



*HealthBridge works with partners world-wide  
to improve health and health equity through research, policy and action*

## **Annual Report 2013**



## INSIDE

- 2 Chair's message  
Remembrances
- 3 Big changes for Bolivia
- 4 Stories of hope from  
Pakur
- 5 Markets for health
- 6 Alcohol control Vietnam  
Tim Stone Memorial  
Award
- 7 Run for the health of it  
Intern's story
- 8 Q&A: Don de Savigny
- 9 Financial summary  
Recently published
- 10 In the spotlight  
Thank you supporters!

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## Message from the Chair of the Board



This will be my last message as Chair of the Board of HealthBridge – I will be stepping down in the fall, and will hand the torch over to Rob Robertson.

It has been a pleasure working with the Board and Staff over the past four years that I have been Chair.

In this report you will see that HealthBridge continued in 2013 to help bring about some Big Changes. In Bolivia, by taking a 'whole system' approach to food and nutrition, local farmers are using homegrown solutions to produce foods that address nutrient deficiencies in women and children.

In Pakur, a rural district of India where maternal and child mortality rates are some of the highest in the world, our local partner is improving access to health services, resulting in increased antenatal visits, immunization and safe deliveries, all of which are proven to save the lives of mothers and babies.

Big changes of another kind are happening in Hanoi, Vietnam, where a small amount of research and a huge advocacy effort has helped to save the livelihoods of those who make a living in local traditional markets. Traditional markets are important for people's diets (more fresh fruits and

vegetables, more affordable, less processed foods), people's physical activity (they can access local markets by foot or bicycle), and people's social interactions, providing important urban and rural connections.

These are exciting times for HealthBridge as we continue to build on our work in Livable Cities with a focus on making cities more livable and accessible for the poor. The challenge of developing projects that address non-communicable diseases (NCDs) is an area with both great need and great promise to improve the lives of many people throughout the world. HealthBridge is well positioned to live up to the challenges involved.

The work of HealthBridge focuses on the development of solutions that contribute to the well-being and improvement of the quality of life for people who are not as fortunate as many of us. Recently, the HealthBridge Board, along with a team of dedicated volunteers, has become more active in fundraising – something that is much appreciated. All of these volunteers and contributors are to be thanked, and congratulated for their success.

Finally, I would like to sincerely thank my colleagues on the Board and the dedicated Staff of HealthBridge, who have made my time on the Board worthwhile and a real pleasure.

**Dr. Frank Eady**  
Chair, HealthBridge Board of Directors

## Goodbye Karl A. Smith and CWL (Bill) Jeanes



HealthBridge dedicates this Annual Report to two Board members who passed away in 2014.



Dr. Karl A. Smith (left) ended his career as Director General at IDRC, and was active on our Board from 2007 until his death. Board Member Emeritus Dr. Bill Jeanes (right) was a founding member of PATH Canada, which became HealthBridge in 2006. Bill served with distinction on our Board for more than 30 years.

# Small Animals lead to Big Changes for rural families in Bolivia

We are nearing the halfway point of our three-year “Small Animals, Big Changes” project in Bolivia, which we are carrying out with our dedicated Bolivian partner CENDA (Centro de Comunicación y Desarrollo Andino). The work is taking place in four provinces of the Department of Cochabamba, and will reach about 1,000 households in 20 villages.

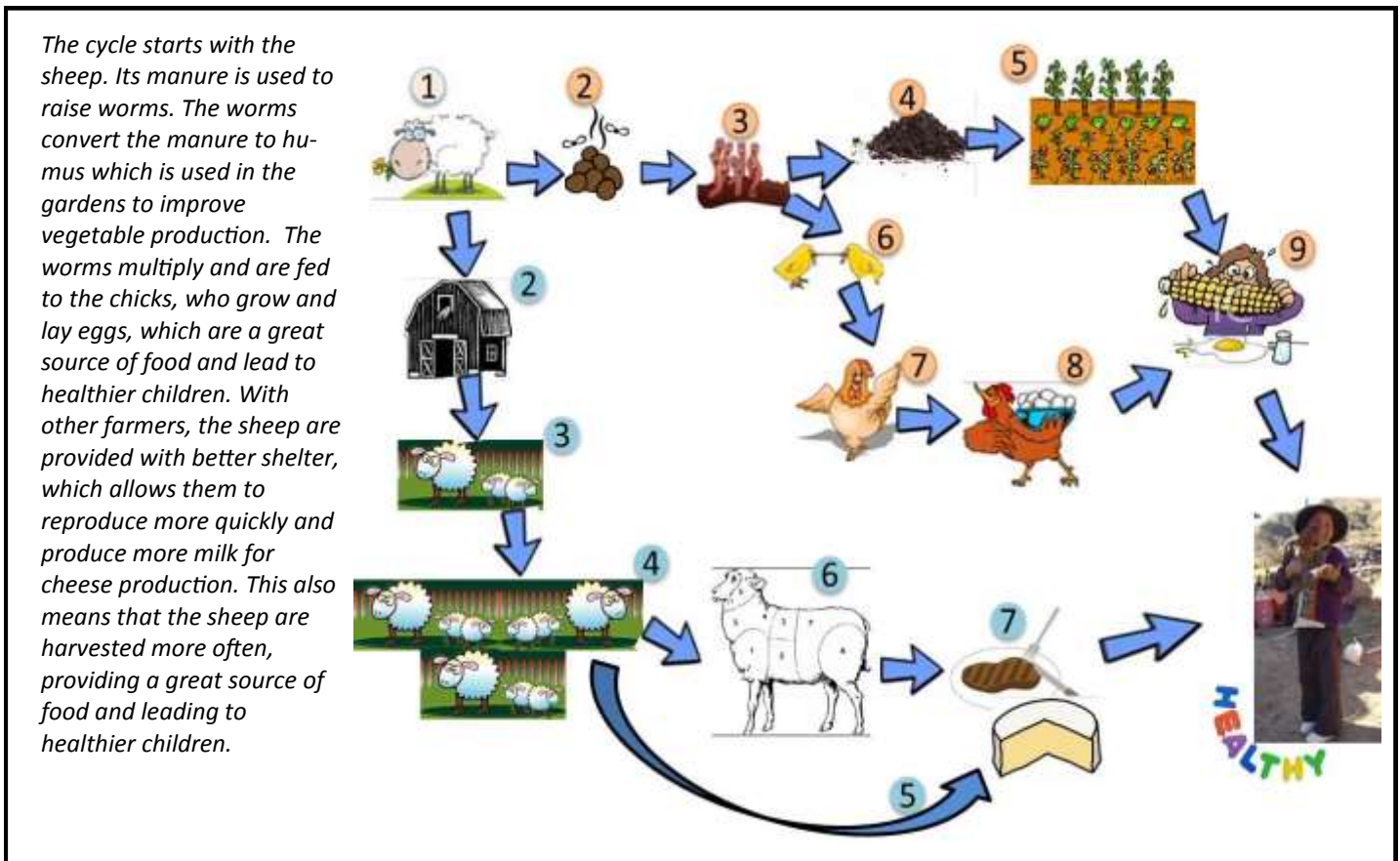
We are working with rural families to improve the production of sheep and chickens, in order to increase the nutritional quality of people’s diets. Initially we were working with chickens and guinea pigs – hence the “small animals” in the project title. But the people were not keen on raising guinea pigs: although they are a delicacy, they are voracious eaters, and are thought to be inefficient at converting grass to meat.

The families have raised sheep for many years, but there is scope for improvement. The farmers like to maintain a large herd size and are reluctant to harvest (eat) too many sheep, as they represent their “bank account”. Also, due to high lamb death rates, and low rates of lambing (ewes having lambs) it is hard for the families to replace any harvested sheep.

So we are working with farmers to increase lambing and survival rates by helping to build improved, roofed corrals to keep the sheep warmer, and by providing training on improved pest control practices. When the farmers are confident that the harvested sheep can be replaced by an increased number of surviving lambs, we believe that they will harvest more of the sheep, leading to increased consumption of meat and improved health.

Some of the families, living in a different ecological zone, have only a few sheep so there is little scope for improving production. With these families, we are introducing chickens for egg production. We are supporting the construction of chicken coops – which keeps the birds warm and improves their growth, and protects them from predators which would otherwise devastate the flock.

Also, we have promoted the introduction of vermiculture – earthworms are raised in a bed of sheep manure, and the worms are fed to the chickens. We are told a hen must consume eight worms to produce one egg. When the production system is stabilized, each family will produce about five eggs per day – roughly one per person in the household, which would make a great addition to their diet.



# Stories of hope from Pakur, India



Since December 2011, HealthBridge and its local partner EFICOR have been working in the Pakur district of Jharkhand state, India, to increase access to essential maternal and child health services.

Pakur is a rural district, and many of the villages lack roads and transportation services, making it difficult

to travel to a health facility. Due to lack of staff capacity and an absence of accountability, many of the government services do not function regularly, or are of poor quality. Before the project, many local people were not even aware of the health services available from the government, and consequently, were not motivated to access health care.

Over the past three years, the project team has trained more than 1,800 community health workers, delivered community health education to over 9,000 men and women, and strengthened the capacity of nearly 400 Village Health Committees. Here are some examples of how the project has made an impact:

## Phul is stronger during her second pregnancy

Phul, which means “flower” in the Santhali language, lives in Amrapara block of Pakur and is pregnant with her second child. During Phul’s first pregnancy, she was very weak and tired but did not understand why. Our counsellors educated her about the importance of proper nutrition and rest during pregnancy, and helped her to access iron-folic acid supplements to prevent anaemia. Phul also received antenatal care. Since then, she has told EFICOR staff that she feels much stronger and healthier during this

pregnancy. With her family’s support, Phul plans to give birth in a health facility. Before the project, only 30% of women gave birth in a health facility; now, 50% of women do so.

Chota Kadam is a small village in a hilly area of Pakur which lacks paved roads. It has a population of 150, and the closest health facility is 8km away. The project team there has trained and mentored a Village Health Sanitation and Nutrition Committee, which is responsible for monitoring government health services and empowering people to seek health care.

Thanks to the support it received from EFICOR, the Committee was able to clear a road so that the local ambulance can now reach the village. The Committee also sanitized its well so that the village has access to clean water. Even after the project has finished, the Committee will continue to be an important advocate for the health of the local people.



## Impact to date of the Pakur Project

- ◇ 1,800+ community health workers trained
- ◇ 9,000+ men/women educated about health
- ◇ Nearly 400 village health committees strengthened
- ◇ 20% more women giving birth in a health facility
- ◇ 19% more pregnant women received antenatal care
- ◇ 34% more pregnant women consumed iron tablets during pregnancy
- ◇ 15% more children are being immunized.

# LOCAL MARKETS FOR HEALTH

## *Hanoi delays closing traditional markets after advocacy campaign involving HB Vietnam*

As part of its attempt to redesign Hanoi as a “more civilized, modern city”, the city government decided in 2011 to bulldoze existing traditional markets and replace them with shopping malls and supermarkets.

HealthBridge Vietnam (HB Vietnam) launched a campaign to convince the government to change its policy to one of protecting, not destroying, traditional markets. It succeeded: the government is no longer implementing its policy to dismantle Hanoi’s traditional markets.

### **No highly processed foods**

Traditional markets are key, positive features in many cities. They allow local residents to buy fresh locally grown food on a daily basis at affordable prices. Since few unhealthy foods are available in traditional markets, there is no incentive to spend one’s money on highly processed foods that are high in sugar, salt and fat, and low in nutrients.

The markets are located close to people’s homes and places of work, which allows for quick, easy access, by walking or cycling. Furthermore, there are more opportunities for social interaction between customers and sellers in traditional markets, providing important urban and rural connections.

Finally, traditional markets require little overhead, which keeps prices low and offers many employment opportunities. Replacing these markets with shopping malls and supermarkets reduces access to fresh

affordable food, requires people to travel longer distances, reduces the connections between the buyers and sellers, and reduces employment opportunities.

HB Vietnam was concerned about this new government policy for two reasons. First, because of the negative effect that it would have on the risk factors for non-communicable diseases (NCDs), which include lack of physical activity and unhealthy diets. NCDs, in turn, are linked to poverty. Second, because of the negative effect that the policy would have on urban livability.

HB Vietnam launched a campaign with three main strategies:

1. Gather evidence of the impact of turning traditional markets into shopping centres and private commercial buildings, to demonstrate the ways in which the markets are important to quality of life in urban areas;



2. Create a network of policy makers, government officials, researchers, professionals, the media, and individuals to collectively advocate to the Hanoi government, and
3. Use the power of the media – traditional, online and social – to raise public awareness about the health and economic importance of traditional markets, and to create public pressure to stop their destruction.

### *Not so super markets*

The transition from traditional markets to supermarkets impacts NCDs and poverty:

- It shifts people’s diet from fresh fruits and vegetables to processed foods;
- It shifts people’s travel patterns from active to passive;

The campaign achieved a number of direct results, which led to the successful cancellation of the government’s policy. Increased public pressure, voiced largely through social and traditional media, forced the Hanoi Government to reconsider its policy, while policy makers gained a much greater awareness of the health, economic and social value of traditional markets.

# Alcohol control policy for better health

With nearly two decades experience working with the Government of Vietnam to develop tobacco control policy, HealthBridge Vietnam (HB Vietnam) is applying its expertise to alcohol control policy.

## Non-communicable diseases

Like tobacco, alcohol is widely used in Vietnam, has long been socially acceptable, and contributes to the epidemic of non-communicable diseases (NCDs). According to Vietnam's Ministry of Health, in 1986 NCD-related illnesses were responsible for 39% of all hospitalizations; in 2006 this figure was 62.4%.

Many of the policies that have been successful at reducing tobacco use worldwide apply directly to alcohol control. These include higher taxes, limits or outright bans on advertising, promotion and sponsorship, and rules about where and when alcohol can be sold and consumed.

The National Assembly (NA) and the Ministry of Health, Department of

Legislation (DOL) approached HB-Vietnam for its support in developing an alcohol control law, specifically a ban on alcohol advertising. The office responded by providing information on best practices in law and policy development, and continues to give input on draft legislation, with the support of the Global Road Safety Partnership.

## Link to Livable Cities

Because HB Vietnam also works to promote livable cities, it has another entry point for its work on alcohol control. The most visible danger of alcohol use is traffic accidents, and our work in this program focuses on improving public transportation, reducing the number of vehicles on the roads, and creating safe paths for pedestrians. The policies that will be subsequently developed will, in turn, make it safer for people to walk and cycle: less air pollution and more physical activity will result in better health, including fewer NCDs among the population.

In order to develop evidence-based

arguments for policy advocacy, HB is also focusing on policy-oriented research. HB Vietnam activities in this area include:

- ◆ Generating evidence on the link between alcohol control and poverty and the benefits of tax and price policies;
- ◆ Reviewing evidence on the impact of advertisements on alcohol consumption and road accidents;
- ◆ Developing a network for NCDs and alcohol control;
- ◆ Providing technical support to the MOH in developing a National Strategy for NCD Control, 2015-2030;
- ◆ Researching alcohol consumption by income group and the opportunity cost of alcohol use.

Our experience has shown that policy changes can take over a decade to bring about but when they occur, the benefits reach the entire population and can be sustained for decades to come, making the hard work well worth the investment.

## Tim Stone Memorial Award

**CONGRATULATIONS** to Hieu Nguyen, the first recipient of the Tim Stone Memorial Award. Hieu is originally from Vietnam and is currently living in Montreal. Hieu will support the Livable Cities Program by conducting a literature review and prepare a paper that discusses the value of urban agriculture as a way of improving the health of urban residents and the best practices associated with such a program.



The Tim Stone Memorial Award was established in 2013 to honour the memory and contributions of Tim Stone who was the Executive Director of HealthBridge (formerly PATH Canada) from 1993-1996. Tim was killed when his Ethiopian Airlines flight was hijacked on its way from Addis Ababa to Nairobi on November 23, 1996. The purpose of this award is to encourage young people who are seeking a career in international development.

# 2013 *Run* for Child and Maternal Health



**W**e would like to thank the many volunteers who made our second annual 5k run such a wonderful success in 2013.

The run was held in Ottawa, Edmonton and Vancouver in September.

All three runs were well attended and helped to raise over \$50,000. Through the run, we continue to educate Canadians about the challenges faced by mothers and children in rural India and other poor regions of the world.



## **No one-size-fits-all solutions:** *An intern's story — Anita Liu*



I had just graduated with a Master's degree in Neuroscience when I was awarded a CIDA-funded internship with HealthBridge, as a Program Officer in Gender, HIV/AIDS and Reproductive Health.

During my Bachelor's, I had studied both gender and medical sciences and was eager to integrate these fields into my career. Although I had prior overseas experience, this intern-

ship was unique, as it provided me with a job title, meaningful responsibilities and a generous stipend that allowed me to not only pursue my 'dream job', but also truly helped me launch a career in global health and international development.

At HealthBridge, I conducted an international policy review on labour policies for domestic workers, to support Vietnam's development of a draft decree on domestic workers' labour rights. I gained solid experience in technical report writing, capacity building, digging for 'grey' (unpublished) literature, and writing grant applications. I was also exposed to the gender network in Vietnam and the work of international NGOs, domestic civil society organizations and United Nations agencies, which ultimately led to my current position as a short-term consultant at the UN Food & Agriculture Organization.

My experience in Vietnam has also been rewarding on a personal level. I have made many friends from different backgrounds who share my goals, values and vision. This experience has also challenged my perspectives on international development: I now truly understand how health policies and development strategies must reflect a country's socio-political, cultural and historical context — there is no one-piece-fits-all solution to poverty alleviation and health.

# Q&A with HB Board member Don de Savigny



**You have been working in the field of global health for many years now. What has been the most exciting time of your career?**

Yes, I have been working in global health for many (almost 40) years, even before it was called global health. I really started to get drawn into the challenges of what was then called tropical public health (later international health and then global health) in 1976 when I joined the London School of Hygiene and Tropical Medicine to do my PhD.

On reflecting, I have been truly fortunate in feeling that all these years in public health have been both exciting and rewarding and it is hard to single out the most exciting times.

But if pushed on that, I would say the most exciting and satisfying times in my career have been the years living in Africa, from 1984-1988 as Director of the Ifakara Health Institute in Tanzania, and again from 1996 to 2003 as lead facili-

tator for the Tanzania Essential Health Interventions Programme (TEHIP) for the Tanzania Ministry of Health and IDRC, Canada. Those times were especially rich in exciting team work at the 'coal face' and extraordinary mutual learning opportunities that we were able to translate and apply in population health to see, first-hand, the impacts. Work that saves lives on a large scale is its own reward that cannot be matched.

**How can HB respond to the broader shift in global health?**

One can ask the same question of Canada. Where ever I go in low income countries I am impressed by the levels of trust one enjoys just by being Canadian. I feel we have so much to offer, but we don't always offer it sufficiently actively, compared with our neighbours and peers. Canada could and should do much more to share its values in universalism, health and health systems & policies, and should do it through agencies like HealthBridge. So how could HealthBridge position itself with the shifts in global health? I have a couple of thoughts for discussion:

1. It is likely that Universal Health Coverage will be the new mantra for health as we move beyond 2015.

Canada and HealthBridge have a lot to offer here.

Canada's rather unique skills and experience with a universal, single-payer non-profit national health insurance system needs to be shared. Hardly any country in Africa has a national health insurance scheme of any type. Also imbedded in UHC are the notions of equity and inclusiveness.

Yet the majority of the planet will soon be living in urban settings, and reaching the growing numbers of urban poor and informal sectors of the population with health services of adequate quality is going to be a huge problem for implementing UHC.

We need to re-think health systems in global health, which has traditionally taken a rural poor focus. HealthBridge's Livable Cities interests can be important

entry points here.

2. Globalization is a reality that brings us closer together in health destinies. But globalization in other arenas, such as trade, agriculture, extractive industries, etc. can and does also pose enormous threats to health and the rights of the poor. It is clear that Canadian development aid is shifting to reflect Canada's trade and business interests. Canada could start to become more of a problem than part of the solution for global health if this plays out on purely economic imperatives for Canada. Private investment in developing countries now exceeds Official Development Assistance by orders of magnitude.

One way to ethically help mitigate Canada's growing footprint in low-income

*Continued on page 10*

## *Congratulations!*

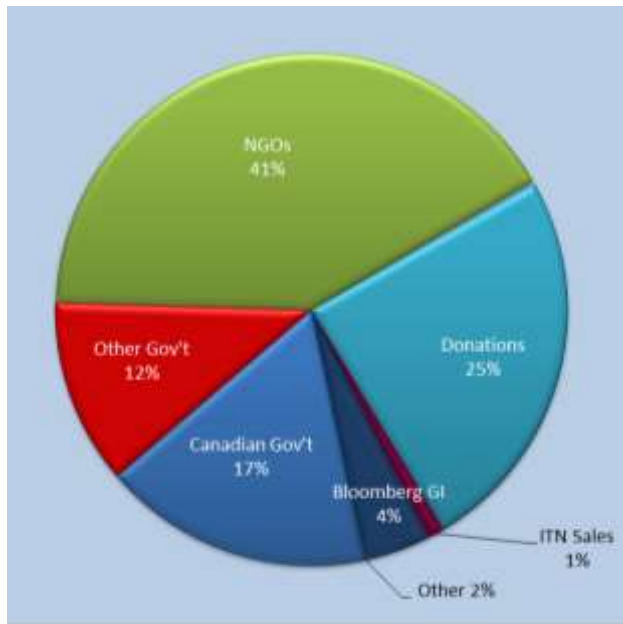
Board Member Emeritus **Catherine Hankins** received the **Member of the Order of Canada** in 2013 for her contributions combatting the spread of HIV/AIDS in Canada and abroad.



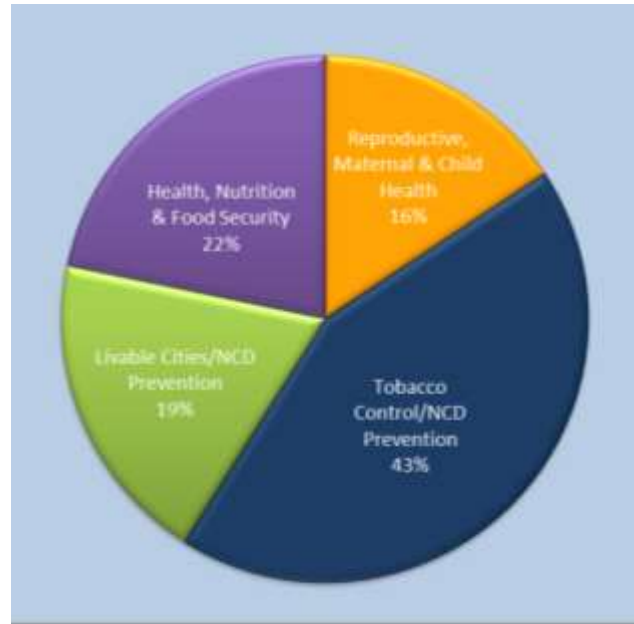
Catherine is Deputy Director, Science, Amsterdam Institute for Global Health & Development, Department of Global Health, University of Amsterdam. A community medicine specialist, she was Associate Director and Chief Scientific Adviser to UNAIDS in Geneva from 2002 to 2011.

# Financial Summary 2013

The summary below is an excerpt from HealthBridge's audited financial statements.  
For more information: [admin@healthbridge.ca](mailto:admin@healthbridge.ca)



Source of Funds



Use of funds by program category

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## Recently published

- Daniel, K. et al. **Broadening the Focus from Tobacco Control to NCD Prevention: Enabling Environments for Better Health.** HealthBridge. July 2013.
- MacDonald, L. et al. **Promoting male involvement in family planning in Vietnam and India: HealthBridge experience,** *Gender & Development*, 21:1, 31-45. 2013.
- Berti PR and Jones AD. **Biodiversity's contribution to dietary diversity: Magnitude, meaning and measurement.** In J. Fanzo, D. Hunter, T. Borelli and F. Mattei (eds.), *Diversifying Food and Diets: Using Agricultural Biodiversity to Improve Nutrition and Health.* Routledge, UK. 2013.
- Siekmans K, S Sohani, J Kisia, K Kiilu, E Wamalwa, F Nelima, D Odhiambo Otieno, A Nyandigisi, WS Akhwale & A Ngindu. **Community case management of malaria: a pro-poor intervention in rural Kenya.** *International Health Journal*; doi: 10.1093/inthealth/iht017. 2013.
- John S, Jones L & Majumdar, K. **Mainstreaming non-communicable diseases into India's development programmes: A preliminary assessment.** HealthBridge, 2014.

## Q&A with Don de Savigny

countries' oil, gas, mining, and other sectoral partnerships, is to invest heavily in Health Impact Assessments (HIA) on behalf of Canadian industries and perhaps with DFATD support. Leadership, skills, methodologies and experiences in Health Impact Assessment in low income countries are few. Developing and building this capacity could be an important new thrust that would respond to these emerging realities in a positive way, and could help with HealthBridge's longer term sustainability.

**Of which of your accomplishments are you most proud? What would you change if you could go back**

**and do it again?**

I think this is some kind of wrong question for our business. Contemporary research for development is all about partnerships, networks and teams, and not individuals. All accomplishments are shared. But if I could go back and re-run my career, I would make the move from a focus on health technologies to a focus on health systems much earlier.

**What do you want your legacy to be?**

I continue to work on intervention research, but now my focus is on health system interventions, rather than health interventions. But at the Swiss Tropical and Public Health Institute, I have a chance to use these real results and experiences to do a lot of post-graduate

teaching and mentoring. Unfortunately, many of my generation in public health have come to the realization rather late in our careers that working in systems and policies is where you get the most traction and impact.

Getting young and early career health professionals turned on to health systems and policy analysis early in their careers in public health is very rewarding. I look forward to seeing what they will do.

## In the Spotlight

**HealthBridge India Programme Director Shoba John** was one of the recipients of an award to mark World No Tobacco Day 2013. Shoba received the WHO Director-General's Special Recognition certificate, for her accomplishment in the area of tobacco control.



**Rachelle E. Desrochers** was co-author of a paper based on HealthBridge's work in Madagascar that was nominated for a prestigious **Charles C. Shepard Science Award**. The paper's title is: Improved equity in measles vaccination from integrating insecticide-treated bednets in a vaccination campaign, Madagascar. TMIH doi:10.1111/j.1365-3156.2011.02953.x

## Thank to all our 2013 Pakur Run supporters!

Thank you for your financial contributions and gifts in kind to the Pakur Run:

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Tenaquip Foundation, Montreal

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### Silver \$2,500+

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- ◆ The Gail Taylor Investment Group of CIBC Wood Gundy, Edmonton

### Bronze \$1,000+

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