Dear Allies,

As an organization, one of our core values is being community driven—we know this is what it takes to achieve long-lasting change. For this reason, we’ve worked with communities for the past 15 years to innovate, test, and adapt our community-led health model. Over time, we’ve brought more communities into the fold, and our roots in Lwala grew to all of Rongo Subcounty, where we have been delivering health services to 125,000 people.

And now, we are thrilled to expand to two more subcounties in Migori, Nyatike and Awendo, where we will work with new communities to advance their health and well-being. This scale-up will triple our reach—both in terms of the population we serve and the community health workers (CHWs) we support—on our way to reaching all 1.1 million people in Migori.

Awendo Subcounty neighbors Rongo and is similar in geography, population size, climate, and economic activities. Like Rongo, Awendo is mostly rural, with an urban center. Nyatike, on the other hand, is located on the coast of Lake Victoria and is larger in population and geography. The climate is much drier but flooding is also common. Additionally, the fisherfolk who occupy the shores of Lake Victoria are more mobile, which can be challenging for providing consistent health services. This expansion will be a critical test of our model as we scale to the entire subcounty, rather than gradual ward-by-ward entry as we’ve done in Rongo. Starting with the larger administrative unit provides the benefit of evaluating and strengthening the entire network of CHWs, health facilities, community committees, and data systems.

We’ve dedicated significant time to building the support we need to begin work Nyatike and Awendo—meeting with communities, engaging with local partners and governments, and establishing plans for supporting CHWs, health facilities, and community committees. Through these entry activities, we have heard about major challenges faced by communities, their ideas for action, and the roles of existing community-based organizations. We also heard a longing for authentic partnership—these communities are looking for a long-term ally to support them in overcoming intractable, systemic challenges. We look forward to rising to their expectations.

We’re also excited about how this expansion will advance national efforts to digitize the community health workforce in Kenya. Since 2020, Lwala has worked alongside our partners to develop the Electronic Community Health Information System (eCHIS), a new national system for collecting and using community health data. After a pilot earlier this year, the Kenyan government is ready for rollout. Lwala will be training and supporting CHWs to use the eCHIS platform in Nyatike and Awendo, which will be the largest deployment in Kenya. This tool will help standardize CHW service delivery and enable government to make evidence-based decisions about community health using real-time data.

As always, we thank you for your allyship and support in advancing communities as the most powerful agents of change.

In solidarity,

Ash Rogers  
Co-Chief Executive Officer

Julius Mbeya  
Co-Chief Executive Officer
OUR MODEL

Founded by a group of committed Kenyans, Lwala Community Alliance unlocks the potential of communities to advance their own comprehensive well-being. We believe that when communities lead, change is lasting.

4,206
community groups
advancing comprehensive
wellbeing

397
professionalized CHWs
directly supported

2,670
CHWs trained across
Migori County

214
facilities equipped to
manage obstetric
hemorrhage

OUR IMPACT

Percent of households visited by a CHW each month

Health Facility Assessment Scores
79% average improvement in quality of care

Contraceptive uptake
As measured by Couple Years of Protection

Childhood immunization rates

27%
increase in young people accessing youth friendly services through community activities and facilities since the same period in 2021

700+
CHWs registered for advocacy network in Migori County

21%
increase in well-child visits at Lwala partner facilities from 2021 to 2022, compared to a 2% increase across comparison facilities

22%
increase in antenatal care visits across Lwala partner facilities from 2021 to 2022, compared to a 5% decrease across comparison facilities

300
hand washing stations and 118 latrines built each month on average
Saving newborn lives through community-based care

The first month of a newborn’s life can be the most joyous. But it can also be the most dangerous, especially if a serious illness or infection goes untreated. Globally, 2.8 million babies die during this vulnerable period each year, with 99% of deaths occurring in low-resource settings like Kenya. Neonatal infections—including sepsis, meningitis, pneumonia, and diarrhea—are a leading cause of death. Though the majority of these deaths are preventable, too often families don’t have access to lifesaving care for their children. Lwala and partners are working to change trends in infant mortality by mobilizing the community health system as a first point of care.

Jane, a new mother, knew something was wrong with her month-old son. He wouldn’t stop crying, and it seemed he was struggling to breathe. While Jane was pregnant, she had attended a parenting class led by community health workers (CHWs), and she remembered these as danger signs of illness in infants. Jane spoke with her mother, who agreed it was best to call their CHW, Rose. “We live far from a hospital,” Jane says, “but I trusted Rose to come quickly and advise me on what to do.”

Like Jane’s son, 1 in 10 newborns under two months old develop signs and symptoms of a possible serious bacterial infection (PSBI), such as pneumonia or sepsis. For years, the gold standard for treating these newborns was referral to a hospital and 7 to 10 days of injectable antibiotics. But in some cases, especially in rural settings, hospitals are out of reach and week-long stays are not possible. Fortunately, emerging evidence shows that many cases of PSBI can be addressed through coordination between CHWs and primary health care facilities.

It’s already standard practice for CHWs to visit newborns in the first 2 days after birth—but without training on PSBI, we miss an opportunity to identify and treat infections before they become life threatening. In 2020, we launched a pilot to fill this gap, in partnership with the Bill & Melinda Gates Foundation, Living Goods, Population Council, and Northwestern University. Across Migori and Busia Counties, we trained 727 CHWs, 104 CHW supervisors, and 104 facility-based staff on PSBI management.

Through the pilot, CHWs counsel families on newborn care, recognition of danger signs, and the importance of prompt care-seeking during household visits. CHWs also assess newborns for symptoms of PSBI and refer sick newborns to nearby primary health care facilities. Here, trained providers confirm the CHW’s assessment and make a diagnosis. In some cases, newborns are treated with injectable or oral antibiotics. In the case of critical illness, newborns are given an initial injection and then referred to a hospital.

This training enabled Rose’s swift response when she visited Jane and her baby. Rose first assessed the newborn, taking his temperature and counting how many breaths he took in a minute. “I observed that he was breathing very fast, so I knew I needed to refer him to a health facility,” Rose says. She even helped organize transportation. At the health facility, the baby was diagnosed with pneumonia and treated with amoxicillin. Health workers kept Rose updated on progress, and when Jane and her baby returned home, Rose continued to visit the family to ensure he completed his course of antibiotics.

Rose’s follow-up visits represent a key component of PSBI management. After newborns are treated at a health facility, CHWs conduct follow-up visits to encourage completion of their medication, as well as return to the facility if needed (e.g. for additional injections). This requires significant coordination.
between CHWs and health facilities, and throughout the pilot, we tested ways to strengthen these linkages. We updated referral slips, for example, to improve the flow of information from CHWs, to facilities, then back to CHWs. Additionally, more than half (53%) of facilities decided to station CHWs at a desk to receive sick infants, review their referral slip, and ensure they see a provider. These “CHW desks” improved both community linkages and families’ experience. “Some clients feel more comfortable in the presence of CHWs who are familiar with them,” said one health provider in Migori.

Results from the pilot are promising: they confirm that CHWs and primary health care facilities can manage PSBI in infants when hospital-level care is not feasible. During the pilot, CHWs identified danger signs in 1,119 newborns under two months and referred them to a primary health care facility. 83% of these newborns were taken to a facility and treated, and 92% were visited by a CHW two days later to confirm their recovery. There were, however, some caregivers that declined or delayed visiting a health facility because of distance or financial barriers. We learned that CHWs can reduce these delays by physically escorting mothers and newborns to the facility. Other family members declined care because of cultural beliefs that newborns should not be taken from the home in the first months of life—we are addressing this belief through community forums, where health providers and religious leaders highlight the dangers of delayed care.

Community-based PSBI management was endorsed by new World Health Organization (WHO) guidelines released in 2015, but it's far from being fully integrated into national health systems and leading global priorities on neonatal health. In Kenya, PSBI management has been incorporated into newborn care guidelines for health providers, while guidelines for community management of newborn care for CHWs is underway. Yet significant action and government commitment is needed to scale up this essential newborn care, including training all health workers, improving supply of commodities, and strengthening linkages between CHWs and facilities. Globally, PSBI must be prioritized in the Every Newborn Action Plan and the Primary Health Care agenda.

Without concerted effort to integrate newborn care into health systems, neonatal mortality will continue to lag behind other improvements in health outcomes. This pilot strengthens the case for community-based PSBI management to save newborn lives, and we will continue working with our partners to pursue a pathway to scale in Kenya.

Jane and her baby offer us hope for the care CHWs can provide—he is now fully recovered from pneumonia. “As a young mother, I was concerned about making the wrong choice for my baby’s health. That’s why CHWs are so important—because of the health messages they spread and the care they give. They offer solutions that are possible for my family.”

- Jane, a new mother in East Kamagambo
Over the past 15 years, Lwala has learned that improving health outcomes requires rebuilding trust. Imagine that early in your pregnancy, you travel 5 kilometers to your nearest health facility to check on the health of you and your baby. When you arrive, you have to wait hours in a crowded room, the nurse who sees you is rushed and rude, and you’re told that some of the tests you need are not available—so you’ll need to visit a different facility even further away. Now imagine this happens every time you seek health care for you or your family.

These experiences cause a breakdown of trust in the health system. For this reason, a central pillar of Lwala’s community-led health model focuses on engaging clients to drive improvements in their local health facilities. When people receive high-quality, dignified care, they are more likely to return again and again for lifesaving services.

Across a network of 10 partner facilities, Lwala brings together community members, facility-based health providers, and community health workers (CHWs) to rebuild trust. We work with these groups to conduct biannual assessments, which identify areas of progress and priorities for improvement. Armed with this information, facility teams develop and implement improvement plans, review outcomes, and make adjustments—ultimately improving the quality of health care.

The journey toward high-quality care at Ngere Health Facility
Ngere Health Facility, which provides services for about 6,000 people, joined Lwala’s quality improvement program in 2018. Soon after, Ngere reestablished its health facility management committee (HFMC), which brings together community members, facility staff, and CHWs to spearhead improvement projects. Over the next two years, Lwala supported the HFMC as they expanded the maternal and postnatal wards and provided clinical training for staff, translating to better care for patients.

Yet a number of challenges persisted: patients noted long wait times and a lack of privacy. The facility also lacked a laboratory and key supplies to test for malaria and HIV. During an early assessment of the facility, 67% of drugs were out of stock. This meant that patients who arrived at Ngere often had to go elsewhere.

One result of these challenges was a low rate of antenatal care—pregnant women in the area sought care elsewhere or skipped it altogether. After last year’s assessment showed declining scores, the HFMC and facility staff held an emergency response meeting. Together, they devised a plan of action to improve the quality of services. First, Lwala supported a training on focused antenatal care, which equips staff to detect pregnancy complications early. Ngere also converted unused staff housing into a temporary laboratory, where they could conduct antenatal care profiling, a series of tests that identifies risks to a mother and baby’s health. Meanwhile, Lwala helped fill gaps in missing test supplies at Ngere and

What does high-quality care look like?
- **Service delivery**: the right services are provided to the right people, in adherence with clinical guidelines
- **Health workforce**: an adequate number of trained staff are always available to provide dignified, patient-centered care
- **Information systems**: data is routinely collected, accurate, and used for decision-making
- **Supply chain**: commodities and supplies are available to support service delivery
- **Finance**: adequate resources are available, and systems are in place to track spending
- **Governance**: structures like health facility management committees are trained, meet regularly, and drive improvement plans
Ochieng, a clinical officer at Ngere, says, “The HFMC and staff have been trained to focus on projects with the greatest impact on the community.” The HFMC’s chairman Akal Azaria adds, “When the needs of the community are addressed, it makes me happy. A healthy relationship between the community and its facility is everything.”

Improvements across Lwala’s 10 partner facilities

Beyond Ngere, the most recent facility assessment showed gains across Lwala’s 10 partner facilities. Since the beginning of this work in 2018, we’ve seen a 79% average improvement in quality of care. This requires constantly identifying new challenges—and working with facilities and communities to implement solutions.

Over the past year, for example, an important focus has been ending drug stockouts. First, facilities have improved their inventory management, including the removal of expired drugs, and HFMCs have been trained to track stock levels. Lwala also supported the transfer of commodities from facilities with an oversupply to facilities with a limited supply. Recognizing this is a systemic issue, Lwala is working with VillageReach and the Ministry of Health to develop a system that tracks commodity levels, which will improve reallocation and procurement. While progress remains, we have seen stockout rates at our partner facilities decline from 52% in 2018 to just 13% today.

The community-led health model recognizes that there is no single solution to improve health outcomes—and address decades of inequities—alone. But when CHWs reach every household, community health committees tackle problems affecting their neighbors, and health facilities improve the quality of their services, we see the health of communities transform.
Strengthening the health system

Mobilizing CHWs as advocates
Too often, CHWs’ voices are excluded from decision-making that impacts their work and the communities they serve. Last year, Lwala joined the Community Health Impact Coalition (CHIC) and CHWs around the world to develop an advocacy training for CHWs. So far, 133 Lwala-supported CHWs have been trained. Additionally, in Migori County we launched a CHW Network as a platform for CHWs to engage in advocacy. In the first 9 months, more than 700 CHWs have registered, largely due to grassroots recruitment and interest in recently passed Community Health Services Legislation. “A fire has been lit,” says our Director for Health Systems Strengthening, Doreen Awino.

Building community health champions post-election
With elections behind us, this is a critical moment to build champions for community-led health in the incoming administration. Working closely with other partners, Lwala oriented Members of the County Assembly on community health-related laws and policies, and we jointly reviewed budgets and work plans to identify ways to strengthen community health. At the national level, we are partnering with the Council of Governors, Ministry of Health, and Community Health Units for Universal Health Coverage (CHU4UHC) to develop memos that articulate community health priorities, which will be used as resources by legislators.

Equipping CHWs to manage childhood illnesses
In September, the national government approved new Integrated Community Case Management Guidelines (ICCM), which outline the role of CHWs in assessing, treating, and referring sick children under 5. Leveraging our implementation experience—as well as results from recent learning pilots—Lwala advocated for the integration of malaria, diarrhea, pneumonia, and Possible Serious Bacterial Infection (PSBI) management into the community health service delivery package. Equipping CHWs to respond to these life-threatening illnesses is critical in reducing infant and child mortality. As a next step, we are partnering with Stanford Digital Medic to digitize new ICCM Guidelines.

Advancing the Obstetric Hemorrhage Initiative (OHI)
Earlier this year, Lwala helped update the National Emergency Management of Obstetric Care Mentorship Guide to include content on managing obstetric hemorrhage. Lwala is now part of the national team working to cascade this training to health providers across the counties. Additionally, we ensured the inclusion of key OHI commodities—including the non-pneumatic anti-shock garment (NASG)—in the first draft of the revised Kenya Essential Medicines List, which should be approved early next year. This will unlock doors for government procurement and widespread distribution.

Next steps in CHW professionalization
Key steps in professionalizing CHWs include registration, training, and certification. In February, Lwala supported Migori County to count and register all CHWs. Since then, we have worked with the government to certify 2,461 CHWs, which means that approximately 90% of CHWs in Migori County have undergone a standardized assessment of their knowledge, skills, and competencies. Importantly, this assessment did not include literacy tests or education requirements, which often exclude women from such cadres but are not a predictor of a CHW’s work-related knowledge.
Delivering health services

Milestones in sexual & reproductive health
In a milestone for sexual & reproductive health, our provision of contraceptives has more than doubled since this time last year. Drivers include our expansion to Central Kamagambo, as well as concerted efforts to reach youth and adolescents (read more here). We also conducted a Mystery Client Assessment, where young people rated the services they received at 14 facilities, as well as the “youth friendliness” of each facility. The assessment revealed gaps in privacy, staff attitude, and availability of IUD services. Since then, we have hosted youth-focused training sessions at 7 facilities to reduce stigma around youth family planning and improve the quality of services for young people.

Mobilizing caregivers to monitor child nutrition
For the past year, Lwala has piloted an intervention called family-led MUAC. Using a color-coded tape, caregivers measure their child’s middle-upper arm circumference (MUAC) to monitor their nutritional status. CHWs already conduct nutritional assessments during household visits–family-led MUAC is designed to promote earlier identification by caregivers themselves. In a recent qualitative study, focus groups revealed that 63% of caregivers felt empowered by family-led MUAC, taking pride in monitoring their child’s health status, and 100% reported taking the measurement at least once a month. However, CHW supervisors and technical staff expressed doubts that this translates to earlier treatment of malnourished children at a health facility, compared to referral by a CHW. We’re taking a closer look at referral rates to inform our decision to integrate family-led MUAC into our community health service package.

Engaging patients in decisions about their health
At Lwala Community Hospital, we routinely survey patients about their engagement with staff, to ensure that health providers listen to their concerns, take time to explain diagnoses and next steps, and provide information on preventative measures. In the latest survey, we learned 54% of patients seeking care at Lwala Community Hospital are from outside of our catchment area. This rate is higher than ever before and is a driver of our increase in patient visits, which is 24% higher than any previous year. Despite this, patient waiting times have remained stable, which is a key contributor to patient satisfaction. Overall, patient engagement scores were high, but we noted room for improvement in ensuring health providers talk to patients about preventative measures and what to do if a condition persists. These findings will guide our improvement process and future staff training.

Strengthening the supply of blood
Lwala has become Migori County’s leading partner in blood availability. Through Lwala-supported blood drives, we collected 4,498 units of blood in 2022, meeting 83% of the county’s target and nearly twice as much as was collected in the same period last year.

CHWs as the first line of defense against malaria
Throughout the year, Lwala has worked to fill gaps in malaria testing and treatment commodities. This quarter, we worked with health facilities to better quantify their commodity needs—and specifically to include test kits for CHWs in their supply orders. This means a more reliable supply for CHWs, who can now refill at their link facility. Additionally, we did a refresher training for CHWs on the new ICCM Guidelines (mentioned above), which now include malaria diagnosis and treatment, and CHW supervisors have also been trained to provide support. Together, this work enables CHWs to identify malaria as early as possible, which is especially important for children under 5.
Thought leadership on community-led health

When young people lead, communities are stronger
In celebration of International Youth Day, Lwala joined Communities at the Heart of UHC in hosting a webinar on young people championing health in their communities. Lwala Youth Peer Provider Fred Opiyo shared what works in meeting the sexual and reproductive health needs of his peers: more privacy, services before and after school, information that addresses stigma, and free or affordable contraception.

Bringing #PayCHWs to the United Nations
Lwala was proud to join our Community Health Impact Coalition (CHIC) partners at the 77th UN General Assembly in New York City. More than 100 people attended a CHIC event focused on professionalizing CHWs, and messages about gaps in payment—only 14% of CHWs in Africa are salaried—were echoed by policymakers and funders the rest of the week. Read more here.

Lwala's Board gathers in Nashville
In September, we were excited to bring our Board together in-person for the first time in three years. We also welcomed two new Board members, Mamka Anyona (Policy and Strategy Lead, United Nations Multi-Partner Trust Fund for Non-Communicable Diseases & Mental Health) and Erin Ricci (Director of Principal Gifts, Philanthropic Partnerships, and Strategy at Health Care Without Harm), who bring strategic expertise in health policy and philanthropy, respectively.

Challenges we’re addressing

Addressing stockouts of essential medicines
While we closed gaps in malaria supplies and other essential commodities for reproductive, maternal, and child health, many facilities in Migori County continued to experience stockouts of tranexamic acid (TXA), which is used to treat obstetric hemorrhage. We worked to identify the sources of the stockout, which included an election-related delay in government procurement. Now that the new administration is in place post-election, we are working with them to procure TXA from local vendors.

Safer water at Lwala Community Hospital
Through our integrated WASH program, we aim to solve the sanitation and water crisis in our communities. Our WASH community committees have made great improvements, like maintaining Open Defecation Free status in 41 communities and repairing the borehole at Rongo Subcounty Hospital, making the new surgical theater operational. However, Lwala Community Hospital is in urgent need of new sources of safe water due to the low water table near the facility. Community latrines frequently wash out due to high water tables in other areas, and in a recent water quality study we found that over 66% of water sources were contaminated with harmful bacteria. To address this, we’re exploring much larger and sustainable water initiatives, including piped water, to ensure safe and sufficient water availability.
Spotlight on community change-makers

All in the family: a mother and son working side-by-side at Lwala

To know the story of how Monica Adhiambo Otieno and her son Moses Omondi both came to work with Lwala Community Alliance is to truly understand the ripple effect of Lwala’s work in the community. Walking with Moses around the village’s perimeter, he points out the thick bush that laboring moms used to walk through to get to the nearest health facility hours away. Moses describes what it was like to grow up in a village with no access to health care: “It was very common for babies to die, and other community members too,” he recalls. “In one week’s time, you would hear mourning from two funerals.” When health care isn’t accessible, and families are losing loved ones at that rate, the consciousness of the entire village is affected.

Monica, Moses’ mother, grew up in a large family, and her education took a backseat to other priorities. She left school after sixth grade, and eventually moved to the village of Lwala where she married. After having three children, Monica made a life-changing decision—to return to school. The strength of her marriage to Moses’ father earned his support, and she enrolled in Lwala Primary School. Entering 7th grade as a 32-year-old—and wearing the same uniform as her own son just two grades behind her—made her a spectacle and subject to taunting. This was exacerbated a year later, when she became pregnant with Moses’ little sister, Olivia, who was born with sickle-cell disease. Despite all of these challenges, Monica persevered, earned her diploma, and went on to become a community health worker (CHW), where she works with Lwala to provide health services to her community.

As a caretaker for Olivia, Moses often took her to Lwala Community Hospital for sickle cell treatment. Haunted by the all-too-common mourning cries of his own youth, he was determined for his sister to have better health care. Now 13 years of age, Olivia is a thriving teenager. Inspired by this experience and by his mother, he began working with Lwala in 2015—first as a volunteer and then as a public health intern. During the COVID-19 response, Moses helped conduct screenings at Lwala Community Hospital, ensuring that patients could continue to access health care in the midst of the pandemic. Today, Moses is a program assistant with Lwala’s Mothers & Children program, which supports CHW training and service delivery—a fitting role for the son of a CHW.

Moses knows better than anyone the importance of a strong community health system: “You can’t just build a health facility,” he says. “You have to build a road, stock the commodities, find the staff, deploy the CHWs, sustain the resources. Lwala helps pull the levers at the systems level.” And as someone who remembers a time before Lwala, he thinks a lot about the legacy of the organization. “Lwala is truly one of a kind, with the community at the center and colleagues who support me to bring forth new ideas. Together, we are ensuring the wholeness of life for all the people we love.”

“My mother’s struggles and triumphs have helped me gain more focus, determination, and patience. She inspired me to also pursue a career in the health care field. I know that she endured a lot, but seeing that she prevailed gives me hope. I too hope to blaze my own trail as the first member of our family to go to college.”

- Moses Omondi, Lwala Program Assistant