Letter from the Managing Director

The first quarter of 2019 has been an exciting and reflective time for the organization. On March 12, 2019, my co-director and friend, Ash Rogers, gave birth to a healthy baby girl – Colette Rogers Switzer. We are excited to welcome this newest member to our Lwala family. Colette’s birth has inspired us to reflect on the right of every woman to a skilled and dignified birth, and the right of every child to reach their 5th birthday.

Despite our commitment to this ideal, today far too many women still die in childbirth and far too many children die from preventable or treatable illnesses. This disparity in health services, and therefore in life outcomes, based solely on where a person is born is unjust and together we must work on equitable access to health as a human right. This was the founding spirit of the organization when Milton and Fred first dreamt of building their community’s first health center. This remains the driving mission of the organization today, and I am proud of the progress we are making every day.

This is why we do not remain satisfied with our impact as it stands. We must always push to combat injustice wherever we encounter it. With this in mind, we are aggressively scaling our successful interventions to reach more people.

Last year we wrote of our expansion which doubled the population served and constituted the first step in our pursuit of countywide scale. With 9 months of operations in our expanded population of 60,000, I am proud to reflect on our success. To date, we have enrolled over 12,000 households into our community health programs. That is over 22,000 people receiving personalized preventative care and treatment that may never have had access in the broken health care system.

Bolstered by these successes and the courageous support of our community, we are preparing to expand once again. We will reach 90,000 people – triple the population served in 2017, and we will recruit, train, and pay another cohort of 100+ Community Health Workers to create a total cohort of over 300. As always, we will welcome traditional midwives to serve as Community Health Workers – becoming community advocates and fierce promoters of maternal and child health.

Every birth is profound, and we have the honor to ensure mothers and babies experience this miracle in dignity and safety. As we welcome baby Colette, we are proud to stand together to create a world in which every family can experience the joy that Ash and her family have found. Thank you for joining us in the fight to provide a safe birth for every mother and every child.

In Solidarity,

Julius Mbeya
We co-authored design principles for community health programming that the WHO incorporated into Guidelines on Health Policy and System Support to Optimize Community Health Worker Programmes.

We are leading the charge to achieve Universal Health Coverage by collaborating on the Kenya national Community Health Strategy 2020-2025.

Our 7 partner facilities improved an average of 14% on our Health Facility Assessment after one year of our Quality Improvement Initiative with major wins including transformed pharmacy management which saves hundreds of dollars per year avoiding, lost, expired, and stolen drugs.

We trained 33 government Community Health Assistants on our supportive supervision model, which includes one-on-one coaching and review of data, field observation, and quality spot-checks. They will supervise our Community Health Workers and this integrated supervision structure allows us to co-implement community health programming with Ministry of Health.

We maintained a 97% skilled delivery rate in our innovation hub and achieved a 96% skilled delivery rate for those enrolled in our programs in our expansion location.

Lwala is partnering with Kisumu Medical Education Trust and the Ministry of Health to implement the World Health Organization’s Post Partum Hemmorhage (PPH) Care Bundle. Lwala is in charge of the non-pneumatic anti-shock garment’s inclusion in the bundle because of our success in rolling it out in 17 facilities already. The bundle will prepare every facility in Migori County to safely treat obstetric hemorrhage.

We remodeled our Maternal and Child Health space, expanding the waiting area and appointment rooms. This was in direct response to feedback in our Q4 2018 patient satisfaction survey.

We have retained a Medical Doctor as part of our care team. He will visit Lwala twice a month to conduct rounds, review complicated cases, and mentor our team, with a focus on clinical diagnosis and treatment of non-communicable diseases.

We have engaged a Biomed Technician to conduct routine maintenance on our medical equipment.

120 girls re-entered school in January 2019 thanks to our Broadened Horizons program. This is the highest number of girls we have ever re-enrolled in school!

We distributed 780 uniforms and 1,012 pad kits to girls in January for the 2019 school year.

We distributed 145 bikes to community members with support from World Bicycle Relief to help reduce transportation costs and increase savings for business owners.

2 Vanderbilt graduate students defended theses based on Lwala’s data – one on multidimensional poverty and one on intimate partner violence.

Our Managing Director, Julius Mbeya, was named a Rainer Arnhold Fellow 2019 at Mulago Foundation. He will join other fellows in priming our model for wider scale.

George shares his journey to become an advocate for people living with HIV and Doreen shares her daughter Patience’s successful recovery from malnutrition at Lwala Community Hospital.
Global Engagement

- Lwala collaborated with the other members of the Community Health Impact Coalition (CHIC) to create the design principles for Community Health Worker programming. The WHO incorporated CHIC’s suggestions into the revised WHO Guidelines on Health Policy and System Support to Optimize Community Health Worker Programmes. Through CHIC, we are working to have these WHO principles adopted by major community health funders globally.

- Lwala, together with the Community Health Impact Coalition, UNICEF, USAID, and Initiatives Inc. released the Community Health Worker Assessment and Improvement Matrix (CHW AIM), which outlines guidelines for creating and operating Community Health Worker programs based on evidence from partners in the coalition, including Lwala.

National Influence

- Lwala is leading the charge to achieve Universal Health Coverage by collaborating on the new Community Health Strategy 2020-2025. The Community Health Strategy will set the priorities over the next 5 years and we are pushing to include many elements of Lwala’s successful model, such as paying Community Health Workers.

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1 To read about our Health Systems Strengthening model go to page 18 or click on the “SYSTEMS CHANGE” section title.
Regional Advisement

- Lwala is pushing for 6 counties in the Lake Victoria Region, representing 6 million people, to prioritize Community Health Workers as formal employees of the healthcare system. To do this, we participate in the Inter-County Coordination mechanism for Human Resources for Health, which convenes representatives from all 6 counties. Thanks to our influence, all 6 counties are drafting Community Health Services bills.

- At our urging, the Inter County Coordination mechanism for Human Resources for Health Working group, will track **Community Health Worker employment levels** along with nurses, clinical officers, and other cadres. This is a major achievement in the recognition of Community Health Workers as part of the formal healthcare system.

County Collaboration

- Lwala continues to provide technical support to Migori County in the county’s quest to enact the **County Community Health Services law**. This law will create a framework for recruitment, pre- and in-service training, accreditation, payment, and better supervision of Community Health Workers. We are making a case for a recruitment and accreditation system that does not exclude traditional midwives. Traditional midwives have been offering care to their communities for decades and are heavily trusted. When ostracized, they pose the greatest challenge to skilled births, but when professionalized, they become the formal healthcare system’s greatest advocate. The law will formalize the current administration’s commitment to paying Community Health Workers into law, ensuring that the practice endures even after the administration changes.

- Lwala is partnering with Kisumu Medical Education Trust and the Ministry of Health to implement the World Health Organization’s **Post Partum Hemorrhage (PPH) Care Bundle**. The bundle includes misoprostol, uterine balloon tamponade, the non-pneumatic anti-shock garment, and more. Lwala is in charge of the non-pneumatic anti-shock garment’s inclusion in the bundle because of our success in rolling it out in 17 facilities already. The bundle will prepare every facility in Migori County to safely treat obstetric hemorrhage.

- Lwala partnered with the Ministry of Health to train 33 Community Health Assistants (CHAs) across Migori County on **supportive supervision**. CHAs are the cadre designated in the community health strategy to supervise CHWs. However, in many counties like Migori, their number is often inadequate to provide proper supervision. Where they are available, they often lack the necessary skills to supervise. The new skills acquired will bolster their capacity as part of the countywide effort to improve CHW performance. Proper supervision of Community Health Workers is critical in achieving quality health outcomes. In fact, supervision is a key element in the WHO recommendations for optimizing community health programs.
Sub-County Implementation

- We worked with the Sub-County Quality Improvement Focal Point to identify key areas of improvement in our partner health facilities including holding regular health facility management committee meetings, tracking annual work plan goals, and keeping updated employee records.

- We are successfully providing direct service delivery in 2 out of the 4 sub-locations in our sub-county – North Kamagambo and East Kamagambo. Expanding to East Kamagambo reinforced our confidence in our commitment to incorporating traditional midwives into our Community Health Worker cadre and empowering community committees to lead our programming.

- We are conducting participatory community entry activities to prepare for our expansion into a new catchment area, South Kamagambo, that will bring our direct service delivery to 90,000 people. These meetings are in line with our strategy to empower communities to drive change. Such meetings include consultations with community leaders, existing Community Health Volunteers, traditional midwives, local leadership, and the Ministry of Health.

QUALITY IMPROVEMENT

- **14% average increase in Q1 Index scores** on the Health Facility Assessment across 6 partner facilities compared to their respective baselines. There was also a 4% average increase in facility scores since the more recent assessment in quarter 4, 2018. Lwala Community Hospital received a score of 58% on the baseline assessment this quarter. This is 10% higher than the next highest score of any facility. This reinforces our strategy to use Lwala Community Hospital as a center of excellence to guide our partner facilities, and we will use the weaknesses identified to improve performance. The most recent round of data was collected piloting our new digitalized tool!

- The two facilities that saw backsliding on quality metrics in Q1 also experienced staff turnover. This highlights the importance of the inclusion of health facilities management committees in our quality improvement model. Because health facilities management committees are led by local community members, they retain the institutional history of quality improvement initiatives, even

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2 To read about our Quality Improvement model go to page 20 or click on the “QUALITY IMPROVEMENT” section title.
as staff turnover. While there are short-term disruptions in quality, we expect these facilities to rebound.

- **25 Quality Improvement Focal Points trained across 8 health clinics** on the principles of service readiness including patient satisfaction, performance measurement, and work planning.

- **Supported antenatal care profiling for pregnant women at 8 partner facilities** by providing lab reagents and training clinicians. This reduces complications in pregnancy, the postpartum period, and early infancy.

- Results from our most recent Health Facility Assessment include:
  - Minyenya Health Center achieved a 12% increase in score since October and a 24% increase since baseline! The increase was driven by major gains in the Medical Products and Technologies section. Before our mentorship, the pharmacy was not organized in any standardized way. Dispensing drugs was difficult, and drugs were often underutilized because clinicians could not find them or did not know they were available. The facility wasted a lot of money letting drugs expire or get damaged in the messy pharmacy. Pharmaceutical management became critically important when government commodity distribution was halted, and facilities started to run low on drugs. Mary, the Nurse-in-Charge, had to sort through all of her drugs to try and find any remaining antibiotics and painkillers for her clients. To solve this problem, Lwala brought in Quality Improvement and clinical staff to coach the Minyenya team on pharmaceutical management and commodity tracking. Together, the teams reorganized Minyenya’s pharmacy and taught the staff to maintain the new system. Now, Mary keeps her pharmacy organized according to this system. She is able to find medicines when she needs them, and she is aware of inventory levels so that she can request more stock as she runs low. This new technique is saving the facility money and saving the clinicians time, so patients have shorter wait times and better quality of care.
  - While Minyenya’s pharmacy transformation is the most poignant example, we found an improvement in pharmaceutical management across all of the facilities in the most recent assessments. Over the last 6 months we coached 6 partner facilities to use stock cards, do inventory checks, and organize stock based on expiration date. When we assessed the facilities in April, we found that clinical staff were managing the commodities well and prioritizing dispensing drugs before they expire. This significantly reduced waste and improved clinical care.
  - Lwala Community Hospital and Ngere Dispensary received the highest scores on the Leadership and Governance building block. They achieved this by having active and well-organized Facility Management Committees and Maternal and Perinatal Death Surveillance and Response Committees (MPDSR). After the facility assessments in October, Lwala’s Quality Improvement team coached Ngere Dispensary staff on the important role that committees play in the proper governance and oversight at the facilities. Together, they resurrected the dormant committee structure and guided them to hold regular meetings and follow the proper procedures. Now, the committees are functioning well, and their importance reaches far beyond an administrative compliance check. MPDSR reviews maternal and newborn fatalities and is the first line of review against the unnecessary and untimely death of mothers and newborns.
  - The Health Facility Assessments & quality improvement process also brings forward critical qualitative findings. When reviewing the facilities’ finances, we discovered that no partner facility, except for Lwala Community Hospital, has received government income in the last quarter. This was a critical finding given the active Linda Mama program which enables facilities to request reimbursements from the government based on the number
of deliveries they provide. Based on this finding, we will prioritize Linda Mama income in our work improvement plans to train the facilities and health facility management committees on this administrative process and lobby the government for consistent reimbursements. The health facility management committees will lead the charge to lobby the government for funds.

- A highlight from the most recent Health Facility Assessment is that Lwala Community Hospital is achieving a baseline of 84% of clinical standards met in a typical patient visit. This is measured through case observations, in which a nurse mentor observes patient visits and records the number of standards adhered to. Now, she will provide precise mentorship on weaknesses to improve Lwala Community Hospital’s performance further.

- The Health Facility Assessments also provide a unique opportunity for facility staff to share with us troubles and constraints they are observing in their daily work. In one instance, the Nurse In-Charge at Ngere shared with us that she can’t keep petty cash on site because she doesn’t have a lock box. We are working with her to prioritize funds to purchase a lock box for her facility. Through the trust we’ve built with facilities we can mutually identify and alleviate these simple issues that can interrupt facility operations.

**COMMUNITY HEALTH WORKERS**

- We identified **32 traditional midwives** in our next expansion site, South Kamagambo. During our consultations with the midwives, we found that all were still actively providing home births. We will recruit all active traditional midwives to join our Community Health Worker cadre when we launch in South Kamagambo in mid-2019.

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3 To read about our Community Health Worker model go to page 21 or click on the “COMMUNITY HEALTH WORKERS” section title.
• The new traditional midwives will join the 36 former traditional midwives in our current Community Health Worker cohort of 204. Incorporating former traditional midwives into our Community Health Worker cohort is a core element of our model. We leverage their trust and legitimacy in the community to better advocate for formal health services and we believe this a core driver of our success.

• This quarter our Community Health Workers received in-service training on the following topics: sexual and reproductive health services, pre-exposure prophylaxis for HIV (PREP), child protection, and responding to sexual and gender-based violence.

• We trained 33 Community Health Assistants from across Migori County on our supportive supervision model, which includes one-on-one coaching and review of data, field observation, and quality spot-checks. The Community Health Assistants are a government cohort and they will supervise our Community Health Workers. This integrated supervision structure allows us to co-implement community health programming with Ministry of Health.

MATERNAL HEALTH

• **97% skilled delivery rate** in our innovation hub and **96% skilled delivery rate** for those enrolled in our programs in our expansion site. We expect that the high skilled delivery rate in our expansion site is due to spillover from our programming in our innovation hub and may change as we enroll more women who have never accessed formal healthcare before.

• **80%** of women attend 4+ antenatal care visits before delivery in our innovation hub. Which is much higher than the county rate of 40%.

• We trained **178 clinicians on the Non-Pneumatic Anti-Shock Garment (NASG)** and used the NASG in **86 cases of obstetric hemorrhage**.

• Lwala is partnering with Kisumu Medical Education Trust and the Ministry of Health to implement the World Health Organization’s **Post Partum Hemorrhage (PPH) Care Bundle**. The bundle includes misoprostol, uterine balloon tamponade, the non-pneumatic anti-shock garment, and more. Lwala is in charge of the non-pneumatic anti-shock garment’s inclusion in the bundle because of our success in rolling it out in 17 facilities already. The bundle will prepare every facility in Migori County to safely treat obstetric hemorrhage.

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4 To read about our Maternal Health model go to page 21 or click on the “MATERNAL HEALTH” section title.
We held 6 maternal health-focused male forums, encouraging spouses to attend their wives’ antenatal care visits, advocate for skilled delivery, and support immunization completion. Men are major gatekeepers to their families’ health, so it is important to engage them in maternal and child health discussions. One participant at the male forum stated, “I haven’t come for ANC visits with my wife in the past, but now I know it is important for me to know about her birth plan,” Juma, 28.

108 women and children used our community transportation and referral system, enabling them to receive prompt medical attention. The community transportation and referral system is an innovation that Lwala spearheaded in response to gaps in short-distance clinical transportation needs.

**CHILD HEALTH**

Lwala was published in a peer-reviewed article from Vanderbilt University in the Public Library of Science journal (PLOS ONE) on our achievements in under-5 mortality in Rongo-Sub County. From this cross-sectional survey, it was found that there was a significant decrease in under-5 mortality before and after the presence of Lwala Community Alliance. In 1999 - 2006, before Lwala’s intervention, the under-five mortality rate was 104.8 deaths per 1,000 live births. After Lwala’s intervention, this rate was 53 deaths per 1,000 live births, and in the last five years this number has decreased further to 29.5 per 1,000 live births. This is compared to regional data which shows the under-5 mortality rate is 82 deaths per 1,000 live births.

98% of HIV-exposed children graduated from our elimination of Mother-to-Child Transmission of HIV (eMTCT) program as officially HIV-negative in November 2018. A cohort of 83 HIV-exposed infants is currently receiving prevention services. This program is an essential element of our goal to create an HIV-free generation.

97% of children are fully immunized in our innovation hub and 67% of children are fully immunized in our expansion site. This is compared to a national average of 57%.

We treated 300 cases of malaria between our health facility and Community Health Workers, compared to 560 cases in quarter one of 2018. This tremendous reduction is due to community case management of malaria by Community Health Workers and Indoor Residual Spraying spearheaded by the county government and partners.

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5 To read about our Child Health model go to page 22 or click on the “CHILD HEALTH” section title.

TRAMUTO FOUNDATION/HEALTH EVILLAGES NUTRITION INITIATIVE

- **803 children screened for malnutrition this quarter**, as part of our initiative to screen every child under five.

- **50 malnutrition cases were identified** in the community and referred to the facility for treatment during our screening process.

- **189 mothers, including 70 adolescent mothers, attended a training on the principles of childhood nutrition.** These trainings emphasize the importance of exclusive breastfeeding, nutrient intake for lactating mothers, and a diverse micronutrient profile.

SEXUAL AND REPRODUCTIVE HEALTH

- We provided **4,210 Couple Years Protection** so far this year, compared to the 3,098 provided in the same time period last year. Couple years of protection is a measure of the number of years that a couple is protected from pregnancy from a particular contraceptive method.
• **2,622 Youth Friendly Corner visits** including 1,314 male clients and 1,308 female clients, compared to 2,025 provided in the same time period last year.

• **4 Male Forums** held, reaching 351 people on topics of sexual and gender-based violence, family planning, and HIV/AIDS prevention. A participant at one of the male forums, James, who is 25 years old told the Lwala team, “Men used to complain about using condoms, now I think we all know we need them to be safe.”

• **10 advocacy events** held by our SRH Advisory Committees on child rights and protection and contraception access. In one instance the committee intervened when a case of abuse was brought forward. They involved the authorities and local gatekeepers to ensure the child was brought to safety and the perpetrator apprehended and charged.

• **13,354 condoms** distributed by our **52 Youth Peer Providers**, through the dial-a-condom program, which allows teens to order condoms from their peers on demand. Tobias, the Youth Peer Provider at Ndege Oriredo Dispensary says, “young people in the area know me and they trust me, so they feel comfortable coming to get contraception.”

• Community Health Workers distributed **6,330 condoms and 129 pills** during household visits and community outreaches. Community Health Workers referred **205 clients for long-acting methods** at those points of care. Household distribution of contraceptives makes it easier for those using short-term methods to obtain consistent refills.

• We host 1 radio show that airs weekly covering topics of sexual and reproductive health. Recently, our Youth Peer Providers and Community Health Workers joined to talk about creating demand for contraception.

• Through our guidance and collaboration, the SRH advisory committees identified teenage pregnancy, HIV/AIDS, and STIs as focus areas for the County Multisectoral Adolescent and Youth Sexual and Reproductive Health Action Plan which we collaborate in implementing.

**HAWI – HIV AND WATER, SANITATION, & HYGIENE INTEGRATED CARE**

• **2,137 people enrolled in HAWI** in our Innovation Hub, receiving community-based HIV and WASH support.

• **14 additional villages verified as Open Defecation Free** by the Sub-County Ministry of Health and awaiting official certification. This represents a community-led process to build dozens of new latrines and change core water, sanitation, and hygiene behaviors. They will join our 12 other villages that have already received official Open Defecation Free certification.

• **2 water points rehabilitated** through the active participation and cost-sharing of community members. This is the next step after receiving Open Defecation Free status to increase access to safe drinking water.

• **5,055 water filters and sanitizers** were distributed throughout the community.

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9 To read about our HAWI model go to page 26 or click on the “HAWI – HIV AND WATER, SANITATION, & HYGIENE INTEGRATED CARE” section title.
• **85** latrines and **121** hand-washing stations built.

**LWALA COMMUNITY HOSPITAL**

• **12%** improvement on our **2nd SafeCare assessment**, which evaluates our service delivery standards across 170 indicators. We saw a major improvement in our Outpatient Services score, which increased from a 51 to 84 due to improvements in workflow management and patient privacy.

• **82%** overall score on the **patient satisfaction survey; the highest of any partner facility!** This highlights that patients respond positively to our commitment to patient dignity, privacy, and quality of care. Lwala also received an **84%** score in response to patients’ willingness to refer others to the facility. We have formed a clinical Quality Improvement committee to steer our quality improvement efforts. Among the issues in the improvement plan is prioritizing patient engagement such as health provider explanations of illness and preventative care.

![Patient Satisfaction Scores](image)

• **84%** of **clinical standards** were met in a typical patient visit at Lwala Community Hospital. This score comes from the clinical case observation element of our Health Facility Assessment. **84%** is **13%** higher than the average score of the other facilities assessed. Our next improvement plans will focus on patient privacy and explanations of preventative care to improve clinical quality.

• Over **300** new HIV-positive clients **enrolled into care through the mUzima mobile application.** This application is a new technology that we are piloting to ensure 100% linkage to care by facilitating mobile enrollment in HIV care from the community. We are using this tool to continue exceeding the WHO targets for HIV care, which are **90% tested, 90% enrollment, 90% on sustained therapy.**

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10 To read about Lwala Community Hospital go to page 27 or click on the “LWALA COMMUNITY HOSPITAL” section title.
• **15,439** patient visits at Lwala Community Hospital compared to 13,175 patient visits provided over the same period of time last year. One contributing factor to this trend was a nurses strike in neighboring Kisii County, which pushed patients, especially high-need patients to our facility.

![](image)

• **185** skilled deliveries at Lwala Community Hospital, compared to 144 over the same period of time in 2018.

• **47** National Health Insurance Fund enrollees and **112** Linda Mama enrollees, which enable Lwala Community Hospital to receive government reimbursements for the services provided. While enrollment is still fairly low, we are actively encouraging our clients to enroll in health insurance.

• Remodeled our Maternal and Child Health space, expanding the waiting area and appointment rooms. This was in direct response to feedback in our Q4 2018 patient satisfaction survey.

• We have retained a Medical Doctor as part of our care team. He will visit Lwala twice a month to conduct rounds, review complicated cases and mentor our team, with a focus on clinical diagnosis and treatment of non-communicable diseases.

• We have engaged a Biomed Technician to conduct routine maintenance on our medical equipment.

**EDUCATION**

• **120** girls re-entered school in January 2019 thanks to our Broadened Horizons program. This mentorship program focuses on supporting girls’ re-entry into the school system after dropping out. This is the highest number of girls we have ever re-enrolled in school!

• **780** uniforms and **1,012** pad kits distributed to girls in January for the 2019 school year. Lack of access to uniforms and feminine hygiene products has historically been a barrier to female education, and further widened the gender gap in school completion.

• **1** new classroom construction project started at Kuna Primary School as a result of a school development plan that the school Board of Management created and Lwala supported.

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11 To read about our Education model go to page 27 or click on the “EDUCATION” section title.
• **394 at-risk girls mentored** through our in-school mentorship program, which aims to prevent school dropouts and teen pregnancy.

• **576** students with access to eReaders as part our literacy intervention. eReaders give students access to thousands of books, thus reducing the cost of school enrollment by eliminating the need for textbooks and encouraging extracurricular reading.

• **27 teacher-designed innovations** scaled-up through the 13 primary schools we support. We believe that teachers are best placed to create solutions to their own challenges. We are empowering them to design innovations that affect learning outcomes for children in their schools.

• **5 School Community Committees began training in quarter one on our advocacy module.** This module is designed to teach School Community Committees to lobby the government and hold the Ministry of Education accountable.

• **2,874 students reached through Health Clubs**, our after-school program focused on sexual and reproductive health, life skills, and negotiation tactics.

**ECONOMIC**

• **497 new businesses formed** during Village Enterprise’s most recent business cycle.

• **2,982 lives impacted** through Village Enterprises’ poverty graduation model since the beginning of our partnership.

• **145 bikes distributed** to community members with support from World Bicycle Relief to help reduce transportation costs and increase savings for business owners.

• **$121,782 USD in assets and $99,748 USD in savings** is currently held by our Savings and Credit Cooperative. This is an independent cooperative that provides access to pro-poor financial products in our community.

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12 To read about our Economic program go to page 29 or click on the “ECONOMIC” section title.
MEASUREMENT AND RESEARCH

- **2,646 households surveyed in quarter one**, as part of our surveying effort of 3,729 households in the latest round of our quasi-experimental, repetitive, cross-sectional survey. The study focuses on maternal and child health, but also collects a wide range of socio-economic data across 273 variables to help us understand more about the drivers of health outcomes.

- **21 enumerators** surveyed for over 60 days to gather a robust dataset that is being analyzed with support from biostatisticians and our Principal Investigator at the Vanderbilt Institute for Global Health. Troy Moon, our Principal Investigator, came to Lwala in quarter one for enumerator training and survey kick-off to guide operations and implementation.

- **1 pending publication** written on the knowledge of Lwala’s Community Health Worker cadre. The preliminary results from this study show that Lwala-trained Community Health Workers are 2.5 times more likely than status quo Community Health Workers to be knowledgeable about danger signs in pregnancy.

- **1 thesis** defended on multi-dimensional poverty analysis using Lwala’s data. It found that the incidence of child mortality in our innovation hub was half of the incidence of child mortality found in a comparison site.

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13 To read about our Measurement and Research activities go to page 30 or click on the “MEASUREMENT AND RESEARCH” section title.

• **1 thesis defended** on intimate partner violence using Lwala’s data found that over 60% of women reported having been physically or sexually abused by an intimate partner. This data is informing strategic planning around targeted interventions for intimate partner violence and gender-based violence.\(^\text{15}\)

• **6 Vanderbilt graduate student groups** partnered with our M&E team to provide literature reviews and impact evaluation frameworks on topics including teacher effectiveness, adolescent malnutrition, and obstetric hemorrhage.

**LEADERSHIP**

• Our Managing Director, Julius Mbeya, was named a [Rainer Arnhold Fellow 2019](#) at Mulago Foundation. He will join other fellows in priming our model for wider scale.

• In February, we attended [Sankalp Africa Forum](#) to meet with current partners and explore new developments in the social impact/entrepreneurship space.

• In March, we attended [Innovations in Healthcare](#) as a second-year member of the global cohort to foster our relationship with the network while opening channels of engagement with Pfizer Foundation, a board member and investor of IIH.

• In April, [Skoll World Forum](#) was an opportunity to steward relationships with over 20 current or potential partnerships in 1:1 meetings, session participation, and social activities. We discussed potential proposals or were invited to submit proposals to 5 partners and created relationships with 7 potential partners.

• [Unite for Sight](#) resulted in engagement with the broader global health community on responsible fundraising, leadership, and ethical development. Our fruitful partnership with the Vanderbilt Institute for Global Health was highlighted in a presentation called An Innovative University and NGO Partnership.

• Next quarter, we plan to participate at the Izumi partners meeting.

• Our Executive Director, Ash Rogers, was named an Aspen Ideas Health Scholar and will attend the [Aspen Ideas Health Festival](#) in June.

\(^{15}\) Miller Morris, Moon Troy, Intimate Partner Violence in Migori County: Household Survey 2018. 2018. *Unweighted data, subject to change.*
Our Model
HEALTH SYSTEMS STRENGTHENING

Lwala’s model has generated ample evidence of success including a child mortality rate of 29.5 per 1,000 live births compared to the regional average of 82 per 1,000 live births, a 300% increase in contraceptive uptake, and virtual elimination of mother-to-child transmission of HIV. As a result, the Ministry of Health invited us to scale our model throughout Migori County to reach a population of one million people. We’ll meet this challenge through a three-pronged approach: direct service delivery, government technical assistance, and peer replication.

Direct Service Delivery


18 Sourced from Lwala Community Alliance’s routine monitoring data, collected at the household level through a customized data collection platform using CommCare, Open Fn and Salesforce.
To provide direct services, Lwala implements our community-led health model. The model rests on four key pillars:

- **Community Committees** – We leverage community committees to lead in the design and implementation of our health initiatives. We revive and train health facility management committees at all of our partner facilities. These committees are an official structure within the Kenyan health system, but they are under-leveraged and often dormant. With the committees resurrected, the facilities are better able to advocate for their interests. Similarly, we establish sexual and reproductive health committees, which advocate for women’s rights and child protection and handle incidents related to rape, abuse, and teenage pregnancy. We leverage our HIV and WASH Integrated support groups to have dual functions: 1) supporting people living with HIV and 2) acting as our advocates for community-wide sanitation efforts. Community and religious leaders spearhead these committees, symbolizing to their constituents that these are issues of upmost importance in the community.

- **Community Health Workers** – Lwala has a cohort of 204 Community Health Workers, including 34 former traditional midwives. We work with community committees to identify active traditional midwives and include all of them in our Community Health Worker cadre. This is a core tenant of our model because we believe that traditional midwives have the potential to be the greatest advocates of the formal healthcare system once they are professionalized. We work closely with the government to train, pay, and supervise our Community Health Workers. The Ministry of Health pays stipends to Community Health Workers and Lwala supplements their pay.

- **Health Centers** – We support 7 government health facilities through our Quality Improvement Program. Every 6 months we use our customized Health Facility Assessment tool to evaluate clinical quality. We use the weaknesses identified in the assessments to create customized improvement plans for each of the facilities. Then, we work with the facility staff to implement the plan and improve on the weaknesses. After 6 months we evaluate the facilities again and create new improvement plans based on the new data.

- **Data** – We employ Community Health Worker-driven data by equipping our network of Community Health Workers with tablets and our customized CommCare application, Lwala Mobile. The Community Health Workers leverage this technology to monitor their caseload, collect data, and receive real-time decision support. Our approach ensures that illnesses are identified early, and no vulnerable community member slips through the cracks.

**Government Technical Assistance**

We engage stakeholders at every level, from global audiences to local opinion leaders to mainstream our tried and true innovations and advocate for a strengthened health system. At the global level we work with the international Community Health Impact Coalition (CHIC), which is a consortium of the most impactful organizations in global health. With this coalition we produce guidelines and develop best practices to influence community health work on a global scale. We also work with the African Union to broadcast our proven interventions to a global audience.

We participate in the national effort to achieve Universal Health Care. We engage with national health working groups where we share our successes and advocate for national replication of proven interventions. To engage at the regional level, we are a member of the Inter-County Coordination for Human Resources for Health working group, which represents 6 counties in the Lake Victoria region. We use this platform to share our successful Community Health Worker model and advocate for the adoption of best practices. In Migori County, we work closely with the government to codify Lwala’s principles into law and leverage government cohorts to oversee our implementation. By working with Migori County, we influence the health outcomes of 1 million people. Our sub-county collaboration is direct co-implementation of our community-led health model reaching 60,000 people.
Peer Replication

The third prong of our community-led health model expansion is peer replication. There are a number of community-led organizations in our region that are looking to implement a cohesive model to create impact. Lwala believes in leveraging partnerships with likeminded organizations, so we sign Memorandums of Understanding with peer organizations to share expertise and best practices. We supply peer organizations with our Community Health Worker training curriculum and community health program guide as a “starter kit” to operating a community-led health model. We are excited about the various ways in which our partners bring our model to life in their own communities.

QUALITY IMPROVEMENT

Lwala believes that in order to provide quality health access, Community Health Worker initiatives must be tied to quality facility-based care. Our objective is to improve the systems and structures within the existing health system to create a seamless continuum of health services. Lwala unites community members and health care workers to improve health facility performance in the 6 key areas of healthcare delivery: service delivery, health workforce, health information systems, access to essential medicines and supplies, financial management, and leadership and governance.

The Quality Improvement Initiative incorporates an integrated structure of clinical coaching and mentorship that is measured through bi-annual assessments.

Health Facility Management Committees — We start by organizing health facility management committees at each government facility. These are Ministry of Health entities meant to build accountability in the health system, but are typically dormant in rural areas. In the past these committees have existed in name only, leaving the facilities without vital oversight structures. We revitalize them, ensure they are led by a representative group of community members, and put them at the center of an iterative quality improvement process.

Health Facility Assessments — We use a Health Facility Assessment Tool that we developed with the guidance of a Quality Improvement consultant. The tool measures facility performance against the 6 World Health Organization health system building blocks. Within the building blocks, we score the facility on 30 specific indicators that we pulled from Kenya Ministry of Health and World Health Organization guidelines. The Health Facility Assessment Tool also incorporates scores from three tools implemented on an ongoing basis: a patient satisfaction survey, staff satisfaction survey, and case observation guidelines. We digitized the tool on our customized CommCare application, so the evaluation is conducted on mobile tablets.

Facility Improvement Planning — Using the information gathered during the Health Facility Assessments, we create tailored work improvement plans for each facility. We generate these plans through a collaborative process with the facility management teams. In order to achieve the goals set-out in the facility improvement plans, we work with health facility management committees to implement a Plan Do Study Act (PDSA) cycle as illustrated by the graphic to the left. Previous work improvement plans have included ensuring 24/7 maternity services are available in all partner clinics and resurrecting underutilized governance structures like the Facility Health Management Committees.
COMMUNITY HEALTH WORKERS

Our community-led health model incorporates former traditional midwives who we recruit, train, supervise, pay, and digitally empower as Community Health Workers. Our Community Health Workers enroll every household in the community and provide specialized, targeted care to every pregnant woman, child under-5, and person living with HIV, and ensure that they receive crucial medical care and facility services through monthly household visits. A core element of our model is the inclusion of former traditional midwives in our Community Health Worker cadre. Traditional midwives are the women in the community who have delivered healthcare to their communities for generations. But, because they have been cut off from formal health systems, the home births they provide are often dangerous for the mother and baby. We transform these women from the largest competitors of skilled deliveries to the greatest champions of maternal and child health.

Integrated Supervision Structure – Incorporating government supervision and collaboration is integral in pursuit of our mutual goal of universal access to health care. We train Community Health Assistants as supervisors for our Community Health Worker cohort. The Community Health Assistants use our mobile data collection system and use a supportive supervision structure for Community Health Worker management. This integrated structure is an important element of our collaboration with the Ministry of Health.

Home-Based Care – Our Community Health Workers provide a suite of preventative care and treatment services including malaria diagnosis and treatment, contraceptive provision, and malnutrition screenings. Offering these services in the household connects every family with formal healthcare and promotes proactive health-seeking behavior.

MATERNAL HEALTH

We are engaging mothers at every step of their healthcare journey. We provide contraceptive services and education so that every family is a planned family. We are distributing pregnancy tests in the field so that a mother can know she is pregnant as soon as she becomes pregnant and providing excellent clinical services to mothers from conception to delivery to post-partum.

Antenatal Care – Antenatal care visits are key to ensure healthy deliveries and protect both babies and mothers. Our Community Health Workers are essential to ensuring every mother gets antenatal care. They map and enroll every pregnant woman into our community-based care program, ensuring that they attend 4 or more antenatal care visits before they deliver and educating them on pregnancy danger signs, diet, and behaviors. Our clinicians also provide education to mothers on a healthy prenatal diet, danger signs in pregnancy, the importance of a birth plan, and the importance of attending at least four antenatal care visits before delivery.

Skilled Delivery – Our high skilled delivery rate speaks to the positive feedback loop we have created between our Community Health Workers, the community, and our partner facilities. We are harnessing the power of traditional midwives in the community and incorporating them into our Community Health Worker cadre. These community stakeholders in turn drive clients towards the clinics, building goodwill and strong ties with the people we serve.
Tackling Maternal Death – Lwala operates an innovative intervention to stop maternal death by employing the non-pneumatic anti-shock garment (NASG) to treat obstetric hemorrhage. Almost 99% of mortalities from obstetric hemorrhage occur in developing nations\textsuperscript{19}. The NASG has been shown to reduce mortality by 59% in cases of severe shock. This low-technology, reusable tool constricts blood flow to the lower extremities while redirecting blood flow to the vital organs, giving women an additional 72 hours to get treatment. In partnership with University of California San Francisco, we train facilities, including tertiary facilities, and health care providers on the NASG, and distribute the garments. We use a trainer-of-trainer model, in which Lwala train trainers to then conduct their own trainings, to multiply the impact independent of Lwala.

CHILD HEALTH

Every child deserves a fifth birthday. Lwala addresses the range of causes of child morbidity and mortality on all fronts. We take a holistic approach to improving the health outcomes and quality of life for children in the communities we serve. This involves teaching parents the warning signs for illnesses, creating a strong surveillance, testing, treatment, and referral network led by our community health workers, and offering clinical care that supports both physical and psychosocial determinants of health.

Elimination of Mother-to-Child Transmission of HIV – We test every pregnant woman for HIV at her first antenatal care visit and again during labor. This allows us to enroll every baby born to an HIV-positive mother into the elimination of Mother-to-Child Transmission component of our HIV program. This program provides the mother with specialized support throughout her pregnancy and immediately following birth. During monthly meetings, hospital staff lead educational sessions on drug adherence, infant feeding, and nutrition. In addition, an HIV-positive mentor mother provides counseling and support to encourage women to accept their status and be proactive about HIV care.

Clinical Outreach – To expand the accessibility of pediatric healthcare, we conduct clinical outreach events at common social gathering spaces such as schools and soccer fields. We offer standard healthcare services, such as immunizations and growth monitoring. The outreaches bring facility services into the community, to make high-quality healthcare even more accessible.

Immunization – Community Health Workers are dedicated to ensuring that all children in our communities are vaccinated. At each household visit, Community Health Workers check the child’s immunization records against the vaccines that they should have received. If the child is behind on any vaccines, they refer them to a health facility and sometimes even bring the vaccine directly to their household. This process is supported by our robust data system, which allows Community Health Workers to track every child and ensure that no child slips through the cracks.

**Malaria Community Case Management** – We combat malaria in 2 ways: facility-based testing at our 7 partner facilities and through community case management. Equipped with rapid diagnostic tests and medication, our Community Health Workers can diagnose and treat malaria cases in their clients’ homes. Our data shows that the malaria burden decreases significantly after the Ministry of Health conducts wide-spread indoor residual spraying. Therefore, we advocate for the Ministry of Health to repeat the spraying program every year.

**TRAMUTO FOUNDATION/HEALTH EVILLAGES NUTRITION INITIATIVE**

Our nutrition program targets four key populations who are vulnerable to poor nutritional status: 1) people living with HIV, 2) children under 5, 3) expectant mothers, and 4) breastfeeding mothers. We provide a tailored curriculum and set of interventions to address the specific nutritional needs of each of these populations. Our Community Health Workers monitor and prevent malnutrition at the household-level and refer at-risk clients to Lwala Community Hospital. From there, our nutritionist can give a clinical assessment and create a long-term care plan.

Exclusive breastfeeding for the first 6 months of a child’s life can have lasting health benefits into adulthood. In line with WHO guidance, our clinicians encourage mothers to initiate breastfeeding within one hour of delivery. Our Community Health Workers then monitor breastfeeding practices for every child until 6 months of age.

We enroll HIV-positive clients and mothers with children under-5 into our community-based nutrition program. Enrolled clients receive tailored nutrition training and seeds for food such as spinach, kale, and carrots to plant in their kitchen gardens. All of these individuals also receive routine care and support from a Community Health Worker on an ongoing basis. Our Community Health Workers are trained to give Middle Upper Arm Circumference (MUAC) readings, which determine whether a person is of normal weight, moderate malnutrition, or severe malnutrition status. If a person reads as moderately or severely malnourished, they are referred to the clinic for confirmation of their nutrition status, and those who are confirmed receive supplements and clinical support.
SEXUAL AND REPRODUCTIVE HEALTH

Our community-led reproductive health program combines advocacy, diverse outlets for contraception provision, and education to empower youth and adults to take control of their sexual and reproductive health.

Through community sensitization, advocacy, and service provision in our innovation hub, the community members themselves have become champions for sexual and reproductive health services. Our sexual and reproductive health model consists of both community engagement and service provision.

Community Engagement – Our community engagement strategy is to create overlapping forums for conversations around reproductive health and rights. This approach allows us to reach a diverse set of the population in settings that feel most comfortable to them. Several of the engagement forums include:

- **Sexual and Reproductive Health Committees** – Community reproductive health committees are at the heart of our model. These committees are made up of religious leaders, local political leaders (village chiefs), teachers, and a diverse group of men, women, and youth. Our committees promote contraceptive access, male involvement in contraception use, and family health in general. The committees hold regular advocacy events to discuss long-acting contraceptives, child protection and rights, and domestic violence. 50–70 people attend each event.

- **Male Forums** – We conduct male forums on the topics of teenage pregnancy, adolescent and youth reproductive health, HIV/AIDS, maternal care, and more. Men are an essential target group because they are often the gatekeepers to women and children’s health. In male-only forums we directly explore norms of masculinity and create a safe environment for men to challenge each other on harmful assumptions. Men are also given a chance to look at contraceptive commodities and understand their uses and side effects. These forums take place in venues where men already congregate – motorcycle taxi stages, gold mines, local pubs, and football games.
Youth Peer Providers – This program is designed to make adolescents feel more comfortable talking about and accessing sexual and reproductive health services by delegating the services to people their own age. To remove barriers that may discourage youths from accessing contraceptive services, our Youth Peer Providers distribute over 5,000 male condoms per month. At the outreaches, community members can access informational material, STI and HIV testing services, and contraception.

Twak Mar Rowere Radio Program – Every Thursday afternoon we host a radio show focused on issues related to sexual and reproductive health, HIV, STDs, family planning, and gender-based violence. The show, whose name means “A sharing platform for young people,” features a different staff member or stakeholder each week. We have a rotating schedule of Youth Peer Providers, Community Health Workers, Community Committee members, and health care providers that join the show. Each week the hosts select a topic to discuss for the first half of the show, then they spend the second half taking listener calls and questions. We have ignited vast listener engagement through text messages and calls included in the show and have created a Facebook page where listeners interact with one another.

Service Provision – The goal of the service provision element of the model is to open as many access points to contraceptives as possible. We provide short-term and long-term methods consistently, and host clinic days for permanent methods.

Our various contraception distribution networks include:

Health Facilities – We support facility-based services with a focus on long-term methods: implants and IUCDs, at our partner primary care facilities. At our partner facilities, we provide reproductive health training, conduct on-site clinical mentorship, drive continuous quality improvement, and ensure a reliable supply of contraceptive commodities. We also partner with Marie Stopes to provide permanent methods during clinic days within government facilities.

Community Health Workers – We provide our Community Health Workers with male and female condoms, two types of birth control pills, and emergency contraception to distribute to community members during their household visits and outreaches. As condoms and pills are short-term contraceptive methods, home-based distribution facilitates consistent contraceptive use by providing refills to clients directly in their homes. Community Health Workers also generate demand for long-acting reversible contraceptives such as implants and IUCDs. The Community Health Workers refer their clients to a health center where they can access long-term contraceptive methods, creating a cycle of positive health-seeking behavior.

Youth Friendly Corners – We operate 5 Youth Friendly Corners to provide services to adolescents and youth. We’ve learned that while integrating family planning services throughout all clinical departments increases uptake for women who have already had a pregnancy, it discourages uptake from a critical age group – youth aged 14 - 24 without children. Young people are more likely to access services if they can do so away from the general patient population. Thus, we equip, staff, and supply youth friendly corners as separate spaces near government facilities. These corners provide games, youth leadership training, and access to reproductive health services in a friendlier environment than a typical health center.

Dial-a-Condom – Our Youth Peer Providers developed what they describe as “Uber for Condoms.” Youth in our communities are given mobile phone numbers for peers who have a consistent supply of condoms. They are able to order condoms on demand without having to travel to a health facility or risk being seen taking a condom from a public dispenser.
HAWI – HIV AND WATER, SANITATION, & HYGIENE INTEGRATED CARE

Community-Led HAWI Model – Consistent with our belief that holistic interventions best serve at-risk populations, Lwala addresses HIV and WASH together in our HIV and WASH Integrated program (HAWI, which also means “good luck” in Dholuo, the local language). Research shows that HIV-positive individuals are more susceptible to malaria, diarrhea, and other enteric diseases. Therefore, we implement WASH interventions in conjunction with HIV care to reduce the relative risk for malaria and diarrheal diseases among people living with HIV/AIDS.

Our HAWI model empowers community members to proactively address HIV and elevate WASH standards in their own communities. The model is composed of 4 key components: Community Health Worker monitoring, support groups, community-led total sanitation (CLTS), and water infrastructure.

Community-Led Total Sanitation (CLTS) – Community-led total sanitation is a process whereby community members improve WASH standards in their own communities.

- First, Community Health Workers train community groups on WASH topics. These new WASH champions then teach their own communities about WASH and support their peers to construct latrines and handwashing stations. We typically select the highest performing HAWI clients to spearhead this community-led process because they are proven WASH champions.
- Next, community WASH groups promote proper WASH practices with their peers in their own communities. The leaders follow up with their neighbors and organize Action Days to construct latrines and safe water sources for those who are unable to construct them on their own, such as widows and the elderly.
- Finally, once the WASH groups have catalyzed their own communities to build WASH infrastructure, villages can declare themselves Open Defecation Free. This designation denotes that every household is covered by a high-quality latrine and handwashing station, which are used appropriately and without fail. The Ministry of Health then verifies that this designation is accurate and bestows official Open Defecation Free status to the village.

The highest performing community-led total sanitation villages who have achieved Open Defecation Free status then qualify for water infrastructure rehabilitation, which further improves WASH standards in their own community.

Water Infrastructure Rehabilitation – Once a village is certified as Open Defecation Free, it qualifies for water infrastructure rehabilitation. It is crucial to perform rehabilitation only in Open Defecation Free villages to ensure that improved water sources will not become contaminated. In addition, this criterion serves as an incentive for villages to accelerate Open Defecation Free processes.

HAWI Outreach – We hold WASH trainings in partnership with our trainer-of-trainers. At the trainings, community members learn about food-borne illness, handwashing, mosquito net use, latrine coverage, safe water practices, and more. During the outreachs, the Community Health Workers liaise with WASH-trained community members to provide education and share testimonies about the benefits of WASH and avoiding the repercussions of stigma relating to HIV.

HAWI Tournament – Lwala holds a HAWI soccer tournament in August every year. Over six days, teams from all over the sub-county enter the tournament, drawing crowds of over a thousand people per day. The crowd size and audience energy create a perfect environment for awareness campaigns and outreach activities. During the tournament, we station clinical officers at tents to provide HIV testing services, rapid diagnostic tests for malaria, contraception, and maternal child health counseling.

Support Groups – We facilitate support groups for thousands of people living with HIV. Our support groups provide psychosocial support to clients who have historically been marginalized by the community. Through sensitization and ongoing community awareness raising, disclosure and discussion of HIV management has been accepted and supported by our community. The highest performing HAWI
clients become WASH champions, a role that empowers them to lead their own communities through community-led total sanitation.

**LWALA COMMUNITY HOSPITAL**

*Lwala Community Hospital* is our center of excellence for providing quality clinical care and support services to the community we serve. We are employing innovative interventions like mobile HIV-care enrollment, low-technology garments to address obstetric hemorrhage, and a high-capacity laboratory that can perform blood transfusions. In turn, our clinic staff provide training and mentorship to government health workers to increase the capacity of all health workers in the area.

**Quality Assurance**

- **Assessment** – Lwala partners with PharmAccess who routinely assesses our hospital using their SafeCare assessment. The assessment grades the facility across dozens of criteria developed from international best practices. Between assessments our clinical staff work hard to improve on the identified weaknesses.

- **Patient Satisfaction** – We survey patients from Lwala Community Hospital bi-annually on their satisfaction with the care they receive at our facility. The results from this survey inform our understanding of hospital procedure, perceived quality of care, and general client happiness.

- **Clinical Mentorship** – Our Nurse Mentor conducts routine case observations in our hospital to spot-check whether our clinical staff’s services are meeting best practice. These observations are based on criteria dictated by the World Health Organization and the Ministry of Health, and staff are measured across several service delivery areas including labor and delivery, postnatal care, integrated management of childhood illnesses, and immunization, among others. Through these assessments, our Nurse Mentor determines areas for improvement and tailors her trainings to address them.

**Innovations in Service Delivery and Technology**

*Lwala Community Hospital* stays at the forefront of emerging medical practice and technological innovations by engaging in strategic partnerships. Because of our unique and challenging healthcare environment, *Lwala* is a perfect pilot site for institutions such as IBM, Moi University, and the University of California-San Francisco.

**KenyaEMR** – The Ministry of Health electronic medical records system, KenyaEMR, operates actively in all HIV and TB patient rooms at Lwala Community Hospital, so that patient information is accessible in real-time. Patient records for all HIV and TB testing, care, and treatment services are housed on this system and allow clinicians to better track their patients’ progress.

**National Health Insurance Fund**

As a level 4 hospital, we are eligible for reimbursements from the **National Health Insurance Fund**. We provide services for maternal child health and HIV free of charge and the reimbursements from NHIF help to offset that cost. Enrollment for NHIF and the maternity focused Linda Mama government reimbursement program is crucial to both the financial sustainability of facilities, as well as the achievement of Universal Health Coverage. As such, we are dedicated to enrolling as many clients in these programs as possible, through outreaches as well as our specialized records clerk.

**EDUCATION**

We collaborate with 13 government-run primary schools. While we provide technical support, training, and evaluation, School Community Committees carry out the design and implementation of initiatives. The education program spans various areas of youth achievement, from health to leadership to academics, while consistently incorporating a gender equity lens.
Breaking Barriers

**Broadened Horizons** – Increasing girls’ access to education and developmental pathways is critical to the progress of the communities we serve. The goal of the Broadened Horizons program is to mentor girls who have dropped out of school and to support them to re-enroll. For those that cannot re-enroll we provide workforce development training.

- **Re-enrollment** – To incentivize parents to keep girls in school, we provide micro-grants to help them pay for school fees. The parents attend weekly training sessions for three months, and we disburse a $30 grant per term. In addition, the girls themselves are given uniforms, books, and pens once they have re-enrolled in school.

**School Supplies for Girls** – Through our New Visions women’s sewing cooperative, we provide reusable pads and school uniforms to build the self-agency of girls to remain in school. By providing girls with these resources, we reduce two of the largest barriers to girls’ school completion – lack of money for uniforms and insufficient access to feminine hygiene materials.

**In-School Girls Mentoring** – As opposed to the Broadened Horizons program, which caters to girls who have dropped out, the in-school girls mentoring program utilizes thirteen mentors to reach at-risk girls in school with the goal of preventing drop-outs.

**Innovations Challenge** – We developed the innovations challenge to engage teachers to design solutions to their own challenges. Participating teachers submit innovations to combat challenges in the areas of parental engagement, student performance, and teacher attendance, among others. Each year, we select the highest-potential ideas and support teachers to implement them in their own schools.

Quality Education Through Participation

**School Community Committees** – School Community Committees consist of headmasters, teachers, students, parents, and local leaders who work to improve quality and safety at their schools. Lwala increases the number of participating teachers, parents, and community members at School Community Committees meetings, while simultaneously improving their capacity to hold the Ministry of Education accountable. We train these committees on effective advocacy techniques, and specifically engage them on key issues including: no-repeat policies, teacher placement, and sexual violence and exploitation of children in schools. The School Community Committees are a critical education governance structure that have been historically under-utilized in our catchment. By leveraging the School Community Committees, we engage a sustainable oversight structure that can advocate for improvements to the education system from within the community.

**School Development Fund** – Once School Community Committees are well organized, we support each school to establish a school development plan. Through our school development fund, we cost-share the implementation of the school development plans by providing in-kind support for materials and labor while the schools fund or fundraise for at least 40% of the cost. These projects typically include constructing new classrooms, water tanks, latrines, handwashing stations, and goal posts. With School Community Committees at the helm, schools have a greater ability to lobby for funds, hold the government accountable, and represent the diverse interests of the various stakeholders in primary education.

**Teacher Effectiveness** – Additionally, we believe in arming teachers with the resources necessary to better serve their pupils. We organize teacher exchanges so that lower-performing teachers can: learn through example from high-performing teachers, visit successful learning environments, and share ideas, successes, and challenges with other educators. To maximize the impact of the highest performing teachers, we organize teacher learning exchange visits across schools. The visits encourage the best teachers to coach and support their peers and provide a space for innovation and discussion. Teachers are encouraged to learn from one another and disseminate best practices across schools. Lwala also organizes learning sessions to encourage collaboration and creativity in the classroom. Additionally, we engage our
teachers in selecting evidence-based training modules and bring those trainings directly to schools. This exposes teachers to cutting-edge pedagogy while keeping them at the forefront of teaching improvement.

Health

**Youth Friendly Corners** – We operate a total of 5 Youth Friendly Corners in the communities we serve. These innovative health centers have a dual purpose: providing health care services, such as contraception, to youths in a private environment, and creating a safe space to spend time with peers when youths are not in school. Stigma and lack of anonymity are major barriers to adolescents and youth accessing contraceptive services. These Youth Friendly Corners are key to our efforts to reduce HIV infection and pregnancy among youth.

**School Health Clubs** – Every week, students and teachers at the government-run primary schools hold health club meetings. Over 2,000 girls and boys in grades 6 to 8 attend the clubs during after-school hours. The health club patrons are Lwala-trained teachers who implement a curriculum entitled Life Skills that discusses comprehensive sexual and reproductive health, contraception, gender-based violence, children’s rights, and more. We added a curriculum entitled Young Love to address the high prevalence of inter-generational relationships that often lead to teenage pregnancy and HIV-infection. Since teachers often resist teaching sex education during class, the school health club program enables students to learn about sexual and reproductive health and other health matters after school.

**Better Breaks** – We hold 3 Better Breaks sessions every year to give kids a fun, safe, and educational activity to enjoy during school vacations. During Better Breaks sessions we administer pregnancy tests, provide contraception, and test kids for HIV. We survey the attendants of our Better Breaks sessions on topics such as contraception access, gender-based violence, and perceptions of safety in the community.

**ECONOMIC EMPOWERMENT**

**Village Enterprise**

To provide economic opportunities to our community, we partner with Village Enterprise, an expert in poverty graduation for the “ultra-poor.” Village Enterprise identifies the poorest members of the community through a poverty assessment. The assessment uses the Progress Out of Poverty Index (PPI), which measures household wealth and ranks households into four wealth categories. Those in the lowest category, ultra-poor, qualify to be enrolled into Village Enterprise, making them eligible for micro-grants and business skills training.

**Business Groups** – Village Enterprise groups all of the enrollees into 3-person business groups to receive training and start a business as a team. Village Enterprise provides each 3-person business group with a start-up grant of $100 and they are required to contribute $10 of their own money to ensure their commitment. Village Enterprise supports farming, retail, livestock and skilled service jobs.

**Business Savings Groups** – Village Enterprise makes groups of ten businesses, or thirty people, to create larger business savings groups. After covering their costs and paying themselves, the participants invest their profits into the business savings group. The participating businesses can then borrow from this common pool of money to grow their businesses and they pay interest on the loan to grow the money pool for the entire group. We track business savings groups from inception to graduation.

**Community Bank**

Lwala Community Bank is a savings and loans cooperative, which operates independently and provides pro-poor financing to staff and community members. The bank is designed to increase access to fair and reliable microfinance and financial products for rural communities. Each member pays into the bank when they join, and after six months they are eligible to begin taking loans from the common pool of money. The assets held by the bank grow as the borrowers pay back interest on their loans. The loan products are specifically designed for the community’s needs – focusing on agriculture and other small
businesses. Lwala also supports mentorship by encouraging successful business owners to mentor newer members and to motivate other entrepreneurs to join the bank.

**MEASUREMENT**

Our Monitoring and Evaluation (M&E) system enables our team at Lwala, service providers, and government policy makers to make **client-centered, evidence-based decisions**. This means that we are building data collection systems while pushing analysis and conclusions at all levels of staffing, from frontline workers to government officials. We are using emerging technologies and platforms such as mUzima and CommCare to inform evidence-based decision-making and create information systems that drive systemic change.

Lwala’s performance M&E starts with an overarching **impact framework** designed to assess our collaboration with the community to improve overall health, agency, and wellbeing. The impact framework consists of a suite of **key performance indicators** (KPIs) and associated targets aligned with our ambitious goals. Each month, we evaluate our progress on our KPIs and compare our results with external results on comparable indicators to understand our impact. Our KPIs are chosen because they are indicators tracked at an international level, in Kenya, and specifically in Migori County (e.g., rate of skilled deliveries).

**Program Evaluation**

We are in the midst of conducting a robust evaluation of our program expansion. This quasi-experimental study employs repetitive cross-sectional surveys to understand health impacts in Lwala sites compared to control sites. The study focuses on maternal and child health, but also collects a wide range of socio-economic data to help us understand more about the drivers of health outcomes. The sampling frame factored in approximately 6,000 households and sample size was calculated using a binomial test to compare one proportion to a reference value. For survival analysis, Cox regression models with clustering at the household level were used to estimate hazards ratios. We will continue to gather this data over time.

**Research Partnership with Vanderbilt Institute for Global Health**

Lwala’s Monitoring & Evaluation activities are supported by faculty at Vanderbilt Institute for Global Health who lead key research initiatives and publish academic studies. We also employ the support of Vanderbilt biostatisticians to set up survey designs and analyze data. Vanderbilt Institute for Global Health published a study in PLOS One that found that prior to Lwala’s intervention, 105 children under 5 died for every 1,000 live births. From 2012 to 2017 that rate dropped to 29.5 deaths per 1,000 live births\(^{20}\). This reduction outperformed rates for our region (82 per 1,000) and for Kenya as a whole (52 per 1,000)\(^{21}\). Another VIGH study in the publishing process shows a 300% increase in contraceptive uptake at Lwala sites, compared to no change across 12 control sites\(^{22}\). And, a third study shows Lwala-trained and supported Community Health Workers (CHWs) are 2.5 times more likely to be knowledgeable of danger signs in early pregnancy and infancy than status quo CHWs\(^{23}\).

**Technology-Enhanced Iterative Learning**

Lwala manages a data system designed for supervision on tailored client care and a sophisticated beneficiary-centered database. The system is built in a Salesforce platform, which houses health and

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\(^{21}\) Kenya Demographic Health Survey (2014)


demographic information for more than 20,000 individuals. Through a customized CommCare application, Community Health Workers access and input information about their maternal, child, and HIV-positive clients in real-time and the data is automatically updated in the database.
Staff Spotlight

GEORGE OMONDI

George joined Lwala in January 2015 as an Electronic Medical Records clerk. He is now a Clinical Data Officer with our Monitoring & Evaluation team.

In his hometown of Oyugis, George started Amsha Vijana, “Wake Up the Youths,” a Youth Group that focused on educating youths on drug abuse and HIV. There was a boy on his basketball team whose brother died of HIV/AIDS. That boy was also sick, and they later found out that he was HIV-positive. Despite being very close friends, the boy hadn’t told George about his status because of stigma. George and his teammates helped organize basketball games in collaboration with organizations including the Red Cross to provide HIV counseling at the games. From there, Amsha Vijana became a youth organization and grew.

During the 2007 post-election violence in Kenya, he worked with a national advocacy NGO called Uraia to help prevent violence in his community. George was elected as a peace ambassador and went to community market places to preach peace to the community.

When George joined Lwala, the data systems were weak and staff were reluctant to move to a digital system. George was a driving force in transforming the system not just as a database but into a point of care system helping in timely retrieval and management of patient data that it is today. Our EMR system now holds all of our HIV patient data and George has trained over fifty staff to use the system at the point of care. Courtesy of his efforts, Lwala hospital is one of the only two facilities using KenyaEMR at the point of care.

George envisions a Lwala that has fully embraced the power of technology. He has championed a new technology called mUzima, which refers to HIV clients tested in the field, directly into Lwala’s EMR system for seamless care. February was the first month of patient enrollment and over 300 patients were tested and logged into the system.

“George is the best staff I have ever worked with; the very best. He is very knowledgeable, very polite and always ready to help you. He has mentored me. I was not always knowledgeable about systems and he has really helped me.” – Christine Onyango, Head Nurse.
**Beneficiary Story**

**DOREEN ONYANGO**

Doreen Onyango’s* baby Patience* was diagnosed with malnutrition in September 2018. Doreen noticed that her baby was small and that she seemed very tired. At her friend’s urging she brought Patience to Lwala Community Hospital for treatment. They were brought to the nutritionist, Nancy, who gave her a full evaluation. Nancy took a Middle Upper Arm Circumference (MUAC) reading, which is a very simple way to assess a child’s weight compared to height.

Patience’s MUAC was 10.7 cm, which indicates severe, acute malnutrition. Patience was admitted to Lwala Community Hospital for four days where she was given supervised feedings and nutritional support from our clinical and nutrition teams. Doreen and Patience were enrolled in counseling and our mother-care peer groups where they received nutrition education and psychosocial support. Finally, they were discharged with supplements and therapeutic feedings to support weight gain.

When Doreen and Patience returned two weeks later, the baby had started to improve and was more alert due to increased micronutrient intake.

Doreen was enrolled in agronomy training and given spinach seeds, pumpkin seeds, and squash seeds so that they could start their kitchen garden. Doreen is a farmer and sells her crops as her economic means, but she had not known how important a diverse diet is for a baby until she joined the nutrition program. Now Patience has a MUAC reading of 14.5 cm, which is healthy and normal.

“I really appreciate the Nutritionist Nancy who gave us supplements and counseling and I encouraged another mother with a very small baby to come receive the same support,” Doreen said.

*The names in this story have been changed to protect the privacy of our clients.*