



# 2021

YEAR IN REVIEW



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# ACRONYMS

AECID	The Spanish Agency for International Development Cooperation
AFD	Amref Flying Doctors
AFENET	African Field Epidemiology Network
AGYW	Adolescent Girls and Young Women
AHAIC	Africa Health Agenda International Conference
AHI	Amref Health Innovations
AIDS	Acquired Immune Deficiency Syndrome
AIMS	Amref Information Management System
AK	Afya Kamilifu
AMC	Amref Medical Centre
AMIU	Amref International University
AMR	Antimicrobial Resistance
Amref	Amref Health Africa
ANC	Antenatal Care
aPNS	assisted Partner Notification Services
ARP	Alternative Rite of Passage
ART	Anti-Retroviral Therapy
ASLM	African Society for Laboratory Medicine
AU	African Union
AYC	Amref Youth Council
BHW	Boma Health Workers
BMGF	Bill and Melinda Gates Foundation
CAFA	COVID-19 Action Fund for Africa
CAIA-MNCM	Canada-Africa Initiative to Address Maternal, Newborn and Child Mortality
CBHP	Community-Based Health Programme
CHW/CBHW	Community Health Worker/Community-Based Health Worker
CCHPs	Comprehensive Council Health Plans
CDC	Centre for Disease Control
CDOH	County Department of Health
CEFM	Child, Early and Forced Marriage
CHA	Community Health Assistant
CHD	Community Health Department
CHS	Community Health Strategy

CHU4UHC	Community Health Units for Universal Health Care
CHV	Community Health Volunteer
CIP	Continuous Improvement Plan
CM	Child Marriage
COE	Centre of Excellence
COS	Council Own Source
COVID	Coronavirus Disease
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CUE	Commission for University Education
CVC	COVID-19 Vaccination Centre
CYP	Couple Year Protection
DALY	Disability Adjusted Life Years
DCPM	Disease Control Prevention and Management
DESIP	Delivering Equitable and Sustainable Increases in Family Planning
DHO	District Health Officer
DHT	District Health Team
DIAGMAL	Diagnosis of malaria in different endemic and health settings in sub-Saharan Africa
DMO	District Medical Officer
DPT	Diphtheria, Pertussis, Tetanus
DR	Developing Regions
EA-REQAS	East African Regional External Quality Assessment Scheme
ECAMM	External Competence Assessment of Malaria Microscopists
EDCTP	European and Developing Countries Clinical Trials Partnership
EFIRE	Expanding Financial Resilience
EmONC	Emergency Obstetric and Newborn Care
END Fund	Ending Neglected Diseases fund
EQA	External Quality Assessment
ESRC	Ethics and Scientific Review Committee
FANC	Focused Antenatal Care
FBHW	Facility-Based Health Worker
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FINISH	Financial Inclusion Improves Sanitation and Health

FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-Based Violence
GF	Global Fund
GHS	Global Health Security
HBCC	Hygiene and Behavioral Change Coalition for COVID-19
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HPF	Health Pooled Fund
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSAP	Health Systems Advocacy Programme
HIS	Health Science Institutes
HSS	Health Systems Strengthening
HTS	HIV Testing and Counselling
ICD	Institute of Capacity Development
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IRB	Institutional Review Board
ISO	International Organisation for Standardisation
J4L	Journey for Life
JOUST	Jaramogi Oginga Odinga University of Science and Technology
JTH	Juba Teaching Hospital
KCHS	Kenya's Community Health Strategy
KEMRI	Kenya Medical Research Institute
LMG	Leadership, Management and Governance
M-Jali	Mobile Jamii Afya Link
MDA	Mass Drug Administration
MHM	Menstrual Hygiene Management
MNCH	Maternal Newborn and Child Health
MNH	Maternal and Newborn Health

MOH	Ministry of Health
MPDSR	Maternal, Perinatal, Death and Surveillance Response
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
NHIF	National Hospital Insurance Fund
NS	Nodding Syndrome
NSA	Nodding Syndrome Alliance
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
ODF	Open Defecation Free
OPD	Outpatient Department
OSC	One-Stop Centre
P4PC	Partnership for Primary Care
PEPFAR	The US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PHSSA	The Partnership for Health Systems Strengthening in Africa
PLHIV	People Living with HIV
PLM	Project Last Mile
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PPE	Personal Protective Equipment
PPP	Public and Private Partnerships
PR	Principal Recipient
PT	Proficiency Testing
PtY	Power to Youth
PWD	People with Disabilities
PWID	Persons Who Inject Drugs
R/CHMT	Regional and Council Health Management Team
RCC	Regional Collaboration Centre
RCOP	Research Community of Practice
RH	Reproductive Health
RHB	Regional Health Bureau
RHITES	Regional Health Integration to Enhance Services

RMC	Respectful Maternity Care
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
RMNCAYH	Reproductive Maternal Newborn Child Adolescent and Youth Health
S/CHMTs	Sub/County Health Management Teams
SAFE	Surgery, Antibiotics, Facial Cleanliness and Environment improvement
SARA	Service Availability and Readiness Assessment
SCH	Schistosomiasis
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SMART	Specific, Measurable, Attainable, Relevant, Time-bound
SMS	Short Message Service
SMT	Senior Management Team
SP	Strategic Purchasing
SPARC	Strategic Purchasing Africa Resource Centre
SRAJ	Sante de la Reproduction des Adolescents jeunes (Youth Reproductive Health)
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STH	Soil Transmitted Helminthes
STI	Sexually Transmitted Infection
SU4A	Stand Up for Adolescents
TA	Technical Assistance
TB	Tuberculosis
THP	Total Health Project
TORs	Terms of Reference
TP	Teenage Pregnancies
TVET	Technical and Vocational Education and Training
TZS	Tanzanian Shilling
UHC	Universal Health Coverage
UMP	Ustawi wa Mwanamke
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
USSD	Unstructured Supplementary Service Data
VEO	Village Executive Officer

VL	Viral Load
VSC	Village Sanitation Committee
WASH	Water, Sanitation and Hygiene
WELCOMM	Worldwide e-Learning Course on Malaria Microscopy
WHO	World Health Organization
Y-ACT	Youth in Action
YFHS	Youth-Friendly Health Services
YLD	Years Lived with Disability
YLL	Years of Life Lost

# Amref at a **GLANCE**



### Our Vision

Create lasting health change in Africa.



### Our Mission

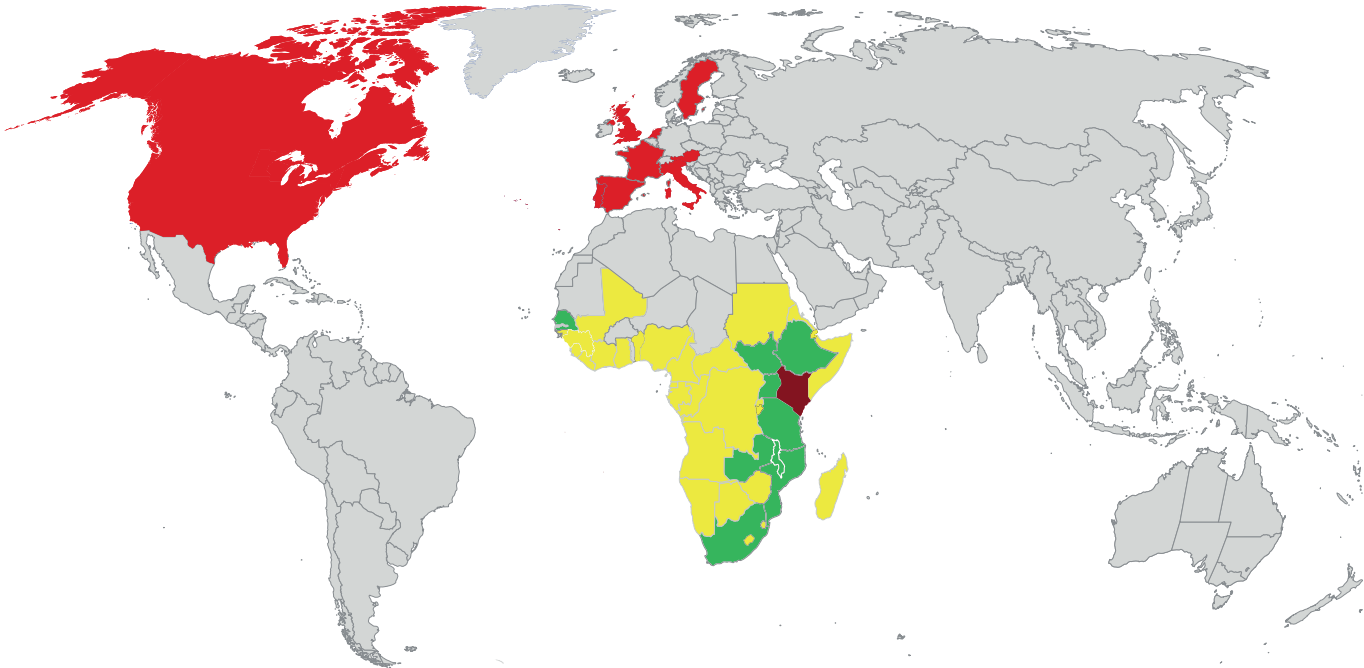
Increase sustainable health access to communities in Africa through solutions in human resources for health, health services delivery and investments in health.





### Our Promise


- Improve the lives of disadvantaged people in Africa through better health
- Bridge gaps between communities, health systems and governments
- Be a leading force for advocacy for health system reforms in Africa
- Be a leader in the NGO community, developing and documenting best practices and training programmes.


### Our Global Presence



 Physical and Programmatic Presence

 Programmatic Presence

 Fundraising Offices

 Global Headquarters

# Amref at a **GLANCE**

## Our Corporate Strategy



## MESSAGE FROM THE CHAIR, INTERNATIONAL BOARD

I am delighted to present the Amref Health Africa 2021 Annual Report. This report provides a highlight of inspiring stories and our collective experiences operating in the context of global health inequities made more complex in the wake of COVID-19 pandemic, and a further deepening of the climate change crisis and its profound effects on human health.

The year 2021 will be remembered as another period that tested Amref Health Africa's resilience. The uncertainties created by the pandemic exposed and exacerbated existing deep-seated health inequalities, many of them rooted in an unfair and broken global health system.

Amref, like many health and development organisations, was affected by the pandemic-related disruptions, which threatened to tear apart the social, economic, health and political fabric of society. However, COVID-19 in many ways forced us to adapt, learn and forge strategic collaborations with primary agents of health change, buoyed by our spirit of "Ubuntu". Thanks to an agile and people-centred approach to our strategy, we were able to adapt and stay true to our vision of creating lasting health change in Africa, while at the same time leading pandemic response by leveraging our relationship to provide strategic counsel on health policy at national, regional and global levels.

We are proud to be among the few institutions that championed for equality to ensure that no one is left behind in the fight against the pandemic.

Additionally, we provided direct support to communities through a variety of interventions that focused on preventing transmission, death, and social harm. Under these pillars, Amref's approach has been rooted firmly with community engagement and awareness-raising delivered through an extensive network of Community Health Workers (CHWs). Through these efforts, Amref is continuously working to address both immediate and longer-term impacts of COVID-19 on the health system, as well as the wider social and psychological impacts.

From South Sudan to Zambia, Senegal, Tanzania, Uganda, Ethiopia, Malawi and Kenya, we see the courageous leadership of CHWs and young people championing health and social action to address the struggles around the continent. Their stories of triumph as they rise against the layered impacts of the pandemic and resist gender-based violence, specifically female genital mutilation/cutting (FGM/C) continue to inspire us and strengthen our belief that solidarity and partnership remain critical pillars to creating resilient communities.



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“We are proud to be among the few institutions that championed for equality to ensure that no one is left behind in the fight against the pandemic.”

In the past year, we have reaffirmed our commitment to promoting lasting health change through our 2018-2022 Corporate Strategy which defines our path to deliver diverse health programming across the continent. To assess progress in the implementation of this strategy, we conducted a mid-term review between March and May 2021. The review process focused on the impact of COVID-19 on Amref's programmes and operations, best practices and lessons learnt, as well as producing short-term recommendations for the remaining period of the strategy, and mid-term, for development of the next strategy. Through the MTR process, we have built a strong connection with our past and present to help us design a better future for Amref.

As we work towards our next strategy, we believe that individually and collectively, African countries need to do better to achieve Universal Health Coverage (UHC) and health security. By leveraging partnerships and opportunities within the Amref fraternity, including **Amref Flying Doctors, Amref International University, Amref Enterprises Limited** and our various country programmes across Africa, Amref will continue leading advocacy efforts for investments in health, aiming for greater and better-targeted investment in the foundations of health systems and an integrated approach based on primary health care that leaves no one behind.

We look forward to working with different African countries, development partners, the private sector, communities, and other global health players to ensure prioritisation of community interests in decision-making and strengthening global systems for pandemic preparedness and response. This will allow a shift from emergency pandemic response to a strategy of future sustainable pandemic preparedness and control with resilient health systems.

Mr Charles Okeahalam | Chair, Amref Health Africa International Board of Directors

## MESSAGE FROM THE GROUP CEO

**H**ealth systems continue to face critical challenges in sustaining COVID-19 response while maintaining other essential health services. The pandemic has revealed global health inequities and glaring gaps in emergency preparedness – factors that slow-down progress towards Universal Health Coverage (UHC) and global health security. The ongoing inequities in access to vaccines and other COVID-19 tools are a wake-up call for African institutions to join forces to secure a safer and healthier future for everyone.

Making a lasting impact in the communities we serve takes steady commitment and trusting partnerships that prevail through tough and unprecedented challenges such as those posed to us by the current pandemic. Despite the challenges we have faced in the past year, I am proud to present snippets of our contributions to strengthening health systems to promote equity and resilience in Africa. Our shared achievements have been made possible through dedication, sacrifice, hard work, resilience and great cooperation from all staff, partners and the communities that have welcomed us into their midst.

We have attained significant milestones in 2021, including implementing 195 projects across Africa that have reached 20.1 million people directly and 48.2 million people indirectly. Out of these, 114 projects continued on to 2022.

We remain a strong pillar in the continent's pandemic response. Through our strong convening power and technical capabilities, variability of country programmes and concerted interventions of our subsidiaries, we continued to support the COVID-19 response efforts of various governments across Africa, including promoting uptake of vaccines and providing technical assistance in a variety of areas, leading global advocacy campaigns for vaccine equity and strengthening future pandemic resilience. These efforts saw Amref represented in various task forces and technical working groups on COVID-19 response across the continent.

In October 2021, we launched a global campaign to end COVID-19 vaccine injustice dubbed “End Vaccine Injustice in Africa”. The [campaign](#) called on world leaders to honour their commitments to low-and middle-income countries to leave no-one behind in the race to bring an end to the COVID-19 pandemic by mobilising and availing more vaccines for the continent. Through a global online petition, we continued to engage and hold rich countries accountable to their commitments to stand in solidarity with all countries, including members of the G7 and G20 as well as heads of multi-lateral and bilateral institutions. As a result of the campaign, more vaccines have been delivered to Africa.



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“Our shared achievements have been made possible through dedication, sacrifice, hard work, resilience and great cooperation from all staff, partners and the communities that have welcomed us into their midst.”

Results of our direct support to communities through initiatives such as vaccine outreach with the Amref International University (AMIU) and moonlight vaccination programmes, among other interventions, are clear evidence of the significance of access to promoting vaccine uptake. Additionally, as the world begins to bounce back slowly from the pandemic, the re-launch of the Africa Dialogues series has been a game changer in promoting expert-driven policy conversations to support Africa to 'build back better' from the pandemic.

The sample stories and programme updates presented in this annual report reflect Amref's agility, resilience, and adaptation in the face of an unprecedented global health pandemic.

Looking back, we have made significant progress in promoting ONE AMREF and enabling a more cohesive organisation with active coordination for the COVID-19 response. We developed various policies, strategies and frameworks to support the implementation of bold steps to support programmes and made significant investments in staff, including leadership training programmes, and job evaluations that guided reviews in grading and benefits inherent to all staff.

Going forward, we will continue to invest in our staff and strengthen our partnerships with the Ministries of Health across Africa as well as our development partners and most importantly, the communities we serve. Through this, we will remain resilient, empowered and supported to deliver on our mandate.

As we reflect on our achievements, lessons and challenges for 2021, we look ahead to a future filled with exciting possibilities to serve our communities and achieve health for all.

Dr Githinji Gitahi | **Group CEO, Amref Health Africa**

## EXECUTIVE SUMMARY

The Amref Health Africa (Amref) corporate programmes report covers the period from January to December, 2021. It presents the progress of all country offices and units on projects, reach, key corporate performance indicators, and cross-cutting themes including research, innovation, youth and adolescents and advocacy. A new feature in this year's annual report is the service contact frequencies<sup>1</sup> which stands at 26.4 million across the organisation.

In 2021, there were a total of 195 projects reaching 20.1 million beneficiaries directly and 48.2 million indirectly. A major contributor to reach that has pushed up the numbers significantly was 5.9 million people reached through mass drug administration (MDA) implemented by **Amref Kenya** (71% of its total reach). MDA programmes continue to grow with **Ethiopia** and **South Sudan** also providing significant numbers towards reach. In general, almost all entities have had increased portfolios in 2021 compared to 2020, where activities were paused or limited due to the COVID-19 pandemic. COVID-19 has also contributed to increased activity in Amref entities with new COVID-19 and Global Health Security (GHS) programmes reaching additional populations through PPE distribution, awareness-raising programmes and vaccinations. A significant increase in reach has been recorded in West Africa where the Canada-Africa Initiative to Address Maternal, Newborn and Child Mortality (CAIA-MNCM) COVID-19 response alone reached 1.4 million people directly (95% of total directly reached in West Africa) through household level distributions and awareness of COVID-19 prevention products such as masks, hydro-alcoholic gel and hygiene kits. **West Africa** has also significantly contributed to indirect reach through media awareness via the CAIA-MNCM programme and ICD through its PHSSA programme, reporting approximately 8 million each. A new feature is also the service contact frequencies<sup>1</sup> which stands at 26.7 million across the organisation. The core programmes demonstrated the following results: over 68,000 health workers were trained in various formats; and over 95,000 health workers trained in COVID-19 topics. The RMNCAH programme area focuses on Gender-Based Violence (GBV), Female Genital Mutilation/Cutting (FGM/C), and Alternative Rites of Passage interventions, as well as the full continuum of maternal and child health.

Disease Control and Prevention focuses on communicable disease programmes as well as COVID-19 interventions. Through these, Amref facilitated over 44,000 COVID-19 tests through health facilities and over 48,000 were conducted through the **Amref Medical Centre** (AMC). Amref also facilitated full immunisations for over 500,000 people and first doses for over 1,000,000 people through programme interventions in health facilities. Under Neglected Tropical Diseases, **Kenya** and **Ethiopia** are undertaking significant work on mass drug administration and South Sudan on epilepsy/nodding syndrome treatments.

The corporate technical agenda is fuelled by 11 Communities of Practice (CoPs), with a total of 508 members from across the organisation. 47 advocacy initiatives were conducted, and 23 research studies successfully published in 2021. The Youth Strategy launched in 2020 reported considerable progress with new programmes such as Power to Youth, increased youth participation in new programme designs and inclusion of youth in Amref national boards.

Going forward into its next strategic period, Amref is adding focus on the quality of its service delivery with the achievements outlined in this report as its foundation. It will seek to establish new programmatic approaches; invest more in technology, data and impact; come up with new and futuristic areas of intervention; and work towards improved partnerships and programming.

<sup>1</sup>Service contact frequencies measure the number of times a service has been provided regardless of the number of people reached.

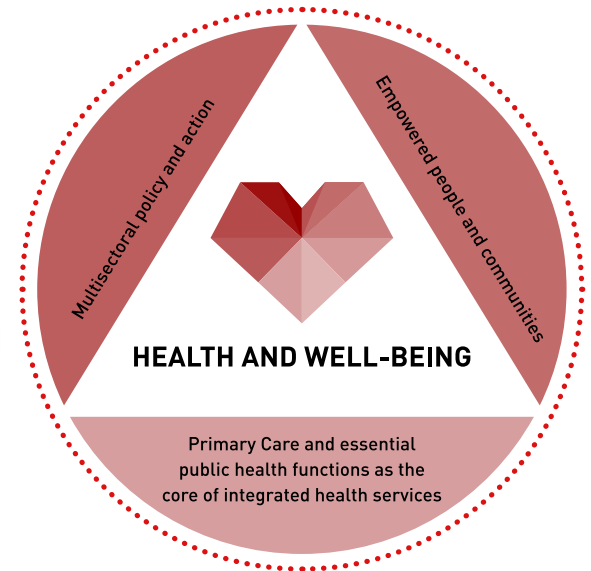
## OUR STRATEGIC CONTEXT

### Communities at the Centre of Programming

Half the world's population lacks access to essential health services, and 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses<sup>2</sup>. To reverse this trend, governments and the development sector need to move countries towards Universal Health Coverage (UHC) by strengthening systems for primary health care (PHC). A contemporary conceptual framework for PHC serves as an approach to health, based on three synergistic components - Empowered People and Communities, Multisectoral Policy and Action, and Primary Care and Essential Public Health Functions (see *Figure 1*). By embracing people and communities, this framework is cognisant of demand-side gaps that have plagued health systems.

To make PHC a robust vehicle for delivering UHC, Amref invests in integrated community-centred care by putting people and communities at the centre of health systems, not diseases. This human-centred design<sup>3</sup> calls for a fundamental shift in the funding, management, coordination, and delivery of health services.

For Africa to achieve UHC and SDGs and thrive within the context of current and emerging threats and shocks such as climate change, epidemics, non-communicable diseases, digitalisation, demographic shifts, and economic transition, people and communities need to be at the centre of health systems. In line with this, Amref is challenging itself to re-imagine each of the six building blocks of the health system to deliberately address PHC system barriers and serve the health needs of populations, with people engaged as agents of transformation.



*Figure 1: (Source: A vision for PHC in the 21st century: Toward Universal Health Coverage and the Sustainable Development Goals (Draft 4 September 2018, WHO)*

<sup>2</sup>[Global Monitoring Report, 2017](#)

<sup>3</sup><https://www.who.int/news/item/28-05-2016-sixty-ninth-world-health-assembly-closes>

2021 HIGHLIGHTS (OUR COLLECTIVE ACHIEVEMENTS)



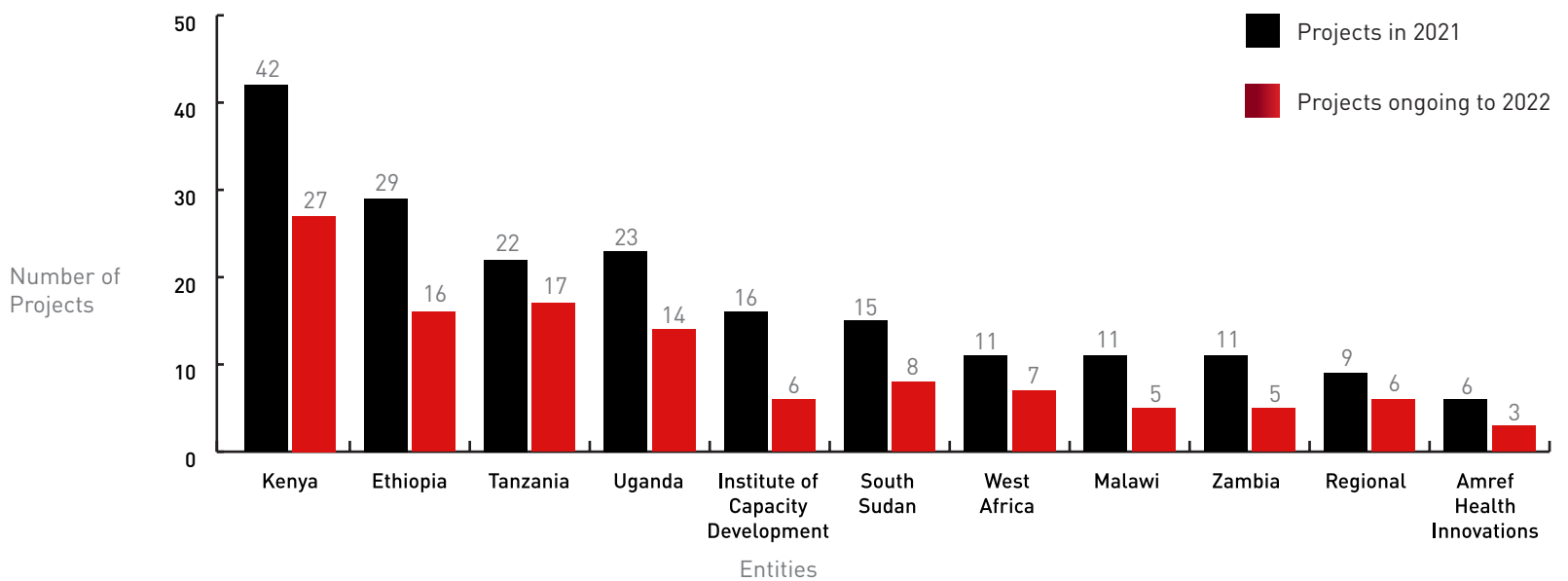
**20.1 MILLION**  
**DIRECT BENEFICIARIES REACHED**



## PROJECTS AND REACH

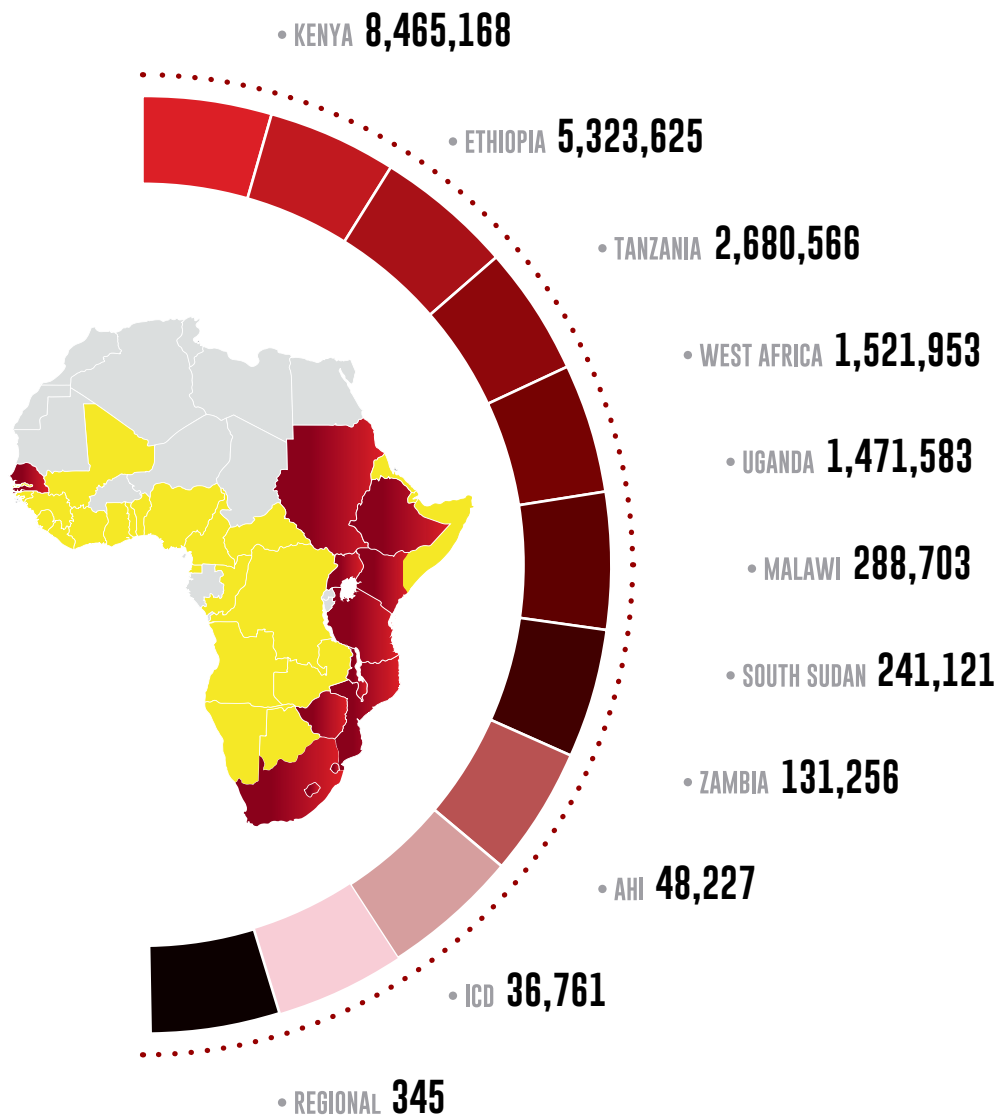
In 2021, there were 195 projects implemented for the duration of the year. Out of these, 114 projects continued on to 2022. The chart shows the breakdown of projects by entity. Kenya continues to take the lead in the number of projects, budgets and reach, although other entities have shown significant growth through increased portfolios and reach of COVID-19 interventions. These include: **Ethiopia, Tanzania, Zambia** and **West Africa**. In terms of scale and reach, significant increases have been noted due to increases in portfolios for most countries, but also due to increased compliance on reporting data at the corporate level.

Amref reached 20.1 million people directly and 48.2 million people indirectly. The most significant increases for direct reach came from West Africa contributed to by the CAIA MNM COVID-19 response, which alone reached 1.4 million people directly (95% of total directly reached in West Africa) through home visit awareness programmes conducted in 13 districts through 1,000 CHWs trained.



The next significant contributor to direct reach and showing the second largest increase from last year is Kenya, where 5.9 million people were reached through mass drug administration by the STH/SCH END FUND, which accounts for 71% of Kenya’s total direct reach; **Amref Health Innovations (AHI)**, which improved its compliance with more accurate information, resulting in a significant increase in numbers; and **Zambia**, with the portfolio increasing by 83% and wider reach by several COVID-19 interventions through the AFENET PACT, Centre for Disease Control (CDC) and the CAFA Personal Protective Equipment (PPE) distribution projects. With the exception of **Malawi** and **South Sudan**, which recorded reductions, all other entities have recorded increases ranging between 60-80% compared to 2020.

Indirect reach also shows an overall 59% increase from 2020, with a significant increase from AHI who have been more compliant with corporate reporting requirements in 2021. **Zambia** with its results corresponding with additional direct interventions; CAIA-MNMC COVID-19 programmes in Senegal, which has had a large impact on the community, with distributions of PPE to 223 health facilities and messaging through media outlets that reached 8 million.



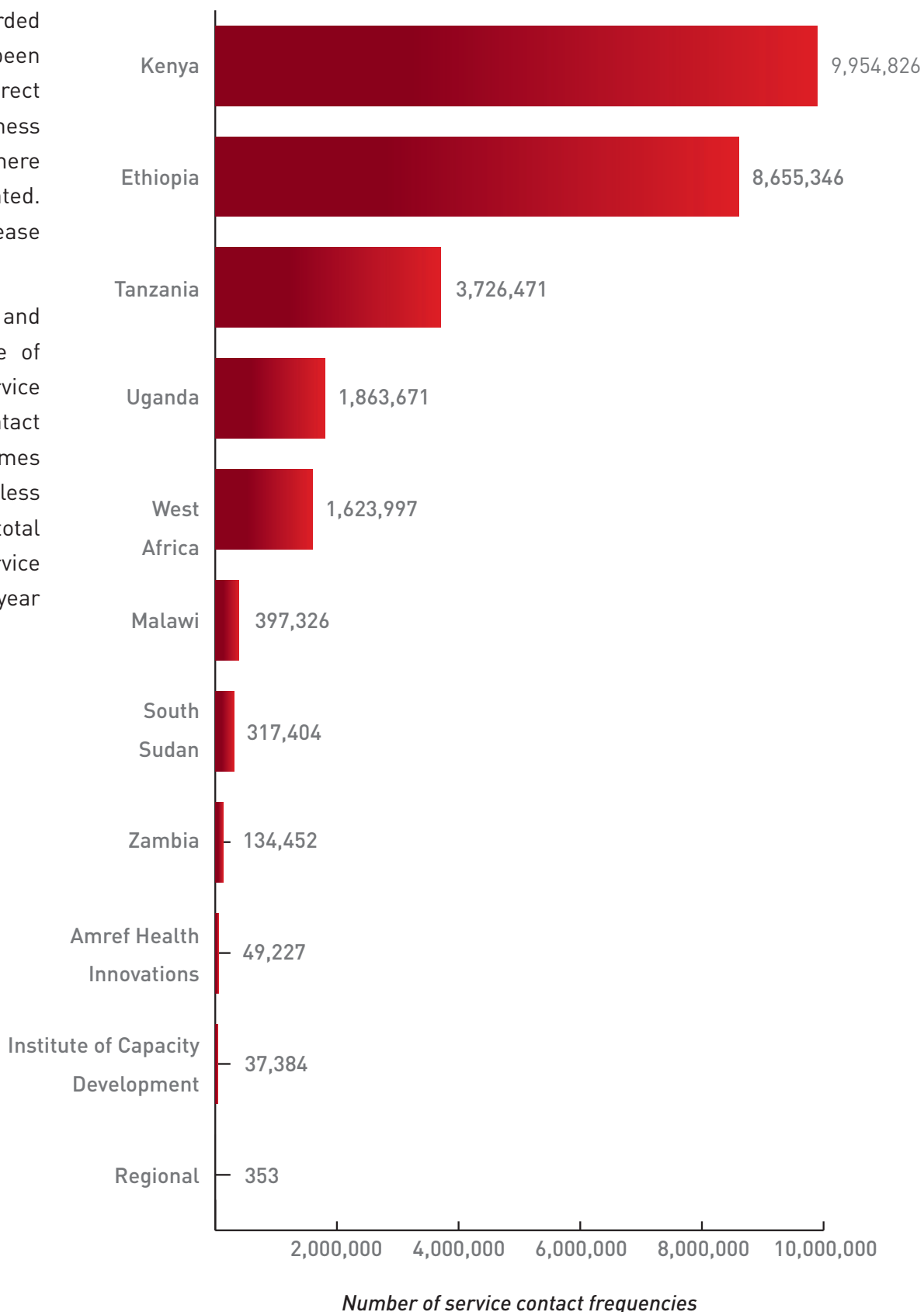
■ Physical and Programatic Presence

■ Programatic Presence



A reduction in indirect reach is recorded only in **Uganda** where there has been significant overlap in terms of indirect reach through media and awareness programmes in the same regions where multiple projects were implemented. All other entities recorded an increase ranging between 30-90%.

In addition to calculating direct and indirect reach, this year, the scale of services is also reported through Service Contact Frequencies. Service contact frequencies measure the number of times a service has been provided regardless of the number of people reached. A total of 26.7 million frequencies of service provision have been recorded for the year 2021.





### **HUMAN RESOURCES FOR HEALTH**

Human Resources for Health (HRH) focuses on enabling health workers to provide services across health facilities and community-based facilities. HRH prioritises training, mentorship and provision of tools to health workers; supporting training institutions through curriculum development and organisational support with leadership, management and governance efforts; and advocating for health worker related issues such as creating an enabling environment, health worker compensation and recognition.

## Health Worker Knowledge and Skills

Over 68,000 health workers were trained in 2021 compared to over 43,000 health workers trained in 2020. The following numbers have been reported for training of health workers facilitated through projects implemented in all entities in 2021. With the exception of CHWs trained face-to-face, all other indicators have met or exceeded targets.

Indicator	Method/ Topic	% Achievement	Target	Value	Men	Women
Community based health workers (CHW) trained	Face-to-face	64%	42,115	26,912	10,238	16,674
	Mobile/ elearning Platforms	108%	16,280	17,510	6,725	10,785
Facility-based Health Workers (FBHW) trained	Face-to-face	94%	19,745	18,554	8,135	10,419
	eLearning platforms	92%	60	55	16	39
	LMG topics	138%	3,655	5,035	2,746	2,289

**Overall Performance:** CHW face-to-face training underperformed due to low turnouts as a result of the COVID-19 outbreak in **Malawi**. In **Kenya**, the cascade of activities, which included face to face trainings for CBHWs running up to the mass drug administration campaign was postponed due to shortage of drugs.

Leadership, Management and Governance (LMG) course attendance showed improved performance mainly in **South Sudan**, where additional participants attended in order to obtain incentives. The 94 percent achievement through eLearning platforms is attributed to the trainings being administered for free, resulting in higher participation levels.

This achievement can also be credited to the extension of the Partnership for Health Systems Strengthening in Africa (PHSSA II) project which included additional six countries for health worker trainings.

The pattern of achievements indicates that mobile and online trainings are becoming more popular and cost-effective, although face-to-face trainings may need to continue depending on the type of training and demonstrations required.



**OVER 68,000**  
**HEALTH WORKERS TRAINED**

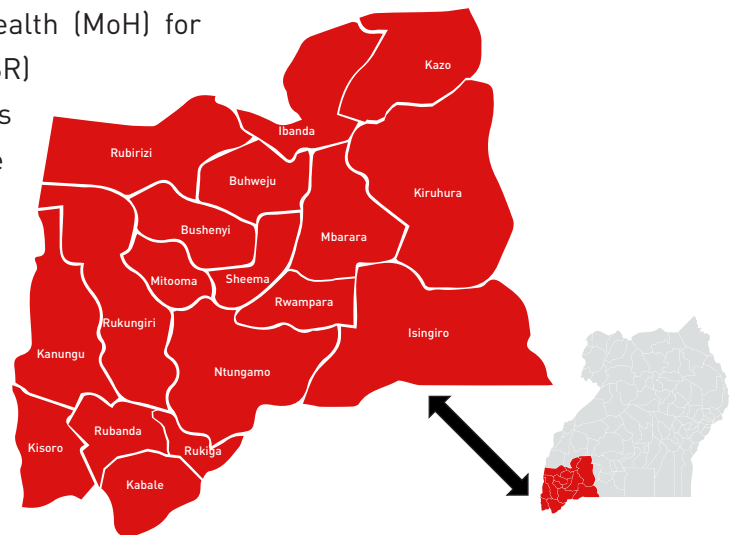
## Health Systems Strengthening on RMNCAH

Health workers need a conducive environment in which their acquired skills can be implemented. Trainings in maternal and newborn care have resulted in programmes producing positive results in improved facilities with more capacity and skills. This is evidenced in the **Uganda, Tanzania** and **Kenya** programmes, which respectively used different approaches to build and evaluate capacity, as shown in the examples below. **Amref South Sudan** also provided significant support through technical assistance to the South Sudan government to address the issue of health worker turnover and capacity, which is discussed in detail in the technical assistance section below.

**Amref Uganda** implemented a mentorship programme in the 18 districts of South-Western Uganda. The programme involved upgrading of skills and knowledge of health workers supported by routine mentorships and visits by key experts to health facilities. As a result, two previously non-functional health facilities – a Level III and a Level IV Health Centres in the South-Western region – can now carry out caesarean section procedures. Key health indicators have improved over the project period beginning March 2021 to February 2022, including increased routine weekly ward rounds; increased proportion of newborns with birth asphyxia appropriately managed (80% to 89% measured); and increased proportion of newborns receiving the complete essential newborn package (80% to 95%) measured between March and December 2021.

Amref Uganda was also recognised by the Ministry of Health (MoH) for Maternal, Perinatal, Death and Surveillance Response (MPDSR) work in South-Western Uganda as a result of clinical skills mentorship for health workers and facilities. Following the intervention, the national MPDSR report showed the Kigezi sub-region performing best with notification and review rates of 83.3% and 95.2% respectively. Ankole region also registered positive performance, notifying 64.7% and reviewing 84.5% of all maternal and perinatal deaths.

Coverage of the districts in which Amref Uganda provided the support is indicated in the map on the right.



*Figure 2: Southwestern districts of Uganda*

**Amref Tanzania**'s Ustawi wa Mwanamke (UMP) project has been supporting efforts to address shortages of skilled health workers, particularly in underserved areas. Through this project, Amref Tanzania is supporting government efforts in operationalisation of community-based health programmes (CBHP) through the use of CHWs. The project evaluation has revealed that Community Based Health Workers (CBHW) selection was mostly done by community members (at 66%). However, a substantial percentage of CBHWs is still being selected by NGOs at 33%. Most CBHWs (87%) revealed they received adequate training that included basic continuous training for one year and a two-week initial induction training upon engagement. As indicated by the CBHP guideline, supervisory roles are provided by Village Executive Officers (VEO) (76%) and facilities in-charge by 58% indicating a lag in the provision of technical supervision to ensure quality community service provision.

Supervision remains relatively unstructured, with only 56% of CBHWs able to tell how often they have been supervised. These findings were useful in advocacy at district and ward level and were key in informing the extension of phase III of the project (UMP III), in which more support on supervisory visits were considered and are currently being made to CHWs. As part of our sustainability approach, the project is deliberately letting councils take the lead in supervisory activities, only facilitating logistics and provision of technical support when the need arises. Based on these findings, councils are being requested to include in their budgets allocations for community-based health services, which include, among others, funds for supervision and monthly incentives for CHWs.

**Amref Kenya** focused on skills training and improving knowledge of health workers. In the period under review, Amref undertook a service availability and readiness assessment (SARA) initiative implemented by the USAID Stawisha Pwani project. Based on the findings and site improvement recommendations, the project supported a three-day training of 30 Facility Based Health Workers (FBHW) from 30 health facilities in Kwale County on focused antenatal care (FANC). The training utilised the Ministry of Health (MoH) national FANC curriculum and provided an opportunity to increase knowledge and skills among FBHW on: provision of quality antenatal care (ANC) services, prevention, identification and management of potential antenatal complications, including care of adolescents as well as enhancing documentation to improve low prevalence of fourth ANC visits.

There was an increase in knowledge and skill based on the pre-post tests conducted, with the pre-test average moving from 78% to 94% at post-test. In addition, the project also trained health care workers on Emergency Obstetric and Newborn Care (EmONC) to address obstetric and newborn complications that contribute to maternal and newborn morbidity and mortality. A total of 28 FBHW were trained from 24 health facilities on EmONC. The training equipped service providers with knowledge on provision of quality care to mothers and children. There was notable improvement in knowledge and skill acquisition in the training; knowledge pre-test average increased from 71.5% to 83.5% and skill post-test average from 29.5% to 91.8%<sup>4</sup>.

HRH interventions and programmes that were undertaken through mobile platforms are reflected in the Technology and Innovations section as well as the Disease Control Prevention and Management sections.

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<sup>4</sup>Source: Project Activity Reports

**Box 1: Supply Chain Management through the c-Stock Approach (Kenya)**

**73% of community based health workers who were trained on the c-Stock platform demonstrated the required skills as a result of the trainings provided by Amref.**

The current Community Health Strategy lacks strong tools and processes for supply chain management at the community level. To fill this gap, inSupply developed the cStock approach, which uses mobile technology, user-friendly dashboards, and quality improvement teams to reduce stock outs of critical commodities in community-based health programmes.

cStock was first piloted in two sub-counties in Siaya and demonstrated positive results. In 2019, the project was awarded a grant from Grand Challenges Canada under the Saving Lives at Birth Programme to scale up the cStock approach in all sub-counties in the county to support the community case management initiative.

The cStock platform was designed to interact with whatever technology is available to the users such as feature phones, smart phones, computers or tablets. Because smart phone access can be limited with inconsistent connectivity, the system also works offline and data is submitted when there is internet access. Using Unstructured Supplementary Service Data (USSD), users with a feature phone or those with no internet access are able to submit their logistics data at no cost. Data sent via USSD is integrated with data sent via the app and all data is available in the DHIS2 platform.



**73%** community based health workers trained on the c-Stock platform

## Technical Assistance to Governments on Human Resource for Health

South Sudan faces a severe shortage of all categories of trained health workforce, including physicians (1 per 65,574 population) and midwives (1 per 39,088 population). This has pushed the MoH to engage inadequately trained or low skilled health workers in health facilities. The situation has further been exacerbated by poor distribution of available health workers as well as lack of policies to govern Human Resources for Health (HRH) development in the country. Training more health workers will reduce this gap immensely as there will be enough health workers distributed across the four levels of facilities in the country and in all states. The key challenge is the absorption of health workers by the government and the retention factors that will still need to be addressed. Moreover, South Sudan, and particularly MoH, lacks competent human resources personnel to guide HRH governance and development. Senior MoH officials have knowledge gaps in building of a well-trained, competent and skilled health workforce, what constitutes a motivated health worker, what kind of support is needed from the national level and the role of senior management teams (SMT) in ensuring that facilities are well equipped, maintained, resourced and able to provide quality health care services. For the Ministry of Health to be at par with the East African Community practices, further technical assistance (TA) will be needed in the foreseeable future. So far, with support from UNFPA, **Amref South Sudan** has provided this to the National Ministry of Health on Human Resources for Health. Key achievements in 2021 are as follows:

**Health Worker Training and Capacity Building:** Health workers increased their capacity to deliver quality health services in their roles as nurses, midwives and clinical officers. Through the LMGT training, senior management teams were able to understand the requirements for facilities to provide comprehensive services to their clients and the importance of collaboration to achieve the desired goals of each facility. The training also equipped them with better understanding of the linkages between various departments and how the successes or failures by one department could impact the whole facility. Through Continuous Professional Development (CPD) programmes, health workers were provided with soft skills training to improve interpersonal relations with patients during service provision.

**Revision of Systems and Processes:** The admission criteria for students willing to join middle level learning institutions were developed and reviewed to support the Ministry of Health in ensuring that all the students admitted meet the required credentials. A government body was established to ensure the authentication of documents received from students to determine admission. This took effect at national level from June 2021. The MoH was also supported in the coordination of Board of Principals Meetings<sup>5</sup> and strengthening of the board's activities. In addition to training, **Amref South Sudan** provided support in development of Terms of Reference (ToRs) for the examination Board.

**Health Worker Retention:** Amref South Sudan initiated a forum where the MoH, Ministry of Public Service and the Ministry of Labour come together to discuss challenges faced by health workers, develop solutions, and ensure all health facilities are well resourced and health worker salaries paid on time. **Amref South Sudan** contributed to the health worker salary harmonisation in partnership with the World Health Organisation (WHO), and the grading of health workers within government grading systems. This process was meant to curb the migration of the health workers from government-owned facilities to NGOs or privately owned facilities. To date, these initiatives have helped stabilise health worker departures, however further work needs to be done for continued sustainability.

Other projects recording outcome data for HRH:

Indicator	Project	Programme	Result
% of facility-based health workers who demonstrated the required skills as a result of training provided by Amref	UNFPA-SRHR	South Sudan	85%
% of health facilities supported by Amref that meet minimum standards	HPF3-Lot 9	South Sudan	100%

<sup>5</sup>Board of Principals is a governance forum for principals drawn from 24 Health Science Institutes (HSIs).

## Reproductive Maternal Newborn and Adolescent Health (RMNCAH)

### Sexual and Reproductive Health and Rights (SRHR)

Globally, it is estimated that 200 million girls and women have undergone some form of female genital mutilation (FGM) and a further 68 million are at risk of being cut by 2030 as a result of increasing population growth rates in many settings. This means that the absolute number of girls who will be at risk will continue to grow if the practice continues at current levels. Despite reports of a steady decline in ubiquity of the practice, high prevalence of FGM/C continues to be recorded among specific ethnic groups, and it is predicted that the COVID-19 pandemic, climate change and other humanitarian emergencies will threaten these gains if efforts to eradicate the practice are not accelerated. Estimated projections reveal that if there is no reduction in the practice of child marriage, up to 280 million girls are at risk of becoming brides by the time they turn 18 and due to population growth, this number will approach 320 million by 2050.

### **FEMALE GENITAL MUTILATION/CUTTING, CHILD MARRIAGES AND TEENAGE PREGNANCIES**



Amref programmes in Tanzania and Kenya reached 1,475 girls who underwent alternative rites of passage against a target of 1,550 (95%). A successful example is the *Koota Injena Project* led by **Amref Kenya**. The project implemented a proof-of-concept learning activity on the effectiveness of engaging clans and clan leaders as advocates of attitudinal and norm change towards the abandonment of Child, Early and Forced Marriage (CEFM) and Female Genital Mutilation/Cutting (FGM/C), and re-defining the value of the girl.

Key outcome areas that emerged as recommendations for design of future RMNCAH projects included: a public declaration by elders to end FGM/C and CEFM in communities; establishment of intergenerational dialogues between elder members and youth; and revitalisation/strengthening of structures to sustain child protection and SRHR interventions within the implementation sites.

Although not specifically promoting alternative rites of passage, **Amref Ethiopia** and **Senegal** have enabled positive changes through their longer-term projects addressing child marriage, gender-based violence and FGM/C. Amref Ethiopia's intervention projects were successful in improving community knowledge about FGM/C and reducing the practice. For example, the 'YES I DO' project implemented over a 5-year period (from 2015 to 2020). The end line evaluation showed a reduction of FGM/C from 54% to 39% in Bahir Dar Zuria and from 53% to 45% in Kewet. In Zone 3 of the Afar region, the percentage of mothers who wanted their children to be cut also reduced to 23% from 76%. A similar finding was also found on the percentage of young women (15-24 years) who did not want their daughters to be cut from 13% to 9.5% in Bahir Dar Zuria and from 21.9% to 10.9% in Kewet.





The Girls Choice Future project by **Amref West Africa** was carried out between 2016-2021 in the Senegalese region of Sédhiou, one of the poorest regions of the world. The project focused specifically on young people under the age of 18, who make up half of the population in Senegal.

As a result of training and working alongside local leaders, high school teachers, circumcisers, journalists and students to enable better access to accurate information, the project contributed to a 7% decrease in the number of child marriages among secondary school students in Sédhiou. In schools that actively participated in the project, the number of girls who became pregnant fell by half.

The number of girls who dropped-out of school due to pregnancy also decreased by 3%. This intervention also made it possible to see the beginnings of change in the population. The rate of early pregnancies also dropped significantly, especially in the Moricounda and Jules Counda neighbourhoods, where the rate was decreased from 23% in 2019 to 11%. For the SRAJ, the use of planning services is 18%, unlike in previous years demonstrating the adoption of new healthy and responsible behaviours in the population contributed to by the intervention.

“Health staff are more available to welcome and refer adolescents at any time and any place without discrimination or stigmatisation, which leads adolescents attending health services regularly without embarrassment or constraint in the sense that they have the privilege of not queuing” - RH Coordinator for the Goudomp Health District, End of Project Evaluation of Girls Choice Future project, Amref West Africa.”

Initiatives targeting youth with the aim of reducing teenage pregnancies and sexually transmitted infections (STIs) were implemented in several country programmes. The Faya project in **Kenya** reached a total of 144,112 adolescents aged 15-19 with comprehensive sexual and reproductive health education. Out of the target reach 1,755 adolescents were referred to health facilities for services that included HIV testing, family planning, antenatal care and sexual transmitted infection treatment. The project is estimated to have averted 17,110 teenage pregnancies. The DESIP project implemented a family planning initiative aimed at mobilising women for increased family planning (FP) uptake. Over the reporting period, the project contributed to the achievement of 140,500 Couple Year Protection (CYPs)<sup>6</sup>; 311,799 Disability Adjusted Life Years<sup>7</sup> averted; 3,855 deaths averted; and 135,610 unintended pregnancies averted.

Work on addressing teenage pregnancies was, however, significantly affected by the advent of COVID-19 pandemic. The end term evaluation of the Stand Up for Adolescents (SU4A) in **Amref Malawi** had shown improvement in teenage pregnancies (TP) recorded in the five years of implementation (2016-2021). Between 2020-2021, the country recorded a significant increase in teen pregnancies due to COVID-19. According to a 2020 Malawi government-led COVID-19 rapid assessment report on teenage pregnancies and child marriages, 13,000 cases of child marriages and over 40,000 teen pregnancies were recorded during March to July 2020. This was a 11% increase in teenage pregnancies compared to the same period in the year 2019.

<sup>6</sup>“A measure that estimates the protection from pregnancy provided by contraceptive methods during a one-year period” <https://www.msichoices.org/media/2188/msi-cyp-infographic.pdf>

<sup>7</sup>“One DALY represents the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of the years of life lost to due to premature mortality (YLLs) and the years lived with a disability (YLDs) due to prevalent cases of the disease or health condition in a population”: <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158>

The programme has since been dissolved, but by its completion had prevented 111 and 78 child marriages in Traditional Authority (T/A) Lulanga, Mangochi township, through the work of community structures built by the programme to enhance capacity in reducing the prevalence of child marriages and teen pregnancies.

## **GENDER BASED VIOLENCE**

Indicator	% Achievement	Target	Value
# of GBV cases responded to or referred appropriately by Amref	79%	19,698	15,475

Through two projects – *Afya Shirikishi* and the Global Fund (GF) – **Amref Tanzania** recorded 681 gender-based violence (GBV) cases reported by CHWs to satellite health facilities, of which 609 were responded to/referred appropriately and 52% received GBV support.

**Amref South Sudan** continued to maintain a functional GBV referral system around the supported One-stop centre (OSC) for GBV case management based in Yambio state hospital. It is notable that this is a flagship element of the UNFPA project. The OSC provided comprehensive case management to 126 GBV survivors with legal, medical, psychological and protection services.

## **FAMILY PLANNING:**

Indicator	% Achievement	Target	Value
# of people reached through family planning	48%	1,261,980	609,403

**Overall performance:** Only 48% of the target was achieved for family planning services. The low figures were due to underachievement in projects in Malawi, Ethiopia, and Kenya.

In **Malawi**, the plans for the first cohort did not go as planned with the remaining target set to be achieved through the second cohort from the Spotlight project.

In **Ethiopia**, conflict in the implementation regions affected project activities in certain locations, bringing down the achievements against target. Despite this, Amref Ethiopia’s quality improvement work for the Primary Health Care Units (PHCUs) guided by the motto “Quality is not costly as you think”, demonstrated the effectiveness of counselling on family planning and possible adverse effects of contraceptive methods. The proportion of women who have had any problem associated with family planning services reduced from 85% to 9%. It also resulted in reducing the unmet need of family planning from 29% to 20%. In another project, the long-acting contraceptive utilisation increased from 25% to 52%. The pooled estimate of the two projects has shown that the contraceptive prevalence rate increased from about 66% to 71%.

In **Kenya**, myths and misconceptions related to modern contraception and eligibility continue to be regarded as a barrier to uptake of Family Planning (FP) commodities. In addition, perceived adverse effects of FP commodities among women and their inability to be involved in decision-making around family planning affects uptake of services. To address this, the USAID Imarisha Jamii project sensitised adolescents and young people on the uptake of family planning services at selected health facilities through mobilisation of specific cohorts and informal groups to support counselling on family planning commodities and services.

## Maternal and Newborn Health

Amref focused on the continuum of care across its wide range of RMNCAH projects, providing interventions for preventing and reducing maternal and child mortality and quality of care services across health facilities supported. An effective continuum of care connects essential maternal, newborn, and child health packages throughout adolescence (SRHR as discussed above), pregnancy, childbirth, and the postnatal and newborn stages. To do this effectively, linkages between the home, first-level facilities, and hospitals, must be strengthened to ensure that appropriate care is easily accessible. Delivering quality newborn health services for example helps minimise delays in care for birth complications and sick newborns. Providing packages of essential interventions that can save the lives of mothers and newborns are highly cost effective when delivered within the continuum of care<sup>8</sup>, which is also how Amref aims to deliver its RMNCAH services – specifically MNH care.



### Box 2: The Smile Campaign, Amref Zambia

The Closing the Gap project developed innovative approaches such the “Smile Campaign” to sustain service provider’s motivation, knowledge and practice. The aim of the campaign was to build the capacity of service providers and community health workers through training and mentorship on inculcating a positive attitude towards work among health workers, stress management, values and attitude transformation and importance of customer care.

This led to improved treatment and care of women during antenatal, labour/delivery and postnatal periods, which is expected to increase demand and utilisation of services from skilled personnel.

Health care providers from Ndola and Kitwe districts of the Copperbelt province proudly wore a smile badge while attending to clients as an indication of their facilities’ commitment to delivering client-friendly services.

*“In the past, people would work haphazardly, but now there is an emotional and psychological aspect where delivery is provided with love and utmost care. For example, where the provider is providing care irrespective of the completeness of the baby layette, the provider will not complain that the woman has no gloves but will still attend to the woman with a smile to have the desired outcome. Due to shortage of staff, the providers go over and above to provide care despite being tired, and work with a smile. Providers have learned that how you treat women will determine if they will come back and how the community will view the facility. So because of Amref there is a reduction of home deliveries” - Provincial Nursing Officer*

<sup>8</sup>Continuum of Care: <https://www.healthynewbornnetwork.org/issues/continuum-of-care/#:~:text=The%20continuum%20of%20care%20refers,the%20appropriate%20time%20and%20place.>

Providing services through the continuum of care also means that client-friendly services are key to improving health outcomes, as demonstrated in **Zambia's** Copperbelt province through the Closing the Gap project. The project was implemented over the past five years with the goal of eliminating preventable maternal deaths through a strong health system with no gap between community and the formal health systems.

The end line evaluation results show a 2.5% decrease in women reporting that they experienced physical force by health workers. The findings indicate an improvement in women's right to freedom from harm and ill treatment from baseline to endline. The results also revealed that more than two thirds (69.3%) of respondents reported that providers responded to them in a timely way and encouraged them to call for assistance when in need of services. Additionally, women in FGDs described the experience they had when accessing antenatal, labour/delivery and postnatal services as a positive maternity and childbirth experience. Generally, the evaluation observed a significant improvement in adherence to respectful maternity care standards by service providers. The Closing the Gap project intervention has contributed to ensuring that pregnancy and maternity are safe, and enhanced experiences for women and their families.

The Ministry of Health in Zambia committed to integrate the learnings from this project in health facilities' activities. Professional organisations such as the Midwives Association of Zambia (MAZ) have committed to include respectful maternity care in the curriculum of nurses and midwives, while midwives unions have pledged to continue with an advocacy role to ensure that RMC is included in the nurses and midwives curriculum and more resources are provided for service training to their members.

Some outcome data recorded globally for the projects include the following;

Indicator	Project	Programme	Result
% of pregnant women supported by Amref who report to have attended all 4 antenatal care visits	Uzazi Uzima II	Tanzania	62%
	Afya Timiza	Kenya	54%
	RHITES, North Lango	Uganda	70%
% of pregnant women supported by Amref who report were accompanied by their husband or partner to at least one ANC visit	Uzazi Uzima II	Tanzania	83%

The following sections describe individual components of the continuum of maternal and newborn care with some examples of successful country office programmes:

### **ANTE-NATAL CARE**

Ante-natal care services have been provided by all Amref entities, with good performance overall but under-achievements noted in Zambia, Tanzania, Uganda and AHI. In most cases, COVID-19 outbreak and the hesitancy of accessing health facilities played a major role in these programmes, as well as low awareness on the need for early initiation of ante-natal services that was noted in Tanzania. Overall achievement is as follows:

Indicator	% Achievement	Target	Value
# of women receiving pre-natal care services through Amref	93%	250,676	232,178

**Amref Uganda** through its USAID projects brought about significant results in the maternal and newborn continuum of care. Interventions were data driven and with the help of a Continuous Quality Improvement (CQI) approach (see Box 1), the projects targeted facilities that had a high burden of poor maternal and newborn outcomes:

Project	Indicator	2020	2021
USAID RHITES Southwest	Increase in PNC Attendance at six weeks	28%	25%
	4 <sup>th</sup> ANC coverage	47%	58%
	Increase in PNC Attendance at six weeks	41%	70%
RHITES Lango	Increase in ANC 1 attendance	21%	47%
	Increase in ANC 4 attendance	43%	70%

### Box 3: Continuous Quality Improvement, Amref Uganda

**Problem:** Absenteeism of staff at health facilities reduced effectiveness and quality of health service delivery. The HRIS data estimated absenteeism in Mbarara at 32% as of July 2020. A correlation between absenteeism and other performance indicators, such as immunisation coverage per facility, was noted. The team analysed data at the health facility level with the District Health Team (DHT) reviewing this to determine levels of absenteeism. A Fish-bone analysis was used to design approaches to reduce absenteeism.

**Intervention:** Data on absenteeism was reported, analysed and reviewed on a monthly basis through the HRIS focal person. The health facilities were supported to compile accurate duty attendance reports through the HRS focal person as well as integrating the human resource component in every support supervision checklist. Additionally, health workers' high levels of absenteeism rates observed from monthly data reviews were submitted to DHO for disciplinary action. A disciplinary committee at DHO level was established and functionalised.

**Result:** Overall, there was a progressive decline in the rate absenteeism among health workers in Mbarara District from 32% in July 2020 to 0.4 % by the end of March 2021

**Learning:** Utilisation of HRIS data enhances support supervision and improves the quality of reports compiled at the Health Facility. Engaging the non-health stakeholders in monitoring attendance reduces absenteeism.



A Meta-analysis of 16 RMNCAH projects in **Amref Ethiopia** included evaluating ANC service utilisation. Accordingly, the ANC attendance rate pooled proportion was 63.1% during the baseline evaluation of selected projects. During the end-line evaluation, the proportion of ANC attendance rate increased to 74.3%. Similarly, the pooled proportion of Skilled Birth Attendants during baseline and end line evaluation reports of selected RMNCAH related projects also resulted in an increment from 45.9% to 63% and the increment in the rate of PNC rose from 23% during baseline evaluations to 66.4% during end line evaluations.

## **SKILLED DELIVERIES**

Skilled deliveries have been an area of focus in **Uganda, ICD, South Sudan, Tanzania, Zambia** and **Kenya**. All programmes had an achievement rate of between 80-100% against their respective targets except for ICD, which recorded hesitancy of mothers to visit health facilities due to COVID-19, impacting indicators. Overall performance is as follows:

<b>Indicator</b>	<b>% Achievement</b>	<b>Target</b>	<b>Value</b>
# of women supported by skilled attendants by Amref for deliveries	48%	554,711	267,726
# of births delivered by skilled attendants trained/supported by Amref	69%	374,685	256,703

**Overall performance:** Percentage achievement in skilled deliveries is lower than expected, mainly attributed to hesitancy towards health facility visits in the wake of the COVID-19 pandemic. This was specifically noted by the programmes implemented in ICD and Uganda, which contributed significantly to lower skilled birth deliveries. South Sudan, Zambia, Tanzania and Kenya, however recorded achievements between 75-100%.

An example of success in skilled delivery is **Amref Uganda's** Total Health project, aimed at increasing skilled birth attendance to reduce incidences of neonatal sepsis in Amuru district. The project strengthened the capacity of skilled health workers to deliver clean and safe MNCH services; improved access to safe and clean MNCH services and sanitation and hygiene practices in all households; and promoted improved governance of WASH and MNCH services in Amuru district. The project contributed to the reduction in the number of mothers reporting neonates with sepsis from 36.4% in 2019 to 33.3% in 2021. This decline indicates the positive impact of the increase in skilled birth attendance on reduction of the incidence of neonatal sepsis in the locality.

Other projects with outcome data in terms of coverage in target areas recorded globally include<sup>24</sup>:

<b>Indicator</b>	<b>Project</b>	<b>Country</b>	<b>Result</b>
% of deliveries supported by a skilled birth attendant trained by Amref	Uzazi Uzima II	Tanzania	84%
	Afya Timiza	Kenya	60%
	USAID, SW	Uganda	69%
	RHITES, North Lango	Uganda	66%

## **POST-NATAL CARE**

Delivery of post-natal care services consistently met targets across all programmes, summarised as follows:

<b>Standard Indicator</b>	<b>% Achievement</b>	<b>Target</b>	<b>Value</b>
# of women receiving post-natal care services through Amref	42%	340,721	143,377
# of Newborns receiving post-natal care services through Amref	97%	29,383	28,382

**Overall performance:** Percentage achievement in post-natal care differs depending on the selection of project indicators. Projects in West Africa and Kenya reported the number of newborns and achieved their targets. Projects in Malawi, Kenya and Uganda reported on the number of women, with Malawi and Kenya achieving set targets. Once again, the low performance in Uganda can be attributed to hesitancy in visiting facilities, a challenge that can be addressed by ramping up advocacy and awareness initiatives in key regions.

## **FISTULA TREATMENT AND SUPPORT**

Fistula treatment and psychosocial support is one of the key components of post-natal services that Amref engages in. As an example, the Tanzania programme uses a holistic and sustainable approach, incorporating elements of community education and outreach, fistula prevention and treatment including surgery, psychosocial support (which involves constant counselling sessions of fistula survivors to enable them recover from stigma and start re-engaging in social activities), and providing livelihoods opportunities (*including orientations and trainings on entrepreneurship skills e.g. small business, livestock keeping, agriculture*). The project utilises existing structures and resources where possible to ensure local acceptance.

**Amref Tanzania** supported the provision of 50 fistula surgical procedures and 82% of successfully treated patients received psychosocial support. Linkages of patients to treatment has largely been achieved through use of fistula ambassadors. In 2021, the ambassadors reached a total of 90 fistula survivors, 50 of whom were medically treated, 18 treated through other partners and 22 awaiting treatment. The holistic approach used for fistula management has been one of the innovative strategies to ensure complete social and economic integration of the survivors. Aside from Tanzania, **Amref South Sudan** also trained a team of health workers on fistula repair and management from Juba Teaching hospital (JTH) as part of establishing the institution as a centre of excellence for provision of routine fistula repair services. As a result of this training, 45 fistula surgical operations were conducted which yielded an 85% success rate.



## IMMUNISATION

Delivery of immunisation services also consistently met targets across programmes in Ethiopia, South Sudan and Kenya as summarised below:

Standard Indicator	% Achievement	Target	Value
# of children fully immunised through Amref-supported facilities	93%	253,280	235,758

**Overall Performance:** All programmes achieved or were close to achieving their targets by the end of the year. South Sudan increased immunisation outreach in 2021, and in Kenya, through the *USAID Imarisha Jamii project*, integrated medical camps were conducted in collaboration with the S/CHMTs and local implementing partners, helping achieve and surpass targets.

**Amref Kenya** through **USAID Stawisha Pwani project** supported Kwale County to improve access to nutrition services. A total of 6,180 children were fully immunised, 99% received DPT1, 102% received DPT3 while 108% received measles vaccines, and 6,180 were confirmed as fully immunised children under one year. This achievement was due to the periodic intensified routine immunisation, strengthened defaulter-tracing and Malezi Bora campaign supported by the project in partnership with the CDOH Services.

Other projects with outcome data in terms of coverage in target areas recorded globally include the following<sup>9</sup>:

Indicator	Project	Programme	Result
% of children in Amref target areas who are fully immunised	Afya Timiza	Kenya	85%
	USAID RHITS-SW	Uganda	81%
	RHITES, North Lango	Uganda	88%



<sup>9</sup> Last entered figures-in most cases, December 2021 taken as the final result.



## **NUTRITION**

**Ethiopia** implemented a two-year (2019-2021) project targeting pastoralist, agro-pastoralist, and pastoral populations in four drought-prone woredas of Afar, Dalifage, Dewe and Telalek. By strengthening the existing health structure, including health posts and farmer training centres, the project focused on reducing morbidity and mortality attributed to malnutrition among children and pregnant women. The following impact data were obtained:

<b>Indicator</b>	<b>Baseline</b>	<b>Endline</b>
Access to a healthy nutritious and balanced diet of vulnerable community	8%	47%
Cases of malnutrition among children under five	35%	20%
Exclusive breastfeeding among eligible children ( <b>below 6 months</b> )	6.3%	67.8%
Children under five suffering from stunting	40.6%	33.4%
Prevalence of moderate stunting	25.7%	21.4%
Prevalence of anaemia in PLW	60%	22%
Prevalence of underweight children under 5	34.8%	24.6%

## Disease Control Prevention and Management (DCPM)

Disease Control Prevention and Management covers the whole spectrum of communicable diseases, a specific focus on COVID-19 programmes and their integration into Amref's regular programmes, and the new global health security unit which also includes laboratory and medical services.

### **COMMUNICABLE DISEASES**

**Overall Performance:** The key communicable diseases Amref works to address are HIV/AIDS, malaria and tuberculosis (TB), with large concentration of activities in Kenya and Tanzania. HIV/AIDS and TB projects met their targets. However, the malaria programmes in Kenya continue to underperform as stock outs of malaria testing kits hamper delivery of interventions. Moreover, a court order barring non-laboratory personnel from testing also reduces the resources available for the work. These reasons were reported in the 2020 annual report and continue to be a barrier. Overall performance is summarised as follows:

Indicator	% Achievement	Target	Value	Men	Women	Boys	Girls
# of people tested for HIV/AIDS	88%	644,463	567,693	137,864	310,392	45,492	73,945
# of people tested for Malaria	53%	498,108	264,945	70,219	61,915	60,275	72,536
# of people screened for TB	93%	592,097	548,448	214,175	216,192	60,752	57,509

HIV Programmes in Tanzania and Kenya have reported the following success rate of treatments<sup>24</sup>:

Indicator	Project	Programme	Result
% of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented within the past 12 months in Amref supported interventions	Afya Kamilifu	Tanzania	98% <sup>25</sup>
	USAID Imarisha Jamii	Kenya	91%

In **Tanzania**, the three major programmes targeting HIV/AIDS, malaria and TB are as follows:

- As a Principal Recipient (PR) for Non-Government Organisations, Amref Tanzania is implementing a Global Fund grant for HIV and TB interventions in 18 regions of the Tanzania Mainland. The project has two goals: to increase coverage of HIV/AIDS prevention and services in general populations to ensure that by 2020, 90% of people living with HIV know their status, 90% of all people diagnosed with HIV are enrolled and receive anti-retroviral therapy (ART) and 90% of those receiving ART attain sustainable viral suppression to help reduce the tuberculosis epidemic and burden by 50% incidence rate and 75% in deaths by 2025.
- *Afya Shirikishi*: This is a five-year grant for a community-based programme on TB and family planning (FP). The goal of the project is to address priority gaps in TB case findings and unmet FP needs at community level in nine regions of Tanzania by 2025.
- *Afya Kamilifu*: Through PEPFAR, Amref Tanzania provides support to the implementation of comprehensive HIV prevention, care and treatment programmes within the Tanga, Simiyu, Mara and Zanzibar regions.



**Box 4: Concept of Digitising Community TB Data Collection System, Amref Tanzania**

The Afya Shirikishi project currently collects TB data using registers that are maintained manually. The aim of digitising the data collection system is to strengthen quality of data and enable timeliness of data submissions. In 2022, the project will focus on developing the reporting system.

Selected results from these Tanzania programmes include:

- Successful implementation of differentiated HIV testing to different key population groups achieving 53%, 121% and 68% of the annual targets for MSM, FSWs and PWIDs with positivity rate of 15%, 13% and 15% respectively. Of those tested positive, 95% of MSM, 96% of FSWs and 97% of PWIDs were enrolled into care and treatment and 100% (with exception of FSWs – 99%) were initiated to ART.
- To improve positivity yield<sup>10</sup>, Amref Tanzania successfully implemented index partner testing, which in 2021 contributed to an average 67% of overall positive. Same-day ART initiation has been maintained at 97% for both adults and paediatrics, three multi-month dispensing for stable patients has been maintained at an average of above 90% in Tanga and Simiyu and 80% in Zanzibar. Viral load coverage for clients currently on treatment ranged from 80% to 95% while viral load suppression was maintained between 96% and 98% in all implementing regions.
- Through Global Fund project, TB community referrals out of the total TB cases notified stood at 51% while through USAID Afya Shirikishi, community TB case notifications contributions was 21.4% falling short of the NTLP-TB notification community contribution target of 30%.

In **Kenya**, the US Centers for Disease Control and Prevention (CDC) project was implemented over a five-year period from October 2016 to September 2021 through funding from US CDC. The project's goal was to improve prevention, care, and treatment of HIV/AIDS, sexually transmitted infections (STIs), and related opportunistic infections by improving STI management, enhancing care and treatment of opportunistic infections including tuberculosis (TB), and initiating programmes to provide anti-retroviral therapy (ART) within Nairobi County.



<sup>10</sup>Proportion of women who newly tested HIV-positive out of the total women tested for HIV

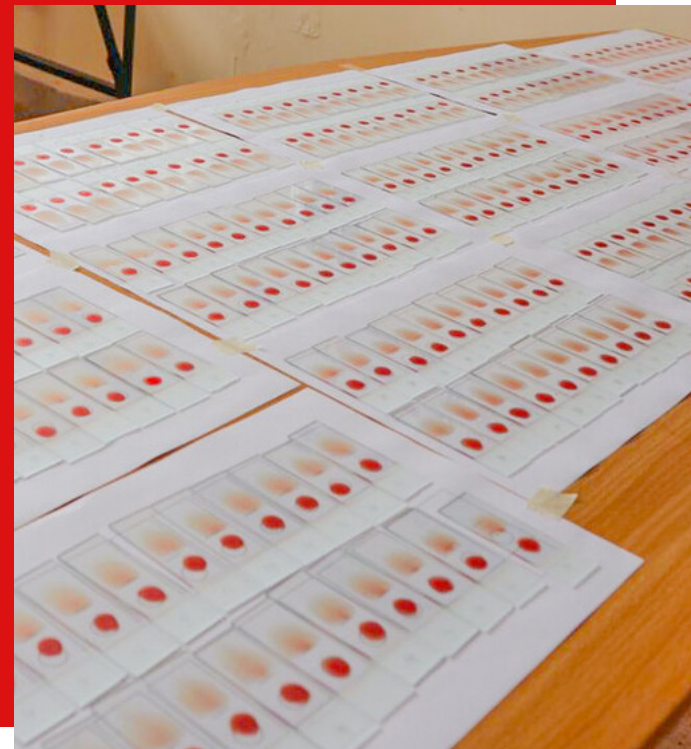
Over 6,000 clients tested positive for HIV, of whom 87% were successfully linked to treatment. Some of the interventions put in place to link clients to treatment included: intensified follow up of clients not initiated on treatment on the same day of linkage, continued reporting on inter-facility linkage confirmed using the E-directory, extended working hours including the weekends for clinicians, and peer support to the house-helpers to help them navigate treatment challenges.

Over time, the programme maintained an impressive high performance in testing for HIV in TB patients from 98% in years 1 and 2, highest in year 3 at 100%, year 4 at 98%, and 99% in year 5. Testing was affected by the lack of test kits in Year 5 Quarter 3.

Another USAID programme in Kenya, *Imarisha Jamii*, had over 75,000 individuals receiving HIV Testing services in all the supported facilities and identified a total of 973 HIV positive clients. The project implemented three main strategies to identify new HIV-positive clients: assisted Partner Notification Services (aPNS), facility HTS Outpatient Department (OPD) optimisation, and targeted community testing in geographical areas/villages with high HIV positivity.

**Box 5: Biosafety Kit, Global Fund Malaria Project, Amref Kenya**

In conducting testing for malaria at community level, Community Health Volunteers (CHVs) generate medical waste that need proper handling and disposal. The biosafety kit was designed by Amref together with the Division of National Malaria Programme to enable proper disposal of waste generated during testing for malaria at household level. The biosafety kit is a container made of hard plastic measuring 20x11x7cm and fits in the CHV's backbag. The kit has two compartments to enable waste disaggregation. The first partition is larger and contains three polythene bags for disposing used infectious and non-infectious material while the second partition is smaller and holds the sharps container. The kit with generated waste is taken to the nearest health facility as soon as possible (not exceeding once every month) for disposal of the waste. Once the waste has been disposed at the link health facility, the CHV is provided with a replacement biohazard sharps container and new plastic waste disposal bags (bin liners) to replenish the biosafety kit.





## GLOBAL HEALTH SECURITY

Amref has recently established the Global Health Security (GHS) Unit, coordinated from the Amref Headquarters. The goal is to guarantee health security of people in sub-Saharan Africa through working closely with regional bodies such as Africa CDC, Ministries of Health and communities to strengthen diagnostics, therapeutics and vaccination capacities. This will ultimately strengthen health systems and reduce vulnerabilities to emerging and re-emerging disease threats in the region. One of the strategic partnerships housed under the GHS Unit has been with Africa Centers for Disease Control (CDC), a specialised technical institution of the African Union established to support public health initiatives of Member States, with a clear mandate to coordinate the response across the 55 Member States. With support from various donors such as the Bill and Melinda Gates Foundation, Lucille and Packard Foundation, MasterCard Foundation among others, Amref is working with the Africa CDC and ministries of health across 31 Member States to support the following core interventions:

1. Strengthening Africa CDC's core capacities at the HQ and Regional Collaboration Centers (RCCs) through staffing to improve coordination of Africa's COVID-19 response.
2. Strengthening leadership and management capacity of National Public Health Institutes across Member States.
3. Increasing access to and uptake of COVID-19 vaccines in 31 countries in Africa through vaccine administration and establishing new and strengthening existing COVID-19 Vaccination Centres (CVCs); procurement, delivery and logistics of essential medical supplies and commodities in 11 Member States; demand creation to improve vaccine confidence; strengthening data management to inform pandemic response and enhancing pharmacovigilance.

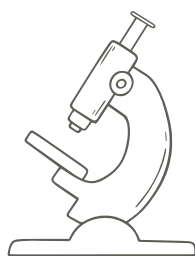
These interventions have been spread across 11 projects, covering 31 Member States at a total cost of \$46 million. It is envisaged that successful conclusion of these projects will have significant contribution to the 70% vaccination coverage target set by Africa CDC by the end of 2022.

### Laboratory Trainings



The Regional Laboratory Training Programme provided distance and face-to-face training for participants in short training courses. In 2021, the following courses were provided: Refresher Training Course in Laboratory Diagnosis of Malaria External Competence Assessment of Malaria Microscopists (ECAMM), Training of Trainers in Laboratory Diagnosis of Malaria and the Worldwide e-Learning Course on Malaria Microscopy (WELCOMM) with participation from 7, 11, 2 and 40 countries respectively. In addition, laboratory staff supported the Kenya Ministry of Health to conduct Training of Trainers courses in COVID-19 antigen testing using rapid diagnostic tests.

### Laboratory Quality Projects



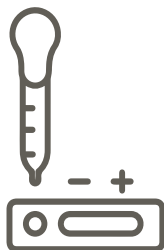
The East African Regional External Quality Assessment Scheme (EA-REQAS) is an integrated proficiency testing (PT) scheme targeting primary level diagnostic testing. In 2021, EA-REQAS achieved accreditation to International Organisation for Standardisation (ISO) 17043, the international standard for proficiency testing providers. EA-REQAS provided two surveys for facilities in six countries (**Burundi, Kenya, Tanzania, Uganda, South Sudan, Somalia**) reaching 163 facilities with a 72% response rate by the second survey of 2021. In addition, the EQUAfrica project aims to improve the quality of bacteriology diagnostics to tackle antimicrobial resistance (AMR) by strengthening external quality assessment (EQA) in pathogen identification and antimicrobial susceptibility in Africa. The project is being implemented by a consortium of international organisations led by the African Society for Laboratory Medicine (ASLM). Amref is implementing activities in four countries (Kenya, Tanzania, Uganda, Ethiopia) in the eastern Africa region. In 2021, Amref achieved two PT cycles (the pilot and Cycle 1) reaching 51 laboratories with an 86% response rate for Cycle 1.

### Diagnostic Strengthening Project



In 2021, Amref was awarded a CDC grant to implement a new regional project - Strengthening and Supporting the Development of a HIV-Related Proficiency Testing Network and Tiered Laboratory Continuous Quality Improvement Programme for Countries Supported under PEPFAR that will be implemented in Sierra Leone, West Africa, and in 12 selected countries in Asia.

### Diagnostics Research



Amref is a member of a five-country African consortium led by the University of Amsterdam and funded by the European and Developing Countries Clinical Trials Partnership (EDCTP) conducting evaluation of an innovative simple molecular test for diagnosing malaria in different endemic and health settings in sub-Saharan Africa (DIAGMAL). In 2021, 15 participants from the five countries attended a practical training course on the Molecular Diagnosis of Malaria using the mini-dbPCR-NALFIA. Amref recruited 224 participants into the study in Busia County, Kenya, an endemic malarial area. Amref also conducted a SARS-CoV-2 antibody seroprevalence survey in Kibera informal settlement in Nairobi, Kenya, in collaboration with the Kenya Medical Research Institute (KEMRI), to determine prevalence of exposure to SARS-CoV-2 as well as evaluate a rapid diagnostic test and two enzyme-linked immunosorbent assays for antibodies to SARS-CoV-2 – 439 participants were recruited. By the close of 2021, samples were undergoing final testing at the KEMRI laboratories.

## COVID-19 INTERVENTIONS

COVID-19 interventions continue from 2020, now more integrated into regular programmes as part of the GHS programming described above. Global progress and achievements for key indicators in 2021 are as follows:

Indicator	Method/ Topic	% Achievement	Target	Value	Men	Women
# of CBHW trained on COVID-19 topics	Face-to-face	110%	34,345	37,710	16,060	21,650
	Mobile	55%	38,465	21,249	7,187	14,062
# of FBHW trained on COVID-19 topics	Face-to-face	116%	4,865	5,656	2,871	2,785
	Mobile	193%	16,746	32,347	16,213	16,134
# of health workers receiving PPE	CBHW	100%	83,796	84,179	35,526	48,653
	FBHW	99%	2,480	2,463	1,442	1,021

**Overall Performance:** The large proportion of FBHWs trained was contributed to by achievements in **Zambia** and **ICD**. The MoH in **Zambia** endorsed the rollout of training courses and provided a list of over 3,000 names and details of participants that needed to be enrolled into the course, against the initial target of 2,000. In ICD, more FBHWs than expected were enrolled through the e-Campus for various trainings offered free of charge.

The CBHW trainings through mobile were much lower than expected in **Ethiopia**, due to the mobile network shut down as well as interruptions of connectivity and functionality of infrastructure at the Ministry of Health caused by the conflict. In addition to trainings and PPE distributions, Amref facilitated 44,409 COVID-19 tests through health facilities and 48,640 conducted through the **Amref Medical Centre** (AMC).

Amref also facilitated full immunisations for 513,780 people and first doses for 1,302,122 people through programme interventions in health facilities.



Some examples from various COVID-19 interventions are detailed below:

### **BEHAVIOUR CHANGE**

The HBCC project in **Amref Uganda** conducted both door to door/in person engagements and mass media drives to curb the spread of COVID-19 created positive change between the baseline and end line points in October 2020 and September 2021 respectively. The project contributed to an improvement in community practices on cough and hand hygiene from 27% to 70.8%.

This was mainly attributed to the 30% increase in the knowledge of COVID-19 transmission among community members (from 35% at baseline to 64.8%). Majority of household respondents (80.4%) could mention at least two ways though with COVID-19 is transmitted.

Proportion of households that knew that wearing a mask prevents the spread of COVID-19 more than doubled (from 30% to 73.3%); this contributed towards the prevention of COVID-19 among the targeted communities.



### **COVID-19 Behaviour Change Communication**

### **ACCESS TO VACCINATIONS**

By the beginning of September 2021, 144.5 million doses had been supplied across the continent and 111.3 million people have received at least one dose, covering only an average of 3% of the eligible population, and by far the lowest proportion across the world. In countries such as South Sudan for example, only 56,000 doses have been administered so far. In **Zambia**, only 250,000 people fully covered.

Amref worked closely with MoHs to strengthen in-country planning and coordination through its presence COVID-19 vaccination task forces, and advocacy, communication and social mobilisation sub-committees.

Amref supported the vaccine roll out in **Kenya** and **South Sudan** by strengthening the capacities of more than vaccinators, almost 3,200 CHVs and opinion leaders, vaccine administration in almost 80 vaccination centres and worked closely through numerous media channels and an extensive network of CHVs to create demand for the COVID-19 vaccine. In **Zambia**, Amref's work to reach people with disabilities has also focused on addressing vaccine hesitancy in communities.

COVID-19 efforts began late in **Amref Tanzania**. However, the programme has been accelerated with training and deployment of health care workers and other staff and providing infrastructure and equipment to health facilities.

Through the support of Africa Centres and Disease Control (Africa CDC), CDC AK, Global Fund support to curb COVID-19 Pandemic and Irish Aid, several efforts have been undertaken to support vaccination uptake including community sensitisation. These included supporting R/CHMT with transport to distribute vaccines and supervise vaccine centres, establishing linkages for People Living with HIV (PLHIV) to access vaccines, and printing and distributed information, education and communication (IEC) materials.

As of December 2021, 53% and 88% of the **Afya Kamilifu** supported HCWs were fully and partially vaccinated respectively, while 44% of PLHIV had received at least one dose.



**Amref Uganda** used the Campaign Advocacy approach with support of the Ministry of Health (MoH) and worked towards creating an enabling environment for successful countrywide vaccination campaigns, with a focus on the central region. Its aim was to make vaccine doses accessible in hard-to-reach areas, with the anticipation of having more doses availed and reducing vaccine wastage.

The initiative used various platforms to influence decision makers at national and community level, increasing the number of people vaccinated within Mubende Region by 31 percentage points – from 23% to 54% of the targeted population (the implementation project vaccinated 407,152 people).

Key focus areas included - supporting planning and coordination at national and district level, and capacity building for village health teams, frontline workers and other stakeholders involved in COVID-19 response in Uganda.

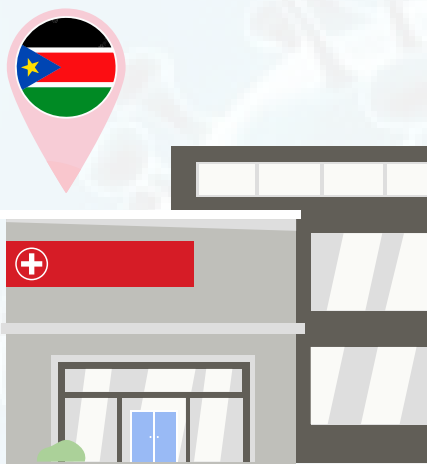
Advocacy also included the use of an outreach model for vaccination against childhood illness and COVID-19, inspired by an increase in vaccine demand as a result of the outreach. The strong advocacy in support of vaccination saw the government agree to proposals to avail vaccines to temporary vaccination centres set up in communities, in addition to the static centres at health facilities.

The programme further advocated to MoH to approve the mix of vaccines, contributing to the increase in the number of fully vaccinated people in Uganda, which stood at 3.9 million out of a population of 10.2 million.



### **SUPPORT TO GOVERNMENT**

Under the Health Pooled Fund (HPF) grant, **Amref South Sudan** supported health service delivery in 34 health facilities – a county hospital, eight Primary Health Care Centres (PHCCs), and 25 Primary Health Care Units (PHCU); paid incentives for over 200 government staff to maintain health service delivery in all 34 supported facilities; facilitated delivery of essential drugs on three quarterly consignments to all 34 health facilities and supported monthly collection of vaccines from State Cold chain store to CHD central store, and distribution to all facilities providing vaccination services.



## **VACCINE EQUITY CHAMPION**

In October 2021, Amref launched a global campaign to end COVID-19 vaccine injustice dubbed “End Vaccine Injustice In Africa” - a [campaign](#) calling on world leaders to honour their commitments to low- and middle-income countries and leave no-one behind in the race to bring an end to the COVID-19 pandemic by mobilising and availing more vaccines for the continent.

We called upon partners and African citizens to stand in solidarity with the rest of the Africans by signing and endorsing the petition. As at close of 2021, we managed to collect at least 189,289 signatures - by individual petitioners and endorsements by African-based institutions. Additionally, we collected numerous [community voices](#) speaking in solidarity with the campaign.

Through the signatures collected, Amref continues to engage, and hold accountable the rich countries, including members of the G7, and G20 as well as heads of Multi-lateral and Bilateral organisations through messaging via various media platforms (social and mainstream) on their global commitments to stand in solidarity with the world in ending the COVID-19 pandemic.

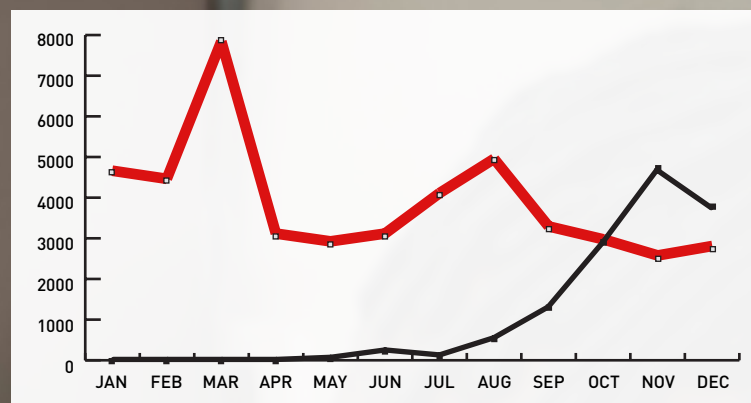
As at the end of 2021, Africa had received more than 587 million vaccine doses, 58% through the COVAX Facility, 36 % from bilateral deals and 6% through Africa Vaccines Acquisition Trust (AVAT) of the African Union. At the time of compiling this report in January 2022, 96 million doses were shipped to Africa, which was more than double that of six months ago ([WHO, 2022](#)). Despite the commendable progress achieved thus far, Africa lags far behind the rest of the world in vaccination, even as wealthier nations stockpile critical vaccine doses and begin administering mass booster shots to already vaccinated citizens.

Additionally, Amref heightened its advocacy for vaccine equity through online and offline engagements. These include – the US President Joe Biden hosted virtual vaccine summit on “**Global COVID-19 Summit: Ending the Pandemic and Building Back Better Health Security to Prepare for the Next.**” The summit held on 23rd September 2021 coincided with the United Nations leaders’ meetings (UNGA) in a bid to marshal more aid to developing nations where inoculations, treatments and supplies remain scarce. Others include hosting a side event at the UN General Assembly 2021, issuing its own [statement on vaccine equity](#) and speaking in various international media platforms on vaccine equity.

## **AMREF MEDICAL CENTRE (AMC)**

The **AMC** had its first round of COVID-19 vaccinations delivered to clients on 29 June 2021. In December 2021, the AMC partnered with the Nairobi Metropolitan Services to deliver vaccines directly to the public. The facility continues to experience growth in terms of the number of clients seeking care.

The peaks in March and August in the graph above were driven by surges in COVID-19. COVID-19 tests totalled 48,640 over 2021, the highest in March with 7,854 tests and the lowest in November with 2,504 tests.



## Water, Sanitation and Hygiene and Neglected Tropical Diseases (WASH&NTDs)

### Water and Sanitation

Overall performance of key indicators in access to water and sanitation are summarised as follows, where all programmes have achieved their targets:

Indicator	% Achievement	Target	Value	Men	Women	Boys	Girls
Access to Water	107%	191,464	205,540	53,190	58,631	44,690	49,029
Access to Sanitation	91%	405,591	367,953	81,080	87,582	94,849	104,442



#### Box 7: Pilot Biogas, Amref Tanzania

At the prototype development stage, the pilot biogas is a waste-energy recovery mechanism. The model tries to improve sanitation in unplanned settlements of urban poor using a simple and cost-effective technology of desludging faeces from households to a centralised biogas production point. The biogas will then be used primarily for cooking. This model is expected to improve sanitation-related income and reduce deforestation through utilising green energy.

Three out of five people have no access to toilets and showers. This causes water-related diseases such as diarrhoea and cholera. Through the FINISH Mondial programme, **Amref Ethiopia, Amref Kenya, Amref Uganda** and **Amref Tanzania** are working with **Amref Netherlands** and partners - WASTE and Aqua for All – to build safe toilets by stimulating a well-functioning market for sanitation and hygiene products. Through this project, supply of quality products is ensured and the demand for toilets is stimulated to encourage households to invest in their health. The project offers small loans through local financial institutions, which households can use if they cannot afford direct payments at once. Construction workers are trained in professional installation of toilets, and advocacy is conducted in partnership with governments to develop policies that further promote this approach.

In 2021, the consortium received €20 million from the Dutch Ministry of Foreign Affairs to build 2 million toilets by 2025. In 2021, a total of 45,500 toilets were built in the four African countries where the programme is active. About 227,500 people benefited from this. To this end, €3,000,000 has been provided in loans and households have invested €6,100,000 themselves. FINISH Mondial also prioritises improving gender equality (for example in making decisions regarding the purchase or installation of toilets), as well as looking into approaches regarding equal access to information, loans, hygiene and sanitation facilities for people with disabilities, the elderly and other marginalised groups.

The Meta-analysis for WASH projects conducted in **Amref Ethiopia** for 11 projects over a decade showed a statistical increase in the proportion of communities with improved WASH facilities, clean water access, safe drinking water and hand washing, among others. This included an improvement in the proportion of water access from 56.6% during baseline to 68.9% during midline and further increase to 69.8% during the end line evaluation. Similarly, the proportion of population who use proper sanitation facilities increased from 58.3% during baseline to 86.6% during end line evaluation surveys. The meta-analysis findings also showed an increase in the proportion of adequate hygiene practice from 41.3% during baseline to 79% during the end line survey. On the other hand, the proportion of the population who had diarrhoea reduced from 11.1% to 2.8% during baseline and end line evaluation surveys. Similarly, the pooled proportion of open defecation reduced from 14.3% during baseline to 7.1% during end line survey.

## Hygiene Practices

Amref WASH programme goals and objectives are centred on improved health through better access to water, sanitation and hygiene. WASH projects contribute to the national WASH agenda by modelling effective approaches and delivery models, informing development of an enabling environment and strengthening systems. This has seen demonstrable improvement in latrine coverage (availability and use) as well as access to hand washing thus positively impacting sanitation and hygiene behaviours and practices. In Kenya, from results of village monitoring and Open Defecation Free (ODF) verification assessment in all project sites, findings showed that in villages previously declared ODF using the national ODF verification criteria, over 90% of those sampled showed no signs of open defecation and showed evidence of continued latrine use and hand washing.

In **Amref West Africa**, the *Sougkou Tol Folo* project funded by AECID helped improve access to water and sanitation facilities in 10 schools to curb the effects of the pandemic through promotion of appropriate hygiene behaviour among school children. Latrine rehabilitation also focused on gender-sensitive sanitation facilities to encourage adolescent girls to attend school during sensitive periods such as menstruation, and to promote their dignity and ensure safety in line with approaches to promoting sexual and reproductive health rights. As a result, behavioural changes, were recorded in the daily practices of schoolchildren in regard to hand washing with soap, sanitation and cleanliness of the school, and other hygiene practices. The hand washing technique is performed according to the standards by almost all the children in the project schools. At school and at home, a routine has been established. Regular monitoring is done by the teaching staff and by the pupils themselves.

“Sometimes, pupils have come to denounce a classmate who, after leaving the toilets, did not use the hand washing device. From now on, everyone is obliged to adopt this practice at the risk of being reprimanded by his or her classmates”

– A teacher from a project-supported school.”

Outcome data reported by Uganda’s Piwa Maleng project are as follows:

Indicator	Result
% of respondents supported by Amref with access to improved sanitation facilities	88%
% of respondents supported with access to a safely managed water source through Amref interventions	98.1%
% of respondents targeted by Amref who practice appropriate hand-washing behavior	82%

### Livelihoods and Entrepreneurship

Most of the WASH programmes in Amref apply sanitation marketing in a bid to progressively move communities up the sanitation ladder. In most instances, sanitation marketing activities are initiated after a community is declared Open Defecation Free (ODF). In other instances, however, depending on locality and socio-economic status, household owners begin with improved facilities. For sanitation marketing, the programme looks to change behavior as well as develop sanitation markets. This works to create demand, build the supply-side, address financing and strengthen the enabling environment (partnerships and policy). Capacity building is core for increasing adoption of improved sanitation facilities and markets. Results of a selection of projects that have worked towards these objectives over the reporting period are as follows:

**Amref Kenya** trained 226 Village Sanitation Committees (VSCs) on sanitation marketing to enable them market different sanitation products, while artisans were trained on product development of facilities such as hand washing stations. As a result, 305,659 people gained access to and use of improved sanitation facilities, and through sanitation marketing created linkages between the artisans/entrepreneurs, the clients (community) and financing institutions. This enhanced growth in the local supply chains for sanitation and hygiene products thus creating job opportunities for artisans and local entrepreneurs as well as income for VSCs in the sanitation value chain.

The Kasasiro Zaabu project in **Amref Uganda** improved business knowledge levels of 175 business group members from 28% to 42% as indicated by the post training assessment results. The business group members acquired knowledge on business management and financial management, helping them to successfully run and sustain their businesses.

Through the pro-poor sanitation project implemented in Mwanza, **Tanzania**, 150% performance by registering six out of the four targeted sanitation entrepreneurship groups. Amref’s support moved these groups from collecting and transporting solid waste to the collection points or disposal facilities to production of briquettes and compost manure. As a starting point, the groups are producing 200kg of briquettes perday and selling it for USD 0.45/kg (TZS 1,050/kg), generating an income of about USD 93/day (equivalent to TZS 215,000/day). At full potential three tons of briquettes per day are expected to generate income of USD 232/day (TZS 535,000/day).

## Neglected Tropical Diseases (NTDs)

Amref's work in NTDs has been focusing on reaching 'end game' targets of elimination and eradication by applying adaptive, multi-disciplinary, collaborative and intersectoral approaches such as WASH & NTDs co-programming. Building on the progress of the London and the Kigali Declarations on Neglected Tropical Diseases (NTDs), our NTD programming has focused on five strategic actions namely:

- i. Intensifying mass drug administration for preventive chemotherapy NTDs
- ii. Expand WASH-NTD integrated interventions
- iii. Mainstream behavior change communication
- iv. Intensify advocacy, partnerships, and coordination
- v. Strengthen systems for monitoring, evaluation, surveillance and research

In the period under review, Amref intervened for seven NTDs namely: trachoma, schistosomiasis, soil transmitted helminthiasis, lymphatic filariasis onchocerciasis (Nodding Syndrome disease) and snake bites.

Overall performance in NTDs are summarised below with project achievements described:

Indicator	% Achievement	Target	Value	Men	Women	Boys	Girls
Mass Drug Administration	76%	12,169,087	9,292,018	2,650,328	2,513,027	1,968,320	2,160,343

Through the Nodding Syndrome<sup>11</sup> Alliance (NSA) Project, **Amref South Sudan** trained CBHWs who conducted identification, referral and follow-up of epilepsy clients. Over 3,000 patients suffering from epilepsy were given treatment in Maridi, Mundri West and Lui hospitals. 90% of patients with epilepsy/NS reported improvement of their quality of life ("**better**" or "**much better**") since inception of treatment, while children of school-going age either went back to school or began engaging in business activities for their survival. Further, 94% of patients with epilepsy/Nodding Syndrome reported a decrease in seizures / nodding episodes.

**Amref Kenya** deployed Mass Drug Administration in 142 County Assembly Wards of western Kenya to eliminate or interrupt the transmission of Soil Transmitted Helminthes (STH)/ schistosomiasis (SCH) without requiring individual diagnosis. Eligible population was dewormed through mixed approach by delivering anthelmintic medicines to the at-risk population regardless of the infectious status of an individual. During the five-day treatment exercise, approximately 5.9 million people were reached with drug administration.

<sup>11</sup>Nodding syndrome is an unexplained neurologic condition characterised by episodes of repetitive dropping forward of the head, often accompanied by other seizure-like activity, such as convulsions or staring spells

**Amref Ethiopia** has supported trachoma elimination efforts focusing on the DRS with a history of underinvestment and unique local contexts, including highly dispersed populations, difficult terrains and severe climate conditions resulting in droughts and flooding. In alignment with the WHO Surgery, Antibiotics, Facial Cleanliness and Environment Improvements (SAFE) strategy, Amref's approach in service delivery for trachoma elimination has been implemented with strong collaboration between MoH and the RHB, with financial support by Sight Savers International and The END Fund.

Amref anticipates reaching an estimated 6.34 million with trachoma antibiotic treatment in 31 districts of the region by 2022. In 2021, MDA campaign and impact surveys were undertaken in Afar and Somali regions. Through these campaigns, approximately 2.6 million people (51% female) in 31 Somali districts and 44,000 in two Afar districts have received MDA treatment.





## HEALTH FINANCING

### Technical Assistance and Strategic Purchasing

The COVID-19 pandemic has put enormous additional pressure on fragile health systems in sub-Saharan Africa (SSA). Although the region accounts for 11% of the world's population, it bears 24% of the global disease burden and accounts for less than 1% of global health spending, leaving health systems underfinanced, fragile and fragmented. COVID-19 has demonstrated how important health system resilience is in maintaining the population's health and protecting social and economic development, more so for the most vulnerable. It is, therefore, more critical than ever for African governments to invest wisely in health.

Before the pandemic, African Ministers of Health and Finance took on this challenge at an October 2020 joint meeting of the African Union (AU) Commission, in which governments renewed commitments to increase domestic investment in health and improve the efficiency and effectiveness of health spending<sup>12</sup>. Increasing health spending does not automatically translate into better access to higher quality services, reduced financial burden on vulnerable households, and improved health outcomes. Therefore, the efficient allocation and utilisation of these resources is equally critical.

Governments need to direct health funds to priority populations and services, and actively create incentives so that funding is used equitably, efficiently and in ways that enhance quality. Collectively, this set of actions is known as "*strategic health purchasing*." The **Strategic Purchasing Africa Resource Centre (SPARC)** is a critical partner in supporting governments to meet the challenge of spending more and spending better on health by:

- i. Providing practical evidence on how to get more value for health spending in sub-Saharan Africa;
- ii. Facilitating a growing network of expertise on the continent available to support country health financing efforts;
- iii. Providing a platform to share cross-country lessons and loop lessons back into country engagements to provide more impactful country support, and;
- iv. Delivering on-demand technical support to advance highly complex processes of change in the strategic purchasing space.

SPARC was established in 2019-2020 and became operational in 2021. It intensified its virtual interactions through additional interactive engagements (Twitter chats and Webinars) guest-written blog posts by members of the FORCE community, a network of African Health Systems Strengthening practitioners committed to supporting country-led health systems strengthening processes to advance Universal Health Coverage, and 'Reflections' podcasts (*a monthly round-up of various SPARC engagements*). These engagements helped strengthen the case for moving health systems in Africa towards strategic purchasing as countries experienced economic headwinds while confronting the urgent need to spend more on healthcare.

In 2021, Twitter chat conversations pivoted to discuss issues affecting strategic purchasing in Africa more broadly, as identified by the strategic purchasing mapping exercise. The conversation explored topics such as the relevance of strategic purchasing during times of crisis like the COVID-19 pandemic, ensuring continuity of PHC, the role of data, communication and the private sector in the pandemic response, and how governance adjustments supported pandemic response. An example is provided in **Box 8**.

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<sup>12</sup><https://odi.org/en/insights/12-leaders-perspectives-on-supporting-africas-health-systems-through-covid-19/>



#### *Box 8: Strategic Purchasing in AHAIC 2021, SPARC*

As part of SPARC's continuous efforts to raise awareness and support countries to adopt creative approaches to using the power of strategic purchasing to advance Universal Health Coverage (UHC) in sub-Saharan Africa, SPARC organised a satellite session at the virtual Africa Health Agenda International Conference (AHAIC) held in March 2021. During the satellite session, SPARC presented thought-provoking statements to raise awareness and increase the appreciation of strategic health purchasing for health practitioners and policymakers. SPARC also highlighted its work towards informing strategic purchasing policy reforms with technical evidence. The SPARC satellite session had 216 people in attendance.

Below are highlights from a selection of SPARC advocacy initiatives at strategic purchasing events and conferences:

- **HSR2020 SPARC Satellite Session:** In January 2021, SPARC collaborated with the World Health Organisation (WHO) and Thinkwell to facilitate a satellite session at the Sixth Global Symposium on Health Systems Research. The session focused on strategic purchasing, which at its core is about improving how ministries of health and government health insurance agencies use information about population health needs and provider performance to make decisions about the benefit packages, contracted providers, and payment methods.
- **World Bank:** In June 2021, SPARC was invited to present to the Health Financing Global Solution Group of the World Bank Group at a webinar themed, 'Building Momentum for Strategic Purchasing across sub-Saharan Africa.' SPARC presented its recent work in the region, introduced the recently launched strategic purchasing policy briefs from nine countries, and set the scene for future institutional collaboration.
- **Launch of Report on 'Health Financing & Taxation for Sustainable Healthcare':** On 24th June 2021, SPARC was invited to share reflections on the importance of tax financing for public health and the value of political will in prioritising healthcare in funding allocation decisions. The report highlighted that none of the five countries studied met the 15% budget allocation to health target, yet there are multiple avenues of leakages of potential tax revenue. The webinar had 111 people in attendance.

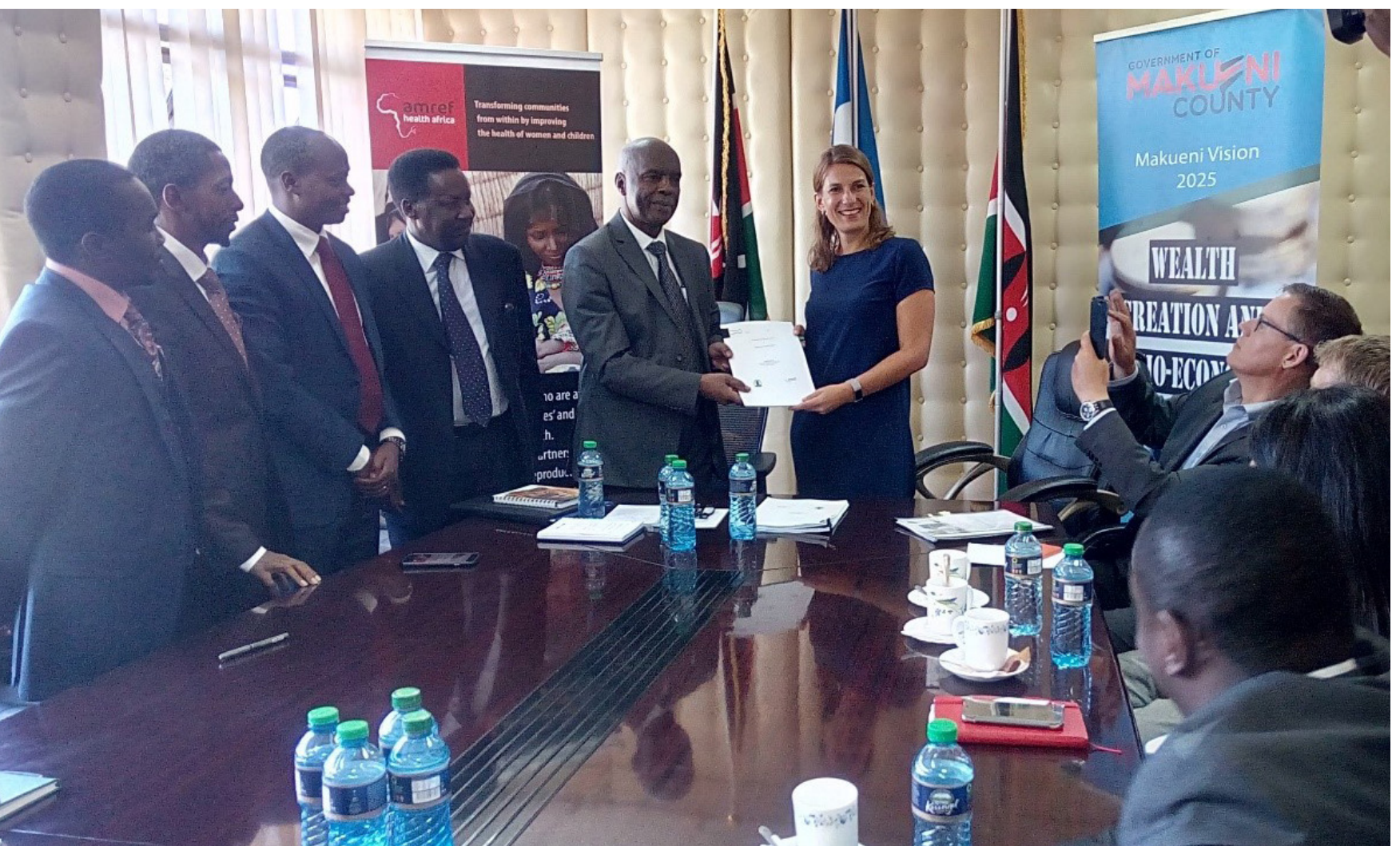
Through SPARC Interventions on Strategic Purchasing, many African countries are on the journey to reposition their National Insurance Schemes to become strategic purchasers so the effects are still on the governance and change of policies side. Rwanda is transitioning the payment mechanism from fee-for-service to capitation. The country is also revising its benefits package, which will ensure better health coverage for the population. Burkina Faso restructured a World Bank Project to drop the Independent Performance Based Financing project component and re-direct the funds to the government priority programme, Gratuite, which provides access to free health care to women and children under-five. Kenya is strengthening the National Hospital Insurance Fund's (NHIF) purchasing functions as part of the UHC agenda and repositioning the fund to be a strategic purchaser through the recently NHIF (Amendment) Bill, 2021.

## SOCIAL ACCOUNTABILITY

The Community Health Units for Universal Health Care (CHU4UHC) project in **Amref Kenya** aims to strengthen community health services through policy enactment at both the national and county assembly levels. The Division of Community Health Services in collaboration with partners in health developed a primary health care strategic framework in 2019 to align the Vision 2030 UHC agenda and the SDGs with Community Health Strategy in the country. In this framework, Community Health Financing was identified as one of the key drivers to sustain the gains on community health services in the country.

The CHU4UHC project provided central support in driving the agenda towards the success of community health financing through various strategic support to the Division of Community Health Services. Such support included: legislative agenda, development of policies to bolster community health and developing the counties' community health investment plans. Over the reporting period the project supported the costing of the Community Health Strategy alongside drafting and tabling of the Community Health Bill at the National Assembly, which was being debated.

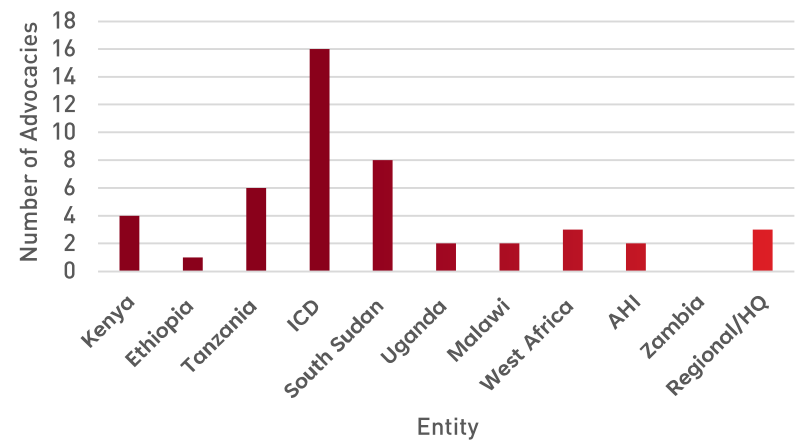
The project put up an investment case for community health services in three supported counties: Nyeri, Kajiado and Kwale to aid in drafting of the county CHS Bills. Kajiado county completed the process and enacted the policy while Nyeri and Kwale counties have tabled the Bills to the respectful county assemblies for debate.



## INFLUENCERS

### POLICY AND ADVOCACY

A total of 47 advocacy initiatives were started in the year 2021. In ICD, an advocacy initiative by SPARC guided engagement with countries to drive policy development, change or implementation for strategic health purchasing, providing varying levels of support based on demand. These included a Rapid Scoping Strategic Purchasing mapping exercise to identify areas of progress and gaps in the health systems inhibiting further strategic purchasing progress, and facilitating stakeholder alignment to allow for effective design and implementation of strategic purchasing reforms. Out of the countries engaged, Kenya, Burkina Faso and Rwanda have made or are making changes towards better strategic purchasing.



**SPARC**'s approach has proven useful in describing the status of purchasing arrangements in countries, framing strategic purchasing progress, and prioritising further actions. There is now a more granular understanding of different external factors, such as the effect of provider autonomy and public financial management constraints on limiting countries' capacity to adopt strategic health purchasing approaches, importance of fragmentation in blocking strategic purchasing progress, role of donors in creating and exacerbating fragmentation and the steps countries are taking to overcome these obstacles.

One of the flagship advocacy initiatives is the **Power to Youth Project (PtY)**, which was launched in 2021. This multi-country intervention aspires to elevate the voices of young people, and through this, change norms and impact harmful practices (including FGM/C and child marriage), sexual and gender-based violence (SGBV) and unintended pregnancies.

The programme invests in civic spaces that allow the youth to run their own advocacy initiatives. It also empowers civil society organisations (CSOs) to demand accountability in policy development and implementation within states. Additionally, it works with social actors and cultural leaders to take responsibility for norms to change.

The programme is implemented in seven countries and involves **Amref Ethiopia, Amref Kenya, Amref Malawi, Amref Senegal** and **Amref Netherlands**. Together with partners Rutgers and Sonke Gender Justice, the first year focused on strengthening relations with local and national governments.

In **Kenya**, successful cooperation continues to be built with youth parliaments. This is a platform where young people, supported by Amref, come together with political leaders and government officials to discuss issues that directly affect them. For example, in Kajiado County, the project supported the dissemination of Anti-FGM policy among the youth and communities for increased awareness and to create an enabling environment for law enforcement. The meetings brought together 104 representatives from different wards. In Siaya and Migori, Amref supported the development of the Youth Empowerment Bill which went through various stages of scrutinisation by Members of the County Assembly, youth and communities. In Homa Bay County, Amref supported the development of a sexual and gender-based violence (SGBV) policy to address the issue. Towards the end of 2021, the Amref PtY project supported the drafting of RMNCAH policy for Kajiado to improve Reproductive Health (RH) services within the county. Amref has been in the forefront of supporting local governments to develop county specific policies as a legal framework for service delivery.

In **Senegal**, the team's efforts towards increasing meaningful youth participation in local politics was acknowledged by national parliamentarians. The PtY consortium in Amref West Africa built capacities of youth in advocacy and communication and prepared them for implementation of advocacy activities to be carried out in 2022. The Senegalese Parliament now has 15 champions, including the youngest member of parliament. As a result of workshops and discussions, the parliamentarians made verbal commitments to champion the project and support advocacy led by the PtY Senegal consortium by emphasising the significant participation of young people in decision-making bodies. This commitment was then materialised when the parliamentary champions, under the leadership of the President of the Health Commission, signed the declaration to have at least 30% of youth actively informed in decision-making. This was an important milestone given the role played by the National Assembly in the development and passing of legislation. The signing of this declaration of commitment is expected to greatly facilitate actions and follow-up of the parliamentarians.



In **Ethiopia**, 27 local youth groups comprising of approximately 1,000 youth have been set up. Vulnerable young people, such as adolescent girls from rural areas and young people with disabilities, are included in these youth-led groups. Through these groups, Amref engages young people on sensitive topics such as SGBV, (unintended) pregnancy and harmful practices. Outcome harvesting methodology has been fully applied in this project to enable documentation of changes and contributions of Amref (and other consortium members) to evaluate the changes in an ongoing manner over the project duration.

Examples of other advocacy initiatives in **Tanzania** and the **Centre of Excellence for SRHR** focusing on budgeting for communicable disease services and FGM/C respectively, are as follows:

**Amref Tanzania** made headways in its advocacy initiatives on tuberculosis (TB) in 2021, through the *Afya Shirikishi* project. A targeted advocacy approach was used by the *Afya Shirikishi* project. The team held meetings with the Mbogwe, Nyang’wale and Geita Town Council (in the Geita Region), working closely with District Medical Officers (DMOs) and District TB and Leprosy Coordinators. The project presented data on TB budgetary allocation by source of funding for the last three financial years, which indicated lack/or very little allocations of council (district) own source and/or central government own funds allocated for TB. The evidence-based asks backed by the officials resulted in commitments by the full councils to allocate between 0.1% to 1.5% of their Council Own Source (COS) funds for TB in the 2022/2023 Comprehensive Council Health Plans (CCHPs).

*Afya Shirikishi* also held meetings with members of parliament who were part of the former TB caucus in a plea to re-instate the caucus committing to logistical and technical support to facilitate elections of new leadership and induct the initial 50 members. This resulted in the reinstatement of the TB caucus by the Speaker of the National Assembly. The project played a significant role in engaging the Tanzanian parliament to drive action towards addressing the TB challenge and building capacity to launch and sustain the initiative. Moreover, the project used existing media platforms on health accountability – previously established by the HSAP project – to drive accountability in health through investigative, thought provoking and solution-oriented journalism. The aim of this was to sustain the platform, stimulate further investments in TB programmes and spark public and policy dialogues and action on TB.



**Amref Kenya**'s support of the Africa-led Movement to End FGM/C was designed to adopt a strong girl-centred approach to support girls to expand their agency, exercise their power and rights and make informed choices to abandon FGM/C. During its first year of implementation, the project reached over 450 girls and boys in five schools of Suswa ward in Narok County. The girls were supported and trained to establish anti-FGM/C school clubs and girls' councils to drive the agenda for girl-led advocacy. The project also developed a girl-centred curriculum through consultative workshops to support capacity building. The trainers of trainers were able to cascade community dialogues to 400 community members, thereby creating an enabling environment for the girls to exercise their power. Overall, 25 youth were trained on SMART advocacy and supported to conduct digital advocacy and communication.

## RESEARCH

The Research Community of Practice (RCOP) continued to grow throughout 2021, building a forum for sharing proposals, best practices and discussing study findings. Some of the key achievements of the RCOP included:

- A virtual media briefing dissemination webinar where COVID-19 related studies conducted across Amref implementing countries in Africa were disseminated to the media.
- Trainings on translating study findings into policy briefs, publication ethics and predator journals, elevator pitches and implementation science in global health.
- Mapping of research competencies across the organisation to understand research strengths and gaps.
- Development of multi-country study guidelines for use in studies involving different countries.

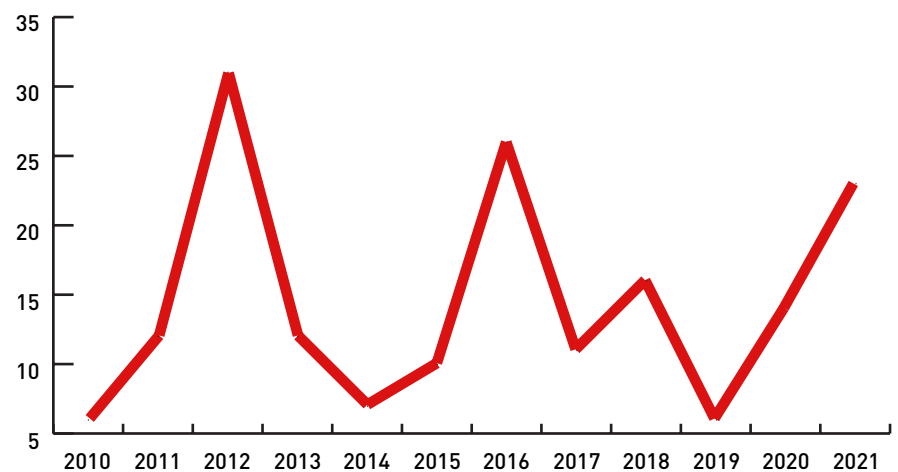


The following achievements were recorded in 2021:

**Publications in peer reviewed journals:** Publications in peer reviewed journals increased in comparison to the previous years. A total of 23 publications were successful, courtesy of the motivation and support from the RCoP. The graph shows trends in the number of publications from 2010 to 2021<sup>13</sup>.

**Policy Briefs:** Seven policy briefs related to COVID-19 studies were developed to facilitate dissemination of research findings<sup>14</sup>. The briefs included:

- Determinants of COVID-19 Vaccine Behaviour Intentions Among the Youth in Kenya: A Vaccine Pre-Introduction Study.
- Impact of Covid-19 Pandemic on FGM/C and CEFM in Ethiopia and Senegal.
- Impact of the COVID-19 Pandemic and Response on Reproductive, Maternal, Child and Adolescent Health Service Provision in Kenya, Zambia and Uganda.
- COVID-19 Knowledge, Practices, and Adoption of Prevention Practices of Urban Communities in South Sudan.



<sup>13</sup><https://amref.org/research-papers/>

<sup>14</sup><https://amref.org/publications/?wpdmc=policy-briefs>

**Amref Research Strategy, 2021:** In 2021, the Research Community of Practice (RCoP) developed, finalised and disseminated the Amref Research Strategy, which included country and programme specific research agenda items.

The research strategy was adopted by the Senior Leadership Team before dissemination to all the implementing countries. Each country was given an opportunity to share its progress with the implementation of the research agenda for input and learning from the rest of the team.

**Ethics and Scientific Review Committee (ESRC):** The ESRC in **Amref Kenya** continues to review and approve research protocols for studies to be implemented in the country. In 2021, 278 protocols were approved, of which 44.2% were expedited reviews, 20.9% were normal reviews and 34.9% were renewals and amendments.

Twenty-five (25) were internal protocols presented by Amref staff, while 17 were protocols by Master's degree and PhD students. The Institutional Review Board (IRB) has maintained a steady increase in the number of protocols reviewed and approved over the year.

The efficiency of the ESRC has been recognised by other institutions and IRBs, leading to signing of reliance agreements with partners such as Centers for Disease Control and Prevention (CDC)-IRB, Kenya Medical Research Institute IRB, Harvard University IRB, University of Maryland and RTI International.



## YOUTH AND ADOLESCENTS



With the immense potential of over 420 million young people aged between 15 and 35 years (35% of Africa's population), Africa can only be transformed by developing a healthy youth population as the basis for human capital development. In 2021, Amref launched its first Global Youth and Adolescent Strategy (2021-2022)<sup>15</sup>, taking a major step towards its transformation into a youth-centric entity. The strategy is anchored on three pillars:

- i. Advancing youth agency in the health agenda.
- ii. Data-driven action for youth-led programmes and policies.
- iii. Maximising youth potential and minimising vulnerabilities through programmes, learning and strategic partnerships.

Highlights of progress against the strategy are as follows:

- **Comprehensive analysis of Amref's policies and strategies on youth participation in governance and leadership:** The current proportion of youth staff across Amref offices is 37% (18-35 years), while proportion of youth staff in decision-making positions (Amref offices) is 46%. A staff survey carried out across Amref resulted in over 320 responses, with staff giving recommendations on the inclusion of youth in decision making bodies, strengthening capacity of youth in leadership and providing an enabling environment for youth to innovate and contribute to robust programmes.
- **Inclusion of youth in governance and decision making bodies:** Initiatives on inclusion resulted in several positive outcomes including: the appointment of one African youth representative (*a global health specialist*) to Amref's International Board Health Programmes Committee; establishment of platforms and youth technical teams to facilitate decision-making between youth members of staff and senior leadership teams in Uganda, Tanzania, Netherlands and Kenya; and prioritised mentorship programmes and leadership courses targeted at youth and female staff, launched through the Amref leadership academy.
- **On-going documentation of adolescent and youth programmes implemented by Amref over the past decade:** A process of mapping models for replication across key thematic areas including SRHR, SGBV, youth-led advocacy, innovation and human-centred design for youth programming, and menstrual hygiene programmes, has begun. The aim of this initiative is to document best practices and approaches from past programmes to support effective design and implementation of youth and adolescent programmes in the future.

<sup>15</sup>[https://newsroom.amref.org/wp-content/uploads/2021/06/Amref-HEALTH-AFRICA\\_-\\_GLOBAL-YOUTH-AND-ADOLESCENT-STRATEGY-2021-2022.pdf](https://newsroom.amref.org/wp-content/uploads/2021/06/Amref-HEALTH-AFRICA_-_GLOBAL-YOUTH-AND-ADOLESCENT-STRATEGY-2021-2022.pdf)

Apart from institutionalising youth interventions programmatically and operationally within the organisation, ground interventions targeted at this demographic cover a multitude of areas including SRHR (FGM/C and CEFM), communicable diseases (HIV/AIDS), and advocacy focused on enabling youth and adolescents to engage in decision-making at various levels. Some of the key highlights for 2021 are documented as follows:

**SRHR:** 83% of adolescents and young people indicated satisfaction with ASRH services offered by the Stand Up for Adolescents (SU4A) project in **Amref Malawi**; and 97% of adolescents were able to report comprehensive knowledge related to SRHR. The project supported adolescents with ASRH services such as family planning, information, distribution of condoms, and recreational materials. During a time in which resources were constrained, Amref Malawi filled the gap effectively and efficiently. out-of-school children were targeted to build their capacity on ASRH, make available ASRH and Youth Friendly Health Services (YFHS), empower them on where to find the services, demand the services, claim their rights and stand against any abuse or coerced marriages. The programme implemented the Journey for Life (J4L) model curriculum to empower the youth, equip them to make informed choices and prevent child marriage and teenage pregnancy. The J4L model has allowed adolescents and youth to be the drivers of effective change through increased self-awareness, discovering their social environment and their roles and responsibilities. They have started to engage with community leaders in dialogue sessions on issues affecting their sexual and reproductive health rights.



**Communicable Diseases:** HIV prevention among Adolescent Girls and Young Women (AGYW) is one of the key interventions covered by the Global Fund grant in **Amref Tanzania**. Results achieved in 2021 include-reaching 97% of targeted AGYW with HIV testing services, with the highest positivity yield of 3.6% among the 15-19 age group. Additionally, 106% of the targeted AGYW were reached with HIV prevention programmes through a defined package of services.



**Box 10: Kutu, Y-ACT, Institute of Capacity Development**

Y-ACT collaborated with filmmaker Peter Gitau to produce a film to shed light on teen pregnancies in Kenya. The film focuses on problems faced by a teenager due to his sexual orientation, societal norms regarding masculinity, and the national narrative around teenage pregnancy. With Tunashow Pictures, Y-ACT submitted the film to the Kalasha International Film festival in September 2021. It received ten nominations and won awards for Best Short Film and Best Supporting Actress and Actor.

Apart from ensuring youth and adolescents are reached, specifically, through youth-led programmes, Amref has significantly focused on engaging youth at various levels – especially at the national and sub-national levels – through capacity building, mentoring and other types of engagement. One of these initiatives is the **Youth in Action (Y-ACT)**, whose progress has been documented since 2020. Y-ACT, AfriYAN and UNFPA partnered in the execution of a regional campaign in Africa that involved the curation of an online platform<sup>16</sup> focusing on the pillars of Education, Engagement and Collective Action/Mobilisation to meet the current needs of the youth population and foster youth-led accountability for the ICPD+25 commitments during the COVID-19 pandemic and beyond. The website, now known as the Youth Power Hub, is multi-lingual and features an interactive chatbot to enable youth find SRH resources and identify ICPD+25 commitments by different countries across Africa. Y-ACT also delivered capacity strengthening of youth-led organisations and youth advocates through training and mentorship, and application of the youth advocacy curriculum. The training enabled youth coalitions to collaborate, identify priority issues for advocacy in each county and develop advocacy strategies to support them. The issues selected in the various counties of Kenya include:

- **Kilifi County:** Increased youth access to Menstrual Hygiene Management (MHM) information and services through development of county MHM guidelines.
- **Nairobi County:** Increased training of health care providers on adolescent and youth friendly services, for effective implementation of the County Adolescent and Youth Sexual and Reproductive Health (SRH) policy.
- **Kakamega County:** Contributed to the reduction of teen pregnancy through the inclusion of a teen pregnancy reduction framework in the draft County Sexual and Gender Based Violence (SGBV) Protection Policy.
- **Kisumu County:** Increased access to sexual and reproductive health services for adolescents and youth through advocating for development and implementation of a Kisumu County Youth and Adolescent Health Policy.
- **Samburu County:** Increased youth access to youth-friendly SRH services through advocating for domestication, approval and dissemination of national guidelines on the provision of youth friendly services.

Y-ACT also used the organisational development system strengthening model to build the capacity of 12 youth-led organisations through mentorship and coaching sessions to address development gaps identified. This resulted in significant improvement/change in all 12 sub-grantees, particularly in governance and leadership, strategic planning, strengthened internal controls on financial management, resource mobilisation, sustainability plans, and increased partnerships and stakeholder involvement in the counties, creating a foundation for sustained impact and longevity of project interventions.

<sup>16</sup><https://www.yactmovement.org/caravan/>

A good example of youth engagement in designing contextually relevant interventions is demonstrated by the **Amref Ethiopia** Advisory Council, where young advisors were engaged in the development of the five-year 60 million USD **Kefeta** USAID Integrated Youth Activity, which Amref Ethiopia won.

The **Amref Youth Council (AYC)** was established in December 2018 and is staffed by youth representatives from diverse backgrounds who collaboratively engage in programme design, implementation, and evaluation of Amref programmes. Amref, recognising the importance of youth voices and their meaningful engagement, ensures youth participation within its programmes as a nod to their ability to direct the trajectory of health outcomes in their communities.

The AYC is currently active in Addis Ababa, Afar, Amhara and SNNP regions, with plans to expand to the regional and district levels to enable more young people to lead and advocate for their health and development. Youth representatives are brought together with the mission of serving as a voice to youth in local and national health and development agendas. A five-year strategy is developed to guide the AYC work in Ethiopia.



## INNOVATION AND TECHNOLOGY

The Digital Health Innovations Community of Practice was formed in 2021. It is charged with leading innovations and scaling up new ideas formulated in implementation offices and programmes. Many of the innovations provided in this section are related to technological mainstreaming into regular programmes. However, there are a number of non-technological innovations that are part of programmes which have been mentioned throughout the document, including box stories where programmes have aimed to implement interventions differently to improve results. This includes the Moonlight Strategy for Immunisation, integrating entrepreneurship and financial inclusion in sanitation interventions, utilising biogas for waste and energy recovering mechanisms, and the Partnership for Primary Care (P4PC) model, among others.

### Mobile Platforms and Trainings

#### *Box 11: Digital Learning Study in Ethiopia*

The study showed most of those who had digital learning experience agreed or strongly agreed that digital learning is cost-effective (88.7%), most effective and efficient (90.3%) with no geographic limitation (95.2%), easier to use (91.9%), and enabling the required skills and knowledge (89%) as compared to face-to-face learning, which were also supported by key informants. More than 90% of survey participants with digital learning experience regarded classroom learning as more expensive than digital learning and the majority were willing to pay for digital learning service, which was also echoed by key informants. The most preferred delivery mode was blended learning.



As an example of country adoption of mobile learning, **Amref Zambia** worked closely with the Ministry of Health (MoH), Provincial and District Health Offices to roll out LEAP, the mHealth platform that provides health workers with mobile-based learning solutions. 6,500 CHWS from 7 of the 10 provinces of Zambia were trained on COVID-19 infection and prevention of transmission at the individual and community levels. The MoH at the central level and Provincial Health Offices recognised and applauded the use of mobile-based training given the restrictions on in-person events, especially for larger groups.

They also acknowledged LEAP's ability to help them disseminate COVID-19 information to more CHWs, particularly those in hard-to-reach areas. In districts such as Mpulungu (Northern Zambia) for instance, the COVID-19 modules through LEAP were the first formal training that Community Health Assistants (CHAs) had received on COVID-19 measures and guidelines.

**eCampus/Jibu:** Through eCampus, the Jibu platform grew to reach over 55,000 users from 21 countries in sub-Saharan Africa, with the number of courses hosted on the platform growing by 5% in 2021 to 120 courses. Jibu is a state-of-the-art mLearning solution responsive to the knowledge management needs of health workers. In 2021, the platform was enhanced with an improved user interface and theme to give it a cleaner look and feel. The functionalities of the solution extended to offer customised platforms (tenancy) to institutions, who can now deliver branded digital learning, hosted by Amref, thus opening up new revenue opportunities.

Additionally, the eCampus team adopted a design thinking approach in the development of eLearning modules with a strong focus on co-creation processes during needs assessment and content creation. eCampus developed a COVID-19 vaccine course in 2021, which reached over 30,000 users from 10 countries. A 25% increase in enrolment in the course was recorded compared to 2020. The course was also translated to French for Francophone audiences in West Africa, resulting in the enrolment of over 1,000 healthcare workers in Senegal.

### Platforms Improving Implementation



**Sanitation Digital Solution in Uganda:** The Sanitation Digital Solution (Sani Digs) project aimed at developing a one stop platform for improved multi-sectorial decision making, planning and real time provision of safely managed sanitation services to peri-urban settlements of Kampala, **Uganda**.

The solution brings together government, sanitation service providers, entrepreneurs, and consumers for continuous engagement and timely provision of services geared towards improving sanitation conditions within the targeted communities.

SaniDigS is now operational in Kawempe Division, with an active call centre to manage sanitation order and delivery coordination; a mobile application (app) for user request order generation; a driver app that enables product/ service providers to accept and honour requests from users and clients, and voice interaction, short message service (SMS), and social media messaging targeting the Kawempe division community. Several households have been able to access sanitation services through this application.

**Tracking the Girls:** The **End FGM/C Centre of Excellence (CoE)** acts as strategic lead on ending the practice in Africa. In addition to carrying out multi-country research and coordinating various tasks, the CoE has worked on the development and testing of a digital monitoring tool dubbed 'Tracking the Girls'. With the help of this tool, Amref can monitor the wellbeing of girls who have participated in Alternative Rites of Passage (ARP). Twice a year, the girls are visited by a local Amref care provider who collects data about their health, wellbeing and development.

To complement these visits, the monitoring tool also relies on a referral system to provide additional support to girls who may need it. By collecting and analysing data, Amref is able to improve and optimise our approach and models to end FGM/C.

## EMERGENCY RESPONSES

**Emergency Response:** The civil war in Ethiopia caused a humanitarian disaster that displaced more than 2.7 million people across the Amhara and Afar regions since June, 2021. Many affected civilians, institutions such as health centres, hospitals, humanitarian stores, universities, research institutes, government infrastructure and offices and internally displaced people (IDP) camps as well as civilian properties and housing were looted and/or damaged.

To address the complex challenges created by this situation, Amref in Ethiopia has been providing humanitarian support in the conflict affected Amhara and Afar regions, delivering essential food supplies, sanitary pads and matters to internally displaced persons (IDPs); rehabilitating and restoring health facilities and delivering technical expertise at national, regional and local level. This includes engaging in document development, assessment and monitoring, and training health service providers on SGBV response in times of crisis.



# AFRICA HEALTH AGENDA INTERNATIONAL CONFERENCE (AHAIC 2021)

In March, we successfully hosted the first ever virtual (*and 4<sup>th</sup> in the bi-ennial series*) [Africa Health Agenda International Conference \(AHAIC 2021\)](#). Since 2015, the Africa Health Agenda International Conference (AHAIC) has established itself as Africa's premier forum on African health issues providing an opportunity to mobilise continental leadership, including government, civil society and the private sector, in investing in the health of the continents people.

This year, the virtual conference, co- convened by the [Africa CDC](#), [Johnson and Johnson](#), [Roche](#), [Takeda](#) and the [International Federation of Pharmaceutical Manufacturers & Associations \(IFPMA\)](#) was attended by over **3,000 delegates**, from across **98 countries** where the AHAIC commission for the State of UHC in Africa, established through the leadership of [Amref Health Africa](#) with support from the [Bill and Melinda Gates Foundation \(BMGF\)](#) released a critical report on the State of UHC in Africa. The report takes stock of the progress made by African countries toward realising health for all through Universal Health Coverage.

The Theme of the conference was '**Decade for Action: Driving Momentum to Achieve UHC in Africa**' under the themes of *Leadership, Accountability, Health, Security and Technology*.

The three-day virtual conference held an array of high-level plenaries, panel discussions and town hall sessions designed to share ideas and find solutions to accelerate progress towards Universal Health Coverage (UHC) in Africa. Kenya's President, **H.E. President Uhuru Kenyatta** formally opened the conference, encouraged stakeholders in health to embrace the empowerment that comes from optimism and hope even during times of uncertainty such as those caused by the COVID-19 pandemic, and urged African countries to consider seven priority areas to anchor their health policies and programmes, including giving greater priority to primary health care; increasing access to health care services; making health care more affordable; harnessing Africa's innovative energy and creativity; strengthening health sector collaboration; improving health security and increasing political will towards UHC.

The WHO Director General, **Dr. Tedros Adhanom Ghebreyesus** spoke on the underrepresentation of women in health leadership despite making up 70% of the health workforce and highlighted the urgent need for gender equality as he paid homage to women and their contributions to health, social and economic development, calling for greater inclusion of women in leadership and decision-making to achieve equality and equity in health.

The discussions were thought-provoking featuring some of the continent's most respected and admired decision makers and opinion shapers in health, from government representatives and health innovators to entrepreneurs, development partners, youth advocates and community mobilisers.

The [State of UHC in Africa Report](#), the key anchor of the conference takes stock of the progress made by African countries toward realising health for all, details the impact of colonial legacies, poor governance, and economic challenges on the continent's health policies and outcomes, and provides key recommendations for transformative change, which African countries should adopt to accelerate progress toward UHC.

Key highlights from the report include revelations that:

- **Africa's health systems are poorly attuned to meet the health care needs of the poor, those living with disabilities and other vulnerable groups, with coverage of essential health care services being decidedly low:** only 48 per cent of the population (*approximately 615 million people*) receive the health care services they need.
- **Quality of health care services provided in African countries is low** and is considered the poorest performing indicator of UHC. When quality of health care services is considered, service coverage scores across African countries are even lower.
- **Coverage of essential services needed by women and girls in Africa is low**, with data indicating that between 2015 to 2019, only 49 per cent of African women had their demand for family planning satisfied by modern methods.
- **The proportion of individuals that are pushed into poverty due to out-of-pocket health care payments each year is high**, at 15 million people (*representing 1.4 per cent of the continent's population*), though the number is gradually reducing.

In its recommendations, the report proposes several actions to ensure steady progress towards UHC, including:

- Re-orienting health systems and health system priorities to respond to population health needs;
- Prioritising and strengthening primary health care as the foundation for UHC;
- Investing in strengthening health system inputs through, for example, boosting the number of skilled health workers especially in primary health care; and
- Investing in health technologies to enhance the performance of all health system functions and strengthening governance and accountability.

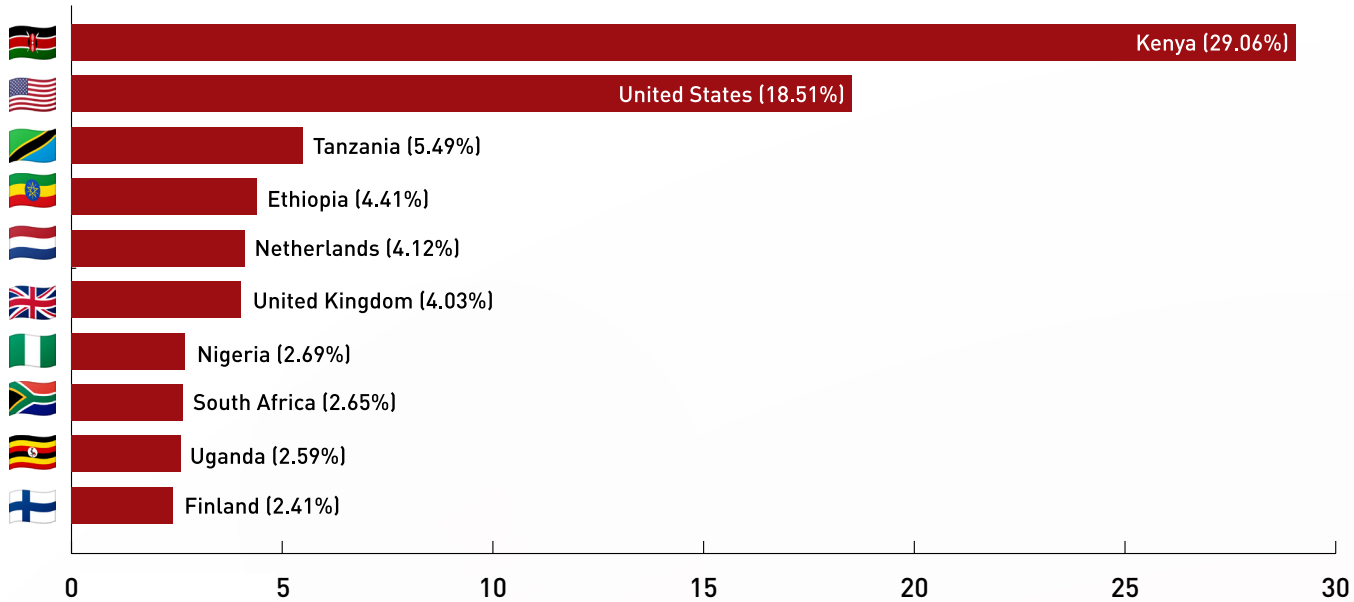
**AHAIC 2021** was convened through the generous support of our co-conveners and other partners including; [Transform Health and Foundation Botnar](#), [Primary Health Care Performance Initiative \(PHCPI\)](#), [Coalition for Health Research and Development \(CHReaD\)](#), [UNFPA](#), [Strategic Purchasing Africa Resource Centre \(SPARC\)](#), [PATH](#), [PATHFINDER](#), [Malaria No More UK](#), [MSD](#), [Philips](#), [General Electric](#), [Governing Health Futures-The Lancet and Financial Times Commission](#), [Nutrition International](#), [Partnership for Maternal, Newborn and Child Health \(PMNCH\)](#), [Living Goods](#), [Eco-Carriers](#) among other partners.

There were a lot of media visibility opportunities we leveraged before, during and post conference that have continued to position [Amref Health Africa](#) as a credible and reliable health thought leader not only within the continent but across the globe.

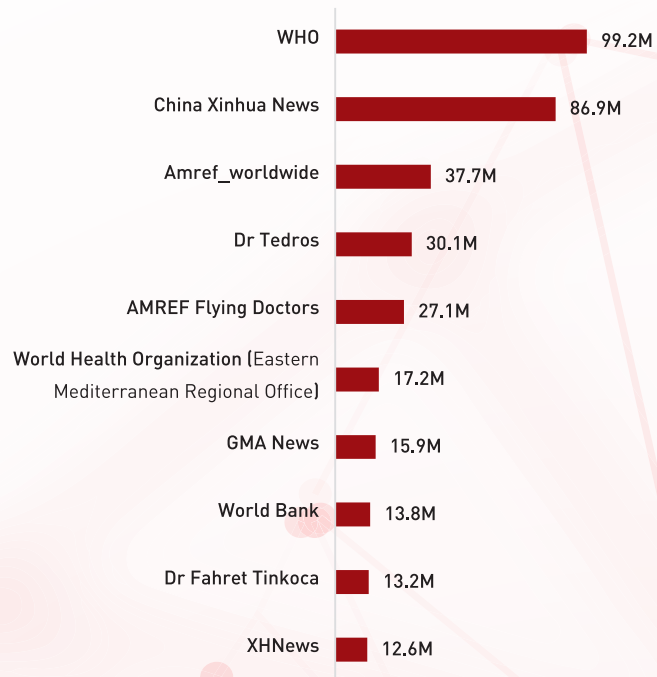
Between October 1<sup>st</sup> 2020 (*the month when we made the [announcement of the establishment of an Independent AHAIC Commission](#) tasked with the development of a State of UHC in Africa report, the subsequent development of a comprehensive [AHAIC communication and social media toolkit](#) among other visibility efforts up until 10<sup>th</sup> March, 2021 when the conference concluded*), the Africa Health Agenda International Conference (AHAIC) garnered a total of **64,791 mentions social media**. This, in turn, drove a **reach to about 1.6 billion people**. Social Media was the main driver for conversation with Twitter remaining the most prominent source. The social media platform had **over 704 million impressions** that was gained from **over 20,000 users mentioning the related topics**. Social media conversation surrounding the [Africa Health Agenda International Conference](#) drove a substantial amount of engagement over the analysed time period. The top hashtag that drove conversation was [#AHAIC2021](#) and [#AfricaHealthAgenda](#).

During the analysed time period, online editorial news from diverse media outlets mentioning AHAIC 2021 as well as State of Universal Health Coverage in Africa Report totaled to **653 online editorial mentions featured in over 42 countries**. An estimated over **120 reporters from 31 different countries** (*local, regional and international*) registered for and covered the 3-day conference.

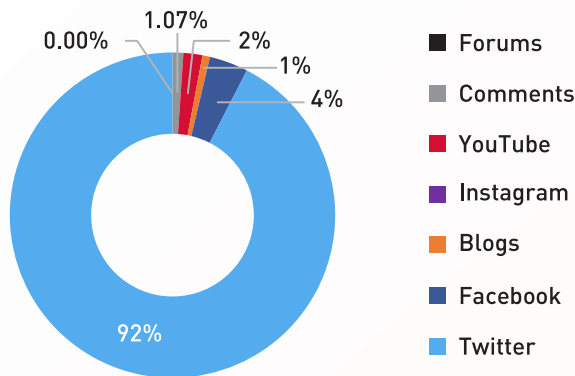
### TOP 10 COUNTRY USERS



### TOP INFLUENCERS BY REACH



### SHARE OF VOICE BY VOLUME



**64,138** Social Posts | **977M** Social Reach

**AHAIC 2021** may be behind us, but the journey to achieving Universal Health Coverage (UHC) in Africa remains ahead. If the COVID-19 pandemic has taught us anything, it is that now is the time to amplify calls for greater commitment, collaboration and action towards achieving health for all on the continent. This is not the time to be silent. We have a responsibility to take advantage of every opportunity to address the challenges that hinder us from achieving UHC, and to strip down the barriers that stand in the way of realising better outcomes for Africa. It is time for us to join forces toward a common goal - because a win for UHC is a win for all of us.



# Our SUBSIDIARIES



## AMREF INTERNATIONAL UNIVERSITY (AMIU)



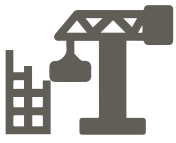
**Enrollment**

The total number of students at Amref International University stood at 1,020 in 2021. Out of this, 109 were Master of Science (MSc) students, 385 were undertaking Bachelor of Science (BSc) courses and 526 were diploma students. The total number of degree students (Masters and BSc) reached 494 and surpassed the minimum requirement of 400 required for award of charter by the Commission of University Education (CUE).



**Graduation**

The Second Graduation Ceremony of AMIU took place on 11th June 2021, with a total of 113 students graduating from six programmes. While a higher number of graduating students was anticipated, graduation was delayed for some students whose learning activities were interrupted due to COVID-19 resulting in non-completion of assignments.



### Infrastructure

The importance of adequate ICT infrastructure, specifically for virtual and e-learning, has become more evident with the outbreak of the COVID-19 pandemic. In the year, under review AMIU adapted to the changing landscape by putting in place three modes of learning: physical/face to face, virtual and hybrid. A higher proportion of classes were delivered virtually compared to pre-pandemic period. As the university aims to admit more students from other countries, this mode of delivery is expected to become essential. Having obtained a grant from Amref Health Africa (NGO), the university plans to upgrade existing infrastructure to improve delivery platforms for teaching and examinations. It will also facilitate the integration of student records, learning platforms and student financial records as well as the installation of anti-plagiarism software in the library.



### New Venture

In 2021, AMIU established a directorate of Technical and Vocational Education and Training (TVET), which has the mandate to oversee the award of diploma courses in technical and vocations skills in Kenya. The directorate coordinates accreditation of courses with the TVET Authority to ensure their inclusion in TVET programmes. During the same period, AMIU was accredited as a TVET Training Centre after meeting the requirements set by the Authority, and plans to welcome its first intake of TVET students in April 2022.

Additionally, in the same year, AMIU was competitively awarded a grant from the Second European and Developing Countries Clinical Trials Partnership Programme (EDCTP2) to facilitate training of MSc Epidemiology students. AMIU and Jaramogi Oginga Odinga University of Science and Technology (JOOUST), a co-participant in this project, were selected as venues for training of the 15 fellows admitted into the programme. Eight students are undertaking their studies at AMIU, while the remaining seven are training at JOOUST.

As part of our holistic approach to education, the students participated in various extracurricular activities that included mobilising communities in Kibera for COVID-19 vaccination. Over 300 residents of Kibera were vaccinated during the first outreach held in December 2021.



### Staff & Resources

A total of 14 Amref staff from **Kenya, Ethiopia, Malawi, Tanzania** and **South Africa** were recruited as part time faculty members of AMIU in 2021. The recruitment was based on relevant qualifications of the applicants pegged to the requirements of the courses on offer in the various departments. Amref staff from various country offices in Africa were also offered partial scholarships in which they paid 80% of the tuition fees to further their studies.



## AMREF FLYING DOCTORS (AFD)

AFD increased its total flight hours from 2,849 in 2020 to 4,202 in 2021, registering a 47% increase. In 2021, 1,306 patients were moved by AFD, 997 by air and 409 by ground - demonstrating an increase of over 100% from 622 patients recorded in 2020. AFD transported a total of 525 patients in COVID-19 patient flights. In 2021, COVID-19 patients made up 48.6% of the total patient transports.

Towards the end of the year, there was a steady decline in requests to transfer COVID-19 patients, which may be attributable to rising immunity due to rollout of vaccines and the milder Omicron variant. Looking ahead, AFD anticipates a continuing decline in COVID-19 transport requests. However, with the gradual resumption of business and leisure travel and resumption of economic activities in our region, medical evacuation requests for non-COVID-19 cases may increase. AFD also continues to see a steady increase in requests for commercial medical escorts reflecting an upturn in the travel industry. In 2021, 25 commercial medical escorts were undertaken as compared to seven in 2020, partially attributable to word-of-mouth promotion of the service among the medical fraternity. In January 2022 alone, AFD had 21 flights and expects this number to grow.

# Our SUBSIDIARIES



## AMREF HEALTH INNOVATIONS (AHI)

### Health Financing

**Financial Resilience:** Between November 2020 and July 2021, Amref Health Innovations (AHI), the social enterprise arm of Amref Health Africa (AHA) partnered with the Bill and Melinda Gates Foundation (BMGF) to implement a project in Kenya dubbed, “Expanding Financial Resilience” (*Project EFIRE*). The goal of the project, which was successfully implemented in Kakamega, Kilifi, Makueni, Meru, Migori and Taita Taveta, was to provide accurate data and evidence to help monitor and mitigate the social and economic effects of the health crisis by expanding the financial resilience of poor and vulnerable households during the pandemic.

To identify poor households in the target counties, Amref and partners digitised a harmonised socio-economic survey tool (questionnaire) that was deployed on Amref’s digital data collection application known as M-Jali (*Mobile Jamii Afya Link*). M-Jali is used to capture and transmit household level data to a web-based database (see more details of m-Jali usage in the Innovations and Technology section below). AHI worked with the existing community health workers (CHWs) structure, as defined by Kenya’s Community Health Strategy (KCHS), to build the capacity of CHWs to use the tool, which they then deployed while collecting the requisite household data as part of their routine door-to-door health education and health promotion campaigns. The project managed to reach over 480,000 households across the six counties by the time it closed in August 2021. So far, EFIRE has provided support to relevant institutions by sharing evidence to inform resilience-building initiatives.

**Public and Private Partnerships (PPP):** Between July 2018 and January 2020, Amref, Philips and the county government of Makueni set out to test a public private partnership model, as a vehicle for delivering UHC at the primary health care level. This unique collaboration sought to find out whether the rollout of selected demand and supply side interventions could lead to delivery of primary healthcare in a more efficient and effective manner.



The Partnership for Primary Care (P4PC) model's value proposition included establishment of a strong health volunteering workforce at the community level, fully functional primary health care facilities creating patient confidence and staff satisfaction, a rollout of national social health insurance and private management of public health care facilities. A feasibility study showed that general service utilisation increased by 92%, skilled deliveries went up by 48%, National Hospital Insurance Fund (NHIF) enrolment grew from around 0% to 15%, and finally, revenue streams from social insurance grew by 400%. A scale up model has been planned to expand this model at county level and then multiple counties between 2021-2023.

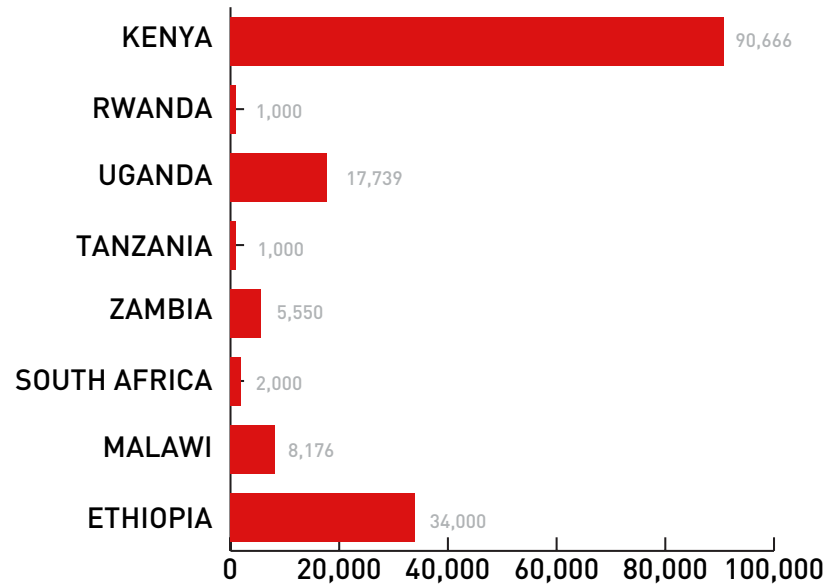
### Innovation and Technology

**Leap and m-Jali:** In 2021, the digital health unit of Amref Health Innovations (AHI) conducted a product review on the viability of Leap and m-Jali for internal and external stakeholders. A clear pricing model for Leap has been finalised for approval, after which a business plan will be generated for all countries with digital tools. AHI is also focusing on improving its operational efficiency by developing and implementing a CIP framework to evaluate features before they are implemented. With new recruitments and additional training for software developers the programme has demonstrated a 50% reduction in turnaround time.

Leap now has new features developed in line with updated Ministry of Health (MoH) tools, as well as dashboards that are being used to track training and service delivery for the i-push programme in Kakamega.

m-Jali, whose objective is to improve health outcomes in sub-Saharan Africa through accurate data collection and analysis, has to date digitised data from Kenya's MoH, socio-economic data, research and other health-related proxy data collection tools to enable stakeholders within the public and private sector plan for health responses using a data driven approach.

Learners registered on the Leap platform are shown in the above graph with Leap achieving 38% of its targeted registration. m-Jali has 11,400 users on its platform from Zambia and Kenya to date.





## THE WORLD IS CHANGING AND SO ARE WE



*The world in which we operate changes rapidly. There is a need for demonstration of impact and value in data. Therefore, Amref has prioritised the following three core areas in its journey to become a world class organisation.*

**Impact:** Amref is on a mission to direct its resources away from 'what we do' to 'what we achieve'. Our interventions are increasingly based on evidence gathered (as demonstrated in the outcomes and results provided throughout this report, and in the research section) and external impact evaluations that are commissioned. Amref is currently investing in significant impact studies in the areas of Sanitation and Hygiene, Leadership Management and Governance and Youth programming, which not only aim to establish evidence for improved programmes but also serve as products that fuel increased funding through credibility. Our aim is to know that what we do makes a difference in the communities we serve. To this end, increased investments in research and the use of the outcomes of the research are informing our technical agenda and programmatic approaches.

**Data:** Across the organisation, with an increased uptake technology, further motivated by lessons from COVID-19, Amref continues to collect not only programmatic data but those related to operations and its external visibility. Although progress has been slow in this area, investments are being made in analytics and accessibility of packaged data for various internal audience, to facilitate greater use of data for decision making. An organisation-wide analytics assessment set to take place in 2022 has been commissioned. This exercise is expected to create a pathway towards becoming a more data-driven organisation, contributing to overall knowledge management processes.

In addition, Amref aims to stay relevant through venturing into areas such as climate change, gender and social inclusion, global health security, and organised technical assistance. These themes affect the sustainability of the impact that Amref has had over the past 65 years and have influenced our new strategic direction, which will position us for the transition from responder/ implementor to a key opinion shaper in the conversations that affect these areas, and designer of sustainable, contextually relevant interventions for Africa.

## A LEARNING ORGANISATION



**Service Delivery Models:** Amref is focusing on building and improving its service delivery models for the various areas in which it has shown significant results through project and programme implementation. These lessons are not captured as sufficiently as they could be when projects and programmes move to the next priority. It is important to establish Amref's way of delivery, not only through a community-based approach in general, but also through specific actions under all programme areas in which Amref excels as well as areas in which Amref is attempting to tread afresh. In 2022, as Amref builds its next corporate strategy, it will also focus on establishing, improving and/or standardising its service delivery models to demonstrate its technical excellence and programming in adherence to quality standards.



**Technology:** The use of technology for training, project implementation, tracking information and innovations is steadily growing across all Amref programme areas, enabling more communities and health workers to be reached, supported and trained than conventional means would allow. Internally, technology is being used to develop easy-access dashboards for various audiences, mobile data collection tools and general improvement of existing systems to adhere to growing demands from programmes. Amref must continue to invest and streamline these requirements to provide the most efficient and effective services that enable evidence-based decision making across all fronts.



**Leveraging Partnerships:** As stated in the annual technical report - November 2021 – Amref should scale up efforts to ensure transition to self-sufficiency of jointly implemented interventions with government through increasing capacity in HRH, RMNCAH and DCPM for budgeting, costing, coordination, advocacy, and resource mobilisation. Amref is already a member of several policy advocacy technical working groups, with representation in several national, regional and district level COVID-19 control committees. Since the onset of the pandemic, Amref has participated in policy development at various levels and is represented at Africa CDC and the Africa Union Task Force for Coronavirus. Such committees enable Amref to present research findings and evidence from project implementation activities. Amref should therefore maintain its technical assistance role with governments and relevant departments through continued presence in high level technical working groups in HRH, RMNCAH, WASH and DCPM.

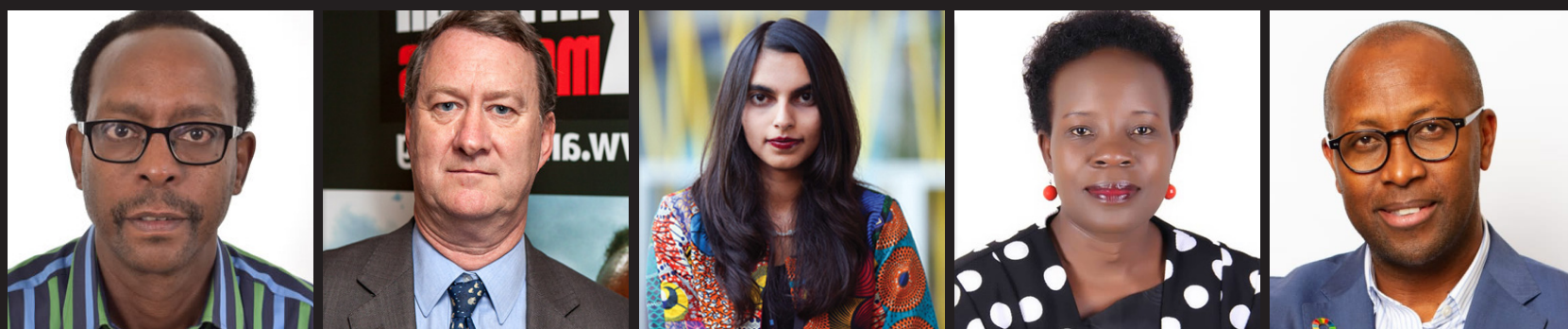


**Integrated Services:** As reflected in the 2021 Annual Technical Report, Amref should maintain and scale up its integrated services model. This model has resulted in increased uptake of WASH interventions and their integration with economic development activities, which are addressing drivers of poverty at the community level through empowering populations to afford sanitation and hygiene services and products. A multi-sectoral approach anchored on social determinants of health should be developed to ensure integrated models are feasible and do not cause beneficiary fatigue through over-interaction with households or communities. In this regard, Amref should also scale up its economic empowerment activities to include women/girls, persons with disabilities (PWDs) and other social minorities through partnerships with institutions that offer these products and services.

# Our GOVERNANCE



*Current International Board L to R: Charles Okeahalam (Chair) | Judith Chinkumbi | Eunice Mathu | Liam Fisher-Jones | Chiara Palmieri*



*L to R: Frank Ileri | Paul Davey | Dr Shakira Choonara | Dr Elizabeth Ekirapa | Dr Githinji Gitahi (Ex-Official member)*

## INTERNATIONAL BOARD

Amref Health Africa is governed by a Board of Directors (the “International Board”) comprising of members from a wide range of backgrounds, bringing a great wealth of wisdom, insight and experience to the organisation. Amref Health Africa has established offices in various countries within and outside of Africa in connection with achieving its objectives (“Country Offices”).

The Amref Health Africa Country Offices in Europe and North America which are established as separate legal entities have separate Boards of Directors (“National Boards”), while Country Offices established within Africa are governed through advisory bodies (“Advisory Councils”).

The Board is at the core of the organisation’s system of corporate governance and is ultimately accountable and responsible for the performance and affairs of the organisation. The primary role of the International Board is to provide policy guidance, financial oversight, strategic orientation and leadership to Amref Health Africa. It is also expected to support the management of Amref Health Africa in fulfilling its vision and implementation of the Strategic Plan.

In carrying out its mandate, the Board is supported by several internal committees. These include:

#### **Human Resources, Nominations and Governance Committee (HRNGC)**

The purpose of the Human Resources, Nominations and Governance Committee is to assist the Board in fulfilling its director nomination and corporate governance development responsibilities. The HRNGC also advises the International Board and the Group Chief Executive Officer on policies and strategic issues with regard to the management of the human resources of One Amref.

#### **Health Programmes Committee (HPC)**

The Health Programmes Committee has a major role given the nature of Amref Health Africa's standing as a leading public health organisation. It advises the Group Chief Executive Officer and International Board on strategic and policy issues with regard to health development.

#### **Audit, Risk and Compliance Committee (ARC)**

The main purpose of the Committee is to assist the International Board in fulfilling its responsibility relative to the compliance of Amref Health Africa Headquarters and Country Offices with all International Board approved/ endorsed Corporate Policies/ Agreements and Procedures. This includes, inter alia, compliance with international accounting standards financial management procedures and reporting requirements; and the management of other risks (*governance, general management, operational, human resource, reputational*).

#### **Finance and Investment Committee (FIC)**

The Finance and Investment Committee provides oversight over Amref Health Africa's financial planning and management. The FIC also assists the Board in setting the investment policy to be adopted for Amref Health Africa's funds and reviews, evaluates and approves investment projects and operational expenditure relating to Amref Health Africa's business as planned.

#### **Fundraising and Communications Committee (FRANCC)**

The Fundraising and Communications Committee's role is to support the mission, goals, and programmes of Amref Health Africa by reviewing and monitoring the organisation's annual fundraising strategy, targets and budgets. This Committee also monitors Amref Health Africa's communication strategy, budget and execution and makes appropriate recommendations to the International Board.

#### **Our Group and Senior Leadership Team**

Amref Health Africa by design has attracted the largest collection of international development professionals and technical experts in the globe tasked with the responsibility spearheading Amref's accomplishment of its objectives. This global team is responsible for planning, organising, leading and controlling the efforts of organisational members, making use of organisational resources to achieve the stated organisational goals and objectives.

# Our LEADERSHIP

## GROUP LEADERSHIP TEAM



*From top Left:* Dr Githinji Gitahi - Group CEO; Jonathan Dutton - Financial Resources Director; Angela Muchiru - Human Capital Director; Desta Lakew - Partnership & External Affairs Director; Samuel Weru - ICT Director; Lolem B Ngong - Chief of Staff to GCEO.

## SENIOR LEADERSHIP TEAM



*From top Left:* Steve Gitau - CEO, AFD; Caroline Mbindyo - CEO, Amref Health Innovations; Prof Joachim Osur - Vice Chancellor, AMIU; Dr George Kimathi - Director, Amref ICD; Diana Amuhaya - Company Secretary; Lizz Ntonjira - Global Communications Director; Ramses Man - Global Fundraising Director; Joanna Arulraj - Director, Monitoring, Evaluation and Learning; Anne-Marie Kamanye - Director, Business Development; Sarah Murithi - Executive Assistant to GCEO.

# Our LEADERSHIP



*From top Left:* Dr Meshack Ndirangu - Country Director, Kenya; Dr Patrick Kagurusi - Country Manager, Uganda; Dr Florence Temu - Country Director, Tanzania; Misrak Makonnen - Country Director, Ethiopia; Morrish Ojok - Country Manager, South Sudan; Boniface Hlabano - Head of Programmes, Southern Africa; Mouhamed El Bachir Lo - Ag Head of Programmes, West Africa Hub.



*From top Left:* Walter Schmidjell - Executive Director, Amref Flying Doctors, Austria; Ky'okusinga Kirunga - Executive Director, Amref Canada; Hubert Chauvet - Chief Executive Officer, Amref France; Guglielmo Micucci - CEO, Amref Italy; Patricia Vermeulen - CEO, Amref Flying Doctors in the Netherlands; Aisha Al-Said - General Manager, Amref Salud África (Spain); Camilla Knox-Peebles - Chief Executive Officer, Amref UK; Robert Kelty - CEO, Amref USA.

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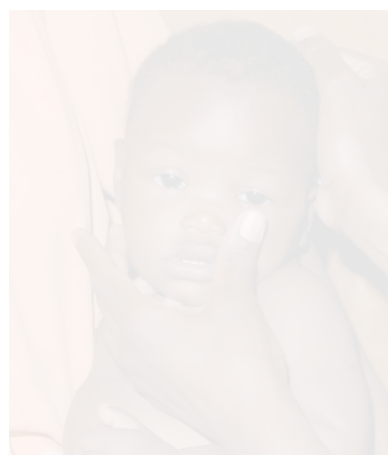
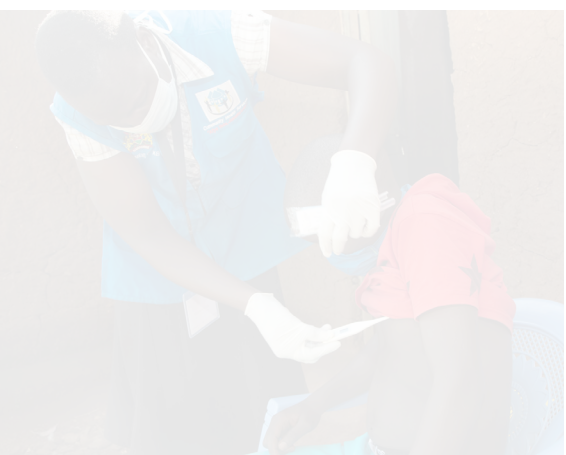
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