Memorial Trust, World Cultural Net, Social Action Volunteers
- Providing financial and logistical support for partner organizations
- Assessing needs and meeting with community leaders
- Strategizing longer-term solutions such as rebuilding a model village, supporting Nepal Children's Organisation orphanages, supporting Kanti Children's Hospital, and rebuilding schools.
- Initiating and completing our official registration as an international NGO in Nepal, hiring five team members (Program Coordinator, Program Manager, Program Officer Finance, and two Nurses), and renting an office in Kathmandu.

# Nepal

INITIATIVES: Earthquake Relief



Up to **500** people served daily in the Metta Kathmandu Earthquake Relief Camp, founded with Global Karuna

**300** villagers and nuns in remote, decimated Chagam received emergency food and shelter

Provided **food and supplies** to Nepal Children's Organization orphanages

Delivered **emergency food** and supplies to unreached villages

## REBUILDING COMMUNITY MODEL VILLAGE ARUPOKHARI, GORKHA

The epicenter of the April 25, 2015 earthquake was located in the Gorkha District of central Nepal. In this region, over 91% of houses were irrevocably damaged, along with 95% of schools and 90% of health facilities. RMF's team traveled the area distributing aid to unreached villages and assessing damage. Among many sites of devastation, we found that in Arupokhari, a remote village in northern Gorkha, 1,226 houses (out of 1,350) were completely destroyed. We also found great medical need in the village. Since the nearest health facility was at Gorkha Bazar, a full day's walk on dangerous roads, residents of Arupokhari and surrounding villages suffered from a lack of health services, health education, and sanitation, even before the earthquake.

### 2015 Update

Inspired by the commitment and attitude of the Nepalese people—especially younger generations—to “build back better,” and in accordance with the Government of Nepal’s vision for building earthquake-resistant communities, RMF developed

a pilot initiative: Model Village Project. The Model Village Project aims to build a high functioning, safe community to be used as a model for other reconstruction projects. The Model Village Project is based in Arupokhari, Gorkha, and takes a holistic approach, partnering with community members, local government, and local organizations to effectively assess needs and rebuild homes, schools, and a health clinic and birthing center.

In 2015, our accomplishments included:

- Initially procuring and providing emergency food and shelter
- Meeting with the Chief District Officer of Gorkha, health officials, the management committee of Saraswati Peace School, a team of engineers and technicians, and community members to strategize and ensure community and government ownership of the project
- Supporting the construction of a prefab house for teachers at Saraswati Peace School (the school is located in Arupokhari and serves 5 villages, each with a population of about 6,000)

- Supporting the repair of Saraswati Peace School’s computers, and a reliable backup source of electricity
- Procuring and providing school supplies
- Developing a long-term, sustainable plan to rebuild the demolished health clinic in Arupokhari, with the community’s support and on land owned by the community (to be located in the heart of the village, accessible to all of Arupokhari and 4 neighboring villages)
- Renovating a temporary structure to house the RMF Health Clinic until the permanent structure is completed, and strategizing the clinic’s operation to ensure sustainability and independence in the future
- Hiring two experienced health officers—a registered nurse and a senior health practitioner—to run the RMF Health Clinic
- Developing a plan to incorporate a fully functional birthing center in the RMF Health Clinic and fund SAB (Skilled Birth Attendant) training for local government health volunteers
- Providing mobile health services by visiting patients in their homes to conduct training sessions on health, sanitation, first aid, proper diet, nutrition, waste management, and midwifery
- Supplying the RMF Health Clinic with medicines, medical supplies, and medical equipment as needed
- Forming a local advisory committee through a democratic process, including a local social worker, the principal of the local school, the local VDC Secretary, and men and women from diverse ethnic groups.

## ORPHANAGE SUPPORT

### Background

Soon after RMF's team arrived in Nepal, we began supporting Nepal Children's Organisation (NCO), an autonomous nonprofit established in 1964, which works for Nepalese children by protecting and promoting their rights as well as providing residential care to at-risk children from all ethnicities and backgrounds.

The earthquake severely damaged NCO's main orphanage in Naxal, Kathmandu, rendering the building uninhabitable. The children—who had been used to having plenty of space and knew this center as their only home—were compelled to relocate to two of NCO's centers in Kathmandu. This created great difficulties not only for the children, but also for the house-mothers and other staff who have relocated to these temporary, overcrowded shelters. This hardship added to the trauma of children who had already lost their parents and families. Since Nepal Children's Organisation is the biggest children's organization in Nepal, the government has also placed many of the children newly orphaned by the earthquake at these centers. NCO welcomed these children, but faced challenges in finding space, integrating new orphans, and addressing psychological issues.

### 2015 Update

- RMF's orphanage support included:
- Initially procuring and providing emergency food supplies
- Hiring two staff nurses to assess, improve, and record children's health status
- Training house-mothers, other staff, and children on hygiene, nutrition, and basic health through sessions with staff nurses
- Funding specialized medical treatment for NCO's children when needed
- Supporting psychological health and awareness through a two-day workshop with American psychologist, Dr. Ron Palomares, who has extensive experience working with children in traumatic situations
- Looking into ways to provide continued psychosocial support to the children
- Supporting the construction of toilets, development of a sick room, and purchase of medicines
- Planning and support for construction of three prefab house in the Balmandir area, which will provide badly needed additional space in earthquake-resistant homes for NCO's children



Caption here.

## PLAN B SCHOOL PROJECT

### Background

With the highest death toll, Sindhupalchowk was the district most heavily affected by the April 2015 earthquake. For at least two decades, this district has also been the country's hub for human trafficking, and most victims are women and girls. Other problems in the area include high crime rates and very little economic opportunity. Even before the earthquake, this was a neglected region of Nepal, despite its proximity to the nation's capital.

Our main partner organization in the Plan B School Project is Seven Summits Women, which has been working for women's education and empowerment in Sindhupalchowk and neighboring districts for years. Their activities are in line with RMF's core value of "Liberating Human Potential," and include empowering female survivors of trafficking, providing them with training in the outdoors and English language lessons.

Following the earthquake, RMF and Seven Summits Women have been active in relief and recovery work, and the team is now focused on rebuilding schools in Bhotenamlang Village, Sindhupalchowk: our Plan B School Project. By rebuilding, equipping, and staffing six schools in Bhotenamlang, we aim to foster lasting socioeconomic change in the region.

### 2015 Update

- RMF's main activities include:
- Initially procuring and providing emergency food and supplies
- Providing 2,064 children in 8 schools with regular, nourishing mid-day meals
- Providing stationery, school bags, water bottles, and tiffin boxes to area schoolchildren
- Improving school attendance and performance by providing nutritious food and essential supplies
- Beginning construction on Shree Ganesh Lower Secondary School
- Working to recruit teachers from Kathmandu to work at least one or two years in Bhotenamlang schools, providing quality education
- Planning to mobilize local women's groups to make school uniforms for the project's schools, contributing to women's livelihoods as well as helping them enhance tailoring skills



**2,064 children in 8 schools receive regular, nourishing mid-day meals**  
**School supplies provided**  
**Teacher recruitment underway**  
**Support of school reconstruction and sanitation projects**

## KANTI CHILDREN'S HOSPITAL

### Background

Kanti Children's Hospital is the only government referral level children's hospital in Nepal. The hospital was established in 1963 as a general hospital with 50 beds, and today has a capacity of 320 beds. The hospital treats children up to the age of 14 from all over the country, a total target population of about 14 million children. Following the earthquake, where large parts of the hospital buildings were damaged, there is a great need for equipment and capacity building for better health service delivery.

In addition to donating more than \$400,000 worth of medicines and medical supplies to Kanti Children's Hospital, RMF began supporting Social Action Volunteers (SAV), an NGO established in 1988 to serve the neediest patients of Kanti Children's Hospital and their families. SAV provides various support programs to long-term care (two weeks or longer) patients and their caregivers in the non-paying ward of Kanti Children's Hospital. Services include provision of medicines and medical supplies, lab and other medical tests, blood donations, transportation and food supplements for patients and their companions, shelter for family members, cooking facilities for families, or complete coverage of both patient and family members.

### 2015 Update

RMF's main accomplishments include:  
Donating more than \$400,000 worth of medicines and medical supplies to Kanti Children's Hospital  
Partnering with Social Action Volunteers (SAV)  
Providing free medicines, medical supplies, lab

and other medical tests, lodging, food and other hospital requirements for selected poor and needy patients and their families

Providing guidance to the parents of sick children regarding proper use of hospital facilities, health education, sanitation, and pharmacy

Funding and helping patients access available services such as X-rays and lab tests

Providing financial support and other arrangements such as transportation for patients who require services outside the hospital such as MRI and CT scans

Organizing a blood donation program and maintaining a blood bank, withdrawing units of blood as required for patients

Managing a kitchen at Kanti Children's Hospital, which patients and families from paying and non-paying wards can use

Managing a playroom and library at the hospital for patients and their siblings

Managing a clothes bank for needy patients and their families

Providing nutrition support to children admitted to the Oncology and Malnutrition Ward

Conducting health-oriented programs such as workshops and seminars, and organizing fundraisers

Conducting multiple health camps, with the use of donated medicines in nearby districts, to provide health checkups to people who do not have access or cannot afford proper health care.

### Partnership with MOHP, UNFPA, WHO and GIZ to foster Midwifery Education in Nepal

In June 2015, UNFPA Nepal invited RMF to join a consortium to support professional midwifery education in Nepal, wherein RMF will be part of the "Collaborative Partnership Agreement for

Supporting Midwifery Education and Cadre in Nepal" between the Ministry of Health and Population, UNFPA, GIZ, and WHO. RMF intends to contribute in the following areas, which are being finalized following discussions with the government, partner organizations, concerned universities and other stakeholders:

- Development and strengthening of faculty in the chosen universities and educational institutions
- Supporting the universities in recruiting faculty members
- Contributing to the remuneration of technical staff
- Sponsoring training and capacity building/skills development programs for the faculty members
- Supporting students from economically and socially disadvantaged and marginalized backgrounds
- Providing scholarships for needy students
- Covering accommodation costs and potentially providing stipends for selected students
- Investments in necessary physical infrastructure and equipment support to one selected university.

**14 million**—the population of children supported by Nepal's only children's referral hospital: Kanti Children's Hospital

More than **\$400,000** worth of medicines and medical supplies provided

**Social Action Volunteers**—Helping the neediest patients and their families

# NEPAL

## BACKGROUND

During the earthquake of April 25, 2015, up to 90% of health facilities in many rural areas were damaged or destroyed. Out of a total of 352 birthing centers, 115 were destroyed and 137 partially damaged. Overall, the earthquake affected more than 8 million people, including 2 million women of reproductive age and over 126,000 pregnant women. To achieve universal access to sexual, reproductive, maternal, and newborn care, midwifery services must respond to 0.9 million pregnancies per annum by 2030, 85% of these in rural settings. The health system implications include how best to configure and equitably deploy the sexual, reproductive, maternal and newborn health (SRMNH) workforce to cover at least 70.2 million antenatal visits, 10.9 million births, and 43.7 million postpartum/postnatal visits between 2012 and 2030 (UNFPA, 2014). There is a significant lack of professional midwives to cater to the current and growing need; their roles will be instrumental in improving maternal and child health in rural areas, and so their numbers must be increased.

### Karuna Girls' School, Lumbini

RMF has been working globally to improve the education and health of girls and women, especially those from marginalized and underserved communities. Following RMF's immediate earthquake relief efforts, we continued our close collaboration with Global Karuna, a grassroots

level organization focused on providing education for rural, underprivileged children in Lumbini (the birthplace of Lord Buddha). The goal of our collaboration is to improve the education, health, and livelihoods of women and girls from remote and socio-culturally disadvantaged communities in Nepal.

Karuna Girls' School provides education beyond elementary school for teenage girls from Lumbini and surrounding areas, where girls are married as young as 10 years of age and face a life of poverty and discrimination. In this region, the average female literacy rate is one of the lowest in the world. Karuna Girls' School also provides vocational training for disadvantaged women. Training includes programs such as midwifery, tailoring, crafts, and tourism. RMF's project includes constructing a 3rd floor to meet the projected demand for 500 girls in need of a safe environment to attend secondary school (grades 6-12). Through this project, the school seeks to offer vocational training to both the students and local women, including tailoring, typing, and computer skills that will help them to find jobs, become financially independent, and contribute economically in the future. Karuna Girls' School aims to keep engaging parents and reach out to community members, teaching them about the importance of girls' education.



Caption here.

## KEY COMPONENTS OF THIS PROJECT:

- Grade eleven and twelve classes are taught in English. Students are slowly developing command of this language, which will be an important skill in the labor market.
- Introducing programs such as tourism, midwifery, nursing, and accounting. This training will be vital after high school.
- Evening vocational training (tailoring, computer skills, handicrafts, tourism, agriculture, and midwifery) for local mothers and other women.
- Consignment with Medical Supplies and Equipment for District Hospital

Due to the blockade in Nepal for the last 4 months of 2015, resulting in border obstruction at the Indo-Nepal border, our consignments with critical medical supplies have been stuck at the port of Calcutta, India. These consignments were generously provided by Project CURE, Convoy of Hope, MAP International, and supported by LDS Charities, International Relief & Development, and Help International, and are to be donated to the District Public Health Office in Kavre, one of the areas most heavily affected by the earthquake. We are in the process of releasing the consignment by rerouting it to another border point. And most likely, we will have the shipment released and donated to the government hospital by the end of February.



Caption here.



## 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 initiative is designed to ensure that all children under age 5 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. In January 2015, RMF launched the malnutrition program, and implementation started in March. During the course of implementation, RMF amended the partnership agreement with UNICEF, dropping Fangak and Nyirol counties and scaling up our work in Ayod and Boma in Greater Pibor.

The ongoing nutrition intervention is coordinated through the Nutrition Cluster (with other relevant clusters including Health and WASH) and implemented with financial and supply/logistics support from UNICEF, WFP, and WHO. The proposed strategy in Jonglei State takes a holistic approach and is designed to ensure the provision of lifesaving nutrition services for acutely malnourished children. Our strategy includes education and nutrition for pregnant and lactating women to promote optimal infant feeding practices, proper hygiene/sanitation, and improved maternal nutrition. We also empower mothers and children through micronutrient supplementation and nutrition education on locally available foods. To ensure efficiency, our strategy also calls for the establishment of a robust reporting and information system and monitoring mechanism, and a surveillance system, with an emphasis on capacity development of health care providers for all target areas.

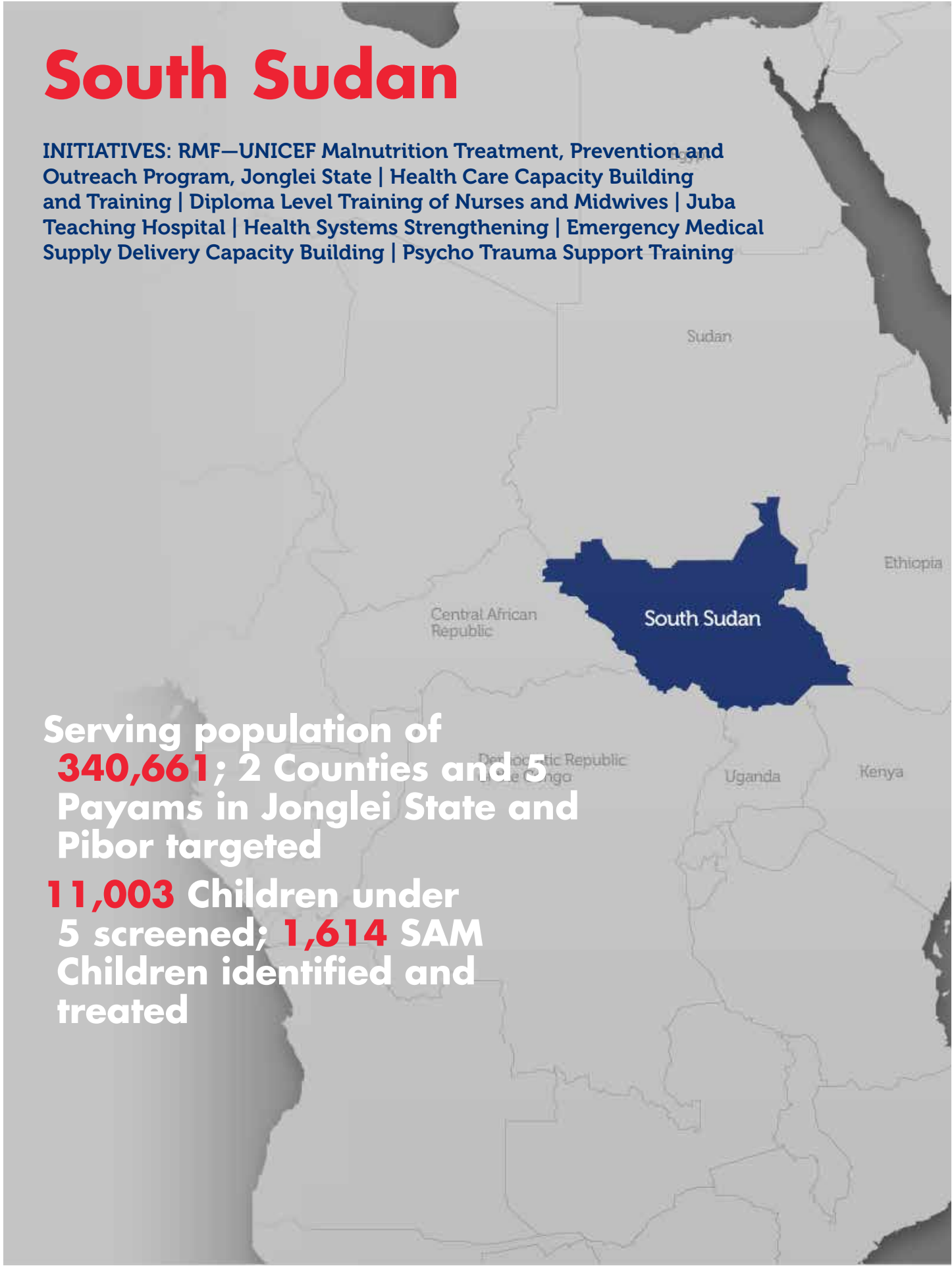
The total estimated populations of Ayod and Boma are 340,661 and 4,283 respectively. Within these populations, our program targets severely acute malnourished children ages 6-59 months. RMF's intervention is especially designed to ensure program sustainability. As with all our initiatives, RMF South Sudan actively involves local authorities' input, community strengthening, capacity building of the local nutrition staff, and supporting mother-to-mother support groups in each county.

The program has three main components: 1. Community Outreach - Community Outreach Workers are trained and sent out to identify acutely malnourished children using MUAC. They screen clients and refer them to nutrition centers. 2. Outpatient Therapeutic Program (OTP) - Children with severe acute malnutrition (SAM) and no complications are treated with ready-to-use therapeutic foods (RUTF) and symptomatic outpatient medications by RMF doctors, nurses, and nutritional experts at nutrition centers in the target areas. 3. Stabilization Center (SC) - Children with complications and no appetite are treated as inpatients at RMF-managed Stabilization Centers until they are stable and ready to be discharged.

In 2015, RMF identified a significant number of moderately acute malnourished (MAM) children not targeted in our ongoing program. Through the Nutrition Cluster, RMF engaged discussion with World Food Programme (WFP) to support Targeted Supplementary Feeding Program (TSFP) activities in the two counties. RMF will begin providing the complete CMAM package targeting SAM, MAM, and PLW in Ayod and Boma in 2016.

# South Sudan

**INITIATIVES: RMF—UNICEF Malnutrition Treatment, Prevention and Outreach Program, Jonglei State | Health Care Capacity Building and Training | Diploma Level Training of Nurses and Midwives | Juba Teaching Hospital | Health Systems Strengthening | Emergency Medical Supply Delivery Capacity Building | Psycho Trauma Support Training**

A map of South Sudan and its neighboring countries: Sudan to the north, Ethiopia to the east, Kenya to the southeast, Uganda to the south, and the Central African Republic and Democratic Republic of Congo to the west. South Sudan is highlighted in a dark blue color. The map is overlaid with text providing statistics on the population and malnutrition cases in Jonglei State and Pibor.

**Serving population of 340,661; 2 Counties and 5 Payams in Jonglei State and Pibor targeted**  
**11,003 Children under 5 screened; 1,614 SAM Children identified and treated**

# SOUTH SUDAN

## MAJOR ACHIEVEMENTS IN 2015

- 7 fixed Outpatient Therapeutic Programs (OTPs) and 2 Stabilization Centres (SCs) established; all providing quality CMAM/IYCF services.
- 11,003 children under 5 screened for signs of acute malnutrition.
- 1,614 Severely Acute Malnourished (SAM) children identified and treated in the OTPs.
- 88 Severely Acute Malnourished children with medical complications referred and treated at the SCs.
- 85% of children enrolled in the feeding program cured.
- 32 RMF nutrition staff members trained on CMAM/IYCF protocols and providing quality nutrition services.
- 66 CNVs received basic training on CMAM/IYCF with more focus on screening criteria.
- 8 mother-to-mother support groups formed, supported by RMF and carrying out IYCF activities, hygiene promotion, and referral services.
- 11,550 mothers and caretakers received appropriate IYCF key messages.
- 1,431 eligible children received Vitamin A supplementation and deworming tablets.
- 168 community mobilizations conducted.
- 3 mass screenings conducted.

## BACKGROUND

South Sudan's maternal mortality rate remains the highest in the world: 2,054 deaths per 100,000 live births according to the 2006 South Sudan Household Survey. Some main reasons for South Sudan's high maternal mortality rate include lack of access to appropriate reproductive health care, poor health infrastructure, inadequate medical supplies, and insufficient human resources in 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, high 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.

**First-ever accredited  
College of Nursing and  
Midwifery in S. Sudan**

**81 Nursing and  
Midwifery Students  
enrolled**

**2nd and 3rd Classes  
of 46 Nurses and 37  
Midwives graduated in  
December 2015**

# SOUTH SUDAN

## 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 with WCF's financial support and partnership, has co-founded and 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 expanded to other strategic locations in South Sudan. These trained, diploma-level nurses and midwives will help replenish the country's supply of professional health care workers, which has been depleted by 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. Residents of 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 serving the population of South Sudan. The college accepts applicants from all 10 states to optimize the distribution of newly qualified health care personnel.

The 2010 intake admitted 36 students (18 nursing and 18 midwifery students). 30 of those students progressed to their final year and graduated August 2013. A second class of 61 students started training in January 2012, and 45 (23 nurses and 22 midwives) progressed to their final year, completed the course in November 2014, and graduated December 2015. 54 students were admitted at the beginning of 2013, and 38 (23 nurses and 15 midwives) completed the course in November 2015 and graduated December 2015. 54 students were admitted in 2014, and they

have all progressed to the second year. 30 first-year students started the course on July 27, 2015, and 27 are continuing with the course. Program graduates 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.

### 2015 Update

The impact of ongoing, armed civil conflict in South Sudan is felt across the country and affects most sectors, including health and education. This led to late recruitment of the 2015 class and uneven national representation among students— many affected areas (mainly the Upper Nile Region) were not accessible, and getting students from this region was complicated further because the County Health Department is nonfunctional in most of the area. With limited resources from donors, the college could not recruit the usual number of 30 nursing and 30 midwifery students, but enrolled 15 nursing and 15 midwifery students who began the course in late July.

The armed conflict also destroyed Malakal University in Upper Nile State, and the university temporary relocated to Juba. Our nursing/midwifery students had to share the limited facility at JCONAM, as Malakal University had nowhere else to go. This exacted pressure on the facility and the college tutors. Lui Church School of Midwifery in Western Equatoria State also relocated to Juba due to armed conflict in their region, and the students and tutors used the limited space at JCONAM for conducting lectures. Despite these difficulties, the second and third classes of JCONAM students completed their course and graduated on December 11, 2015. The occasion brought the two classes together and was attended by RMF Founder and CEO Dr. Martina Fuchs whose presence inspired both the outgoing nurses/midwives and students still in the program.



Caption here.

# SOUTH SUDAN

## JCONAM (CONTINUED)

### Summary of Major Achievements in 2015

- In collaboration with the National Ministry of Health, we supported recruitment for the 2015 intake; 15 nursing and 15 midwifery students joined the college in July 2015.
- Supported the graduation of our second and third classes (46 nurses and 37 midwives) who graduated December 11, 2015.
- Procured and provided essential medicines for students and college staff, which reduced the economic burden on the implementing partner IMC, while students, teachers, and non-teaching staff continued to benefit from the essential medicines provided.
- Conducted training on Respectful Health Care (RHC) for third year students (23 nurses and 15 midwives) prior to graduation.
- Previously trained health care professionals continued to practice and disseminate the basic concepts of RHC and RMC (Respectful Maternity Care) to students and JTH staff, improving patient outcome.
- Respectful Maternity Care (RMC) supervisory checklist continued to be used in maternity unit of Juba Teaching Hospital and neighboring PHCCs within Juba city.
- Trained two college tutors as trainers in the use and propagation of eLibrary technology, providing them with tablets preloaded with medical books/information to act as reference guide.
- 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 in the implementation of nursing and midwifery curricula in the diploma program.
- Coordinated RMF activities and participation in meetings/workshops with UN agencies and NGOs supporting JCONAM and other National Health Training Institutes.
- Sponsored 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 support human resources capacity by employing two highly experienced and qualified national tutors.



Caption here.

# SOUTH SUDAN

## JUBA TEACHING HOSPITAL

### Background

Juba Teaching Hospital (JTH) is a 580-bed facility and the only national referral hospital in the country of South Sudan. The hospital is located in South Sudan's capital, Juba City, in Central Equatoria State. With a national population of 10.16 million (based on annual population growth of 3% from a census conducted in 2008) and a lack of properly functioning primary health care facilities in the rest of the country, many South Sudanese have nowhere to go but this national referral hospital. Even before the civil conflict erupted mid-December 2013, Juba Teaching Hospital was overwhelmed by continuously increasing demand. The few existing military and police hospitals are non-functional country wide, forcing soldiers and officers to share the limited facilities with civilians. JTH's departments and services include: Accident and Emergency Department, Pediatrics, Internal Medicine, General Surgery, Obstetrics/Gynecology, Ophthalmology, Mental Health, Physiotherapy, ENT, Diagnostic Services: Laboratory, Radiology, and Finance/Administration/Statistical Units. JTH was established in 1927, in structures that previously served as army barracks. Most of the hospital's infrastructure is dilapidated and in great need of upgrades and renovations, which would create an environment conducive to the healing of patients and their community, and improve working conditions for the health 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 Juba Teaching Hospital (JTH) for several years. In a Health Systems Strengthening project at Juba Teaching

Hospital, RMF, with support from Medical Mission International, started to upgrade infrastructure at JTH in spring of 2013, beginning with the wards of the Pediatric Department, and supporting the procurement of furniture, medical equipment, and supplies for the Pediatric Department. We achieved several milestones, including the full renovation of Pediatric Wards 5 and 7 (with a total bed capacity of 120 beds); development of guidelines and policies, and provision of supplies, for 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 head nursing staff in various departments on the importance of infection control and waste segregation in the wards/outpatient departments; procurement of protective gear; facilitation, regular monitoring, and supportive supervision of the JTH healthcare workers on policy guidelines; support of high speed WIFI internet services for the JTH Resource Centre, providing internet access to doctors and nurses at the hospital; assessment for improving the water and sanitation situation at JTH; and training programs on Respectful Maternity Care and Respectful Health Care.

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

## ACCIDENT & EMERGENCY DEPARTMENT

The improvement of the Accident and Emergency Department at Juba Teaching Hospital was initiated in mid-February 2014 when RMF founder and CEO, Dr. Martina Fuchs, visited Juba with a pledge from a generous private RMF donor. During that critical moment for the nation, Dr. Martina Fuchs had a series of meetings with the National Minister of Health and his team, and with Juba Teaching Hospital leadership. During these meetings, the 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 conditions in the Accident and Emergency Department, creating a welcoming and healing facility available for all South Sudanese and foreigners residing in the country, and supporting peace from within through provision of better health care services, with a strong focus on respectful care.

The Ministry of Health and Juba Teaching Hospital's leadership took the lead in the project's preparation and procurement process, making sure that there would be no interruption of services for patients. 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 Kariom visited the site on July 8th to kick off of the project, following the inauguration of the South Sudan Reference Laboratory by President Salva Kiir.

The contractor, Pan Koung Ltd (a South Sudanese owned construction company), donated additional improvement work beyond the work stipulated in our agreement, as a sign of commitment towards their new country. The improvement work on the four blocks was successfully completed in January 2015. At the time of completion, RMF's CEO, Dr. Martina Fuchs, visited South Sudan and toured the site with MOH Undersecretary Dr. Makur Kariom, an engineer from the ministry of housing, and JTH administrators. The MOH, through the leadership of

H.E. Dr. Riek Gai Kok, provided furniture for all the four blocks and opened the building for patients.

### Antenatal Care Unit

South Sudan's maternal mortality rate remains the highest in the world: 2,054 deaths per 100,000 live births according to the 2006 South Sudan Household Survey. Some main reasons for South Sudan's high maternal mortality rate include lack of access to appropriate reproductive health care, poor health infrastructure, inadequate medical supplies, and insufficient human resources in existing health facilities. On average, about 1,300 women attend antenatal care services at Juba Teaching Hospital per month, and about 30-35% return to give birth at the hospital. RMF's team talked to some of the women visiting the ANC at Juba Teaching Hospital, and most of them complained about the long waiting time, lack of privacy, and no shelter for waiting, which made it very difficult during rainy season and extremely high temperatures (approaching 40°C). The ANC infrastructure was dilapidated and small, with no waiting area, no privacy, and limited examination space which led to long wait times.

In collaboration with Health eVillages, RMF upgraded and improved the infrastructure of Juba Teaching Hospital's antenatal care unit, considering the lessons learned from our work there. The improvements included: partitioning the interior of the block to create 3 private examination rooms, creating family planning space, HIV counseling and testing (PMTCT) rooms, a storage facility, lavatory, and a well ventilated and spacious waiting room adequate for collaborative ANC services. The improvement work was successfully completed by Doyen International Construction Company in December 2015. RMF then furnished the ANC unit; we installed air conditioning systems, and provided furniture and examination tables. The unit is fully operational now, providing quality ANC services.

# SOUTH SUDAN

## UPDATE

### Health eLibrary

Juba Teaching Hospital does not have a functional library to enable health care professionals to make easy reference checks. Some departments have a few outdated medical textbooks only accessible to consultants; it is very difficult for most health care professionals to do reference checks when faced with difficult medical cases. This hinders accurate diagnoses and treatment, leading to poor quality care. RMF had a number of discussions with Pediatric, Obstetrics, and Gynecology departments on how to improve service delivery and reduce the alarming maternal and under-5 mortality rates occurring in JTH. The team continued to implement the Respectful Maternal Care and Respectful Health Care approach introduced by RMF, and all sought to have access to health-related information in a timely manner to enable quick, accurate decisions in patients' treatment and care.

In February 2015, RMF (through support of its Global Maternal Child Health Coordinator) refreshed the health care professionals working in Pediatric, Obstetrics, and Gynecology departments on the concepts of Respectful Maternal Care and Respectful Health Care. At the same time, RMF introduced a digital reference system using tablets preloaded with medical journals/information. Health care professionals (consultants, doctors, nurses, and midwives) were trained and provided with Health eVillages tablets to do quick reference checks during patient care, and encouraged to increase their expertise and knowledge by reading medical information in their free time. Two national tutors from Juba College of Nursing and Midwifery were trained as trainers to follow and monitor use of the tablets. The tablets are designed so that information can be accessed offline. However, RMF also installed high speed wireless internet in the maternity block (serving the maternity ward and a section of the pediatric unit) to enable health care

professionals to conduct further medical research online.

RMF continued to monitor the impact of the tablets through monthly patient satisfaction surveys and health care questionnaires. The two trainers (national tutors from Juba College of Nursing and Midwifery) interviewed the health care workers using the tablets and patients in the pediatric and maternity wards, conducting patient satisfaction surveys and health care questionnaires. Results were analyzed monthly. Overall, use of the tablets and internet access have improved patient care in Juba Teaching Hospital.

### Maternal Near-Miss Audit

Juba Teaching Hospital is the only national referral hospital in South Sudan and receives patients from all parts of the country. On average, the maternity ward assists in 17-20 normal deliveries and performs 3-5 Caesarian sections per day. The maternal mortality rate is about 2 per month. Most of these mothers die from preventable pregnancy-related causes, and a number of near-miss cases go unnoticed.

Real Medicine Foundation, with financial support from Health eVillages, conducted a maternal near-miss audit in Juba Teaching Hospital. The audit aimed to investigate the frequency of near-miss events, calculate the mortality index for each event, and compare the socio-demographic and obstetrical correlations of near-miss cases with maternal deaths. We trained 7 nurses/midwives working in the maternity unit, 4 third-year JCONAM midwifery students, and 2 national tutors from JCONAM in qualitative data collection. The data collection process was closely supervised by the lead investigator, RMF's team leader, and 2 international UN midwife volunteers attached to Juba Teaching Hospital and JCONAM.

A total of 1,010 mothers from the national referral hospital participated in the study, out of the 1,041 sampled: a response rate of 97.5 %. Nearly half (49.7%) of the clients visiting the JTH Maternity and Gynaecology Unit were young pregnant women (15-24 years of age) at the time of their visit, with a mean age of 25.07+ standard deviation (SD)= 5.65) years. During the study period, there were 994 deliveries, 993 live births, 94 near-miss cases and 10 maternal deaths. 165 near-miss events were identified among the near-miss cases, which implies a mean of 1.7 near-miss morbidities per case. This resulted in a total maternal near-miss and maternal mortality ratio of 94.1/1,000 live births and 1,007/100,000 live births, respectively, based on morbidity based criteria. The severe maternal outcome ratio (SMOR) and the maternal near-miss ratio were 10.47 based on morbidity based criteria 41.3/1,000 based on organ failure based criteria. These near-miss indicators provide an estimate of the complexity of care that is required by the population served by the health care facilities in the assessment. The likelihood of mortality and post-test odds 95% confidence interval 25% (10%, 51%) for ruptured uterus, severe postpartum haemorrhage 9% (4%, 17%) and eclampsia 11%, (3%, 30%), anaemia, pregnancy related haemorrhage, and dystocia were the highest associated and contributory factors contributing to the occurrence of maternal near-misses.

The mortality index was 9.2%, indicating that the number of women requiring essential obstetrics care is higher than available literature recommendations. This study demonstrates other contributing factors: the lack of resources, poor quality community health care, and fatal delays. All near-misses should be interpreted as case studies and opportunities to improve the quality of service provision. Organizational change should

especially address delays in conducting emergency Caesarean sections, referral barriers, and human resource problems in the health care system. Fully functional intensive care units (employing intensive care's structure, supplies, and well trained providers) need to be available in territory care units, including Juba Teaching Hospital and other teaching and state hospitals. Additionally, policies of notification for near-miss cases and severe maternal morbidity should be implemented in all health care units, with the principle of "no shame no blame."

### Emergency Medical Supplies

On September 16, 2015, South Sudan saw another tragedy when a fuel tank exploded in Maridi (a town in Western Equatoria State), killing over 200 people and leaving scores injured. This happened when the truck veered off the road and residents (including soldiers, women, men, children, and boda-boda riders) rushed to where the fuel truck overturned about 20 kilometers outside of town to collect fuel in jerry cans. Because of fuel shortages in the country as well as economic crises and insecurity, the local community saw this as an opportunity to salvage fuel for financial gain. When the fuel truck exploded, the only county hospital in Maridi, under-equipped and understaffed, was not able to cope with the large number of severe burn cases, and mortalities increased each day.

The national MOH, with support from partners, sent medical professionals and supplies to Maridi County Hospital and flew the severe burn cases to Juba Teaching Hospital, the only national referral hospital in South Sudan. The Accident and Emergency Department, well renovated and furnished by RMF, was opened, and burn survivors were housed in two of the blocks. At that time the hospital was running low on basic supplies/ pharmaceuticals to treat the burn victims. RMF's team met with hospital

# SOUTH SUDAN

## UPDATE

administrators, hospital pharmacists, and the doctors/consultants managing the burn patients, and came up with a list of supplies/pharmaceuticals most needed at that critical moment. RMF then organized emergency procurement of the needed supplies, worth \$3,000, locally from Juba and provided the supplies to Juba Teaching Hospital. The Minister of Health, H.E. Dr. Riek Gai Kok, personally visited the burn victims and acknowledged RMF's support during that critical time. Burn victims' lives have been saved, their economic burdens reduced, and their quality of life improved through the supplies provided by RMF.

### Juba Teaching Hospital 2015 Updates:

- Continued implementation of RMF's annual work plan guided by our MOU with the National Ministry of Health.
- Improvement work on the Accident and Emergency Department was successfully completed, the blocks furnished and operational. The unit has changed the face of the hospital as the community feels it is a sign of unity and a safe and much better place to get health care services and to convalesce. The two blocks housed burn survivors evacuated from Maridi following the fuel tank explosion.
- The Antenatal Care Department was renovated and upgraded, making it more suitable for conducting collaborative ANC services. There are adequate examination rooms, a waiting area, family planning, and PMTCT rooms. This improved unit ensures privacy and reduced wait times.
- Procured and provided furniture and equipment for the ANC department improving quality of care.
- Emergency supplies/pharmaceuticals procured and delivered to save the lives of Maridi burn victims when the hospital was running low on medicines and the victims were not able to afford medicines from private pharmacies.
- Refreshed maternity and pediatric staff on the basic principles of Respectful Maternity Care and Respectful Health Care leading to the improved service delivery and patient care.
- Conducted maternal near-miss audit in Juba Teaching Hospital. The JTH administration and head of Obstetrics and Gynecology will work together to implement the recommendations derived from the study.
- Trained and provided the nurses/midwives/doctors/consultants working in the Pediatric and Maternity departments with tablets preloaded with medical journals/books to act as a quick reference resource for the health care professionals.
- Installed internet and set up regular payment of internet subscription fees to provide maternity and pediatric staff and other health care workers visiting the maternity unit with easy online access. This together with the provided Health eVillages tablets have improved quality of care provided in JTH.
- Continued rehabilitating the equipment set at Juba Teaching Hospital with focus on the Pediatric and Maternity departments.
- Continued maintenance and repairs, where needed, of already upgraded/renovated Pediatric, Accident and Emergency, and ANC departments.
- 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 JTH health care workers and janitors on implementation of waste management policy guidelines.
- Monthly provision of adequate cleaning materials to Pediatric Department, 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 staff continued to be improved through implementation of the waste management policy, developed with the support of RMF's team.
- Additional cleaners were hired and stationed at the Pediatric Ward 5's surgical unit to increase the workforce and ensure proper cleaning and maintenance of the renovated ward.
- Installed and furnished a prefabricated office expansion for RMF's South Sudan team inside Juba Teaching Hospital grounds, easing coordination significantly.
- Continued provision of high speed WIFI internet service for Juba Teaching Hospital Resource Centre, facilitating research and improving continuous medical education for health care professionals and students.

# SOUTH SUDAN

## JUBA TEACHING HOSPITAL

South Sudan has only one psychiatrist in a country of an estimated 10.16 million people. This one psychiatrist is heading the mental health department in the national MOH and clinically supports management in Juba Teaching Hospital and overall the whole country. There are no adequate specialized mental health services across the country; cases are handled in the routine clinics. Many South Sudanese are traumatized following the decades of civil war and the ongoing internal armed conflict that erupted mid-December 2013, but most health care professionals lack basic training in mental health care. A number of patients suffering from trauma arrive at health facilities and are treated for different medical conditions without receiving psychological care.

RMF founder and CEO Dr. Martina Fuchs met with the only psychiatrist, Dr. Atong, in Juba in February 2015. RMF then came up with the concept of psycho trauma training to support health care professionals and schoolteachers, the front liners in patient management and young adolescents in school. Elisabeth Scheffer & Associates, LLC (ESA) was contracted by RMF to develop training materials and execute training in Juba. The main aspects of the training were psychological care for children, psychological first aid, and post-traumatic stress disorder.

Three categories of people have been trained, and are now able to provide basic care for traumatized persons:

1. Schoolteachers: 17 primary and secondary schoolteachers from 10 schools were mobilized with the support of the Central Equatorial State Ministry of Education. The 17 teachers completed three main course units designed for psycho trauma support. The training was conducted by a ESA consultant psychologist with the support of a Ugandan midwife working at JCONAM and JTH. The training used an interactive and friendly way of teaching. 6 of the teachers were selected and educated further to train more teachers in Juba, with the goal of expanding to other counties.

2. Health care professionals: 27 health care professionals serving in Juba Teaching Hospital participated in the training and completed all three course units of psychological trauma training. The hospital administration and all departmental heads acknowledged the importance of the training, which contributes significantly to patient care.

3. Nutrition team members: 11 RMF nutrition team members (mainly nurses/midwives and clinical officers implementing the RMF-UNICEF malnutrition program in Jonglei State and Greater Pibor Administrative Area) were trained on psycho trauma support. The RMF team, serving in conflict areas, encounters many traumatized clients and parents/caretakers of the malnourished children. Through the training, the team is now able to integrate the psychological aspect of the psycho trauma support with the Infant and Young Children Feeding (IYCF) initiative.



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## BACKGROUND

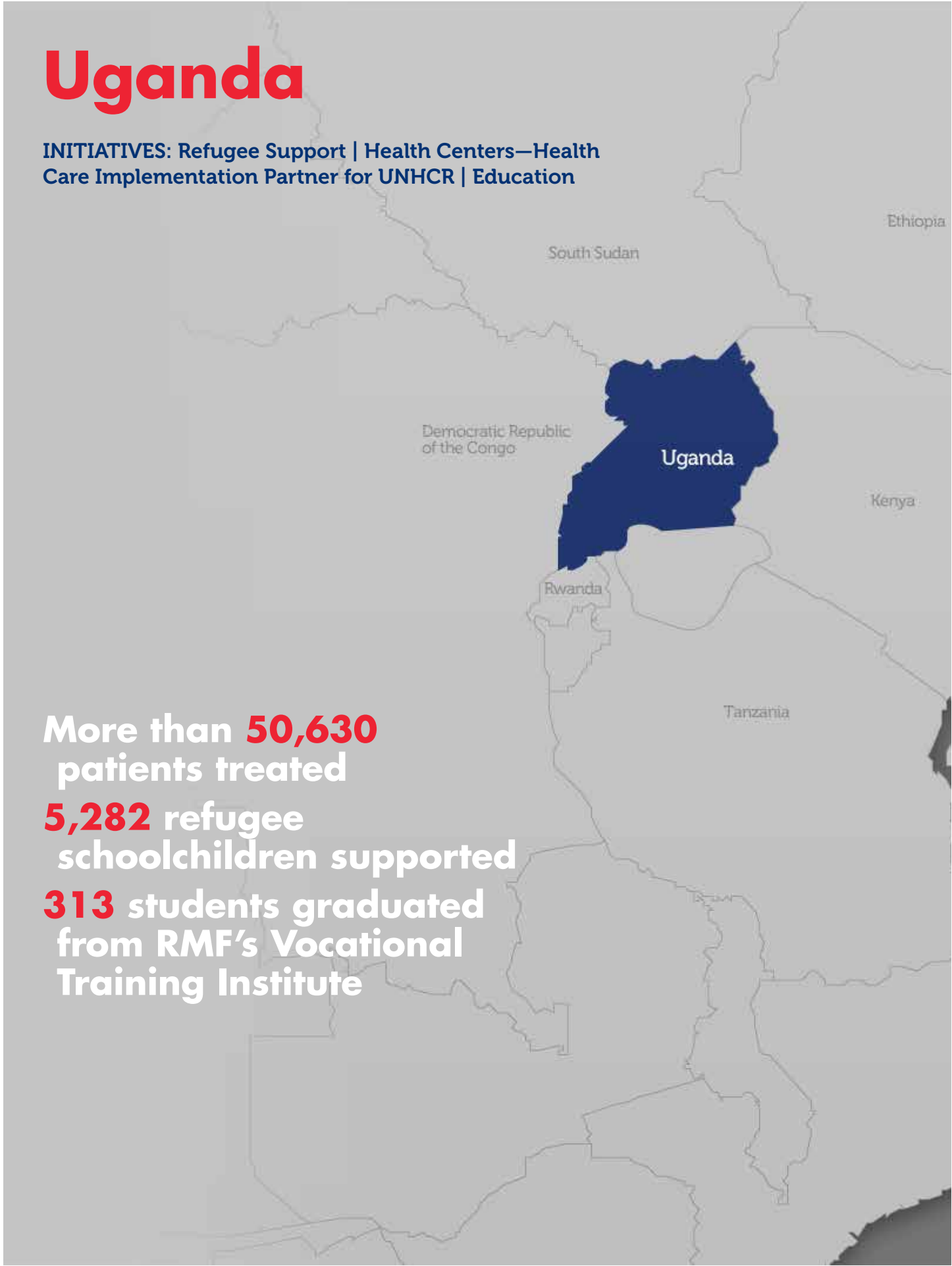
The Kiryandongo Refugee Settlement in Bweyale, Uganda is a UNHCR managed refugee settlement that provides shelter, land, and support for more than 60,000 people, including Ugandan IDPs and refugees from Kenya, the Democratic Republic of the Congo, Rwanda, Burundi, and South/Sudan. RMF has partnered with UNHCR and the Ugandan Office of the Prime Minister (OPM) in supporting Kiryandongo Refugee Settlement and the surrounding community of Bweyale (an additional 49,065 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 2015, we

had 49,065 new refugees from South Sudan, with over 170 new arrivals every day; some are coming from other refugee camps to settle in Kiryandongo.

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

# Uganda

INITIATIVES: Refugee Support | Health Centers—Health Care Implementation Partner for UNHCR | Education

A map of East Africa with Uganda highlighted in dark blue. Neighboring countries labeled include Ethiopia, South Sudan, Democratic Republic of the Congo, Rwanda, Kenya, and Tanzania. The word 'Uganda' is also written in white on the highlighted area.

More than **50,630** patients treated  
**5,282** refugee schoolchildren supported  
**313** students graduated from RMF's Vocational Training Institute

## 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 the official Implementing Partner of UNHCR in Kiryandongo Refugee Settlement, RMF has been able to expand our existing support of health programs and address two goals: emergency care and operations, and maintenance of the originally targeted 24,722 (20,269 new cases and 4,453 old cases) of refugees and asylum seekers in Kiryandongo Refugee Settlement through the delivery of quality, sustainable health care services. Beneficiaries of these health care services also include Uganda nationals; the host community is comprised of more than 74,220 people. By the end of December 2014, the project was already benefiting 35,664 refugees (as per UNHCR). By the end of 2015, the refugee population had grown to 49,065.

In addition, RMF continued to provide medicine and medical supplies to Panyadoli Health Centre III, payment of staff salaries, and other operational support. In the course of the past few years, through

RMF/WCF's support, Panyadoli Health Centre III has become a reliable source of health care for the community, handling a wide variety of issues including maternal and child health care, malaria, malnutrition, HIV/AIDS, and community health prevention through outreaches. Patients requiring advanced care can now be treated at Panyadoli Health Centre III thanks to the additional medical and human resources made possible by the RMF/UNHCR/OPM partnership. Patients continue to come from all different parts of Kiryandongo, some even leaving Kiryandongo Main Hospital because of better availability of medication and supplies and higher quality medical treatment offered at Panyadoli Health Centre III. With the huge influx of new refugees in 2015, mostly from South Sudan, more than 50,630 patients were treated at Panyadoli Health Centre III compared to 46,966 in 2014. Another way RMF continues to support quality health care for the community is by maintaining the pipes, taps, and solar powered water pumps which we installed in previous years to supply all the clinic buildings with clean water.



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# UGANDA

## 2015 UPDATE

RMF's partnership with UNHCR has made a significant impact on Kiryandongo Refugee Settlement, initiating an overall improvement in the community's quality of life and considerable improvement of health indicators. The increase in the number of staff at all health facilities has added tremendous value to health services. New medical and non-medical staff were recruited by RMF, the government of Uganda, and UNHCR, including a Program Officer, 2 Medical Doctors, a Head of Finance and Administrative Officer, a Finance and Administrative Officer, 4 Clinical Officers, a Senior HIV/AIDS Counselor, an HIV/AIDS Counselor, 8 Nurses, 4 Midwives, a Lab Technician, 2 Lab Assistants, 4 Data Clerks, 4 Security Guards, 10 Ward and Compound Cleaners, and 3 Drivers. The establishment of a health clinic at the Reception Centre has also reduced overcrowding at Panyadoli Health Centres II and III, allowing for shorter wait times, providing another source for immunizations, and positively changing health seeking behaviors among refugees.

In RMF's role as Implementing Partner for UNHCR and our mission to expand current health programs in Kiryandongo Refugee Settlement, 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 activities. Disease surveillance and prevention training was provided for community health promoters (VHTs) at a time when there were outbreaks of deadly diseases, such as Ebola in West Africa. As a result, one of the trained VHTs was able to detect a suspected case of polio in Magamaga. HIV/AIDS Voluntary Counseling and Testing (VCT) was provided at Panyadoli Health Centre III by RMF staff. ART clinics have been conducted, condoms distributed, and opportunistic infections properly managed. Communities have been sensitized on HIV/AIDS prevention, care, guarding against discrimination, and the dangers 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 including immunization, HCT, ANC, deworming, condom distribution, and vital health education on issues like gender based violence. Community health promoters (VHTs) were trained on their roles, disease surveillance, and disease prevention, and further sensitization campaigns were conducted with topics including chicken pox, Ebola, and jigger prevention/response.

### 2015 Key Numbers:

- 100% access to primary health care
- 51,411 patient consultations during the year at all UNHCR supported clinics
- 2 staff trainings on HMIS
- 29 staff trainings on UNHCR Code of Conduct
- 50 VHTs trained on disease surveillance and outbreaks
- 45 routine trainings of health workers on SOPs
- 0.0 crude mortality rate
- 0.0 under-five mortality rate
- 89% measles coverage
- 1:53 clinician/patient ratio per day
- 0.7 health facility utilization rate
- 48% bed occupancy rate
- 62.2% hospitalization rate
- 26% vaccine coverage rate
- 100% postnatal Vitamin A distribution
- 8/month routine immunization programs established and maintained

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



Caption here.



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## KIRYANDONGO REFUGEE CHILDREN EDUCATION AND SCHOOL SUPPORT

### Background

When 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 UNHCR and the Ugandan Office of the Prime Minister (OMP), and with support from WCF, we established a school support program to cover fees and supplies for nursery, primary, and secondary school children in the Kenyan refugee community at Kiryandongo. In subsequent years, students from South Sudan, the Democratic Republic of the Congo, Burundi, and Rwanda have been accepted into our program as well. RMF pays a portion of the costs for tuition, school uniforms, school supplies, and examinations for students whose parents cannot afford the fees. We also cover the cost and travel expenses for senior high school students' final examinations, and continue to provide funding for the annual registration of candidates in Senior Level Four and Senior Level Six in our sponsorship program. RMF also facilitates candidates taking their national exams in the city of Masindi.

### 2015 Update

Dr. Martina Fuchs, RMF founder and CEO, visited all RMF-sponsored Kiryandongo Refugee Settlement schools, as well as the Vocational Training Institute, during her visit in November 2015. She also conducted a needs assessment meeting with RMF Uganda's team. In the schools, Dr. Martina met with teachers to hear about educational accomplishments and needs, and interacted with students from South Sudan. Many South Sudanese students were refugees that had just arrived. Most are minors, and they shared with Dr. Martina their harrowing experiences in South Sudan since December 2013; a sad majority of these students have seen family members killed in front of their eyes. RMF was sponsoring a total of 5,282 schoolchildren by the fourth quarter of 2015; this number is significantly higher than last year's support of 4,393 students. The increase is mainly due to the recent influx of South Sudanese refugees; Kiryandongo Refugee Settlement is receiving an average of about 170 new arrivals every day.



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# UGANDA

## KIRYANDONGO: PANYADOLI VOCATIONAL TRAINING INSTITUTE

### Background

In April 2011, after the refugee community presented RMF with issues surrounding the lack of skills and vocational training for students graduating from the settlement high school, we initiated the Panyadoli Vocational Training Institute in Kiryandongo Refugee Settlement. With feedback from the community, and after researching which skills could provide the quickest, most sustainable income earning opportunities for students and meet RMF's economic investment requirements, we narrowed the programs down to two: Hairdressing and Beauty Therapy and Tailoring and Garment Cutting. With the generous support of WCF, we renovated an abandoned 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: "Focus on the person as a whole." The longer-term vision for Panyadoli Vocational Training Institute is that it will function as one of several models for income generating opportunities, helping the populations we support around the world to eventually become self-sufficient again.

### 2015 Update

In 2015, RMF's Panyadoli Vocational Training Institute offered classes in theory and hands-on techniques for Hairdressing and Beauty Therapy, Tailoring and Garment Cutting, Carpentry and

Joinery, and Bricklaying and Concrete Practice. Completing its fifth year, our Vocational Training Institute has held eight graduation ceremonies since 2011, and a total of 313 students graduated in 2015 alone. The Vocational Training Institute is continuing to generate some income to sustain itself, by tailoring garments, such as uniforms for the nurses at RMF's Panyadoli Health Centre III, and by offering hairdressing services to residents of Kiryandongo Refugee Settlement and surrounding communities. RMF/WCF's support in running the Vocational Training Institute has helped empower local 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 Training Institute now own shops in different trading centers, and others are employed in shops in the region. RMF Bricklaying and Concrete Practice students were able to build a hairdressing classroom, and we are proud of their work. All the men who have gone through our Bricklaying and Concrete Practice training have been able to find jobs and are currently employed. Carpenters have made workshops and are able to produce quality furniture and door frames for people living in Kiryandongo district.



Caption here.

# UGANDA

## RMF AND JICA PARTNERSHIP

In 2014, RMF Uganda began a partnership with JICA, the Japan International Cooperation Agency (we already had a partnership with JICA in South Sudan). With JICA funding, RMF purchased materials and provided staffing costs to support a large intake of students for our 3-month, intensive program at Panyadoli Vocational Training Institute. The partnership with JICA boosted the capacity of RMF's Vocational Training Institute for the whole of 2015, supporting us to fully train 313 graduates in our four courses of study: Hairdressing and Beauty Therapy, Tailoring and Garment Cutting, Carpentry and Joinery, and Bricklaying and Concrete Practice. When JICA's support ends with 2015, WCF will again be the school's primary funding partner, and all four courses will still be maintained by RMF/WCF.

### Tailoring Shop Program

As part of the economic component of RMF's global work, the goal of RMF's Tailoring Shop Program is to set up sustainable, market-based business opportunities for refugee and IDP graduates of the Panyadoli Vocational Training Institute's Tailoring and Garment Cutting Program. Initially supported by Frost Family Foundation, RMF started this program in 2013, sponsoring 10 Tailoring and Garment Cutting graduates to set up their own tailoring shops with the purchase of fabric, thread, a sewing machine, and other equipment. In order to be approved for the program, tailoring graduates must agree to give 10% of their profits back to the Vocational Training Institute.

RMF also paid the monthly shop 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 the Vocational Training Institute; these funds are used to procure supplies for the next round of students. In response to requests voiced by the members of our Tailoring Shop Program, further training was conducted, covering business management, business planning, marketing management, recordkeeping, customer care, and creativity in business, led by Adolph Byamungu, one of RMF's vocational instructors who has experience running his own business in his home country, the Democratic Republic of the Congo. RMF has since incorporated this training into the regular curriculum at Panyadoli Vocational Training Institute.

## 2015 SUCCESS STORIES



### Doreen Aweko

Doreen has had significant improvement in her business, including additional materials in her store. Doreen started her tailoring business with the capital she got from

RMF, and with the profit she made out of this donation, she started selling grain from Bweyale, Kiryandongo to Juba, South Sudan for a good profit. She began by using her tailoring profits to start selling grain to South Sudan, and now she uses her grain selling profits to strengthen her tailoring business. With two successful businesses, Doreen now earns a double income. As a woman, Doreen faces many challenges, including theft and safety, but her growth cannot be challenged; even though she is in a business mostly occupied by men, she has managed to compete strongly and equally.



### Martha Aryemo

Martha operates her business near the market of Bweyale. She has managed to get many customers because of the basic skills she exhibits in attending to people. Martha also adds to her business by

buying second-hand clothes. She modifies the clothes to add value, and then sells them at a higher price to earn a profit. Martha has also turned her shop into a workshop, where she teaches those that want to learn either how to start a tailoring business or how to use a sewing machine. She is given money for instructing, which adds to her profits. Martha shares one of her challenges with a smile: some customers don't want to pay after the work for them is done.



### Santa Auma

Santa is one of the most successful students RMF's Vocational Training Institute has ever produced. Santa is now employing four young women in her shop who help her with the daily tasks of running

the business. Santa is very proud of her growth and of having successfully overcome challenges in the past, such as a broken sewing machine. In addition to selling in Uganda, Santa and her team are also exporting their products to South Sudan where there is a ready market. Santa can save up to UGX 600,000 per month. She says that she is seeing a lot of changes in her life: paying school fees for her children, paying rent, and training other people from different areas.

# UGANDA

## WORLD CHILDREN'S FUND MAMA KEVINA SCHOOL, TORORO

### Background

The World Children's Fund Mama Kevina Comprehensive Secondary School is an orphanage and boarding school that provides education and care for orphans and underprivileged, vulnerable children in Eastern Uganda. The boarding school caters to orphans and some paying students, and is located just a few kilometers outside of the town of Tororo in Eastern Uganda. Tororo is 200 kilometers from Uganda's capital city, Kampala. Mama Kevina School was opened in 2006 with international financial support, and with the goal of providing both secondary education and vocational training to orphans and vulnerable children. 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, and several of our boys had been forced to be child soldiers. Enrolled at the school are students ranging in age from 11 to 24, who attend secondary grade 1 to secondary grade 4.

### 2015 Update:

Throughout the year 2015, RMF and WCF continued to provide financial support for WCF Mama Kevina School's monthly operational needs. This funding is being used to cover critical school needs such as salaries for teachers and support staff, food for students, renovation and repair of the school, medical care for students, and stocking the library and laboratory. The funding from RMF and WCF has enabled the school and grounds to be renovated and maintained as a pleasant, bright environment, and the school has achieved a high academic standing. WCF Mama Kevina School's academic and aesthetic achievements have begun to attract more paying students, and will consequently help the

school towards becoming self-sustaining, without losing the major objective of helping orphans and less privileged children. In the 2015 Uganda National Examination (UNEB), WCF Mama Kevina School was ranked 2nd best in the Tororo District, moving up from the 3rd position that it held in 2014. We applaud the entire team for making this happen.

### RMF's work in 2015 included:

- Support of school administration through payment of staff salaries and daily operation of the school
  - Supply of laboratory reagents and equipment for science classes
  - Installation of lightning rods on school buildings to prevent possible loss of life and property in case of lightning strikes
  - Renovation of older school buildings, greening and beautification of the school compound, creating a pleasant environment for reading
  - Provision of nutritious food for the students of WCF Mama Kevina School, including all daily meals and support of the school gardening project so that the school can produce its own food; students are much healthier because they receive a balanced diet
  - Support of the school's development of a eucalyptus forest as a future source of firewood
  - Procurement of medicines and medical supplies for the school clinic and payment of clinic staff's salaries so that the school nurse and medical officer can treat children on 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
  - Installation of handwashing facilities in the compound to reduce 4Fs related illnesses
  - Provision of resources for extra-curricular activities, allowing students to participate in regional games and sports to enhance student performance and the school's regional standing
  - Support of participation for Gloria Ajobilo, a senior one student at WCF Mama Kevina School, who challenged all participants in the 5,000-meter competition in Tororo and was chosen to represent Tororo District at the national level in Gulu, northern Uganda. Gloria Ajobilo performed so impressively in the 5,000-meter event that spectators commented, "If this girl is given sufficient training and exposure, she will win a gold medal at the Olympics."
  - Support of WCF Mama Kevina School's Inter-House Music, Dance, and Drama Festival. This part of school co-curricular activities promotes children's talent development. It is an activity the students eagerly await because every student, teacher, and support staff member gets involved in one way or another. It is both fun and educational for the students; the theme for the year 2015 was "Conserving the environment is everybody's responsibility." The winning house is rewarded with a trophy and a cow; at the end of the event the cow is eaten by the whole school. Rewards are also given to individuals who perform exceptionally well in their respective houses.
  - The school hosted 10 student teachers on internship from top Ugandan universities: Makerere University Kampala, Kyambogo University, and Uganda Christian University.
- This is another indication that the school is building an attractive image in the country.
- 87 candidates sat for their Uganda Certificate of Education (UCE), and will be joining an advanced level of education in early 2016.
  - The school conducted a welcoming ceremony for students joining senior one and a farewell party for students completing senior four. These are joyful moments that every student waits for with excitement.
  - The school conducted an honorable send off for Sliver Onyango, one of the senior security guards of the school. This officer had set a remarkable record for the school. Sliver has been working for WCF Mama Kevina School since 2006, and throughout his tenure as head of security the school has never lost valuable property. The students fondly referred to him as "team no sleep" because no student could manage to sneak out of school.
  - Support of students' field studies as required by the Ministry of Education
  - Purchase of single seater desks that are required during national examinations; Uganda's national examinations board recommends that during the national examinations every student should sit alone so that students are assessed individually
  - Facilitation of visits by experts in different subjects to give students special guidance as part of the preparation for national examinations conducted at the end of 2015
  - Support of two students' medical operations: George Ogoli who was suffering from a hernia in his testes, and Dorothy Nyapendi who had a wound on her leg that would not heal

# UGANDA

## COMPLETION OF THE CONSTRUCTION PROJECT

In December 2013, WCF and RMF allocated funds to construct key buildings that WCF Mama Kevina School was critically in need of. These buildings included: a classroom/administration block, a multipurpose dining hall, girls' dormitories, and boys' dormitories. This massive construction project was completed in early 2015. The completion of the new buildings has created positive impact in the school and surrounding community. First and foremost, the school's biggest challenge of accommodation was overcome. Besides improving student and staff experience, the main purpose of funding this construction was to significantly increase the school's capacity to attract paying students, whose tuition will help subsidize orphan support. Our long-term goal is to guide WCF Mama Kevina School towards self-sufficiency and to establish a school model that can be replicated.

### Impact in the Community

The new buildings have added tremendous value to the area where the school is located: Agururu slum. Agururu used to be a neglected and feared slum, but with the establishment of the school, social infrastructures have been extended to the area. These include: integrating the road leading to the school into the district plan so that it is periodically graded, and extension of the power line to the school, both of which have benefited the school and the community. Gradually the slum is changing into a middleclass settlement area.

- Benefits brought by the construction of the girls' and boys' dormitories, multipurpose hall, and classrooms block include:
- Children sleep in well aerated dormitories
- Children are safe at night, since matrons and patrons sleep in the dormitories to provide effective supervision and guidance
- The school has spacious, ventilated classrooms. The multipurpose hall has provided sufficient space for conducting examinations

- The new buildings have provided space to conduct co-curricular activities such as music, dance, and drama.
- The multipurpose hall has provided space for entertainment, watching news, and other forms of recreation

### Food Security

Throughout 2015, RMF/WCF provided funding to ensure that WCF Mama Kevina School had sufficient, nutritious food for the children. This has enabled the school to feed the children a regular, balanced diet, and completely overcome cases of malnourishment, which used to be a problem when the school had just been founded. Since the students are well fed, they are able to concentrate on their studies, which has contributed greatly to the academic achievements of WCF Mama Kevina School. To sustain food security, the school has developed a farm that is used seasonally to grow maize and vegetables.

### Study Tours and Sports Outings

Uganda's Ministry of Education requires that students be taken for study tours so that they get an opportunity to correlate theories with realities in the field. Students enjoy these moments because they are full of fun and learning. In 2015, students visited tea estates in central Uganda and landing sites on Lake Victoria, among others.

### Background

In early 2013, RMF, in cooperation with Italy's Associazione Devoti Madre Teresa Per I Bambini, started funding 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. Buwate Sports Academy seeks to develop the youth advancement component of our humanitarian work through games, sports training, vocational



Caption here.



Caption here.



## UPDATE

training, and other educational opportunities. One of the major roles of the academy is that of a safe haven for the youth we are targeting in Buwate and Kireka, 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 on 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 and services we were able to provide. The move to secure land and set up an onsite health clinic, a vocational training center, and a stadium is still ongoing. Currently the academy is still using the playground of a community primary school.

### 2015 Activity Summary

- Schoolbooks were purchased and distributed to orphaned and vulnerable children across the three terms of the school year. These children are now free from the stress of trying to raise funds to buy 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 school supplies has greatly improved the children's academic performance.

- RMF recruited two more full-time, qualified staff members at Buwate Sports Academy to oversee tailoring and hair dressing training, thus promoting professionalism and sharing our values of respect and dignity.
- Food, charcoal, and cooking oil were purchased and one afternoon meal provided for all Buwate Sports Academy children and youths each 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 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 (or American soccer) in our community.
- Equipment, including more than 30 balls, 15 pairs of soccer shoes, and goalkeeper gloves, was purchased, helping motivate the children to play hard and improving their self-esteem.
- School fees for the children on the sponsorship list were fully paid.
- 4 boys and 1 girl who were given scholarships to affluent schools in Kampala have continued to sustain the sponsorship because of excellent performance in sports.
- Throughout 2015, the Buwate Sports Academy team conducted community dialogues to generate joint solutions on how to reduce

poverty among widows, single mothers, and 'elderly parent headed families.' Among the practical solutions that were reached was the introduction of hairdressing training, which will commence early 2016.

- RMF's founder and CEO, Dr. Martina Fuchs, visited Buwate Sports Academy purposely to encourage and strengthen the academy team and the community. During her visit, Dr. Martina held community discussions to encourage parents and guardians to move out of dependency on aid. Dr. Martina emphasized the fact that RMF's role is to empower the community so that it is able to stand proudly on its own when RMF phases out.
- Buwate Sports Academy conducted activities to mark important international and local events, which included: United Nations International Day of Peace - Global Peace Games for Children and Youth, International Women's Day, Easter holidays sports, Independence Commemoration Games, and Christmas holidays games, among others. During these events, children were taught important human values, such as respect for all life, non-violence, understanding through listening, preserving the planet, sharing with others, and respect for women rights.
- Students were transported to compete with teams outside of Buwate, showing students the difficulties other sports academies face, which helped them further appreciate the services Buwate Sports Academy is able to provide and

gave them opportunity to compare their skills development rate.

- Buwate Sports Academy organized an under-12 tournament held on Buwate grounds. The matches included Buwate Boys vs. Kiwatule Sports Academy and Buwate Boys vs. Kiira Young Stars. Buwate won the tournament 2-0.
- The academy was able to pay registration fees for the Christmas Cup so that the children could participate in the tournament.
- Wages and incentives for the support staff members were paid on time.
- Buwate Sports Academy was able to purchase essential sports items.
- 4 academy coaches were facilitated to go for a 3-week training session with One World Play Project. After the training, they were offered 100 balls, which they delivered to Buwate Sports Academy. This is promoting a public relationship between Buwate Sports Academy and the world outside Buwate.
- Buwate Sports Academy is continuing with our tailoring training program. This is an initiative to impart livelihood skills to our members.
- Buwate Sports Academy purchased a digital camera and computer to facilitate report processing.
- Children who were in candidate classes (primary seven and senior four) completed their national examinations. Results are expected in early 2016.

## 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 1st birthday. Life expectancy in the region hovers just above 40 years.

### Background

The Lwala Community Health Center was founded by brothers Milton and Fred Ochieng' 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 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 completed another infrastructure expansion in 2015. Other programs include Emergency Ambulance Services, Maternal and Child Health Outreach Programs, Education, and Economic Development 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 around 20,000 people who are able to access health care at the Lwala Community Hospital by foot or short motorcycle transport.

# Kenya

INITIATIVES: Drought Relief | Primary Health Care | Mobile Clinics | Health Systems Strengthening | Upgrade, Renovation, Support—Lodwar County and Referral Hospital, Turkana



**30,574** patients seen  
**446** babies safely visits delivered  
**5,334** Child Welfare Clinic visits provided for vaccinations and monitoring for children under 5  
**1,107** HIV/AIDS patients enrolled in HIV Care

## 2015 UPDATE

- The hospital connecting wing was completed and clinical services have fully moved into the new spaces, including the lab, pharmacy, maternal and child health services and the registration office.
- The “Thrive thru 5” program, an effort to reduce under-5 mortality to 50% of the regional rate by the end of 2016, continued in 2015. At the end of the year, 3,725 children and 3,258 mothers had been enrolled in the household outreach program. The number of under-5 deaths averaged 3.5/month in 2015, down from 7/month in 2014.
- In 2015, the skilled delivery rate was 97%, surpassing our target of 96%. Furthermore, all identified mothers who had home deliveries received medical care within the first 24 hours after delivery.
- LCA had great success with its goal of near zero mother-to-child transmission of HIV. Over 30 mother-baby pairs attended a graduation ceremony in December to celebrate those children who were declared HIV-free after 18 months of follow-up.
- Community outreaches added to a cumulative total of around 8,500 individuals reached in 2015, attracting many parents, typically mothers, to discuss issues around family planning options/methods and child health.
- Hospital statistics for 2015 include:
  - 30,574 patient visits (average 2,548/month)
  - 446 babies delivered (average 37/month)
  - 7,716 HIV patient visits (average 643/month)
- LCA’s HAWI (HIV & WASH Integrated) project was launched in conjunction with the public health team to address stigma and shift a heavy focus of HIV care from clinical care to community care and prevention.
- Family planning targets set in the beginning of 2015 were surpassed for the year; 943 women received long-term family planning out of a targeted 585, and 1,809 individuals received short-term family planning out of a targeted 1,520.
- LCA’s Community Led Total Sanitation (CLTS) effort led to four villages being qualified for open defecation free (ODF) status.
- The Better Breaks program, which operates week-long events for youth during the April, August, and December school holidays, was successful in engaging youth and providing access to health information and services. In 2015, more than 1,700 youth attended the events, and a total of 325 adolescents were tested for HIV, 189 were tested for pregnancy, and 99 were tested for sexually transmitted infections.
- In 2015, 1,957 youth attended youth outreaches and 1,820 youth were referred to the Lwala Community Hospital or the Minyenya Dispensary for testing, counseling, and FP services.
- 21 out-of-school YPPs actively educated fellow youth on sexual and reproductive health and made referrals for counseling, testing, and FP service provision at the Lwala Community Hospital and Minyenya Dispensary. A key role for the YPPs is to lead health clubs in the community, which served 413 participants in 2015.
- 81 in-school YPPs were recruited in February, trained in March and April, and led in-school health clubs and acted as peer educators within their schools and communities throughout 2015.
- The New Vision Sewing Cooperative, consisting of 10 women tailors, manufactured reusable sanitary pad kits and school uniforms that were distributed to class 6-8 girls at 13 partner schools.
- The ratio of girls to boys sitting completing primary school was 44:56 in 2015, up from 37:63 in 2009 (before the girls’ education program was launched).
- Through the Development in Gardening (DIG) agricultural program, 34 mothers were trained on how to grow and maintain a kitchen garden for both nutrition and income generation. By the end of the year, 88% of these mothers had a fully functioning kitchen garden and the average income from the gardens increased by over 400%. Another 209 community members graduated from the DIG training programs in improved farming techniques and farming as a business.
- The in-school and out-of-school girls mentoring program was well received by participants and the community. 166 in-school girls (ages 10-16) at six primary schools successfully completed participation in weekly mentoring sessions while 112 out-of-school girls participated in weekly mentoring over a 5-month period. The in-school mentoring program will be scaled from 6 to all 13 primary schools in 2016.
- Planning for a new e-Reader project with class 6 students was completed in 2015. Three pilot primary schools were identified in a competitive process involving head teachers from all 13 public primary schools, a program assistant staff was recruited, monitoring and evaluation materials were created, and a shipment of 150 e-readers was received. The program will launch in January 2016.
- Patient information has been entered into KenyaEMR (the country-wide electronic medical records system) in real-time for all of 2015. In December, a full set of equipment and hardware components needed to run KenyaEMR at each point of care was installed at the Lwala Community Hospital upon the completion of hospital construction and will be put into use in early 2016.
- Julius Mbeya, a Kenyan national, began his tenure in July as LCA’s Managing Director in order to shift more executive decision-making to Kenya. He has demonstrated strong leadership and is focusing on implementing LCA’s new 2020 Strategy and making decisions regarding the future of programming, personnel, and finances in Kenya.
- Ash Rogers, LCA’s new Executive Director, began her tenure in December. Ash joins LCA after working nearly four years at the Segal Family Foundation, where she served as the Director of Operations.

## HOSPITAL EXPANSION UPDATE

The Lwala Community Hospital construction project is complete! The project consisted of three major components: 1) construction of a new connecting wing to provide additional outpatient and staff office space at the Lwala Community Hospital, 2) expansion of the current hospital building to create additional inpatient ward space, and 3) development of new housing units so that clinical staff are located nearby the hospital for better round-the-clock staff coverage at the hospital and response to emergencies. Despite some delay in the completion of the project, the project has been remarkably successful, the quality of the final work is high, and the new hospital space is already enhancing the quality of healthcare delivered to patients. The new connecting wing houses the child welfare clinic, maternal services, the pharmacy, the health records room, and an expanded laboratory.

All of these spaces have been in service since August 2015. These rooms provide sufficient space for their intended purpose and because of the new layout of the rooms and increased waiting room space, the overall flow of patients has improved drastically. The renovation of the existing hospital now provides separate inpatient wards for males and females, a pediatric inpatient ward, delivery and post-natal rooms, an office for the Head Clinician, and a Nursing Station. The new staff housing units include two bedrooms, a spacious living area, a modern kitchen, a bathroom, and a small balcony. The staff housing portion of the project was nearly completed, with only the final touches remaining. Prior to the project, all maternal and child health services (including well child visits) were provided from a single room located right next to the inpatient and sick patient areas of the hospital. With the new connecting wing, maternal and child health services are separated entirely from the inpatient and sick patient areas. Additionally, the adult inpatient wards have been expanded to accommodate more patients at any given time and to ensure that pediatric, neonatal, and adult patients are not mixed.

The expanded laboratory space ensures no contamination of specimens as well as enough room to house a large amount of new equipment to accurately diagnose malaria, TB, sickle cell anemia, and more. The centralized location of the new lab will improve patient flow and increase nurse/clinician consultation with lab technicians in diagnosing patients.

Five new service provision rooms have been added to the hospital to greatly assist with the increase in patient numbers that the hospital has seen in the last few years. Additionally, the layout of the entire hospital has shifted to ease patient flow. For example, the laboratory and pharmacy have been moved closer to the outpatient rooms to make it easier for patients to navigate the various services they may receive at the facility.

With the completion of the construction project, LCA will focus on improving the quality of health service provision within the new space. Focus areas such as staff training, development and retention, and development of electronic data systems will receive even greater attention. The LCA operations team will be responsible for maintenance of the new construction and renovation and of all equipment and furniture. With these new objectives, LCA aims for community members to more frequently and consistently seek preventative care. In the future, there may be opportunities to build additional staff housing in accordance with the latest design, though we believe that the new staff housing is sufficient at present.

We are able to better serve the community as a result of the expanded space. With a better equipped and resourced hospital in place to provide high quality, comprehensive healthcare and community-based programs that encourage positive health-seeking behavior, we anticipate that the health and well-being of the people of North Kamagambo will improve significantly over time.



## BENEFICIARY PROFILE: DEBORAH ACHIENG

No pregnant mother wishes to pass HIV to her unborn child. Deborah Achieng, a farm worker and mother of four children who had little understanding of the virus, was no different. That is why, after a Community Health Worker (CHW) from LCA visited her at home and provided health education, Deborah visited a health clinic where she could be tested for HIV. As a result of this visit, Deborah learned that she was HIV positive.

Deborah had suspected that something was wrong with her health because she had been losing a significant amount of weight. Because she was also two months pregnant and had not started her antenatal care (ANC), the CHW kept visiting Deborah to encourage her to start antenatal care. After a one-month follow up, Deborah finally decided to visit the Lwala Community Hospital.

During her ANC visits, Deborah received counseling on infant feeding, safe sex practices, and family planning. She also joined a support group of HIV positive mothers at the health center.

When Deborah went into labor, she contacted the CHW who then called for an ambulance from LCA. Deborah was picked up and rushed to the facility where she immediately received the single-dose anti-retroviral prophylaxis. Four hours later, baby Shamimah was born, and she received a pediatric dose of nevirapine. Because of Deborah's attention to ensuring her child received the necessary care and treatment, Deborah's baby is now HIV free.

Shamimah Adhiambo finally graduated from the Prevention of Mother-to-Child Transmission program at 18 months and has been confirmed as HIV free. Today, Deborah is a happy mother who hopes that one day Shamimah will be a nurse. The CHWs will monitor Shamimah until age 5 for childhood illnesses and will also offer advice to the mother.

Deborah says she does not pay attention to any form of stigma. When she comes for her ARVs at the clinic, she does not mind the stares she gets from those around. She says all she knows is that she is there to take care of herself and her family. Accessing treatment is something that will make her life better. She looks forward to having one more child. But "not immediately," she adds, with a smile.



Caption here.

## LODWAR HEALTHCARE CLINIC AND MOBILE CLINIC OUTREACH

### Background

The September 7th, 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 7th 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 are now available to a population of over 106,000 people in some of the most remote regions of Turkana, including the Villages of Nabuin, Chokchok, Nadapal, Nayanae, Elelea, Kaitese, Nayuu, Nakabaran, Kanamkemer, Nawoitorong, Lomopus, Nakoriongora, Kangikukus, Napetet, Nakwamekwij; 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.

**Target population of more than 106,000 reached**

**14,794 patients treated at Health Clinic and Mobile Outreach Clinics in remote areas**

**18,845 Cases managed**

## 2015 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. During the first three quarters of 2015, 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 106,000 people. The mobile clinics saw an average of 725 patients per month, and at our permanent clinic over 620 patients per month were treated.

- 14,794 were treated and 18,845 cases managed during 2015. These numbers continue to be high because of many factors, including focus on service delivery to very 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.
- 98 outreach clinics conducted by the mobile clinic team.
- 37 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.
- 1,085 patients tested positive for malaria, and 391 for typhoid fever, using RMF's lab set up.
- We made 43 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.

# KENYA

## Public Health Education

Prevention has become the best way to overcome most of the common diseases. Most of the diseases can be prevented from occurring in the community if the necessary education is passed to the community to better their knowledge about them. The knowledge emphasizes on signs and symptoms and intervention that the community can do that includes emergency calls for referral. In our sessions on health education, a reduction in many common diseases and illnesses has been observed and we are working to intensify health education since the community is putting it in action.

This month of August, we intensified health education before medication by spending more time with each patient. All villages which had medical outreach that month received education on topics that included diarrheal diseases, nutrition, malaria, poliomyelitis, importance of immunization and hygiene. The communities in the rural villages where we had mobile clinics were grateful for the good education and wished if more time could be allocated in the future. Moreover, they requested a repeat of the topics taught in future medical outreaches.

## 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. 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 addition, we emphasize and educate on diseases that occur due to lack of immunization. The message keeps being received very positively. In 2015, 1,674 children and mothers have been immunized.

## 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. 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 benefit tremendously 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. 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.

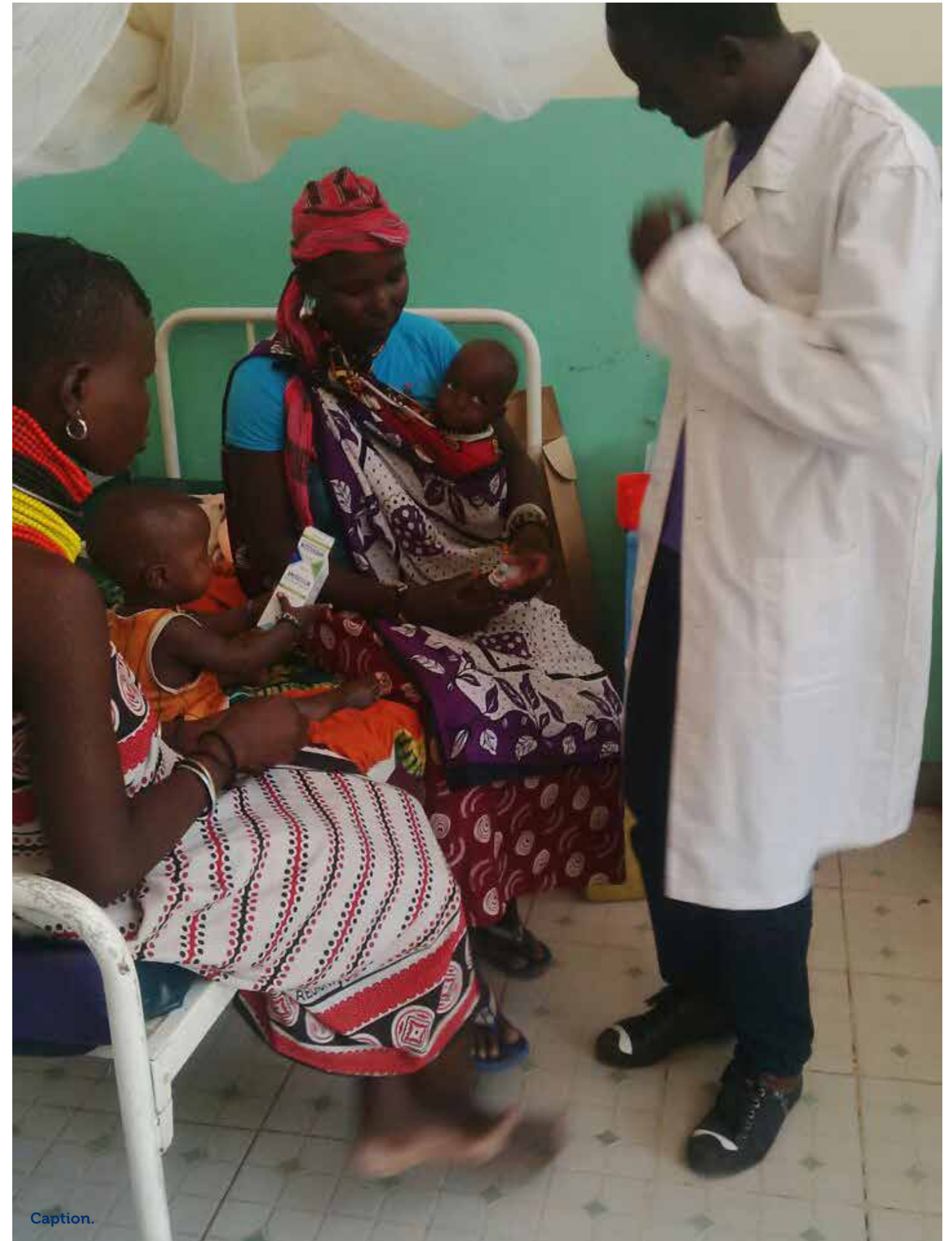




Caption.



Lomanat Ekiru on admission (L) and on discharge (R).



Caption.



## BENEFICIARY PROFILE: DAVID EKAI

In June, we took David Ekai, 8 years old, for surgery at Lodwar County Referral Hospital where he had a urinary stone removed from his urinary bladder. David had suffered from this condition for the last three years. We paid for his medical investigation at Moi Teaching and Referral Hospital in the town of Eldoret where a scan was performed and the result revealed no urinary stones at that time. Also, urinalysis was done and showed signs of infection which was treated at that time.

However, in June, the grandmother brought David to our Lodwar Clinic because the same pain with passing bloody urine had started again. This time, the team was able to take him to Lodwar Hospital to see the visiting pediatric surgeon. The patient was scanned and found to have a urinary stone which was subsequently successfully removed.

David Ekai and his grandmother are full of joy and grateful for the good that the program has done to them. The grandmother thanks all those who made David's successful surgery possible. She herself would not have been able to afford David's surgery.



Caption.



Caption.



Caption.

## NURSE MANAGER REPORT: DEREK LOWOTO

Early this October the program faced a medicine shortage. Even from the government, who supplements our medication supply, there was no medicine supply, which put the program in acute shortage. We were worried about how to reach the rural villages without medicines. Many calls from the rural villages were streaming in requesting medicine for children that were sick.

After being in a state of dilemma, God opened the way where RMF was able to wire money twice which we utilized for purchasing medicines. The arrival of the first consignment was a great joy though not enough but it served the purpose. We were then able to reach right away to reach villages in our catchment area.

In December we managed to save the life of a grandmother who had a spider bite. Early that morning when she was waking up, a spider bit her on the right lower limb. After consulting with the area pastor about the medical clinic, she was informed by her relatives that the medical clinic was to be in their village that morning. Also, the pastor informed the medical team by cell phone that a member in his village had been bitten by a spider and urgent help was needed. Due to this the team packed very fast and headed to the village. There the team found the grandmother, oozing excessive secretions from her eyes and nose. She was given the necessary medications with two hours of observation and recovered quickly.

Mercy, 8 years old, sustained burns to half of her right upper limb while cooking with her grandmother over a fire at night. By accident, she had hot soup poured on her by her grandmother in the kitchen. Mercy lives with her grandmother in Nabuin Village about ten miles from Lodwar Town and had to walk up to our Lodwar Clinic to seek treatment. In the clinic, Mercy received treatment with dressing on alternate days. The treatment took one week and she healed well. Her grandmother was grateful for the free services that Mercy received since she had no money for medical treatments.



The grandmother receiving injectable medicine for the spider bite.



Community meeting before medical clinic in Lomopus Village.



Mercy with her grandmother at the Lodwar Clinic.



Derrick Lowoto, Nurse Manager, cleans the burnt parts with normal saline.

# Mozambique

INITIATIVES: Mobile Clinic Project

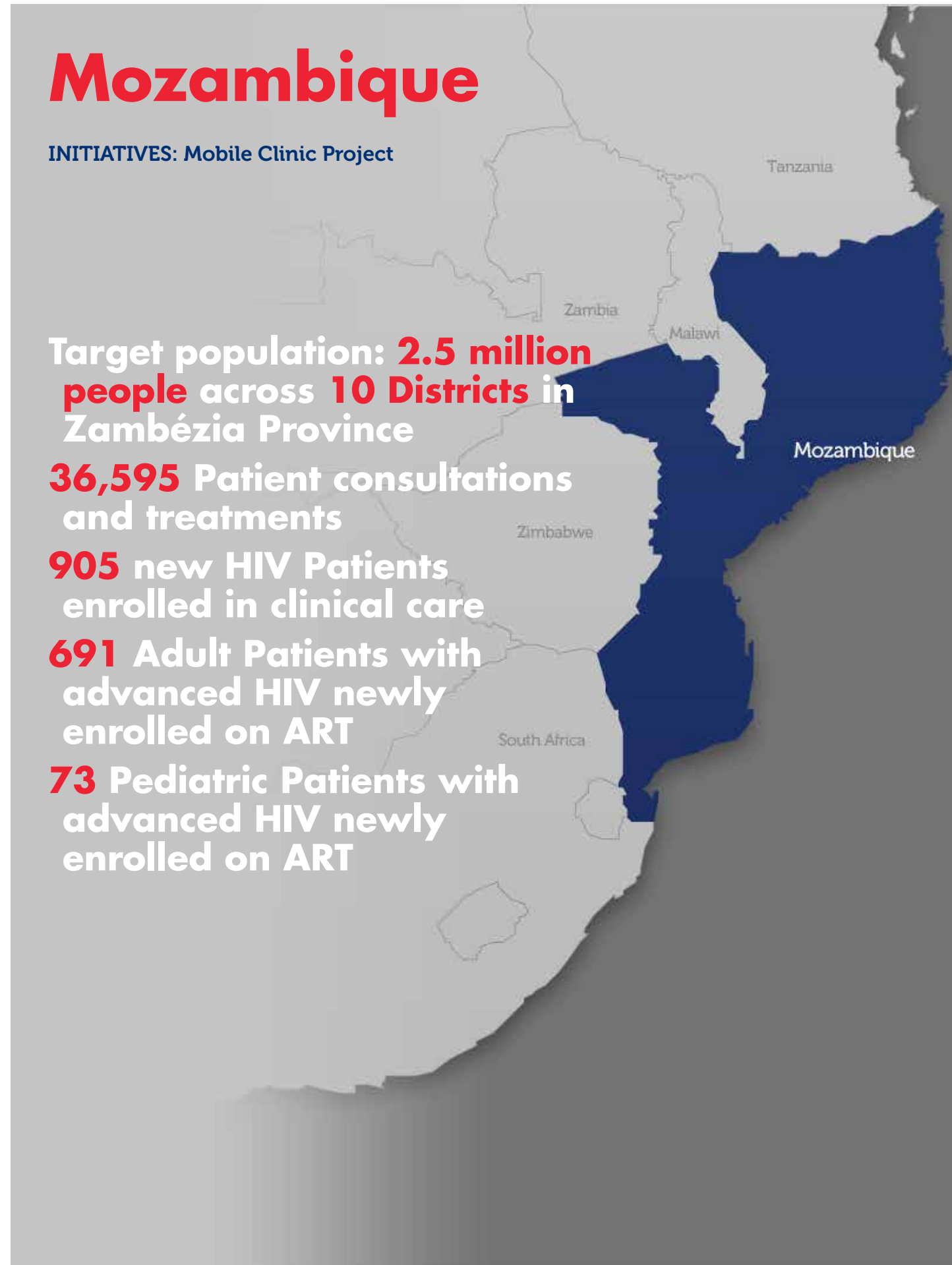
Target population: **2.5 million people** across **10 Districts** in **Zambézia Province**

**36,595** Patient consultations and treatments

**905** new HIV Patients enrolled in clinical care

**691** Adult Patients with advanced HIV newly enrolled on ART

**73** Pediatric Patients with advanced HIV newly enrolled on ART



## BACKGROUND

RMF's Mobile Clinic in Mozambique was initiated as a model of health care provision, intended to reach remote and rural communities with extremely limited prior access to health care. Since its inception in 2008, our hugely successful Mobile Clinic has been delivering high impact health care in some of the most difficult to reach regions of Mozambique. A collaboration between RMF, Vanderbilt University's Friends in Global Health (FGH) and Medical Mission International, the Mobile Clinic 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.

The Mobile Clinic addresses the most common health problems observed within the targeted region including HIV/AIDS, tuberculosis, malaria, malnutrition, and diarrhea. The main services provided include: HIV services, including counseling and testing, positive prevention packages for HIV+ patients, distribution of male and female condoms, PMTCT for HIV+ pregnant women, public education regarding the importance of adherence to ARV treatment, point-of-care lab control, CTZ prophylaxis and initiation of ART; TB services, including TB screening, treatment and follow-up, transport of sputum samples for TB

smears collected by DOTS-C volunteers and Mobile Clinic staff; rapid testing for malaria, HIV and syphilis, collection of blood and other biological samples for lab tests and transport to laboratory; antenatal clinics, family planning, nutritional monitoring and supplementation for children and adults; general clinic consultations to adults and children, first aid for medical emergencies; support of DPS-Z in health-related celebrations and events.

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 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 of four extremely isolated sites in 2015. The direct target population for the Mobile Clinic in 2015 included the communities of Furquia and Mbawa in Namacurra District with an estimated population of 50,181 inhabitants. Health staff supported the implementation of services in those MOH health facilities.

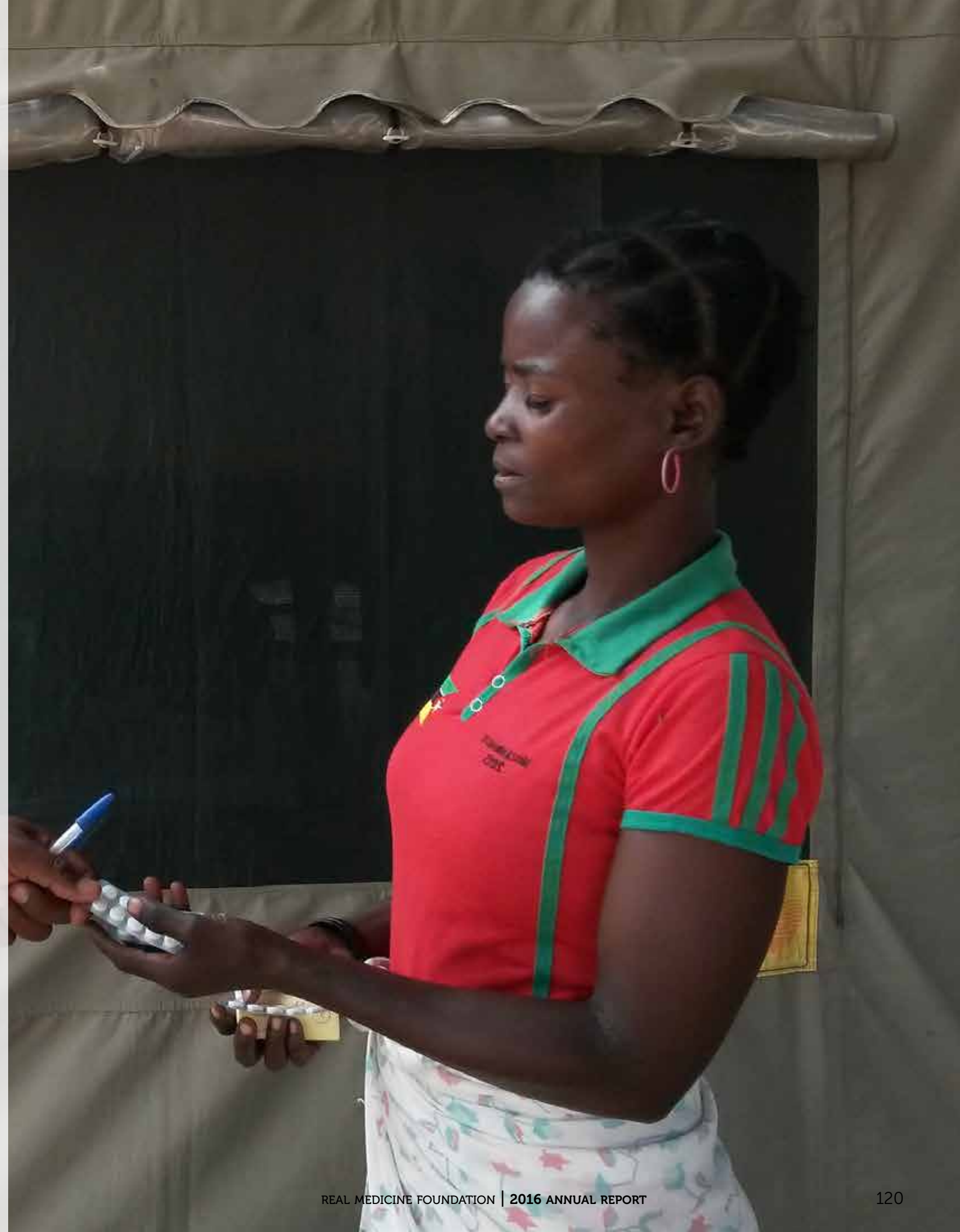
# MOZAMBIQUE

## 2015 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 tested for malaria, TB, STIs, and HIV. Malaria prevention, diagnostics and treatment were prioritized during the rainy season. HIV testing is now 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 assists with medication (ARVs, cotrimoxazole, isoniazid, ferrous salt, mebendazole) and blood sample transport.

During the severe flooding occurring in the rainy season, the Mobile Clinic provided technical assistance and support to the DDS/DPS to assist the affected population in Namacurra District. Reinforcement of community clinical linkages was maintained through continuous coordination with the existing Health Councils (Conselhos de Saúde) in the targeted communities. Several monthly meetings were 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 officially integrated the 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.



# MOZAMBIQUE

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

- HIV services, including monitoring and quality control at the point of care delivery, prophylaxis with cotrimoxazole (CTZ) and initiation of ART
- Health counseling and testing (HCT), including distribution of male and female condoms
- HIV counseling and testing for pregnant women and prevention of mother-to-child transmission (PMTCT) 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 smear samples, collected by C-DOTS volunteers and Mobile Clinic staff
- Rapid testing for malaria, HIV and syphilis
- Evaluation and nutritional supplementation for children and adults
- Basic First Aid for medical emergencies
- General clinical consultations for adults and children
- Referral of patients to health facilities according to clinical needs
- 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
- Reinforce patient adherence and retention
- 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
- Transport of extra stocks of medicine and medical supplies in preparation for potential flooding (and subsequent health facility isolation) during the rainy season
- Update and organization of individual patient forms for receiving ARVs (FILAS)
- Update of patients lost-to-follow-up in the database and lists for active case finding
- Reinforce CD4 requests and follow up
- Reinforce pediatric ART enrollment
- Reinforce therapeutic failure identification among patients
- Emergency plan elaboration in order to provide support and guarantee the continuity of HIV C&T to possible displaced persons in case of flooding during the rainy season, including 3 month's supply of ARVs, other medicines and medical supplies for all health facilities at risk of isolation, such as Furquia and Mbawa.
- Refresher sessions on clinical protocols and MOH HIV/AIDS clinical orientations
- Distribution of job aids and algorithms



Caption.



Caption

## Health care services and ART (PEPFAR supported):

- 905 new HIV patients were enrolled in clinical care in 2015.
- 810 individuals with advanced HIV infection were newly enrolled on ART; 691 adults (>15 years), 73 children (0-14 years old).
- 1,250 (92%) of 1,360 eligible HIV+ patients receiving care, received CTZ prophylaxis.
- 808 new HIV patients enrolled in clinical care patients were screened for STIs at the last visit during the reporting period.

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

- In the reporting period, 2,842 pregnant women were registered for ANC services in the two health units: 1,482 in Furquia and 1,360 in Mbawa; 2,770 pregnant women received HIV counseling and testing with 303 (11%) positive results. Following Option B+, 255 (84%) HIV+ pregnant women received ART during this period. Efforts to strengthen ART adherence counseling and follow-up of female patients' children in the Child-At-Risk Clinic (CCR) are ongoing.
- Partner testing continues being reinforced through "palestras" (lectures) in the health facilities and communities encouraging men to accompany their pregnant partners. During the reporting period, 1,175 partners of pregnant

women were tested. 87 were diagnosed HIV+ and referred for ART care and treatment.

- Health facilities supported by the Mobile Clinic work with 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 meetings, HIV+ women join the larger group to participate in demonstrations of nutritional food preparation for children.
- Provision of health care services and early HIV diagnosis in infants born to HIV+ women
- 238 children were enrolled in the Child-At-Risk Clinic (CCR) during reporting period.
- 246 pediatric patients received virological testing, with 56 positive results reported.
- Rapid testing was offered to 116 children, with 5 positive results reported.

## Voluntary Counseling and Testing – Children (PEPFAR supported):

- 317 children were counseled and tested for HIV, with 73 positive results, of which 61 initiated ART.

## Diagnostic services for TB care and treatment (PEPFAR supported):

- 73 patients were enrolled into TB care and treatment. 67 received counseling and testing for HIV, with 42 positive results, of which 40 initiated ART.

# MOZAMBIQUE

## EMERGENCY INTERVENTIONS:

During the first quarter of 2015, Zambézia Province was impacted severely by massive flooding and heavy rains, which caused disruptions in technical assistance and service delivery in FGH-supported districts. Based on official information received from the Emergency Operations Center (COE) on March 4th, approximately 96,000 people were temporarily displaced province-wide, with approximately 7,013 residing in Namacurra District. The Mobile Clinic team, in collaboration with the FGH multidisciplinary team based in Namacurra District, provided technical assistance and support to the DDS/DPS to address the following essential service/support areas:

- Supply chain support (transport of essential medications and relief items)
- Patient evacuations
- Direct clinical assistance for displaced persons residing temporarily in displaced person camps in Furquia (Ronda camp) and in Birigodo (Mbawa area)
- Information, education, and communication (IEC) activities including HIV prevention, GBV, diarrhea, malaria, etc., in the displaced person camps at Furquia and Mbawa
- The Mobile Clinic team provided technical assistance to prevent the disruption of clinical HIV services (care and treatment) among displaced persons.



Caption.

# Nigeria

INITIATIVES: Primary Health Care | Medical Outreach



Access to health care for over **154,000** in one of the most remote areas of Nigeria  
More than **20,800** patients treated  
Lab and Dental services

## BACKGROUND

Nigeria, the most populous African country, and the eighth most populous country in the world, unfortunately also records high numbers of maternal mortality and child mortality. As Nigeria's political environment has become more stable, these factors have improved, but in 2015, Nigeria's maternal mortality rate was estimated at 814 per 100,000 and its under-5 child mortality rate was estimated at 109 per 1,000. Both of these rates are still among the world's highest. The number of people in Nigeria living with HIV/AIDS is also very high, estimated in 2014 at 3,391,600, the second highest in the world.

Since 2006, Real Medicine Foundation, supported by World Children's Fund (WCF) and in partnership with the Kwara State Ministry of Health, the Nigerian Youth Service Corps (NYSC), and the Gure Gwassoro Ward Development Committee, has been working to improve health, including HIV/AIDS and especially maternal and child health, in one of Nigeria's most remote areas: the community of Gure in Kwara State. Gure is located near Nigeria's border with the Republic of Benin, and before RMF's arrival in 2006, its only health center, Gure

Model Health Center, had been abandoned. RMF helped reopen, improve, and support the Gure Model Health Center, providing the only source of accessible health care for a population of over 154,000 in the Baruteen Local Government Area and its surrounding towns. The health center also receives patients who travel to Gure from the Republic of Benin to seek medical treatment.

To staff the Gure Model Health Center, RMF reached out to one of our partners, the Nigerian Youth Service Corps (NYSC), which was created to help reconstruct, reconcile, and rebuild the country after the Nigerian Civil War. As part of its strategy to improve the country's health and infrastructure, the NYSC deploys graduating professionals, including physicians, to Nigeria's remote regions for their final year of service to their country. Having staffed the Gure Model Health Center, improved its infrastructure, and fully stocked the center with medical supplies and medication, RMF opened the Gure Model Health Center and began providing consistent, high quality health care to this previously underserved community.



## 2015 UPDATE

RMF's provision of medicine and supplies to the Gure Model Health Center has continued to enable high quality medical services, with patient numbers rising again in 2015. 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 immediate, comprehensive health care delivery versus the previously necessary referral to the state hospital in Ilorin. RMF 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 more than 3,400 patients per month, with a total of 20,818 patients treated during the clinic's 2015 year of operation (January - June).

Services provided include:

- Primary health care, family health care
- Maternal and child health care, including perinatal and delivery services
- 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



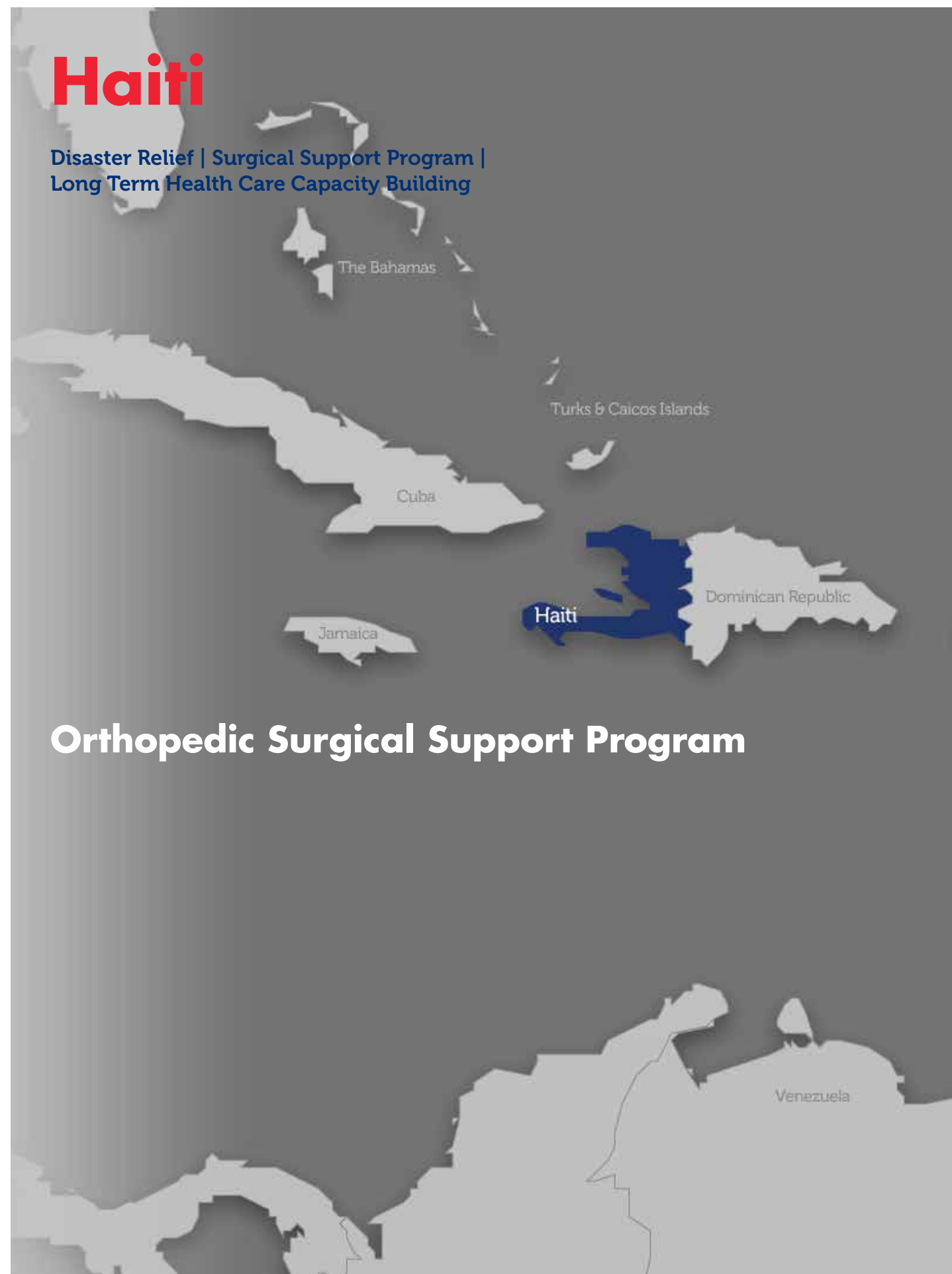
Caption.

## BACKGROUND

In the aftermath of the January 12, 2010 earthquake, in addition to tackling some of the community's immediate relief needs, RMF moved forward with a comprehensive, sustainable long-term strategy to help rebuild Haiti's shattered public health system. Our work during the initial weeks was focused on the provision of medical staff, medicines, 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 Surgical Clinic 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 health care 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.

Six years have passed since most of Haiti's infrastructure was devastated by the 2010 earthquake. Much progress has been made in rebuilding efforts, but there is still much work to be done. The country's social and healthcare statuses remain dire and are worsening because of the dwindling presence of NGO-run primary healthcare clinics in the areas most affected by the earthquake, especially in Port-au-Prince. While a very positive initiative, having given more people access to basic care, sadly most relief efforts in Haiti remained disorganized and unstructured and did not define a clear and continuous pathway for patients in search of diagnoses 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 private Haitian healthcare institutions which share our philosophy, and by researching funding for larger partnerships.



## ORTHOPEDIC SURGICAL SUPPORT PROGRAM

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

Most of our patients continue to originate from the St. Vincent's School for Children in Port-au-Prince, which 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, an ambulatory clinic, and surgeries. However, the school was destroyed in the 2010 earthquake. RMF's surgical program started its first instalment with both adults and children, and then refocused its aim toward specialized care only for children and young adults. The patients selected for surgical treatment come from the metropolitan area of Haiti's capital, Port-au-Prince, but now some patients also come from very remote provincial towns located in the southern and northern departments of the country.

### 2015 Update

Our dedicated surgical team of two orthopedic surgeons and one anesthesiologist performs these specialized orthopedic procedures at the Lambert Santé Surgical Clinic in Pétiön-Ville, making it possible for these young patients to regain their ability to walk, to do

so proudly, and, most of all, to become free from society's discrimination toward their visible and incapacitating conditions.

### Third Edition of the Program, 1st Part (through late 2014)

The first part of the third edition of RMF's orthopedic surgical program was completed in December 2014, benefiting children, teenagers, and young adults who were incapable of enjoying a normal childhood or starting a meaningful young professional life. We were able to add 10 new children to our growing population of very satisfied patients, between October and December 2014, bringing our total patient tally to 50 patients who have received this specialized care and seen their lives completely changed by it. 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 wellbeing. Our main desired outcome is to optimize each patient's chance to thrive as an active member of his or her community.

We treated 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, age 10, Nancy Samedi, age 6, and Edouard Julien, age 14; Edouard had returned for a second surgery to complete his treatment, which was 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, age 3, Anne-Christelle Guillaume, age 10, Junior Janvier, age 13, Cadeus Boileau, age 13, and Rosembert Stevenson, age 14.

This part of our surgical program also included follow-up surgeries for two children, who our team had operated on during previous program installments. Their overall course of treatment best symbolizes our philosophy of health care, incorporating quality and continuity of care.

Manoach Loudort is a 6-and-a-half-year-old boy for whom we had done a corrective tibia osteotomy in 2013 for his post-traumatic left tibia injury. Upon noting recurrent bowing after the first procedure, clearly diagnosed at 6 months plus postoperatively at age 4, we decided to perform a temporary growth arrest on the medial side of his femoral growth cartilage during the second half of that same program installment to try and progressively correct the recurrent deviation. We finally had to perform another, more aggressive correction osteotomy this year, 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 been finally stopped, and now Manoach's left leg will soon be allowed full weight-bearing, as we will continue to follow his progress.

Pédaline Louis, currently 13 years old, was first treated by RMF in 2013 for a severe bilateral bowed leg deformity from rickets. She was able to see her life drastically changed by the first surgery on her right leg that year and is now able to benefit from the same surgery to realign her left lower limb to finally match her new appearance and functionality.

### Third Edition of the Program, 2nd Part (through late 2015)

Despite several setbacks and obstacles to this third edition's completion, with an interruption after the first 10 children received surgeries at the end of 2014, RMF's constant efforts to honor its engagement to the remaining patients finally

paid off. In December of 2015, the last selected pediatric patients of this installment were able to be screened again and treated before Christmas, making Christmas more joyful for many of these families, as their loved ones got to see the children's impairing conditions addressed and corrected. These 10 new patients had various conditions, ranging from residual developmental lower limb deviations from the normal axis, to Blount's disease and severe dysplastic lower limb deformities. Treating these children was another occasion for us to be able to stay true to one of our key principles at RMF: providing continuity of care. We were able to continue treatment for children with illnesses in both lower limbs or with severe conditions requiring multiple surgeries.

Such was the case for Richardson Edouard, age 16, and Stevancia Dejuste, age 10; both have been part of this orthopedic surgical program since its beginning in 2012. Richardson suffered from Blount's disease, a developmental growth pathology very common in the Haitian population, and incurring moderate to severe bowing at the knee level to the point of limited walking capacity. Richardson underwent his first corrective procedure in 2012 as one of the first patients of RMF's pilot surgical program, which addressed one lower limb and required monitoring to evaluate and follow the progressive correction of his condition. The second limb surgery was finally done this past year, concluding his treatment.

Stevancia is also a perfect example of this principle, as in 2012, a severe bone growth afflicting her thigh and shin bones resulting in major leg discrepancy was able to be diagnosed as benign through a bone biopsy and pathological exams. This first procedure set in motion a plan to correct her severe condition and restore a more satisfactory level of ambulation and function to her lower limbs. She

# HAITI

## UPDATE

has been part of all three installments of the surgical program, and after another surgery in 2013-2014 to correct the severe lateral deviation of her knee and shin bone, a lengthening procedure was last done in 2015 to try and decrease the remaining leg discrepancy. The remaining 8 patients suffered from a variety of orthopedic conditions of congenital, developmental, and post-traumatic origins afflicting their knees and/or their overall lower limbs.

One of our young patients, Medgine Olivier, exemplifies such a case, with bilateral dysplasia of her skeleton resulting in a severe bowing deformity of both her lower limbs. A combination of nutritional and growth disturbance factors is probably to blame for her condition. Medgine, who has been in the care of a local NGO-supported orphanage and child support services for very low or no income families in the rural Port-au-Prince area, was brought to our attention after word of mouth information spread from the satisfied families from previous surgical program installments. Medgine underwent her first corrective surgery in December 2015, with very good postoperative results, and is now very anxious to have her other leg straightened out like the first one.

It is our utmost belief that this surgical program is significantly impacting young lives in Haiti, helping children and young adults improve their final outcomes in society by treating the severe and disabling conditions which make them both outcasts and depressed in their youthful years, a period in their lives where they should be fully embracing new experiences and discoveries. What we are able to provide through this program is, in one word, hope-- for these children and young adults to joyfully participate in all activities reserved for their age group and to be able to pursue their

dreams and goals, but also hope for parents as their children become more functional and productive members of their community. We believe that this program can be made into an even more efficient one; with the appropriate resources and base of operations, preferably in a more socially conscious healthcare facility, we can offer hope and much needed treatment to many more disenfranchised children in Haiti with absolutely no such other organized and empathic recourse for treatment of their ailments.

### **Public Private Partnership: Centre Hospitalier du Sacré-Cœur, Hôpital CDTI**

RMF's overall vision for our work in Haiti remains firmly in place: to promote and provide sustainable health care. This vision 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 serving 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.



Caption.

## POLICLÍNICO PERUANO AMERICANO SAN CLEMENTE, PISCO

On August 15, 2007, a 7.9 magnitude earthquake struck just off the coast of central Perú, killing more than 500 people, injuring more than 1,000, and leaving at least 37,000 families homeless. The areas most affected were Pisco, Ica, Chincha, Cañete, and Huancavelica. RMF arrived in October 2007, and we began our relief efforts by supporting the Children's Hospital in Lima (which experienced a substantial influx of patients from earthquake-affected areas), helping other NGOs distribute aid and food, and running a temporary health clinic to offer primary healthcare services. Next, RMF Perú found a suitable permanent location for our health clinic, opening the "Policlínico Peruano Americano" in San Clemente, the poorest district in Pisco, in December 2007. The clinic's target population is San Clemente (population 30,000), but because of its reputation of delivering high quality medical services, our Policlínico Peruano Americano also receives many patients from other areas in the province of Pisco (population 125,000).

RMF's Policlínico Peruano Americano was originally located in an earthquake safe residential building with several examination rooms, a large waiting area, a 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: family planning, arthritic pain, hypercholesterolemia, lower back pain, and acute diarrheal disease. In February 2011, by invitation of the mayor and the City of San Clemente, RMF's Policlínico Peruano Americano moved to a new building with the sponsorship of local authorities. From our new location, 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 economical for RMF Perú to rent and manage, and brought us in closer partnership with local health and political representatives.

RMF's Policlínico Peruano Americano continues to relieve strain on the existing health infrastructure, which was unable to meet the population's needs even before the earthquake. Policlínico Peruano Americano provides general medical services, Pap smear exams, laboratory services, EKG exams, and dental services. In addition, the philosophies adopted at our clinic strongly emphasize education and prevention – we are not only treating our patients for their illnesses; we are also educating patients as to why they are sick and how they can prevent sickness in the future. We also conduct dental outreach campaigns at least once a month, to reach grossly underserved patients.

# Perú

INITIATIVES: Primary Health Care, Medical and Dental Outreach

Serving **30,000** in San  
Clemente; **125,000** in the  
Province of Pisco  
**9,291** patients treated  
Ultrasound, Dental, and  
advanced Lab services

## 2015 UPDATE

- An average of 35 patients (age newborn to 60+) were treated per day at our clinic and during our team's medical and dental outreach efforts, with an average of 775 patients treated per month.
- Echography and ultrasound exams continue to be performed, and we are now providing EKG exams as well.
- Since dental patients are still rare at our clinic, our dentist and team have been visiting local schools to offer their services through dental outreach campaigns. The dental care team held 9 fluoridation campaigns at different elementary schools in San Clemente, treating a total of 2,392 children. In addition, oral hygiene talks were given at schools in San Clemente and at our clinic.
- Moving towards the clinic's self-sustainability, we are now charging patients for their medication; it is provided at cost. Patients too poor to pay will not be charged.
- Santo Domingo church authorized RMF Perú to provide laboratory blood testing to measure the hemoglobin levels in children ages 5-7 years old. Participating children had free breakfast at the church, and were then checked by our team. We served 242 children in the course of several days in September 2015.
- For the sixth consecutive year, RMF Perú and the Peruvian American Medical Society (PAMS) carried out our Medical Mission on

August 18th, 19th, and 20th for the people of San Clemente and surrounding areas. A total of 260 patients were treated, many with histories of diabetes and hypertension. 63 patients received dental services, including dental treatments, extractions, and fluoridation. 28 patients received psychological care, and 9 patients were referred to medical specialists in Chincha for treatment of more complex medical conditions. Following a brief orientation on how to improve mental health, we also organized psychotherapy sessions and art workshops for several patients. Additionally, the PAMS Medical Mission 2015 donated an EKG machine to our Policlínico Peruano Americano; an EKG Marca Edam, model SE-3.

- In January 2015, municipal elections were held, and San Clemente elected a new mayor. At that time, the new administration committed to renew the long-standing agreement that RMF Perú had with the previous authorities. Unfortunately, at the end of 2015, they had still not signed the agreement. Although the new mayor's office has made some utility payments (water and electricity), these payments are not consistent, and this has caused some issues providing service to our patients, who are mostly low-income residents of San Clemente. If we continue having challenges with San Clemente Municipality, we will look for a new location where we can continue the health services provided at our clinic since 2007, with a total of 14,490 patients on record.



Caption.



Caption.



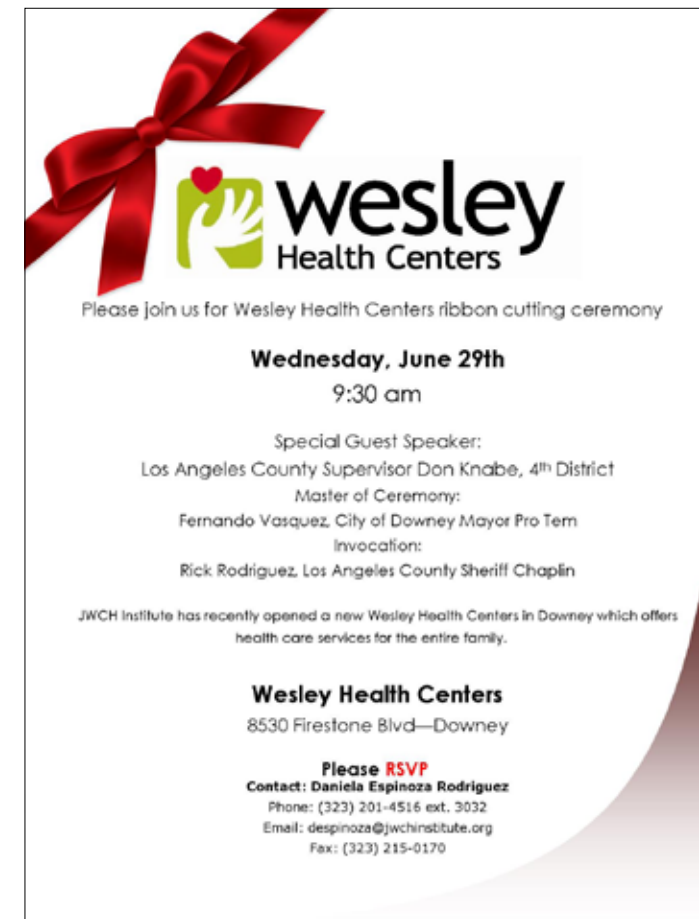
Caption.

# Los Angeles, California

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.**



## **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, which is set to open its doors in 2016 as Wesley Health Center Downey, run and operated by JWCH Institute, a network of FQHC clinics in Southern California. Real Medicine Foundation remains one of the first partners of the coalition to help attract funding support and to provide outreach programs.

The health center will serve 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. The health center will provide a full continuum of care for men, women and children, including primary health care, pediatrics, prenatal care, women's health care, family planning, diabetes care, behavioral health care, homeless health care, HIV services, STD testing and treatment, oral health care, pharmacy services, vision care, and supportive services which include chronic disease case management, youth services, housing assistance, health education, nutritional assistance, substance abuse counseling, and research. Most health coverage is accepted; patients are seen regardless of ability to pay.



# LOS ANGELES, CA

## 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 and 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.



Caption.



Caption.

# Our Partners



PAM & PIERRE OMIYAR | OMIYAR GLOBAL FUND OF THE HAWAII COMMUNITY FOUNDATION | MICHAEL K WILSON TRUST | THE MAYA FOUNDATION | STEIN FAMILY PHILANTHROPIC FUND | FROST FAMILY FOUNDATION

## IN US \$

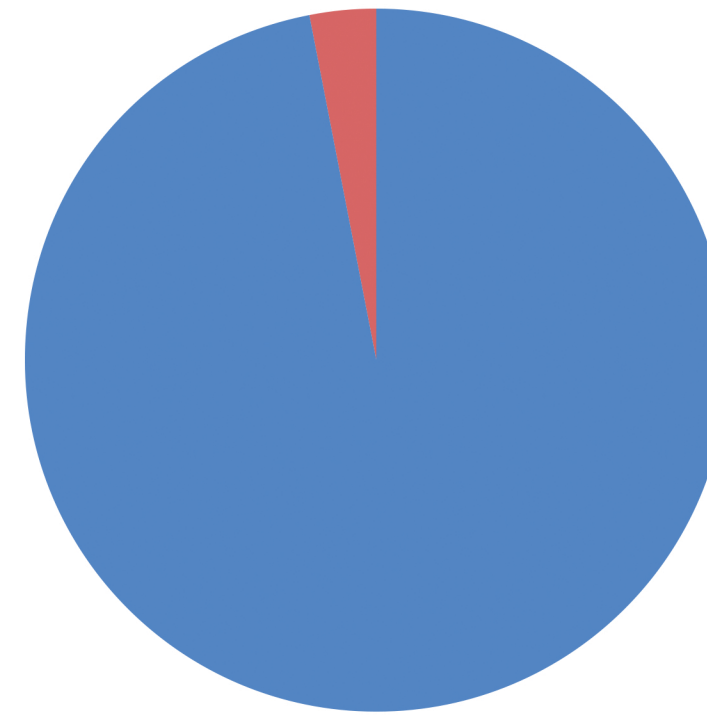
### FY 2014

### FY 2015

	FY 2014	FY 2015
<b>CONTRIBUTIONS &amp; GRANTS TO RMF USA*</b>	<b>\$3,910,162</b>	<b>\$7,298,335</b>
<b>EXPENSES*</b>		
Program Expenses	\$3,602,916	\$6,659,208
Administrative Expenses	\$192,362	\$145,820
Fundraising	\$20,529	\$37,274
In-Kind Expenses	\$0	\$0
<b>Total Expenses</b>	<b>\$3,815,807</b>	<b>\$6,842,302</b>
<b>Total Net Assets</b>	<b>\$786,415</b>	<b>\$1,233,001</b>
<b>International Contributions**</b>		
Contributions to RMF Germany (100% used for program expenses)		\$558,888
Contributions to RMF Pakistan (100% used for program expenses)		\$142,413
Contributions to RMF South Sudan (100% used for program expenses)		\$334,198
Contributions to RMF Uganda (100% used for program expenses)		\$274,802

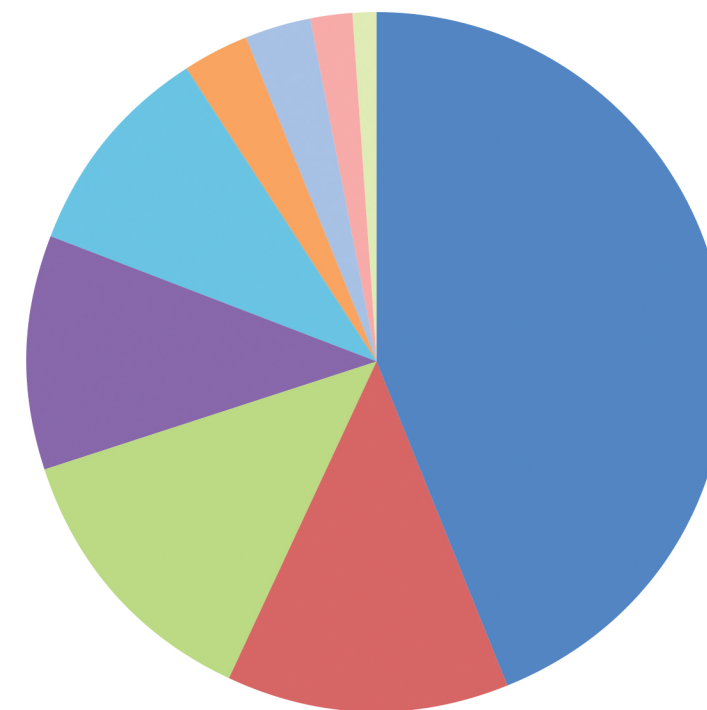
\*Fiscal 2015 IRS Form 990 US Contributions and Grants, and Expenses. Copies of 2015 Form 990 or earlier years may be found on RMF's website or requested from head office in Los Angeles.

\*\*The Fiscal 2015 international figures are set up in accordance with international accounting standards.



■ Program Expenses 97%

■ Admin Expenses 3%



■ Medical 44%

■ Medical and Vocational Training 13%

■ Nutrition/ Malnutrition Education 13%

■ Disaster Relief 11%

■ Education and School Support 10%

■ Economic Sustainability/Livelihood 3%

■ Psycho Trauma Support and Counseling 3%

■ Food/Water 2%

■ Housing 1%

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Bombo Road  
Kampala  
Uganda  
Phone: +256.783.180.655

## REAL MEDICINE SOUTH SUDAN

Juba Teaching Hospital  
Juba  
South Sudan  
Phone: +211.955.190.498

## REAL MEDICINE UK

10 Sovereign Park I Cleveland Way  
Hemel Hempstead  
Hertfordshire HP2 7D A  
United Kingdom  
Phone: +44.771.784.7323

## REAL MEDICINE SERBIA

Karadjordjeva 31/4  
Beograd  
Srbija  
Phone: +381.64.1249.722

## REAL MEDICINE HAITI

75, Rue Lambert  
Pétion-Ville  
Haïti  
Phone: +509.3933.9988

## REAL MEDICINE PAKISTAN

Hse 328, St 67  
Sector E-11/3, MPCHS  
Islamabad  
Pakistan  
Phone: + 92.334.513.2910

## REAL MEDICINE NEPAL

House No. 349, Ward No. 6  
Chhuechepati  
Kathmandu  
Nepal  
Phone: +977.1.449.2352

## REAL MEDICINE PERU

Calle Beatita de Humai N° 125  
San Clemente, Pisco, Ica  
Perú  
Phone: +51.956.621.833

## REAL MEDICINE PHILIPPINES

37 Dapdap Street  
Mambaling, Cebu City  
Cebu, Philippines 6000  
Phone: +63.921.316.1496

## REAL MEDICINE KENYA

c/o Lodwar District Hospital  
PO Box 18  
Lodwar  
Turkana  
Kenya  
Phone: +254.708.209.691

## REAL MEDICINE NIGERIA

c/o Gure Model Health Care Clinic  
Gure  
Baruteen, Local Government Area (LGA)  
Kwara State  
Nigeria  
Phone: +234.815.258.3417



Caption.

