From Reaching Out to Scaling Up: Pursing a Decade of Community-Driven Impact

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Problem

- Under 5 mortality rate: 82 /1,000 live births
- 53% facility delivery rate
- Gap in health workforce
- Political tension leading to health worker strikes
- Community distrust of formal health system
- Criminalization of traditional birth attendants
Our Mission: To build the capacity of rural communities to advance their own comprehensive wellbeing

- Develop, engage & support community committees that drive their own health solutions & hold health systems accountable

- Onsite support to government primary care facilities to improve quality of maternal & child care

- Recruit, train, pay, and supervise community health workers, whom are pulled heavily from existing cadres of traditional birth attendants

- Track every pregnant mother, child under 5 & person living with HIV

- Support community initiatives to promote health & overall “wholeness of life”
Achievements

• 97% skilled delivery rate

• 80% completion of prenatal visits

• 300% increase in contraceptive uptake

• 94% immunization coverage
## Elements of the Model

<table>
<thead>
<tr>
<th>Community Committees</th>
<th>Community Health Workers</th>
<th>Health Centers</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design, implement &amp; evaluate health initiatives. Hold health systems accountable.</td>
<td>Track &amp; provide care to every pregnant mother, child under 5, person living with HIV.</td>
<td>On-site training &amp; coaching for quality improvement.</td>
<td>Individual-level, real-time data, plus rigorous evaluation.</td>
</tr>
</tbody>
</table>
Big Impact by 2030

“Investment in Community Health Workers in sub-Saharan Africa can yield an economic return of $10 for every $1 invested by providing jobs, thwarting epidemics, and keeping people healthy”

U.N. Secretary General’s Special Envoy for Financing the Health MDGs and for Malaria, 2015

• Prove that community-driven solutions are uniquely positioned to transform systems. We seek to shift the aid paradigm in favor of investing in bottom-up innovation.

• Revise community health strategy across Kenya to professionalize Community Health Workers. This will ensure that 65 million people have access to health care, regardless of their distance from a health center.

• Reduce under-5 mortality, saving 250,000 lives across Kenya

• Support a global movement to professionalize Community Health Workers, opening health access to an additional 1 billion people
Scaling Impact: cut under-5 mortality 64%

Under-5 Deaths per 1,000 live births

1 – Household Survey of 30,000 population, supported by Vanderbilt Institute of Global Health
2 – Kenya Demographic and Health Survey, Nyanza Provence
Scaling Impact: Improved Maternal Outcomes

- Nearly 300% increase in family planning service visits, compared to no change in service visits at control sites\(^1\)
- ANC visit completion increased from around 55% in 2011 to 80% in 2014 at Lwala supported sites, compared to only 40% for control sites\(^1\)

**Percentage of live births delivered by a skilled provider**

- Virtually 100%\(^3\) facility deliveries compared to 70% at control sites\(^1\) and 53% County Average\(^2\)

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2 – Kenya Demographic and Health Survey, Migori County
3 – Internal Lwala data collected through Salesforce platform, across population of 30,000
Systems Change Strategy

LWALIA'S COMMUNITY-LED SOLUTIONS ARE UNIQUELY POSITIONED TO TRANSFORM HEALTH SYSTEMS

Influence
Share research & advocate for community-led health

Advise
Expand technical assistance across hotspots of poor health

Model County
1,000,000
Government adoption + peer replication + direct service

Replication
150,000
Direct service expansion

Current Population Served
60,000

Innovation Hub
30,000

Country
County
Community
Creating a Model County

• Constitutional changes in Kenya have devolved health services to county governments.

• Historically under-resourced counties, like Migori, are ill-prepared to take on the new responsibility. Migori County faces a disproportionate health burden stemming from limited human capital at the local government level, ill-suited health policies, poor infrastructure, and endemic surges of cholera and malaria.

• Counties with innovative community health models and the capacity to enact them have access to more resources through the central government, along with the power to negotiate for additional support from bilateral and multilateral funders.

• Migori County (which represents 1 million people) has asked Lwala to support its development of a comprehensive community health strategy.
Global Market Strategy

Geography: Migori County

| Market Size | 1 million people; 53% facility delivery rate |
| Existing Substitutes | Traditional birth attendants; under-supported community health volunteers |
| Align with National Priorities | Community health policy devolved to county governments; movement for professionalized CHWs (HRH advocacy); focus on maternal / child health |
| Distribution | High density of traditional birth attendants; relative *physical* access to health infrastructure |
| In-country relationships | Invitation for scale-up from MoH; Founded & led by local people |
| Collaboration partners | Strategy aligned with UNDP 6-county initiative w/ UNFPA as the county-level coordinating partner; implementing partner of University of Maryland (PEPFAR) & Planned Parenthood Global (Closing the Gap) |
## Global Market Strategy

### Market Assessment

<table>
<thead>
<tr>
<th>Market &amp; User</th>
<th>Target User</th>
<th>Mothers &amp; children under 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influencers</td>
<td></td>
<td>Traditional Birth Attendants, Community Health Workers, male partners, mothers-in-law, other community members</td>
</tr>
<tr>
<td>Relevant point of care</td>
<td></td>
<td>Home &amp; community-based care, with links to primary care facility</td>
</tr>
<tr>
<td>Competing products</td>
<td></td>
<td>Home-based delivery, traditional medicine, pharmacies, under-supported community health volunteers, private hospitals</td>
</tr>
</tbody>
</table>

| Distribution | Delivery channel | Existing cadres of traditional birth attendants, re-trained government community health volunteers, community committees |

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<thead>
<tr>
<th>Evidence &amp; Regulation</th>
<th>Additional evidence needed</th>
<th>Cost analysis at scale; health outcomes with randomized or more robust quasi-experimental control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory process</td>
<td></td>
<td>Approval received from MoH for next stage of growth, but change in community health policy needed for long-term sustainability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advocacy &amp; Financing</th>
<th>Target payer</th>
<th>County Ministry of Health, precedent of CHW payment in Nairobi County, costing fitted to county budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination</td>
<td>Scaling allies</td>
<td>Working through peer civil society organizations to replicate model &amp; act as an advocacy network</td>
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</table>
## Global Market Strategy

### Strategy To Scale

<table>
<thead>
<tr>
<th>Objectives</th>
<th>2018</th>
<th>2017</th>
<th>2020</th>
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<tbody>
<tr>
<td>Prove replicability &amp; answer key scaling questions, through <strong>expanding direct service</strong></td>
<td>• 3 additional government health facilities. 6 total facilities</td>
<td>• 3 additional government health facilities. 9 total facilities</td>
<td>• County ownership of community health strategy</td>
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<tr>
<td></td>
<td>• Launch rigorous program evaluation</td>
<td>• Continue rigorous program evaluation</td>
<td>• 5 additional facilities</td>
</tr>
<tr>
<td></td>
<td>• 60,000 population</td>
<td>• 90,000 population</td>
<td>• 14 health facilities strengthened</td>
</tr>
<tr>
<td>Build network of civil society implementers replicating community-led health model</td>
<td>• Train 2 replication partners</td>
<td>• Train 3 additional replication partners</td>
<td>• 150,000 population</td>
</tr>
<tr>
<td></td>
<td>• 30,000 population</td>
<td>• Establish advocacy platform for community health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Strengthen Migori County’s ability to <strong>drive maternal and health outcomes</strong></td>
<td>• Usage of Lwala data to inform policy creation</td>
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<td>• Dissemination of program evaluation results</td>
</tr>
<tr>
<td></td>
<td>• Identify learning goal from co-implementation of “direct service model”</td>
<td>• Evaluation year 1 expansion &amp; begin incorporating lessons into community health strategy</td>
<td>• Support revised community health strategy &amp; incorporation of policy into county budgeting process</td>
</tr>
<tr>
<td></td>
<td>• Co-County plan to improve data systems</td>
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<td>• Host regional conference to share “Migori County Model” with other counties in Kenya</td>
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Theory of Change

- Recruit primary care facilities thru public private partnership with MOH
- Onsite nurse & clinical officer training & mini nurse rotation (HC 2 & HC3)
- Roll-out quality improvement program in reproductive, maternal & child health in HC2 / HC3

Key

Activity

Intermediate outcome

Final outcome

- Increased uptake in family planning services
- Fewer unwanted pregnancies
- Reduction in maternal mortality

- Improved clinical care for children under-5
- Increased completion of 4 ANC visits
- Increased % of skilled deliveries
- Improved maternal care
- Elimination of mother-to-child transmission of HIV
- Positive health-seeking behavior by mothers
- Improved clinical care for children among families
- Reduction in child mortality

- CHWs trained in under-5 disease prevention, detection, treatment & referral
- CHW-led home-based prevention & care of preventable illness & malaria

- Active follow-up for immunizations
- Increase in on-time immunizations
- Early detection & treatment of under-5 illnesses
- Positive health-seeking behavior for children among families
- Increased community involvement and participation in management and delivery of health services

- Train CHWs in reproductive health education
- Train CHWs in pregnancy tracking & accompaniment
- CHWs trained in under-5 disease prevention, detection, treatment & referral

- Active home-based surveillance of under-5 households
- Active follow-up for immunizations
- Early detection & treatment of under-5 illnesses
- Increased completion of 4 ANC visits
- Positive health-seeking behavior for children among families

- Connect CHWs to HC2s (formal health system)
- Recruit CHWs from traditional birth attendants & community leaders

- Train health management committees on clinical quality support at HC2s
- Train health management committees on clinical quality support at HC2s

- Connect CHWs to HC2s (formal health system)
- Recruit CHWs from traditional birth attendants & community leaders

- Community participation in county health budget making & monitoring

- Decrease in maternal mortality
- Reduction in child mortality
Cost Analysis

At-Scale Cost of CHW Model

1 - Cost per household per year is calculated as:
Total project cost / total number of households served (Using an example of one sub-county: $300,000 total project cost / 25,000 households served by ~210 CHWs = $12/household)

2 - Cost per capita per year is calculated as:
Total project cost / total population of the region (Using the same example: $300,000 total project cost / 150,000 total population = $2/capita)
Research Plan

• Collaboration with Vanderbilt University faculty
• Household survey instrument developed using Demographic and Health Survey and other validated tools; adapted locally
• Sampling frame = administrative locations in 2 sub-counties of Migori County
• Baseline survey carried out across sampling frame sites
• New intervention sites selected from sampling frame annually
• All sites considered as control sites until selection; 2 sites remaining as control at end of research period
• Findings shared internally and externally on an ongoing basis
# Health Impact

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
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<tbody>
<tr>
<td>Children under 5 lives saved</td>
<td>950</td>
</tr>
<tr>
<td>Individuals Enrolled (Lwala Direct Service)</td>
<td>150,000</td>
</tr>
<tr>
<td>Individuals Enrolled (Peer replication)</td>
<td>850,000</td>
</tr>
<tr>
<td>Lives Improved - Facility Deliveries (Direct service)</td>
<td>20,250</td>
</tr>
<tr>
<td>Lives Improved - Immunizations (Direct service)</td>
<td>22,312</td>
</tr>
<tr>
<td>Lives Improved - Couple Years of Protection (Direct Service)</td>
<td>46,000</td>
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</tbody>
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## Financial Goals

- No single source of funds makes up more than 30% revenue
- 10% annual increase in earned revenue
- 20% annual increase in national health insurance fund reimbursement
- 3 – year budget projections are dependable
- 3 – month cash reserve
- 1 – month operating reserve
Program Goals

Train clinicians across 9 facilities on care protocols

Recruit & train 160 Community Health Workers directly

Achieve 97% skilled delivery rate

Achieve 90% immunization rate

Reduce percent of underweight children by 10%

Reduce under-5 mortality rate to half the regional average

Reduce infant mortality rate to a third of the regional average
Part of a Global Movement


Key Differentiators:

• **Community Innovation:** Community Committees lead design, implementation & evaluation

• **Transformed Traditional Birth Attendants:** Turning the main competitors to a facility delivery into the loudest champions of skilled births, contraceptive use & immunizations

• **Ministry of Health demand:** MoH approached Lwala asking for us to scale our model to the entire county (1 million people)

• **Academic Partnership:** Longstanding partnerships allows us to rigorously evaluate our work

• **Data Driven:** Comprehensive and accurate data collection facilitates our targeted, realistic, and effective innovations