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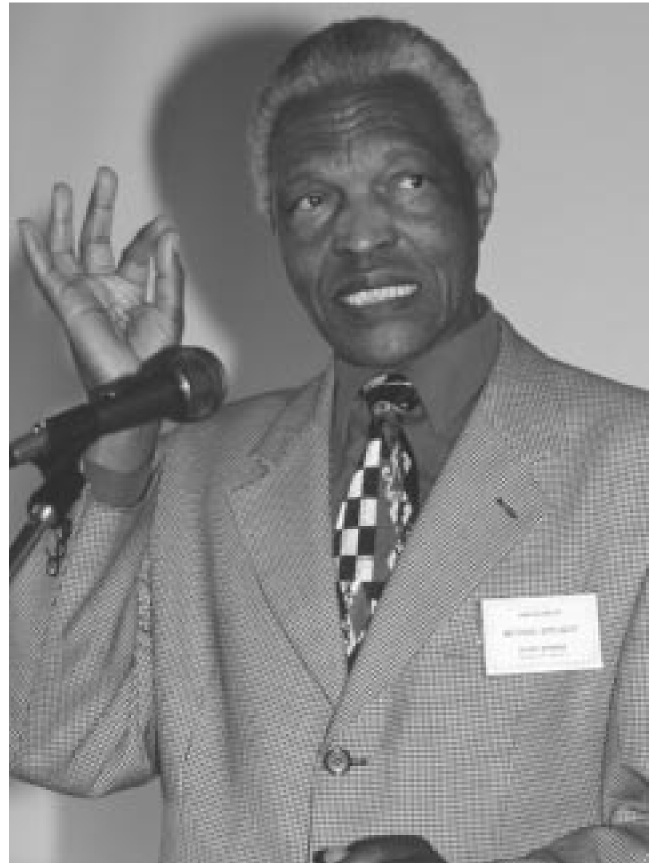
The year 2000 was marked by huge growth and change within AMREF. Africa-wide, our expenditure has increased by 20% in the past year enabling us to help more disadvantaged people to enjoy better health.



At the same time as this growth has come a revision of our whole strategic direction. AMREF is decentralising its operations, allowing managers in the field to take the major decisions about the way our work is done. By moving power away from the centre and out to those on the frontline we are hoping for faster, more appropriate decision-making and, ultimately, better service to the communities we work with.

AMREF is determined to make a real difference. To do so it has decided to concentrate its efforts in three main areas: enabling communities; giving people a voice; and ensuring that lessons are learnt form all the work we undertake.

Enabling communities to help themselves

Poverty is more than just financial. Often in disadvantaged communities it is the lack of knowledge, information or experience that cause most health problems. Working with the communities AMREF will help build the capacity of people to deal with their problems. Sometimes this will be through selective formal training but more often it will be by working with communities to understand the capacity that already exists within the group to improve their lives. AMREF simply helps with some of the tools; the communities themselves do the real work.

Giving people a voice

Many disadvantaged people feel powerless to change the societal rules that affect them. These rules might be formal written laws or unwritten societal and cultural norms that work against their ability to develop. The laws of a country can enable people or make their burden that much more difficult. By giving people a voice and by assisting them to demand their rights, especially the right to healthcare, AMREF directly helps improve the lives of the people it represents.

Ensuring development lessons are learnt

Development in Africa will only occur when we begin to learn from our successes and our failures. The dissemination of lessons learnt from the work we do is therefore essential. This dissemination needs to begin internally within AMREF and spread to other non-governmental organizations and most importantly to the health ministries across Africa. Only in this way can AMREF make any real impact on the huge problems that face Africa and its health systems.

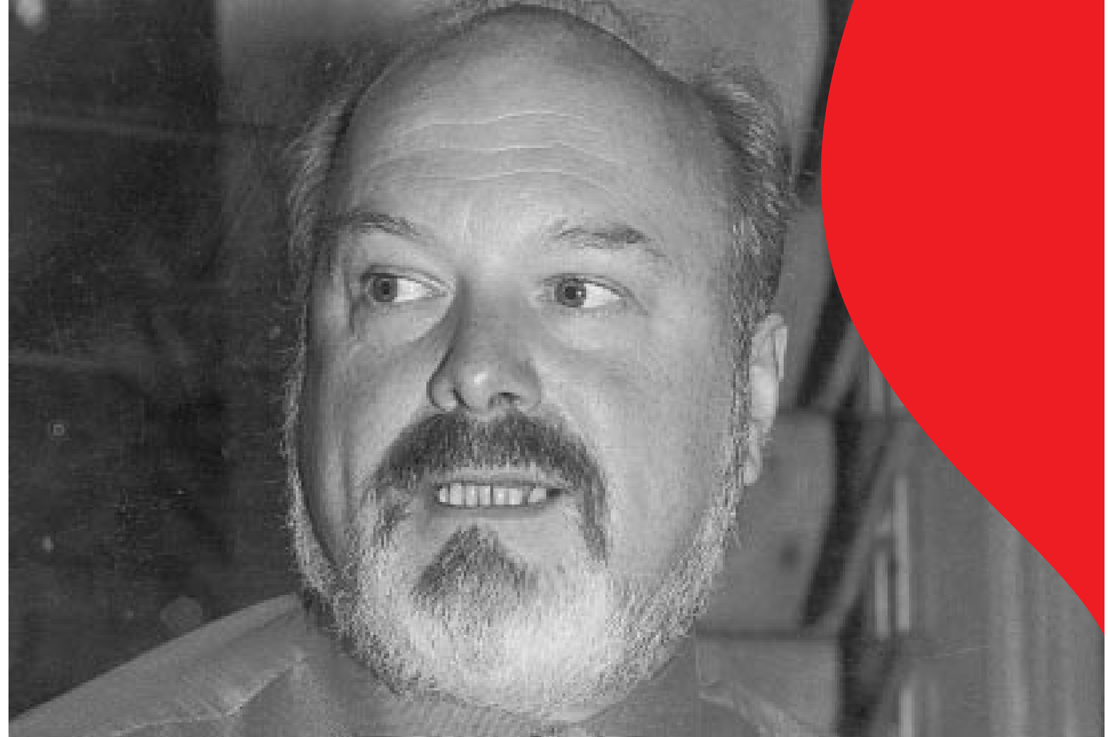
All AMREF programmes are now organised to enable communities, give people a voice and ensure that lessons are learnt. When linked with decentralization of decision-making and the growth in the overall scale of work undertaken, I feel confident that in the future AMREF can make an even greater impact on the lives of the disadvantaged of Africa.

AMREF

B. A. Kiplagat

Bethuel Kiplagat - *Chairman*

message from the director general



I sometimes feel as though I spend all my time in meetings. And this year more than most. The enormous growth in the amount of AMREF work across Africa and the imperative to develop a strategy that will take AMREF into the next Millennium have challenged all of us inside the organisation.

It would have been wrong to stop or slow our development work in the field while developing our new strategic plan but sometimes it has felt like trying to change the tyres while driving at 100 km/hr along the most potholed of roads.

2001 is the year when the new strategic plan will begin to become a reality. Providing communities with the tools they need to help themselves (capacity building); giving people a voice (advocacy) and ensuring that the development lessons are learn't from the work we do (operations research) are the three cornerstones of our new strategic plan. We already see the benefits to the communities where these elements have been put into place.

Sometimes words and jargon and strategic documents obscure the reality of the work on the ground. In this document, I hope we can better show the direction of AMREF in the future by giving examples of how, over the course of this last year, communities have been helped by our work in these three priority areas. In doing so we also hope to show the improvement our new strategy can bring to the lives of the most disadvantaged in Africa

John Batten - *Director General*

building the capacity of Mozambiquan health workers

Sara Cumbane has worked as a nurse for 15 years. At Chongole maternity and health centre, on the coast of Mozambique about 400 Km north of Maputo, Sara and her assistant treat 400 to 500 people a month for malaria, bronchitis, wounds and malnutrition. At the ante natal clinic Sara sees many young adolescents. Because of their age and the extra risks of a first pregnancy, she often advises them to go early to the district hospital in Inhambane. But often this advice is ignored and later she has to find transport to take them to the hospital 60 kilometres away for Caesarean section. Sara has been lucky so far, and has never lost a mother during childbirth. However, there are stillborn cases especially when a woman has been through prolonged and difficult labour.

Sara has attended several AMREF workshops, and she is very eager to introduce community-based healthcare to the surrounding villages. Uppermost in her priority list are family planning, environmental sanitation and maternal health.

"I want each home to have a good latrine and clean drinking water. In these villages women have 8 to 10 children by the time they are 30 years and family planning is something they and the community need education about. In maternal health I would like mothers and the community in general to understand risks in pregnancy and the consequences for the mother, the baby and the family."

Chongole health clinic has no electricity and therefore does not store vaccines. However, immunisations are given twice a week, when vaccines are collected from the nearest health centre, some 7 kilometres away. Sara is one of the few health workers in Mozambique who have had any formal training. The vast majority of her colleagues have not. Sara and thousands others will be the beneficiaries of a project in which AMREF, is assisting the Ministry of Health in the implementation of a national continuing education programme for health workers.

The project will borrow heavily from AMREF experience in Kenya and Uganda, and already senior managers from Mozambique have visited these model continuing and distance education projects in East Africa. Mozambique's public health sector has approximately 16000 workers, both local and foreign and an equal number of people per health facility. On average Mozambicans travel over 10 kilometres to the nearest health facility except in Maputo City where the average is two kilometres. There is 1 bed per 1000 patients.

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Sara talks to a patient at the clinic

learning lessons in southern Sudan

Michael Lugalla, a former military officer and father of seven, trained first as a community health worker before being promoted to the Primary Health Care Support Supervisor.

"As a Primary Health Care Supervisor, I can now manage a dispensary. I monitor the supply of drugs, check on the register and focus on the common diseases. I also organize workshops for community and maternal child health workers."

The new position has enabled Michael to help more people. But not as much as has the knowledge Michael has acquired from the AMREF Clinical Officers Training School in Maridi, south Sudan. The school at Maridi is one of AMREF's most innovative programmes.

Michael training a group of health workers.

Clinical Officers are new to Sudan. They are intended to replace the long-existing role of medical assistant. The school in Maridi started in October 1998 with an intake of 18 students, all qualified Community Health Workers, three of whom were women. After one year they qualify as Primary Health Care supervisors. Following a suitable period of experience in the field they return for a further year of training, qualifying as clinical officers. The course is community-based, with more than fifty percent of the student's time spent in practical work.

learning lessons in Southern Sudan

South Sudan has become synonymous with civil war. A human disaster has continued here for 20 years. Millions of people live in displaced peoples' camps while millions more live as refugees in neighbouring countries. In this irreconcilable conflict, people's energies have been tied up in civil war. Social services have come to a standstill and people have endured hardship, barely able to realise their basic needs.

Emergency interventions are intended as short-term measures to help populations recover. Short-term intervention techniques have not led to much improvement, and may well have created the 'dependency syndrome', a condition in which the population becomes apathetic, is incapable of assuming responsibility, and awaits the arrival of foreigners, who will do everything that is necessary.

This is why the AMREF Clinical Officers course in Maridi is so important. It is proof that development is possible in a complex emergency such as the civil war in south Sudan. It is a crucial capacity building programme whose product, the clinical officers, are a vital link in maintaining community health facilities in this disadvantaged region where 10 doctors care for six million people.

One lesson which has already been learnt and applied has led to the decision to recruit school leavers directly into year one of the new course. The original intention was to take qualified Community Health Workers, and to start at year two of the clinical officer course.

It has now become very clear how important basic secondary education is, and how difficult it is to provide the essential elements of this secondary education if it is lacking. It is also clear that there needs to be thorough theoretical investigation into teaching approaches, including the production of suitable textbooks, the integration of those textbooks into classroom and bedside teaching, and the possible application of new teaching techniques including the use of multimedia and the Internet.

a mother and her two children take refuge in a bunker as the skies above echo with the buzz of an Antonov bomber

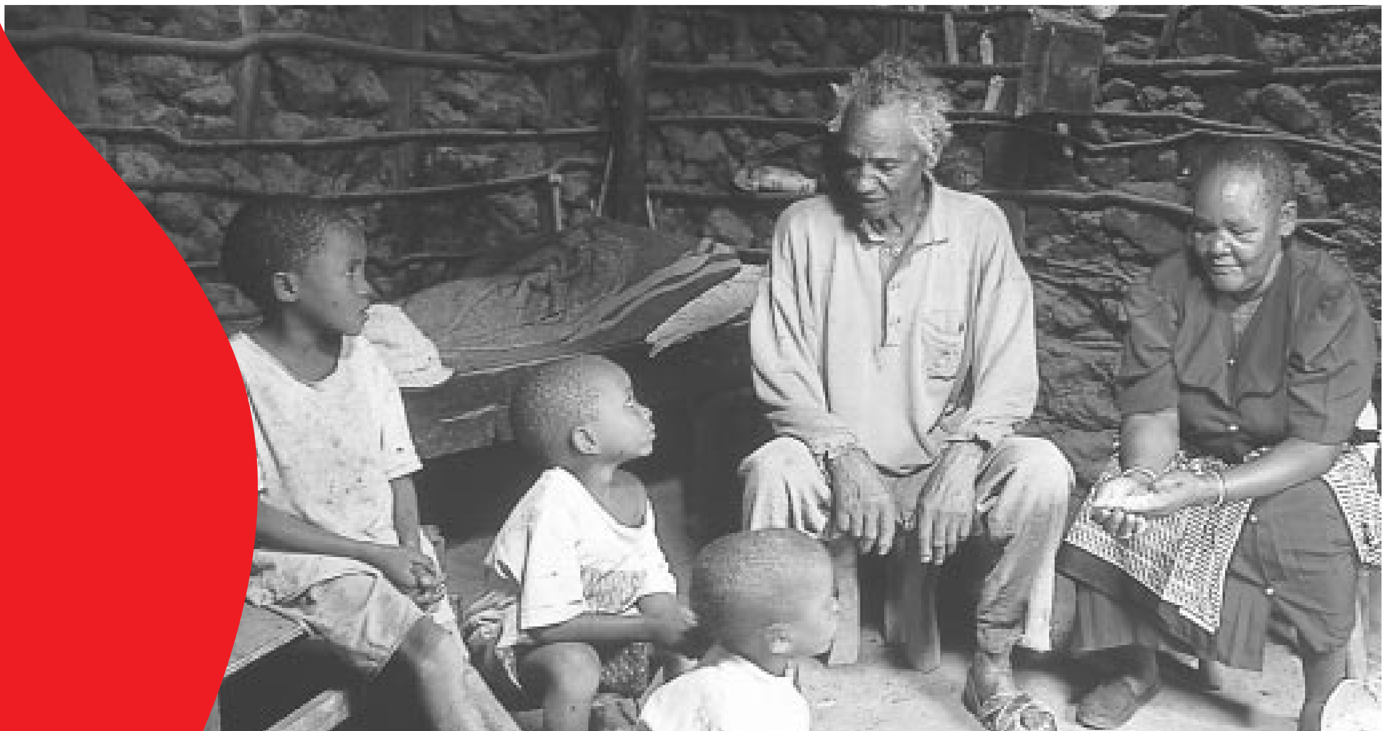
a voice against domestic violence

During Lavina's first year of marriage, her husband Iddi used to come home late and pick up petty quarrels with her. Often this would lead to a beating. At some point, Lavina tried to involve her in-laws but they were unsuccessful. When things were really bad Lavina would go to the village chairman who would reconcile them. But this reconciliation was often short-lived.

One day, the Domestic Violence Watch Group was moving from house to house, introducing themselves and distributing a brochure on their work. Lavina decided to use the brochure to influence her husband. She used it to discuss their deteriorating relationship and his denial of her sexual rights. Although he refused to listen Lavina did not give up. In 1996, the couple had their first child, and Lavina used this opportunity to impress upon Iddi how good it would be to bring up this child with love and peace. Over time Iddi changed and today theirs is a model family.

Like Lavina, thousands of Tanzanian women of all ages and social classes live in abusive relationships. Women in Mwanza in North West Tanzania and throughout the Lake Victoria area are among the worst affected by violence as they are also denied a voice by the traditional practices that place them at a lower social status. In addition, religious or cultural restrictions prevent women from leaving their homes and from receiving health care from male providers.

It is this situation that prompted AMREF to model a comprehensive sexual and reproductive health service in Mwanza that responds to the needs and rights of women. The Jijenge! Women's Centre operates from a poor neighbourhood in Mwanza Municipality, providing a comprehensive women-friendly sexual and reproductive health service.



a voice against domestic violence

The Jijenge! project helps women to express their needs in a free and caring environment. Thus, through careful programming and commitment, the centre created a relationship of trust and opened lines of communication between women and service providers.

At the community level, structures have been set up to carry out surveillance for violence against women, create awareness and provide support to victims of violence. This has resulted in the formation of the Domestic Violence Watch Group and the Community Interest Group who educate the community on women's rights and sexual health and provide support to victims of violence. The watch group provides community education on domestic violence in public meetings, schools and churches and has influenced community leaders to speak out against violence against women.

An evaluation of Jijenge! showed that a women-friendly service is tenable within the Tanzanian health care system. Even more important was the finding that when communities are made aware and involved, they can infact support women's rights and protect them against gender violence.

Today, AMREF is replicating this model at Makongoro clinic, the regional maternal and child health centre in Mwanza. Makongoro will in turn support the other eight health facilities in the region.

Makongoro clinic, with a daily attendance of close to 100 women, is being assisted to create an enabling environment for proper women-friendly sexual and reprodutive health service delivery through training of its staff and physical modifications to the building to enhance privacy for women, to freely access quality counselling and care.

Already, 51 health workers from the clinic have been trained to improve delivery of women integrated services.

The profile of women's rights has been raised through community awareness campaigns. Emphasis is placed on leadership in existing community groups including women groups who are trained to carry out surveillance for violence against women, create awareness against violence and provide support to victims of violence. The media has been used to initiate debate and increase awareness of the problem.

Lavina and her husband Iddi did not just improve their relationship. They have become ambassadors of what AMREF is doing in the community.

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children playing in Kibera

Like many urban slums in Africa, Kibera slum in Nairobi houses over 650,000 people who live in abject poverty.

Open sewers run like tiny rivers outside doorsteps, spreading dirt and disease everywhere. HIV/AIDS infection rates are estimated as high as 60%. Dysentry, typhoid and diarrhoea are endemic. Malnutrition amongst the children causes stunting and other growth disorders.

Four years ago, AMREF began to work with the community here, to address their pathetic conditions. Today, clean toilets and bathrooms are becoming a common sight. Landlords have been encouraged to sacrifice small portions of their land, and AMREF helps them build toilets and bathrooms. Where these facilities exist, the tenants now enjoy better health, and their appreciation is seen in the way they religiously maintain them clean, through a rotational duty rota that is managed by the landlords.

Through AMREF's initiative, some residents of Kibera came together, and built water tanks that now provide clean water to the area at an affordable rates. A resident, Toma Aganase, whom AMREF trained to look after water tanks, is a typical example . She sells clean water at affordable rate, and ploughs back the profits to maintain the tank and personnel.This provides Toma with a regular income but more importantly ensures that someone will continue to maintain the service long after AMREF have moved on from the area. Water tanks have sprung up around the slum, initiated and built in collaboration with AMREF, but manned wholly by the community itself.

Trained health workers, amongst them traditional midwives, have greatly improved the community's health status on the ground. They move around, giving health tips, and administering treatment for common ailments, and the more serious cases referred to the nearby Kibera health centre. The health centre is yet another AMREF initiative, that was built using local labour and resources. It also acts as the community's social and conference hall, where they meet regularly to appraise their projects, and identify other areas of improvement. The health centres modern operating theatre and laboratory are equipped to deal with any emergencies, and services offered are paid for,

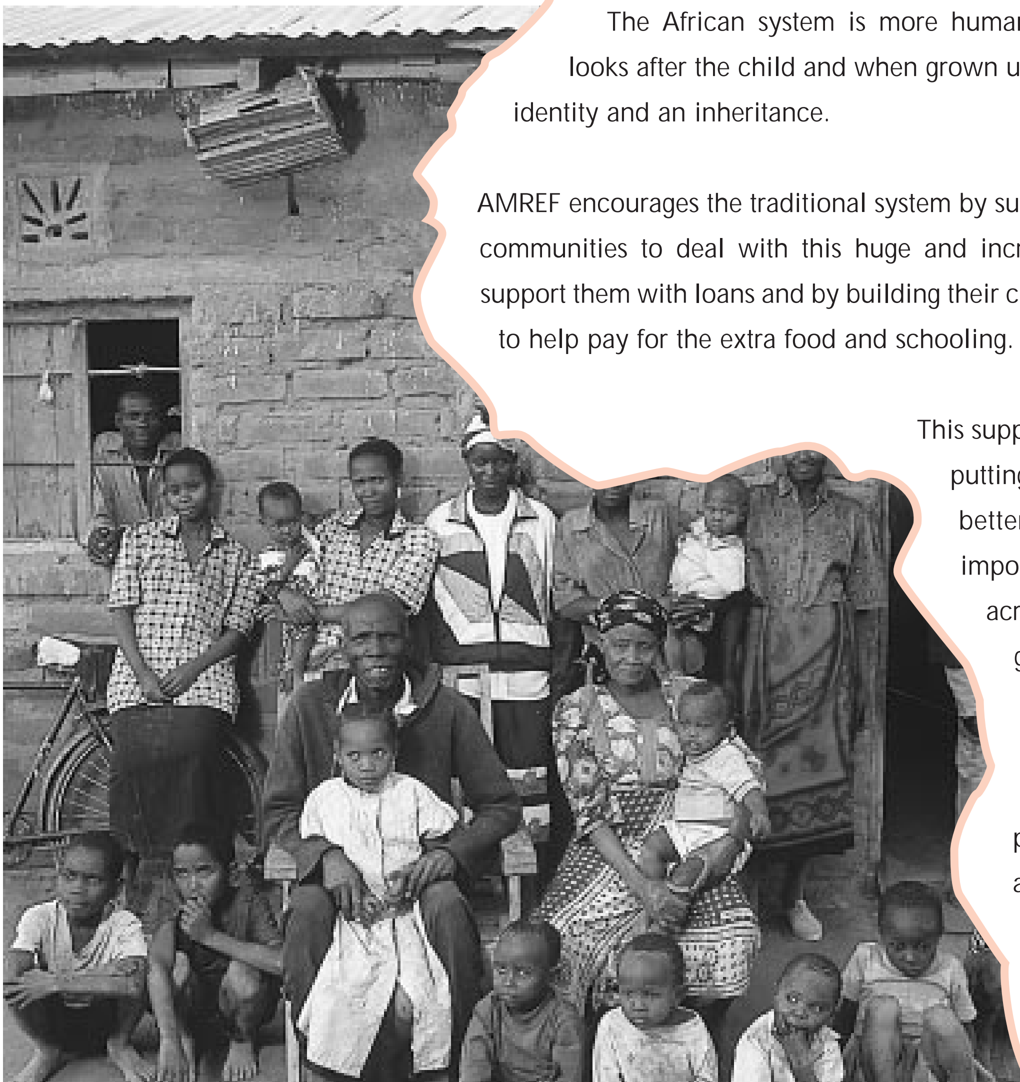
finding African solutions to African problems

In Luwero, Uganda, wars and the AIDS epidemic have wiped out a whole generation. In many places only children and grandparents remain. There is a real problem with orphans. A problem, which unfortunately looks set to repeat itself across Africa as the AIDS pandemic takes hold.

Most international organisations try to solve this problem by building orphanages. In the West the standard way to deal with orphans is to put them in an orphanage.

AMREF, being an African organisation looked at it differently. In Africa, orphans are traditionally cared for by the community. The guardians get the benefit of any land the parents leave on their death while the children remain in their care and then the children ultimately inherit their parent's land when they come of age.

Institutionalisation of the orphans hurts the child twice. Not only do they loose their parents but they also loose their inheritance, their home and all their family ties. A child in a city orphanage reaches 18 and is asked to leave. They walk out of the door with nothing. No land and no home and no relationship to their relatives or home community.

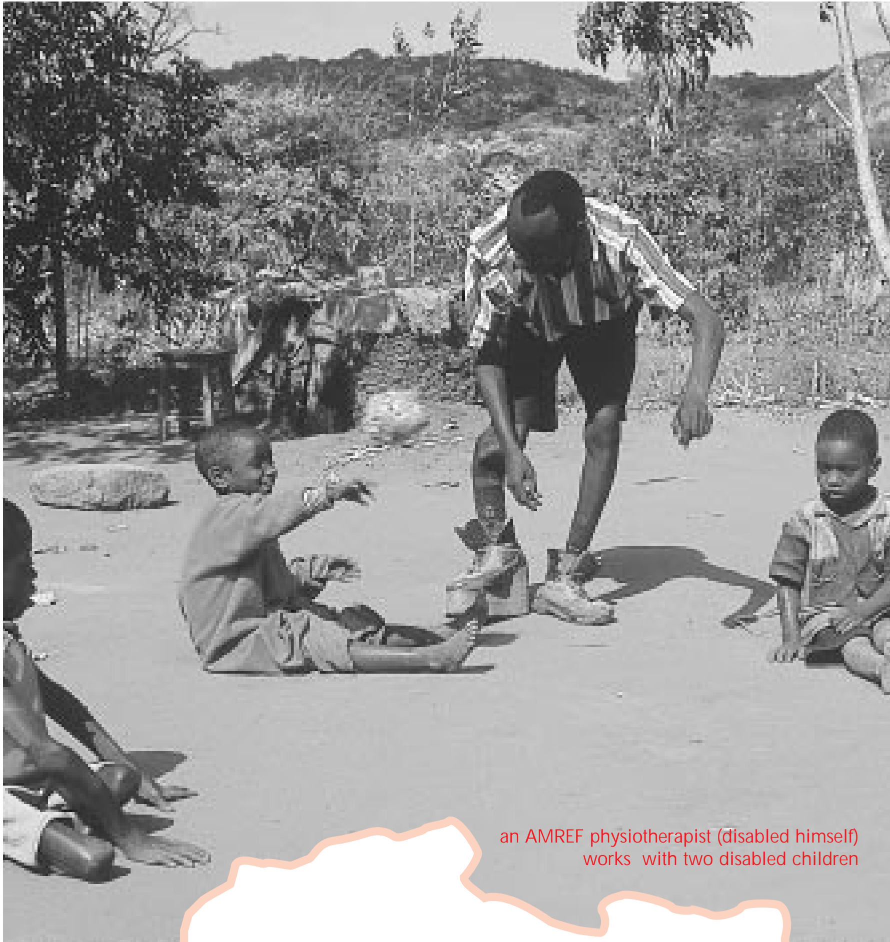


The African system is more humane. The community looks after the child and when grown up the child has both an identity and an inheritance.

AMREF encourages the traditional system by supporting the guardians and the communities to deal with this huge and increasing burden, themselves. We support them with loans and by building their capacity to generate the extra income to help pay for the extra food and schooling.

This support costs only a fraction of the price of putting children into institutions and is much better for the child. This project is important because as AIDS takes its toll across Africa the problem of orphans is going to grow. Most African economies simply cannot afford the burden that large orphanages are predicted to become. AMREF is promoting this African solution across the whole of Africa to help all economies deal with the problem.

giving the disabled a voice



an AMREF physiotherapist (disabled himself) works with two disabled children

In many parts of Kenya handicapped people are more disabled by the attitudes of society towards them than they are by their actual physical or mental disability.

Alice (not her real name) is the mother to two mentally disabled girls. She does not know the cause of the disability but it is likely to be hereditary.

The real problems began for the two daughters started when they began to mature. Men in the community decided that they were an easy target. After all "they would never get a real husband, would they?". The girls were raped. On more than one occasion and often by members of their own family.

Both girls became pregnant. One baby died at birth; the other is now two years old. The baby is also disabled.The clan would rather not deal with this publicly. Rather than taking the rapists to court they decided on a simple fine of cattle for the fathers. The others got off scot-free.

Both of Alice's daughters are afraid to walk in their own neighbourhood. Afraid of their own relatives. Alice now has to look after her children and her new grandchild. But she is determined about one thing. Her granddaughter will never ever suffer the fate of her daughters nor the silent compliance of the community. Alice intends to shout about the problem and shame her community into treating all disabled people with the dignity they deserve.

AMREF believes we should be helping Alice in this campaign. Supporting her morally by simply providing someone to talk to. Supporting her with training in the art of public speaking to enable her get her message over more effectively. Supporting her by finding platforms from which to speak. And by providing her with financial assistance to travel locally and occasionally to town to lobby politicians.

This sort of support costs very little. Alice and her children will do all the real work. They will provide the voice. AMREF's role is just to help her got heard.

lessons of the ebola outbreak in gulu

some children play at the Gulu town marker

Agnes Lawin's stepfather was in Gulu hospital in northern Uganda, following an eye operation. In most African countries inadequate staffing has necessitated that relatives take care of in-patients - cooking for them, feeding and cleaning them. Agnes's mother therefore went to Gulu Hospital to take care of her husband. She contracted Ebola in the process, and died. When her husband left Gulu hospital he went to his first wife, in a distant village, abandoning Agnes and her six siblings. At the blink of an eye these children became destitute. As if this was not enough, the family's huts were razed to the ground, and they were forced to move away, taken in by a jobless elder brother.

This was the fate of many like Agnes whose relative had died from Ebola as well as those who had themselves survived the disease. At least 20 Ebola survivors were rejected by their families, forcing them to go back to hospital. The community viewed survivors and relatives of people who had died as potential sources of the disease.

This stigmatisation and rejection were some of the issues that AMREF, through community-based training and education, tried to minimise during the months when Ebola ravaged Gulu. Social life literally came to a standstill and panic took over.

AMREF concentrated on community mobilisation, awareness creation and education as well as health workers training. AMREF aimed at enabling the people of Gulu prevent the spread of the disease through understanding the disease, teaching proper handling of suspected Ebola victims at the home and hospital level. Household and personal hygiene as well as proper burial procedures were also taught.

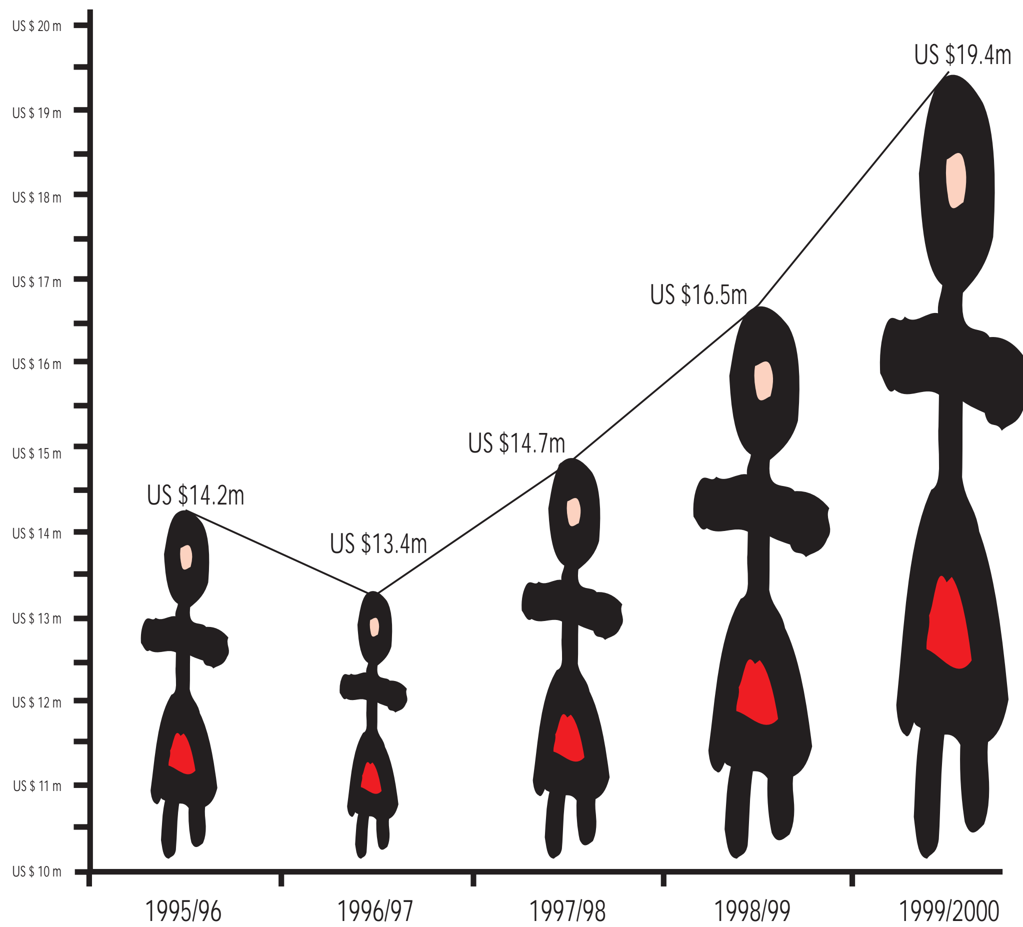
AMREF trained over 450 people, among them health workers, government and NGO managers, police officers, ambulance crew and school teachers.

AMREF also provided much needed medical supplies as well as logistical support to the District Health Medical Team.

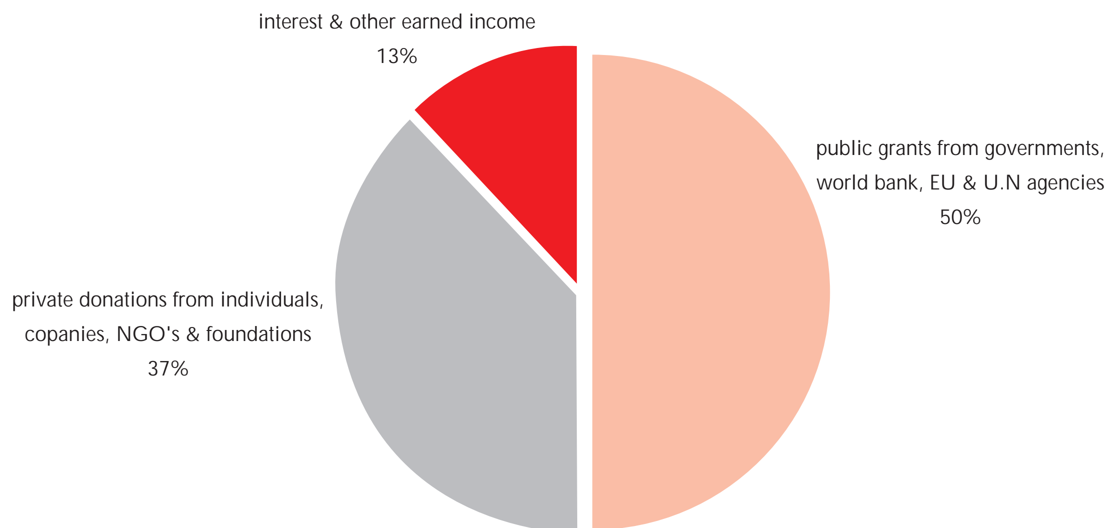
A total of 173 people died, in the Gulu outbreak. The fatality rate was 23.7 percent.

growth of income

all figures in US$ million

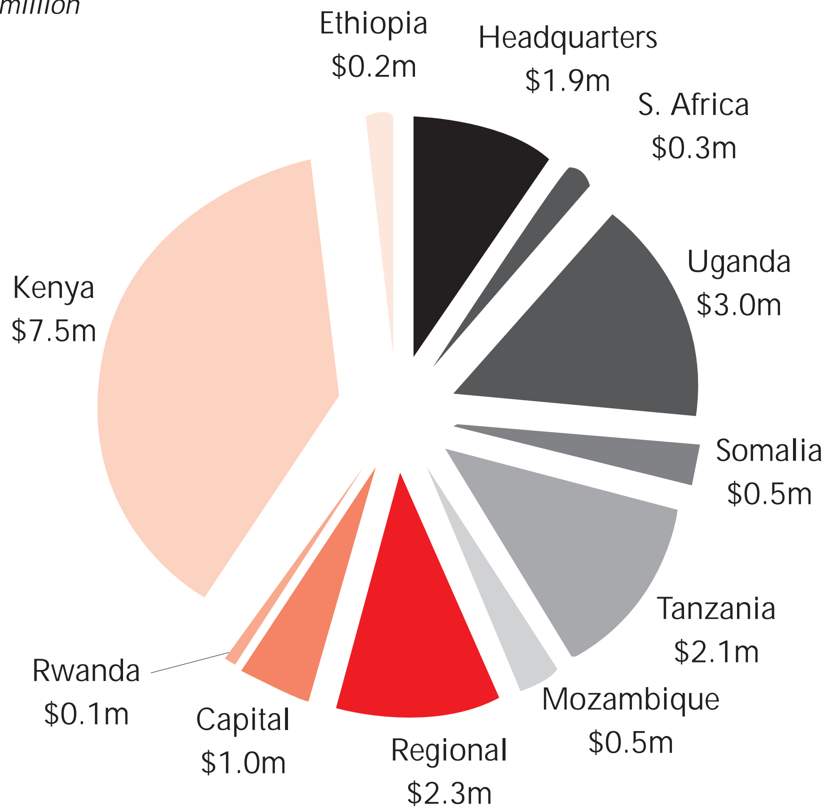


source of funding



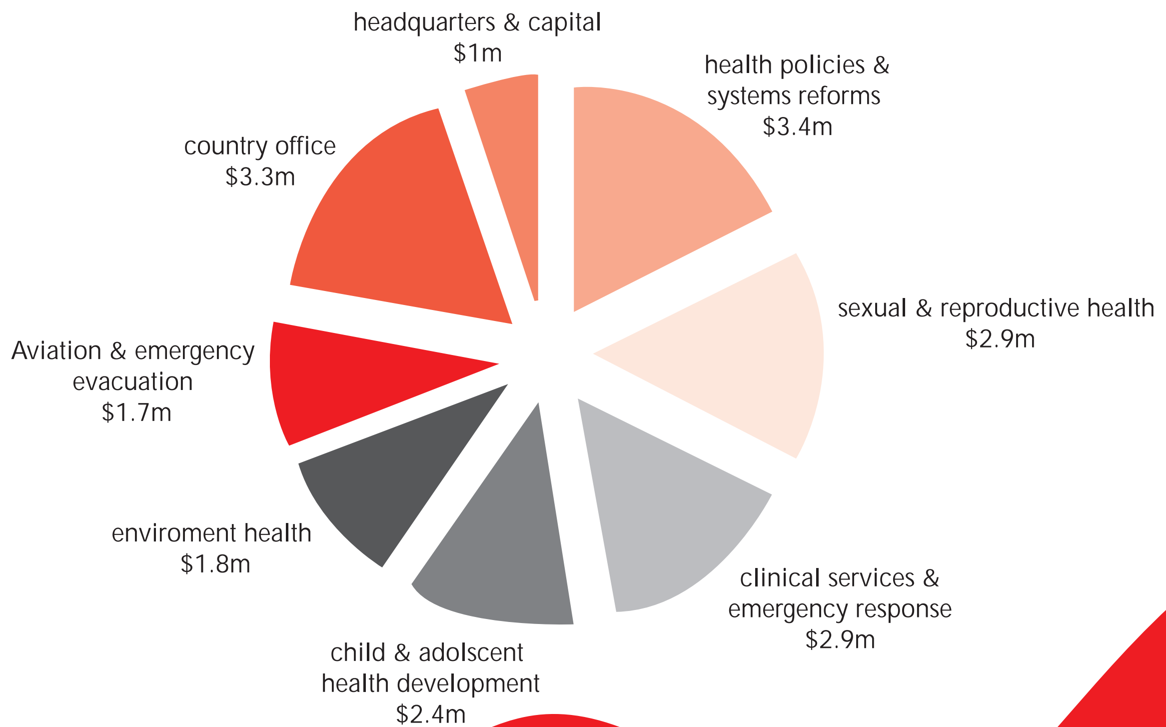
expenditure by country

all figures in US$ million



expenditure by programme

all figures in US$ million



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