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Policy of the Medical-Social Project Department DAHW (GLRA)



 **DAHW**
Deutsche Lepra- und
Tuberkulosehilfe e.V.



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Jürgen Hammelehle



Dr. Adolf Diefenhardt

The context of work has changed considerably in the 50 years of existence of *German Leprosy and TB Relief Association (GLRA/DAHW)*.

Leprosy and Tuberculosis present with different dynamics in various countries. With our partners we have reached a number of targets, mainly in Leprosy work. We still have the responsibility to maintain them and to identify new strategies that take into account new policies like integration and decentralization.

International cooperation strategies, funding and implementation concepts have been altered and improved at increasing pace in the past years.

Internationally, there is consistent emphasis on capacity building and health status as main contributors to sustainable development.

The headquarter of DAHW in Wuerzburg (Germany) has therefore seized the opportunity of the 50th jubilee in 2007 to reflect on the way forward.

This DAHW project policy provides the base to address the following aspects:

1. Which priorities in terms of countries, sectors (diseases, socio-economic measures) or service delivery areas should be developed taking into account the need to consolidate and improve quality of project support in diverse conditions in different countries?
2. To which extent do we carry out activities by DAHW staff (DAHAW as implementer) and what can be provided by the local partner (DAHAW as advisor)?
3. Should DAHW support preferably the direct service delivery level (project level) where assistance is carried out of patient level or should DAHW focus on the support for national programs (program level)?
4. To which extent do we address social needs in comparison with medical requirements? What

allocation should go for the promoting of (operational) research?

5. Which role play co-funded or joint projects with partner organizations from ILEP, WHO, the UNION, national Governments, German partners, international donors etc.? What is the potential, anticipated and requested contribution of DAHW in the development of German and international health interventions?

How to design a tool to measure the useful and cost-effective investment of our funds and to establish a user- and partner-friendly structure for performance measurement is a further priority of DAHW's medical-social department.

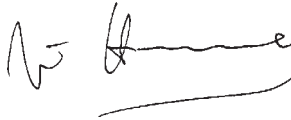
The DAHW policy tries to develop the impressive work that was started and carried forward by many into a future that will hopefully see the elimination of both diseases, Leprosy and Tuberculosis.

This policy paper will help on our way for the next 50 years of DAHW project support with new challenges to come. We hope it will be helpful by identifying and developing essential elements for our work, among them: quality, feedback mechanisms and a spirit of partnership.

Sincerely yours,

Jürgen Hammelehle

Dr. Adolf Diefenhardt




Chief Executive Officer

Deputy Chief Executive Officer
Head of the Medical-Social-Projects-Department

on behalf of the Managing Board of GLRA (DAHAW)

Würzburg, November 2005

Medical Social Project Department DAHW – MSP-(GLRA)

Since 1957 DAHW (German Leprosy and TB Relief Association; GLRA) has been supporting partners worldwide, currently in more than 300 projects. The projects focus on Leprosy, Tuberculosis, TB/HIV and social rehabilitation in more than 35 countries in 4 continents.¹ The financial volume corresponds to about 10-13 Million Euro yearly.

80% of the resources are spent in so called core countries. Africa receives most of the financial support, (>60 %), Asia benefits from the majority of projects (>40 %), Most of the project funds go into Leprosy and Tuberculosis control, the rest either in social or health projects for former Leprosy patients or their families, for related diseases or the so called „neglected diseases“.²

Approximately 50% of the funds are allocated to support **National Programmes**, often in connection with capacity building, logistics, administration and personnel. The rest is used to support **initiatives, non-governmental organizations, teaching institutions or patient groups**.

The average project volume is 40.000 € per year whereas the average project support lasts for more than 16 years. Approximately 10% of the projects have a yearly volume above 100.000 €.

Research, co-financed projects as well as strategic cooperation with international organizations (WHO = World Health Organization, UNION/IUATLD = International Union against Tuberculosis and Lung diseases, ILEP = International Federation of Anti-Leprosy Association etc.) and international or German NGO's play an ever more significant role.



Foto: Rolf Bauerdick

14 core countries with DAHW Country Offices:

India, Pakistan, Thailand, Uganda, Sudan, Ethiopia, Tanzania, Togo, Senegal, Sierra Leone, Nigeria, Brazil, Columbia, Yemen.

7 core countries without officially DAHW owned office:

Nepal, Afghanistan, Paraguay, Argentina, Bolivia, Egypt, Liberia.

15 further project countries:

Angola, Burundi, Cameroon, Ghana, Kenya, Madagascar, Mozambique, Mali, Ecuador, China, Bangladesh, Vietnam, Cambodia, Syria, Estonia.

² For example: concomitant diseases during Leprosy and tuberculosis treatment; further more: „neglected“ diseases like Leishmaniasis, Buruli Ulcer, Lymphatic Filariasis, Sleeping Sickness etc.



A lot of external factors have changed in the last 10 years: international cooperation strategies, internal policies regarding the 2 diseases, financing mechanisms and the prevalence of Leprosy and Tuberculosis.

1.1 Leprosy and Tuberculosis

Several indicators show that Leprosy is on the decline worldwide. For the next 5 years a figure of yearly 200-350.000 newly detected cases worldwide is realistic. Surprisingly, this decrease is most evident in countries that have a high number of new cases, in countries with low numbers there is no visible and significant decline of new cases. The long expected „final push“, elimination, will not be reached so quickly. The particular epidemiology and pathology of Leprosy require more than ever Leprosy services that combine good accessibility and quality of services.

For the past 10-15 years, Tuberculosis has held the attention and focus of National Programmes, of WHO, as well as other international organizations and powerful financing mechanisms. Tuberculosis causes more than 2 million deaths per year and is in 7th rank of mortality worldwide. The epidemic is spreading rapidly, especially in Africa and Eastern Europe. Significantly, the increase is due to HIV/AIDS co-infection especially in Africa, and the emergence of multi-drug-resistant Tuberculosis in Eastern Europe. It is worth mentioning that - despite this - the main diagnostic tools and many drugs are for both Tuberculosis and Leprosy more than 70 years old.

1.2 International strategies and policy

Integration and decentralisation

Leprosy, as well as Tuberculosis Programmes, being specialised vertical Programmes in the past, are increasingly integrated and decentralized in the basic or primary health care setup. The challenge for health personnel and district systems is to combine improved access for patients with professional and high quality Leprosy, TB and TB/HIV services. Furthermore capacity building with minimal standards and quality on one side, and on the other side, the linking of Leprosy and TB control with other 'neglected' or regular diseases is of prime importance. Experience shows that vertical Programmes can be integrated successfully if the – often fragile – basic health structure is supported as well.

International quality standards and performance measurement

In regard to the above mentioned diseases, the task consists primarily of control and reduction, as well as an improvement of the living conditions of people, who continue to suffer for their whole lives from medical, psychological and social consequences of their diseases. Elimination or even eradication of Leprosy, Tuberculosis or AIDS are long-term goals but is only realistic in geographically limited circumstances over the next 10 years. Control requires quality assurance in treatment and rehabilitation to ensure the long-term goal of elimination and to avoid further emergence of multidrug-resistance for Tuberculosis.

Development orientation

DAHW projects support the development and empowerment of people. Education and health status have been clearly identified as *the* human factors that influence poverty and a productive social development of mankind. They are not considered as arrival points but as essential enabling factors of development.

Several WHO and MDG (Millennium Development Goals) documents have identified these two key elements for development of any kind.³ DAHW, as usual, will continue to focus on these two areas.

Comprehensive solidarity with people means also to assist – where possible and in line with the mandate – in a humanitarian emergency situation. To determine this in a given context it requires a thorough assessment of the situation, the capacity of DAHW and its partners and a conceptual strategy which type of aid and which requirement of support is needed and realistic.

1.3 Financial support

It is not easy for National Programmes and WHO to mobilize funding for Leprosy. In the presence of decreasing Leprosy cases both DAHW and ILEP (worldwide federation of most operational Leprosy charities) continue to face this challenge. Despite this, Leprosy work is financed to a great extent by DAHW and the 14 ILEP members worldwide. The DAHW budget compared to the budget of all other Leprosy organisations is about 20%.

A significant increase for Leprosy Programmes or neglected diseases is not expected in international donations (from neither private donors nor government funds). Co-financing and increasing delegation of key-tasks to partner countries are therefore indispensable.

New financing mechanisms like the Global Fund for Malaria, HIV and Tuberculosis are arranged in relevant countries and have a great influence on the national TB- and HIV-Programmes. The administrative and human capacity is often missing to implement Programmes of this magnitude. Here DAHW can make a significant contribution.

1.4 National and international partners

The funding opportunities (esp. in Tuberculosis) and the need to invest in research, quality assurance and monitoring and evaluation exercises are increasing. DAHW is part of a national and international network and has been asked to assume responsibility for some of these tasks. **Independent and objective evaluation of results and efficient coordination** are becoming increasingly important.

The questions for each country where DAHW operates are:

1. Which priorities in terms of countries, sectors (diseases, socio-economic measures) or service delivery areas should be developed taking into account the need to consolidate and improve quality of project support in diverse conditions in different countries?
2. To which extent do we carry out activities by DAHW staff (DAHW as implementer) and what can be provided by the local partner (DAHW as advisor)?
3. Should DAHW support preferably the direct service delivery level (project level) where assistance is carried out on the patient or should DAHW focus on the support for national programs (program level)?
4. To which extent do we address social needs in comparison with medical requirements? What allocation should go for the promoting of (operational) research?

5. Which role play co-funded or joint projects with partner organizations from ILEP, WHO, the UNION, national Governments, German partners, international donors etc.? What is the potential, anticipated and requested contribution of DAHW in the development of German and international health interventions?



Foto: Rolf Bauerdick

³ Sachs, Jeffrey et al: Macroeconomics and health: investing in health for economic development. Report of the commission on macroeconomics and health. Geneva (WHO) 2001

DAHW Mandate

– Vision and Mission

DAHW's roots lie in the 1950s during an encounter in Ethiopia between a French Leprologist, Dr. Feron and 2 young Germans from Würzburg. The two men were deeply impressed by the sacrifice and commitment of Dr. Feron for patients affected by Leprosy.

Since the early days of DAHW, its key mandate has and always will be, the financial and technical support for the humanitarian efforts of nongovernmental, faith based and national initiatives in the fight against Leprosy and Tuberculosis.

DAHW is convinced that its mission toward global efforts to combat Leprosy, and other stigmatizing diseases and conditions, reflects a comprehensive concern for mankind, and pays due attention to the vision that the integrity and dignity of each and every person is respected.

DAHW's Constitution (February 2002) describes the mission of DAHW in the following way:

1. Support of public health measures through the direct and indirect fight against Leprosy and Tuberculosis
2. Support of the integration of both diseases into the basic health care system
3. Support of the fight against other diseases of primary importance

The guidelines from May 2003 translate this in the following way:

„DAHW is an independent NGO involved in development assistance and has a global focus on Leprosy and Tuberculosis control. DAHW is . . .

1. a medical and social charity organization that has professionally supported the improvement of health and social systems in developing countries for more than 45 years,
2. a charity that focuses especially on Leprosy patients who are stigmatized because of their disease or disability and who are excluded from certain social services, benefits or areas of normal life because of their disease,
3. a charity that also supports patients with Tuberculosis, with a view to secure much needed commitment and funding for Leprosy in a situation where Leprosy cases are reducing
4. DAHW can furthermore support people who suffer from other regional or global diseases, insofar as these diseases. . .
 - are of a chronic and serious nature,

- create a social, professional or economic handicap and therefore jeopardize personal dignity,
- can be treated with appropriate intervention opportunities,
- can be tackled in cooperation with other partners with a clear and distinctive distribution of tasks.

Other diseases can be taken care of if. . .

- suitable project partners can be identified,
 - DAHW infrastructure can be used in the country of interest,
 - opportunities for mid-term funding is reasonably available
5. DAHW is well aware of the link between political and economical structures, poverty and the need for socio-political engagement. It expresses this in appropriate terms and regards itself as a charitable organization with a development oriented strategy within the health and social system of developing countries. . .“



Foto: Erwin Eder



Several basic principles enable the planning and influence its implementation:

3.1 Complementarity and subsidiarity

Before initiating a project it is important to affirm with ILEP partners and other organizations a „gap-situation“. A gap exists if no other partner is present in the same region and in the same sector. Duplications should be avoided.

Demands usually emerge in the field and the capacity of the partner is confirmed. The support of DAHW takes into account the principles of subsidiarity and complementarity. What the (local or international) partner can perform should be provided by him.

3.2 Privileged approach for the disadvantaged and marginalised

Projects and partners receive support if the target group are people who are particularly vulnerable or disadvantaged because of their disease and/or their social, religious and ethnic backgrounds. Nobody should be discriminated in any DAHW project because of his race, sex, age, social status or religion.

3.3 Comprehensive assistance for self help

Human rights and reduction of discrimination are benchmarks for comprehensive sustainability and remain the central aim for target groups in our projects.

Medical assistance in such a situation is complemented by contributing to improved mid to long-term and sustained economic benefit for the beneficiaries.

The aim is to educate, support and enable the partner or the individual to assume more responsibility for himself.

3.4 Quality assurance cycle

DAHW-MSP policy, personnel, processes and systems, communication methods, partners and selected indicators all contribute to the quality and success of project support. International and national targets are used as reference points and effective instruments.

Fulfilling these targets perfectly is not always realistic and possible. Good results are often more a reflection of current trends in the diverse conditions and infrastructures within the various countries.

Continuous monitoring and supportive supervision are important for positioning and improvement towards international targets. DAHW staff is encour-

aged at all levels to contribute for the application of quality management („Plan-Do-Check-Act“ cycle).

3.5 Quality – more than technical standards

Quality service for people is more than performing and delivering cost-efficient, technically correct and highly competent projects.

It includes all possible efforts toward the elimination of diseases and problems, and the determined search for solutions ...

... but experience and tradition tell us that not everything is possible, that limits are part of life and that acceptance of limits is part of serenity in and quality of life: „Sometimes we cure, often we care and always we try to console.“ (France 15th century)
Man is the final reason and end of our endeavour, not the result or the efficiency.

3.6 Strategic partners

The principle of partnership is essential in planning and implementing all DAHW projects. Apart from being beneficial for any development, certain measures and solutions can be reached more quickly, efficiently are more sustainable due to synergy effects if different organisations combine their strengths and co-operate.

It is in our best interest to create alliances with local partners, with international and UN organisations (WHO, UNION-IUATLD, Stop TB Initiative, Patient Organisations etc.), with German and international NGO's (ILEP, ILEP Partners, Caritas, Missio Würzburg, CBM = Christoffel Blindenmission, Misereor etc.), in order to arrive at a „win-win-Situation“ for all stakeholders, including target groups.

Partnerships, alliances and mutual agreements between DAHW and partners (national, international etc.) should be expressed transparently for all parties by general, „Memoranda of Understanding“, „Protocol d'accord“ etc.. More specific agreements or contracts linked to a project should contain reference to a plan of action with indicators, a budget and allocation of responsibility.

4.1 Projects as the basis of DAHW MSP department

Projects are the core instrument of the department for medical-social projects within DAHW.

These projects are usually carried out by partners that submit project proposals with specific activities and objectives to DAHW.

DAHW supports this process through technical advice, financial assistance and supportive supervision, including capacity building and project assessments.

Representatives and medical advisors (sometimes also social workers) of the DAHW offices play an important role in providing feedback, support and collating information, communication and documentation of financial and technical data between international networks and project partners. All this is part of a human gesture between people and not just expression of a development bank or competent technical support.

Projects should be integrated within the national health and development policy, National guidelines of the health ministry, the international UN Millennium goals, the targets of WHO, ILEP and other

reasonable approaches have to be decided upon in each situation.

4.2 Project structure

The final aim of medical social projects is the social or physical integrity of the patient or the target groups. A project usually focuses on one sector and within the sector on one or few sector delivery areas. Within these service delivery areas (SDA), projects should determine few key indicators within the following output areas:

1. **Improved accessibility** to medical and social services for disadvantaged and sick people
2. **Quality of projects**, in which funding, activities and measurable aims are transparently linked
3. **Economic and efficient** use of financial resources
4. Projects are not only the expression of good ideas and necessary services but also of **teamwork, self-initiative and subsidiarity** in which a partner determines his contribution and implements it as an input-commitment.

The following table shows the partition of sectors, SDA's and output areas:



Foto: Martina Vornberger

DAHW Project structure

Sector

- A medical oriented Leprosy projects
- B medical oriented Leprosy and TB (with/without HIV component) projects
- C pure TB projects (with/without HIV)
- D medical Leprosy projects combined with any other diseases
- E medical Tuberculosis projects (w/without HIV component) with any other diseases
- F combined med. Leprosy/TB with any other disease
- G Other diseases without Leprosy or TB (neglected, general diseases HIV projects etc.)

- H DAHW Bureaus**
- I other sectors (should be extremely rare)
- S social-economical and development oriented projects for sick or vulnerable people or communities (including peda-gogical projects/ Programmes)

Service Delivery Area (SDA)

- 11 Measures for individual diagn. and treatment, counselling, reaction treatment, laboratory routine – including investments in this sector
- 12 Prevention of disabilities, physical rehabilitation, incl. surgery; patient education and sensibilisation – including investments in this sector
- 13 any other patient support, including Home Based Care, food for patients/children – include. investments in this SDA
- 21 Early case detection strategies and mass screening, IEC measures, health education in communities, advocacy, social mobilization
- 22 Training, capacity building (in-cluding planning, journals, congresses) or sponsorship of health/administrative staff
- 23 Logistics, infrastructure and management support of projects/programmes
- 24 Research (basic, operational, pilots)
- 25 M&E, consultancies, supervision (incl. rep/rec), External quality assurance, TST (technical support teams)
- 26 Any other programme support.
- 31 Income generating activities
- 32 house construction activities (social, not med/ped. purpose)
- 33 Educational activities, schools, Kindergarten – incl construction activities in this field
- 34 Social welfare, including charity and food distribution
- 35 Any other development project: e.g. relief items distribution etc.

Output areas

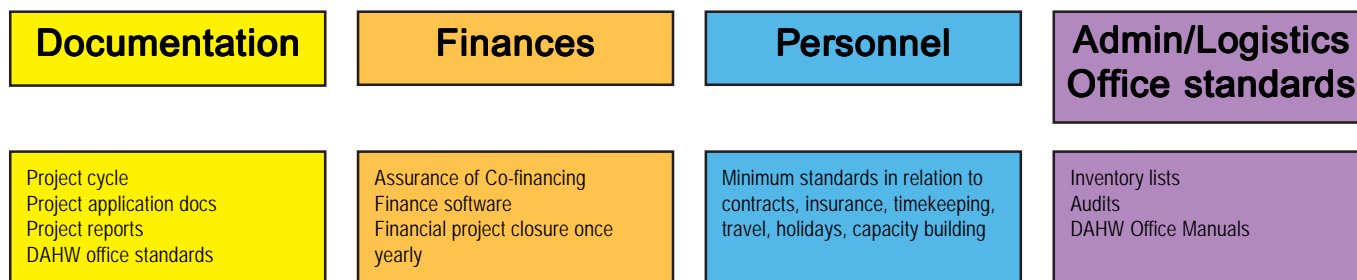
- 1. **Improved access** to medical/social services
- 2. **Quality oriented project measures**
- 3. cost-efficient input of financial resources
- 4. Support of **Teamwork, selfinitiative and subsidiarity**, in which the partner defines and commits his share of the project

Indicator

- 1. International standards
- 2. National standards
- 3. Project- and program-relevant, specific indicators

Development of indicators and identification of a few project relevant key indicators.

DAHW Office administration



4.3 Administrative project support

Entrusted funds need to be carefully used and well documented. DAHW country offices should have a commonly agreed and standardized reporting and documentation system. Minimal communication and reporting standards have been identified for the offices and for the projects.

DAHW offices (in countries without an office it is DAHW Würzburg) are responsible to facilitate collection of essential documents from the partners and forward at least 3 main project documents to DAHW Würzburg: budget, plan of action with key indicators and project contract/ memorandum of understanding.

In case the DAHW office is implementing projects, the office applies the same standards like any other project.

Administrative tasks of project management (general reporting, admin and financial reports, personnel reports) are determined by minimum standards and measurable indicators that are measured within the project cycle.

Details of the above mentioned minimum standards will be described in the DAHW manual which is yet to be completed.

4.4 Project output and outcome documentation

Projects determine their targets according to local factors and in view of reasonability and feasibility. The project cycle usually lasts one year, however can also last longer.

Targets are expressed in specific indicators that can be measured and checked. They should be SMART (specific, measurable, appropriate/accessible, reasonable, time bound).

These indicators can be classified in identifiable „Service Delivery Areas“ such as: Diagnosis and case

social rehabilitation, capacity building, research etc.(see above).

A project may have many activity, process, output or outcome indicators.

Projects are requested to identify a few selected key indicators that reflect the main targets. These key indicators⁴ are obtained through process- or activity indicators that are described in the Plan of Action (standardized DAHW document). This Plan of Action is made as part of the project application document and is updated and filled in at the end of the project as the „Achievement Report“. Key indicators may relate to international standards and possibly correspond to at least one of the main output areas: **access to services, quality of services and self-initiative/contribution or participation of partners/patients/clients.**

The project monitoring is done by the partner, and supportive supervision by DAHW contributes to quality assurance. External evaluations (possibly regular) and audits – depending on the project volume – should be part of the standard quality measures. The fact that selected key indicators can never really reflect all the (positive and negative) aspects of an intervention does not undermine the operational importance of key indicators or main project targets.

Projects are validated by these self-defined and achieved targets that are measured and documented as key indicators. Achieved indicators ideally confirm the appropriate and effective utilisation of DAHWs financial and human resources.

A project validation model will be developed that rates project success according to different quality levels.

⁴ Usually only a few **KEY** indicators (e.g.: minimum 2 or 3) per SDA (service delivery area) should be identified by the project as decisive performance results that can be used to determine the validity of the project. That does not mean that the other activity or process indicators are less relevant and cannot become at another stage key indicators too. Nevertheless – key indicators help the project partner and DAHW to understand where the focus and the priorities lie.

4.5 Criteria for new projects

Apart from the above mentioned criteria (see under 2 –DAHW organizational profile), new projects and project partners are accepted according to feasibility for DAHW, inclusion into a country or regional strategy and capacity and reputation of the partner.

By using DAHW funding the partner accepts assessments and evaluation missions and he is requested to use DAHW specific application documents, administrative procedures and requirements.

The responsibilities and commitment of DAHW and the partner should be documented in a contract or specific Memorandum of Understanding. This is especially relevant for projects beyond a certain financial volume.



Foto: Rolf Bauerdick



Foto: Erwin Eder

5.0 Improving project support further

In order to develop, implement and supervise the above mentioned framework and improve the work in the interest of beneficiaries, the following supportive measures are of particular relevance:

5.1 Training and feedback-culture

Quality is nurtured in an environment of attentive research for truth of knowledge and experience in front of human needs. Therefore constant training and supervision of responsible staff and open feedback facilitates improvement of quality.

For this reason we place a high value on (with DAHW partners and DAHW staff) capacity building, professional development workshops, seminars, project visits and regional conferences.

To avoid that this constant development benefits only the individual person, the following criteria apply to any mission, training, conference etc.:

- Responsibility to spread the obtained knowledge, experience etc. through memos, lectures or written summaries for any need arising within DAHW
- An organizational culture that promotes exchange, monitoring and communication between different (management) levels
- Responsibility to support and document operational research, and by doing so eventually improve procedures and service delivery
- Innovative initiatives and creative solutions that have a sustainable positive effect are of particular interest
- Responsibility to participate in evaluation missions, to perform them and to use the gained knowledge pro-actively for the benefit of DAHW projects.

5.2 Research and lecturing

Leprosy and Tuberculosis Programmes work with diagnostic and therapeutic tools that are more than 70 years old. Other neglected and stigmatizing diseases like Leishmaniasis, Buruli ulcer and Sleeping Sickness share the same fate.

The need to develop and evaluate better instruments in the area of diagnostics, therapy and public health approaches is beyond doubt. Operational research should therefore represent a certain percentage (5-10%) of DAHW project funding.

In order to be effective and innovative, research of this nature needs to be presented and documented

in scientific journals, conferences, workshops and seminars. The Medical-Social Project Department of DAHW supports teaching endeavours in the form of lectures or articles. Established contacts to Missions-ärztliches Institut Würzburg, the Universities of Würzburg, Berlin and Heidelberg should be further developed and possibly extended, especially in relation to any project work or research.

5.3 Co-financing

Most of the funding for DAHW projects is obtained by donations from Germany and Europe (~70%).

Furthermore there is significant support by other non-governmental institutions and trusts as well as funding from towns, regions or German states (~10-20%).

More public funding from BMZ, KfW and EU could be mobilised to create a stronger impact (around 10-20%).

New international funding mechanisms in the field and emerging alliances (CBM, Misereor, Global Fund etc.) have been developed and could be extended. These co-financing initiatives require careful and comprehensive documentation and reporting. They also require specific and additional human as well as administrative capacity and competence.

The Medical-Social Project Department, together with Country Offices share the responsibility and willingness to plan, carry out and increase co-financed projects in a pro-fessional manner.

DAHW will also contribute to support fundraising activities in the respective countries (e.g. Pakistan, India). Furthermore the need for international consultancies, especially in the field of TB facilitates networking and project support.



Foto: Rolf Bauerdick

6.0 The point of reference



Our work faces a double task: **Implementation of activities and methods** after having **identified needs that express the fundamental desire and dignity of every human being**.

Standards and quality

Targets and guidelines, standards and performance measures reflect a **structured framework** that clearly highlights the priorities of health or social interventions for the beneficiaries. The technical application of a (quality) management system is a reflection of this attempt, too.

Attention to man

Man is more than a technical or biological summary of issues or problems. A working culture and an education that welcomes what lies at the root of man's heart is part of a reasonable realism. The respect for all human needs – because they reflect our dignity and destiny as patients or employees – is the only guarantee that the insurmountable value of man is not manipulated by political interests and reducing prejudices.

Both factors need to be cultivated and developed by DAHW stakeholders in order not to lose the complete picture. The consistent attempt to improve the DAHW work is a reflection of this. A „worldwide DAHW culture“ is born as a free, pro-active and responsible participation in this process to improve care and reduce suffering. This means

- it supports the common good by fighting professionally against disease and marginalization of people. By doing so it strives to achieve an ever better investment of funds that have been entrusted to us by numerous concerned people who have pro-actively decided to invest some of their own resources for this endeavour.
- it seeks to appreciate and reflect the given need for happiness, the desire for love and compassion that is part of every individual person, especially if he/she is sick or vulnerable.



Foto: Rolf Bauerdick



Foto: Rolf Bauerdick



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