Interview with Desta Lakew and Dr. Rispah Walumbe (Amref Health Africa)

Lissa Harris

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Lissa Harris: Can you introduce yourselves and your organization, and talk about the problem that you're trying to solve? How are you trying to tackle it?

Desta Lakew: I'm Desta Lakew, and I am the group director for partnerships and external affairs for Amref Health Africa. Amref is the leading health development organization NGO headquartered in Africa. We serve about 35 million people across more than 40 countries. I'm based in the headquarters in Nairobi, Kenya. My role has been to onboard significant partners for the organization who will help us advance some of the key causes that we're working on.

We started out as Flying Doctors of Africa, where we would go out and find people who needed help and provide medical services. Over time, that's shifted to more work around capacity building, working with governments, and working in and with the communities that we serve. Our primary goal is to ensure that people in the last mile have access to first-level care. We deal with the social determinants of health.

Recently, we launched our new strategy, which addresses things that affect our ability to connect people to first-level care, like the impact of climate on health and health system strengthening. We're largely focused on health system strengthening and addressing the social determinants of health that prevent people from accessing healthcare or health services. We also deal with specific verticals like RMNCH [Reproductive, Maternal, Newborn, and Child Health], women's health, water sanitation, NCDs [non-communicable diseases], and communicable diseases. Our work is premised on the belief that everyone has a right to access healthcare and on the principle of universal health coverage. We work to ensure that healthcare is available to everyone here on the Sub-Saharan African continent. Let me turn it over to Rispah.

Dr. Rispah Walumbe: Thanks, Desta. The only thing I would add is that we have always known the importance of universal health coverage, but one of the things that we've learned, working with

communities for almost 70 years, is that primary healthcare is at the foundation of achieving universal health coverage. Primary healthcare emerges as a really important part of our new strategy, and in order to accelerate work in primary healthcare, we have weaved our ability to be a thought leader in the space, especially on the continent, with our technical capabilities and prowess. We've also collaborated with other people in the space, particularly those who are the duty bearers, the policymakers, the people who influence what happens on the ground when it comes to communities and the outcomes we see in communities.

Amref is looking at achieving these big goals of lasting health change in Africa by being a thought leader, being a technical leader, and collaborating with different partners and different policymakers at the regional level, at the global level, and also at the national level, throughout our country offices.

Lissa Harris: How much of your work is direct service, and who are you serving most directly? Is it NGOs, or governments? Who benefits from your work and how?

Dr. Rispah Walumbe: One thing that has been at the heart of Amref is our focus on communities and people. All our work is geared towards that because we've found that over the years, people have created systems that don't necessarily respond to what people actually need. Instead, they just focus on curing diseases. What we are working on, and have been working on, is figuring out what a people-centered healthcare system actually means, then translating that into something tangible, whether it's through shifting our service delivery models, providing direct service delivery, or policy creation. A lot of it is focusing on community participation and community engagement, and making sure that communities are leading the design of these systems we are looking to create, so they respond to the health system needs of the day.

Lissa Harris: How do you engage with communities and with people in communities? How do you approach that interaction?

Dr. Rispah Walumbe: We've done so in different ways. Desta alluded to how we started off as Flying Doctors, and now, we work in service delivery in some of our country offices, where we support medical services being delivered on the ground. Another way we work in communities is through the policymaking process. We work directly with communities to design programs and projects that are going to be sustained within the community.

[We also collaborate with] community health workers. Community health workers are very important to us, and we worked quite a bit with community health workers through the COVID-19 pandemic, when we were responsible for training human resources for health. Community health workers are a really important part of this work because they work directly within the communities and they understand exactly what communities need. We were responsible for

training and giving them the capacity to deliver, and we let them lead the way. We wanted to be a facilitator in the process.

There are many other ways that we work with communities and for communities. A lot of the work we do is at a policy level, where we engage with governments through technical assistance. We work alongside governments to co-create policies as an NGO, and as a civil society organization. We also work to build the capacity of other civil society organizations and community-based organizations because we know we cannot do it alone.

Partnership is critical, so we've supported a curriculum for civil society organizations. The example that comes to mind is that we host the Global Alliance for Vaccine Initiative, and we support the secretariat for the civil society team. One of the things we've been doing there is just making sure we are as responsive as possible. We're learning along the way, and being a civil society institution and advocating at different levels–global, local, regional, national–has really been about making sure that everyone in the ecosystem is working towards a specific goal.

Desta Lakew: Our approach has always been community-centric. Even the interventions that we do on the ground take that into account. Central to everything we do are the questions: Is the community involved? Is this what the community needs? Whether it's delivering service or working with partners, including governments, we put the community at the center of everything. For example, in Kenya, we're involved in figuring out what the universal healthcare package looks like, and whether it is serving the community's needs. We work at the center, where community and government meet.

A lot of it has to do with health system strengthening, and a lot of it has to do with human resources for health. Do we have the right human resource capacity? Are we reaching the last mile, and meeting the needs of those who are living at the farthest end of the spectrum? How do we make sure their needs are met? Is the government responsive to their needs? How do we deliver so that they can own the intervention? For example, if we build a borehole in a community, we're not going to come in, build a borehole, and leave, as many NGOs would do. Amref comes in and builds capacity within the community so the borehole remains active and functional even after we leave. We train the community. After we understand what the community needs, we develop an intervention with the community at the center of that intervention. Then, we focus on how we can move on and ensure they have the ability to continue where we left off. It's community ownership, and not only understanding what the community needs, but ensuring that everything they need is accounted for.

In Kenya, for example, the ruling recently came that community health workers would be paid. Most of them are women, and they're unpaid workers. They deliver at the last mile, and we can

utilize that network of community health workers to do a number of things, whether it's vaccine delivery, health interventions, or disease surveillance. We equip them, we train them, we put them out in the community where they come from, where they're known, and they become the tentacles that reach out and ensure the community is supported. If they need to advocate for specific things, the system is designed to respond to their needs and figure out the best way to help them achieve their objectives.

Lissa Harris: What makes your approach different and distinctive from other organizations that are working on similar problems or in a similar space?

Desta Lakew: We live here. Out of our 2,500-person staff, 98% are Africans—people who live in the community, who work in the community, who are part of the community. We are not a fly-in, fly-out agency. We live within the communities that we serve, so there's a vested interest, especially in the community health workers that we train, that their community is taken care of. We work at all levels of government to ensure that their voices are heard and that we are here all the time. If they need us, whatever that intervention might be, we are here. We also give them the tools they need to continue beyond our intervention.

Lissa Harris: Is there a particular example you can share, or a story that illustrates the impact of the work that you do in communities?

Desta Lakew: Yes. As we've had many epidemics and pandemics, we've trained our health workers on a mobile platform. That mobile platform has a chat functionality that allows the community health workers to communicate with others, like Amref team members and other community health workers. Recently, there was a Marburg outbreak in Tanzania. We found out because one of our community health workers discovered a household in which the inhabitants were being taken to the hospital and dying. This happened to a few people within that household, and she reported it. And in reporting it, the Ministry of Health in Tanzania was able to understand what it was and ensure very fast, rapid action to contain the Marburg epidemic.

It's [often a question of training our health workers to] know what they're looking for. We need people who can do surveillance for us, especially at the last mile. Even if it's informal, even if it's done on a mobile platform, if you're able to identify and report things that go wrong, things that you normally wouldn't see until something's blown up and becomes a systemic problem, [then you are an invaluable asset]. We train health workers, we equip them, and we link them to the Ministry of Health Information System.

We [also raise awareness in communities.] For instance, we have been working with the Africa CDC [Center for Disease Control] to deliver COVID vaccines to our communities and across Africa.

[Before we even get to the delivery, we work to] raise the awareness of the community. So it's first raising awareness and driving demand, and then actually delivering the vaccines.

We look at innovation in very different ways. Sometimes you think about innovation as a really sophisticated thing, but innovation in our context could be something very, very simple. It could be having camel caravans to deliver health services to migrants or communities that move across different geographies, where you might not be able to go in a vehicle. We also look at One Health models, which take into account that our communities, human beings, live and interact with animals and the environment. How do we make sure that when we call communities to get interventions, we're also looking at their animals, and at how the environment impacts them? We work to create solutions that look at the way people are living now, and rather than trying to shift that or modify that, we work within that context to deliver service.

We also have solar-powered mobile units in four countries where we can deliver emergency vaccines if there's a pandemic like COVID or anything else. Then, when that pandemic has subsided, those mobile units fit next to a health delivery unit, so [they become] a government-run facility. We work with governments to say, "What is the need? We have this migrant population, let's follow their route and ensure that wherever they are, we are able to deliver." Whether it's a camel or a mobile unit–which hitches to any SUV and is solar-powered–we can deliver. There is also telemedicine, so that if someone sees a situation, they can call in. We try to make health accessible at every level, and there are very few organizations that look at health delivery as holistically as we do.

Dr. Rispah Walumbe: Desta talked about our integration model, and we also have the Kimormor model. Within Kenya and in Turkana, which are semi-arid and very dry, we have a big migratory population. The Kimormor service was designed to make sure that when we get to people, we meet them where they are, whether it's a watering hole or a camp, and we meet their needs comprehensively.

My second point is about the policy process when it comes to the community health workers in Kenya. People generally look at the pronouncements that were made earlier this year around paying community health workers, but I look at the trajectory that led up to that point. I think that Amref was instrumental in advocating for community health workers to be renumerated. The process took several years and lots of advocacy. One of our staff members was instrumental in the process, writing some of these policies at a county level and a sub-national level, and writing some of the legal instruments that are now being used at the national level. These initiatives started at the community and sub-national levels then accelerated into policy and became law.

These things make such a huge impact, but it's not something that happens overnight. That's why the way Amref works is so important; we are in the community because we *are* the community, and we are there for the long haul. We work with the community and look at these issues as a long-term projection so they're sustainable. Whatever interventions we're looking at, they don't happen overnight, and they're not short-term. Whether it's in policy, or in legal instruments, it's for the long haul. Many other, similar benefits packages are being designed across the continent.

Desta Lakew: That's our regular work. I'd like to add that last year, for the first time, we attended COP27 [2022 United Nations Climate Change Conference] in Sharm El-Sheikh. We didn't know what we were getting into, and we just went because we are seeing so many climate-related weather incidents that are impacting our community. Our programs and country offices are continuously calling us at HQ and saying, "There's been a flood, there's a drought, people are dying." As a result waterborne and vector-borne diseases began increasing, along with cases of cholera. At Amref, we felt it was important to understand climate health a little better [to better address these issues.] So we went to Sharm El-Sheik, and what we found was that the climate discussions were largely around fossil fuels and pollution that were not the making of the African continent. Less than 4% of our emissions come from Africa.

When we realized that, we also realized that health was not part of the conversation in a significant way. The working groups like agriculture and environment may have had a small element of health to them, but they were not focused on it. We realized we need to put together the climate health agenda and push it ourselves, and to make sure that ministries of health, who were never involved in any climate discussions before, are involved moving forward because health is the human face of climate. We have a conference that we host every other year, and this year, climate was one of the key pillars of that conference. Then we got together and said, "Now, how do we amplify this in a way that we can make a difference?"

We pulled together the group Africa Negotiators for Climate and engaged them. We engaged ministries of health, we engaged other partners like civil society organizations, funding partners, and foundations, and said, " If we want to affect change for our continent, for our people, we need to have a common position." We developed that common position, galvanized action around it, brought it to the Africa Climate Summit in September, and then brought it to COP28. We were able to do that because our advocacy arm is strong, our policy arm is strong, and our technical capabilities and understanding are strong, so we are able to rally support.

We sat on the health day steering committee for COP28. Our group CEO became a health envoy for COP28, and we were able to include language about adaptation, building health systems, and resiliency, which is critical for our continent, and Southeast Asia and Latin America, as well. We focused on Africa, and said, "This language is very important to include." We see that adaptation,

and this language is already in the COP28 proceeding. We are now waiting for final dissemination. Surely millions is better than nothing, but millions are not billions, which is what we see on fossil fuels and those types of emissions.

We are bringing the key causes for poor health and poor health infrastructure, and the importance of building stronger policies, to the forefront. We have a voice, and it's a trusted voice, which is very important. We have a brand that is respected not only by regional bodies like Africa CDC, or WHO AFRO [World Health Organization African Region], but a voice that is respected within the community. They know they are at the heart of everything, and we have their interests in mind. That's one example of how you can take rapid action contributions to the continental agenda and place health at the center of climate discussions. There are not many organizations on this continent that can do that, and not many organizations that can speak on that. As an organization that's as large as we are, we need to have the agility to respond to crises as they come up.

Lissa Harris: How do you measure success? What is the evidence that you look for to see if you're making progress?

Desta Lakew: I would first ask: Have policies changed, or shifted? Is people's health improving in communities? Do people have access [to healthcare and services]? Those are all things that we can look at. We have a very robust monitoring and evaluation platform so we can follow how many women, children, and health workers have been trained, what they've been trained in, and what issues we have affected change around. This system helps us determine if we are reaching the goals that we set for ourselves, so we are able to lead with the confidence that we're making that shift for people.

Our systems are very strong. For example, the Global Financing Facility uses our backend financial system. We also have the ability and the capacity to train other local NGOs because we don't just work directly with the community, we also engage local, community-based organizations and CSOs [civil society organizations]. Therefore, we have the obligation to train them and build their capacity so they can support the delivery of service as we outline them. Having these robust systems in place and having the metrics to measure our success is important for us.

Dr. Rispah Walumbe: I can also add that when we look at success, the first question I usually ask my team is: What does success look like to you? I look at it [from different perspectives] because many things influence a singular health outcome. Our new corporate strategy puts us in two buckets: a social determinants of health bucket and a primary healthcare bucket. We understand that policies take a really long time.

So yes, we ask: Have policies changed? Have people changed, or has the rhetoric changed around particular areas of work? [But we look at that from many levels.] For instance, if you measured us around community health workers three years ago, you'd have said we failed if your metric of success was whether or not there was legislation in place that pays community health workers. But if you measured us based on all the incremental processes that were put in place over time that brought us to that point, then you would've seen success. I think that's key to understand.

There's a nuance behind the metrics of success that we look at, and we try to articulate that in our projects and programs. We understand that we have a big goal–we want a policy changed, or a legal instrument established–and that outcomes are often changing. We also know that there are different incremental steps that can get us to our goals. Even something as simple as capacity building within a community-based organization or civil society organization is such an important metric to look at in the long-term process.

Desta Lakew: Health financing, for example, is an area that we also push for, and we start by asking: Is this essential financing meeting the needs of the community? We even challenge global health financing institutions that we work with and ask, "What is the opportunity cost for countries who are funded by global health financing organizations?" Whether it's GFF [Global Financing Facility], or Gavi, we assess whether we are delivering in a way that doesn't create verticals or silos. We work very closely with ministries of health, so we look at a single country, for example, Ethiopia, and say, Ethiopia will need to have one instrument for a GFF, one instrument for Gavi. The question becomes: How do we organize these global financing institutions to recognize that the demand they place on a country constrains them, and does not allow them the flexibility to build their capacity while they're delivering the service that they need to deliver?

If you have three or four different processes through which you secure funding, and different metrics for each one, countries have to apply for vertical funding. These big global verticals need to be able to say, "Okay, we recognize that we need to achieve X." Then, we need to have systems that speak to each other so the country does not have to duplicate the same thing four times to get financing from global financing institutions. We look at and consider the way the systems are structured for health financing, at the way policies are structured, and at supporting countries that are prioritizing the health market, but we have a different lens through which we look at this. Our lens asks: Are the systems streamlined, and do they interfere with the government health plans?

Every health minister has some kind of health plan and health agenda. Our goal is to ensure that those health agendas are met, and that in meeting those agendas, governments are delivering on the ground for the communities that need them the most. We step back and look at what factors are impacting health delivery. What are the issues that countries are facing? Is it a human resource issue? How do we bring in partners and donors to support that? Is it a delivery issue?

What are the mechanisms that we could think about to support the delivery of healthcare? Is it a policy issue? How do we help them think it through and refine their policies so that the most important issues in the delivery of healthcare are at the center of all decisions and policies?

It's important to look at both sides, at government as the delivery institution and community as the recipient, and ask, "Where is there a disconnect? What areas can we streamline and support?" This requires playing the delivery role, the technical support and policy support role, and also looking at any gaps and coalescing our [strategy]. For example, we established a health leaders policy forum. It's simple: a WhatsApp group of health ministers across Africa. These health ministers, who normally would have to go through a very formal process, whether it's through the AU [African Union], Africa CDC, or WHO, can directly communicate. We launched this during COVID because there were vaccines we had to shift from one country to another before they expired.

We realized that health ministers are elected, but they don't necessarily come with the package of knowledge that's needed to lead their country to better health. We wanted to create a platform for health ministers to learn from each other. It's a self-learning model, it's an informal model, and we convene when these ministers are present, whether it's the World Health Assembly, World Health Summit, or other regional meetings, to make sure that there's a learning agenda. It's not just strengthening health systems in terms of making sure that there are appropriate screening facilities, but it's also strengthening the capacity of ministers to be able to learn from one another and to be able to convene around critical issues.

A few years ago, at the World Health Summit, there was a session at the World Health Assembly and our group CEO was moderating the panel. There were two ministers of health from Africa and two ministers of health from Southeast Asia on this panel. The ministers of health from Africa were Somalia and South Sudan, two of the most fragile countries that you could imagine. The conversation was about pneumococcal vaccines. The African ministers of health had no access to these vaccines, so tens and thousands of young children and babies were dying. It turned out this was not an issue of not having a stockpile of pneumococcal vaccines; rather, it was that the ministers did not understand the mechanism by which they could access these vaccines, which was through Gavi. So they didn't access them.

We were able to convene with them, and eight ministers of health from different countries, and say, "These two countries are having a challenge. They are dealing with these kind of populations. How do we help them navigate the system? How do we introduce that they need a moratorium on payment? What are the mechanisms that we can use, and how do we learn from one another about the best way to access the resources needed to deliver care?"

That was what sparked the idea of creating and pulling together this health leaders policy forum. We also brought the climate health conversation forward in that forum so that ministers were cognizant of it. 2023 was the first time that we've had 20 ministers of health from Africa at the COP. Never before has this happened. We are beginning to see language [addressing these issues], understanding of their impact, and more vocal participation in this subject area. When we create platforms, we can't just go with the norm. We need to be flexible enough to understand what the need is and find solutions for that.

Lissa Harris: I think everyone working on social problems learns as much from things that don't work as things that do. Is there an example of something that you tried that didn't work, and a lesson that you learned from it?

Desta Lakew: We learn as we go. We're continuously getting feedback from communities and the government. Our model is a learning model, and we adjust as we go. Because of that, we haven't had many situations where we've failed miserably.

Dr. Rispah Walumbe: A situation that warranted adaptation was when we were designing how we deliver technical assistance. We were looking at what technical assistance model already exists and thinking we would try and replicate that. We'll just bring in somebody who has technical expertise and assume that all will be well. But we found that if you just pick an individual and assume that you can put them in the ministry, or put them in a particular area based solely on their technical expertise, then [you aren't necessarily responding to the community's needs]. We had to learn how to be as responsive as possible to the institutions that we were giving technical expertise to, and how to tailor and adapt our support as we went along. This goes back to how important localization is.

Desta Lakew: We have a co-creation model, so we don't come in with solutions. You can't apply [pre-made] solutions and expect them to stick. The approach that we take is co-creation: co-creation with communities, co-creation with partners, with CSOs, with funders, with governments. That helps us understand the nuances of each situation and tweak things so that the end product, the delivery mechanism or the model that we select, is one that was developed with consultation. It's a very consultative and co-creative process.

For example, one of the issues that we deal with in relation to gender-based violence is female circumcision and its impact on our communities. Many communities across many countries continue to practice female circumcision on very young girls. Once that happens, that girl typically does not go back to school. It's a problem for the child, it's permanent damage, and it also leads to early child marriage. Our approach is not just to say, "This is a bad thing, don't do it." We build consensus in communities. We convince the elders, educate the boys as well as the girls, and

work with those communities so that they say, "This is not a practice we want to continue." In all of the communities in which we do FGM [female genital mutilation] programming, the recidivism rate is extremely low, around 10%. Someone may eventually come back and say, "No, I'd like to be circumcised." Or the parents will say, "No, our child has to be circumcised." But the most important [task we undertake is developing an] an understanding of the community and building solutions around that common understanding. We relay that to the medical community and the ministries of health so we can collectively find a solution that works, or works as best as it can.

Dr. Rispah Walumbe: To add to what Desta was saying, we've had to learn how to be more adaptive and responsive rather than being prescriptive in our approach. When we've hit a roadblock our answer is not “no,” our answer is, "Then what? How do we navigate this?" That's really important for us, because again, we are working with communities, and we can't go back and tell them we have failed and therefore, it's done. We always come back and say, "How can we navigate this? What could we do to change?" That’s what Amref has done over the years [to evolve from a] Flying Doctors institution to an organization that delivers health systems change.

Desta Lakew: Sometimes funders or partners come and say, "This is what we'd like. Can you deliver?" We've had to push back a number of times to say, "This is not what the community needs, and this is how we can work with you to accommodate that." As an example, I mentioned that we have solar-powered refrigerator mobile units that latch onto SUVs and go into communities in whatever part of the country we’re working in. We have that in Tanzania, Rwanda, Ethiopia, and Kenya. We had a funder, a partner, who came in and said, "We’re making these amazing radiological tools for cancer screening, and we would like this high-end equipment to be in this mobile unit. So when you go, you're not only testing high blood pressure and giving vaccines, but you're also screening for cancer."

Our response was, "Great idea, but it's not going to work in X, Y, Z communities because there is no referral mechanism." You can put thousands of dollars of equipment in a mobile unit, screen people, and tell them, "You have breast cancer," or “You have cervical cancer. Good luck." We don't do that. Our main aim, even as we diagnose or provide the ability for diagnosis, is to have a referral mechanism in place. We will push back to a funder and explain that diagnosing is not the priority. The priority is establishing a referral mechanism so that if we go to a community and do cancer screening, we are able to explain what comes next.

Lissa Harris: Setting aside the issue of funding, because everyone struggles with funding, are there challenges that you are facing that you haven't been able to solve yet? Whether that's scalability or opposition to your work, are there broad challenges that you're still working to overcome?

Desta Lakew: There are issues within the environment in which we operate that are challenging sometimes, like technology or access to Wifi. We use mobile platforms to do our training and to connect our health workers with each other and their supervisors. If there isn't access to Wifi, it presents a challenge. There are also some intrinsic challenges, like the roads, and the distances between health facilities and communities. The geography of Africa is extremely diverse, and there are geographic considerations that create challenges, as well as conflicts that create challenges. We have the most fragile health systems, and when conflict happens in one country, there are displaced people, and another country now has to address their health issues, as well.

I would say conflict, climate, and COVID are key environmental and political situations that we have to overcome, that are not necessarily driven by whether we get funding or not. These are systemic issues that create a fragile context in which we have to operate and in which governments must operate to deliver service.

Another challenge is donor-driven funding. That's not necessarily about whether we have the money, but if the money is being directed to the right place for a particular community. When a donor comes and says they want to fund a very specific issue, and that issue is not the biggest killer in their community, it's challenging. It's a challenge that not only Amref has, but that our ministries have as well.

Dr. Rispah Walumbe: In terms of political shift, not necessarily conflict, but just change, the prioritization of certain issues [becomes challenging as] in some cases, all the work that we've been doing is put on the back burner. That's something that we grapple with. The final issue that I see is not necessarily external funding, but internal funding from a domestic resource mobilization perspective. For some countries, investing in an issue, even if they see it as a priority, is just not feasible.

The shift has to happen in terms of looking at how we can incrementally work on an issue. If it's not the goal tomorrow, how can we work on what we have already to stepwise increase the ability to fund some of these projects? Even if it's not financing in terms of funding externally, we are working with ministries of health who are beholden to the budget for the country. They have to deal with their counterparts in the finance sector and competing priorities, as well.

Desta Lakew: And ministries are typically not well-funded.

Lissa Harris: Can you talk a little bit about how you're working to advance systems-level change, whether that's through partnerships or policy?

Desta Lakew: Partnerships are key, and partnering with regional bodies: Africa CDC, AU, AFRO, or WHO. We also have very highly-respected convenings. We do a biannual where we bring in some

key issues for the continent, discuss them, and make sure policymakers, academics, practitioners, communities, and all actors are present to advance conversations in priority areas. We also participate very actively in other global platforms to ensure that priorities are also present there. Then, of course, we work with governments directly.

Dr. Rispah Walumbe: We also connect policymakers from different countries to learn from each other. Right now, one of the things we're doing through the support from Skoll is looking at country pairing, for instance, Kenya and Ethiopia, to learn about primary healthcare networks and what that can mean for innovative service delivery.

Lissa Harris: It's wonderful to connect people so they can learn horizontally to each other.

Desta Lakew: The simplest solutions sometimes work best.

Lissa Harris: What do you think is most needed from other actors or partners to advance systems-level change?

Desta Lakew: Consensus. And prioritization.

Dr. Rispah Walumbe: I'll add adaptability, and having the space to allow for responsiveness, because that's what we've seen succeed.

Lissa Harris: How do you see your work evolving over the next five years?

Desta Lakew: We have a strategy that goes to 2030, but it's not a strategy that is stagnant. It's an evolving strategy, so as roadblocks or key issues come up, we identify the shifts that need to take place. For instance, climate was never in our strategy at all in the past. At the heart of everything we do is ensuring access to care, and ensuring that last-mile communities get access to first-level care. Continuously scoping the environment to understand what the barriers are is something that we do very well. We have people on the ground who do that, and we have people in the policy space, like Rispah, who do that. [They help us identify] the barrier that one individual in a county, or a community, or a remote area, faces to access first-level care. At the same time, we work to understand and address the challenges that health systems face in delivering that care.

Lissa Harris: Is there anything that we didn't get to that you think is important to add or to expand on?

Desta Lakew: I would say that Skoll has been fabulous because they've allowed us to help shape the type of intervention and body of work that we're doing with them. I think all funders and all partners, not just funding partners but delivery partners as well, need to have that flexibility and

that open-mindedness. Organizations need to stop coming in with a solution that's created outside of the continent to deliver to the continent. That is critical. If we want solutions to work, if we want people to access care, if we want to deliver lifesaving interventions, we have to deliver them with a deep understanding of the context, of the fragility or the strength of the system, of the community.

Are they displaced? What are the social and environmental challenges that they're facing? Health is not a standalone issue, and I think that is key. Health relies on transport, on politics, on funding, on hospitals and clinics, and community understanding. You can build the best delivery system and climate affects it. You can build the best delivery system, and no one comes because transportation is an issue. We prioritize building knowledge within the community because they are the ones that advocate for service and they are the ones who build the demand for service. A whole-of-society approach is critical.

Lissa Harris: That has been a common thread in a lot of these interviews, even among people working on very different problems: being responsive to community needs and involving communities in the solutions. Rispah, is there anything else you want to add?

Dr. Rispah Walumbe: [We also need to build] a more multi-sectoral approach. We need to have discussions around finance and health and to bring those two ministries together to have a conversation so they can better understand the bottlenecks that need to be navigated. At the end of the day, they're advocates for their docket. How do we bring ministers of environment to work with ministers of health? That's one of the adaptability goals we've been able to achieve to create that responsive trajectory.

That's also needed to really break the silos. We've worked so much in silos, so much in our own little cocoons, but I think we'll make the most progress when we're working through our whole-of-society approach. For instance, I'm trying to see how we can use health as a guiding indicator for climate, education, and all these other things.

Lissa Harris: Wonderful. Thank you both for your time and your expertise, and thank you for being part of this project.

Lissa Harris is a freelance reporter and science writer (MIT '08) based in the Catskills of upstate New York. She currently writes about climate, energy, and environment issues from a local perspective for the Albany Times Union, her own Substack newsletter, and various other digital and print publications.

** This interview has been edited and condensed.*