



Investing in African Health

AMREF UK

Annual Review 2009



Letter to AMREF Supporters

Investing in African Health

Over the past year, the global economic recession has affected all of us, but nowhere has it been felt more acutely than in the developing world. In Africa, the rising cost of food and fuel has made an already difficult economic situation worse for the continent's poorest and most vulnerable communities. When people live a hand-to-mouth existence, even a small rise in the cost of living can mean destitution.

At AMREF, we believe that only healthy societies can overcome poverty and inequality. Creating healthy societies — societies that can weather global pressures such as recession and drought — means investing in health workers, health education, health care delivery systems, and health policies that work.

An investment in AMREF is just such an investment in Africa's long-term health and prosperity. In 2008-09, we continued to train health workers — from village health teams that use drama and dance to educate their neighbours about disease prevention, to midwives who deliver babies safely, to doctors who correct debilitating but treatable conditions such as trachoma and fistula.

We worked with communities and governments to pioneer new ways to treat, track, and prevent common diseases, and we used the findings from our innovative programmes to influence health policy in Africa and beyond. We continued to do what we do best: provide African solutions to Africa's health problems.

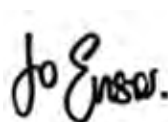
Here in the UK we were equally busy. We continued to diversify our resources so that AMREF can expand its

lifesaving programmes during times like these, when they're needed most, and we continued our successful collaborations with partners such as the Department for International Development, the European Union, and many other companies, trusts, and foundations in the UK. You'll find them highlighted in the pages that follow.

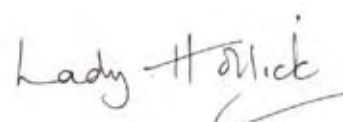
Without giving too much away, we're also excited to announce our plans to launch two new fundraising and awareness campaigns in 2010: One focusing on maternal, newborn, and child health, and another on our Flying Doctors programme.

Ultimately, if the global recession has demonstrated that the world's economies are even more interdependent than we previously imagined, then one of its most important lessons is that our own health and prosperity depend on the health and prosperity of Africa. AMREF's work is as urgent as it has ever been.

We would like to thank you, our donors and supporters, for your unflagging support and generosity during these difficult economic times, and we would like to thank our staff and board of directors for their dedication and hard work. Without you, our lifesaving work would not be possible.



Jo Ensor
Chief Executive Officer



Lady Hollick
Chair, AMREF Board of Directors

Lady Hollick (left) and Jo Ensor (centre) in Katine.

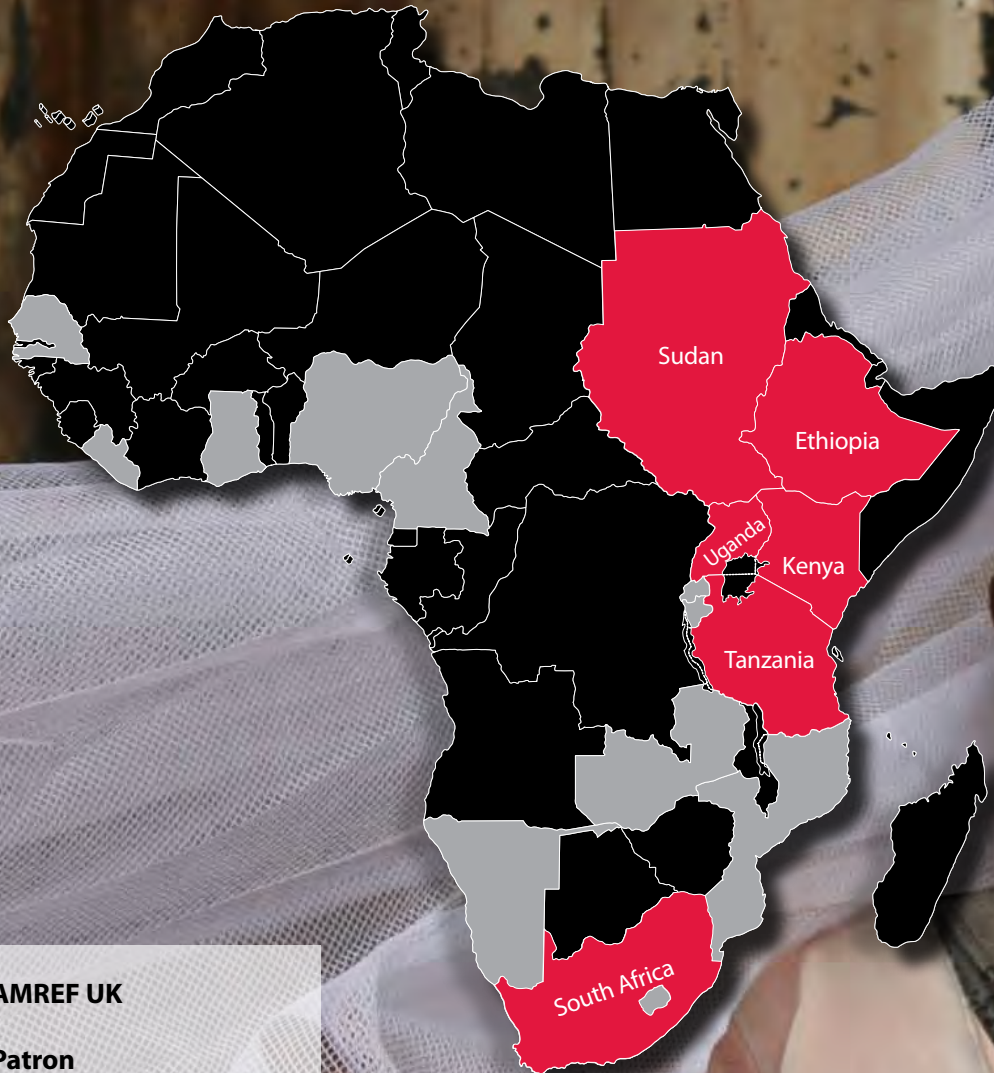
Photo: Stevie Mann/AMREF



Where We Work

■ Main programme countries

■ Countries from which AMREF trainees have come



AMREF UK

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Building **Healthy Communities** & Strengthening Health Systems

Africa is overwhelmingly rural. Most people live in towns and villages, far away from the capital cities where health services tend to be concentrated. Those who do live in metropolitan areas often live in densely packed slums where health care can be similarly elusive. Acute poverty and chronic poor health make these communities some of the most vulnerable in the world.

Public health policy and planning frequently overlooks the specific needs of communities in favour of a broad-based approach to health care delivery. This is partly out of necessity — effective, far-sighted programmes and services require money and expertise that governments do not always have — and partly because the communities themselves lack the tools to articulate their needs and advocate for their right to good health. As a result, less than 50% of people in sub-Saharan Africa have access to high-quality, affordable health care or essential medicines.

AMREF works to bring these people and the formal health care system closer together. On one hand, we provide communities with the education, training, and basic infrastructure to manage their own health and lobby government for better services. On the other, we

work with governments to help them deliver health care more effectively, based on our successful programmes and our field research. We measure our success by how readily governments and communities can adopt our programmes and make them their own. When this happens, we know we've made a long-lasting difference.

In 2008-09, AMREF continued its innovative work with nomadic peoples in East Africa, training health workers among their communities and establishing new mobile health clinics on their traditional migratory routes. Our work in these inhospitable regions of Ethiopia and Kenya has become increasingly urgent as drought and cattle-raiding make traditional ways of life more difficult.

Our Zingatia Maisha programme, a partnership with the Kenyan Ministry of Health and GlaxoSmithKline, continued to bring antiretroviral drugs (ARVs) to thousands of people living with HIV/AIDS. Adapted to both rural and urban contexts, the programme brings health workers who work with HIV-positive people together with HIV/AIDS support groups, training them and helping them to collaborate better. As a result, more people are receiving ARVs and more people are sticking to their drug regimens.

Our Work Laying the Groundwork for Good Health in Uganda

“This is a very exemplary borehole. You can admire how the community has owned the project. They really feel that it is theirs,” says government health inspector Moses Amolo, indicating one of the boreholes AMREF recently handed over to the people of Soroti District in northeastern Uganda.

“It is a big improvement. You cannot believe how it was before. Everything, all of the health centres were badly destroyed by rebel attacks. There was no clean water, people were sleeping in the open,” says Robert Emwoku, the headteacher at Ojuba Community Primary School and a member of Ojuba Village’s water and sanitation committee. He smiles proudly: “[My] pupils are benefitting especially. They are the ones who are maintaining the sanitation of the borehole.”

Ojuba is one of the many rural communities that dot the forested plains of Soroti. Badly affected by drought and by a war that displaced thousands of its residents, the region has only just begun to recover.

AMREF was among the first non-governmental organisations to lend a hand to the long-term rebuilding process, and in 2009 we completed our groundbreaking project in the region, the four-year Soroti Integrated Disease Management Programme.

“Because the need in Soroti was so great, we knew we must address the health problems from the ground up,” says programme manager Nico Tumukwasibwe. “There were very few government services, and the communities were very fragile.”

The programme, which has been fully adopted by the people and government of Soroti district, is an example of AMREF’s unique, collaborative approach to health. Bringing together the district government, community leaders, and the people of Soroti, we have repaired health facilities, sunk boreholes (making sure to teach communities how to maintain them), provided basic health education, and improved service delivery by training village health teams (VHTs) how to diagnose and treat simple diseases and refer more serious cases to the newly refurbished clinics.

“AMREF and the village health teams have helped us to run the health centres more smoothly and serve more patients,” says nurse Daphine Akello.

Attached to Bugondo Health Centre near Soroti Town, the district capital, she sees many referrals from the VHTs. She continues: “Thanks to the VHTs, the nurses and clinical officers can spend more time with individual patients. We also have more time to manage our supplies, so there are fewer stock-outs.”

Since the project started, AMREF has sunk 14 boreholes, distributed 12,000 insecticide-treated bednets, and trained 126 water and sanitation committee members. We have also established 44 community development committees to help plan and manage the overall development of the region.

“You can see the difference everywhere,” says headteacher Robert Emwoku. “People are healthier, more secure. We feel like we have control of our own future now.”

“Our goal when we started this ambitious project was to see it taken over by the district health authority and the communities. We can now say that our interventions are sustainable, they work, and we have done our job,” says Tumukwasibwe.

“The next step is to apply the lessons here to other parts of Uganda.”

Our work in the Soroti district of Uganda is supported by the European Union.



Better health means better livelihoods. Photo: Dan Chung/The Guardian



67 nurses and nurses’ assistants trained

14 water management committees established

2124 community health workers trained to make basic diagnoses and assist district health planning

Training Health Workers

Over the course of her career, a single nurse will save a thousand lives.

Africa needs more health workers. Per capita, the continent has the fewest doctors in the world — about 25 per 100,000 people — and the highest burden of disease. Britain spends more per year on healthcare than all of the countries in east and southern Africa combined.

Did you know, for example, that a single nurse will save approximately one thousand lives over the course of her career? That in three years and for approximately £4,000 per year, a clinical officer can be equipped with the skills and knowledge to perform 70% of the duties of a physician in a rural area? Or that for about £350 a villager can be trained to provide basic health education and medical referrals to his community?

Every year AMREF trains over 10,000 health workers from across Africa.

We train doctors, nurses, clinical officers, midwives, laboratory technicians, and community health workers. Whether we're teaching surgeons how to repair fistula, or helping village health team to stage educational dramas

about handwashing, we provide health workers with the tools they need to make a difference.

In 2008-09, our e-Learning Programme helped 5,448 Kenyan nurses to upgrade their skills while on the job. We also graduated 93 clinical officers from the National Health Training Institute in Maridi, Southern Sudan, bringing the total number serving the area up to 300 — a tenfold increase since we began our work there.

Africa's health worker crisis continued to be one of the focal points of our research and advocacy work as well. We contributed to UK and international consultations on health including the G8 civil society consultation, a UK Government White Paper on poverty and health, and the Conservative Poverty Impact Fund, a mechanism for international health financing.

On page 14 of this annual review, you'll find an insightful interview with Dr. Peter Ngatia, AMREF's director of capacity-building, on the social and economic benefits of investing in African health workers.

Our Work Training Doctors, Repairing Lives

Today, Edina Japheth is the happily married mother of a young child. But just a few years ago she was treated as a pariah in her own village, rejected by her neighbours and her family because of an injury she sustained during childbirth that left her incontinent.

“I was fetching water by the river near my home when labour started. I went to see my aunt, who is a traditional birth attendant. At first everything was fine, but the labour went on for many hours. Eventually my aunt sent me to the nearest medical dispensary. They said they couldn’t deliver my baby either, and I was referred to the district hospital.”

Edina was rushed into surgery for an emergency cesaerian section, but by then it was too late. Her baby had died. Discharged from the hospital and still coping with the trauma of her loss, she discovered that she was wetting the bed and incontinent throughout the day. She was suffering from fistula, a hole that can develop between the bladder and the vagina during childbirth.

“People looked at me as though I was not a human being, and even my family started to keep their distance, refusing to eat with me because I was unclean. My husband rejected me. It was terrible.”

6000+ women have received life-changing obstetric surgeries since 2002

463 women received surgery in 2008-09

18 doctors and nurses were trained to perform fistula surgery in 2008-09

Edina suffered with the injury for three years, until she heard about the Tanzania National Fistula Programme run by the Ministry of Health in collaboration with AMREF and Women’s Dignity, a Tanzanian charity.

“Under this programme we now offer fistula repairs free of charge,” says Dr. Gaudens Konba. A gynecologist and obstetrician, Dr. Konba has received training from AMREF on three separate occasions and now works at a district hospital in southwestern Tanzania, where he performs the surgery on as many as 100 patients per year.



A new mother awaits treatment.

Dan Chung/The Guardian

In 2008-09, AMREF and its partners trained seven doctors and eleven nurses and operated on 463 women in Tanzania — more than six thousand since the programme began, seven years ago. Fistula can be repaired with local anaesthetic and patients tend to recover quickly, making it a very effective medical intervention.

Edina was discharged after two weeks and went home to her family. A year later she was married to a young man in a neighbouring village, got pregnant, went straight to the district hospital, and delivered a healthy baby. She has put the years of stigma and discrimination behind her, but cannot forget them.

“When I think about the suffering of those years before, it seems very far away, but I think it is important that people understand that fistula is an injury, not a hygiene problem.”

In addition to our work with surgeons, AMREF is teaching midwives, traditional birth attendants, and other frontline health workers to identify labour complications and make quick referrals. We’re also educating communities about fistula to discourage stigma and discrimination.

Our work in Tanzania is supported by the Federation of Gynecology and Obstetrics (FIGO).

Giving Mothers & Children a Healthy Start

In Africa, childbirth and childhood are the two most dangerous events in a person's life. Statistics bear this out: An African woman is six hundred times more likely to die from pregnancy-related complications than her British counterpart, while an African child is twenty-four times more likely than a British child to succumb, before age five, to common illnesses such as diarrhoea, malaria, and upper respiratory tract infection. HIV/AIDS often further complicates the situation.

Those who survive these early tribulations can be saddled with chronic health problems: crippling obstetric injuries in mothers, physical and mental disabilities in children. In a population as overwhelmingly young as Africa's, where over 40% of people are under 15 years old, the social and economic costs will be enormous if we accept the status quo.

That's why our investment in Africa's long-term health begins at birth. We believe that with good health care and nutrition, mothers, newborns, and young children can overcome the cycle of ill-health that puts them — and Africa as a whole — at an early disadvantage.

AMREF places special importance on these vulnerable groups, making sure that many of our programmes are designed with their needs in mind.

We make sure that women and their partners have the education they need to make informed decisions about starting a family. We make sure families have access to clean water and know how to protect themselves from preventable

diseases. We make sure pregnant women have access to medical care and advice during and after their terms. And we make sure mothers and children have access to essential medicines, insecticide-treated bednets, and the care of professionally trained midwives.

In 2008-09, under the auspices of our innovative Katine Community Partnership Project (see page 13 for more information) in northeastern Uganda, we quadrupled the number of women accessing family planning services for contraception and advice during pregnancy. Our efforts also increased the number of women delivering their babies under the supervision of midwives and nurses.

In Tanzania, expert doctors from our Flying Doctors Emergency Service performed free postnatal operations on women rendered incontinent by birth complications, and we conducted outreach to reduce the stigma associated with such obstetric conditions.

We continued to make maternal, newborn, and child health one of the cornerstones of our research and advocacy programme, pressuring donors, African governments, and international organisations such as the UK Department for International Development, International Monetary Fund, and World Bank to increase their support of family planning, midwife training, malaria prevention, and other measures.

Photo: Stevie Mann/AMREF

Our Work Protecting Mothers & Children from Malaria in Coastal Tanzania

It's the rainy season in eastern Tanzania. The villages of Mtwara are buzzing with excitement — and mosquitoes. Today is Village Health Day, a monthly event organised by AMREF and local leaders that brings people together to eat, socialise, and talk about health. Especially malaria, a leading killer of children under five and pregnant women across sub-Saharan Africa.

In Namkuku Village, a drama group performs a skit about insecticide-treated bednets. The audience has formed a circle around them and watches intently as the actors dramatise the conflict within a family about who should sleep under their net.

“You're a strong man,” says the actress who plays the wife. Like everyone in the cast, she belongs to the AMREF-trained village health team. “You have some immunity against malaria. Our babies have no immunity yet. If they are bitten by mosquitoes, they will get much sicker than you.”

The actor playing the husband pretends to think about this for awhile. Finally, he agrees. “You're right. We will get a second one. You and the babies will sleep under this one in the meantime.”

Because of its coastal setting and relative impoverishment, Mtwara District suffers from malaria mortality rates twice the national average. The majority of the deaths are among infants, young children, and expectant mothers. AMREF's Mtwara Malaria Control Programme works closely with district authorities and local communities to provide education, training, nets, and medicine so they can overcome the burden of chronic ill-health caused by malaria.

Community health worker Amina Nwaya explains why education is important: “The problem isn't that people in my village can't afford nets,” she says. “Some can, some cannot. The bigger problem is education. People have resigned themselves to getting sick. They think the nets do not make a difference or they even believe that sleeping under a net will cause suffocation.”

Trained by AMREF, Amina regularly visits the families in her village to make sure they are protecting themselves against malaria. Like the 1298 other health workers AMREF has trained in villages across the district, she is especially vigilant when it comes to new mothers and their babies.

“Malaria can progress very, very quickly in infants especially. I teach mothers to identify the symptoms and encourage them to call on me any time. Then I can advise on treatment and make a quick referral to the



Community Health Workers show off insecticide-treated nets.

Photo: Stevie Mann/AMREF

local health clinic.”

9000+ bednets distributed to families in Mtwara

90% of children now sleeping under insecticide-treated nets

The Mtwara Malaria Control Programme has distributed over 9,000 insecticide-treated bednets since its inception in 2007. Over 90% of young children, nearly 80% of mothers, and 50% of fathers now sleep under nets. Malaria deaths have dropped significantly among mothers and children as a result.

Liyaya Dihone, a mother of three from nearby Mbambakofi Village, has seen firsthand the difference bednets and health education can make: “Before AMREF came, I used to go to the dispensary every week for malaria treatment. I or one of my children was always sick. I worried I would lose them, but like most people, I accepted that malaria was a fact of life. You couldn't escape it.

“With AMREF's help, I have come to realise that I myself have the power to protect my children's future.”

Our work in Mtwara is supported by the European Union.



A photograph of three young girls standing outdoors. The girl on the left is wearing a tan top and red skirt, looking to the right with her hand near her mouth. The girl in the middle is wearing a pink top and a patterned apron, looking towards the camera with her hand near her mouth. The girl on the right is wearing a pink patterned dress, looking to the right. The background is a soft-focus outdoor setting.

Preventing and Treating Disease

When it comes to fighting disease in Africa, context is everything.

Distributing bednets and essential medicines can make a big difference. So can digging boreholes and educating people about handwashing. These are some of the most important things AMREF does.

But in the longer term, overcoming the terrible burden disease places on African societies means understanding how the interaction between poverty, cultural practices, gender, the environment, and existing health infrastructure can complicate things.

Informed by extensive research and fifty-two years of field work, our programmes are context-obsessed. We build relationships with vulnerable communities and work hand-in-hand with health workers and government at all levels, tailoring our projects to community needs, monitoring every aspect and identifying what works best and what could work better. We export the best parts, adapting them to suit local contexts, and we learn from our mistakes.

In 2008-09, we continued to build on our successful malaria control programmes in Ethiopia, Uganda, and Tanzania, focusing on malaria prevention at the village level and in the home, especially for mothers and children under five.

Our pilot integrated disease management programme in the Luwero and Kiboga districts of Uganda, a partnership with AstraZeneca, has made it much easier for people to be tested and treated for HIV, TB, and malaria co-infection — one of the deadliest and most overlooked problems in the region.

Already a success in Kibera, where it has been adopted by the government, our Personal Hygiene and Sanitation Education (PHASE) programme — a collaboration with GlaxoSmithKline — has been adapted to a slum setting for the first time. Working with students, parents, teachers, and health authorities in the Kibera slum of Nairobi, we've significantly reduced the rate of respiratory and gastrointestinal infections. As a result, school enrolment has risen and absenteeism dropped in every one of the participating schools.

Our Work Preventing Gender-based Violence — and HIV — in South Africa

Sifiso Zondo remembers vividly the 16-year-old girl who came to see him at the police station in Jozini, South Africa where he works as a trauma counsellor.

“She was very brave. She had been assaulted and she wanted to report it. Here, the victims of sexual violence are often too embarrassed to come forward,” he recalls. The girl arrived at the station with one of her parents just a few hours after the attack. She was immediately referred to Sifiso. “Her family didn’t want her to report the incident. I see this a lot of the time — there is shame and taboo associated with rape,” he says.

Recruited and trained as part of *Masisukume!* (“Stand up and take action!”), AMREF’s programme to address gender-based violence in South Africa, Sifiso, 26, works as a liaison between local authorities and victims of physical and sexual violence.

“Before I started working here, the police dealt with the victims directly. For a traumatized person this could be very intimidating,” he says.

Sifiso counsels his patients about HIV and other sexually transmitted infections, and refers them to health care workers. “My job is to make them feel comfortable and protected. I give them information and support and help them to file their police statement so they can begin the process of recovery as soon as possible.”

Though it is a middle-income country that runs regular awareness campaigns about safer sex and HIV/AIDS, South Africa has one of the highest HIV-infection rates in sub-Saharan Africa, at about 18% per cent among 15 to 49-year-olds. Compounding the problem is the high rate of sexual violence.

“Violence against women is a big problem here,” Sifiso says, “current attitudes make it difficult for many girls and women to negotiate safer sex with their partners, and there is a culture of silence.”

The Masisukume! programme, launched in 200x with support from the UK Department for International Development (DfID), works with communities and local government to reduce the incidence of violence against women, and with it, the number of new HIV infections. In addition to training counsellors like Sifiso, AMREF educates traditional leaders, police, and other leaders who can use their influence to change attitudes within their communities. Since 2007, the programme trained over 325 leaders and service providers in the Umkhanyakhude



Community police liaisons are making a difference in the lives of women.

Photo: Stevie Mann/AMREF

1700 students in 15 schools educated about gender-based violence

150 community policing forums trained to prevent violence

18 traditional leaders sensitised about women’s rights and health

District of KwaZulu Natal, resulting in an increase in reporting and better care for victims.

Thanks to Sifiso’s counselling, the girl reported the assault and she and her parents received counselling and support. Of his patient he says, “I admire her bravery, and I am proud that I could help. Without support from a counsellor, no one would have listened to her.

“The fact that this girl challenged her family and convinced them she should report the crime shows there is chance to change the general perception of gender-based violence in the community.”

Our work in South Africa is supported by DfID.



Letter from **Kibera**

Amina Abdi is 13 years old and a student at Ushirikia Childrens' Centre in Kibera, a large informal settlement of over a million people on the outskirts of Nairobi. Her school is one of 30 where AMREF and GSK have launched PHASE, a personal hygiene and sanitation education programme targeted at students, teachers, and their friends and families. Here she describes her life in Kibera and how the programme has benefited her neighbourhood.



Photo courtesy of AMREF Kenya

Life in Kibera is of hope and despair, happiness and sadness. Last week, a train derailed and some people died. I was very sad. Sometimes houses catch fire because people's houses are crowded and people lose property. There is also shortage of water and we do not have toilets.

I am a class 5 pupil at Ushirika children centre in Laini Saba neighbourhood of Kibera. I love to study and I love my teachers. I have been in this school ever since nursery school. The only problem was that before PHASE we had just one latrine that we shared with boys.

When we are in our periods it was very difficult. We had no sanitary towels and when we go to the toilet to change the cloth material that we use, there is always a line. So people make noise: "You. . . young girl, what are doing in the toilet for all that time? Come out. This is not a hotel!" For boys, it's easy because when pressed, they can help themselves anywhere in the slum. They don't care. For short calls, they just stand against a wall and it's done. These are some of the things that make life in Kibera challenging.

Ever since AMREF introduced the PHASE programme, I have seen admirable changes in our school. AMREF built for us a four-door latrine and now we have more privacy especially during our menstruation cycle. We also have a water tank and water supply. We use the water to drink, cook and wash our hands after visiting the toilet.

I am a member of the PHASE school health club. There are 28 of us, and we meet every Tuesday and Thursday

64,067 students, teachers, and community members reached by the PHASE programme

96% of students now wash their hands after using the toilet

10% increase in school enrolment since 2007 after school. Club activities include cleaning the school compound, washing school latrines and ensuring that they are properly used. Club members also supervise filling water into our leaky tins [handwashing stations] and advising other pupils to ensure their personal cleanliness is improved. We also share health messages to the entire school, our siblings and our parents.

The PHASE project is very important because through it, we can prevent the spread of diseases like cholera, typhoid, dysentery and intestinal worms. We always wash our hands and we also get drugs for de-worming and vitamin A which have greatly improved our health. Through PHASE project, we have come to know the importance of personal cleanliness, and of eating clean, properly cooked and balanced foods.

Now we have more time in class without being sick and we are slowly improving our academic performance. We really thank the GSK and AMREF for bringing PHASE to our school.

AMREF's work in Kibera is supported by GSK.





Photo: Dan Chung/The Guardian

66% of people in Katine now have access to clean water

2000 textbooks and **300** desks were distributed to Katine schools in 2008-09

400% increase in number of women accessing maternal health services.

Katine Community Partnership Project

In 2008-09, AMREF entered the second year of its innovative development project in Katine, an impoverished area of northeastern Uganda. Created in partnership with the Guardian and Barclays, the project works with the communities of Katine to help them recover from years of war, drought, cattle rustling, and neglect while at the same time educating the British public about international development via regular media coverage in the Guardian newspaper and on www.guardian.co.uk.

We're pleased to report that our work in year two has made significant improvements to the quality of life in Katine, increasing the standards of education, water, and health. With its emphasis on community groups and planning structures such as village savings and loans (VSLA) and water and sanitation (WATSAN) committees, the project is also making it easier for people to organise themselves, analyse their situation and jointly plan for the future. This allows them to weather periods of difficulty, such as the drought we saw this autumn, when lighter-than-expected rains made for smaller agricultural yields.

Highlights from 2008-09

The project rehabilitated 16 classrooms and began construction on four others, as well as two school stores and two offices. We distributed nearly 300 desks and over 2,000 textbooks to schools across Katine. School enrolment increased by 17%.

The project has worked with village health teams and WATSAN committees to improve hygiene and sanitation in homesteads. By the end of September 2009, latrine coverage had improved from 7% at project inception, to 39%. More than 2,000 households in Katine now have a good-quality latrine in their homesteads. Drilling new boreholes and repair of existing boreholes has meant that access to safe

water has increased to 66% from 42% at the start of the project reducing the time and distance to access safe water for women and children who bear the brunt of water collection. Women's workload is reduced and they have more time to spend on other productive activities. Children, especially girls, are able to reach school on time and do more homework.

While our work of refurbishing Katine's health centers is ongoing, we're already seeing improvements in maternal, newborn, and child health, thanks to the hard work of AMREF-trained village health teams (VHTs). These volunteers are responsible for sensitising communities on the benefits of family planning, dispel myths and misconceptions about pregnancy and child birth, promote family planning uptake and make referrals to the health facilities. We've seen a small rise in the use of contraceptives and a large increase — about 400% — in the number of women accessing family planning and maternal health services, including pre- and postnatal care.

Thanks to the technical support we received from FARM-Africa to improve income-generating opportunities, local farmer groups harvested their first-ever crop of high-yield, drought-resistant cassava. This helped the farmers to mitigate the effects of drought in 2009. The groups, which double as Village Savings and Loan Associations (VSLAs), have now saved as much as Ush 3.4 million (£1,054), with individual members saving between Ush 50,000-300,000 (£16 – £93) each.

Of course, challenges remain. Revitalising an area as badly affected as Katine is a long, demanding, and intensely collaborative process. Having achieved so much already but with so much work to do, we decided that the project would be extended to four years, allowing for a longer and more seamless transition as the people and government of Katine take the project over.

Better Health through **Advocacy**

An Interview with Dr. Peter Ngatia

AMREF's advocacy work continues to focus on the critical shortage of health workers across sub-Saharan Africa, and the importance of good health care for mothers, newborns, and children under five.

In the interview that follows, Dr. Peter Ngatia, AMREF's director of capacity-building, talks about the health care crisis and some possible solutions. A graduate of the University of Alberta, Canada, and a former faculty head at the Kenya Medical Training Centre, Dr. Ngatia has over the course of his professional life conducted numerous research projects on the issue of human resources in health.



Dr. Peter Ngatia

Dr. Ngatia, what are the root causes of Africa's health crisis?

The big problem, as you have said, is the shortage of health workers in the continent of Africa. This means of course that we have fewer doctors than we need, fewer nurses, fewer midwives and fewer health care workers at all levels. Only a very few, a minority of the African population have access to healthcare. As a result, minor illnesses become dangerous and they kill.

Most people understand why doctors and nurses are important. But AMREF also trains thousands of community health workers each year — who are they and what do they do?

When you have a crisis of the nature that we have here, you try to look for sustainable solutions. Community health workers have been used as a way of ensuring that at least there is minimum access, minimum access to health care providers.

They are trained for short periods of time and they assume responsibility — sometimes of what doctors or midwives would do in a healthcare facility. They provide treatment for the common illnesses. For example, malaria: They can quickly provide anti-malarials to a child before that child can get to a clinic or dispensary. They can be trained how to deliver mothers who have no serious complications.

What is the longer term impact of community health workers?

I think the long term impact of a community health worker is as long as you have sufficient numbers of health providers you are going to be able to provide health education, health promotion activities. And as long as people know what ails them, people understand how to prevent illnesses because of the kind of health education that they are having, you are going to see fewer and fewer sick people. Less diarrhoea, less malaria, less childhood disease.

For the health system, there is also significant long-term impacts. The congestion that you see in national hospitals, like the Kenyatta national hospital here in Kenya, will decrease because there will be less sick people, and even when they are sick they are referred to the next health facility, and that allows for the specialised hospitals, or the health care system that is specialised, to deal with specialisation, rather than dealing with simple ailments which could have been handled at the community level, or at the next level of the health care system.

"This speaks to how much we underestimate the cost of simple diseases like malaria.

That's right, yes. They are very, very expensive diseases because if you are getting malaria, or if a child is malnourished, what you are looking at here is not just the consequences of that illness at that point in time, but in the future. If a child is malnourished when they are two, three, four, five, the effects of that will be seen when they are teenagers. Chronic poor health, developmental disabilities. And when there is sickness in the home, it is the mother or the father, and in the process, the economic activities, whether it is farming, or herding cows, or whatever it is, it suffers as well. And you see the economic decline, you see starvation, you see hunger and famine come as a result of that.

So really, training health workers is very cost-effective in the long term.

I always say that training health workers is saving lives. When you train a health worker, a nurse for instance, you are training somebody who will save lives. And it has been documented that if for instance you have one nurse trained, they can save almost a thousand lives during their years. Clinical officers, I call them the doctors of Africa. These are, they are trained at a fifth of the cost and they can do almost 70% of what a doctor would do in a rural environment. I say rural environment because that's where most of our people are. As long as you have health workers, as long as you have healthy people, then everything else improves. Poverty and health are inextricably linked.

What can governments do to help mitigate the crisis and engage community health workers? And I mean both African governments and donor governments.

Taskshifting has been shown to make a big difference. Our own work in the field has shown that, for example, clinical officers and midwives can be trained to do some of the work that doctors and nurses do. This can save many lives in places where there are few doctors. It's also one of the ways that Africa can deal with the problem of brain drain, because as you know it can be difficult to retain doctors and nurses in hardship areas when there are more lucrative offers elsewhere. Meanwhile, the international community must recognise at the same time that there is this issue of brain drain. It is a problem. Governments need to work together to manage the migration of health workers.

Treasurer's Report

I am pleased to report that 2008-09 was another successful year for AMREF UK, in spite of the economic downturn seen in here in the UK and around the world.

Our gross income for the year remained steady, at £5,109,111 — up slightly from 2008. While our income from fundraising activities fell by 12%, to £1,110,638, our income from grants increased by 7%, to £3,978,128, thanks to our successful partnerships with institutions and corporate donors such as Europe Aid (European Commission), the Department for International Development (DfID), Accenture, GlaxoSmithKline, AstraZeneca, UBS Optimus Foundation and Barclays Bank. We also benefited from our partnerships with Trusts and Foundations such as the Big Lottery Fund, Direct Relief International, FIGO and Medicor Trust.

In proportion to our increased grant funding, we spent more this year on charitable activities: £4,677,674, up from £3,984,896 in 2008. However, with the fall in our fundraising income, we've taken tough decisions to trim our operating costs to make sure we can successfully navigate the current recession.

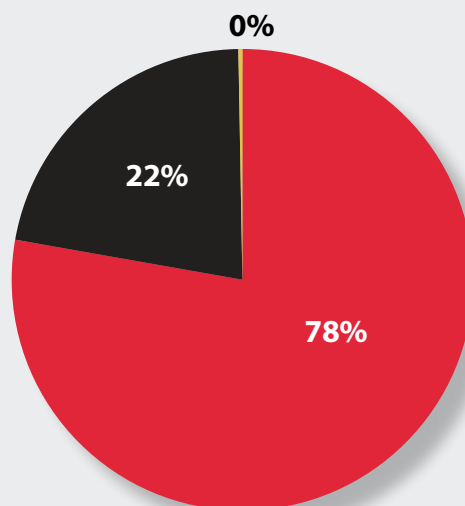
In 2009-10 we are making a strategic investment in our fundraising activities. With a new strategy and better-resourced team in place, we expect to grow our income over the next year.

I am also happy to report that AMREF UK continues to be an extremely cost-effective organisation. Ninety-one percent of our expenditure goes to projects in Africa the remaining 8% on cost of generating funds 1% on governance.

We continue to be generously supported by institutions, corporates, trusts and foundations and individuals, to whom we are extremely grateful.

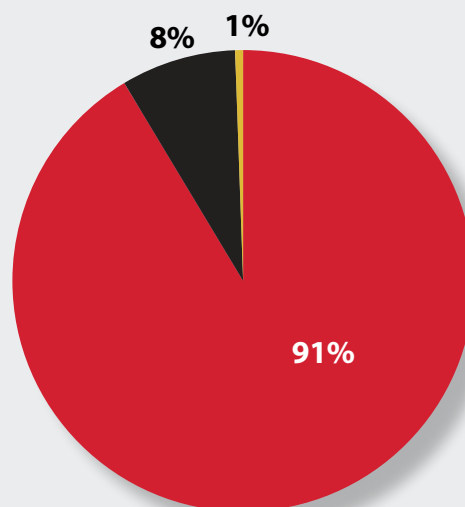
Gautam Dalal
Treasurer

Income £5,109,111



Grants for projects £3,978,128
Fundraising £1,110,638
Bank interest £20,345

Expenditure £5,120,663



Grants for projects £4,677,674
Cost of generating funds £416,101
Governance costs £26,888

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Providing Emergency Care



Our Flying Doctors Service in 2008-09

In 2008-09, AMREF's Flying Doctor Emergency Service continued to provide emergency care, specialist surgical services, and training in some of the hardest-to-reach and most vulnerable communities in East Africa and beyond.

This year, we evacuated a total of 737 patients, for a total of 748,541 miles, including evacuation flights from Africa to destinations in Europe, South Africa, and the Middle East. Traffic accidents, cardiovascular ailments, and infectious diseases (particularly malaria) were the most common causes of crisis. Our flight team also evacuated a number of patients suffering from childbirth-related trauma and gastrointestinal diseases.

We added two new nurses to the team, bringing the total to 10, along with one full-time emergency physician and a number of on-call doctors and specialists. As always, the Flying Doctor Emergency Service is provided free of charge to people who cannot afford to pay.

We added a third airplane to our fleet of air ambulances, each of them equipped with trauma and intensive care facilities, as well as an on-board incubator for infants in crisis.

Photo courtesy of AMREF Flying Doctors

Thank you.

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Abercrombie & Kent
Action for Global Health
Allan & Nesta Ferguson Charitable Trust
Association of Commonwealth Universities
AstraZeneca
Attila Katona
Band Aid Charitable Trust
Barclays
Big Lottery Fund
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