Objective:

Right to essential services

Mother to Mother groups meet in Narok West, Kenya, to champion the use of healthcare facilities

Right to essential services

We help people to access services that are essential for healthy lives, using a holistic approach to programming. We strengthen health services; we improve health governance, making services accountable to the people they serve; and we tackle unequal gender and social norms that are harmful to health and wellbeing.

What we want to achieve:

- Improved accountable governance and increased financial commitment for good-quality essential services that ensure equitable and inclusive access, quality service provision and community participation, and a global system that supports this.
- The most vulnerable and marginalised people, in particular women and girls and those most likely to be left behind, are able to access quality health services.
- Communities have increased capacity to anticipate, adapt and organise to prepare for and respond to health challenges.

Highlights

We are implementing health programmes in eight African countries, Myanmar, and Central America. Over the past year we have seen improvements in reproductive, maternal and child health in Kenya, Malawi and Nigeria, progressive shifts in social norms in Kenya and strengthened resilience in the face of health-related emergencies in Sierra Leone and Ethiopia.

The Ellis-Hadwin health legacy project - launched in 2017 in five countries - is testing our health programming approach in Sierra Leone, South Sudan and Burundi, while supporting the continuation of our holistic, integrated approaches in Kenya and Nigeria.

This year, we also commenced a five-year, USAID-funded project in Kenya that aims to reach 170,000 orphans and vulnerable children, from 52,000 households, who are affected by HIV/AIDS.

Improved health services for girls and women

With over £3m funding from the UK Government, our three-year UK Aid Match programme to improve the health of mothers and babies in **Kenya** and **Malawi** came to an end in 2018. Thanks to a combination of our own monitoring and external reports from partners and others, we know that 40,000 vulnerable pregnant women have had access to life-saving healthcare in Kenya and Malawi. For a second year running, the Department for International Development gave the project an A rating.

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In **Kenya** the community referral system in Isiolo County using frontline workers increased the utilisation of maternal and newborn health services as envisioned. Our internal learning exercise revealed a 36% rise in assisted deliveries at the end of the project in the areas where the referral system operated. We also saw advances in social norms in Isiolo. Through the work of our partner CREAW, the council of elders has made commitments to address harmful cultural practices such as female genital mutilation (FGM) and early marriages. For example, the Meru tribe chapter of the council of elders has outlawed FGM in their constitution. Overall, the project has reached close to 34,000 people in Isiolo.

Our three-year, UK Aid Match funded Partnership for Improved Child Health (PICH) project in **Nigeria** is working to reduce mortality among under-fives, targeting nearly 200,000 children. We are implementing an integrated community case management approach to improve nutrition and address three main causes of childhood illnesses: malaria, pneumonia and diarrhoea.

> The PICH project in Nigeria addresses childhood illness: health workers can now provide life-saving interventions to over 130,000 children under five

In the second year of the project, thanks to our partnership with two local organisations - Ohonyeta Caregivers and Jireh Doo Foundation - and local and national government bodies, we have evidence of increased access to healthcare after building the capacity of more than 1,130 health workers and selected community health volunteers and extension workers. They are now able to provide first- and second-line life-saving interventions to over 130,000 children under five (66% of the vulnerable populations of children under five), as recorded by our internal reporting. These interventions have contributed to a fall in child mortality and morbidity in Benue State, north-central Nigeria.

Community readiness and resilience

In **Sierra Leone**, we continued to strengthen community resilience and preparedness after the Ebola outbreak, through structures like mothers' support groups, village development committees and health facility workers. As a result, there is better coordination of health service delivery in terms of access and quality, ownership and maintenance of health facilities, as well as improved relationships between health workers and community members who visit the facilities. After improvements to 11 peripheral health units, monitoring data shows that attendance has increased by an average of 18% and satisfaction levels of community members by 72%.

In **Ethiopia**, external evaluation confirms that our three-year Preparedness and Early Response to Public Health Emergencies project in Gabella state has made significant changes. Thanks to our consortium approach with Amref Health Africa, the Ministry of Health and the National Meteorology Agency, by 2018 disease surveillance reporting had increased by nearly 60% over the project's lifespan, now the highest level in the country. The state laboratory's microbiology unit now has the capability to analyse specimens in-house, rather than sending them to the capital, which could reduce diagnosis time by at least two days. Communities are receiving better and faster service as a result of training close to 500 health workers and community health volunteers. Various community and government stakeholders are also working more closely as a result of our work.

Challenges and learning – strengthening our integrated approach to health

We have expanded our holistic approach to health, but not all country programmes have been able to adopt this approach, especially those in fragile settings and where the weakness of public health services is a challenge. We have also faced challenges in monitoring the impact of this integrated approach, for example with livelihoods and inclusive markets, to ensure resilience of the communities we work with, sustainability and long-term impact. We will improve these aspects at country programme and project levels over the next year.

We are researching ways to integrate interventions on non-communicable diseases into our health work. In Kenya, we are exploring the barriers faced by adolescent girls when accessing nutrition services; there and in Sierra Leone, we are researching how to engage with the private sector in our health work. These approaches will build our knowledge base and capacity of integrated health programmes, helping to ensure that programming is more fully grounded in evidence.