

A photograph of two young African children peering over a weathered wooden barrier. The child on top is looking directly at the camera with a curious expression. The child below is also looking towards the camera. The background shows a rustic wooden structure.

Putting African Communities First



**Enhancing Capacity and Participation
to Close the Gap in Health Systems**

Strategy 2007 - 2017



 Main Programme Countries

 Countries where AMREF has provided Technical assistance

 Training Programme Reach

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Foreword

Health development as the beacon of development

Over the past ten years, the status of health in Africa has changed, and all too often not for the better. Health indicators across the continent continue to be an urgent challenge to those of us working in the field. Despite significant expenditures by governments and donors targeted at combating specific diseases, infant and maternal mortality statistics show little, if any, improvement. In some countries, including Kenya, negative trends are alarming. This is not to say that all efforts are misdirected – for example, Africans now have greater access to free antiretroviral therapy – but clearly we should and must do a better job across the board in improving the health of the people of Africa. Over and above the benefits of good health itself, a reduced burden of disease (morbidity and mortality) releases resources that go into productive activities and into creating wealth. Inputs into health are therefore not just a dead-end expenditure but wealth creation investments at all levels of society. For the African Medical and Research Foundation (AMREF), this means making health a community issue within the National Health System.

And so AMREF is launching a new and different sort of strategy, one that we believe, over the next ten years, will bring important but previously marginalised actors into the health care arena: not only for disease prevention, treatment and care but also for health promotion.

I am especially excited about three innovative aspects of this strategy. The first is AMREF's redefinition of the concept "health system". I have said before that until people become engaged with their own health care, we will continue to wipe the floor while the tap continues to leak. I am therefore very gratified that AMREF is redefining the health system to include the people and communities we work with.

Communities need to be part of the system in a broader sense than is currently the practice. This is perhaps not an easy concept, but we believe it is vitally important if we are to see changes in health care indicators. To illustrate: in some communities up to 80 per cent of individuals seek help from traditional healers. Therefore traditional healers represent an untapped source of expertise within the communities where they work for improving referral systems between communities and ministry of health facilities, and for information about affordable, safe medicines. To take another example, we have learned from the challenge of HIV that community members are often the best people to encourage their friends to go for counselling and testing, and to provide care and support for those who are HIV-positive and for orphans and other vulnerable children. Indeed, we need to be imaginative and seek additional opportunities to discover and make use of community resources.

The second aspect of the strategy is creating stronger links between ministries of health and the communities they serve. If I can continue my household analogy about mopping the wet floor, it sometimes takes many hands working together to stop a leaking tap! You might need an upset family member to initiate the process, a plumber, and a supplier of parts, or sometimes just a child to turn off the tap properly. The lesson is that we need to know what other people can contribute and engage their skills in getting to a solution. The other side of the analogy is that our health systems can be more responsive if we all work together and keep each other informed of what we are doing and what is happening in our communities. To this end AMREF's new strategy has a strong component of building better communication links, for example, strengthening health management information systems at community level and tying them into MOH systems.

If I can push the analogy just a bit further, the third innovative aspect of our strategy has to do with determining the reason why the tap is leaking in the first place. AMREF is initiating a research effort that will focus on why communities have not been more involved in their own health care in the past, and what constraints exist that currently inhibit their participation. As AMREF researchers are tasked to look for solutions regarding a specific disease, they will, at the same time, work with the affected

community to examine why that disease is a problem for them and how the community can play a role in combating it. For the last two years many people, both inside AMREF and those we have consulted, have contributed to formulating this new strategy. It is the product of a highly participatory process, guided to its present form by AMREF's Senior Management Team. We are excited about putting the strategy to work. On behalf of AMREF's Board of Directors, I would like to congratulate the team and wish them well as they develop innovative interventions to push the strategy forward.

To the AMREF Family in Africa and abroad, this is YOUR BABY! Let us keep the baby bouncing into healthy childhood and thereafter into robust youthful years and eventually a healthy adulthood. The collaboration we have established is like placing Africa in an embrace. Let us go on to have a loving and healthy embrace around Africa.

We in the AMREF Board of Directors take this opportunity to invite all partners working to improve the health of the people of Africa to join hands with us in expanding effective and efficient health systems in all our countries that fully incorporate our people in their communities. We in Africa are a COMMUNITY PEOPLE. And if it doesn't happen in our communities, it doesn't happen elsewhere and it won't happen. So let us help make it happen in our nations by ensuring that health promotion and health care services are, indeed, happening in a truly bottom-up approach: from the families in our communities to the tertiary hospitals and throughout all the arms of the health system.

I bless those that will implement this Strategy and pray that through their diligence, they will help bring the blessing of improved health to the people of Africa. I bless Africa's partners who work faithfully with Africa to reduce the burden of disease she carries and thus move the people of this great continent forward towards robust health.

Professor Miriam K Were, EBS, IOM
Chair, AMREF Board of Directors

Acknowledgements

This strategy is the result of over two years of intense debate within AMREF and with our stakeholders in Africa and beyond. There has been such wide involvement in the process it's difficult to thank everyone by name.

However a group of colleagues took the deliberations of many and drafted and re-drafted this strategy. I want to thank Florence Muli-Musiime for leading this group, and Daraus Bukenya, John Nduba, Peter Ngatia and Blanche Pitt for being willing members of the group. I also thank Linda ole-MoiYoi for her infinite patience and contributions made whilst editing and improving this document; and the AMREF communications team for designing and printing the completed strategy.

Many other people have contributed to the thinking behind the strategy and have reviewed and commented on the evolving versions of the strategy:

- all the AMREF staff who attended the 2005 and 2006 Annual Programme Meetings and added their wisdom and experience to the process
- colleagues on the AMREF corporate senior management team (SMT), remembering especially the May 2006 SMT meeting during which we agreed on the conceptual framework and much of the thinking now captured in the strategy
- members of our five country programme senior management teams and the staff of our country programmes, and members of the country programme Advisory Councils and Boards in Kenya, South Africa, Tanzania and Uganda
- colleagues in AMREF's 12 offices in Europe and North America
- the contributions to the strategy made by AMREF's stakeholders in Africa and beyond
- members of the CIDA/Sida team that reviewed AMREF in 2005/2006 and, most importantly, by
- the members of the AMREF Board of Directors who added greatly to the evolving strategy and approved the document.

Michael Smalley
Director General

Glossary of Terms

Community: The concept of a “community” has changed with time. In the past communities were seen as homogenous, geographically concentrated, and stable over time. Today they tend to be temporal, culturally diverse, mobile and bound by common needs rather than by common interests. They coalesce around groupings such as settlements, schools, factories and faith-based institutions. Fast growing, informal urban settlements are the clearest example of the new and emerging African concept of a community. Increasingly communities are organising into local civil society organisations (CSOs) and community-based organisations (CBOs), and developing abilities to identify priorities, needs and solutions to problems. The emergence of these groupings provides the continuity and long-term commitment required for sustainable development.

Empowerment: In the context of AMREF’s strategy, empowerment means to build the strength, competencies, voice and confidence of health care workers and of the communities where we work, enabling them to participate in programme work, to identify their own strengths, weaknesses and needs, and to join in meaningful partnerships to solve problems and monitor progress.

Equity: Although the concept of equity applies to many broad areas, AMREF views equity as the equal access to quality health, and the absence of discriminatory practices.

Evidence-Based Advocacy: AMREF uses “evidence-based advocacy” to mean a targeted set of activities to influence policy and practice, based on reliable and documented evidence from research, aimed at a defined audience of decision makers.

Health System: AMREF views the community as the organising principle of the health system, and is defining the health system in a deliberately inclusive way. That is, the health system includes a country’s

- formal sector, public and private
- health care training institutions
- informal and community-based sectors, including CSOs and CBOs
- most importantly, the communities they serve.

The “peripheral end of the health system” refers to district and community level.

Programme Driver: A programme driver is a cross-cutting, process-oriented parameter that ensures AMREF’s strategy and interventions are holistic, integrated and focused on improving the health system as a whole.

The Gap: Communities should be an integral link in any health system set up to serve them. Unfortunately this is not always the case, especially when the community is poor, vulnerable, marginalised or remote. The gap refers to the disconnect between communities (including the informal sector of the health system) and the rest of the health system that causes dysfunction in health promotion, prevention and health care service delivery and contributes to worsening health status, especially among poor, vulnerable and marginalised groups.

Abbreviations and Acronyms

AIDS	Acquired-Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Ante Natal Care
ARV	Anti- Retroviral
ART	Anti Retroviral Therapy
CBO	Community-Based Organisation
CBHC	Community-Based Health Care
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
DFID-WELL	Department for International Development and the WELL Project
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Service (for Tuberculosis)
DPT	Diphtheria, Pertusis and Tetanus
FBO	Faith-Based Organisation
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRDH	Human Resource Development for Health
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-Government Organisation
OECD	Organisation for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
Sida	Swedish International Development Agency
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Executive Summary

Introduction

The African Medical and Research Foundation (AMREF) was founded in 1957 as an international African health development organisation by three reconstructive surgeons working in Kenya who were concerned that rural Africans were failing to access the surgical care they needed. The surgeons concluded that if the patients could not get to them, then they would go to the patients – and so the “Flying Doctors” were born. Continuing that tradition of innovative solutions, AMREF today carries out pioneering interventions that provoke health care improvements of significant importance, in Kenya and beyond.

While AMREF’s service delivery efforts on the front lines have saved many lives, we have learned over the years that vertical disease treatment programmes are in themselves not enough to improve the overall health of those we serve. Consequently, during AMREF’s last strategy period, 2000-2005, “Better Health for the People of Africa”, our role moved away from purely service delivery, toward capacity building, operations research and advocacy.

In this, AMREF’s 50th year, we are refining our strategy further by adding a strong component of community empowerment, so that over the next ten years we can use our current programmes to better advantage. The rationale for this shift is that AMREF has become acutely aware of the gap between vulnerable communities and the rest of the health system. These communities are often but not always remote geographically, but they are very remote in practical terms from policy makers and health system managers. Therefore, they have little opportunity to provide input to policy decisions regarding their own health needs or the ways in which they receive health services.

The gap exists despite increased expenditures by governments and donors and despite successes in the prevention and treatment of common diseases. In addition, poorly directed health financing has hastened the deterioration of peripheral health infrastructure, further undermining health promotion and the quality and efficiency of basic preventive services at community, health centre and district levels.

The Gap between Communities and the Rest of the Health System

Although African health systems are meant to reach all communities, the systems are stressed by the burden of seemingly intractable diseases, insufficient human resources, organisational development failures, funding issues and, most important for AMREF’s 2007-2017 strategy, insufficient community involvement/engagement, from design to implementation to evaluation of services. The gap between communities and the rest of the health system is reflected in the following, among others:

- barriers to communication that compromise the ability to share information and a reluctance to guarantee communities a voice in decision making
- a disconnect between the informal health sector (e.g., community-based health care workers and traditional service providers) and those in the formal sector
- missed opportunities to increase health promotion and preventive care efforts in communities
- attendant problems of access to, and utilisation of, quality services
- weak data collection and research on community health needs, strengths and weaknesses for appropriate policy formulation
- compromised or ineffective referral systems and access to specialist services

AMREF's Strategy for 2007-2017

To help close the gap, AMREF's strategy, guided by our mission and vision statements and our core values, is designed to create a broad-based culture of health promotion, prevention and care in the African health arena. We will work closely with partners at all stages, and especially with poor and marginalised communities to bring them into an integral and vibrant relationship with their health system, enabling them to achieve their full health potential, as is their right. At the same time AMREF will orient its capacity building and research efforts toward developing and testing models that help make health systems more responsive to communities. Knowledge will be a core product and used to influence policy and practice.

Strategy Goal

To advance Africa's health by catalysing an evidence-based movement aimed at reducing the gap between communities and the rest of the health system.

Programme Drivers

AMREF is well aware that pressures to revert to a programme of purely disease-driven interventions will be compelling. To counteract these pressures and ensure that AMREF acts in a holistic and integrated way, we will use a series of process-based, cross-cutting programme drivers that reflect our core values and to which all interventions will respond. For example, programme drivers will ensure that our interventions are pro-poor, culturally sensitive, and that gender is mainstreamed in all activities.

Programme Themes

For this strategy period, AMREF has chosen to focus on three interrelated programme themes.

1. Partnerships with Communities for Better Health

For health systems to better meet the needs of the poor, they must place people at the centre, ensure wider use of indigenous knowledge, and promote enlightened leadership. Making health systems responsive to community health needs and priorities, and redressing the disproportionate burden of disease and health threats affecting the poor will require the development of a framework for community participation and health interventions based upon knowledge and pragmatic policy options.

2. Building Capacity for Strengthened Communities and Health System Responsiveness

To enhance the capacity of the formal sector of health systems to respond to community health needs, the priority areas AMREF will address are: health management information systems at both informal and formal health sector levels (HMIS); improving the skills of health care workers, especially those of community health workers; and organisational development in health-related civil society organisations.

3. Health Systems Research for Policy and Practice

AMREF will expand its capacities for research and policy analysis to develop credible evidence related to policies and practices that will contribute to closing the gap between communities and the rest of the health system. This theme area will also provide the data for Themes 1 and 2 and vice versa. Knowledge is a core product and will provide the basis for engaging in strategic partnerships to advocate appropriate changes in African health policies and practices. In this strategy, AMREF has set out its research agenda.

Risk Analysis and Mitigation

We have considered the likely risks facing AMREF as we implement this strategy and have developed a set of actions to mitigate them. The implementation plan will provide more detail; in this document we describe six major risks that AMREF has identified and the actions that will be taken to mitigate them.

Implementation Mechanisms, Monitoring and Evaluation (M&E)

Our interventions will be implemented through a variety of mechanisms, including community-based problem solving, innovative institutional arrangements, training and technical assistance, among others. AMREF will continue to provide service delivery but will use it as an implementing mechanism in the context of our three programme themes rather than solely as a component of vertical, disease-based programming. Service delivery will also afford a learning opportunity, contributing evidence for more appropriate policies and practices.

As we move through the next 10 years, AMREF will continuously monitor its interventions and evaluate progress. For our full implementation, monitoring and evaluation plan we have developed a companion document to this strategy.

Organisational Arrangements

AMREF's Board of Directors ensures that AMREF is managed according to the strategy and policies it approves. This encompasses its mission, its financial and human resource management, and takes into account the global framework within which AMREF operates.

AMREF provides a flow of information to national offices and its partners to support fund raising. A comprehensive and user-friendly web site, presently receiving over 1 million hits every month, supports this information flow.

Ensuring quality where AMREF already works and finding cost-effective ways to extend AMREF's footprint within Africa is part of the new strategy. Moving forward, AMREF will explore three mechanisms: developing strategic alliances; extending AMREF's training programme with partners in new countries willing to provide facilities and staff; and creating regional hubs in the horn of Africa, southern Africa and West Africa.

In conclusion AMREF, in collaboration with our partners, intends to keep the issue of closing the gap between communities and the rest of the health system at the forefront of the development agenda for improving African health.

Vision, Mission and Core Values

Vision

Better Health for the People of Africa

Mission

AMREF is committed to improving health and health care in Africa. We aim to ensure that every African can enjoy the right to good health, by helping to create vibrant networks of informed and empowered communities and health care providers working together in strong health systems.

Core Values and Beliefs

Health as a Human Right

AMREF believes that health is a basic human right and operates its programmes with a rights-based approach.

Pro-poor

AMREF identifies priorities and allocates resources on a pro-poor basis, giving priority to people and communities that we believe to be the most vulnerable.

Empowered Communities

AMREF believes that communities are resourceful and that empowered communities are a prerequisite for improving individual and community health. We work with and through communities, putting the interests and opinions of the communities first.

Strategic Partnerships

AMREF believes in strategic partnerships as a means to conduct successful and sustainable interventions. AMREF develops and nurtures partnerships with like-minded organisations that share our core values and strategic focus.

Gender Equity

AMREF is committed to mainstreaming gender considerations in all of its interventions. As AMREF strives to abolish gender inequities, we make a conscious effort to remove unfair practices and promote the well being of both genders.

Non-discrimination

Adhering to international conventions, AMREF does not condone discrimination based on sex, religion, race or culture, internally or in its programmes and interventions.

Professional Standards

AMREF sets high professional, ethical and medical standards and monitors these closely within our projects, among ourselves and among those with whom we partner.

Transparency and Accountability

AMREF believes in honest communication, absolute openness, and the transparent use of influence, power and resources. AMREF has zero tolerance for corruption, both within the Foundation and in our dealings with outside agencies.

Sustainability

Through advocacy and empowerment, AMREF aims to enable communities and the rest of the health system to sustain mutually designed and implemented interventions.

Evidence-based Policy and Practice

AMREF uses its grassroots work with African communities to generate and document evidence aimed at influencing donor/government policies and practices that bring about lasting benefits to the most vulnerable groups and communities.

Innovation

AMREF upholds a commitment to innovation in our work and the work of our partners. We constantly develop and encourage new, effective methods and tools for improving the health of communities.

Environmental Protection

AMREF is committed to developing and maintaining sound, robust environmental protection policies in all of its activities.

Background and Comparative Advantage

Background

The African Medical and Research Foundation (AMREF) was founded in 1957 by three reconstructive surgeons working in Kenya who were concerned that rural Africans were failing to access the surgical care they needed. The surgeons concluded that if the patients could not get to them, then they would go to the patients – and so the “Flying Doctors” were born. Continuing that tradition of innovative solutions, AMREF today carries out pioneering interventions that catalyse healthcare improvements of significant importance, in Kenya and beyond. The core programme has expanded to include Ethiopia, South Africa, South Sudan, Somalia, Tanzania and Uganda. In addition AMREF has been a programme partner in several other sub-Saharan countries.

Over the past 50 years, the Foundation has continuously worked with the very poor (lowest economic quintile), marginalised rural and urban populations, nomads, those in camps for internally displaced people, and those in situations of chronic insecurity. We especially target disadvantaged communities that lack access to adequate healthcare and that have little opportunity to engage with policy and decision makers to decide their health priorities. We also target those groups that are particularly vulnerable to diseases of poverty (women, children and adolescents) and work with remote district hospitals and communities, clinics and laboratories.

Working with Partners

Local Communities: Using a community-based approach, AMREF learns how communities view their own health, health care needs and strengths, and how well they link to the formal health sector for services. Together we design and test models that address targeted health issues, for example, the prevention and treatment options for a particular disease, or improving access to a health centre or hospital. AMREF also invests considerable effort in building the capacity of local civil society organisations, enabling them to decide on health priorities, to deliver and manage their own interventions and to work with the rest of the health system.

Governments, NGOs, FBOs and CBOs: AMREF has been working constructively with sub-Saharan ministries of health, ministries of education, NGOs, FBOs and CBOs to effect positive changes in health care policy and service delivery.

The Development Community: AMREF has forged strong working links with the international development community and universities (in and outside Africa) as well as with United Nations agencies. During the past 20 years, AMREF and these partners have continued to test and implement new approaches to improve health within and for communities and to build the capacity of health professionals to work with communities.

The Private Sector: AMREF engages with the private sector as a source of funding and, increasingly, through public/private partnerships to harness the expertise of AMREF and business partners in finding solutions that are sensitive to community needs and issues, and that increase community access to effective services.

Building on Success: Moving Forward with a New Strategy

The increasing burden of disease in the late 1980s and early 1990s, characterised by the emergence of drug-resistant malaria and HIV/AIDS, saw AMREF placing emphasis on these specific disease control initiatives. The 2000-2005 AMREF strategy “Better Health for the People of Africa” refocused AMREF’s role away from purely service delivery toward capacity building, operations research and advocacy, concentrating on malaria, HIV/AIDS, TB, sexually transmitted infections, water and basic sanitation, family health, clinical outreach services, and the development of training and learning materials.

In its 50th year, AMREF is refining its strategy to take better advantage of its current programmes through an increased focus on

- community empowerment – empowerment that will enable communities to participate in health care planning, policy formulation, and health service delivery
- the peripheral end of the health system, making it more responsive to communities

By building on our successful past and current programmes, and by strengthening our community-based approaches, capacity building and research efforts, we with our partners look forward to seeing significant and lasting improvements in the health systems and health care of Africa.

Comparative Advantage

An International African Health Development Organisation

AMREF is unique as the largest international African health development organisation. AMREF's uniqueness can be attributed to its international structure developed around a strong African base. With headquarters in Nairobi, Kenya, the Foundation is able to provide African-oriented technical expertise through its country offices in Africa, concentrating on the development and implementation of AMREF's technical programme.

AMREF has over 800 employees based in Africa, comprising a diverse and resourceful team with the skills, knowledge and experience to face the challenges of improving health in Africa.

A Strong Network of Northern Partners – The International Forum

AMREF benefits greatly from strong international links through 12 European and North American affiliate offices that support fund raising, build awareness of AMREF and its programmes and take AMREF's African voice to policy and decision-makers in the North. These northern AMREF offices are part of the "one AMREF" and fully participate in the implementation and outcomes of AMREF's strategy.

Successful, Innovative Health Activities

AMREF develops, tests, evaluates and promotes the adoption of best practice models that are appropriate, relevant and affordable; focuses on training and capacity building at all levels; and influences policy-makers to make changes to policy and practice based on evidence-based best practices. Among the successful programmes implemented by AMREF in partnership with governments and targeted for scaling up are the following:

- The Personal Hygiene and Sanitation Education (PHASE) Project was introduced in Kenyan primary schools, and in 200 the Government of Kenya adopted PHASE for nationwide scale-up. It is also being replicated in Uganda, Zambia and South Africa.
- The Tanzanian Ministry of Health adopted AMREF's training curriculum for Community Integrated Management of Childhood Illnesses (CIMCI) at a time when the Government was beginning to make IMCI operational as the overriding national strategy for child health care.
- AMREF's component of the Home-Based Management of Fever Programme in Uganda has influenced national policy makers to consider community drug distributors as essential partners in preventing malaria-related morbidity and therefore needing official recognition and motivation to become more involved.
- The Comprehensive Nursing Training Programme in Uganda has been adopted as a national policy and curriculum for the training of nurses in Uganda.
- The "Jijenge" Project in Tanzania that piloted male involvement in reproductive health through a rights-based approach is being replicated as a model by UNFPA in Tanzania.

- The “Angaza” Project in Tanzania has established a model for the rapid scale - up of HIV testing and counselling; the Government has now adopted the “Angaza” model to scale up HIV testing and counselling nationally.
- The “Umkhanyakude” Project links traditional healers with health professionals in the formal health sector of South Africa to better manage HIV/AIDS, TB and other infectious diseases.
- An e-learning project has been used to retrain 22,000 nurses in Kenya.

Through continued capacity building and research activities such as those listed above, AMREF is increasing its emphasis on strengthening health systems so as to ensure that they better serve the needs of poor and vulnerable communities. Over the next ten years, AMREF’s programmes will focus on those areas that offer the greatest opportunities for enhancing the capacity and participation of households, communities, civil society institutions and the health system.

The regional AMREF laboratory programme has played a major role in developing national laboratory policy in Tanzania, Kenya and Uganda. It has achieved standardisation of laboratory procedures with the East African Ministries of Health through the regional External Quality Assessment Scheme.

A Credible Health Development Organisation

As a recognised partner in the health care arena, AMREF is well positioned to act as a facilitator and broker in linking communities to their health systems. Others see this emergent role as essential in the fight against poverty and underdevelopment. A number of factors contribute to AMREF’s dynamic Africa-wide and international reputation, including:

- a non-political reputation that allows AMREF to act in ways that governments cannot; a reputation as a major facilitator in promoting African health initiatives
- an African headquarters able to provide management, technical and administrative expertise to support its work on the continent
- country offices concentrating on development and implementation of AMREF’s technical programme
- trust, established over 50 years with governments and communities as an organisation that provides expert opinions and advice based on practical experience on the ground
- a network of collaborating agencies – civil society partners at community level, ministries of health, ministries of education, NGOs, training institutions and international organisations working in health sector development in Africa; and partnerships with world-renowned institutions including the London School of Hygiene and Tropical Medicine, the DFID WELL consortium, Johns Hopkins University, UN agencies, major donors and African medical institutes throughout the continent
- local and international recognition and credibility that has seen AMREF win two major global prizes in the past decade: the Hilton Humanitarian Prize in 2000 and the Gates Global Health Award in 2005

Strategically, AMREF has always implemented its activities in close co-operation with governments but at the same time ensures the Foundation’s independence. This has enhanced AMREF’s convening capacity, and as a result, we have been able to bring NGOs, governments, and various other development actors together with minimal formalities. A prime example is AMREF’s facilitation of the harmonisation of regional AIDS/STD approaches in East Africa, which has resulted in participation by ministers of health and their senior technical staff.

AMREF’s credibility as a health development

AMREF’s Training Programme - Diploma in Community Health (DCH)

AMREF has an Africa-wide training programme that provides established health professionals with appropriate skills and tools to work more effectively with communities and their informal health sectors. Training for the DCH, launched in the early 1990s, has attracted over 480 students from 27 countries in sub-Saharan Africa. It has been accredited as a joint training programme of AMREF and Moi University, one of the largest health training universities in Kenya. By maintaining contact with the graduates, AMREF has built relationships with a cadre of individuals who can help advance our strategy.

organisation in eastern and southern Africa is unmatched, and its potential for having increased impact in other parts of the continent is growing. AMREF has taken a leadership position in advocating western donor support for strengthening African NGOs so that these can provide technical assistance to their own health systems.

A Commitment to Strengthening Our Capabilities and Maintaining Institutional Integrity

AMREF is committed to learning from its work in order to strengthen its programmes. We ask critical questions about the value-added in all our work; we are self-critical and do not settle for second best. We learn from our successful interventions and from those that succeed less well. AMREF is open to constructive criticism from our partners, peers and competitors, and we listen.

We place great importance on ensuring quality control in all of our programmes and management systems. We carry out our own internal project evaluations, both mid-term and final. External assessments of the whole organisation were carried out in 2000/1 and 2005/6 by CIDA and Sida, both key funders of AMREF. These evaluations have added significantly to AMREF's planning process, taking into account past shortcomings and successes. Over the last four years, AMREF has also been involved in an organisational strengthening programme that has improved its technical leadership and the quality of its programming.

AMREF regards accountability and transparency, especially in the area of financial controls, procurement and project management as essential to maintaining our integrity and credibility. The risk-based internal audit function serves to ensure accountability in our financial dealings and supports the effectiveness and efficiency of our interventions. To meet our legal obligations, an international audit firm carries out an annual external audit. Independent project audits are undertaken at donor request. As an organisation that promotes "openness", AMREF considers all of these audits within the public domain and shares the results willingly. A final measure of fiscal responsibility is the oversight function exercised by the Audit and Finance Committee of the Board of Directors.

The Gap in the Health System

Introduction

Over the past ten years there has been a dramatic upsurge in funding for health-related programmes in the developing world. By 1999 total donations from the G8 countries were \$865 million dollars (including HIV/AIDS treatment), a more than 10-fold increase in three years. In 2003 the US Government's PEPFAR programme designated 15 billion dollars for HIV/AIDS. OECD donations for health also increased dramatically. In 2002 the Global Fund was created, with a focus on HIV/AIDS, TB and malaria, and since then it has dispersed \$3 billion. In addition several poor countries in sub-Saharan Africa (e.g., Tanzania, Zambia, Central African Republic) have increased spending on health care to equal roughly 10 per cent of their budgets. Kenya doubled its spending on health care from \$6.50 to \$14.00 per capita in the past 5 years.¹

Private foundations have also increased donations; for example between 1995 and 2005 the Bill and Melinda Gates Foundation has provided approximately \$6 billion, \$2 billion of that for HIV/AIDS, TB and malaria.² Between 1995 and 2005, giving by US charities for health and research totalled \$22.4 billion for domestic and foreign health programmes and research. In 2006 the World Bank designated \$87 million for HIV/AIDS, TB and malaria and \$250 million for maternal and child health.³

Despite the increased expenditures on major diseases, the African health crisis progresses relentlessly, creating many challenges and dilemmas for policy makers and the managers of health systems. It has been said that 80 per cent of health is created at home and in the community, and 20 per cent is repaired in clinics and hospitals; it has become clear that, recently, donors and health systems have focused too much on the 20 per cent and not enough on promoting health.

Although there has been some success in the prevention and treatment of key diseases, all is not well with the health system as a whole. The focus on disease-based funding has distorted health planning and, unintentionally, has isolated communities from decision-making and resource allocations. The breakthroughs in HIV/AIDS treatment have come at the same time that maternal mortality and life expectancy have worsened. Maternal mortality is in many ways a proxy measure of the effectiveness of health systems as a whole, and life expectancy is an indicator for child health, and remains so despite the impact of HIV/AIDS. It is clear that we need revised perceptions of health systems and corrective strategies.

The Health Context

Evidence of the health crisis abounds and is reflected in a decline in several key health indicators and a lack of attention to continuing threats. For example, over the past 10 years

in many countries of sub-Saharan Africa

- child and maternal mortality rates have increased or stagnated at unacceptable levels
- equity gaps have increased
- life expectancy has decreased (1/2 – 2/3 of the life span of well to do populations)
- those infected and affected by HIV/AIDS continue to be underserved, including orphans and those who will never have access to ARVs
- chronic conditions including diabetes and high blood pressure, mental illness, and injuries from domestic violence and child abuse receive insufficient attention⁴

The direct and indirect economic costs of disease and ill health in Africa have been shown to be staggering and because of HIV/AIDS are growing⁵. Africa has 14 per cent of the world's population, but 69 per cent of the world's HIV infections. AIDS

1. L. Garrett, *The Challenge of Global Health*, Foreign Affairs, Jan-Feb 2007. This paper has excellent information on how increased spending on vertical programming has had mixed results. 2. Bill and Melinda Gates Foundation, Global Health Program, Seattle WA, www.gatesfoundation.org 3. L. Garrett, 2007.

Of the 39.6 million people living with HIV in 2005 globally, 24.5 million were in sub-Saharan Africa. Sixty per cent of new infections occur among women and young people. The high AIDS -related mortality in Africa is responsible for the estimated 12 million AIDS orphans on the continent, compared with 15 million globally (UNAIDS/WHO, *Report of the Global Aids Epidemic*, May 2006).

is having a debilitating effect because of prolonged illness and treatment. It is leading to depletion of household savings and assets, and is worsening already unbearable poverty in African communities.

TB in often drug-resistant strains has emerged in association with HIV/AIDS, reaching epidemic proportions on the continent, with prevalence estimated by WHO at 518 per 100,000, and a mortality rate of 81 per 100,000. About 10 per cent of TB deaths occur among children under age five. Treatment is not enough;

HIV and TB require not only medical care, but also careful follow up for compliance and for detection of treatment failures. Stigmatisation is still rampant in many countries and will remain so until communities become educated and sensitised.

It is estimated that about 80 per cent of the world's episodes of malaria occur in sub-Saharan Africa, however only 8 to 25 per cent of people with clinical symptoms of malaria seek care at a health facility, and the majority of deaths occur in the home. It is Africa's leading cause of under-five mortality (20 per cent) and constitutes about 10 per cent of the continent's overall disease burden, accounting for 40 per cent of public health expenditure and consuming 25 per cent of available household income. As drug resistance spreads and transmission patterns alter with environmental and climate change, malaria will continue to present major challenges to health systems.⁶

Maternal mortality rates in Africa are high and, as noted earlier, on the rise in some countries (typically between 500 and 1000 per 100,000 pregnancies). Malaria is thought to be responsible for up to 20 per cent of all deaths among pregnant women. Underlying this unacceptable maternal mortality rate are substandard prenatal care, poor access to emergency obstetric care and treatment for infections, and a high risk of STDs.⁷

Although there are no complete figures on abortion, it is estimated that about 1.5 million abortions take place each year in Africa. African countries have the highest adolescent pregnancy rates in the world. It is reported that about 40 per cent of girls have given birth by the age of 18, with a large proportion of pregnancies unintended, underscoring a continued need for education on family planning options and availability of methods. Pregnancy in very young girls is associated with increased mother and child morbidity and mortality, and early entry into reproductive life increases the risk of anaemia, malnutrition, and sexually transmitted diseases including HIV, in addition to the risk of obstructed labour.

At 38 births per 1,000 people, the birth rate far exceeds the mortality rate of 14 deaths per 1,000. Consequently, the population of the continent is expected to rise from more than 900 million as of this writing (more than 700 million in sub-Saharan Africa) to 1.8 billion by 2050. Young people aged 10-24 years old constitute 33 per cent of the population, while 43 per cent are children under 15. Unfortunately, despite the increase in health expenditure, it has not kept pace with increasing population.

The prevailing low literacy levels among women, the huge disparities in educational opportunities for girls and the impact of poverty on education for all children will continue to exacerbate the health situation. Traditional gender roles and responsibilities deepen gender inequity and make women more vulnerable to poor health; men often remain uninvolved in family health issues, although they are the decision makers of the family.

In summary, whilst curative services must be efficient and effective, greater attention must be given to preventing ill health and to strengthening the effectiveness of health systems. To date much of the programming that has been made possible by increased spending has been vertical, disease-oriented, and has given insufficient attention to a holistic approach to managing health.

4. WHO, *The World Health Report 2005, Making Every Mother Count*; World Bank, *World Development Report 2005; Sub-Saharan Africa Demographic and Health Surveys* see http://www.measuredhs.com/pubs/browse_region.cfm 5. WHO/UNICEF, *The Africa Malaria Report*, 2003. 6. Ibid 7. Ibid

With vertical programming, there are few occasions for African communities to voice their concerns, have input into projects and interventions taking place in their own communities, or have their own approaches to disease management examined and, where appropriate, integrated into programmes. While recipients of donor money are often aware of infrastructural, cultural or human resource constraints in the communities where they work and for which they are responsible, their hands are tied by vertical disease programming that does not necessarily examine access and equity issues.

In Kenya, the country's public health and medical systems are seriously compromised. Over the last ten years, the country has lost 1,670 doctors and 3,900 nurses to emigration and thousands more nurses have retired from the profession. Morale is low in sub-Saharan Africa where doctors and nurses lack the infrastructure, tools and medicines to save lives.

(L. Garrett, p. 28)

The Human Resource Context⁹

A parallel crisis affecting Africa's health workforce is a major contributor to the weakening of health systems. Low salaries, poor working conditions, limited opportunities for professional development, limited supportive supervision, low staff morale, poor governance, weak management, political violence in several countries, and HIV/AIDS are responsible for a rapidly deteriorating state of staffing in health services. It has been estimated that HIV/AIDS accounts for between 19 and 53 per cent of all deaths among government workers in sub-Saharan Africa.¹⁰

Because aid and loans constitute a large proportion of many governments' health budgets, international agencies and donors are a major influence on policy-making. Neither governments nor donors have explicit human resource policies, and the growing "global labour market" for health professionals is contributing to severe distributional imbalances. As in most countries, Africa's health professionals are concentrated in urban centres; others have left their countries or the continent altogether. It is estimated that every year Africa is losing about 20,000 skilled health workers through external migration.¹¹ The failure of health professionals to find employment in the formal sector (internal migration) is as great a problem if not greater. "Push factors" combined with "pull factors" (demand for human resources in wealthier settings) are also generating large-scale migrations of top-level medical personnel from poorer to wealthier regions within Africa and from the African south to the OECD in the north. Professional mobility and internal losses have become so significant that it is impossible to reverse or ameliorate the human infrastructure crisis without addressing the forces operating on the health labour force.¹²

Another facet of the human resource problem is the quieter but steady erosion of health worker training institutions in many African countries. In some countries, training institutions have borne the brunt of political instability and economic hardship. Initially designed to follow a western medical model of training health professionals, these institutions do not have the resources to update and realign training through curriculum change and teaching methods to make it more relevant to Africa's health needs. Lack of public/community health capabilities is often cited as a major problem among the graduates of these institutions, and consequently there is lack of public health leadership in the health systems in which they work. The training institutions are unable to balance the bias towards clinical (and increasingly commercial) medicine with Africa's huge need for preventive health services. Medical training institutions and their graduates, moreover, have been disconnected from the policy reforms of the past decade.

According to the World Bank, decentralisation, prioritisation, and privatisation have generated, at best, mixed results for healthcare. These policies have failed to revitalise the public health sector, while unregulated, private commercial clinics and non-profit NGO/FBO activities have grown. The number of trained health workers in the formal public health sector (regularised jobs) are most likely being fast outpaced by the number of untrained and unregulated workers in the "informal health sector,"

8. UNFPA, *State of the World Population Report*, 2006. 9. For additional background information, see M. Clemens, *Do visas kill?* Center for Global Development, 2006.

as these traditional and private systems expand to fill the need for services. This situation has led to increasing “out of pocket” expenditure for health care and further loss of equity.

The Gap Between Communities and the Rest of the Health System

With significant increases in health care spending over the past few years by donors and African governments, an unavoidable question arises. Why are we not seeing better results? While the foregoing statistics may be in part attributable to HIV/AIDS, it is AMREF’s position that we need sustainable programmes in effective and efficient health systems that focus not only on curing diseases, but also on preventative health services.

To take just one example, poor sanitation in communities and lack of proper food are directly linked to common poverty-linked infections and nutritional diseases that result in over one half of childhood deaths before the fifth birthday. In addition, lack of access to quality services compounds utilisation issues. Of HIV clients in Kwa Zulu, Natal, 80 per cent go to traditional healers first rather than a health centre.¹³

The crisis affecting African health systems manifests itself in many ways. There are policy-making, regulatory and governance issues; there are challenges of infrastructure, including roads and telecommunications; and there has been a failure to ensure the link between communities and the rest of the health system.

Historically communities have been seen as closely tied to health systems, but not necessarily part of the system. In addition, the recent emphasis on disease treatment has resulted in governments and donors giving insufficient attention to the needs and voice of communities.

The gap between communities and the rest of the health system is reflected in the following, among others:

- barriers to communication that compromise the ability to share information and a reluctance to guarantee communities a voice in decision making
- a disconnect between the informal health sector (e.g., community-based health care workers and traditional service providers) and those in the formal sector
- missed opportunities to increase health promotion and preventive care efforts in communities
- attendant problems of access to, and utilisation of, quality services
- weak data collection and research on community health needs, strengths and weaknesses for appropriate policy formulation
- compromised or ineffective referral systems and access to specialist services

Moreover, because existing health systems are structured, funded and managed largely as disease treatment systems, resource allocations, accountability and monitoring, and the attendant mindset of health professionals are dictated more by the needs of treating diseases than by prevention and health promotion. Similarly data collection on health issues is based on health facilities, and excludes information about what is happening in communities. For example, health data does not include changes in behaviour or lifestyles and therefore cannot inform planning on these essential health determinants.

Lack of capacity for health information management and technologies is an important constraint to evidence-based health service programming, health surveillance, and service delivery. Furthermore, critical information is collected and stored by other sectors, but inter-sectoral harmonisation of the systems is lacking. It is unlikely that improvements in the quality and efficiency of

10. L. Twafik and S. Kinoti, *The impact of HIV/AIDS on the health sector in sub-Saharan Africa*. The Issue of Human Resources. The Sara Project, Academy for Educational Development, Washington, D.C., 2001. 11. K. Blanchet et al., *One Million More, Mobilising the African Diaspora Health Care Professionals for Capacity Building in Africa*, The Save the Children Fund, 2006. 12. WHO, *Making Every Mother Count*, The World Health Report 2005; The World Bank, *World Development Report*, 2005. 13. “Umkhanyakude” AMREF’s Traditional Health Practitioners Project in South Africa.

health services available to communities can be achieved without basic health information collection and processing systems, including increasing the routine use of information for health programming.

Poorly directed health financing has also hastened the deterioration of peripheral health system infrastructure where it existed, further undermining the protection, quality and efficiency of basic services at community, health centre and the district referral levels. This situation is exacerbated by poor and weak transport management, skewed staff deployment, weak support and supervision of peripheral health services by higher levels, lack of appropriate continuing-education opportunities for health workers at these levels, poor access to essential medicines, and dilapidated medical equipment coupled with poor maintenance.

In response to increased disease burdens and human resource depletion, community structures have often gone their own way. Community-based organisations, traditional providers of health care, community health workers and others have recognised the necessity of taking on added responsibility for health care service delivery.¹⁴ The private sector is also expanding in communities, but it remains largely unregulated and CBOs often fail to be open and transparent in their management practices, including accounting for funds.

Although the community-based health care (CBHC) approach is people-driven, potentially empowers and leads to greater equity, it has largely been sidelined by governments' focus on national agendas and vertical disease programmes. CBHC has also mistakenly been seen as a low-cost solution. In recent years communities have relied on themselves for resources, while governments have concentrated their diminishing resources in the secondary and tertiary curative services, thus marginalising the CBHC approach. Therefore CBHC must be revisited and subjected to analysis to determine the best options for financing.

Because the national health systems have been and continue to be the main vehicle for ensuring access to health care, a focus on community needs and strengths would constitute a paradigm shift from government to community-driven health care. For this shift to become a reality, clearer recognition and understanding of the issues need to be developed among the African leadership as well as among the international community. There also may be innovations in Africa that are relevant to closing the gap between communities and the rest of the health system that neither governments nor the international community has recognised. These innovations should be identified and subjected to an analysis that moves beyond previous frameworks. Ultimately, health research, research on human resources for health, and high-level advocacy will be necessary to elevate the issue of community isolation to a position where political commitment will be forthcoming to create effective solutions.

Closing the Gap: Catalysing a Community Movement for Better Health in Africa

In developing its strategy for 2007-2017, AMREF is looking differently at service delivery, partnering, capacity building and research. As the preceding statistics in this chapter indicate, vertical programming for service delivery, especially during the past 10 years, has come up short and needs refocusing. Therefore, AMREF shall not do service delivery for its own sake but rather as a mechanism to test service delivery models and to strengthen the participation of communities in the health system. We also aim to develop and advocate a vision of a mixed public-private system that works, despite an environment dominated

AMREF's "Umkhanyakude" Traditional Health Practitioners Project in South Africa links the MOH with traditional healers to the benefit of both, and the communities they serve. Among many other things, traditional healers have learned how to avoid transmitting HIV, to avoid contracting TB from their patients, and how to keep health records. In turn, the MOH recognises the healers' competencies and works with them to track and refer patients, especially those on ARVs and DOTS therapies.

14. A. Haines et al., Achieving Child Survival Goals: Potential Contribution of Community Health Workers. The Lancet, Published online, March 6, 2007 (www.thelancet.com)

by uncertainty and political and economic fragility. This vision must move beyond the vocabulary of the past – “health sector reform”, “manpower planning” or “health for all”.

In formulating this vision, African health professionals (doctors, nurses, dentists, pharmacists) and the client communities must be engaged, along with the next generation of youth whose potential future careers in the health sector will be affected. The future vision must include multiple actors working together, including government, civil society (NGOs, FBOs, and CBOs, etc.), as well as traditional health care providers and the private sector. A new approach to and level of community participation is needed, so that communities are not just used as sources of information and data collection, but are fully integrated in planning, implementation and evaluation of programmes. Radical reforms and new innovations, including the scaling up of best practices, are needed. These innovations may include the development of entirely new cadres of briefly trained, modestly salaried, community-based health workers.

Catalysing a community movement for better health in Africa through enhanced partnerships with civil society and through capacity building in communities to increase demand for quality and efficient service delivery would strengthen the health system, and enhance participation and accountability. AMREF will contribute to this process by strengthening the capacity of different actors within the health system to understand, monitor and respond to disparities in health status at the community level. The Foundation will bring its 50 years of experience to bear on strengthening health systems – and helping to close the gap between communities and the rest of the health system. Opportunities for AMREF’s programming lie in the generation and use of information, capacity building and advocacy for the promotion of best practices affecting gap issues. AMREF’s actions over the next ten years will begin to chart a path for the longer-term realignment of social investments for building people and institutions for better health, and will focus on building that sorely needed African leadership.

At the same time, AMREF recognises that building a human and institutional infrastructure for good health is not a “quick fix” but a long-term challenge. Achieving the UN Millennium Development Goals by 2015 will require sustained social investments in human resources. Actions need to be undertaken by governments, educational institutions, and international agencies, including private foundations and international, regional and national NGOs. African leadership and ownership are essential, but international responsibility is also important to navigate an increasingly global world. Localising the MDGs would be a step in the right direction. Longer-term financing as opposed to short-term project support will be vital to facilitate this search for solutions.

The Strategy

Introduction

AMREF's strategy for 2007-2017 is designed to build on its strategy of the last five years with added emphasis on community empowerment and engagement in the health system. We aim to create a revitalised culture in the African health care arena, such that communities become an integral partner in a vibrant health care system, and where especially the poor and marginalised can achieve their full health potential, as is their right. By making communities the fundamental organising principle of the health system, individual/ community access to and use of health care opportunities should be less constrained by their circumstances, such as socio-economic status, gender, or geographic distance.

With this strategy AMREF will actively facilitate the engagement of communities in their health care, from planning through to implementation and evaluation of prevention activities and service delivery. AMREF will also strengthen the capacity of health systems to understand, monitor and respond to disparities in health status at community level, and will, with our partners, develop, test and scale up equity-enhancing interventions that improve people's access to and use of health services.

We recognise that there are many policies and practices that contribute to the gap between African communities and the rest of the health system, and that AMREF does not have the capacity or the resources to deal with all of them. We also recognise that poverty and gender inequities, especially the failure of men to contribute to the health of their families, exacerbates the gap. Therefore we will focus on AMREF's comparative advantage and make appropriate programmatic choices. We will supplement, support and strengthen efforts made by communities, governments, and civil society to strengthen health systems.

During its 50-year history, AMREF has established its reputation as a provider of quality health service delivery. In this strategy period, AMREF will continue to support service delivery (increasingly through local partners), but it will not be an end in itself. Knowledge will be a core product of our strategy. AMREF will learn from and use this knowledge and practical on-the-ground experience to test new models and share knowledge of what works and why, in order to have greater impact on policy and practice across the continent.

Goal Statement

To advance Africa's health by catalysing an evidence-based movement aimed at reducing the gap between communities and the rest of the health system.

Programme Drivers

Forging the link between communities and the rest of the health system demands holistic, integrated and cross-cutting approaches, driven by the needs of the community. However AMREF is well aware that much of its funding will continue to come through programmes that are disease-based, and that the internal and external pressures to revert to purely disease-based interventions will be compelling. To counteract these pressures and ensure that AMREF acts in a holistic way, we will use a series of programme drivers that are cross-cutting and process-based, and reflect our core values. Programme drivers will operate on two levels: 1) overall cross-cutting drivers for all programme themes; and 2) specific drivers listed under each programme theme below. Every intervention, and especially those funded by vertically driven programmes, will be expected to respond to the programme drivers. In this way AMREF will ensure that it remains focused on its strategy goal.

Overall Programme Drivers: In implementing the programme themes of this strategy, AMREF and its partners will ensure that:

- health interventions and projects are pro-poor (identify the people most in need) and are accountable to the people they serve
- culture, including customs, beliefs and behaviour is taken into account in our interventions, especially those that have a bearing on health at the community level and that may affect disparities in health access
- gender is mainstreamed in all activities
- pertinent information is communicated within the system in such a way that disparities and changes in health status can be monitored and the appropriate responses taken
- health systems have the capacity to respond and to evolve
- all stakeholders strengthen and contribute to the health system

Programme Themes

Informed by the African health crisis, AMREF's comparative advantage and five decades of experience working with communities and health systems in the region, the AMREF strategy will be pursued through three interdependent programme themes. These themes respond to specific core issues that create and sustain the gap:

1. Partnerships with Communities for Better Health
2. Building Capacity for Strengthened Communities and Health System Responsiveness
3. Health Systems Research for Policy and Practice

1. Partnerships with Communities for Better Health

This programme theme is grounded in health as a human right. For health systems to better meet the needs of the poor, they must place people and communities at the centre, ensure wider access to indigenous knowledge, promote enlightened leadership and develop partnerships with like-minded organisations.

With disease-oriented programming, most poor and disadvantaged communities in Africa have become largely isolated, non-participants in the delivery of their own health care or in policy formulation that affects their health. Low participation of African communities in the governance of the affairs that concern their health has also meant that there is little community voice in how national resources are deployed and used.

Strategic Objective: To create community movements and organisations that will ensure that communities are an integral part of a responsive health system, and to harness community resources for improved health service delivery.

Specific Programme Drivers: All interventions within this theme will generate knowledge relevant to at least one of the following:

- the creation of more powerful organisational forms such as partnerships, networks, advocacy forums and public-private - community partnerships as vehicles for change
- community participation and ownership
- increasing male involvement in ensuring the protection of the right to good health, and in promoting the improvement of the health status of women, children and adolescents

Entry Points: Marginalisation, vulnerability and the risk to health underpin this programme theme. Children, young people, women of reproductive age, and the workforce in poor rural, urban, and emergency settings are most marginalised and vulnerable to health problems and need to be recognised as actors in the system. With health promotion and prevention as an overarching agenda to bring about behaviour change and promote conditions that enhance good health, this programme theme will focus on the following groups:

Children under five years old: In addressing the determinants of health in children under five years, AMREF will consider access to health care and the processes that affect:

- prevention and integrated management of common childhood illnesses at the household and primary health care levels: malaria, acute respiratory infections, acute diarrhoeal diseases, immunisable diseases and childhood nutrition
- prevention, early diagnosis and treatment of malaria in children including equitable access to long-lasting insecticide treated nets (LLIN) and malaria diagnostics
- prevention of mother-to-child transmission of HIV
- enhancing care and treatment of AIDS and TB in children, including HIV and TB diagnostics and paediatric drug formulations
- promotion of personal and food hygiene, clean water and basic sanitation at the household level as a means of preventing childhood illnesses

Pre-adolescents, adolescents and youth (5 to 24 years): In addressing the determinants of health among pre-adolescents, adolescents and youth, AMREF will consider:

- giving pre-adolescents, adolescents and youth a voice in the development of appropriate health care provided in a friendly way.

- prevention, care and treatment of HIV and AIDS through health promotion, youth- friendly HIV testing and counselling, antiretroviral therapy and management of opportunistic infections including, TB
- promotion of sexual and reproductive health, including psychosocial life skills, substance abuse prevention and education on sexuality and family life
- protection against gender-based violence
- promotion of personal and food hygiene, clean water and basic sanitation in households and institutions such as schools
- promotion of children and youth as change agents

Women of reproductive age: The AMREF community health response to improve maternal health will consider:

- protection of reproductive rights, including promotion of informed choice and protection against gender-based violence
- prevention, care and treatment of HIV and AIDS through health promotion, HIV testing and counselling, antiretroviral therapy and management of opportunistic infections, including TB and sexually transmitted infections
- promoting access to and utilisation of reproductive health services for safe motherhood, including family planning, safe obstetric care and the management of complications of pregnancy
- prevention and management of malaria in pregnancy
- promotion of maternal nutrition
- promotion of personal and food hygiene, basic sanitation, improved access to clean water as determinants of maternal health

The workforce: The AMREF community health focus on the workforce will consider:

- supporting the links between workplace programmes and communities
- prevention, care and treatment of HIV and AIDS through health promotion, HIV testing and counselling, antiretroviral therapy and management of opportunistic infections, including TB and sexually transmitted infections
- prevention, care and treatment of malaria in the workplace through health promotion
- promotion of personal and worksite hygiene and safety to prevent infections and injuries

Anticipated Outcomes:

Community – Health System Partnerships

- the creation of a growing coalition of influential, like-minded organisations, including community partnerships, networks, advocacy forums as well as public-private-community partnerships as vehicles for change
- national policies that recognise community structures and institutions as integral to health improvement for communities
- health systems that effectively include community structures and institutions in health improvement processes
- health systems that respond to the health problems and needs of their communities

Harnessing Existing Community Resources

- communities that are capable of identifying their own strengths and weaknesses, health needs and threats
- community participation in, and “ownership” of, health care planning and services
- communities that demand and use quality health services

2. Building Capacity for Strengthened Communities and Health System Responsiveness

Capacity building is the process by which individuals, groups, communities and organisations increase their ability to perform core functions. For both the formal and informal sectors of the health system, the priority areas AMREF will address are:

- improving health management information systems (HMIS) at community level and their links to existing MOH systems
- human resource development, including improving the skills of health care workers, especially community health workers and other community members
- organisational development in health-related organisations, including development of institutional and legal frameworks

Strategic Objective: To enhance the organisational and technical capacity of health systems and CSOs to improve quality of care and respond to community health needs.

Specific Programme Drivers: Eventually all of the programme drivers will have an impact on the capacity building theme, but knowledge generation in the following areas is considered particularly critical:

- essential skills required for the management and delivery of quality health services that meet the needs of women, men, children and adolescents
- systems and tools that facilitate the delivery of equitable and effective health services
- organisational capacity that improves access and quality of service, and facilitates partnership with communities in the delivery of equitable and efficient health services

Entry Points:

- MOHs
- Communities/CSOs and health actors that influence health provision at the community level, including
- planners, policy makers,
- implementers and providers,
- trainers/supervisors
- training institutions and other facilities

Anticipated Outcomes:

HMIS

- the development and testing of community-based HMIS and their links to other health planning systems
- community health systems that are more effectively capturing and using available information/evidence
- the adoption and use of pro-poor community-based health planning, resource allocation and monitoring by ministries of health

Improved Quality of Care, Efficiency

- the capacity of managers and service providers at the peripheral level of the health system strengthened to promote service efficiency and quality
- skills improvement for diagnosis, treatment and specialised care at the peripheral end of health systems
- knowledge that will encourage policies and practices to promote improved quality of care by all categories of health providers

- strengthened community structures and systems for care and support of orphans and other vulnerable children
- increased, more formalised use of trained community-based health care workers and traditional service providers

Human Resource Deployment

- strengthening peripheral laboratory services
- the development and testing of new approaches for the rational development and deployment of human resources and health technologies
- improved technical and management skills applied to the health needs of communities
- strengthened health governance in CSOs, CBOs, DHMTs and FBOs

3. Health Systems Research for Policy and Practice

The need to strengthen research for influencing policy and practice is increasingly evident as health systems struggle to adequately respond to public health challenges. Many best practices exist within communities, but few resources are dedicated to developing the mechanisms to replicate them and bring them to scale.

Making health systems responsive to community health needs and priorities and redressing the disproportionate burden of disease and emerging health threats affecting the poor are contingent upon generating a framework for community health interventions based upon new knowledge and pragmatic policy options. Support for health systems research and policy analysis can effectively harness community-based health information and build community and professional competencies that counter health system failures and disconnects.

Strategic Objective: To generate and communicate the evidence for effective policy and practice that will have a positive impact on the interface between communities and the rest of the health system, and to advocate the adoption and scale-up of best practices.

Specific Programme Drivers: This programme theme will generate knowledge addressing issues raised through the other two thematic areas and relevant to at least one of the following:

- health system improvements that can lead to closing the gap
- culturally sensitive health planning and programming
- health systems that take an integrated approach to health with special emphasis on public health and a shift away from purely disease-driven vertical programming
- processes that encourage pro-poor health planning and financing

Research Agenda: In this strategy period AMREF and a wide range of partners will use operational and evaluative research and policy analysis to generate credible evidence related to closing the gap between communities and the rest of the health system. To this end, AMREF's research will focus on:

- the importance of community participation in effective and efficient health services – from health promotion to prevention to care
- the role, engagement and integration of community health workers and civil society in the health system
- interventions that contribute to improving health worker competencies and retention
- innovative, integrated health programming at community level
- approaches for organisational transformation for better health

As this research continues, AMREF will work with national governments and development partners at all levels to review/develop, track and use community-driven health indicators in health system planning. At the same time we will identify a body of African community-based best practices that can be translated into scaled up action.

Within this broad research agenda, we have developed the following research questions, which will be under continual review. AMREF is cognisant of the fact that there are, and will be, new and emerging health challenges on the continent, and we will prime our research programme to be prepared to evaluate these in the context of this strategy.

Research Questions:

1. What are the quantitative and qualitative indicators of the gap that can be developed to inform policy options and programme choices?
2. What is the evidence that engaging with community organisations and networks to enhance civil society participation in health systems will contribute to closing the gap, and what are the implications for policy and practice?
3. What information do people require to pro-actively manage their own health?
4. What are the equity- (social, economic, cultural) and gender-based barriers that prevent access to quality health care, and what are the community-based solutions?
5. What are the barriers that prevent the integration of community health workers into the health system and how can these barriers be overcome?
6. What is the optimum ratio (numbers against population) for community health workers in sub-Saharan Africa?
7. Where are the opportunities to improve the role and performance of community health workers (including issues of equity, recruitment and retention)?
8. What are the best practices for community-based referral systems and their links to the formal sector?
9. What are the options for retooling the skills of health professionals in the formal sector and enhancing their performance and job satisfaction in delivering quality health care at the peripheral end of the health system?
10. What are the key components of a community-based health information system and how can they be linked to district and national HMIS?
11. What components of current disease surveillance systems should be extended beyond health facilities and applied at community level?
12. How can the health system take a more integrated approach to managing the disease burden in communities?
13. What is the impact of the unregulated, informal private sector on the health of poor communities, and what are the lessons for health policy and practice?
14. How can information communication technologies (ICT) and other appropriate technologies contribute to improving health outcomes in vulnerable communities?
15. What are the key components of a strong community-based health-financing model that will help to close the gap?
16. What is the state of community health in Africa (e.g., tracking expenditures, quality of care, relevance of programming accessibility and utilisation of services, and community and civil society participation in health service delivery)?

Anticipated Outcomes:

Generating the answers to the research questions above will contribute to a better understanding of the causes of the gap between communities and the rest of the health system. AMREF also expects to be able to identify and document evidence of policies and practices that have had a positive impact on closing the gap.

Communicating the evidence to influence change is the ultimate outcome of this research theme. To provoke a reduction in policy gaps and the scaling up of best practices, AMREF, working with relevant government ministries, development agencies, the OECD and other strategic partners, will use the evidence arising from our research to:

- identify critical issues
- coordinate responses to influence positive changes in community health care

Risk Analysis and Mitigation

We have considered the likely risks facing AMREF as we implement this strategy and have developed a set of actions to mitigate them. The implementation plan will provide more detail; here we refer to the six major risks that AMREF has identified.

Risk	Mitigation
AMREF is unable to fund the new strategy – both for institutional development and for programmes.	<ul style="list-style-type: none"> • Recruit a senior fundraiser to develop fundraising strategy and plan with targets • Expand AMREF's capacity for writing high quality proposals • Dialogue with key donors on health issues facing Africa and on the relevance of the AMREF strategy • Strengthen the interactions between AMREF and national offices to ensure a unified approach to strategy, proposal development and fundraising • Ensure and maintain cost effectiveness across AMREF
Can we effect change in health systems whilst working through partners?	<ul style="list-style-type: none"> • Selection of partners will be critical: need clear criteria including very clear indicators of success • Involve partners in design and planning • AMREF will provide processes, supervision, coordination, facilitation and quality assurance
For the strategy to work all AMREF staff must buy into the strategy and work together.	<ul style="list-style-type: none"> • Implementation of the strategy must be a constant item on the senior management team agenda • Effective information sharing and communication • Review all job descriptions, roles and responsibilities across AMREF and adjust the appraisal system to ensure consistency with the strategy
Failure to manage AMREF's information and knowledge will jeopardise the strategy.	<ul style="list-style-type: none"> • Embed knowledge management in project plans, including time and money to carry out necessary tasks • Build staff capacity for knowledge capture and management • Make documentation part of performance management and job descriptions
Failure to influence governments and donors will be an obstacle to success.	<ul style="list-style-type: none"> • AMREF will use existing participation in government annual reviews and planning processes to discuss emerging evidence • AMREF will ensure it is represented by the right people and that senior AMREF staff deliver difficult messages • Use reliable and well-documented evidence and communicate effectively • Continuous relationship building with MOHs and other partners
Changes in government and donor agendas/policies may threaten the relevance of the strategy.	<ul style="list-style-type: none"> • Need to monitor external environment on an ongoing basis and regroup if necessary – this will be a living strategy • Seek to influence governments and donors about the priority of strengthening health systems

Chapter 5:

Implementation Mechanisms, Monitoring and Evaluation

In carrying forward AMREF's strategy for 2007–2017, we will review our existing implementation system and structures and modify and incorporate them as appropriate.

Implementation Mechanisms

The implementation mechanisms that AMREF will employ cross cut the three programme themes of this strategy and are described below:

Community-based Problem Solving

Community participation is the process of involving communities in setting health priorities, and in planning, implementing and evaluating interventions and activities. The process itself is empowering and builds competencies and confidence in those involved. It is also a mechanism for mobilising human and material resources at local level for health development efforts. The process entails a truly democratic dialogue with communities where not only is community involvement a right, but is also part of the broader social development and realisation of human potential. Working together with the informal sector and communities in true partnership will be a new challenge for many health workers in the formal sector, donors and academic institutions. This challenge will be new to the communities too.

Innovative Institutional Arrangements

AMREF recognises that engaging with civil society at the programme level provides a number of advantages. Local and district level CSOs work at the grassroots, close to communities, and are thus well placed to offer insight on the ground. They have a wealth of experience from which much can be learned and are better placed than formal sector actors to work directly with, and provide services to, the community. They can help identify and give a voice to community needs and are an important resource for health promotion. Working with them facilitates community-based planning, joint identification and efficient utilisation of resources and allows for more focused, effective and responsive interventions.

CSOs also represent important partners for local level advocacy. And, at national and international levels, partnerships with CSOs provide important opportunities for creating alliances that speak with one voice and so provide a more effective means to influence agendas. AMREF will work locally, nationally and within Africa to raise awareness of the importance of civil society in promoting health improvement for all. Working with CSOs in consortia with specialised NGOs enables a complementary mix of skills and experience.

Networking

Networking is a key feature of this strategy and will be promoted at all levels. The focus will be on strengthening cooperation among ministries of health, NGOs, civil society, training institutions in Africa and AMREF. Efforts will be made to selectively explore collaborative and mutually beneficial arrangements with northern institutions, and existing collaborative arrangements will be reviewed to enhance the equity dimension of such initiatives.

Service Delivery

AMREF shall not engage in service delivery for its own sake, but as a mechanism for testing service delivery models that enhance effectiveness, efficiency, quality and accountability at the community level. Service delivery will also be used to strengthen the participation of communities in health systems, to test quality assurance mechanisms and to build the capacity of service providers within district health teams, the informal health sector and communities. Service delivery without the opportunity to learn will not be part of this strategy.

Technical Assistance

AMREF will build managerial and technical capacity of health development CSOs to enable them to more effectively take on their roles and responsibilities and transfer skills to communities. This entails strengthening the capacity of CSOs to establish and govern themselves, develop effective programmes, gain access to sustainable resources and adopt best practices. AMREF will also assist CSOs to carry out needs assessments, baseline surveys, and the design, implementation, and M&E of interventions, as well as to maintain HMIS systems that link to the formal health sector. AMREF, as appropriate, will act as their representative voice and help them become more effective advocates for change. We will also use technical assistance to CSOs as a mechanism to create a group of like-minded organisations that share AMREF's commitment to strengthening health systems.

AMREF will work with governments, CSOs and communities to build their capacities to make the transition from curative-centred programming to preventive care, health education and the promotion of good health. AMREF will place special emphasis on those activities that link communities to the district level of health care. We will continue to promote the provision of technical support from within Africa for community health and scale up models that reduce the gap between communities and the rest of the health system.

Training

Training is one of the AMREF's strengths and will be a key element of this strategy. AMREF will use training as a tool for disseminating health information and for sharing knowledge and skills. Continuing and distance learning will be a core element, and new training methods, for example using information technology, will be pursued. It is anticipated that AMREF's training programmes will be extended to other sites and countries through e-learning and strategic partnerships during this strategy period. Opportunities will be explored for using e-learning in existing AMREF courses such as the Diploma in Community Health.

Research and Knowledge Management

AMREF will continue to facilitate the development of innovative models for community participation in the improvement of their health, as well as the documentation and dissemination of lessons from successful case studies. AMREF will work with CSOs to enable them to contribute to setting the research agenda, and to unleash the underused human resource potential within communities to carry out research themselves. Together with others AMREF will use evidence of the need for change, and will encourage and support the scaling up of successful models particularly those that have been shown to enhance community-based service efficiency and those that will promote closing the gap.

Operations research activities will be built into all programmes to ensure the continued collection of vital information and for strengthening M&E. AMREF will continue to collaborate with other institutions to ensure the continued production of high quality research in relevant areas of this strategy. This strategy places a premium on health systems and policy research. Documentation, publication and dissemination of findings and lessons learned will be enhanced. Emphasis will also be placed on sharing of experiential learning, on the exchange of ideas and on fostering dialogue in the region.

Evidence-based Advocacy

This strategy will integrate our project level experiences and research and use the resulting evidence base to influence policy and practice regarding issues affecting the gap between communities and the rest of the health system. Our work to influence policy and decision makers will involve all of AMREF; through our national offices in Europe and North America, AMREF has a special opportunity to take African evidence and an African voice to policy and decision makers in the north.

Our evidence-based advocacy initiatives will make use of rigorously vetted information, and a coordinated plan for communication, building an environment conducive to supporting intended changes to policy and/or practice. A successful evidence-based

advocacy campaign takes time to design and implement, and consequently AMREF will manage a limited number of campaigns at any one time.

Grant Making

AMREF uses grant making alongside a commitment to strengthen the governance and management skills of recipient CBOs and NGOs. AMREF has systems in place to support grant making for issues that fall within AMREF's overall strategy. This strategy element will depend on resources availability.

Monitoring and Evaluation (M&E)

To ensure that the strategy goals and objectives are monitored and evaluated over the next 10 years, a full M&E plan will be developed and modified over time as required. Existing quantitative and qualitative indicators will be adapted as appropriate, and others will be developed and defined for both the successful implementation of the strategy as a whole and for specific outcomes that contribute to realising the strategy goal. Milestones will be set at yearly intervals along with end-of-project targets.

There will be a central reporting point at AMREF for M&E, and together with its partners AMREF will determine responsibilities for monitoring and reporting on each indicator. Baseline surveys will be carried out as necessary, and data sources, collection methods and schedules will be determined for both outcome and output levels. Limitations regarding data collection and analysis will be identified from the outset and mitigated as much as possible.

Organisational Arrangements

During the past four years AMREF has made substantial progress in revitalising its programmes through organisational strengthening activities, developed as a result of AMREF's desire to deliver cutting edge health development initiatives. Through this process, AMREF has gained:

- improved technical leadership
- a sharper focus in existing programmes based on simple assessments of our comparative advantage
- a consistent approach to programme and project management
- an increased focus on supporting the smaller country programmes in Ethiopia and South Africa (and the decision to temporarily withdraw from Mozambique)
- strengthened proposal development
- a greater capacity for communicating about AMREF to external audiences
- improved HR management (including an internal HIV staff policy)

This organisational strengthening has contributed to a doubling of the financial support for AMREF's programme and project portfolio over the past four years.

Governance

The Board ensures that AMREF is managed according to the strategy and policies approved by the Board. This encompasses its mission, its financial and human resource management, and takes into account the global framework within which AMREF operates. An important secondary role of the Board is to support management in fulfilling AMREF's role as a service provider, as a knowledge-based advocacy organisation and as a conduit for public and private funding.

The International Forum

AMREF and the national offices that make up the International Forum have recently taken the important decision that all are part of one AMREF. This decision will have implications for programming and joint activities during this ten-year strategy period. The alliance between AMREF and the national offices has been crucial to the development of AMREF during the past 50 years. During the strategy period there will be four shared roles:

- building awareness of AMREF and of Africa's health agenda
- working with existing and new donors to increase AMREF's funding base and the amounts of restricted and unrestricted funding flowing to AMREF
- jointly developing and using shared information systems for programme planning, financing and reporting
- taking Africa's voice for health to the capitals of the north through jointly planned lobbying and evidence-based advocacy

The International Forum is represented on the AMREF Board by its Chair.

Programme Planning

AMREF works through senior management teams at the institutional level and in each country programme. These teams provide a flow of management issues and decisions through the organisation. AMREF organises Annual Programme Meetings each year that bring together middle and senior managers in country programmes and at the institutional level. The link between programme management and the Board is through the Board's Health Programme Committee.

Programme Management

AMREF has a new programme and project management system that encourages staff to take responsibility for specific tasks in a standardised manner across the organisation.

This includes:

- the design, funding, implementation and monitoring of projects that support AMREF's mission and strategy
- establishing decision-making boundaries
- ensuring more efficient capture and dissemination of knowledge

The system provides the backbone for AMREF management, providing links to:

- performance management
- organisational capacity development
- organisational knowledge management (including the systems to capture and manipulate that knowledge)

AMREF is also reviewing and rationalising its institutional monitoring and evaluation framework and plan against the evolving strategy.

Tracking Progress

The external environment in Africa and in each country programme will be monitored through the life of this strategy to ensure that the document and AMREF's programme remain relevant to the needs of Africa and its people.

Financial Systems

AMREF has a comprehensive financial management system that tracks income and expenditure across the organisation and has links to procurement and inventories of stores and capital assets. A Finance Manual supports the management of AMREF's financial assets. The AMREF internal audit group (which reports to the Board's Audit and Finance Committee) uses a risk-based audit approach. AMREF's finances are audited every year by an internationally recognised audit firm. Its annual accounts are published.

Human Resource Systems

AMREF has an institutional HR group linked to HR capacity in all country programmes. HR management is directed by a Board-approved HR manual, and is supported by the Board's HR Committee.

Information Technology

AMREF has a dedicated IT function that supports email and Internet services throughout the organisation. Furthermore, the IT team spearheads the development of databases at both the organisational and programme levels and participates in the design and use of new ICT tools and methods in health improvement.

AMREF Country Programme Strategies

This institutional strategy provides the framework for the development of country programme strategies. Each country programme strategy will pay special attention to its country context but will operate within the programme boundaries outlined in the institutional strategy. Advisory councils in each country (an advisory board in South Africa) assist in setting priorities, identifying opportunities and monitoring programmes.

Communications and the AMREF Brand

AMREF provides a flow of information to national offices and its partners to support fund raising. A comprehensive and user friendly web site, presently receiving over one million hits every month, supports this information flow. The Board's Fundraising and Communications Committee also supports AMREF's communication efforts.

AMREF has re-evaluated its brand and developed a common position. A brand book is available, and the organisation is now well placed to speak with one voice about AMREF. We have agreed that AMREF is an international African health development organisation and that all parts of AMREF, including our country programmes in Africa and our national offices in Europe and North America, are part of one organisation. During the next ten years AMREF will work to maintain clarity in its brand and use the power of its brand to foster the work of the organisation.

Financing

During the past five years AMREF's total expenditure has grown from \$19.4 million to \$58 million. This growth has come from a substantial increase in our project income. AMREF is receiving more grant money and larger grants. This is a result of a deliberate policy to target bigger grants with longer lives and so make grant reporting more time and cost effective. We will continue this policy.

Unrestricted funding supports AMREF's institutional development, much of our internal technical leadership, our capacity for research and our outreach to external audiences. The full implementation of this strategy over the ten-year period will require \$40.3 million of unrestricted funding to develop and maintain the necessary core institutional competencies. Since AMREF's unrestricted funding base has always been fragile, we have developed a ten-year plan for unrestricted funding. We will pursue five options to increase the amount and security of unrestricted income, including:

- increasing the programme portfolio and thereby increasing the total amount of overhead recovery
- Seeking new donors willing to grant the organisation unrestricted funds; these donors will likely be government agencies, individuals with personal wealth, foundations and corporations
- investigating novel ways of raising funds; for example, AMREF is currently exploring web-based giving
- building an endowment fund and using it as a source of unrestricted funds
- making use of fee income from a consultancy arm of the organisation

The Board's Fundraising and Communications Committee will support AMREF's new fundraising activities.

Geographic Footprint

AMREF is often asked for our opinion on health issues affecting Africa, and we are increasingly an “African voice for health”. In order for AMREF to strengthen its African voice we must have a presence beyond our existing “heartland” of East Africa, the horn of Africa and South Africa. AMREF will therefore re-examine its geographic footprint during the coming ten-year period.

The politics of health development are such that AMREF will not have a credible voice without some form of presence in the sub-regions where we are currently not working. Addressing this situation involves ensuring quality where AMREF already works and finding cost-effective ways to extend AMREF’s footprint within Africa.

In moving forward AMREF will explore:

- developing strategic alliances, often involving technical assistance, to create a group of like-minded organisations willing to work together and ultimately to share management and technical capacities
- extending AMREF’s training programme with partners in new countries willing to provide facilities and staff to deliver AMREF training programmes
- creating regional hubs in the horn of Africa, southern Africa and West Africa

AMREF currently has no physical presence in West Africa, and the first priority for this hub will be to pursue partnerships with governments and health institutions in the region. The regional hub for West Africa will initially cover both Francophone and Anglophone countries. AMREF will also use strategic partnerships and alliances to host the regional hubs to avoid the massive up-front expenditure required for new country programmes. These partnerships will provide AMREF with a cost-effective and flexible mechanism for responding to new country programme opportunities.

In East Africa, where our country programmes are mature with established infrastructure and programme portfolios, a regional hub will not be created. However, opportunities for the sharing of core resources and competencies among the three country programmes in Kenya, Tanzania and Uganda will be explored.

Conclusion

Implicit in AMREF's strategy for 2007-2017 is the belief that communities should be seen as the organising principle of health systems. Currently, however, a gap exists that separates marginalised and vulnerable communities from the rest of the health system. This gap prevents the integration of these communities into the system and exacerbates disparities in health care, weakening health promotion and disease prevention. To help overcome these disparities and close the gap, AMREF's new strategy places the needs of communities first in all of its programming initiatives.

Specifically, AMREF's strategy goal is to "advance Africa's health by catalysing an evidence-based movement aimed at reducing the gap between communities and the rest of the health system". The cross-cutting, process-oriented programme drivers that have been developed for this strategy will ensure that AMREF acts in a holistic and integrated manner and focuses on community needs. Every intervention, and especially those funded by vertically driven programmes will be expected to respond to the programme drivers (e.g., pro-poor, culturally and gender sensitive, among others). In this way AMREF will ensure that it remains focused on its strategy goal.

Informing the selection of the three themes for this strategy are: the African health crisis, AMREF's comparative advantage, and five decades of AMREF's experience working with communities and health systems in the region. The three interdependent themes have been selected to respond to specific core issues that create and sustain the gap:

- Partnerships with Communities for Better Health
- Building Capacity for Strengthened Communities and Health System Responsiveness
- Health Systems Research for Policy and Practice

Moving through the next 10 years, AMREF will continuously monitor its interventions and evaluate progress. For our full implementation, monitoring and evaluation plan we have developed a companion document to this strategy. As we gather knowledge and evidence in our programme work and research, we will develop advocacy initiatives to influence policy makers to promote identified best practices.

Working in collaboration with our partners, AMREF intends to keep the issue of closing the gap between vulnerable communities and health systems at the forefront of the development agenda for improving African health.

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