REAL MEDICINE FOUNDATION

ANNUAL REPORT 2013

REALMEDICINEFOUNDATION.ORG

Liberating Human Potential

AFRICA • AMERICAS • ASIA • EUROPE

CONTENTS

HISTORY AND MISSION

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

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

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

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

Real Medicine Foundation's vision is to move beyond traditional humanitarian aid programs by creating long-term solutions to health care and poverty related issues. By empowering people and providing them with the necessary resources, we pave the way for communities to become strong and self-sufficient. In just eight years, Real Medicine Foundation has worked in 18 countries on 4 continents, with currently active projects in 13 countries, and has aligned with governments, international agencies, including the UN, to reach those most in need. In 2011, RMF was granted United Nations Special Consultative Status and PVO Status with USAID. Real Medicine Foundation is a US based non-profit public charity 501(c)(3), headquartered in Los Angeles, California, with branches in the UK and Germany, and with offices and partners all over the world.

Dr. Martina Fuchs, and RMF South Sudan team give emergency supplies to IDPs

YEAR IN REVIEW

Dr. Martina C. Fuchs, Founder and CEO

We Made History This Year.

We are proudly reporting that we made history this year: On August 29th, 2013, 30 South Sudanese Nurses and Midwives graduated from the Juba College of Nursing and Midwifery (JCONAM), co-founded by RMF in 2010 – the first ever Diploma Nurses and Midwives graduating in South Sudan! During the graduation ceremony the Minister of Health and his team officially acknowledged RMF to now be part of South Sudan's history, the newest country on this planet that became independent in July 2011 after decades of war and civil strife. And we couldn't be more delighted.

Dr. Martina Fuchs, JCONAM graduates and Ministry of Health representatives

This is just one of the groundbreaking projects Real Medicine Foundation has been establishing around the world, new ways of doing humanitarian work, creating innovative, highest quality models, turning victims into leaders and aid into empowerment. Also in South Sudan, we initiated and piloted a Respectful Maternity Care Training program at Juba Teaching Hospital, focusing on solutions and creating yet another model that inspires and teaches people, during the highly vulnerable process of childbirth and on a much larger scale, to treat patients and each other with respect and dignity, some of the core values of our organization. During the height of the violent conflict that erupted in mid-December in Juba, we were able to get a large shipment of medical supplies into the country to support Juba Teaching Hospital, the only national referral hospital for 9.86 million people; RMF's team members risking their lives to transport by truck from Kampala to Juba more than 13,000 tons of medicines, medical supplies and equipment, 856 boxes, when almost everyone else had left the country and the need of the patients and wounded was at its most desperate. And we started to upgrade and renovate this hospital, beginning with the Pediatric Wards and preparing to continue in early 2014 with the Accident & Emergency Department, continuing our global work in secondary and tertiary healthcare capacity building as we did already in several other countries, such as in Turkana, Kenya, at Lodwar District Hospital which became a teaching hospital just a few months after RMF had started our work and whose Pediatric Department is now considered the best in the region. An additional intention of our work at Juba Teaching Hospital is to support the country in healing from the inside, and to be a part of the reconciliation and peace process by ensuring access to quality healthcare for everyone; in the words of the Minister of Health, '*Service delivery will create peace.'*

In India, our massive Malnutrition Eradication Initiative in Madhya Pradesh, where we have been working in 5 districts, 600 villages for 3 years now and have impacted hundreds of thousands of children and their families, has been picked up as a model by the Government of Bihar to be implemented in their state by RMF, making history here as well.

In Eastern Uganda, we are creating a model for a self-sustainable school, now housing 400 students that started out in dire straits since it tried to help as many orphans of war and HIV/AIDS as possible. And in the Kiryandongo Refugee Settlement in Western Uganda a part of our work is focused on the economic component of RMF's vision, providing vocational training and business opportunities for refugees who have lost everything in their home countries, creating new models here as well.

I couldn't be more proud of our global teams and the work we have been able to do, and the tremendous impact we had this past year – in the countries we have been working in for several years and new countries such as the Philippines in the wake of catastrophic Typhoon Haiyan/ Yolanda. Our now more than 200 team members around the world working across four continents are the cornerstones of our organization, the living foundation our impact is built on. This is how we have been able to turn victims into leaders with our work, despair into hope and creativity and new beginnings and possibilities: in South Sudan, Kenya, Uganda, Mozambique, Nigeria; Haiti, Peru, the US and Armenia; India, the Philippines, Pakistan, and Sri Lanka. To our teams and all of our supporters, old and new, around the world – THANK YOU!

Let's continue to make history! There is little we cannot do if we do it together.

Sincerely,

INDIA

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

66 Local Staff across 600 villages

2,521 Village Nutritional Training Sessions held

49,465 Families counseled at special family sessions on malnutrition prevention and treatment in 2013

31,339 Children's condition improved directly since program began because of our intervention

2,588 Children received lifesaving treatment since launch of program

The RMF Malnutrition Eradication field team in Madhya Pradesh

Malnutrition Eradication & Treatment

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

CNE measures arm circumference on child in India

During 2013, RMF in India continued to work with communities and also worked towards positioning our program for scale. In addition to the local partnerships built over the past 3 years, RMF's work was also recognized internationally, and in June 2013 was accepted into the World Bank's 2013 Development Marketplace as an innovative social program. With this award, RMF is now positioned for scale in other districts of Madhya Pradesh and other states in India.

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

After 19 months of use, RMF's CNEs have collected data on recovery rates, referrals, and demographics of over 8,000 children in our target communities. Armed with this information, RMF is currently in the process of analyzing trends from the data in order to gain a better understanding of malnutrition in Madhya Pradesh. Once completed, relationships between gender and age and malnutrition, success of referrals and NRC treatments' impact on recovery rate, relapse rates, mortality, and length of recovery will be available. In addition to this comprehensive study of the data, RMF's CNEs continue to use CommCare daily to aid in referrals, counseling, and child tracking.

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

INDIA

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

Community Management of Acute Malnutrition (CMAM) Pilot with the Madhya Pradesh Department of Women and Child Development

In February of 2013, following several meetings of the Government of Madhya Pradesh (MP) and CMAM partners, a Technical Steering Committee on CMAM was formed with representatives from RMF, Valid International, Vikas Samwad, UNICEF, technical experts from the State, and the MP Departments of Women and Child Development and National Rural Health Mission. During several meetings over the course of spring and summer 2013, this committee formalized regular guidelines for CMAM in Madhya Pradesh, worked on quality assurance and safety protocols for the locally produced RUTF (Ready-to-Use Therapeutic Food), and training modules for frontline workers.

However, the controversy surrounding CMAM in India is far from over. Despite evidence, both internationally and within India, of its effectiveness, consensus on the use of RUTF remains elusive. As of December 2013, with protocols and approvals issued by the MP State Government, RMF is still waiting for final permission from the Government of India to proceed.

Organizational Development and Positioning for Scale

In 2013, RMF India was pleased to announce a partnership with the World Bank's Development Marketplace for our programs in India. The Development Marketplace (DM) is a competitive grant program that identifies and funds innovative, early stage development projects that are scalable and/or replicable, while also having high potential for development impact. With support from the DM grant, RMF worked towards expanding our organizational structure and preparing for scale. In addition to increased program presence, RMF also engaged outside technical experts to streamline financial reporting and strategies, document our HR policies and strategy, and strengthen our M&E processes. In addition, RMF has been invited to present our model to several states across India, demonstrating the replicability and impact of our program. Since RMF works closely with national systems, our program is easily adaptable to other high-risk states. RMF is currently working with the Government of Bihar to share our lessons from Madhya Pradesh.

RMF India team accepting World Bank grant award

Summary of accomplishments over the past year:

- 1,774 children with SAM (Severe Acute Malnutrition) identified and families counseled; 13,335 since the program began in 2010
- 4,265 children with MAM (Moderate Acute Malnutrition) identified and families counseled; 31,715 since the program began in 2010
- Overall improvement in 31,339 identified children in the three years of operation
- 333 children who received lifesaving treatment at Nutritional Rehabilitation Centers (NRCs), 2,588 since our program began in 2010
- 2,521 village nutrition training sessions conducted, with over 30,141 people in attendance
- 49,465 family counseling sessions conducted on topics such as nutrition, public health services, breastfeeding, and hygiene.

Success Stories

Shivani

RMF CNE Savitri Kajle first diagnosed Shivani in Maidarai village (Khandwa district) with SAM in late 2012, presenting with a MUAC of 9. As a one-year-old, Shivani's nutrition was particularly important because children suffering from SAM in the first two years of their lives face developmental difficulties, stunting and delayed growth, and future health complications. Savitri counseled the family extensively, and Shivani was admitted to the Khandwa NRC for 14 days of treatment with therapeutic feeding. However, the burden of such a long hospital stay is often too much for the families, and Shivani's mother left the NRC before her treatment was complete.

However, Shivani's story did not end there. One of the cornerstones of RMF's program is continuous follow up with children, even after they have been admitted for treatment. On her visits to Maidarai,

Shivani after treatment

INDIA

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

Savitri continually observed that Shivani had not fully recovered and had recurrent bouts of diarrhea and fever. Children suffering from SAM have weakened immune systems and even minor infections can be fatal. Recognizing this, Savitri continued to refer Shivani to the NRC and Anganwadi Worker. She was admitted to the Khandwa NRC (Nutrition Rehabilitation Center) twice more for treatment, spending over 30 days in NRCs, and has now recovered. As her visits continue, Savitri will ensure that Shivani does not relapse, and counsel her parents on best feeding practices and nutritious foods to help her grow.

Pinki

Pinki was initially identified as suffering from malnutrition by RMF in late 2012 when he was seven months old. One of the contributing causes to Madhya Pradesh's high malnutrition burden is poor diet in pregnant women; up to 70% of pregnant women in MP suffer from iron and protein deficiencies, leading to low birth weight infants. Pinki and his mother were victims of this; he was born underweight, only 1.2 kilos (2.65 pounds) at birth.

Again, the assistance of RMF's CNEs helped Pinki recover from this disadvantage at the start of his life. Initially diagnosed with a MUAC of 8.5, Pinki was immediately referred to the nearest NRC in Khandwa. Although he completed his initial treatment, he was still classified as SAM at discharge and referred to the Anganwadi Centre in his village for enrollment in the Supplemental Nutrition Program. Under this scheme, his family received regular take home rations to help him grow and gain weight. However, over the course of the next few months, he still did not recover. With close follow up by RMF's CNEs, Pinki was admitted to the NRC twice more. After many rounds of treatment and continued counseling, Pinki has finally recovered and is gaining weight at home, eating nutritious foods under the guidance of RMF's CNEs.

Pinki after treatment

Naitik being measured for progress

Naitik

Naitik was first diagnosed in late 2013 at eight months old with a MUAC of 11.5 and severe recurrent diarrhea. Children are often exposed to unsanitary conditions in and around their homes, which leads to diarrhea and malnutrition. RMF's CNEs counsel families on both sanitation and hygiene practices to prevent diarrhea, and the availability of ORS at Anganwadi Centers free of cost for the treatment of diarrhea. However, despite this, Naitik still slipped into malnutrition, and, with the help of one of RMF's CNEs, was admitted to the NRC.

In the NRC, he received treatment for both his diarrhea and malnutrition, and after 14 days of treatment was discharged. He is now a healthy child with a MUAC of 12.8, and both he and his family are followed up with every two weeks by an RMF CNE.

INDIA

INITIATIVES ■ Adolescent Girls Outreach Program

Continuing Follow Up with Adolescent Girls

Adolescent Girls Outreach Program

Adolescent Girls gather at an RMF outreach event

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

Since malnutrition in Madhya Pradesh does not exist in a vacuum, RMF's team in India in 2012 started thinking of new ways to reach these girls. After discussion with the UNICEF District Coordinator in Khargone, RMF devised a way to expand our intervention and decided to design a workshop for adolescent girls. In India, "adolescence" is not a homogenous category – as there are school going adolescent girls as well as those who have dropped out to work at home or in the community, or to get married. In our pilot workshop, we decided to work with the girls in the middle schools and high schools in the villages in Madhya Pradesh we are working in.

2013 Update:

Following our first workshop on the 1st of September 2012, RMF has spread outreach into communities beyond the first 44 girls who attended the workshop. Sharing lessons on women's health to adolescents is particularly important in India, where many topics such as menstruation are taboo in tribal society. Faced with stigma, adolescent girls are often not comfortable talking about feminine hygiene and health, and in extreme cases feel isolated from their families and peers when they reach puberty.

RMF CNE leading an Adolescent Girls workshop

Over the past year, RMF has developed a successful format for implementing an adolescent education curriculum through a close working partnership with district administrators and community leaders. With the pilot program already successfully tested, the roadmap is clear, and we continue to look for donor support to expand this program.

Rayaki's Story

Before participating in RMF's first workshop, Rayaki, a 13-year-old girl from Gopalbura village in Khargone district, was having trouble sharing her experiences after her menstrual cycle began. She felt that the painful cramps that she was experiencing were abnormal, and she did not feel comfortable talking to her parents or teachers about her feelings. Noticing that she was withdrawn, her parents' and teachers' concern for her grew to frustration.

However, following RMF's open forum held at her school, Rayaki realized that her feelings were normal, that the changes she was undergoing were a standard part of life, and that she should not feel ashamed. In the one and a half years following the program, Rayaki has become more engaged with those close to her. She is proactively seeking out information about her own health, including tips on how to cope with her menstrual cramps, and she is no longer ashamed of the changes in her body. She is more actively participating in school, and has developed a close relationship with Antim Gupta, RMF's coordinator who conducted the workshop.

INDIA

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

15 Local Staff across 100 Villages

12 Videos produced in Local Languages on Nutrition and Health Related Topics

502 Screenings conducted in 50 Villages

4,391 Households reached with Video Screenings

108 Adoptions of Practices outlined in the Videos observed

CNEs learning to use digital movie cameras

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

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

Piloting Films and Adoption Practices

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.

Mothers attend a screening in Khandwa

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

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

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

With this technology, we can target our messages very effectively, and also adapt the messages that are more difficult for communities to understand. Over the course of the next year, we will carefully monitor what works and what doesn't, with the goal of scaling this technology to all the districts we work in. RMF is sharing content as it is produced. All of the videos are also available on YouTube and Vimeo.

CNE Jamanti counseling during a film

Success Stories

Bokera Village, Pandana Block, Khandwa

Bokera is a small village, about 50 kilometers from the main city of Khandwa, whose residents live along a central lane and depend on seasonal labor and agriculture for their livelihoods. Over the past 3 years, RMF CNE Anjila Dharemrey has identified and referred many children with Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) for further treatment.

Sevanti and her family live with her sister and mother in a joint family home. Her youngest daughter, Pushpa, is 18 months old. Before viewing a video on complementary feeding, Sevanti had never been counseled on proper breastfeeding and complementary feeding practices. Now, after viewing RMF's video with Anjila in her home, she has increased the frequency of regular feeds to her child and also supplemented her diet with additional breastmilk.

In addition, for the other children in her family and household, she and her mother have started using local techniques and practices to increase the quality and nutrition content of the meals they serve. She now washes her vegetables before chopping them to prevent nutrient leeching, and has increased the amount of green, leafy vegetables and pulses she feeds to her children. Sevanti is one of hundreds of mothers that have learned and changed since RMF started screening videos in the communities we serve in 2013.

Sevanti, right, with her daughter, sister, niece and mother

PAKISTAN

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

Agra Clinic treated 25,766 patients

Nowshera MCH Center for IDPs launched

MNCH Research Study on Community Midwives successfully completed and findings shared with policy makers

MNCH Research Study on Maternal Health Equities Module II launched

Children with donated teddy bears at Agra Health Center

Background

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

In July 2010, the flooding of the Indus River Basin at an unprecedented scale inundated nearly one-fifth of Pakistan's total land area, directly affecting 20 million people mostly by destruction of property, infrastructure and livelihood. In Dadu District of Province Sindh, with funding from the US Sindhi Diaspora and other philanthropic sources, RMF accessed 74 remote, isolated villages with a mobile health clinic providing healthcare to 5,675 patients and ensuring 4,000 families had access to clean water (via purification sachets) during our 9-month relief project. RMF's intervention in the province of KPK was extensive; with funding from Google Inc. and APPNA our intervention began with relief work in form of 12 free emergency medical camps in the immediate aftermath of the floods which provided healthcare to more than 20,000 men, women and children. This was followed up by static clinics in Gulbella and Agra in District Charsadda that provided medical care for 15,763 people over 14 months and 25,766 persons over 19 months, respectively. With the crisis of the floods under control, the health department of KPK is now faced with a new crisis of Internally Displaced Persons (IDPs) who are made refugees in their own country, driven out of their homes due to the ongoing Taliban militancy in the northern tribal areas of Pakistan. IDPs have sought refuge in surrounding districts including District Nowshera where their health needs are met by a cluster of CSOs and NGOs under the umbrella of the WHO.

In line with our mission to move beyond traditional humanitarian aid programs by creating long term solutions to healthcare and poverty, RMF Pakistan also partnered with the University of Alberta, Canada starting in late 2011 to conduct two qualitative 2-5 year long research studies in Province Punjab to identify innovative, contextually specific solutions to the problems faced by poor, marginalized women in terms of Mother and Child Healthcare.

2013 Update:

2013 saw Real Medicine Pakistan transitioning our Agra clinic back to the local government and then moving into District Nowshera as a member of the WHO Cluster of CSOs and NGOs in provision of comprehensive maternal and child health care services to Internally Displaced women and children who have sought refuge in this district from the ongoing Taliban driven conflict. We successfully completed our DFID funded MNCH research study on Community Midwives and shared the findings with key stakeholders and policy makers of the Government of Pakistan. Our CHIR funded research study on Maternal Health inequities entered into the data collection stage of Module II.

PAKISTAN

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

Agra Clinic in District Charsadda, Province KPK

Background

The 2010 floods have been officially recognized as one of Pakistan's worst natural disasters to scale. The province of KPK was the most severely affected in terms of destruction where massive damage to infrastructure and property was sustained. Against a backdrop of recurrent natural and human-made calamities in this Province – including the protracted fighting and mass displacement witnessed in 2009 due to the Taliban invasion of Swat – the long term effects of entrenched food insecurity and poverty in KPK, especially District Charsadda, were ubiquitous. According to the January 2012 UNOCHA (Office for the Coordination of Humanitarian Affairs) report, 2 years after the floods, Union Council Agra was identified as one of the most flood-devastated areas within Charsadda District that was still in need of aid in all areas of development including health. Agra which is located at the fork of River Kabul has been subject to regular low intensity flooding for the past many years; hence the BHU of this Union Council had never been functional. Statistics prior to floods are that 30% of women have no access to MCH care, only 9% of patients actually receive medicines prescribed at government health facilities and child mortality rates are 25% and 10% of children succumbing to pneumonia and diarrhea, respectively.

In response to this critical situation, on March 1st, 2012, RMF joined hands with Pakistan Health Foundation (PHF) UK to provide comprehensive primary healthcare to the people of Union Council Agra. PHF was founded in 2011 by members of the Rotary Club Reading, UK whose sole mandate was to fund the construction of a 10-bed hospital in UC Agra on land purchased by PHF from local land owners. While the main hospital building was under construction, RMF began to serve the local populace with immediate service by starting provision of quality primary healthcare services from a small makeshift building in one corner of the compound of the construction site.

Project Completion Report: During this 19-month project from 1st March 2012 to 30th September 2013, a total of 25,766 men, women and children (63% women/girls and 37% men/boys) were treated for a variety of diseases. Due to a well-coordinated referral system to tertiary level health facilities in Peshawar, a total of 837 patients were referred to receive advanced medical care. More than 4,000 women of child bearing age attended the hospital of which 1,370 women came for antenatal visits, 2,005 women visited the hospital for gynecological problems and 717 women sought out consultations on family planning, a total number of 4,085 MCH-related consultations.

As a sign of RMF's engagement with the local communities, we received a large number of volunteers from the surrounding villages to help with our outreach activities. Close interaction and coordination with the local health authorities at the district and provincial levels led to RMF's Agra clinic to become a hub for polio vaccination campaigns conducted by the Government and partner organizations like Rotary Club International. Over a period of 9 months from January 2013 to September 2013, a total of **1,704** children under the age of 5 years were administered polio drops.

Three years after the fateful floods, in August 2013, District Charsadda was the last to be taken off the list of flood affected areas of KPK and the government announced that the road to recovery was at last present. The Pakistan People's Health Initiative (PPHI) a semi-government body had signed an MOU with the KPK Health Department to adopt all the BHUs in the main districts of Charsadda, Nowshera and Swabi. In a matter of a few months, the PPHI was intending to revitalize the BHU in Union Council Agra. Given our concept of not duplicating services, RMF decided to conclude our primary health care services in the Agra Health Project.

Administering oral vaccine at RMF's Agra Clinic

Agra physician treating local man at RMF clinic

PAKISTAN

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

MCH Health Center in District Nowshera, Province KPK

Background

An estimated 5 million people have been displaced due to conflict, sectarian violence and human rights abuse within Pakistan since 2004.
In 2013, militant clashes between Taliban and subsequent military intervention in the Khyber and Khurram Agencies, led to a massive displacement of nearly 1.1 million people to surrounding host districts, mainly Peshawar, followed by Nowshera, Kohat, Hangu, Tank and Dera Ismail Khan. This number is estimated to be higher since according to the IDP Vulnerability and Assessment and Profiling Project (IVAP), 34% of KPK's displaced populations are not registered.

Displacement leads to a host of serious challenges such as threat to life and freedom of movement, not to mention inadequate access to food, housing and basic services including healthcare. Although many IDPs take refuge in government designated camps, the vast majority, that often come as cohesive groups, are absorbed by surrounding host communities, either by relatives or rented accommodations, an aspect driven by a range factors such as camp conditions, lack of privacy and tribal dynamics The average IDP family lives below poverty line with an income of Rs 2,500 - 5,000/- (USD 25/- to 50/-) per month. The key focus of the government is safe and voluntary repatriation of IDPs; hence the humanitarian response is mainly provision of emergency relief such as food, healthcare, clean water and sanitation rather than long term solutions. The chronically burgeoning populations overburden the district health facility infrastructure; this pressure is eased and addressed by a cluster of NGOs and CSOs under the umbrella of the World Health Organization (WHO).

RMF was invited by the WHO cluster to join hands in addressing the health needs of internally displaced persons in the refugee camps and host communities in any of the above mentioned host districts of KPK. RMF responded by establishing a Maternal Child Healthcare (MCH) Center in Union Council Taru Jabba to address the gap in MCH care for the women and children of the IDP community in District Nowshera. On October 1st, 2013, Real Medicine Foundation leased a site in Union Council Tarru Jabba. The space available proved to be insufficient for the proposed MCH Center. With funds from generous philanthropists from London the existing building was expanded to increase the rooms and utility area. With the construction complete within five weeks, the center opened its doors in the last week of November 2013. By the end of the year 2013, a total of 720 women and children had received quality healthcare. Pediatric care was provided to 71 children and 22 infants, and 623 women were provided with MCH and primary health care.

Newborn at the MCH Center in Nowshera

Girl being treated at the Nowshera Health Center

PAKISTAN

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

Mother, Neonatal and Child Health (MNCH) Research Projects

Background

With a maternal mortality rate of 297/100,000 live births; Pakistan is one of the six countries estimated to contribute to half of all maternal deaths worldwide. In 2011, RMF Pakistan partnered with the School of Public Health, University of Alberta, Canada to research and identify innovative, contextually specific solutions to the many problems the poor and marginalized Pakistani women face, and launched two qualitative studies on Gender, Class and Social Exclusion in three districts of Punjab. The aim of the first research study in District Chakwal, funded by the Canadian Institute of Health Research (CIHR) was to explore the role of class and gender inequities on the design and delivery of maternal health services in Pakistan. The second research project in Districts Jhelum and Layyah, funded by the Research Advocacy Fund (RAF), aimed to evaluate if Community Midwives are fulfilling the government objective of improving access to the full scope of skilled maternity care for poor, disadvantaged and marginalized women. Our aim is that our research findings will provide empirical evidence for the formulation of maternal health policies and health care system practices in Pakistan.

2013 Update:

Our **RAF funded study** has come to a successful completion. Using social exclusion as a conceptual framework for understanding the multi-dimensional nature of the disparities in women's ability or willingness to access maternal health services, the objectives of this study were to
1) Assess the coverage of CMW maternity care to the socially excluded;
2) Explore challenges faced by CMWs in providing services;
3) Map the social, financial and other barriers poor and socially excluded women face in accessing CMW services.

Children encountered in the field during MNCH research

Using both quantitative and qualitative research methodology, data was collected in three overlapping modules over a 9-month period in 2011 and 2012 in two districts, Jhelum and Layyah in Punjab.

Module I in each district consisted of qualitative in-depth interviews with 38 community midwives, 15 local dais (traditional birth attendants), 30 other health care providers in both the public and private sector, and a variety of program managers and policy makers to understand the challenges individual CMWs are facing as well as the institutional challenges they may be facing in establishing their practices. Five CMW monthly reporting meetings were attended and over 20 hours of observation were carried out to document CMW training in labor rooms and obstetric wards in Layyah.

Module II aimed to identify the social, financial, geographic and other barriers socially excluded women face in accessing CMW services. Interviews were conducted with 78 women of reproductive age (15-49) who had given birth in the last two years, 35 husbands of women who had given birth in the last two years, and 23 older women (aged 50 years plus). Eleven interviews were conducted with women and their families who had experienced either childbirth complications or a maternal death. Finally, 18 focus group discussions were held with men and women of varying socioeconomic statuses. Furthermore, informal interactions took place with a variety of community members.

Module III aimed to quantitatively measure levels of social exclusion through measures of material assets, poverty of opportunity, and caste, and to investigate the associations between social exclusion status and uptake of CMW care. A cross-sectional, clustered and stratified survey was conducted in the two districts (n (total) =1,457) with women who had given birth in the past two years.

Overall, our findings suggest that poor, socially excluded women are not receiving necessary biomedical maternity care; they are 7 times more likely to report attendance by a dai and 80% less likely by a physician compared to the richest, socially included women. They are also 4 times more likely to deliver at home compared to the socially included. Our data also show that the CMWs have yet to emerge as a significant and relevant maternity care provider in rural Punjab. Only 3% and 11.7% of all births in Districts Layyah and Jhelum, respectively, in the last two years were attended by a CMW. Among the small number of women who received CMW care, our data suggest that CMWs are providing services equally to

PAKISTAN

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

socially included and excluded women. Key barriers for CMWs to work effectively were consequences of complex interaction of gender values that situate women as economic dependents, and the presence of providing men, with the additional exacerbating fact that midwifery is demanding work, but considered a low-status occupation traditionally performed by dais.

Programmatic barriers such as poor quality training, uniformity of policies that result in neglect of the context-specific ground realities, and a failure to incorporate the gender and social realities of CMWs' lives into the design of the program further hindered the interested CMWs in establishing their practices. The few CMWs who are committed and struggling to practice are largely providing care to members of their biradari (relatives) and poor, socially excluded women. These two groups are not their stated target clients but are being served by default as the CMWs try to gain experience and exposure in order to reach their real target, the paying patients. Our research also provided examples of CMW characteristics that predict success in CMW functioning. These include a poverty-pushed desire to work, greater family support to overcome the gender and social barriers, and individual CMWs' professionalism and work ethics. The successful CMWs had developed linkages with other providers. Characteristics such as CMW age and marital status did not emerge as important predictors of success.

Socially excluded women also face barriers in accessing CMW services. The data showed that they were unable to pay CMW fees and that, combined with a lack of respectful maternity care directed particularly towards poor, socially excluded women, deters them from seeking not only services from CMWs but from all biomedical services.

These findings were shared with funders and key stakeholders in a knowledge dissemination seminar held in December 2013, conducted in collaboration with researchers from the University of Alberta; hard copies of the complete report were shared with all involved. The University of Alberta is currently in the process of publishing these findings in academic journals.

The **CIHR funded study** initiated Module II of the study in June 2013. Having successfully completed Module I (ethnography phase) and having shared findings with key stakeholders in 2012, Module II focuses on services of health facilities surrounding the field site where the ethnography phase was conducted, aiming to evaluate the quality of care of public and private health facilities provided to and the satisfaction pattern of pregnant and lactating women, with the specific objective to map women's experiences of maternal healthcare use, specifically antenatal care, skilled birth attendance, and emergency obstetric care and postnatal care.

Our field team established a site setup in District Chakwal and after the requisite networking and obtaining of NOCs from the relevant health authorities, data collection commenced to investigate how Gender, Caste, and Economic Status influence women's healthcare service provider selections. This objective was accomplished by attending, on a daily basis, an extensive participation-observation session in local MCH health facilities. Alongside this, in-depth interviews and focus group discussions were conducted to explore how societal constructs such as gender, caste and class influence the quality of care in healthcare facilities ranging from District Headquarter Hospitals (DHQs), Rural Health Centers (RHCs), and Basic Health Units (BHUs) to private clinics.

By the end of the year 2013, data had been collected through

- 32 exit interviews with ANC and PNC clients;
- 3 in-depth exit interviews of delivery clients;
- one maternal death explored in detail;
- 5 visits to the District Headquarters Hospital (secondary level health facility);
- 28 visits to the RHCs.

Currently transcription of this data is underway.

Field team conducting interviews in Chakwal

PHILIPPINES

INITIATIVES ■ Disaster relief

Typhoon Haiyan/Yolanda relief

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

RMF Philippines team and volunteers handling emergency supply shipment

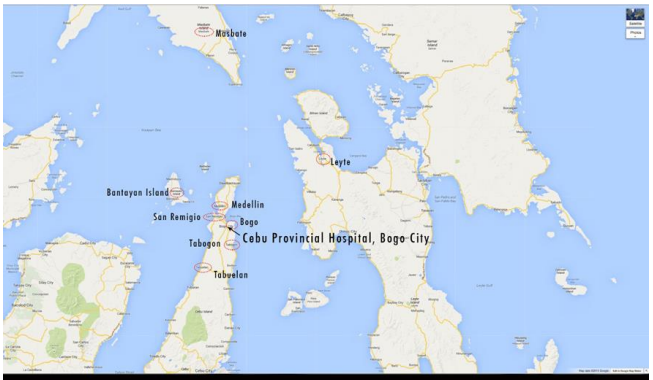
Emergency Supply Delivery/Typhoon relief

Background

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

2013:

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



Focus of RMF Disaster relief in the Visayas, Philippines


Cebu Provincial Hospital-Bogo City

Cebu Provincial Hospital-Bogo City

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

PHILIPPINES

INITIATIVES ■ Disaster relief

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

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

New mothers sharing beds at Cebu Provincial Hospital-Bogo City

Daanbantayan District Hospital

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

Daanbantayan District Hospital

Consultation room at Daanbantayan District Hospital

PHILIPPINES

INITIATIVES ■ Disaster relief

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

Bantayan District Hospital post-Typhoon Haiyan/Yolanda


Damaged roof at Bantayan District Hospital

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

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

RMF and IRD unloading emergency supplies

RMF staff and medical volunteers with supplies

Dividing up the supplies for transport

SRI LANKA

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

Healthcare for more than 4,000 Post-Tsunami

2,523 patients treated

Long term medical support for 6 Children

36 Preschool children and students supported

RMF's Dr. Chamal and patient at RMF's Yayawatta Clinic

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

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

Yayawatta Primary Health Care Clinic

2013 Update:
RMF's Yayawatta Clinic's beneficiaries include the population of Seenimodara, Kadurupokuna, Moreketi-Ara and Palapotha. Having access to free healthcare is especially important for young mothers, children, and the elderly in the community. Using our clinic activities as a hub, we provide regular medical camps and healthcare outreach programs to preschools, schools and communities in the surrounding areas. Patients with more serious conditions are referred to the local District Hospital in Tangalle and then followed up with regularly by RMF's physician.

In 2013 our clinic was open for 10 days a month, seeing as many as 25 patients per day and 650 a quarter. The first Thursday of each month is also set aside for a health education program for mothers and expectant mothers, administered by a government nursing officer and hosted by our clinic staff at the clinic building. Our family planning program for women continues to be very effective with administration of Depo-Provera to an average of 6 women per month. The diseases we see most frequently are respiratory tract infections, viral fevers, gastrointestinal tract infections, heart disease, hypertensive disorders, skin diseases and different forms of arthritis.


Mothers wait to be seen at Yayawatta Clinic


Young patients at RMF's Yayawatta Clinic

SRI LANKA

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

Long Term Medical Care of Children

Background

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

2013 Update:

All five of our patients have continued with their regular growth hormone treatment, are growing in height and are maintaining healthy weight gains. All five patients and their caregivers also regularly consult with Prof. Sujeewa Amarasena, the Head of Pediatrics, Karapitiya Teaching Hospital, to discuss their progress. Our oldest long-term patient, Tharindu, is being treated for familial hyperlipidemia with lipid lowering medication. We also continue to provide the families of all these children with nutritious food packages every month.

Madumekala receives a food package

Professor Sujeewa and RMF long-term patients

Preschool and Student Support

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, 2km inland from Tangalle. In 2013 we supported the staff salaries and some of the costs of supporting the 15 children of primarily lower income farmers and laborers including bus fares to and from school. The objectives of this program are: Educate children on basic English knowledge, modern communication technologies, health awareness and proper sanitation; Environmental awareness, integrating eco-awareness and outdoor activities into their routines; Natural disaster awareness and environmental pollution, including small skills they can utilize to help preserve their surroundings; Provide students with diversity education about cultural and ethnic diversity, and with at least one nutritious meal a day.

Palathuduwa Preschool students performing a play

Students of Minhath Preschool on a field trip

The **Minhath Preschool, Dickwella** was constructed by RMF in 2006 as the first ever preschool for the children of the Tamil/Muslim minority community in Dickwella, Sri Lanka, a region hit hard by the tsunami. Based on the Montessori Education Model, in 2013, 20 children benefited from the preschool classes that include academics, art classes, performance events and sports activities. This educational basis allows these children the chance of an advanced education that they were excluded from before. Lessons are taught in three languages: Tamil, English & Sinhala. RMF supported the salaries of the teachers and some of the school costs throughout the year.

SOUTH SUDAN

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

First ever accredited College of Nursing and Midwifery in South Sudan

130 Nursing & Midwifery Students enrolled

13 Nurses and 17 Midwives Graduated in August 2013

JCONAM's first graduation class of Nurses and Midwives

Background

South Sudan's maternal mortality remains the highest in the world, at 2,054 deaths per 100,000 live births; 200,000 women die in childbirth every year according to the 2006 South Sudan Health Survey. Some of the major reasons for the high levels of maternal mortality in South Sudan are women's lack of access to appropriate reproductive health care, poor health infrastructure, inadequate medical supplies, and insufficient human resources in the existing health facilities. The WHO recommends that a skilled attendant be present at every birth since midwives can prevent up to 90% of maternal deaths where they are authorized to practice their competencies and play a full role during pregnancy, childbirth and after birth.

Since the signing of the Comprehensive Peace Agreement (CPA), South Sudan has struggled to provide efficient and quality reproductive health care to its population, with less than 10% of deliveries occurring in the presence of a nurse, midwife or doctor. There is a serious shortage of skilled birth attendants, in particular qualified midwives, in South Sudan, a country with a population of 9.86 million.

Juba College of Nursing & Midwifery (JCONAM)

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

During their training, the students serve as staff in the outlying primary health care clinics and units in Munuki, Nyakuron, Kator and Malakia as well as Juba Teaching Hospital. The immediate population in Juba and surrounding areas, estimated at 500,000 are direct and immediate beneficiaries of this newly qualified health care staff. Upon graduation, nurses and midwives return to their home states to work for at least two years to serve the population of South Sudan. Our first class of 13 nurses and 17 midwives graduated in August 2013 and are all employed serving within the country. The college accepts applicants from all 10 states to optimize the distribution of newly qualified health care personnel.

2013 Achievements at Juba College of Nursing & Midwifery:

- RMF facilitated the November 2012 prospective student interviews which culminated in at least 362 students being admitted into various national health training institutes across South Sudan. More than 1,320 candidates applied and all underwent a rigorous interview process, led by the National Ministry of Health-Directorate of Training and Professional Development and assisted by tutors within these institutes and other stakeholders. During the first week of the academic year in January 2013, JCONAM admitted a new class of 30 nursing and 30 midwifery students. Recruiting for the next class of students took place in November 2013 and will be admitting 30 midwifery and 30 nursing students in early 2014. With the 2013 admissions, the current student population stands at 64 nursing and 66 midwifery students.
- Devised a clear strategy with college administration on how to handle and improve the skills of the students in clinical areas.
- Recruited highly experienced South Sudanese national tutor to increase teaching workforce and pave the way towards in-country teaching capacity building, and actively lead the implementation of a new program supporting students in clinical areas.
- Established a model skills laboratory and library at college, both of which are serving as models for other institutes in South Sudan.
- Procured and kept the College dispensary stocked with essential medicines for the students and the College staff.
- Instituted feeding program for the students minimizing study time wasted by the students while preparing meals.
- Procured 60 bed mattresses, blankets, bed sheets and pillow cases for the new first year students, helping them to settle into their new accommodations at the JCONAM students' hostel, and will provide accommodation materials for the new students for the year 2014.
- Procured and delivered a full supply of examination and surgical gloves for the students in clinical practices to ensure infection control. The students in clinical practice reported a big improvement in infection control measures during the year 2013 due to the supply of gloves.
- Procured and delivered four new laptops for the College tutors helping them carry out their daily program activities more efficiently.

SOUTH SUDAN

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

- Upgraded the internet bandwidth subscription, installed and connected six additional desktop computers to the internet in addition to the four computers newly connected during the previous year. All tutors are now able to access wireless internet services within the College and the students are accessing internet through the computer lab. This means that there are now 10 internet connected computers available for the students to use at the College's computer lab, greatly increasing their access and usage of the latest educational health materials. In an ever-changing global environment, it is essential for training institutes especially in the health sector, to be current on newest information and research via the internet.
- Contracted and funded the construction of a generator structure for the student hostel; the students no longer experience the problem of power cuts since there is now a functioning standby generator.
- Consistent supply of clean water provided to the student hostel following the rehabilitation of the water pump.
- Continued the supply of office consumables and scholastic materials to the college administration and students.
- The first class of JCONAM students comprised of 17 midwives and 13 nurses, graduated on August 29, 2013. RMF supported the graduation ceremony with materials and funding for the entertainment.
- Collected, documented and shared the profiles of the new graduates with partners in healthcare projects across South Sudan and continued to follow up with them and provide a support network.
- Coordinated with International Rescue Committee (IRC) the Training-of-Trainers (ToT) training for the 30 third-year JCONAM students on Clinical Care of Sexual Assault Survivors (CCSAS).
- RMF South Sudan participated in the first ever review of the National Nursing and Midwifery Strategic Plan for the year 2013-2017.
- The RMF South Sudan team in Juba received and delivered $10,000 worth of donated medical supplies and teaching materials to JCONAM from US donors in January 2013.

Healthcare Trainings and Evaluation for Medical Professionals

In mid-2013, RMF South Sudan also conducted healthcare trainings and evaluations of health facilities on behalf of CARE International in the following areas: Evaluation of three Health Facilities in Unity State, Basic Emergency Obstetric and Newborn Care (BEmONC) Training in Bentiu, and Training on Sexual and Gender-based Violence (SGBV) in Bentiu, Unity State. These were trainings for medical and Ministry of Health professionals in Unity State in partnership with the South Sudanese Government to meet the goals of its Health Sector Development Plan 2012-2016 (HSDP), i.e. "Contribute to the reduction of maternal and infant mortality and improve the overall health status as well as the quality of life of the South Sudanese population." through the implementation of the Basic Package of Health Services (BPHS).

Delivering medical supplies

RMF built generator housing

JCONAM students in new cafeteria

Nursing student giving presentation to class

JCONAM student receiving diploma

Audience for the JCONAM's first graduation

SOUTH SUDAN

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

Renovation and Upgrade of Pediatric Wards

Waste removal and management program

Large shipment of Emergency Medical Supplies delivered to Juba Teaching Hospital

Families being seen in the newly renovated Pediatric Ward

Juba Teaching Hospital

Background

Juba Teaching Hospital (JTH), a 580-bed facility and the only national referral hospital in the whole country of South Sudan, is located in its capital, Juba City, Central Equatoria State. With an estimated population of 9.6million based on annual population growth of 3% from a population census conducted in 2008 and lack of proper functioning primary health care facilities upcountry, many South Sudanese have nowhere to go to but to this only national referral hospital which is overwhelmed due to continuously increasing demand. JTH's departments and services include: Pediatrics, Internal Medicine, General Surgery, Obstetrics/Gynecology, Ophthalmology, Mental Health, Physiotherapy, ENT, Diagnostic Services: Laboratory, Radiology; Finance/Administration/Statistical Units. JTH was established in 1927, in structures that previously served as army barracks, and most of its infrastructure is now dilapidated requiring upgrades and renovations, refurbishing and remolding to create an environment conducive to healing for patients and their community, and the healthcare professionals serving them. The hospital is directly funded by the National Government through the National Ministry of Health and supported by RMF, UN agencies and other local and international NGOs. RMF's direct partnership with Juba Teaching Hospital started in the last quarter of 2012, with active implementation of our work, generously supported by Medical Mission International, beginning in the first quarter of 2013.

Renovation and Upgrade of Pediatric Ward 5

Pediatric Ward 5 has a 50-bed capacity and is the biggest pediatric ward at Juba Teaching Hospital, consisting of a surgical pediatric unit and a medical unit. The buildings were dilapidated and in very poor shape with broken drainage and plumbing systems. In the course of 2013, RMF initiated and completed the full renovation and upgrade of the entire ward, including all units, and created a clean, welcoming and respectful environment for the patients, their families and the healthcare professionals serving them. Following this work, and through the committed leadership of the head of the Pediatric Department, Dr. Hassan Chollong, and with his key pediatric staff, RMF developed clear policies and guidelines for the maintenance of all Pediatric Units on this newly established level. In addition to supporting equipment and supply needs, RMF also provides monthly cleaning materials and hired two additional cleaners to supplement the limited available capacity provided by the Ministry of Health.

The renovation work included the cleaning and painting of the interior and exterior of all buildings, plumbing repairs, roof and floor repairs, window and door replacements, and refurbishing and painting of all beds, drip stands and bedside tables. We also procured, i.e. new mattresses and bed sheets for all patient beds. The new Pediatric Wards resulted in significantly increased patient numbers as well as shorter patient stays because of its welcoming new setting, conducive to healing.

Repairing ceilings and painting the Pediatric Ward

Pediatric Ward after renovations

Entrance to Pediatric Ward after renovations

SOUTH SUDAN

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

Waste Management Program at JTH

Juba Teaching Hospital, being the only national referral hospital in all of South Sudan, has an immense patient attendance and turnover in all its departments and as a result the hospital generates an enormous amount of wastes (medical waste and non-risk garbage). The wastes are normally segregated from the sites of generation, and then taken from the various departmental sites daily to the designated place on the hospital grounds. The non-medical waste is supposed to be taken off-site monthly to a dumping ground designated by the Juba town council that is non-hazardous to the community in Juba City, while the medical waste should be incinerated on a daily basis by the incinerator for the hospital. Waste management in Juba Teaching Hospital falls within the responsibility of the Department of Public Health; there are two professional public health officers who are responsible for ensuring proper waste disposal in the hospital. The department is purely dependent on resources allocated to Juba Teaching Hospital from the National Ministry of Health. Due to budget cuts for the hospital, coupled with the government austerity measures imposed in 2012, the department has not been able to deliver its mandate, and the last time the wastes were removed from the hospital grounds prior to our program was in December 2012. Hence the wastes at the hospital had collected over the course of 6 months and become a hazard to the health care workers, patients, visiting guests and staff. Even worse, the dumping grounds onsite are next to the pediatric wards exposing most vulnerable children to these high risk wastes. Due to high risk factors and the bad odors being generated, the health care providers serving in the wards next to the site (Pediatric, Tuberculosis, Leprosy and HIV/AIDS Units) were very demoralized. The janitorial workers had also been exposed to high risks due to lack of protective gear such as gumboots, heavy duty gloves and wheelbarrows for ferrying the wastes from the production sites to the dumping site. The incinerator for burning the medical wastes was not well maintained and an inadequate supply of fuel deterred routine usage. This caused some of the medical waste to build up outside of the incinerator creating further health issues.

RMF's waste removal and management program has been generously supported by the Omidyar Global Fund of the Hawai'i Community Foundation and by The Stein Family Philanthropic Fund. Its goal is to ensure that Juba Teaching Hospital is free of hazardous wastes and has an appropriate waste management strategy in place moving forward.

The Objectives of our program are to:

- Assist the Ministry of Health to ensure proper waste collection and disposal at Juba Teaching Hospital
- Assure that a long term Strategic Plan to deal with regular waste removal and incineration is implemented
- Improve the Working Environment for the health care providers and casual workers at Juba Teaching Hospital
- Empower Public Health Workers in waste management at Juba Teaching Hospital.

RMF hired trucks to transport waste from JTH

RMF and JTH Medical Administration

JTH Cleaners with new protective gear

Achievements/Activities:

- On the 30th of May 2013, RMF South Sudan hired a company to start removing the wastes and transport them to an appropriated dumping site outside of Juba town. Half of the wastes were removed and the remaining waste was segregated in one place.
- The RMF South Sudan team, in coordination with JTH's Director General and Public Health Officer, drafted and finalized a Waste Management Policy Guideline, which now governs the waste management in JTH.
- The janitors working at JTH were trained on waste segregation, transportation and safety precautions.
- The nurses in charge of various departments were trained on the importance of waste segregation and infection control.
- JTH procured and labeled colored bins for proper waste segregation and disposal.
- RMF procured and delivered protective gear such as rubber boots, face masks, heavy duty gloves and overalls for all janitors.
- On the 24th of August, RMF hired a company to initiate the second phase of waste removal. Most of the waste was removed with only a small portion left as the responsibility of Juba Teaching Hospital.
- Following a visit of the Minister of Health, Hon. Dr. Riek Gai Kok on September 10th, the Mayor of Juba Town Council ordered the removal of the remaining wastes and committed to performing the weekly removal of the wastes moving forward.

SOUTH SUDAN

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

Emergency Shipment of Supplies from Uganda to Juba Teaching Hospital

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

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

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

856 boxes of supplies purchased in Uganda for shipment to Juba

RMF truck delivery at the South Sudan border customs check

JTH Director General welcomes RMF Team and supplies

JTH Lab technician eagerly helps distribute the supplies

SOUTH SUDAN

INITIATIVES ■ **Juba Teaching Hospital** ■ **Respectful Maternity Care Trainings**

Introduced Training in Respectful Maternity Care (RMC) to Juba Teaching Hospital and other medical professionals

Trained 4 Master Trainers, 26 second year Midwifery Students, and 16 Maternity Staff within Juba City on RMC

JCONAM Midwifery Students during large group learning session

Respectful Maternity Care Training

Background

According to the Southern Sudan Household Health Survey (SHHS) 2006, South Sudan is known to bear the highest maternal mortality ratio in the world at 2,054 per 100,000 live births, with only 10% of deliveries attended by skilled birth attendants and about 14% of deliveries occurring in a recognized health facility. These numbers can be attributed to many issues: poor access to quality reproductive health services, including family planning, limited access to skilled birth attendants, poor access to emergency obstetric and neonatal care, and inadequate equipment and medication. Infrastructure complexities involving lack of transportation to facilities, economic factors, certain cultural beliefs and a lack of knowledge about the benefits of facility-based birth and antenatal care also contribute to these overwhelming numbers.

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

Transforming maternity care into a welcoming and supportive experience through the systematic introduction of a Respectful Maternity Care (RMC) training program will increase utilization of services, improve community and health system relationships, and improve staff morale and job satisfaction. RMC training is possibly one of the most significant interventions that can be introduced in order to approach the objectives of Millennium Development Goal (MDG) 5. Addressing this problem should be a priority because if women are not willing to seek lifesaving care, then improving training, equipment, medication stocks, and financial barriers will fail to reduce the number of women dying.

Respectful Maternity Care Training Program – RMF Concepts

What makes RMF's RMC training approach unique is that this program is based on our concepts of "Friends helping Friends helping Friends" and "Liberating Human Potential": Treating each other and the people we are supporting around the world with the respect and dignity you give to friends; we listen, learn and partner with the local populations, and empower local leadership. We train, educate and employ locals, producing innovative solutions and co-creating strong communities that sustain and grow (healthcare) capacity. By empowering the people we are trying to help, we discover visionaries and partners who are best able to solve their problems. What this means is that the program brings a **solution-oriented** approach to the community and facilitates them to create a sustainable and independent response to challenges rather than dictating a preordained set of solutions from outside the community. This mechanism of building **community resilience** is a cornerstone of RMF's vision. The program itself is the first to operationalize the teaching of compassion and respect to maternity workers rather than just document and define the problem of D&A in facilities.

Role Playing during the staff RMC training workshop

SOUTH SUDAN

INITIATIVES ■ Juba Teaching Hospital ■ Respectful Maternity Care Trainings

The RMC training program at Juba Teaching Hospital, designed and conducted by RMF Coordinator of Maternal Child Health Programs, Cindy Stein Urbanc and RMF Clinical Trainer, Reagan Turner-Bell, consists of 6 modules facilitated over a 2-day period with key core competencies:

- Building rapport and trust with patients through respectful communication, attitudes, behaviors, and cultural sensitivity
- Guarding the privacy and modesty of women
- Providing hands-on labor support in collaboration with family members
- Informed consent and evidence based maternity care
- Promoting mother-baby bonding
- Fostering a positive work environment, ensuring all staff members have an equal voice, respectful leadership.

The training utilizes a methodology that incorporates proven learning methods shown to maximize retention of core concepts as well as ensure that there is a transition from knowledge acquisition, to attitude change ultimately to behavior change. The components are a combination of:

- Facilitated large group conversations
- Small group activities and simulations
- Role playing
- Visual imagery prompting (through video and photos)
- Worksheet activities
- Personal sharing exercises
- Quantitative knowledge testing

RMF identified two medical officers from the maternity department of Juba Teaching Hospital and two national midwifery tutors from Juba College of Nursing and Midwifery who were trained as RMC Master Trainers by RMC consultants. The four Master Trainers are now able to supervise, mentor and train more college students and maternity staff across South Sudan. We conducted training on RMC for 26 second year Midwifery Students from JCONAM and the trained students are now replicating the concepts of RMC instilled in them while in their clinical practices. RMF also conducted and trained 13 Maternity Staff from Juba Teaching Hospital and 3 from primary health care centers in Juba (Nyakuron, Munuki and Malakia) where maternity care is offered.

Pre and post-tests provided the feedback that participants adopted positive attitudes as well as core knowledge from the program. Qualitative assessments showed that participants not only really enjoyed the material and the process of learning in the innovated way the workshops were conducted, but feedback indicated 6 distinct areas that participants felt encouraged about as the result of the RMC program:

1) Their commitment and intention to change behavior
2) They have a strong desire for more extensive training
3) They were particularly excited about improved collegial relationships
4) They felt a lot of hope for an effective change
5) They expressed a commitment to evidence-based practice
6) They felt the RMC concepts served as building blocks to peace building and conflict resolution on a larger scale.

JCONAM Midwifery Students - small group learning session

Graduates of the RMC program with their certificates

UGANDA

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

More than 23,400 Patients treated

1,286 Refugee School Children supported

Vocational Training Institute with 40 Tailoring and Hairdressing Students

CO, Nurse trainees and RMF team at Panyadoli Health Center III

Background

The Kiryandongo Refugee Settlement in Bweyale, Uganda is a UNHCR managed refugee settlement that provides shelter, land and support for more than 25,000, comprised of Ugandan IDPs and refugees from Kenya, Congo, Rwanda, Burundi and South/Sudan. RMF has partnered with UNHCR and the Ugandan Office of the Prime Minister (OPM) in supporting Kiryandango and the greater surrounding community of Bweyale (an additional 30,000 residents) with health care, education and vocational training since 2008**.**

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

Panyadoli Health Center III

2013 Update:

The Panyadoli Health Center treated 23,402 patients this past year with some months seeing as many as 3,000 patients, for a wide variety of issues including malaria, malnutrition, maternal and child care, and HIV/AIDS; cases requiring tertiary care are referred to the closest county hospital.

Our consistent supply of medicine and supplies to this health center also enables the running of a smaller second clinic at a further away location in the settlement and enables Panyadoli Health Center III to handle more complicated cases. In addition to the continuous medical support, RMF has also has maintained the solar powered water pumps, pipes, and taps that supply all the clinic buildings and that we had installed in a previous year. Our vision continues to be to expand and upgrade the Panyadoli Health Center III's capacity and services so it can function as a Level IV Hospital.

The quarterly supply of medicines to Panyadoli Health Center III continued throughout the year and has significantly helped to keep the refugee population in good health. With the massive influx of new refugees arriving at Kiryandongo from South Sudan, starting in late December 2013, the demand on medicine, supplies and staffing at Panyadoli and across the settlement has greatly increased. Approximately 12,000 refugees have arrived as of early 2014 and as many as 40,000 more are expected. RMF has drawn up detailed plans on what is needed across the settlement to accommodate these new refugees and is waiting on approval from the settlement administrators and funding from donors to ramp up our programs.

Patients waiting to be seen at Panyadoli Health Center III

Child treated for malaria at Panyadoli Health Center III

UGANDA

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

Kiryandongo Refugee Children Education and School Support

Background

When the Kenyan refugees arrived at the Kiryandongo Refugee Settlement in 2008, there was very little support in terms of school fees for their children, and there was no provision for a nursery school at the settlement. RMF stepped forward in collaboration with the UNHCR and Ugandan Office of the Prime Minister and with support from World Children's Fund to establish a school support program to cover fees and supplies for Nursery, Primary and Secondary School children of the Kenyan refugee community at Kiryandongo. In the subsequent years, students from South/ Sudan, Congo, Burundi and Rwanda have been accepted into our program as well. RMF pays a portion of the tuition fees, school uniforms, school supplies, and exam fees for the students of parents unable to afford the fees. We also cover the cost and travel expenses for the final examination tests for the senior high school students.

2013 Update:

RMF is currently sponsoring 1,286 students. The refugee children we presently support are from Kenya, Congo, Burundi, Rwanda, and South/Sudan and attend the following schools in the settlement: Beth Cole and Day Star Nursery Schools; 147 students; Arnold Primary and Can Rom Primary School, 1,091; and Panyadoli Secondary School, 48 students. We also continued to provide funding for the annual registration of candidates in Senior Level Four and Senior Level Six that are in our sponsorship program and facilitated candidates taking their national exams in the city of Masindi.

With the enormous influx of new refugees arriving at Kiryandongo from South Sudan, starting in late December 2013, a major percentage of them minor children, the amount of children needing support to attend school has started to increase significantly, and we expect this intensified need to continue well into 2014.

Secondary School students at Kiryandongo Refugee Settlement

Primary School students at Kiryandongo Refugee Settlement

Kiryandongo: Panyadoli Vocational Training Institute

Background

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

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

UGANDA

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

2013 Update:
RMF completed its third year of vocational training classes in 2013, covering both theory and hands-on techniques for hairdressing and tailoring. Our Vocational Training Institute has had three graduation ceremonies since 2011 and graduated a total of 110 students. The Vocational Centers are continuing to generate some income for the school by tailoring garments, i.e. uniforms for the nurses at RMF's Panyadoli Health Center III, and by offering hairdressing services to the refugee population at the Kiryandongo Settlement and its surrounding communities.

Tailoring student in RMF Vocational Training Center

Tailoring student learning hand sewing techniques

Tailoring Shop Program Background

The goal of RMF's Tailoring Shop Program is to set up sustainable, market-based business opportunities for the refugee and IDP graduates of our Panyadoli Vocational Training Institute (PVTI) Tailoring Program. Supported by Frost Family Foundation, we started this program in 2013 with the sponsorship of 10 RMF Tailoring Training graduates to set up their own Tailoring Shop businesses with the purchase of sewing machine, fabrics, threads and other equipment. In order to be approved for the program tailoring students are expected to give 10% of their profits back to PVTI. RMF purchased a sewing machine, enough fabric for several months, threads, needles, and enough tables and chairs to set up new shop locations for each of the 10 selected. RMF also paid the monthly shop space rent for one year to help the tailors become profitable and save enough money to continue their businesses in a sustainable fashion without further donations. After a 3-month grace period, they were also expected to give 10% of their profits back to PVTI; these funds were to be used to procure supplies for the next round of vocational training students. The official launch of the second phase of our Tailor Shop Program happened in June, and by the start of July, early Q3, the program had officially launched with all 10 tailors set up for business. Some of the tailors are located in the main Bweyale Market Center where the populations of the neighboring districts of Lira, Gulu, Masindi, Luwero, and Nakasongo are coming to shop on Saturdays and Wednesdays. Other tailors have located along the neighboring highway where they have negotiated good rates with landlords. By the end of 2013, in the approximately 6 months that had passed since the tailors had received the start-up kit and shop space from RMF to start their businesses in the country, all 10 tailors were doing well and were making some kind of a profit.

RMF Country Director and team of Tailor Shop participants

Tailoring graduate in her own shop in Bweyale

UGANDA

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

Success Stories

Hairdressing and Beauty Therapy Program

Vicky Acayo

Vicky successfully completed the hairdressing and beauty therapy courses at RMF's Panyadoli Vocational Training Institute (PVTI). She expresses that before joining PVTI, she was mostly at home looking after her four children, supporting them through subsistence farming. She discovered PVTI when it was advertised in the refugee settlement through posters and one day during a church service through an announcement that there were vacancies in the program and that youths were encouraged to apply.

Vicky working on customers' hair at her salon in Kiryandongo

After graduation, she again began brewing alcohol to earn capital to start her own small business and finally managed to raise 200,000 Ugandan Shilling ($80), enough to purchase a few hair oils, tail combs, and a room for rent at the cost of 50,000 Ugandan Shilling ($20) per month. Vicky is now running her own *God Gives Beauty Salon* in Kiryandongo.

With bliss she says, that the skills she learned at PVTI have enabled her to care for her children after separating from her husband and their father. She has also employed three people to work as assistants in her salon, and has plans to expand her salon to a full service beauty house/parlor. As she told us, nowadays in Uganda, every woman likes to visit the hair salon and she is sure of customers coming every day. She is very grateful for the free education she received from RMF. Her dreams and vision are now very big: a better education for her children and a good standard of living.

Mary Media

Mary lives in Bweyale Trading Centre, and prior to attending Panyadoli Vocational Training Institute (PVTI), she was a stay-at-home mom with no source of income to support her struggling family. One day when she was going to the market, she noticed the poster advertising PVTI, and told her husband about the opportunity; he agreed it was a great idea to apply.

Mary with her home hair plaiting salon

When Mary finished her first semester at PVTI, she felt she had already acquired the skills to begin a new life with. While still attending Panyadoli Vocational Training Institute, she bought some salon equipment such as rollers, tail combs, and hair relaxers, spending about 50,000 Ugandan Shilling ($20), and finally settled on plaiting at home (home-based salon), sometimes going to her customers' homes to deliver the service. This gave her more time for practicing her skills after school and she could also charge her customers more affordable fees to attract them to her services. By graduation, she was already an expert and had already attracted many customers. Since her income was still fairly small, she felt it wise to take her earnings from plaiting and invest them in buying hens, cocks, and goats to sell them in a year for profit to reinvest in her hairdressing business. Her plan is to take the profits from this endeavor and open a salon at the Trading Centre where her current customers can find her and she can attract new ones. Also, she says, she plans to go back to school for further hairdressing training.

UGANDA

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

Florence Kabwimura

Florence Kabwimura had dropped out of school some time ago and worked as a barmaid to earn a living. She heard about Panyadoli Vocational Training Institute through OPM officers (Uganda Office of the Prime Minister) who had gone to the bar where she was working to relax after their work. They were concerned about Florence and told her about this vocational training opportunity, and she decided to apply for the hairdressing program.

After graduating in 2011, she was employed by the manager of the *Ladies Choice Salon* in the Bweyale Trading Centre at Nyamusasa Road. She says that the skills she learned from PVTI have enabled her to reach the standards of living of an independent life, and she has managed to save some money with future plans to open up her own salon.

Florence at work as manager of a salon in Bweyale

<u>Tailoring and Garment Cutting Shop Program</u>

Auma Santa

Auma at work in her own shop

Auma Santa operates an overlocking machine that runs on a generator, sewing ladies' skirts in her own shop. She started by herself and one other employee; now she has five additional assistants as students in training. Auma is a very hardworking businesswoman and is progressing rapidly as seen from her product demands. Her profit has increased from 300,000 Ugandan Shillings ($120) to 600,000 Uganda Shillings ($240) per month. She also receives revenue from the income of her students in training.

Rose Nekesa

Rose Nekesa operates two sewing machines, one provided by RMF and one by another NGO, and has been very successful in her business operations. She began by herself, but now is training students. Each of her students gives her 3.25% of their income per activity. Her business start was tough but she was persistent and is now beginning to realize profits in her business, ranging from 100,000 Ugandan Shillings ($40) to 150,000 Ugandan Shillings per month ($60), training other tailors and employing others in her business.

Paying school fees for her children is easy now. She has fine-tuned and developed her techniques in many of the designs requested by her customers. She is now saving for the future.

Rose operating her sewing machine in her shop

UGANDA

INITIATIVES ■ Congolese Refugee Support

Assessed emergency situation at Bundibugyo Refugee Settlement

Purchased and delivered medicine and supplies for Refugee Health Clinic

Congolese refugees overwhelm the staff at Bundibugyo Settlement

Congolese Refugee Crisis

The fighting in the Democratic Republic of the Congo (DRC) in early 2013 drove an influx of more than 65,000 refugees into Uganda and the situation continues to be extremely challenging. There is no water, sanitation, healthcare, shelter, or roads to support these people and all repatriation processes have been halted. The establishment of additional shelters, water sources, communal kitchens, start-up vaccination for under-five-year-old children and support to existing health centers have been ranked as urgent priorities. The refugees are camping at the Bundibugyo and Kyangwali Refugee Settlement areas at Bubandi sub-county headquarter land. In the course of 2013, most of the large international NGOs have left Bundibugyo. Even the International Red Cross has almost entirely withdrawn from the camp. Currently, Malteser International is in charge of health, and UNHCR and OPM (Uganda Office of the Prime Minister) are operational at the transit center. Very basic needs of the refugees (soap, clothes) are no longer met. The OPM and UNHCR identified challenges and opportunities surrounding the continued provision of services, and in August 2013 RMF Uganda was asked by the Bundibugyo Camp leadership to support the supply of urgent medicines and medical supplies to help fill significant gaps in healthcare provision to the refugees.

The camp is erected near the Bubukwang Health Centre III; this is where any donated drugs go and where treatment is carried out. As the health center buildings are few compared to the large number of patients, tents were erected to act as wards. Since the camp is located in a swampy, wet area, all of the tents are prone to flooding when it rains, rendering it wet and very cold for those living within them, especially at night. The majority of the Congolese adult and child refugees are not immunized, either because they were living in very remote areas of the DR Congo where government health facilities are not located, or because they were too poor to afford the private sector clinics. Many also have little to no knowledge of TB, Malaria or HIV/AIDS. Most refugees interviewed still treat themselves with traditional herb remedies. In the later part of 2013, an immunization program was put in place at the settlement to immunize all children below 5 years.

RMF Uganda provided a large consignment of medicines and medical supplies to Bundibugyo Camp in October 2013, and in late 2013 we have received renewed urgent requests from the Ugandan Office of the Prime Minister and the leadership at Bundibugyo Camp to continue our support into 2014. The situation remains desperate, especially for small children and pregnant women.

Medicine supply tent at Bundibugyo

Organized games for children at Bundibugyo

UGANDA

INITIATIVES ■ Boarding School and Orphanage Support

Full operational support of school programs and 400 students

New Construction Project started with 4 new buildings planned

Students at Mama Kevina with sports achievement certificates

World Children's Fund Mama Kevina School, Tororo

Background

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

2013 Update:

Continuing in 2013, the World Children's Fund (WCF) and RMF provided financial support to the school's monthly operational funding needs. This funding is being used to cover the school's various operational expenses, enabling it to significantly raise the level of academics and support for the students and orphans, and also facilitating the school to attract more paying students. Starting in December of 2013, a new WCF supported construction project began that includes a major upgrade of the campus infrastructure with four new buildings: Classrooms, Multipurpose Dining Hall, Girls' Dormitories, and Boys' Dormitories. These new buildings will significantly increase the school's capacity and thus the possibility to accept a greater number of paying students to help subsidize the support of the orphans. Our long term goal is to guide WCF Mama Kevina School towards self-sufficiency and to establish a school model that can be replicated. RMF's work in 2013 also included:

- Support of the school administration in payment of staff salaries and the daily running of school programs;
- Supply of school text books, laboratory and chemistry equipment for science practices;
- Supply of computers to equip students and staff with computer skills and knowledge;
- Provision of nutritious food for the students of WCF Mama Kevina School and support of the school garden to reduce food expenses;
- Procurement of medicines and medical supplies for the school clinic and payment of the clinic staff's salaries so that the school nurses and medical officer can treat the children within school premises and educate them on good health behaviors, thus significantly reducing morbidity, i.e. cases of malaria among school staff and students;
- Providing the students with the tools for extra-curricular activities to participate in the regional games and sports to enhance the performance of the students and the standing of the school in the region;
- Support of the local youths in the surrounding poor areas.

One of the WCF Mama Kevina School students won a gold medal in the International World Games and Sports in Moscow. Our students are also gaining notoriety in the eastern region of Uganda, with several students doing very well in regional games and sports. Some of the students have been performing so exceptionally well in tournaments that they have been approached with sponsorships and athletic scholarships.

RMF's New Construction on campus

Song and Dance competition

Students during a lunch break

UGANDA

INITIATIVES ■ Sports Academy

Sports Academy for Children and Youths

Provision of supervision, equipment, food and medical care

Sponsored sports camps and tournaments

Sponsored team wearing uniforms provided by RMF

Buwate Sports Academy

Background

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

2013 Update:

- Buwate Sports Academy team members and members of the community received sportswear and sports shoes, clothing, soccer balls and other general and sports equipment, such as goal nets, training kits for girls, and charcoal for cooking.
- Celebration of International Women's Day in Buwate, coinciding with the goods distribution from a large container that Associazione Devoti Madre Teresa Per I Bambini had provided.
- Food was purchased and one afternoon meal provided for all 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 the children and youths were paid as needed, and first aid kits were distributed. Sensitization of the community on HIV/AIDS took place through regular outreach and education activities.
- Buwate Sports Academy has also managed to enroll 30 girls, who are playing football in our community. Given the nature of the Ugandan culture, this is quite unusual.
- Four of the children that attend the Sports Academy received partial sports scholarships to secondary schools through their talent in football/soccer.
- Transported the team to football exchange visits, i.e. the Lovena Sports Academy in Kireka.
- School fees are being provided as possible with available funding.


Clothing, shoes, and water bottles donated


Students show off their new gear


New uniforms for all the teams

KENYA

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

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

77,286 Patients treated in past year

Over 1,000 Pediatric patients per quarter

LDH Nursing Staff and mother and child patient of Pediatric Ward

Lodwar District Hospital, Turkana

Background

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

2013 Update:

After successful infrastructure repairs to the entire Inpatient Unit at Lodwar District Hospital, we embarked on ensuring the wards were provided with the emergency medical equipment and supplies necessary for a fully functioning hospital. For years, Lodwar District Hospital survived on very little emergency equipment, with wards having to share equipment across departments and frequently not having it available when most needed. Prior to 2013, the entire hospital had only two functioning oxygen concentrators, one suction machine, and one nebulizer. There were also very few working stretchers, wheel chairs and weighing scales. In order to bring Lodwar District Hospital up to the standards of a functioning and efficient emergency/referral hospital and to motivate staff to provide the best and most immediate care, we realized that we needed to purchase each ward its own independent equipment.

The renovated and resupplied Pediatric Ward

By the end of 2013 we are happy to report that the entire Inpatient Unit including the Pediatric, Male, Female, Maternity wards, the Operating Theatre and the Casualty/Outpatient departments are fully and independently equipped with their own emergency equipment. During 2013, the Pediatric wards also continued receiving their medical and emergency supplies from RMF, with MMI's continued generous support, thus enabling the wards to maintain the tendency our work had initiated in 2011: very low mortality numbers yet recording high and increasing numbers of patient visits.

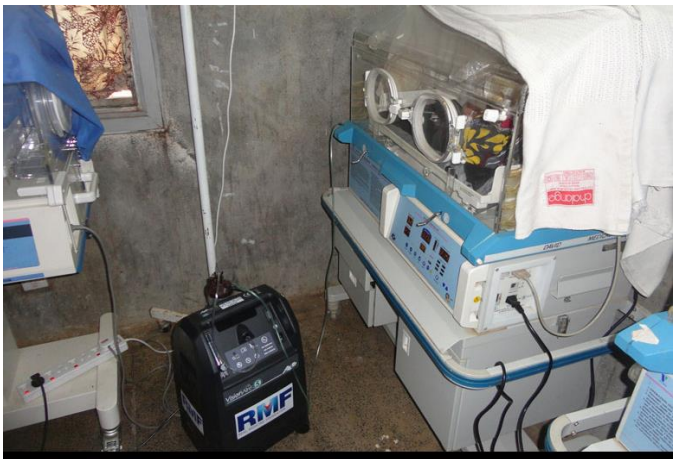
KENYA

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

Achievements in 2013 include:

- Male, Female, Maternity, Pediatric, and Casualty/Outpatient departments/wards as well as the Operating Theatres all received the necessary (emergency) equipment including nebulizers, oxygen concentrators, oxygen flow meters, suction machines, stretchers, patient weighing scales and wheel chairs to be fully and independently equipped.
- Pediatric ward patients continued to receive free high quality medical services including free medicines and medical supplies, and treatment for the third year running.
- We continued to ensure that the supply of essential and emergency drugs at the pediatric ward and non-pharmaceuticals for the entire hospital was consistently maintained.
- Pediatric ward has continued to record low mortality numbers for the third year in a row.
- A new Occupational Therapy Department was created with equipment and supply provisions from RMF, following all the main ward infrastructure improvements, and recorded ***1,321*** patient visits.
- Physiotherapy and Orthopedic departments received infrared massagers and cervical collars.
- Suction machines, skeletal traction equipment, amputation sets, external fixator sets and hand drills were purchased for the Operating Theatre.
- As a result of the above, Lodwar District Hospital registered a large increase in the number of patients visiting from ***35,967 in 2012*** to ***77,286 in 2013*.**
- RMF/MMI activities at the hospital were recognized and appreciated by the Provincial Ministry of Health team that visited Lodwar District Hospital for their yearly assessment in March 2013.

LDH Nurses testing suction machines newly provided by RMF



RMF Oxygen concentrator used with incubator in Maternity Ward

Success Stories

Losekon Lobei

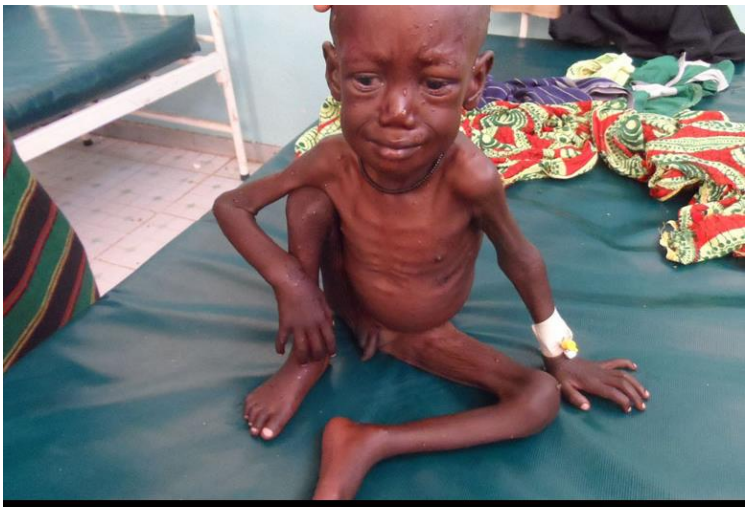
Losekon is a 2-year-old boy from Karukoi village in Kerio division, the third born in a family of three children. He is raised by his father, a herdsman, as his mother died after being shot at when Losekon was only four months old. Losekon was brought to Lodwar District Hospital severely malnourished and with vomiting, bloody diarrhea, sunken eyes and loss of skin turgor.

Losekon was immediately admitted to LDH's Pediatric ward for emergency treatment and then enrolled in our nutrition program, free of charge. Losekon was discharged after four weeks of treatment at the Pediatric ward, stable, healthy and happy. Losekon's father commented:

"I am so grateful to the hospital and the donors that are providing this treatment for free to our children. I am a herdsman, with no income; I would never be able to afford to purchase these drugs for my son. Thank you for treating and healing my son."

KENYA

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



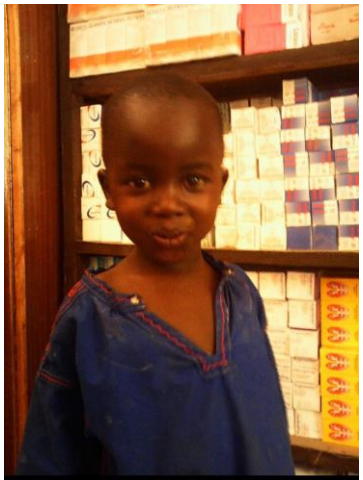
Losekon Lobei upon admittance

Losekon on day of discharge

William Ekiru

William Ekiru is an only child and orphan, both his parents died due to AIDS. This was his second admission to Lodwar District Hospital, dehydrated, weak and wasted. He was also suffering from scabies, making it difficult for him to urinate. William was diagnosed with TB, severe malnutrition, and HIV. He had been under the care of relatives who sadly were mistreating him, even eating his food during his last stay at the hospital. Upon admission this time, William was retained at the hospital and stayed under the hospital's care, to protect him from abuse and ensure his recovery.

William Ekiru on admission at the Pediatric ward



A healthy Ekiru after treatment

William weighed 7.2kg on admission and had a MUAC of 10.3cm. In addition to his treatment for TB, he was started with F-75 formula and graduated to F-100 formula after three days. RUTF (Ready-to-Use Therapeutic Food) was given to him for one month. He was then put on a plumpy'nut-soy food product. His improvement was drastic.

KENYA

INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics

Reached a target population of more than 106,100

19,122 Patients treated at Health Clinic and Mobile Outreach Clinics in remote areas

23,747 Cases managed

118 Mobile Clinics held

Health education outreach in Lodwar District

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.

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 more than 48,000 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 5th 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.

2013 Update:

The continued quality and regularity of medicines and medical supplies provided by RMF this past year has allowed the health clinic and mobile outreach clinics to be conducted and maintain a high level of service. Our clinic staff serves all villagers who come for treatment, but we see an especially high number of children and pregnant women. An average of eight mobile clinics has been conducted each month, reaching the most remote regions of Turkana, with the target population being able to access our services now at more than 106,100 people. The mobile clinics saw an average of over 1,500 patients per month, and at our permanent clinic over 500 patients per month were treated.

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.

Community Health Worker with clinic medicine supplies

Achievements in 2013 include:

- **19,122 patients** were treated and **23,747 cases** managed during 2013, an **increase** of **27%** compared to 2012. These numbers were higher because of many factors, including focus on service delivery to even more distant rural villages, word-of-mouth marketing among the villagers, informing each other about the availability of medical care, and continued availability of medicines and supplies.
- Added medical personnel to increase human resources in service delivery to our patients; we now have five fulltime clinic staff members.
- Vaccination program. Previously, mothers living in and near Lodwar used to take their children to Lodwar District Hospital for immunizations, and those living in remote rural villages didn't have access to immunizations for their children. Since 2013, we are offering this service both at the permanent Lodwar Clinic and during mobile outreach clinics to the rural villages.
- The Lodwar Clinic used to be in darkness without electricity, but through RMF funding, it received electricity. The supply of electricity has enabled several things to occur in the clinic such as immunization (requiring refrigeration for the vaccines), laboratory testing facilities and night lighting for emergencies and security.

KENYA

INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics

- Laboratory services at the Lodwar Clinic have enabled the swift and accurate diagnosis of illnesses for our patients. Previously, care had to be based solely on the clinical diagnosis which had limitations, frequently forcing us to refer patients to other health facilities for lab diagnostics. Having lab services on clinic grounds has been a great stride forward in providing comprehensive care to our patients.
- Ambulance services have remained available continuously, the mobile clinic vehicle was kept in good condition by servicing it on a regular basis and at any time mechanical problems would arise.

Asha Chalangat

Asha before surgery

In July 2013 we encountered a patient needing urgent help. Asha Chalangat, 6 years old, had a large tumor on her left jaw that extended to her left ear. Asha's grandmother reported that the tumor was first noticed when Asha was two years old, and it had continued to grow ever since. She began having pain, reduced hearing, and cosmetic challenges brought by the tumor when interacting with other children in the village. Asha had stopped even going to school due to bullying from other children there. Before our encounter with the patient, her grandmother with whom Asha is living told us how she had been going from one organization to another seeking funds to take the child for treatment, but all in vain. Moreover, she is the only bread winner for the family and was trying to provide by selling firewood that she collected from the bush about 4 miles from Lodwar town. Asha's mother was pregnant with her while in school as a young girl herself, and after giving birth she had moved away and broken off contact. Asha was left with her grandmother when she was one and half years old.

Seeing the need of this patient, we considered how to best help her. We referred Asha to Moi Teaching and Referral Hospital for surgery and covered the costs. In that hospital she had several evaluations and then a definitive surgery. Post-surgery Asha is a joyful little girl and her life seems to be starting anew. She has resumed schooling and is in good health now. Her grandmother expressed tears of joy for the good care Asha received from RMF's International Health Programs in planning and paying for her medical/surgical care.

Asha after surgery

Malnutrition

Handing out food supplies

The Lodwar Clinic program is not limited to provision of medical care to the patient but also addresses other human needs such as food and water. Rural communities in Turkana are poor and most of the time the sick that come for treatment are hungry because they have no food to eat. This makes it hard for such patients to take medicines.

So far the program has tried to meet this need by buying food to cater to such cases during our mobile outreach clinics in the remote villages of Turkana and for those patients staying under observation in the clinic while on treatment. This provision has benefited countless patients who could have died due to lack of food while on treatment.

KENYA

INITIATIVES ■ Drought Relief ■ Primary Health Care ■ Mobile Clinics

Vaccination Program

The provision of Maternal Child Healthcare services is rare in most parts of Turkana. The main reason for this is the scarcity of health facilities in the region. Before our program started providing healthcare services to Turkana's very remote rural villages children and expectant mothers used to go without immunization or travel very long distances, usually walking many miles to Lodwar District Hospital to seek these services. Children typically grew up without being immunized against immunizable and thus preventable childhood diseases. Many older children and adults had not been immunized either. RMF has brought vaccination programs to the most remote villages of Turkana, immunizing especially children and expectant mothers within our coverage area, a target population of more than 86,900 people. This started to and will continue to effectively minimize and, hopefully, eliminate mortality, deformities and diseases related to childhood immunizable diseases.

Child receiving oral immunization in rural village

Malaria and Typhoid Fever

By Clinical Officer Derrick Lowoto:

The availability of medications has enabled some of our more complicated cases to be treated in our Lodwar Clinic. This has benefited many patients that are not so ill as to warrant admission. All this has been made possible through RMF support and funding that has enabled the team at the Lodwar Clinic to purchase medications on a monthly basis. It has also allowed us to employ well-trained and experienced laboratory personnel to provide various important tests. Additionally, the program can offer referral from the remote villages in Turkana to our clinic or to other secondary and tertiary hospitals in the country. With the RMF partnership, medical bills incurred by the very poor patients can be paid. This has greatly benefited the rural communities within our area and beyond.

Patient being treated for severe malaria and typhoid fever

Initially communities living in the rural villages had difficulty accessing health services, but since RMF entry into these communities, things have changed. All medical cases are treated on site by our five staff members or referred to other health facilities for further management. Staff interest and commitment to patient care has enabled the program to enter into these communities, and our service is felt within our reach and beyond. The rural communities who are the beneficiaries have all rejoiced for the good RMF has done to them to bring medical services near to them.

In our recent interview with a former beneficiary, she expressed praises for bringing RMF to offer services in her community. She recalled how she had severe malaria and typhoid fever and had no money to go to the hospital. But due to the presence of our healthcare outreach program in her village she was driven many miles to Lodwar District Hospital for admission and was discharged healed after five days. The program paid her medical bills. The communities within our reach pray for a long life for RMF.

KENYA

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

32,930 patients treated

96% of women in the area are delivering in health facility

643 babies safely delivered

160 Kenyans employed through various programs

Lwala school girls participating in a mentoring session

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 and other diseases contribute to a significant infant, child and adult mortality rate; i.e. more than 30% of the children in the Lwala primary school have lost one or both parents. The official HIV prevalence in the province is 15.1%; the prevalence in the county is 20-24%. These rates are the highest in Kenya.

Background

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

2013 Update:

- Average number of monthly patient visits increased from 2,600 in Q3 to 2,755 in Q4. Year-end statistics indicated that there were 32,930 patient visits in 2013 (compared to 24,026 in 2012).
- Clinical officers have been conducting daily rounds and ensuring proper documentation of all the procedures done to the patients.
- There were a total of 643 deliveries at the Lwala Community Hospital in 2013. 96% of women in the area are now delivering in the health facility.
- The average monthly deliveries at the Lwala Community Hospital was 44 in Q4, an average of 10-20 deliveries less than previous quarters but typical for this time of year across the history of the organization; this could also potentially indicate an uptake in family planning methods.
- A Maternal Child Healthcare nurse followed up with 18 malnourished, under-5 children who are on a supplemental feeding regimen. All 18 children were identified to be improving.

One of the children born at the hospital

- Youth friendly clinics are ongoing twice a month (one at the hospital and one in the community). 469 youths were reached with family planning education and services in Q4.
- Lab moved to a new location and was equipped with upgrades, giving enough space to improve infection control by clearing patient congestion in the waiting area. Old lab transformed into space for family planning services and VMMC.

KENYA

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

- The Hepatitis B laboratory test was introduced to patients.
- 943 persons tested and counseled for HIV, 25 new patients enrolled in HIV care, all staff participated in World AIDS Day event.
- Activities to expand and improve quality of HIV programming continued, including restructured and ongoing medical education trainings and development of HIV clinical care protocol.
- In an effort to further improve access to the Lwala Community Hospital and facility infrastructure, i.e. graveling on a stretch of the road to Lwala was completed by the local government and is now improved for all weather conditions.
- Installation of broadband internet facilities completed by Datapath team; Safaricom internet hooked up.
- Several initiatives were undertaken to expand and improve quality of education programs.
- Salama Pamoja ("Safety Together": a program to reduce gender based violence) mentoring meetings with in- and out-of-school girls continued (36 in-school girls and 45 out-of-school girls). Five out-of-school girls were willing to go back to school and one has reintegrated in Form One at Tuk Jowi Girls' Secondary School.
- In October, a 2-day workshop was held for the out-of-school girls. The group recapped the topics covered to date through drama, skits, and role plays. Girls were then educated on family planning, business ideas/development, and the importance of girls' education.
- In November, special mentoring was conducted at Tuk Jowi Primary School for classes 5-7 with boys and girls separately. This was upon the health club patron's request who felt the students were at risk since they were sexually active.
- All six of planned six water tank installs for 2013 were completed by the end of Q4; all 13 local primary schools now have access to clean drinking water. Kameji, Andingo and Kunu Primary Schools completed latrine construction; Tuk Jowi Primary School is near completion on six latrines. WASH training for school health club members was held in December with 21 students attending.
- Regular health club meetings in schools are ongoing. Health club patrons in all schools were trained on counseling skills in order to identify and support students with emotional and other problems.
- 29 sponsored students are continuing with their high school education. Meeting with secondary school sponsored students took place in November. Six students were rewarded for exceptional academic performance. Sponsored students reported to various Lwala Community Alliance departments for December community service.

Success Stories

In Her Own Words: Lillian Anyango

Lillian (right) and Sheila (middle) with the twins

"My name is Lillian Anyango, and I live near Lwala, Kenya. About one year ago, I gave birth to two healthy babies. The boy, Geoffrey, was named after his ancestor, and the girl is called Valery. Taking care of twins is not easy; they behave like they have one brain. When one is awake, the other is also awake. When one is crying, the other is also crying. The boy is more aggressive and stronger than the girl, and both compete for my attention. I am proud to be their mother.

In my community, many women give birth in their huts without anyone with skills to help. Early last year, some people working with the Lwala Community Alliance started visiting all the pregnant women they could find. They are called the Community Health Workers. One of these workers named Sheila came to me when I was 6 months pregnant. Because I was carrying twins, my pregnancy was difficult, and I could not sleep well because of stomach discomfort and back pains. Sheila would come visit me three times a week to see how I was faring on. Over time when the problems increased, she would check on me twice a day.

Sheila encouraged me to go to the Lwala Community Hospital for check-ups. On the day when the labor pains started, I immediately went to the hospital because Sheila had taught me that the complications I had been having could get worse if I attempted to deliver at home. Sheila and the community health nurse came to check on me when they heard that I had come to deliver my babies. I had difficulty during my labor, and my blood pressure became very high. Sheila and the nurse called it eclampsia and rushed with me in the ambulance because I needed to go for

KENYA

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

a Caesarian. I then was able to safely deliver my twins. I feel great to have these two babies because it is not easy to give birth to twins. Since they were born, I haven't seen them get seriously ill except for the normal diarrhea that kids get when they are getting to a different development stage like crawling, sitting, and standing. I still take them in for check-ups and shots at the Lwala Community Hospital.

The Community Health Workers have been very friendly, loving and caring to me and are committed to their work. Even after I had given birth, they kept on visiting to check on me and my babies. Sheila also calls me on my phone often to find out how I am doing. If the Community Health Workers hadn't given me good information about how to deliver safely, I am not sure that the outcome would have been the same."

Beneficiary profile: Benta Auma Ouko

Benta Auma Ouko is a mother of six and a grandmother of one. Several years ago, Benta was a peasant farmer earning an annual income of approximately $465 from sugar cane farming and maize produce. As a result, she was having difficulty meeting her and her family's basic needs and at times was doing casual labor at people's farms in the community in order to bring in additional income.

In 2010, Benta enrolled for the first WASH (Water Sanitation and Hygiene) training and was among the first group of graduates. The training participants were taught how to keep water safe for drinking and construct ventilated pit latrines and discussed the importance of hand washing. Participants also learned a new simple technology of using empty bottles as tippy taps (hand washing stations). After completing the training, Benta went back to her home armed with this information and began implementing what she had learned one step at a time. Before the training, her children were prone to diarrhea and consequently missed school quite often. Benta used the little money she earned from her farm to treat her children, which often put a strain on her household budget.

Over the next 3 months, the WASH Coordinator noticed Benta's application of WASH theory at her home and proposed that she attend the WASH Trainer of Trainers (TOT) course, making her a trained Community WASH Mobilizer. In July 2010, an intern from the US visited Lwala and trained a group of six community members, including Benta, how to make bar soap for local sale and use since latrines were now being constructed in the community. These community members then formed the Furaha Soap Making Cooperative, which over the last 3 years has increased its profits from the production and sales of soap to the hospital, local schools, and individual community members. The cooperative has also diversified its production to include liquid soap, disinfectants, and hand washing products that they sell to markets both in and outside of North Kamagambo.

Currently, Benta has a steady income from WASH trainings as a TOT facilitator in the community and sales from the Furaha Soap Making Cooperative. Her children consistently attend school with zero incidence of diarrhea infection. Benta is informed and knowledgeable on health issues that are curable with proper sanitation and hygiene. If the WASH program had not started in Lwala, she would still be where she was 3 years ago. Benta's vision is to cover North Kamagambo with WASH messages and for community members to implement WASH practices to be free of waterborne diseases.

Benta with several of her children


Benta uses a tippy tap to wash her hands

MOZAMBIQUE

INITIATIVES ■ Mobile Clinic Project

20,589 patient consultations and treatments

Target population: 12 districts in Zambézia Province, 2.5 million people

Families wait to be seen at a Mobile Clinic Outreach

Mobile Health Clinic Outreach

Background

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

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

The target population includes 12 districts (Alto Molócuè, Chinde, Gilé, Ile, Inhassunge, Lugela, Maganja da Costa, Morrumbala, Mopeia, Namacurra, Namarroi and Pebane), comprising approximately 2,500,000 people. Starting in 2012, a revised strategy was implemented for the increased and enhanced utilization of the Mobile Clinic, integrating it within the CDC/PEPFAR-supported HIV care and treatment services supported through Vanderbilt University/FGH. RMF funding, together with CDC/PEPFAR support for the Mobile Clinic operating in Namacurra District, has allowed our teams to deliver quality HIV/AIDS care and treatment services to the populations in four extremely isolated sites in 2013. The direct target population for the Mobile Clinic in 2013 included the communities of Mexixine, Malei, Furquia and Mbawa in Namacurra District and the health staff supporting the implementation of services in those MOH health facilities.

2013 Update:

In 2013, the Ministry of Health of Mozambique officially integrated the RMF Mobile Clinic in Namacurra into the strategy to support implementation of the very ambitious national ART acceleration plan. During the year, implementation of the "Option B+" strategy and World Health Organization guidelines to initiate ART to all children under 5 years of age determined the focus and direction of the Mobile Clinic in Namacurra District. The number of health facilities providing ART in Namacurra increased from 2 to 7 in 2013, including the 4 supported by the Mobile Clinic during the course of the year, Mexixine, Malei, Furquia and Mbawa. With additional funding support from CDC/PEPFAR, the RMF Mobile Clinic addressed the most common health problems observed within the targeted region, such as Malaria, Malnutrition, Diarrhea, HIV/AIDS and Tuberculosis. An additional focus of the Mobile Clinic during 2013 was to support the ART acceleration plan in Zambézia; services included:

MOZAMBIQUE

INITIATIVES ■ Mobile Clinic Project

- The Mobile Clinic continued ART expansion to remote communities, advancing to Furquia after leaving Mexixine and advancing to Mbawa from Malei. A total of 20,589 consultations were done by the Mobile Clinic team in the past year.
- In addition to 8,275 people benefiting directly from activities implemented by the Mobile Clinic during 2013, the extent of benefits to family groups participating in Mobile Clinic activities indicate that up to 12,314 people also benefited from education and outreach efforts focusing on vaccinations, maternal and child healthcare, HIV counseling, and ART and TB medicine adherence.
- HIV services, including monitoring and quality control at the point of service delivery, prophylaxis with Co-trimoxazole (CTZ), prophylaxis with Isoniazide (INH) and initiation of ART.
- Clinical WHO staging of HIV and clinical management of opportunistic infections.
- Health counseling and testing, including distribution of male and female condoms.
- HIV counseling and testing for pregnant women and HIV positive women for PMTCT.
- Psychosocial support and positive prevention packages for HIV positive patients.
- Community linkages for treatment adherence.
- STI screening and treatment.
- TB services, including screening, treatment and follow-up.
- Collection of blood and other biological samples for analysis and transport to the laboratory.
- Transport of samples of TB sputum smears, collected by Community DOTS (directly observed therapy) volunteers and Mobile Clinic staff.
- Mothers to Mothers (Mães para Mães) support group started for HIV+ mothers, aiming to help meet the special needs of HIV positive pregnant and lactating women and their babies by offering a venue for psychosocial support, mutual assistance and education.

"Mothers to Mothers" Support Group gathered in Mbawa

Other services included in the support package that the Mobile Clinic provided are:

- General clinical consultations (adults and children).
- Rapid testing for Malaria and HIV.
- Basic First Aid for medical emergencies.
- Referral of patients to health facilities according to clinical needs.
- Evaluation and nutritional supplementation for children and adults.
- Support for DPS-Zambézia in health-related events/health fairs.

Dispensing Medicine to patients from Mobile Clinic

NIGERIA

INITIATIVES ■ Primary Health Care

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

More than 30,700 patients treated

Lab and Dental services

Nurse consulting with patient at Gure Model Healthcare Center

Gure Model Healthcare Center, Baruteen LGA

Background

Nigeria's child mortality rate of 124 per 1,000 for 2012, while improving over the past few years, is still ranked among the 10 countries showing the highest child mortality rates of all 191 countries tracked by the World Health Organization. Nigeria's maternal mortality rate also improved but still stands at a high 560 per 100,000, also among the highest rates in the world. Real Medicine Foundation, supported by World Children's Fund, has partnered with the Kwara State Ministry of Health, the Nigerian Youth Service Corps and the Gure Gwassoro Ward Development Committee to support the previously abandoned Gure Model Health Center. Situated near the Nigeria/Benin Republic border, this health center is the only access to healthcare for a population of over 154,000 in the Baruteen Local Government Area and its surrounding towns. Patients continue to cross the border from the Benin Republic to seek treatment here.

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

2013 Update:

Because of RMF's presence and the provision of comprehensive, high quality medical services, the Gure Model Healthcare Center continued to experience rising patient numbers in 2013. 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 continued the provision of regular supplies of laboratory reagents to conduct basic laboratory tests, thus facilitating more inclusive, comprehensive health care delivery versus the previously necessary referral to the state hospital. We also maintained our focus on good relationships between the community and all involved parties and stakeholders.

Patient being seen at the ANC Ward

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 regularly seeing more than 2,700 patients per month. Services provided include:

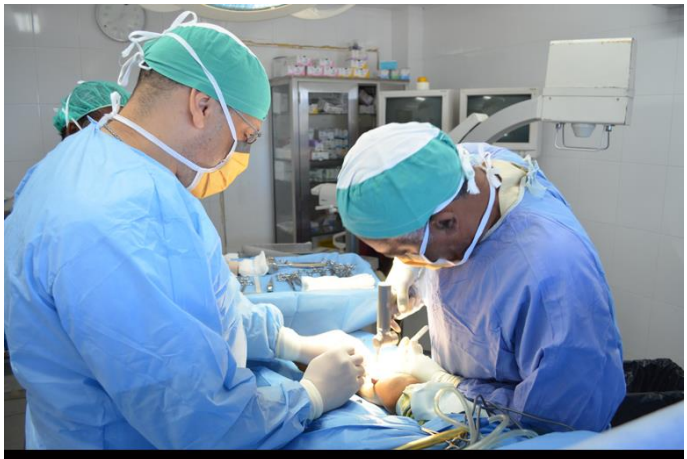
- Primary Healthcare, Family Healthcare
- Maternal and Child Healthcare
- Community Outreach and Training
- Weekly Immunizations for newborns and infants
- Dispensary for Medicines
- Malaria treatment
- HIV/AIDS support
- Management of systemic diseases such as Hypertension and Diabetes
- Dental care

HAITI

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

Surgical Support Program

Hospital Equipment and Supply Support



RMF's Dr Patrick Dupont performing orthopedic surgery

Background

In the aftermath of the January 12, 2010 earthquake, in addition to tackling some of the immediate relief needs, RMF moved forward with a comprehensive long-term strategy for sustainable health services development in Haiti to help rebuild its shattered public health system.

Our work during the initial weeks was focused on the provision of medical staffing, medicines and medical supplies and strategic coordination to help meet the surging needs of the health crisis on the ground.

For all of 2010 and much of 2011, RMF provided free clinic services at Hôpital Lambert Santé 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 healthcare to patients in need of primary, secondary and even tertiary care. We were able to provide for more than 1,800 consultations and 450 surgeries over this time frame.

Four years have passed since most of Haiti's infrastructure was devastated, and while much progress has been made in rubble clearing and somewhat in rebuilding efforts, there is still much work to be done. Social and healthcare status remain dire despite the proliferation of primary care clinics all around the most affected areas of the country and more so in Port-au-Prince. While a very positive initiative, giving more people access to basic care, sadly the effort remains disorganized and unstructured and not defining a clear and continuous pathway for the patients in search of diagnosis and treatment; secondary and tertiary care is still desperately lacking.

Surgical Support Program

RMF continued our Surgical Support Program in Haiti that we had started in 2012, providing complex surgeries and longer term follow up treatment for children and adults suffering from chronic or acquired orthopedic conditions, ranging from congenital deformities to posttraumatic impairments, in many cases caused by the January 2010 earthquake. Over the past two years, generously supported by Child Survival Fund, Real Medicine Foundation has been able to provide specialized orthopedic care and follow up treatment for 40 children and adults who were desperate for treatment of their posttraumatic or congenital ailment, preventing them from thriving or taking care of responsibilities and their families' needs.

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

In 2013, in addition to following up with the 2012 cases, the program concentrated on children with lower limb deformities and patients with severe conditions and deformities, focusing on improving their overall health, functionality, and optimizing their chances to thrive as active members of their communities. There were five young children selected who were all affected with a fairly common lower limb deformity known as Blount's disease, afflicting them with increased weight and specific morphologic features, including moderate to severe progressive medial leg bowing and tibial bone changes. After careful screening by a dedicated surgical team including two orthopedic & trauma surgeons and an anesthesiologist, the patients were prepped for their surgeries, which were then performed at the Lambert Santé Surgical Clinic in Pétion-Ville, through an ongoing collaborative effort with RMF dating back to the early weeks after the January 2010 earthquake. Some of these surgeries were conducted with the help of Dr. Kaye Wilkins, a renowned pediatric orthopedic surgeon from San Antonio, Texas, and longtime collaborator of the Haitian orthopedic surgeon community. He was able to graciously donate some of his time and expertise to procure astute treatment to our most severe cases of this disease.

HAITI

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

Success Stories

Josefina Saint-Louis

Josefina Saint-Louis, 8 years old, our second youngest patient, suffered from a moderate right proximal tibia deviation resulting from Blount's disease, while her other limb was insignificantly affected. With a lateral closed wedge osteotomy, we were able to correct her tibia to offer her a more anatomically aligned lower limb while relieving pressure on her medial growth plate, hopefully impairing the disease's chance to progress. Josefina, due to her being overweight, a usual component of Blount's disease, is still in physical therapy and not yet allowed complete weight bearing until her osteotomy has completely healed radiologically.

Julien Edouard

Julien Edouard, 12 years old, was one of our heaviest young boys in the group, weighing close to 115kg. A classic textbook case of Blount's disease (obesity, specific morphotype and bilateral deformity), overweight and having lower limb deformity which impeded significantly his day-to-day activities, prevented him from practicing any sport. We had to address one limb at a time and performed a corrective high tibia valgus osteotomy procedure on his right leg and with some over-correction. Two months after surgery, he was already showing radiologic signs of bone healing. Weight bearing has been allowed already and Julien is very happy with his surgery and the overall appearance of his right leg now. He is hoping that he will have the chance to have his other leg corrected, too, as he is looking forward to being able to practice a sport that he likes very much: soccer!

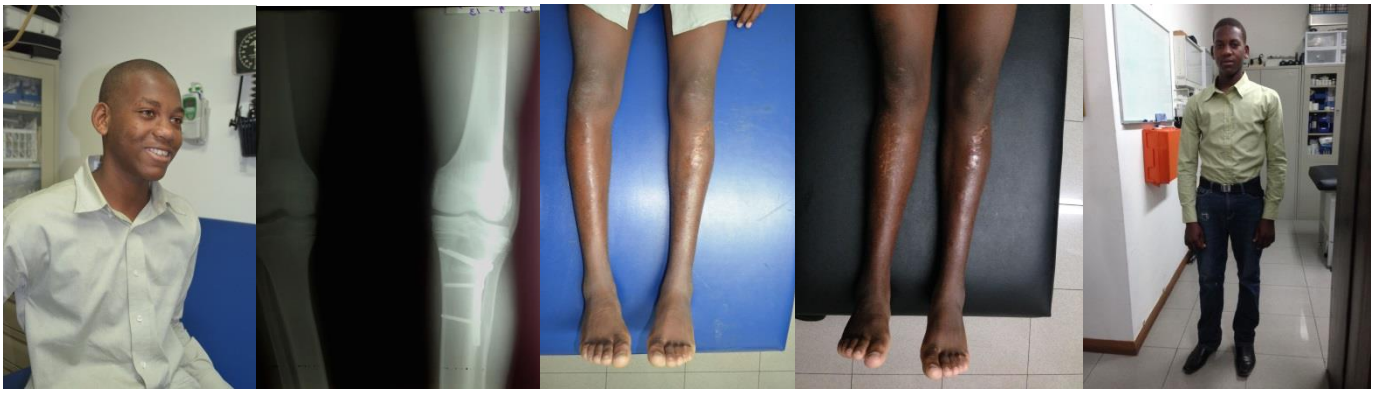
HAITI

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

Stevenson Francois

Stevenson Francois, 16 years old now, is a strapping young teen with a different outlook on life after his two knee surgeries. He underwent his second surgery for bilateral medially deviated legs in mid-2013. His first operation, done more than a year ago on his left leg, has healed with very satisfactory results, both anatomically and functionally.

Very happy with his first procedure, Stevenson is the first of our patients to complete his course of treatment for his bilateral condition as his second proximal tibia osteotomy was done with a bit of over-correction since this deviation was more pronounced on the right side. Now able to stand straighter/more balanced on his feet, Stevenson is looking forward to using his new found legs in sports activities as well as future work endeavors.

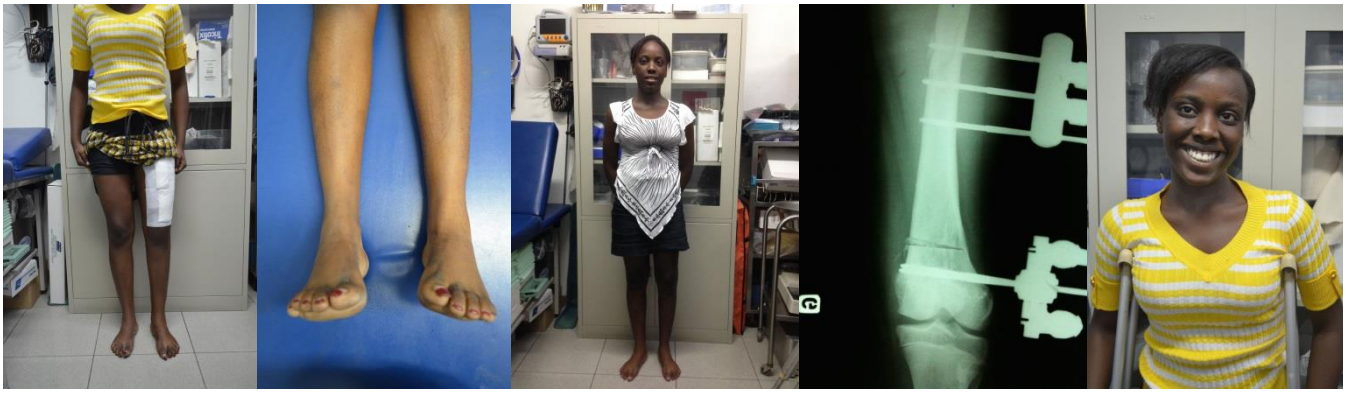


Cherley Etiene

Cherley Etiene, now 13 years old, was a young girl who came into our care more than a year after she was injured during the earthquake. She suffered from a closed distal femur growth plate fracture, which in the midst of all the emergencies being treated in the aftermath of the earthquake, failed to receive proper care. The resulting turmoil following this catastrophe prevented her to access adequate continuity of care and resulted, as these injuries sometimes can, in progressive deviation and shortening of her left lower limb, due to partial growth plate arrest.

She is by far the most operated on and the second patient in our program to complete her course of treatment. After a successful procedure in 2012 aiming to restore a more anatomical alignment of her knee joint with an external fixator, she managed to restore more than adequate knee mobility with an intensive physical therapy regimen. This year, we were able to complete her treatment course by addressing the more than two inches leg discrepancy she had left from her injury.

Through an escalator technique, we lengthened her thigh bone to recuperate the difference and provide her with an equal limb to the non-affected side. Cherley just turned 13 after her third surgery and is now a young girl, looking forward to all usual activities of teenagers and not afraid anymore of her appearance and gait. As she is continuing to attend physical therapy to strengthen her lower limb, she has already recuperated almost all of her previously attained range of motion. Her overall appearance has changed much since her first evaluation.



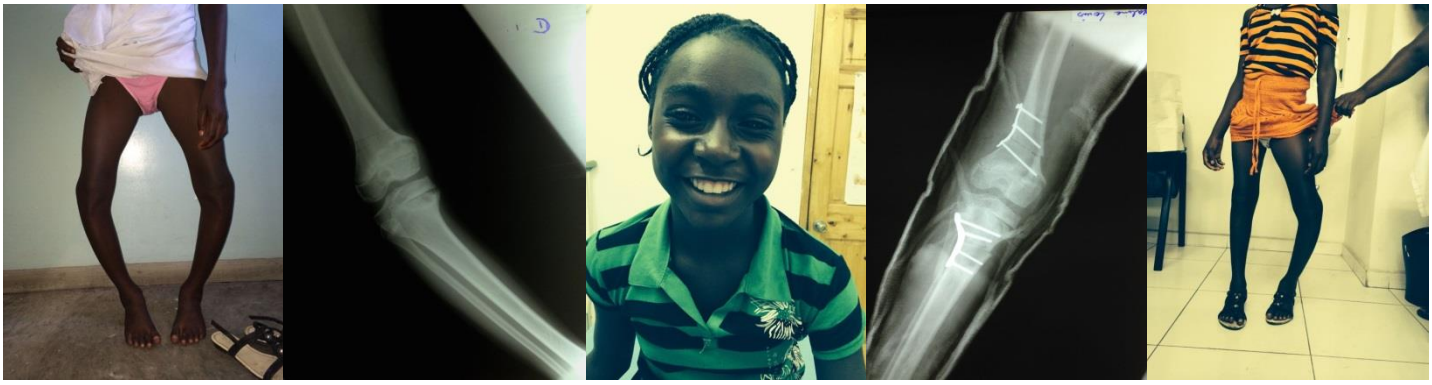
HAITI

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

Pédaline Louis

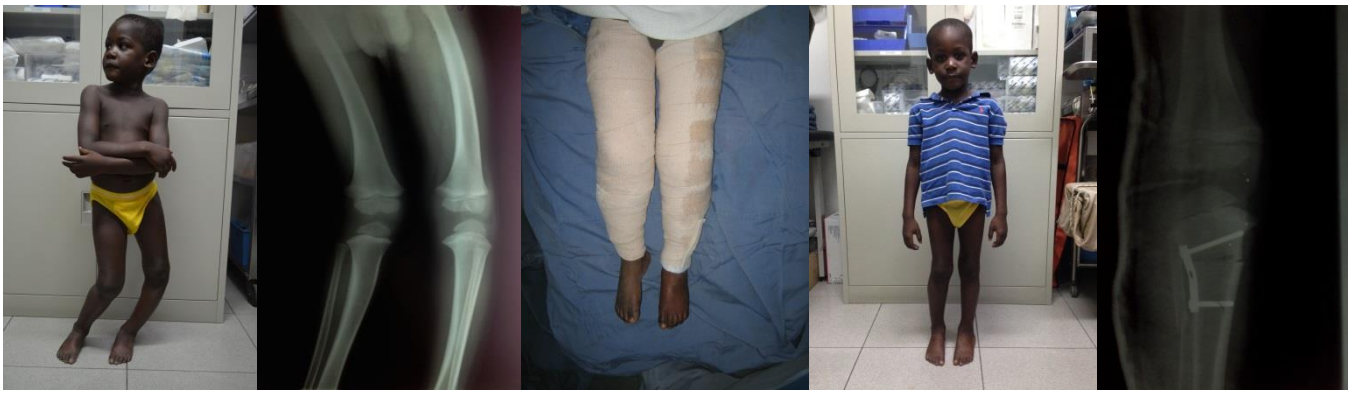
Pédaline Louis, 12 years old, this young girl from a very remote provincial town has been dealing with a very severe deformity as a result of a malnourishment syndrome (probably rickets) and shows overall visible signs of growth impairment. She was brought by very poor but concerned parents to St. Vincent's School in search of a solution. Her severe bowed legs are a result of changes in both her thigh and shin bone, giving her a duck walk gait, which sadly was source for much mockery by children in her hometown.

With the help of our surgical program, Pedaline underwent corrective surgery on both bones of her right lower limb, a double osteotomy re-aligning her severely deformed limb and was rewarded with a straight leg postoperatively, showing a striking difference.. Her follow-up x-rays showed a much better position of her knee joint and her smile at the removal of the cast after bone healing confirmation, spoke for itself. The very satisfactory results gave this young girl hope that she might be able to walk "normally" someday and stand straight. Her only wish is to see both her legs identical now.



Claudenson Alfred

Claudenson Alfred, 5 years old, was also suffering from a progressively acquired growth defect, referred to as "wind swept deformity", with severe bilateral and divergent leg bowing. His condition, of course, prevented him from emoting a normal childhood and exposed him to the same mockery as Pédaline. Because of his young age a bilateral approach was feasible and we were able to fully correct both his limbs in one surgery, leaving him with more anatomically correct and aligned legs. The healing process of his osteotomies was rapid because of his young age and allowed this young boy to be able to have his casts removed after only 6 weeks of immobilization. Without any rehab, Claudenson was soon normally ambulating and even running with his friends in his hometown. Upon follow-up three months after his procedures, Claudenson is now a happy boy, no longer, as he says "the kokobe" which means cripple, of his village.



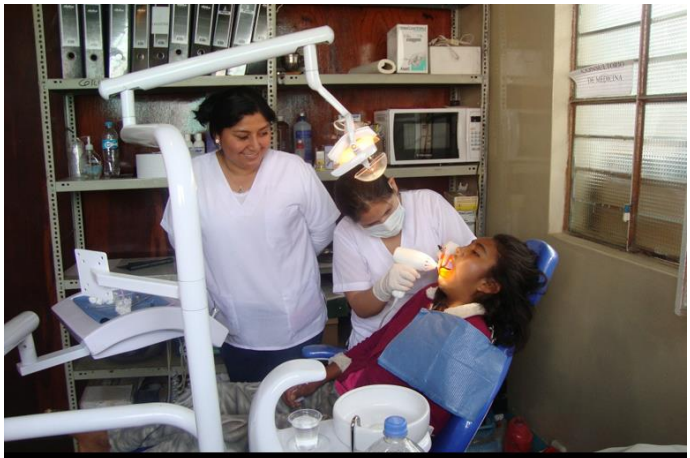
PERU

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

Serving a population of 30,000

14,631 patients treated

Ultrasound, Dental and advanced Lab services



Dental Campaign held at the RMF Clinic in Perú

Policlínico Peruano Americano in San Clemente, Pisco

Background

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

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

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

Dr. Hugo Tapia and RMF team with donated micro-centrifuge

2013 Update:

- An average of 61 patients per day are treated at our Policlínico Peruano Americano and during our team's medical and dental outreach efforts, representing all ages from newborn to 60+, with an average of 1,220 patients treated per month. In our dental camps 468 patients are being treated regularly; 2,812 dental patients were reached during the past year.
- 3,849 procedures were performed in 2013.
- Pap smear campaigns are conducted each month with an average of 31 women attending.
- 3 Medical Outreach Campaigns were carried out with a total of 321 patients seen.

PERU

INITIATIVES ■ Primary Health Care ■ Medical and Dental Outreach

- We held a free Medical Outreach Campaign with RMF CEO, Dr. Martina Fuchs on Saturday, July 27th in Pisco, in the town of Santa Rosa, with mostly children and elderly patients being seen and treated. Most of the children were treated with fluoridation and tested and, if necessary, referred for treatment for anemia. The children were also presented with toothbrushes, toothpaste, balloons, and toys. Children and adults requiring medical attention were attended to by RMF Peru's Dr. Mabel Bardales and Dr. Fidel Sotelo, with a total of 95 patients reached, 57 of which were medical patients, and 38 were children treated with fluoridation and tested for anemia.
- For the fourth consecutive year, a medical outreach mission was conducted for the populations surrounding San Clemente by the Peruvian American Medical Society (PAMS) and RMF Perú. This mission was led by PAMS' Dr. Hugo Tapia, who brought with him a team of three volunteers in primary care specialties, one medical student, one dentist with two dental students, a nephrologist, a specialist in infectious diseases & internal medicine, and a psychologist. The mission took place on August 13-15, from 1pm to 6pm each day, and a total of 144 patients were treated. Included were also, i.e. free testing and clinical analysis of cholesterol levels, diabetes and urinary tract infections, and free medication for those in need. A total of 372 medical analyses were conducted. Dental services were also offered during the mission; 27 dental patients received treatment, including extractions and fluoridation, and toothbrushes and toothpaste were given out free of charge. In addition to the medical services provided, $840 worth of medical supplies, including a micro-centrifuge, were provided by PAMS.
- An additional Medical Outreach Campaign was performed by two American physicians, introduced by PAMS. Dr. Willy Thuet (emergency physician) and Dr. Christina Thuet (pediatrician) treated many patients over the course of three days and donated medicines.
- For the fifth consecutive year, RMF Perú held the "Chocolatada" a Christmas celebration for 200 local children, who received gifts and treats.

RMF CEO Dr. Martina Fuchs visiting in July 2013

Drs. Christina and Willy Thuet and RMF team during Medical Outreach

PAMS Medical Outreach held through RMF Clinic in Perú

Children enjoying the Chocolatada celebration with donated toys

UNITED STATES: LOS ANGELES

INITIATIVES ■ Medical Outreach and Healthcare Education ■ Children's Programs

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

Yoga class for children at Florence Western Medical Clinic

Children's 'Back to School' event at Florence Western Medical Clinic

Florence Western Medical Clinic (FWMC), South Los Angeles

RMF's Community Outreach Programs located at FWMC are 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. Under the direction of its medical director, Dr. Kevin Thomas, 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 include physical therapy and healthcare education services as well as non-medical services such as physical fitness and yoga for adults and children, programs for new mothers, assistance to families with children without insurance, arts & crafts and reading programs for children, and much more. Most of the children who participate in our programs are being raised by family members other than their parents, and are at significant risk for future physical and psychological problems. In consideration of this fact, our 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 are i.e. engaged in low-impact exercises; discussions include 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. Individual donations and monies allocated by RMF's participation in the 2013 LA Marathon "Athletes for Real Medicine" as well as generous contributions from donors such as Mizrahi Tefahot Bank Ltd made several of our programs in Los Angeles possible.

In 2012, we added RMF's signature "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 (if you go alone). RMF believes the best healthcare is preventative and introduced a new 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.

JWCH/DRMC Family Care Center, Downey, South Central Los Angeles

JWCH Institute, Downey Regional Medical Center (DRMC) and AD+ World Health have partnered to create the JWCH/DRMC Family Care Center, a Federally Qualified Health Center; Volunteers of America provided the final funds to complete construction. The center will open in March 2014 as a primary, preventative and urgent care family clinic in Downey to serve the underserved and underinsured in Southeast Los Angeles County. Real Medicine Foundation remains one of the first partners of the coalition to help attract funding support and to provide outreach programs. The local community has been in desperate need of a healthcare home where children and adults can receive the full spectrum of primary and preventative care. With the implementation of the Affordable Care Act, much of our underserved population now has medical coverage but no access to medical care without the addition of more clinics. Clinic services will include comprehensive primary care for children and adults; mental health services; prenatal care and education; preventive education on asthma, diabetes, heart disease, HIV, STDs, teen pregnancy, obesity; women, infants & children (WIC) enrollment; urgent care; nutritional and exercise education. Patients are seen regardless of ability to pay. The clinic also serves as a training site for DRMC's family practice residents, optometry, podiatry, dental and nursing students, family nurse practitioners and physician assistants from Western University of Health Sciences.

ARMENIA

INITIATIVES ■ **Primary Health Care** ■ **Mobile Clinic/Ambulance Outreach**

Clinic serviced a population of over 6,800

Emergency Ambulance for remote villages

Support for 88 chronically ill patients

Vaccination program

Mother and daughters, beneficiaries of Shinuhayr Clinic

Primary Healthcare Clinic in Shinuhayr, Syunik Marz

Background

Accessibility to free, quality health services for children and mothers in rural Armenia is extremely limited. It is estimated that 33% of the country still live below the poverty line. The Shinuhayr Primary Healthcare Clinic is the only comprehensive clinic available in the region servicing its surrounding seven villages with a population of over 6,800. There is a great need for perinatal, pediatric, cardiovascular, infectious disease, orthopedic, and geriatric services in this region. Approximately 350 families fall under the 'socially vulnerable' category and benefit from the services of RMF's project. In addition, 265 disabled persons, more than 570 children ages 0-7 years and about 1,115 school children ages 8-17 years, and 53 single mothers benefit from improved healthcare services.

Working closely with our program partner, the Armenian Relief Society (ARS), RMF supports the Shinuhayr Primary Healthcare Clinic to provide the clinic with critical medicine inventories and medical supplies. This project indirectly impacts all members of the eight communities it serves. It directly impacts those socially vulnerable individuals, including members of large families, pensioners and children, who present with acute or chronic illnesses during a clinic or house visit. RMF also provides these patients with free medications and makes sure that patients are followed up on by RMF staff to assure their continuum of care. Special attention is provided to chronically ill patients with cardiovascular disease, hypertension and diabetes. These patients are seen every month by our nurses to assess their health status and to ensure medication compliance.

2013 Update:

The Shinuhayr Clinic Project came to an end in early 2013 after 5 years of successful service. We are very proud of all that we have accomplished together since our program started in 2008 and hope to one day return. Over the past five years the clinic treated more than 30,000 patients. For now, our lack of sufficient and consistent operational funding support or grants directed towards Armenia mean we completed the project in the spring of 2013. If we are able at any point to find a source of funding that covers a minimum of 1 year of clinic/staff operations then we will be happy to restart this project. RMF's long term vision continues to be the upgrade of the clinic building to reestablish a hospital, and to expand our programs to include vocational training and small business sponsorships focused on women and youth entrepreneurs.

Mariam Tevosyan in back brace before surgery

Mariam's Story: Mariam Tevosyan is one of our long term patients and success stories. In 2011 her parents heard about RMF's program and visited the RMF team to present their daughter's story and ask for help. Three years before that, when their daughter was eight years old, they had noticed that she had a back problem. They visited a doctor who diagnosed that Mariam's spine had a 32 degree scoliosis deformation and she was prescribed to wear a corset, but after three years of wearing corsets and being sponsored by RMF, the parents noticed that their daughter's condition had worsened. At the end of 2012 Mariam's doctor informed us that she was now ready to have a surgery on her spine to correct it. Since then RMF volunteer Nairy Ghazourian completed a fundraising campaign in late 2013 raising all of the funds for Mariam's operation, which is planned for early 2014. We all hope this surgery will help Mariam to have a normal and happy life.

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Jonathan M. White, MBA	Chief Operating Officer
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Kemvette M. Jones, BS	Accountant/Bookkeeper
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Santosh Pal, MSW	Program Manager, Health and Nutrition, India
Rubina Mumtaz, BDS, MPH	Country Director, Pakistan
Stephney Minerva Fernando	Project Coordinator, Sri Lanka
Theresita (Tita) Q. Dumagsa, BSFN, RD	Project Director, Philippines
Antonio (Tony) R. Dumagsa, MBA, BSME	Project Director, Philippines
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Salau Rotimi, BA	Project Coordinator, Nigeria
Taban Martin Vitale, MD	Team Leader, Healthcare Projects, South Sudan
Okang Wilson Ezekiel, NPA/MDTF, BPHS	Project Coordinator and Finance Administrator, South Sudan
Naku Charles Lwanga, BSocSc	Country Director, Uganda
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Jewish Community Federation & Endowment Fund
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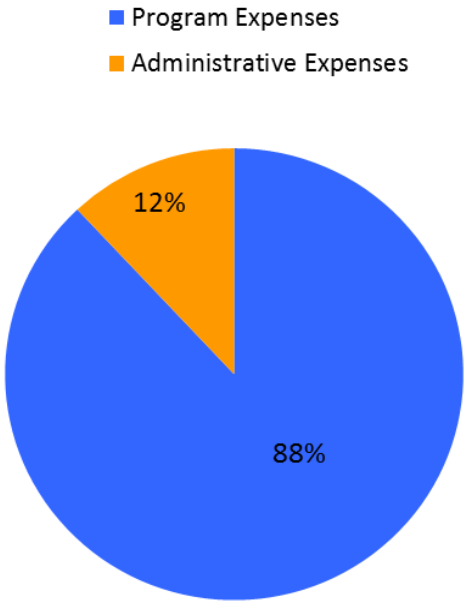
Pamela Omidyar Trust
PAMS I Peruvian American Medical Society
Persimmon Contracting Ltd., Calgary, AB, Canada
Pfizer Inc.
PhRMA I Pharmaceutical Research and Manufacturers of America
Picture Head Studios, Hollywood, CA
Playtogive, Inc.
Radley Studios, Los Angeles, CA
RAF I Research & Advocacy Fund
Rotary Club of Juba, South Sudan
Rudy's Barbershop
Schwartz Family Foundation
See Your Impact
Share International, Inc
Silicon Valley Community Foundation
Sirpuhe and John Conte Foundation
Solutions Healthcare Marketing, Inc.
Sony Pictures Entertainment, Los Angeles, CA
SSWU I South Sudan Women United
Stanford University I Center for Innovation in Global Health
Stanley & Marion Bergman Family Charitable Fund
Stein Family Philanthropic Fund
Steven Bochco Productions, Inc.
Tahoe Associates, LLC
The Amy L. Sheyer Trust
The Annenberg Foundation
The Babaian Family Trust DTD
The Long Island Community Foundation at Nassau Hall
The Maya Foundation
The New York Community Trust
The Rosenthal Family Foundation
The Sacherman Fund
The Salvation Army
The Surly Goat, West Hollywood, CA
Tides Foundation
Tiger Freight Services, Inc.
TISS I Tata Institute of Social Sciences, India
Total Contact Management, London, UK
UBS AG I Employee Giving Program
UN ECOSOC I United Nations Economic and Social Council
UNDP I United Nations Development Programme
UNFPA I United Nations Population Fund
UNHCR I United Nations High Commissioner of Refugees
UNICEF I United Nations International Children's Fund
Union Bank of California, Los Angeles, CA
University of Alberta, Canada – School of Public Health
University of Pittsburgh at Bradford, PA
Walmart Foundation
WHO I World Health Organization
Whole Foods Markets
World Bank Development Marketplace I The World Bank
World Children's Fund
Zanmi Lasanté, Partners in Health, Haïti

FINANCIALS

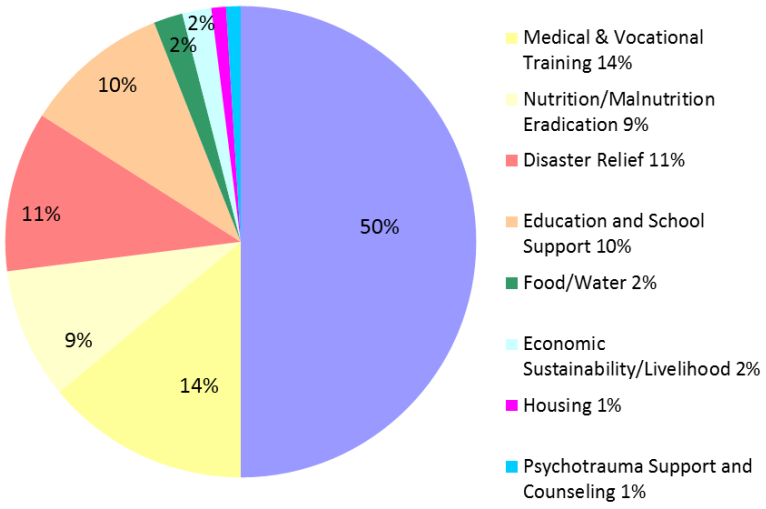
FISCAL YEAR 2012 (June 2012 - May 2013)

In US $	Fiscal Year 2011	Fiscal Year 2012
Contributions and Grants to RMF USA*	**1,580,963**	**1,624,321**
Expenses*:		
Program Expenses	1,178,216	1,339,562
Administrative Expenses	143,563	179,443
Fundraising	22,333	21,244
In-kind Expenses	219,914	55,500
Total Expenses	**1,564,026**	**1,595,749**
International Contributions**		
Contributions to RMF Germany (100% used for program expenses)		**612,850**
Contributions to RMF UK (100% used for program expenses)		**117,027**
Contributions to RMF India (100% used for program expenses)		**105,000**
Contributions to RMF Pakistan (100% used for program expenses)		**96,482**

Total Expense Breakdown



Global Program Expenses by Category



*2012 IRS Form 990 US Contributions and Grants, and Expenses. Copies of 2012 Form 990 or earlier years may be requested from head office in Los Angeles.

** The 2012 international figures are set up in accordance with international accounting standards.

CONTACT US

REAL MEDICINE AMERICAS

REAL MEDICINE USA
11700 National Blvd., Suite 234
Los Angeles, CA 90064
Phone: +1.310.820.4502
Fax: +1.310.437.0721
Email: info@realmedicinefoundation.org

REAL MEDICINE PERU
Calle Barrios Altos Nº 426
San Clemente, Pisco, Ica
Perú
Phone: +51.956.621.833

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

REAL MEDICINE EUROPE

REAL MEDICINE DEUTSCHLAND e.V.
Lechstr. 8
D-53332 Bornheim
Deutschland
Phone/Fax: +49.228.223.404

REAL MEDICINE UK
10 Sovereign Park I Cleveland Way
Hemel Hempstead
Hertfordshire HP2 7D A
United Kingdom
Phone: +44.144.2288.499

REAL MEDICINE ASIA

REAL MEDICINE AND NUTRITION TRUST
201, D-96 Birkhe Ram Complex, opposite community centre
Munirka Village, Munirka
New Delhi 110067
India
Phone: +1.91.956.094.4255

REAL MEDICINE PAKISTAN
70, Nazimuddin Road
Sector F-7/4
Islamabad
Pakistan
Phone: + 92.334.513.2910

REAL MEDICINE SRI LANKA
No.62, Medaketiya
Tangalle
Sri Lanka
Phone: +94.725.798.603

REAL MEDICINE PHILIPPINES
37 Dapdap Street
Mambaling, Cebu City
Cebu, Philippines 6000
Phone: +63.921.316.1496 and +1.703.421.8231

REAL MEDICINE AFRICA

REAL MEDICINE UGANDA
Kamalu Makarere Kavule
Kamalu House Building
Bombo Road
Kampala
Uganda
Phone: +256.702.994.110

REAL MEDICINE KENYA
c/o Lodwar District Hospital
PO Box 18
Lodwar
Turkana
Kenya
Phone: +254.737.826.149

REAL MEDICINE SOUTH SUDAN
Resource Center
Special Wing
Juba Teaching Hospital
Juba
South Sudan
Phone: +211.929.934.043

REAL MEDICINE NIGERIA
c/o Gure Model Health Care Clinic
Gure
Baruteen, Local Government Area (LGA)
Kwara State
Nigeria
Phone: +234.803.825.3627