


NILINDE

LESSONS LEARNED

Creating a pathway for strengthening child protection and welfare for orphans and vulnerable children in Kenya

PEPFAR

USAID FROM THE AMERICAN PEOPLE

NILINDE Healthy. Safe. Stable. Secure

PLAN INTERNATIONAL

> We have empowered service delivery partners and community workforce to improve quality services and enhance efficiency in their delivery. These investments contribute to sustainable programming to combat the HIV epidemic and its aftermath.
>
> **Tessie San Martin,**
> *President and CEO, Plan International USA*

CONTENTS

For Plan International Kenya, Nilinde has provided an opportunity to reach the hard to reach and often neglected orphans and vulnerable children, empowering them to live and thrive. It has also bolstered our influencing and advocacy resolve, both in program design and in intentional policy dialogue around child protection and well-being. Nilinde was not just a project but an approach, a way of life.

Kate Vorley
Country Director, Plan International Kenya

The three years of implementing Nilinde has been a stimulating experience for both the project teams and the beneficiaries. The journey has tested the resilience of Nilinde's Theory of Change and confirmed that it is possible to lift the often left out in society, especially orphans and vulnerable children [OVC], to health, safety, education, and stability. For us, the successes resulted from intentional engagement with the community, both as drivers of change and as implementers; partnership and collaboration with stakeholders in OVC programming, which has provided linkages and strengthened the referral framework for service delivery; and working with the government line ministries and the Department of Children Services with the mandate to ensure child protection in Kenya. We are grateful for USAID support in funding Nilinde but also in supporting the cause that all children deserve to live and thrive regardless of their background. Because of this, so many families have been lifted from extreme poverty through household economic strengthening and have improved their health outcomes in a way that is holistic and sustainably linked to universal health care through the National Hospital Insurance Fund. We share our achievements, lessons, and challenges as an inspiration that when we work together in an integrated and coordinated manner, all children will thrive.

Stephen Ingabo
Ag. Chief of Party

> The identification and response to child protection issues in the community has greatly improved because the community appreciates data use. This has improved our efforts in addressing child welfare and protection.
>
> **Mr. Stephen Gitau,** *DCS - Kwale County.*

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (drugs)
ART	Antiretroviral Therapy
CBT	Community-Based Trainer(s)
CHV	Community Health Volunteer(s)
CLHIV	Children Living with HIV
CMM	Community Mentor Mother(s)
CPIMS	Child Protection Information Management Systems
DDIU	Data Demand and Information Use
DCS	Department of Children Services
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
ECDE	Early Childhood Development Education
GOK	Government of Kenya
GRI	Graduation Readiness Index
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
HVA	Household Vulnerability Assessment
LIP	Local Implementing Partner
MOEST	Ministry of Education Science and Technology
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PSS	Psychosocial Services
QIT	Quality Improvement Team(s)
SDP	Service Delivery Partner(s)
SRH	Sexual and Reproductive Health
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VL	Viral Load
VSLA	Village Savings and Loan Association
WASH	Water, Sanitation and Hygiene
YSLA	Youth Savings and Loan Associations

EXECUTIVE SUMMARY

In Kenya, approximately 3.6 million children—almost one-fifth of the total population under age 18—are orphaned or considered vulnerable. It is estimated that 1.1 million, or 44 percent, of these children have been orphaned due to HIV, having lost either one or both parents to the disease. Ninety percent lack medical, psychological, material, or social support. In response, the United States Agency for International Development (USAID) in Kenya designed the Support to Orphans and Vulnerable Children in Nairobi and Coast Counties of Kenya (Nilinde) project. Designed as a five-year program that was initially programmed to end in August 2020, it ended in June 2019, after three and a half years of implementation, due to budget constraints. Made possible with funding from the President's Emergency Plan for AIDS Relief (PEPFAR), the Nilinde project was implemented in six counties: Nairobi, Mombasa, Kilifi, Kwale, Lamu, and Taita Taveta. Driven by PEFPAR's strategy and aligned with national priorities, the focus on these counties was informed by the geographical disparity of the HIV disease burden in Kenya. In 2015, the Nilinde-focused counties contributed to 18 percent of the national disease burden; Nairobi and Mombasa alone contributed 14 percent.

Nilinde is Swahili for "protect me." It is a plea for protection from the orphans and vulnerable children (OVC) in Kenya who are unable to access critical services. Nilinde sought to improve the welfare and protection of children affected by HIV and AIDS in these counties. Plan International served as prime, and mothers2mothers, Ananda Marga Universal Relief Team (AMURT), and Childline Kenya were core partners. Nilinde used case management, a family-centered approach that works to support every child in four key domains: healthy, stable, safe, and schooled. Over the life of the project, Nilinde provided a wide range of services to 75,030 households and 183,547 OVC.

KEY RESULTS PER DOMAIN

HEALTHY: The overarching goal of Nilinde's interventions was for OVC to achieve and sustain healthy outcomes. The project achieved greater community involvement in service delivery, strengthened referrals and linkages to other service delivery partners (SDPs), and supported the direct delivery of age-appropriate services. Of the 163,454 OVC that Nilinde reached in its third year, for which reliable data were available, 98 percent of OVC had received key health messages, 91 percent were provided with HIV services—including HIV education and testing—and 4,780 HIV-positive children were linked to treatment and supported for retention in HIV care and adherence to anti-retroviral (ART) regimens. The project ultimately contributed to viral load suppression rates of 96 percent (3,905) from among the 4,083 children who had received their results. More than 15,000 children below age 5 were fully immunized and dewormed and received vitamin supplements, 97 percent of adolescents received sexual and reproductive health (SRH) education, and 95 percent of adolescent girls were educated on menstrual hygiene management.

STABLE: The interventions aimed to reduce the economic vulnerabilities of households with OVC. Nilinde adopted a household graduation approach that used a community-driven household vulnerability assessment (HVA) to assess, target, and reach 56,805 households with diverse economic strengthening interventions. As a result, 1,142 households graduated from extreme poverty to sustainable livelihoods. In addition, 20,992 households enrolled in village savings and loan associations (VSLAs), 21,717 enrolled in rotating (merry-go-round) savings and credit associations, and 18,332 households were provided with productive assets. These households now engage in income-generating activities, which has increased their sense of self-reliance. Through 1,367 VSLAs with a membership of over 20,000 caregivers, households mobilized Kes. 87 million (US $870,000) in savings within one year, which they loaned to one another. They used these loans to buy assets and invest in small businesses, leading to increased income. These households were then able to meet their basic needs, such as food, health care, shelter, and education for their children. The VSLAs are evidence of local ownership and self-reliance, and they contributed to improved health outcomes by enabling households to pay fees for the National Hospital Insurance Fund (NHIF), providing coverage for 28,722 OVC.

SAFE: The interventions aimed to prevent and mitigate violence and the abuse, exploitation, and neglect of children. Nilinde strengthened government systems and collaborated with relevant stakeholders to improve child protection and welfare. The project enrolled and linked 4,787 households to the government cash transfer program, where each caregiver receives a monthly stipend of Kes. 2,000 (US $20) to complement their income. This linkage with the government will promote sustainability beyond the life of the project. Nilinde trained caregivers in parenting skills and sensitized them to child protection and child rights, leading to improved child participation, reduced occurrences of child neglect, and an increase in positive parenting practices. The heightened awareness of children's rights directly contributed to greater numbers of children possessing birth certificates; 71,753 children had them by Year 3, and 85,504 children had them by the end of the project. Working with the national-, county-, and community-level structures to strengthen systems, improve referrals, and bolster child participation ultimately improved children's rights, gave children a voice through children's assemblies, and kept issues affecting children on the national agenda.

SCHOOLED: The interventions supported OVC, including adolescents, in overcoming barriers to accessing education. The project strove to increase school enrollment, attendance, retention, and progression among OVC. Since Nilinde's interventions, the number of OVC enrolled in school increased from 134,301 in 2016 to 144,859 at the project's end, and 135,957 were retained in school during the final academic period, compared to 86,906 in 2016. The project also

registered 133,114 progressions to the next school level. This improvement is attributed to the payment of school fees, regular tracking of school attendance, provision of life skills education, distribution of sanitary towels for girls, continual school monitoring, and parental involvement in OVC education.

KEY ENABLERS

Nilinde intentionally wove key enablers into the program to catalyze sustainable quality, reach, and access to OVC services. These enablers included empowerment and engagement of the community workforce as drivers of OVC service delivery, developing and strengthening the capacity of local SDPs to provide quality services, multi-sectoral partnerships and collaboration, gender and disability inclusion, use of data for decision-making, adaptive learning, and knowledge management. Nilinde also innovated the use of VSLAs to expand the inclusion of vulnerable populations in universal health coverage, worked with Community Mentor Mothers to lead the case management approach, and used community link desks to strengthen health service delivery for OVC. These overarching approaches directly contributed to self-sustenance, viral suppression in 3,905 children living with HIV (CLHIV), and community ownership of OVC support and protection.

LESSONS TOWARDS SUSTAINABLE SELF-RELIANCE

When community members drive the OVC agenda and collaborate with the government and other partners, the needs of OVC, including CLIHV, are better and more sustainably addressed. Nilinde's targeted beneficiaries acquired knowledge and skills that empowered them to improve both their health status and their health-seeking behaviors, which should enable them to adopt healthy choices and practices in the future. An empowered community workforce and strengthened linkages with partners are two community resources that promote sustainable health service delivery for OVC.

A strong stakeholder coordination mechanism, anchored within government infrastructure, promotes equitable distribution of resources, collective planning and priority setting, and accountability in resource use. Collaboration among multi-sectoral stakeholders can result in diversified services and synergies.

Effective use of technology both reduced the cost of doing business and allowed timely access to data for individuals and community-based partners' analysis and use, hence empowering the community and increasing their self-reliance. The Web-based OVC Management Information System, WhatsApp groups, and a national SMS platform for monitoring viral load data contributed in complementary ways.

Working within and strengthening existing community and government policies and structures facilitated project entry and implementation. This was particularly true of Nilinde's adoption of elements of the government's Community Health Strategy, including trained community health volunteers.

It is important to consider gender dynamics in household economic strengthening (HES) interventions. Nilinde found that in some cases, women's leadership in this area led to household tensions that could be mitigated though male engagement.

Programs should be prepared to react to unintended consequences. For example, in some Nilinde-supported households, when the adults began to focus more on their newly successful businesses as a result of successful HES interventions, children began taking on household duties and chores that were previously carried out by adults—a phenomenon that was mitigated with additional positive parenting skills training, among other actions.

RECOMMENDATIONS

Considering its critical role, donors and the government should initiate a policy dialogue on institutionalizing the community workforce in the continuum of care for sustainable long-term HIV treatment. Nilinde also recommends that the NHIF systems consider frequent payments at lower rates for vulnerable groups, and enhance collaboration with VSLAs to support increased uptake of NHIF, toward the goal of universal health coverage.

Donors may need to allow for longer planning and transition timelines when programs are requested to make geographical shifts due to changing strategy or budget constraints. PEPFAR's classification of counties informed Nilinde's prioritization and resource allocation when funding became more limited. The "maintenance" (low burden) counties were allocated fewer resources and support, with a resulting reduction in program intensity and one exit. The rapid scaling down meant a decrease in service delivery to beneficiaries, affecting the pace of achieving 90-90-90 goals around knowledge of HIV status, enrollment in treatment and care and viral load suppression, and limiting time to build the capacity of institutions to sustain the gains of the project.

CONCLUSION

Nilinde has empowered SDPs, county government structures, and the community workforce to own OVC programming and sustain service delivery beyond the life of the project. Households have also been empowered with new resources and skills. USAID's investment in this project has contributed to sustainable programming and strengthened livelihoods that will help to combat HIV and its impact on children and families, as demonstrated by the results and testimonials in this document.

> By strengthening our capacity to meet the needs of our households, Nilinde has sustainably placed the care and protection of our children in our hands as a community.
>
> **Caregiver,** *Kilifi County.*

SECTION 1:

OVERVIEW

BACKGROUND

In the last two decades, the Government of Kenya (GOK), with support from other partners, has invested in the AIDS response, and HIV underpins all national dialogues on public health, sustainable development, and economic growth. Kenya has lost close to 1.7 million people as a result of AIDS-related complications. Nearly 1.6 million Kenyans are living with HIV, and over 650,000 of them access antiretroviral therapy (ART). Close to 101,560 new HIV infections occur every year.[1]

About 3.6 million children in Kenya are orphaned [2] or otherwise vulnerable, representing almost one-fifth of the total population under age 18. An estimated 1.1 million, or 44 percent, of these children were orphaned due to HIV, having lost either one or both parents to the disease.[3]

Kenya has achieved great progress in addressing the needs of its OVC. Legislation, policies, and governmental and non-governmental structures have established a strong foundation for improving OVC welfare and protection. Through capacity development and public awareness initiatives, Kenyan households are better equipped to care for and support OVC. Unfortunately, these advancements alone cannot address all of Kenya's pressing OVC issues. In too many cases, those with the greatest need for OVC support are unable to access necessary services. Where access has been improved, the lack of coordination among service providers often leads to an overabundance of services in one area (e.g., health) and limited services in another (e.g., education).

One USAID response to this growing crisis was the Support for Orphans and Vulnerable Children in Nairobi and Coast Counties of Kenya (Nilinde) project, which sought to reach populations with the highest density of OVC affected by HIV and AIDS in the greatest need of services. With an equal emphasis on improving access to services, building the capacity of OVC stakeholders, and strengthening the systems and structures that seek to protect and care for OVC, USAID—with funding from PEPFAR— has made invaluable contributions to Kenya's commitment to address the critical needs of its marginalized populations. These contributions are geared toward achieving OVC priorities as laid out by the National Council for Children's Services, in their documents "The National Children Policy Kenya 2010" and its long-term development blueprint, "Vision 2030".

The GOK, USAID, and Plan International each played a role in designing the Nilinde project. Nilinde, which means "protect me" in Swahili, is guided by the belief that improving the welfare and protection of children affected by HIV and AIDS in a sustainable manner can be done only by (1) building the capacity of each affected household, and empowering them to provide for children under their care, and (2) strengthening the "supply response" of social service systems and structures at the county and community levels. These overarching approaches also benefit from focused institutional capacity-building of community-based organizations and the community workforce, which directly contributes to sustainable OVC care and protection.

A project beneficiary displays an information, education and communication material edveloped by children for children.

1.6 million

the number of Kenyans living with HIV; more than 650,000 of them access ART

3.6 million

the estimated number of OVC in dire need of critical services in Kenya*

* Kenya Ministry of Health; National AIDS Control Council. *Kenya AIDS Progress Report 2016.*

1.1 million

the total number of OVC that have been orphaned due to HIV, having lost either one or both parents to the disease

ABOUT NILINDE

The Nilinde project was implemented between August 24, 2015, and June 30, 2019, in six counties in Kenya: Nairobi, Mombasa, Kilifi, Kwale, Lamu, and Taita Taveta.[4] The focus on these counties was informed by the geographical disparity of the HIV disease burden in Kenya, clustered as high, medium, and low. In 2015, the HIV prevalence rates in the Nilinde-focused counties was as follows: Nairobi, 8.0; Mombasa, 7.4; Taita Taveta, 6.1; Kwale, 5.7; Kilifi, 4.4; and Lamu, 2.30.5 These six counties contributed 18 percent of the national disease burden; Nairobi and Mombasa alone contributed 14 percent.[5]

Nilinde was led by Plan International; other core partners included AMURT, Childline Kenya, and mothers2mothers. The initiative aimed to improve the welfare and protection of the most vulnerable households affected by HIV by increasing the resiliency of parents and caregivers and empowering them to improve the health and well-being of the OVC in their care. This work included a key HES model that emphasized gender integration and women's economic empowerment. In this way, Nilinde strengthened household and community capacity with knowledge, skills, and services to reduce economic vulnerability and reduce the risk and impact of HIV, AIDS, and other negative health conditions. By working toward the goal of supporting an AIDS-free generation for Kenyan children, Nilinde empowered OVC to pursue full and productive lives.

Nilinde also focused on steering communities, government partners, and other facets of society to be champions for the rights of girls and boys and to provide comprehensive, coordinated care to children made vulnerable by HIV and AIDS. Nilinde identified 32 SDPs as subgrantees and 164 site-level partners, all based in the community, and trained them to strengthen service delivery structures. With financial support as well as technical and management assistance from Nilinde, these community-based partners effectively strengthened their own capacity. They deserve great credit for consistently reaching the project-supported households and children with services, linkages, and referrals.

The project reached 75,030 vulnerable households caring for 183,547 vulnerable children, youth, and adults. Focusing on the different types of vulnerability within households and using an evidence-based HES model, Nilinde enabled caregivers to increase the resiliency and well-being of all members of the household.

A section of community workforce pose for a group photo after receiving Nilinde branded reflector jackets.

STRATEGIC RESPONSE

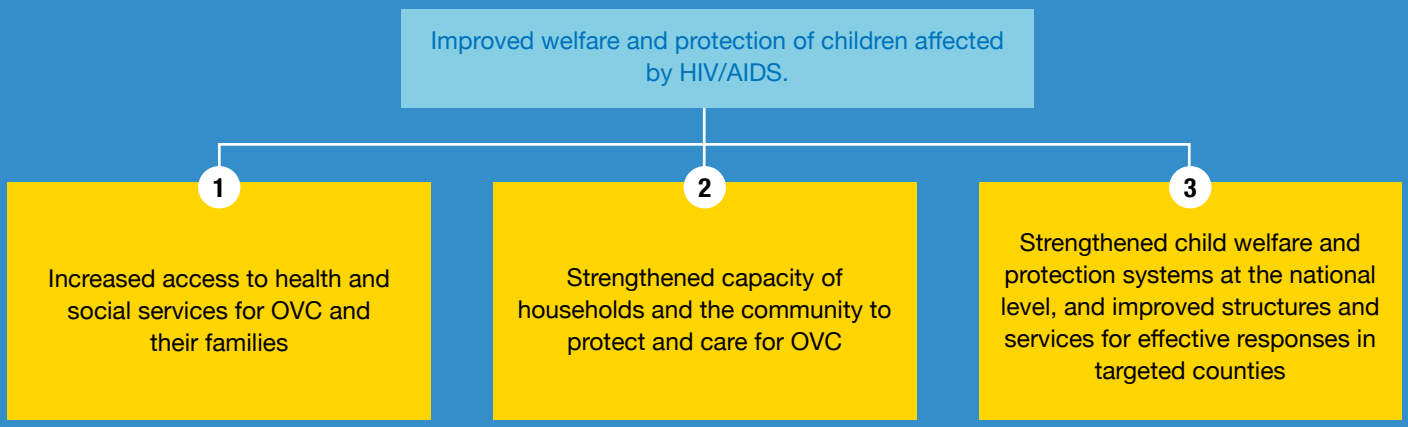
THEORY OF CHANGE

> If communities work together, families increase their capacity and ability to care for and protect their girls and boys. If government systems are strengthened and children and youth participate, girls and boys will be healthier and more resilient.

IMPLEMENTATION FRAMEWORK

As defined by USAID Kenya, to implement the Theory of Change, the project's logical framework was guided by an overarching purpose and three output areas:

Figure 1. Nilinde's implementation framework



To achieve the three outputs and consequently contribute to the overall purpose of the project, Nilinde adopted a case management approach to ensure timely, individualized, context-sensitive, and family-centered care for OVC.

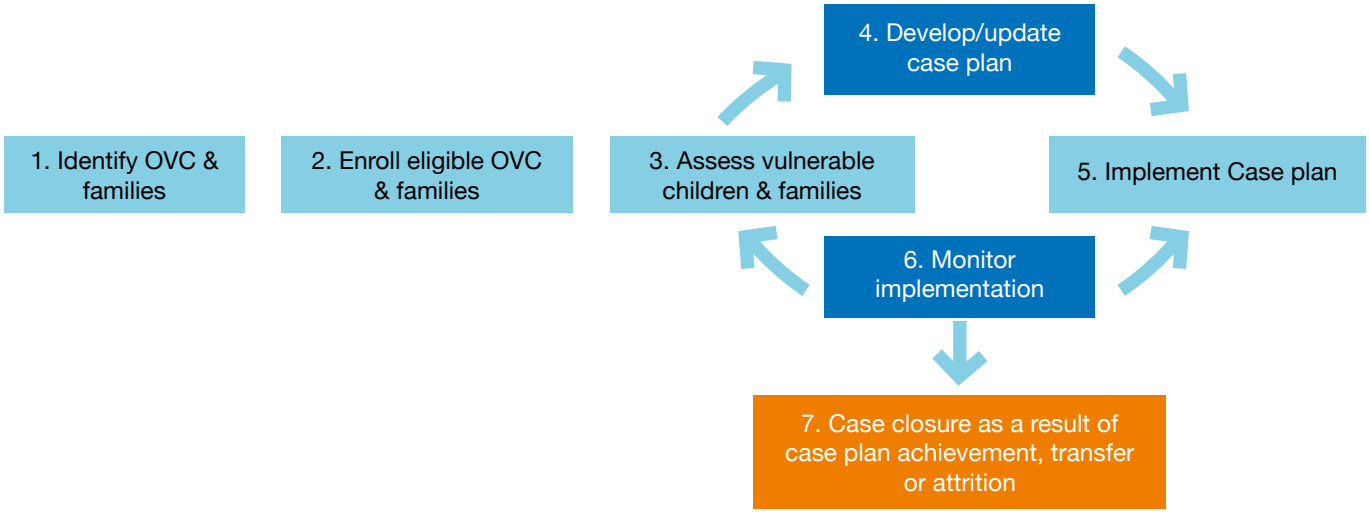
CASE MANAGEMENT

Case management is the process of identifying and assessing needs, planning and facilitating services, making and tracking referrals, and monitoring service delivery. Case management is overseen by a case worker or manager, who can be a community volunteer or a member of community-based organization, non-governmental organization (NGO), or government body.

In the early phases, Nilinde and other PEPFAR OVC programs relied on standard tools and information systems that produced routine data regarding perceived needs and services at the household level. If well-implemented, this type of case management, when combined with the community health volunteers' (CHVs) knowledge of the household, can adequately address children's needs. Initially, though, Nilinde experienced challenges with assessing the responsiveness of services to household needs and quality of services provided because the tools were not optimal, and the literacy level of some CHVs was low. Gradually, Nilinde strengthened the case management process by adopting newer tools, user-friendly standards of practice, and site-level support.

The process started with assessments at the household level to identify the needs of OVC in terms of health, food security, economic empowerment, education, and child protection. The project then developed and monitored household-specific case plans and either provided services or made referrals to relevant providers for services outside the project's scope. Partners included health facilities, government line ministries, political offices, private partners, NGOs, faith-based organizations, and U.S. government (USG) partners. Close monitoring of the case plans and collaboration with partners helped households access services and begin to achieve milestones.

Figure 2. Framework for case management.



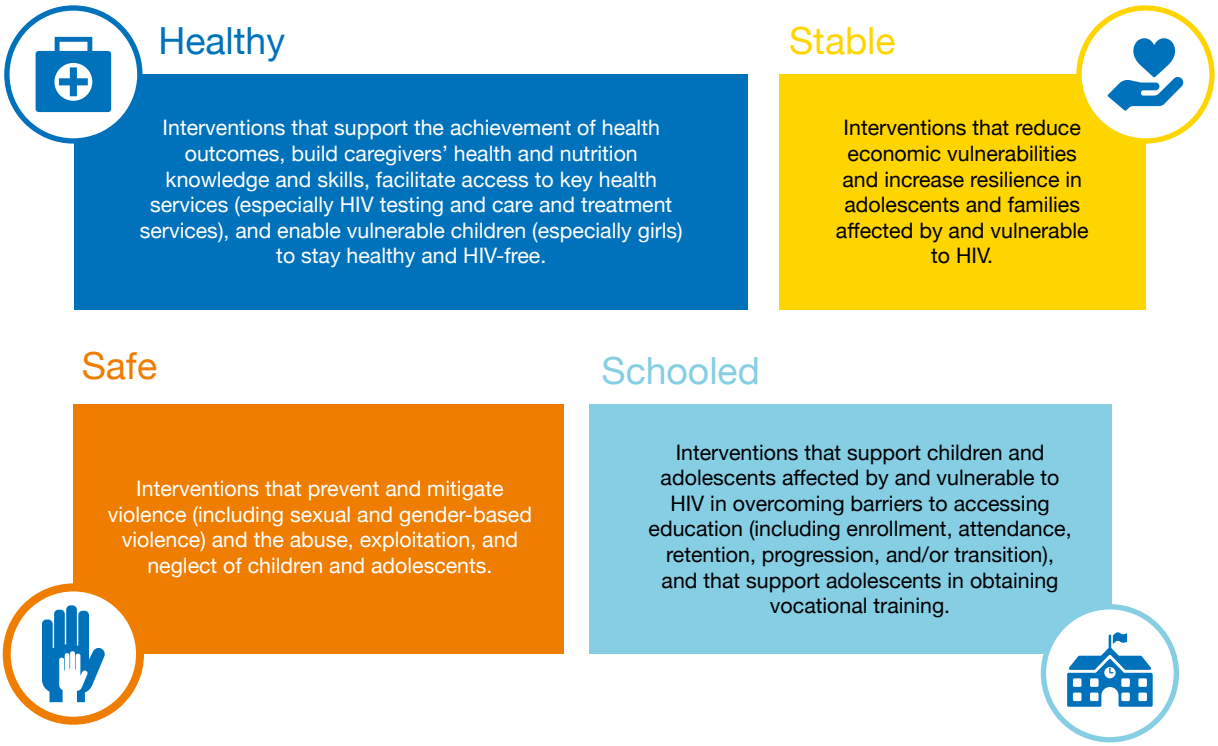
Raphael, one of Nilinde's caregivers in his thriving mixed kitchen garden grown on a raised kitchen bed. This method is used in arid areas to minimise water run-off and pest infestations.

SECTION 2:

PROMOTING A HOLISTIC CHILD

As USAID's first large stand-alone OVC program in Kenya in many years, Nilinde was tasked with providing holistic, community-based care for OVC. To do this, the project had to address children's multiple and potentially overlapping vulnerabilities. Using the case management approach outlined above, Nilinde delivered interventions centered around the four key case management domains: healthy, stable, safe, and schooled. Figure 3 illustrates specific interventions relevant to each domain.

Figure 3. The four domains of case management.



HEALTHY DOMAIN: BUILDING A CULTURE OF HEALTH AND WELLBEING

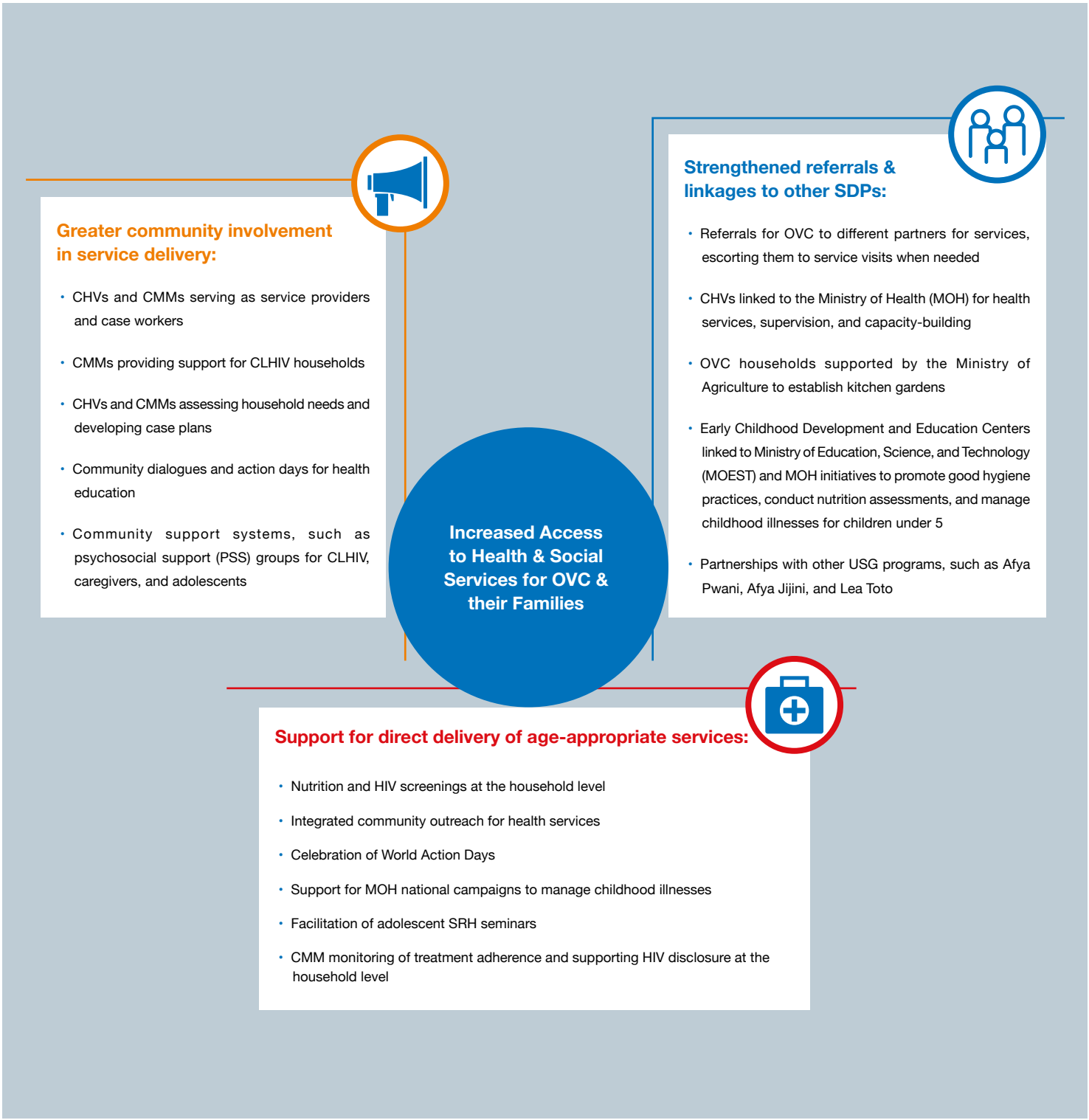
BACKGROUND

Kenya has made remarkable progress in improving reproductive, maternal, neonatal, child, and adolescent health outcomes, and reducing new HIV infections and HIV-related morbidity and mortality. However, according to the Kenya Demographic Health Survey 2014 report, only 67.5 percent of children between 12 and 23 months are fully immunized, 11 percent of children under age 5 are underweight, and 26 percent are stunted. Teenage pregnancy remains a major health concern in the country, with 15 percent of women ages 15–19 having had their first child. Roughly 102,000 children (under age 15) in Kenya are living with HIV, and in 2016, 51 percent of all new HIV infections were among adolescents and youth (ages 10–24). The country has achieved HIV treatment coverage for only 77 percent of eligible children, against a goal of 90 percent.[11]

The most common health challenges among OVC are incomplete immunization, malnutrition, risk of HIV infection, tuberculosis, malaria, and diarrhea. Nilinde was designed to improve the welfare and protection of OVC affected by HIV by increasing their access to needed health and social services.

STRATEGIC APPROACH

Nilinde employed a multi-pronged approach to deliver health services to OVC through greater community involvement in health service delivery, strengthened referrals and linkages to other key SDPs, and support for direct delivery of age-appropriate services. Nilinde's community-based approach comprised CHVs, Community Mentor Mothers (CMMs), and community-based trainers (CBTs). This community workforce worked directly under Nilinde sub-grantees who were also based in the community.



CASE STORY 1: NURTURING YOUNG DREAMS THROUGH GOOD HEALTH

Jose (not his real name), a 10-year-old orphan, was recruited to the Nilinde project with a viral load of 100,000 copies/ml. Viral load (VL) is the term used to describe the amount of HIV in the blood. The more HIV, the higher the VL. The Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya indicate that VL above 1,000 copies/ml is considered high.[6]

Jose was malnourished and sickly, and he could not start school on time like his peers. Nilinde linked Jose to the Lea Toto community outreach program for care, treatment, and food by prescription to manage malnutrition. Nilinde also provided his family with regular food subsidies. Jose was enrolled in school, and Nilinde supported his aunt, Caren, so that she could care for him more effectively. Says Caren, "I was trained on positive parenting and the importance of adherence to medication. This has helped me know how to take care of myself, Jose, and my other children. I make sure he takes his drugs, and I'm disclosing to him bit by bit as he grows older. I don't want to scare him."

Caren lives in the Soweto village in the Kibera informal settlement in Nairobi. She is one of the caregivers that Nilinde has trained on business skills and linked to a VSLA. Caren took a small loan of Ksh. 1,000 (US $10) and used it to start vending githeri (a local cuisine) and porridge in her community. This modest business has enabled her to consistently provide meals for her children.

Over the last two years, Jose's life has drastically improved. His VL is currently at 99 copies/ml. He is healthy, he loves to play with his friends, and he is proud to go to school and learn like other children. He aspires to be a medical doctor when he grows up.

KEY RESULTS

The CHVs and CMMs worked closely with caregivers to develop individualized case plans for each household and to facilitate OVC receiving required health services. By the final year of implementation, over 98 percent of project-supported OVC and caregivers had received education on HIV risks, water, sanitation, personal hygiene, SRH, and maternal and child health, among other services. More than 15,000 OVC under age 5 have been fully immunized, dewormed, and given vitamin supplements. These children are achieving positive health outcomes, including living beyond their fifth birthday—a major milestone for this age group.

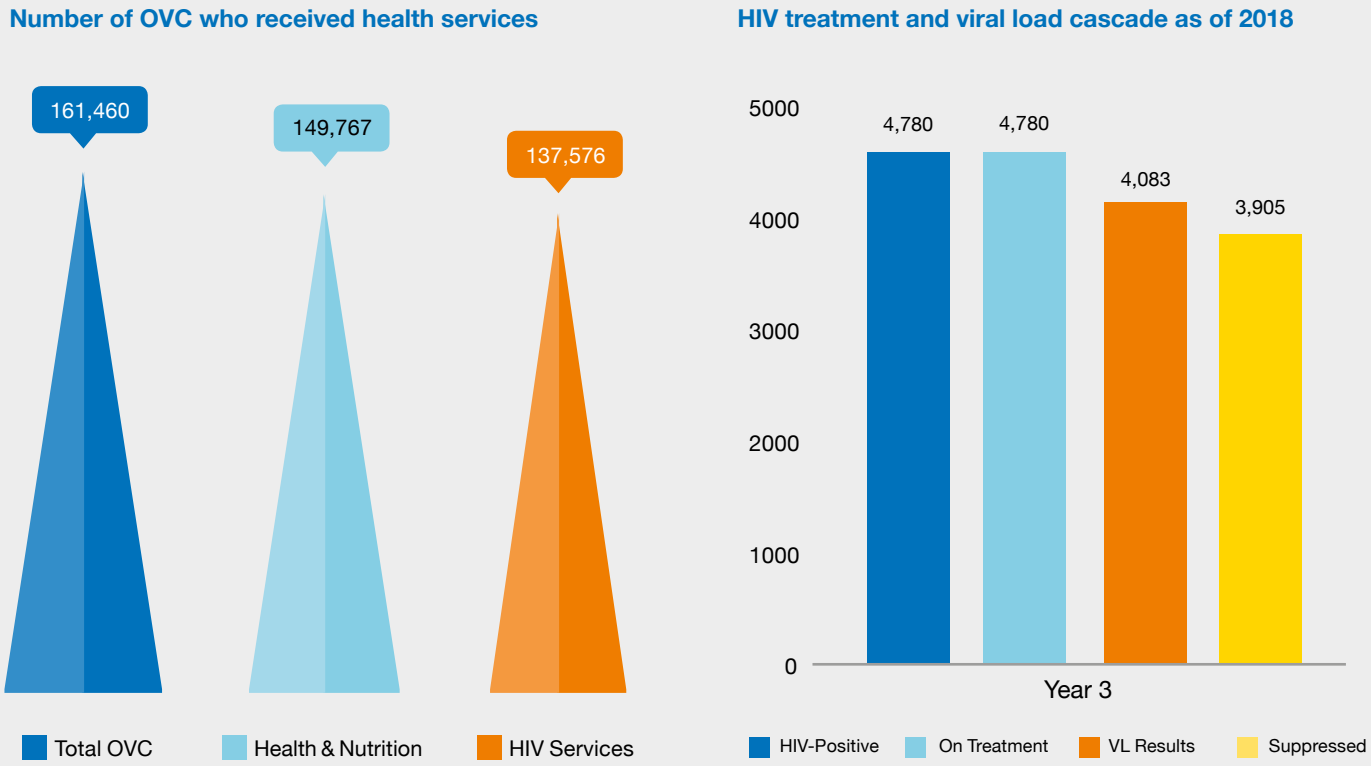
Adolescents were a critical target of Nilinde, as they represent the age group most at risk of contracting HIV. Ninety-seven percent of the 83,000 adolescents ages 10–17 supported by Nilinde received SRH education, and 95 percent of the 43,000 adolescent girls were educated on menstrual hygiene management. Referrals and linkages were made for reproductive health services and sanitary towels, which empowered adolescents to manage their own health, avoid risks associated with HIV infection, and make healthy decisions.

Nilinde reached 91 percent of OVC with HIV services, including HIV prevention messages, HIV testing services (HTS), and HIV treatment and care. The numbers are impressive: 4,780 HIV-positive OVC were linked to HIV treatment and supported for retention and adherence to treatment, 4,083 CLHIV shared their VL results with the project, and 3,905 achieved VL suppression, thus improving the health status of the children, their families, and their communities. Similarly, Nilinde supported communities in increasing their uptake of health services for children and adolescents at the facility level, thereby contributing to the achievement of the national HIV/AIDS and reproductive, maternal, neonatal, child, and adolescent health strategic goals. Additionally, Nilinde supported 28,722 caregivers in subscribing to the NHIF, thus providing 67,112 OVC with access to medical care.

3,905

the total number of CLHIV (of the 4,083 who shared their VL results with the project) who achieved VL suppression

Figure 4. Number of OVC served with health services and HIV treatment and VL suppression cascade



CASE STORY 2: A NEW LEASE OF LIFE

In Ngomeni Health Center, Kilifi County, Fazul (not his real name) was revealed to have defaulted on his treatment at the Adolescent HIV Clinic for quite some time. The health workers were worried about him. The facility assigned a CMM, Jemimah, to find him and bring him back for treatment.

Fazul had lost both parents to AIDS and was living with his uncle's family in Kilifi, who had supported his adherence to HIV treatment. However, as Fazul got older, he became violent and rude to his uncle and his teachers in school. Due to his rebellious behavior, his uncle took Fazul to his grandparents in Lamu. However, his uncle had not disclosed Fazul's HIV status to his grandmother, so she did not know that he needed adherence support. After searching for one month, Jemimah found Fazul and learned that he now refused to take his antiretroviral (ARV) drugs, which he had been taking since childhood. Fazul's health had started deteriorating. He was bedridden and admitted to the hospital for tuberculosis. His VL was over 80,000 copies/ml.

The CMM committed to work with Fazul and support him to achieve VL suppression. She started weekly household adherence counseling sessions and encouraged Fazul to join and actively participate in the adolescent Operation Triple Zero (OTZ) club facilitated by Nilinde adolescent OTZ champions at the Ngomeni Health Center. He was linked to an OTZ champion, who mentored Fazul and helped him commit to turning around his health status. Nilinde also supported Fazul in rejoining school by paying his school fees. Fazul's morale was boosted, and he became open and honest with his peers on issues affecting his adherence to his ARV drugs.

With four months of consistent support, Fazul's health made a tremendous turnaround. He recently passed his national primary school examination and joined high school. Now Fazul is a role model to other adolescents, and he urges them to remain adherent to their ARV drugs and to give their studies all the seriousness they deserve. His current VL is at undetectable levels, and his school performance has greatly improved. Fazul aspires to be a lecturer when he grows up.

KEY LESSONS:

- Use of case plans to guide provision of services to CLHIV improved the quality of targeted services, especially tangible services such as emergency food baskets, transport for care and treatment, and educational materials.
- Synchronizing project activities with school holidays enabled better follow-up of CLHIV in boarding schools. In addition, when students in boarding schools disclose their HIV status to a supportive person, they are able to sustain care that leads to optimal adherence to drug regimens, retention in care and treatment, and VL suppression without being stigmatized.
- When county and sub-county health management teams are involved in HTS outreach planning and implementation (e.g., mobilizing for HIV rapid test kits, providing HTS counselors, and offering supportive supervision), the activities yield a high success rate. Programs therefore should endeavor to plan and budget for the role of these teams.
- Health education and learning activities complement service delivery. Nilinde's targeted beneficiaries acquired knowledge and skills that empowered them to improve their health status and their health-seeking behavior, both now and in the future.
- A community workforce can reach vulnerable households and sustain care. Nilinde delivered quality health services to the OVC under its care through a strong community workforce and strengthened linkages with partners. This workforce remains in the community to sustain health service delivery for OVC.

Health care worker provides HIV testing services to an OVC.

STABLE DOMAIN:
From vulnerability to sustainable household resilience


A Nilinde supported caregiver at her grocery.

BACKGROUND

Children growing up in extreme poverty require special attention, as poverty affects them differently from adults. Inadequate nutrition, lack of early learning, exposure to stress, and other consequences of poverty deprive children of a decent start in life; these effects then trickle down to future generations and weaken the human capital needed for sustained economic growth.[7] Development partners must therefore increasingly apply HES approaches in resource-poor environments to achieve a variety of sustainable socioeconomic goals.

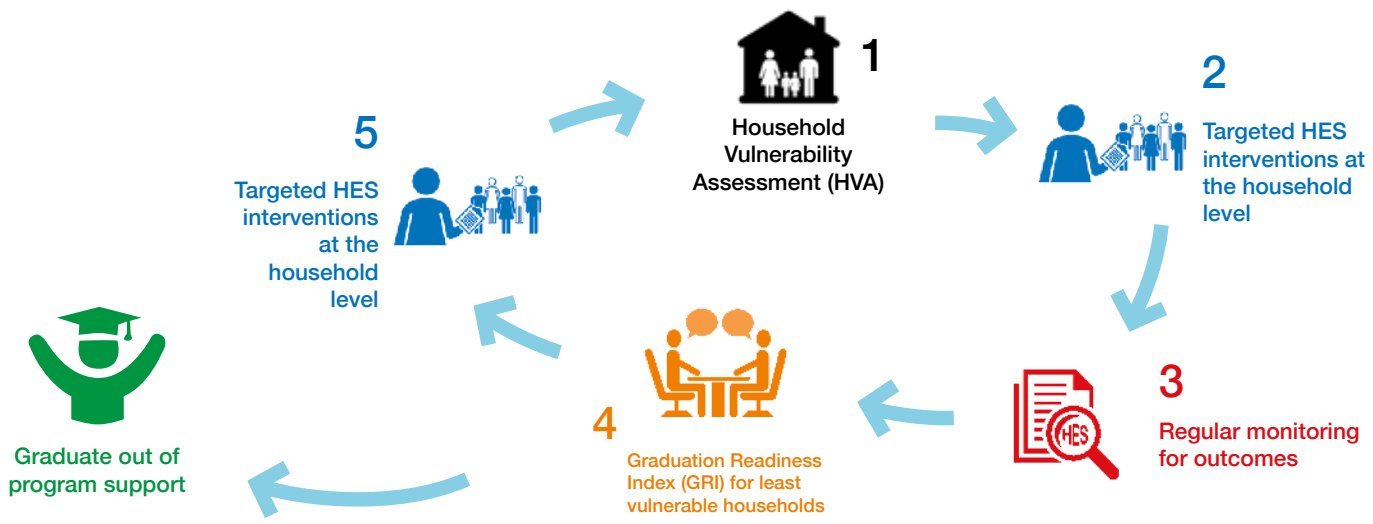
STRATEGIC APPROACH

Nilinde adopted a household graduation model that used a community-driven HVA to categorize households into three levels of vulnerability: highly vulnerable, moderately vulnerable, and least vulnerable. Nilinde then provided tailored interventions to each category of household. The most highly vulnerable households were characterized by food insecurity and were therefore provided with interventions such as asset transfer (e.g., small livestock) and kitchen garden training. Moderately vulnerable households were characterized by irregular and limited income and were provided with money management interventions, such as VSLA enrollment and financial literacy training. The least vulnerable households were characterized by regular but inadequate income sources and were provided with income-growth interventions, including linkage to markets and training in entrepreneurship and small-business management.

Nilinde initiated a household "collaborative empowerment process" that established a network of community-based workers to track, monitor, coach, and mentor beneficiary households. This network comprised economic-strengthening officers employed by SPDs and community structures, including Economic Strengthening Committees, Household Graduation Committees, Household Graduation Assessment Teams, CBTs, Lead CHVs, and CHVs.

SDPs identified CHVs who showed an interest in empowering households through economic strengthening. The project trained these CHVs on their roles within the graduation model and then assigned them responsibilities, including coordinating with other CHVs to carry out the required interventions at the household level, based on needs identified through the HVA. This network of community-based workers engaged closely with government extension officers, private-sector service providers, and other relevant partners to help target the households who most needed to access critical services for resilience-building. Nilinde monitored the beneficiary

Figure 5. Nilinde's household graduation model.



households throughout the process, and used reflective sessions to continually improve service delivery.

Nilinde conducted HVAs annually to determine the progress of each household with respect to the three levels of household vulnerability. Eight weeks after each HVA, a community-led household graduation assessment was done for all households that had been ranked least vulnerable in the most recent HVA. All households that attained a threshold score of 150 (out of a possible 200) on Nilinde's Graduation Readiness Index (GRI) were deemed resilient and selfreliant enough to graduate out of project support. Nilinde continued to monitor the graduated households to avoid having them relapse into vulnerability. Graduated households also served as role models for those still experiencing vulnerability.

RESULTS

Using diverse HES interventions (see Figure 6 on the next page), Nilinde reached 56,805 households. Through these interventions, households became increasingly self-reliant and able to meet their children's critical needs, including HIV care and treatment, education, and food security. As a result, 1,142 households were able to graduate from extreme poverty to sustainable livelihoods.

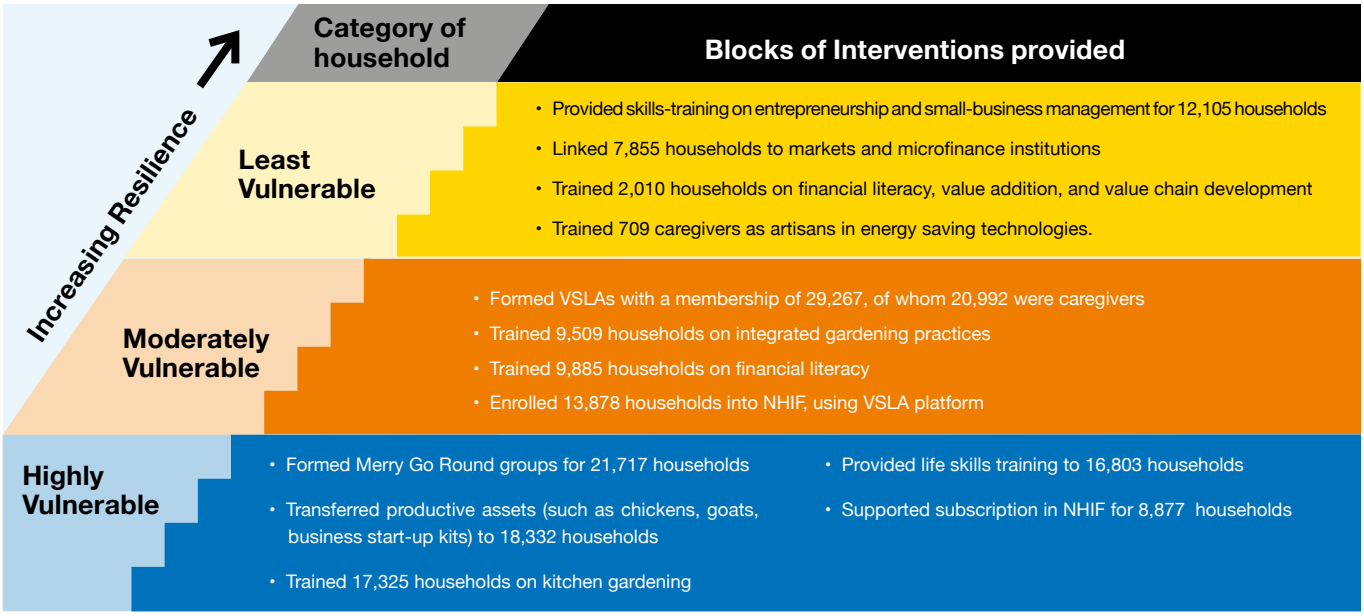
Nilinde's HES interventions also improved the community's sense of ownership for OVC support and triggered a renewed sense of hope. For example, household graduation ceremonies reminded communities that escaping poverty was a realistic and achievable goal, and graduated households encouraged other struggling households to join them on their journey to self-reliance. This model also enabled resources to be efficiently allocated to other, more vulnerable households.

Graduation Readiness Index (GRI)
Nilinde developed the GRI as a tool to identify households that exhibited strong indicators of resilience after HES interventions. The GRI identifies households that should exit from the project and become model households who can mentor others. It also identifies households who are struggling and in need of individualized support.

CASE STORY 3: NEW SKILLS CREATE A NEW LINE OF HOPE

Winfred is a 38-year-old mother of four living in the Kibera informal settlement in Nairobi, Kenya. Over the last eight years, she has struggled to find employment, and her children's education, safety, and food security has suffered as a consequence. Through Nilinde, Winfred was trained in business skills and received six chickens to start a poultry business. With the income she has generated through her business, Winfred enrolled in a VSLA and can now pay her children's school fees and her rent. She can also afford a balanced diet, thus improving her children's nutritional status, and she can pay for an NHIF subscription, which gives her household access to health care. Today, Winfred dreams of expanding her business so she can make improvements to her home.

Figure 6. Interventions provided to households by vulnerability levels



Beneficiaries celebrate and receive certificates during a community graduation ceremony.

CASE STORY 4: SHARA GONA BOUNCES BACK

Shara Gona harvesting her tomatoes.

Shara Gona is a 42-year-old widow and mother to three children. She currently lives in Gongoni Ward in Kilifi County with two of her younger children, ages 16 and 13, and a grandchild, age 5. Shara Gona is HIV positive, and one of her children also lives with HIV. When her husband died of HIV-related complications, life became unbearable for Shara Gona, and she struggled to meet her family's basic needs. Her three co-wives moved away and eventually remarried—but Shara Gona stayed.

When Nilinde undertook the HVA, Shara Gona was at the time bedridden and had no knowledge of her HIV status. Hers was a highly vulnerable household that needed immediate support.

Nilinde linked Shara Gona to care and treatment and provided emergency supplies to boost her household's nutritional status. She responded positively, and quickly regained her strength. Shara Gona was trained on kitchen gardening and given a goat as a productive asset. Her CHV and CBT also linked her to an agriculture extension officer. Shara Gona was also trained in financial literacy and linked to a VSLA. Her last-born son was linked to an adolescent PSS group, and both children received school fees to reduce Shara Gona's financial burden.

Shara Gona says that her first step was to transform her mind and shift toward self-determination and self-reliance. She turned her focus to kitchen gardening, planting and harvesting maize for corn flour and an assorted variety of vegetables, such as tomatoes, brinjals (eggplant), and spinach. She says, "I am known in the market as the supplier of tomatoes, from which I have made Kes. 3,800.00 [US $38] in the past month. I pay relevant school levies for [my] children, and I'm able to save Kes. 200–400 [US $2–4] at the VSLA. I have also invested the money in a separate business to bake and sell half-cakes to expand my income."

"Looking at my journey," she adds, "my viral load is undetectable, and my son is well and in school. I do not beg for food—on the contrary, I support others. I am thankful." Her NHIF subscription is active and ensures that ill health does not deplete her savings and assets.

During monthly caregiver support group meetings, Shara Gona shares her story and emphasizes the importance of drug adherence and positive living. She is a testament of how targeted support to households can transform beneficiaries from abject poverty and high vulnerability to stability, resilience, and self-reliance.

Shara Gona's maize harvest is enough to take her through the next season.

Nilinde has proven that projects can effectively and sustainably graduate households from dependence on support by delivering targeted interventions through a well-trained community workforce and using a reliable outcome tracking system that allows the project to analyze results, identify trends and patterns, and efficiently respond. Community involvement through a participatory process is key in enhancing household empowerment and ownership and curbing the challenges of dependency. With improved household collaborative empowerment (targeting, mentoring, and monitoring), the rates of household graduation can only increase.

KEY LESSONS:

- Through well-coordinated peer review forums and ongoing mentorship, communities can embrace and institute their own mechanisms for asset transfer (e.g., goats, chickens) and replication. For example, in Nairobi, three SDPs initiated a replication program that enabled an additional 44 highly vulnerable households that had not received Plan-led assets to receive productive assets from the initial beneficiaries.
- As the number of VSLAs across the project's coverage area becomes larger, it is crucial to find and use a suitable online tracking system for effective monitoring and reporting of the VSLAs' performance and progress. Generally, the performance of the VSLAs was a fair indicator of how the vulnerable households were faring financially. Through 1,367 VSLAs with a membership of over 20,000 caregivers, households mobilized Kes. 87 million (US $870,000) in savings within one year, which they loaned to one another. These households then used the loans to buy assets and invest in small businesses. They used this increased income to meet their household needs, such as food, health care, shelter, and education for their children. The 1,367 VSLAs are evidence of local ownership and self-reliance and provide another means of improving health outcomes.
- There are significant differences between HES approaches in an urban context and in a rural setting. In urban settings, access to finances and financial literacy each play a critical role, and some interventions cut across all levels of vulnerability. Within rural settings, the VSLA was very popular, as it provided a way for caregivers to regularly meet and address other factors besides financial issues. This made it a favorite platform for reaching groups of caregivers with training on non-economic topics, such as parenting skills.

The Nilinde graduation model is a reliable and evidence-informed strategy for transitioning OVC households out of extreme poverty. As a programming tool, it has the potential to gradually build household resilience by providing targeted responses, promoting collective community stability, and providing opportunities for expanded reach to other vulnerable households.

> Nilinde recognized the resources in the community and worked with the existing government structures, such as the Area Advisory Councils. This has made it possible for community members to sustainably support orphans and vulnerable children within the same communities.
>
> **Mr. Mwasiwa Boga,** *Department of Children Services, Taita Taveta County*

SAFE DOMAIN:
Towards a society that champions child protection

School girls come together in solidarity to advocate for their rights and child protection.

BACKGROUND

The United Nations Children's Fund estimates that 76 percent of children in Kenya have experienced at least one form of violence (sexual, physical, or emotional) prior to the age of 18.2 Additionally, two in three girls and three in four boys have suffered at least one episode of physical violence before the age of 18, and one in four girls and one in three boys have experienced childhood emotional violence.

In most cases, the perpetrators are close relatives, neighbors, friends, or other children who are well-known to the victims. Nilinde's interventions were designed to protect OVC and their caregivers from abuse, violence, and exploitation; build their capacity to improve family relationships; and reduce cases of child neglect.

STRATEGIC APPROACH

System strengthening. Nilinde worked closely with the county coordinators of the Department of Children's Services (DCS) to strengthen the Child Protection Information Management System (CPIMS). Nilinde supported the system's development, provided technical training to DCS county coordinators, and supported community-level structures: 25 Area Advisory Councils and County Technical Working Groups (TWGs) for Child Protection and for Sexual and Gender-Based Violence. As a result, DCS now has quality data for decision-making.

Collaboration, referrals, and linkages. Nilinde worked with key stakeholders, including DCS, the civil registration office, the MOE, the MOH, Childline Kenya, and county governments, to better enable them to understand the needs of and provide relevant services to their vulnerable children. Nilinde collaborated with DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partners to provide adolescent girls with SRH services and life skills to keep them safe at home, at school, and in the community. These referrals also provided avenues to OVC who needed legal, social, and emotional support.

Child-centered participation. Nilinde mainstreamed child participation into all of the project's management processes. The project supported 137 PSS groups for CLHIV, PSS groups for children living with a disability, residential learning seminars for adolescents, and school clubs. Children were encouraged to advocate for their rights via the Kenya Children's Assembly and to participate in advocacy on other issues affecting children.

Community-Level Engagement. Nilinde worked with SDPs, CHVs, Quality Improvement Teams (QITs), and CBTs at the community level. Nilinde also conducted community outreach sessions on key messaging for OVC, held community forums, and mobilized CHVs to train parents on caregiving skills.

Figure 7. Strategic approach to child protection.

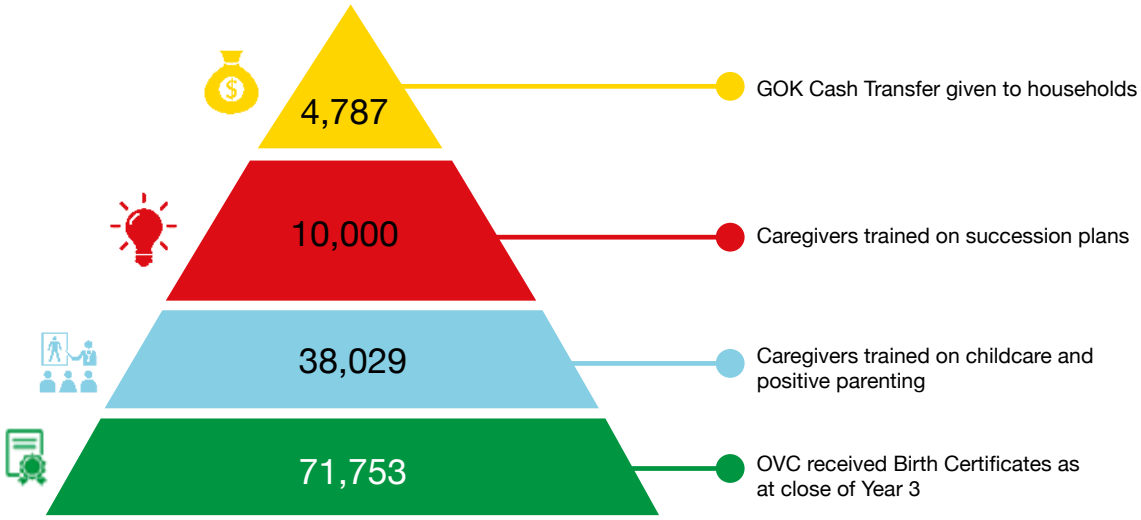
RESULTS

Increased access to government safety nets. In partnership with DCS, the project enrolled 4,787 households in the government OVC cash transfer program. Each caregiver receives a monthly payment of Kes. 2,000 (US $20) to complement their income. This linkage with DCS promotes sustainability beyond the life of the project.

Enhanced child participation. Through Children's Clubs, Nilinde trained teachers on child protection issues and enrolled 54,428 OVC in these clubs. Nilinde also supported the participation of children in Children's Assemblies at the county and national levels to advocate for their rights and voice their opinions.

Improved child rights. Nilinde worked with schools and community-led outreach programs to train 80,408 OVC and 35,530 caregivers on child rights and protection. In collaboration with the Department of Civil Registration Services, Nilinde sensitized caregivers on the importance of birth registration and enabled 71,753 (34,888 male, 36,865 female) OVC to acquire birth certificates. Caregivers with no legal documents also got an opportunity to acquire them.

Figure 8. Services offered and corresponding beneficiaries.



CASE STORY 6: RESTORED HOPE FOR A BRIGHT FUTURE

Jessica, now 17, was orphaned at a young age. Life has not been easy for her since her parents' death. As a child, Jessica struggled with taking medication and adhering to treatment. She did not fully understand her HIV status. After finishing primary school, Jessica found work as a househelper in Thika, a town 50 km from Nairobi, but her employer was abusive. In 2016, she was rescued from her employer and brought to Nairobi. She was enrolled in the project and started secondary school. Nilinde helped Jessica with school fees for the year. Unfortunately, things took a twist in 2017, when her caregiver chased her out of the house.

Using Nilinde's vast network, Jessica was found living at a distant relative's house, where she was not readily welcomed. Nilinde staff, along with the CHV and a CMM, worked with the sub-county Children's Department to extract Jessica from her relative's home and bring her back to Nairobi. The project covered Jessica's transport costs, and Martha, the CHV who had been supporting Jessica in Nairobi, offered her a place to stay. Martha took Jessica to the Lea Toto program for care and treatment, and convinced the principal of Jessica's secondary school to allow her to re-enroll the following year. The project helped Jessica obtain a birth certificate, supplied her with sanitary towels, and linked her to a PSS group, peer-to-peer counseling, and SRH training.

Jessica's life has greatly improved, thanks to the combined forces of Nilinde, the community, and the government. Her VL is now undetectable, and she is able to attend school regularly. Jessica wants to continue studying, keep healthy, and succeed. Her story serves as an inspiration to her peers and to many people around her.

KEY LESSONS:

- Using caregiver champions to train other parents on parenting skills created a multiplier effect that expanded the program's reach, as more caregivers received relevant and contextualized knowledge and skills.
- The process of seeking justice in child abuse cases is long and complex, and most cases collapse due to "follow-up fatigue" and unproductive use of limited family resources. Ensuring representation of Area Advisory Council members on the Court Users Committee may reduce the length of this process, possibly resulting in justice for survivors of abuse.
- OVC are particularly vulnerable to abuse, violence, and exploitation. Nilinde has worked at the national, county, and community levels to improve child rights by strengthening systems, improving the referral process, and bolstering children's participation in child protection activities. Child protection thrives best in an environment where all stakeholders—both public and private—and community members are responsible for the well-being of all children.

SCHOOLED DOMAIN:
Overcoming barriers to school enrollment, retention, and progression

School children participate in developing their vision boards at a children's event.

BACKGROUND

Access to quality education can significantly improve the lives of OVC and their families. Both formal and informal learning opportunities provide students with age-appropriate life skills and knowledge. Yet despite the obvious benefits, millions of vulnerable children lack the education they require to fulfill their potential. In countries with high HIV prevalence, OVC frequently experience discrimination in accessing education and health care.[8] Interventions to overcome educational challenges are therefore critical. The main problems affecting OVC education in Nairobi and Coast Counties include lack of adequate funds for fees and materials, the great distances between homes and schools, unsafe learning environments, and minimal parental involvement in their child's education. In rural areas along the coast, child marriage, child pregnancy, and child labor also hinder OVC from accessing basic education.[9]

At the project's inception, rates of school enrollment, attendance, and progression (moving from one grade to the next) varied across the six target counties. In Nairobi, progression rates were 70 percent for girls and 75 percent for boys. Similarly, in Taita Taveta, school enrollment was recorded as 89 percent, and school progression was about 70 percent for both girls and boys. In Kilifi and Kwale counties, there were high rates of truancy and dropout, and in Mombasa County, there was a significant gap in school progression between boys (78 percent) and girls (60 percent).

APPROACH

Nilinde partnered with the MOEST at the national and county levels to continually monitor school attendance, retention, and progression for OVC.

- **Collaboration and partnerships.** Through partnerships with the GOK and other NGOs, such as Ahadi Kenya Trust and the Bata Shoes Company, the project continually promoted school attendance through community conversations to address the root causes of OVC dropout, such as lack of fees, uniforms, and sanitary towels. Community conversations also facilitated timely re-entry and continuation for students who had dropped out. These linkages will promote sustainability beyond the life of the project.beyond the project life.
- **Provision of educational materials and fees.** To address dropout rates associated with a lack of school fees and materials, Nilinde provided educational materials, school

fees, and levies, and partnered with the DCS and NGOs (including One Girl Can, World Vision, and Life Skills Promoters) to provide back-to-school kits, sanitary towels, and education subsidies for OVC from highly vulnerable households. For sustainability, Nilinde empowered SDPs and caregivers to advocate for the allocation of funds to support OVC education at the county government level.

- **Promotion of safe learning environments.** To increase the accessibility and sustainability of Early Childhood Development and Education (ECDE) and primary education services, the project promoted safe learning spaces by building the capacity of teachers to incorporate life skills, nutrition, HIV/AIDS, and Water, Sanitation, and Hygiene (WASH) education in schools. Nilinde also helped to improve the development and use of ECDE and primary school resources through the provision of age-appropriate teaching and learning materials.

- **Parent and caregiver engagement.** Nilinde encouraged and supported caregivers to enroll their children in school, and then followed up on their attendance through monthly school visits.

Parental engagement was also enhanced using Plan International's Community-Led Action for Children (CLAC) model. Pre-primary education enhances children's cognitive, social, and emotional growth and is critical for OVC. Through CLAC parenting sessions, caregivers embraced early enrollment for OVC in ECDE centers. CLAC also encouraged community participation by having caregivers and school stakeholders develop local solutions to problems affecting OVC education. The training was provided by MOEST officers, who will continue to support schools and monitor their progress after the life of the project.

- **Involvement of QITs** Nilinde worked with QITs at the sub-county level for strategic local resource mobilization and sustainability of education support. Through this approach, QITs lobbied for support from the National Government Constituencies Development Fund, which allowed 952 OVC to access secondary school education.

RESULTS

The project has registered an increase in school enrollment, attendance, retention and progression among OVC. Early in the project (2016), 134,301 OVC were enrolled in school; 86,906 of them were retained and progressed to the next grade level. Since Nilinde's interventions, the number of OVC enrolled in school has increased to 144,859, of which 135,957 were retained in school and 133,114 progressed to the next level. This improvement is attributed to payment of school fees, regular tracking of school attendance, provision of life skills education, distribution of sanitary towels for girls, continual school monitoring, and parental involvement in OVC education.

School levies, bursaries and material support. A total of 59,632 OVC received school fees and levies to support school retention and progression. The project also paid the required fees for 1,107 OVC in form 4 to take the 2017 Kenya Certificate of Secondary Education exams, and 206 OVC qualified for degree courses. Through this financial support, 20,059 OVC were also re-enrolled in school and monitored to help ensure that they were retained.

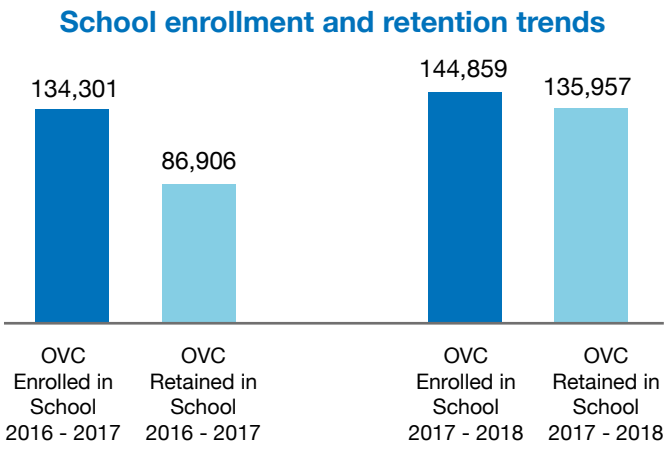
ECDE services. Nilinde worked through ECDE centers to provide health education, nutrition support, and parenting skills to the caregivers of young OVC. Nilinde partnered with Kenya Institute of Curriculum Development and county education offices to build the capacity of ECDE teachers on the nation-wide competency-based curriculum, which focuses on nutrition, school preparedness, and the importance of play through stimulating activities. Nilinde made sure that OVC were included in all school activities and events. Over 2,240 ECDE teachers were trained to better support cognitive stimulation and learner preparedness to transition OVC to the next level of education.

School improvement plans. To help address schooldropout rates and truancy, especially in Kilifi, Mombasa, and Kwale counties, school Boards of Managers were trained on how to develop School Improvement Plans, which helped them identify the causes of school dropout in specific school communities and develop local solutions to address those issues. Through the SDPs, 90 ECDE and primary schools mobilized resources to improve the child-friendliness of their school environment: providing teaching and play materials, establishing and sustaining school feeding programs, and improving WASH education and facilities. These enhancements improved school attendance and increased the number of OVC retained in school.

"Nilinde paid my school fees for two years, which enabled me to complete my secondary school education. My father could not afford to pay my fees, especially after losing his masonry job. I was out of school for two terms and almost dropped out. Through Nilinde's support, I am now pursuing a degree in education, and I am certain my future is secure."

-Violet Achisa, 20 years old, Nairobi County

Figure 9. School enrollment and retention trends.



Community-Led Action for Children is a parenting model used to engage and empower children and caregivers in communities affected by HIV in Kenya.

Activities include parenting education, improvements to ECDE centers, support for timely transition to primary school, and strengthening of community referral systems.

"The majority of OVC are enrolled in APBET [Alternative Provision of Basic Education and Training]. These schools are not fully recognized by GOK due to their inequality in providing ECDE. Through partnership with Nilinde, teachers in these centers were trained on MOEST pedagogical skills and the ECDE curriculum, school management skills, and development of learning and play materials. This has made it easier for the OVC to transition to public primary schools, and it improved school attendance as the schools became more child-friendly."

- Grace Kabura, ECDE Coordinator Nairobi-County

KEY LESSONS:

- Community empowerment and engagement contributed to the attendance, retention, and progression of OVC in schools. This is only possible with proper communication and coordination of activities among the key stakeholders in the education sector.
- ECDE centers provided a platform to offer a range of services, such as WASH, immunization and deworming, growth monitoring and promotion, life skills, and parenting skills, which contributed to the holistic development of OVC. Through this forum, stakeholders also addressed the challenges faced by OVC in accessing basic education.
- Integration of health services, play, and early learning in the ECDE centers led to the holistic development of children, who then thrive and achieve their growth milestones on time and are more likely to ultimately achieve their full potential.

Nilinde's partnership with MOEST demonstrated that educational support for OVC can be integrated into community development work, especially through the resources and structures that exist at the grassroots level. The Nilinde interventions and models used to boost OVC enrollment, retention, and progression in school can be replicated throughout Kenya to sustain support for the education and well-being of the country's OVC.

SECTION 3:

PROMISING PRACTICES

Over its three and a half years of implementation, Nilinde has been recognized for its innovative approaches and promising practices in providing holistic, community-based care for OVC. Three such promising practices:

- Community link desks, which improve health service delivery for OVC; strengthening facility linkages to service providers beyond the local government health facility is key to retaining patients on HIV treatment and other child protection services
- Use of VSLA as a platform to expand inclusion in universal health coverage for vulnerable populations, and allow more people to sustain their NHIF subscriptions and access health care
- CMM-led case management, which promotes achievement of the UNAIDS 90-90-90 goals through targeted individualized care and treatment support

COMMUNITY LINK DESKS IN STRENGTHENING COMMUNITY-FACILITY HEALTH SERVICE DELIVERY

BACKGROUND

The *Kenya Community Health Strategy of 2006* established the services provided by the first level of the health care system—the community—and was a big step toward linking hard-to-reach communities to health care. The strategy outlined the types of services, the service providers, and the relevant community health service linkage structures to be established. Kenya has made remarkable progress toward strengthening community-facility linkages; currently, more than 6,000 community units are linked to health facilities. However, weak community-facility linkages are still a challenge in some parts of the country. Strengthening these linkages increases access to health services, thereby improving health service delivery.

To support Nilinde's 183,547 OVC, services were provided to households by 3,442 CHVs, using the case management approach. Yet, by the end of Year 2, Nilinde still struggled with weak linkages, inconsistent coordination between its community partners and health facilities, lack of feedback on bi-directional referrals, poor beneficiary compliance with HIV treatment referrals, and inability to access information on the treatment outcomes of CLHIV under project support. To address these lingering concerns, Nilinde initiated the community link desk model.

COMMUNITY LINK DESK OBJECTIVES

Community link desks were established in health centers with the goal of strengthening linkages and coordination between the MOH and the project's community-based SDPs; improving follow-up, tracking, and documentation of referrals made to health facilities as part of case management; enhancing OVC compliance to referrals; and increasing the project's awareness of HIV treatment outcomes for CLHIV as required for case management.

IMPLEMENTATION APPROACH

A *community link desk* involves a community-based resource person placed in the reception area or at a customer care desk in a government health facility. By establishing this desk, health center visitors see a familiar face upon arrival and are more likely to feel comfortable and supported in accessing services. In short, the desks help to bring "the face of the community" to the facility.

Through this approach, a Nilinde-supported CHV sits at the reception desk of the local government health facility and is responsible for helping health care workers welcome patients, support health education sessions, review patient referral notes, and direct patients to the right department, based on their needs. CHVs then follow up with health care workers to see that referral feedback is provided to their fellow CHVs and to the project, using a signed copy of the referral note.

Nilinde trained CHVs to identify, execute, follow up on, and track referrals as part of case management. The project also held strategic meetings with health facilities and SDPs on how to better link project-supported households to health services. SDPs prioritized scaling up community link desks in high-volume health facilities.

OUTCOMES IN HEALTH SERVICE DELIVERY

The community link desk strategy increased the number of OVC accessing services as documented by completed referrals. In addition, it increased access to essential health services for OVC under age 5, increased knowledge of HIV status among OVC, improved project access to information on HIV treatment outcomes for CLHIV, and helped the project link 100 percent of the CLHIV to HIV treatment. As of the final year of implementation, 100 percent of CLHIV were retained on HIV treatment, and 85 percent had reported VL results. By focusing on linking the community to the facility, coordination between SDPs and health facilities greatly improved.

> "OVC and caregivers visit this facility since they know me from home and trust me as their leader."
>
> *CHV at St. Francis Health Centre Nairobi*

LESSONS LEARNED AND RECOMMENDATIONS

By having a familiar face seated at the entrance of the health facility, linkages and service delivery were improved for vulnerable households. Additionally, the link desks improved data collection, tracking, follow up on referrals, and feedback to the community for better access to health services.

Strengthening of facility linkages to other existing service providers beyond the local government health facility is key for retaining patients on HIV treatment and other child protection services.

Indicator	Dec-17	Mar-18	Jun-18	Sep-18
# of Active Community Link desks	17	30	48	82
# of Completed referrals for < 5 year old services (Growth Monitoring, Vitamin A & Deworming) (n= 15,764)	1,707	3,583	8,650	10,332
# of Completed HTS Referrals	4,716	5,118	5,766	5,855
% of OVC with known HIV status	68%	72%	75%	87%
% of CLHIV linked to HIV Treatment	4,431/4,528 (97%)	4,687/4,710 (99%)	4,847/4,847 (100%)	4,780/4,780 (100%)
% of CLHIV whose VL results are known to the project	2,328/4,431 (52%)	2,098/4,687 (45%)	2,626/4,847 (54%)	4,083/4,780 (85%)

> Nilinde has demonstrated that one sector cannot adequately address issues affecting a child. Early marriages, poverty—these all affect school retention and progression. Nilinde addressed other social determinants of health, such as economic stability, safety, and education, and built households' capacity for self-reliance.
>
> **Ms. Dorothy Randu,** *Chief Officer of Education - Kilifi County*

VSLAS EXPAND INCLUSION OF VULNERABLE POPULATIONS TO UNIVERSAL HEALTH COVERAGE

Caregivers participate in a VSLA session.

BACKGROUND

The effects of HIV on the economic stability of OVC and their families include increased dependency on strained income and revenue streams. Caregivers struggle to save or gain assets. VSLAs provide simple savings and loan facilities for communities that do not have easy access to formal financial services. In a VSLA, members have flexibility regarding the amount of money they wish to save. However, there are barriers to inclusion in a VSLA, both internal and external. Internal barriers include a lack of money to save (some highly vulnerable households are not able to save at all and therefore do not enroll in VSLAs), fear of debt, movement or relocation, and, in some cases, stringent VSLA standards. External barriers include poor targeting by development organizations in both geographic coverage and individual household identification, poor messaging, and prejudice against community members living with HIV. Households cited extreme poverty, disability, gender, and HIV as factors inhibiting their enrollment in a VSLA.

IMPLEMENTATION APPROACH

To address these barriers and bring economic-strengthening initiatives to the most vulnerable populations, Nilinde used several different approaches.

Targeting for inclusion. Nilinde mapped vulnerability at the community, household, and individual levels through participatory wealth ranking.

Design and implementation. In addition to its usual strategies of capacity-building and graduation programming, Nilinde provided asset transfer support and emergency food baskets to highly vulnerable households. Caregivers were mentored and provided with appropriate services, including linkage to safety nets, such as birth registration and NHIF, for OVC.

VSLA group policies. Some VSLAs adopted flexible minimum savings requirements, initiated flexible loan terms, reduced penalties, and permitted in-cycle withdrawals to encourage vulnerable households to join VSLAs.

Enrollment in NHIF. Using the VSLA platform, Nilinde educated households on the benefits of enrolling in NHIF, which would enable them to access health care services without having to sell assets, thus allowing them to protect and accumulate household assets and savings over time. VSLA groups initiated daily saving goals of Kes. 20, making it possible for caregivers to afford the monthly NHIF subscription of Kes. 500 for family coverage. As of September 2018, Nilinde supported 9,738 caregivers with NHIF subscriptions, reaching 16,200 OVC.

RESULTS

Nilinde has supported caregivers in making investments that improve the well-being of their families. More than 18,000 highly vulnerable households have been supported in enhancing their household income, improving their nutrition, and accumulating assets.

By linking households to social safety nets, such as the NHIF, they are better able to benefit from the impact of HES interventions, as unexpected health care expenses will be less burdensome. Flexible savings plans within VSLAs have enhanced the attainment of universal health care coverage, making it easier for vulnerable populations to participate. Nilinde also provided vulnerable households with supplemental skills training, such as financial literacy, entrepreneurship, and small-business management, which further helped participants benefit from VSLAs.

A caregiver displays her newly acquired NHIF card.

COMMUNITY MENTOR MOTHER-LED CASE MANAGEMENT

Globally, HIV care and treatment is recognized as a pillar in halting the spread of the HIV epidemic. Evidence shows that treatment can avert new HIV infections, decrease the number of AIDS-related deaths, and prevent related illnesses. The goal of an AIDS-free generation by 2030, led by UNAIDS through the 90-90-90 strategy, has rallied unified intervention efforts. Kenya is progressively scaling up HIV treatment services, achieving 75 percent ART coverage among those ages 15 or older, and 84 percent among children below age 15. VL suppression rate among children below age 15 is 77 percent. However, Kenya still misses opportunities to scale up HIV treatment, due to low linkage rates, and has yet to meet the third 90 goal: 90 percent of those on treatment are virally suppressed.

At the start of the project's Year 3, of the 4,022 CLHIV, 83 (2 percent) were not linked to treatment, 1,611 (41 percent) still did not know their VL results, and 10 percent of those with results had a VL above 1,000 copies/ml.

APPROACH

The Nilinde project trained 112 CMMs to provide community-level HIV service delivery to CLHIV. As case workers, CMMS identified new CLHIV and enrolled them in the project, linked CLHIV to HIV treatment, supported their retention in treatment and care services and their adherence to ARV drugs, and supported caregivers in obtaining VL results. CMMs also developed family case plans for households with CLHIV that included family members who did not know their HIV status, and accompanied those members to HIV testing.

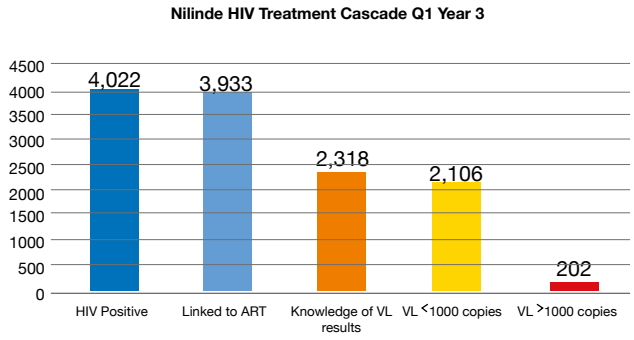
In some cases, children were also escorted to the facility for treatment. CMMs closely monitored all those linked to treatment through periodic household visits, during which they reviewed clinic attendance and adherence to medication as prescribed, through pill counts and seven-day recall methods. CMMs also performed directly observed treatment at home for children with a high VL, and linked them to support groups.

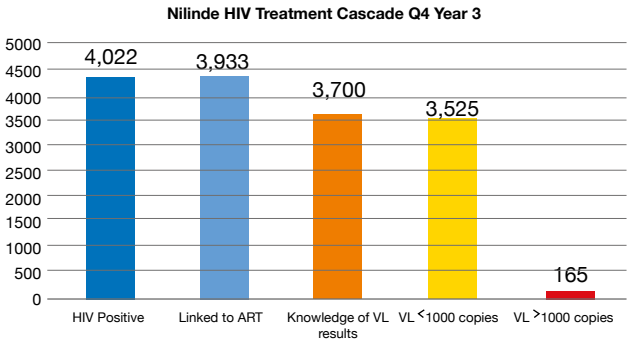
RESULTS

During the project's third year, the CMM-led case management model was in full implementation, with intensified efforts on VL monitoring and greater support from CHVs. This led to the enrollment of an additional 297 CLHIV, 100 percent linkage to HIV treatment, a 27 percent increase in knowledge of VL results, and an overall 5 percent increase in VL suppression rates. Figure 10 shows the results of the Year 3 treatment cascade.

Figure 10. HIV treatment cascade for Year 3.

Comparing the HIV treatment cascade of quarter 1 and 4 of year three of the project





CONCLUSIONS

CMM-led case management is a promising service delivery model for improving linkages to HIV treatment, increasing individual knowledge of VL results, and contributing to VL suppression for CLHIV.

> Poverty and family separation contributes significantly to child abuse. We have realized that, of the early pregnancies reported in Kilifi County, 90 percent of those girls live with extended relatives such as grandparents and aunts, not own parents. Nilinde's approach to get families out of extreme poverty and keep families together has been the missing link.
>
> **Mr. George Migosi,** *DCS - Kilifi County*

SECTION 4:

KEY ENABLERS

COMMUNITY WORKFORCE AS DRIVERS OF SERVICE DELIVERY

BACKGROUND

Projects are often initiated for the benefit of communities, yet the communities themselves are not significantly involved in the implementation—they are merely the beneficiaries or recipients of project deliverables, for which they lack a voice or a sense of ownership. In recognition of the role of community members as champions of their own change and writers of their own story, Nilinde embraced a community model for its OVC programming.

STRATEGIC APPROACH

The project worked with 32 SDPs who received sub-grants and 164 community sites. The 4,341 community workforce members comprised 3,613 CHVs, 296 CBTs, 112 CMMs, 132 Volunteer Children Officers, and 188 ECDE assistants. The community workforce served 75,030 households and were trained on community engagement and thematic service delivery areas, such as HIV screening, the entire 90-90-90 strategy, case management, child protection, HES, referrals and linkages, and cash grants.

Nilinde disbursed and monitored funds of Kes. 16.9 million to group-based income-generating activities run by 164 CHV groups, with a total membership of 3,675 CHVs and CBTs. These groups have recorded profits from businesses in both urban and rural areas, ranging from boda boda transportation to leather turning, water kiosks, table banking, and hiring of tents and chairs. Through this effort, the groups have been motivated to sustain their service delivery efforts within their respective communities.

The community workforce is a pillar of service delivery for OVC programs. They support timely initiation of HIV treatment, monitor adherence to care and treatment, and motivate the community to sustain engagement on income-generating activities, among a myriad of other functions. Capacity-building for the community workforce improves the quality of service delivery and the sustainability of gains. Inclusion of the community workforce in supporting long-term HIV treatment is a critical component in the continuum of care.

INSTITUTIONAL CAPACITY DEVELOPMENT

Local SDPs in Kenya have varying levels of internal management and governance structures. There is a pronounced need to promote resource accountability and to build the capacity of local implementing partners (LIPs) to sustain the localization of OVC programming. For this reason, Nilinde used a cascade model, which involved building the capacity of 32 SDPs charged with training 164 LIPs at the community level to successfully support OVC welfare and protection.

Nilinde conducted targeted organizational capacity assessments for 13 SDPs, and developed capacity-building plans to guide institutional strengthening. The project implemented an organization growth trajectory using USAID's Human and Institutional Capacity Development model, and offered technical assistance in governance, risk assessment and management, and resource mobilization to 22 SDPs and one core partner.

- Nilinde collaborated with the USAID-funded 4Children project to train government officials from five Nilinde counties and community-based organizations to develop sustainability, investment, advocacy, and resource mobilization plans. This has ensured that counties have advocacy documents to support resource mobilization for OVC.
- Nilinde strengthened the leadership structure of SDPs, resulting in the creation of standards of practice that led to more consistent and improved service delivery.
- Institutional development from Nilinde helped some SDPs generate additional financial resources, which in turn allowed them to increase their coverage in terms of both case load and geographic area.
- LIPs and SDPs now have increased profiles and an enhanced ability to take part in decision-making on school management boards and TWGs and in the use of community development funds.
- SDPs were linked to government capacity-building structures, including training in Alternative Provision of Basic Education and Training to meet government requirements.
- Nilinde built the financial capacity of SDPs to align with donor financial reporting requirements, raising their standards of financial management and improving their efficient use of project funds.

A team of lead CHVs participate in a review and feedback meeting.

"Council of Imams and Preachers of Kenya [CIPK], one of Nilinde's SDPs in Taita Taveta County, received three grants from AMREF, URAIA, and The Global Fund to Fight AIDS, Tuberculosis, and Malaria as a direct result of their strengthened management and governance structures. CIPK has since expanded their program coverage to Lamu County and increased their grant portfolio to Kes. 41.3 million [US $410,000]." - *Phillip Nyange, Program Officer, Nilinde*

"St. Johns Community Centre received proposal development support from Nilinde and is now a core partner on the USAID-funded CASE-OVC and Afya Jijini projects. These projects have expanded service delivery to orphans, including those under Nilinde." - *Joseph Gitu, Programs Manager, St. John's Community Centre, Nairobi County*

"Institutional development provided by Nilinde helped us in our organization to establish a social fund to assist members in need. We have since opened a formal bank account and undertaken an annual audit. Personally, I have grown. I was recently appointed to UWEZO Fund (a literacy and numeracy initiative) as an area CBO [community-based organization] representative." - *Peter Kamau, Shalom CBO*

MULTI-SECTORAL PARTNERSHIPS AND COLLABORATION

Out of school youth get hands-on training in electrical wiring.

YOUTH EMPOWERMENT

As OVC surpassed the age of 18 and left school, Nilinde needed to find a way to exit these young adults from project support in a responsible way that preserved their dignity and helped them launch into adulthood. Nilinde designed a "youth buffer strategy," targeting out-of-school youth between the ages of 18 and 24. Most of these youth had either dropped out of school, completed secondary education, or attended polytechnic or tertiary institutions. Nilinde worked with community-based youth trainers to support the formation of Youth Savings and Loans Associations (YSLAs), deliver employability trainings, and link youth to emerging opportunities in technical and vocational education and training, apprenticeships, and internships. Nilinde worked closely with private-sector partners and other donor-funded projects, such as Kenya Commercial Bank Foundation, German Development Agency, and Research Triangle Institute, to link these youth to viable training and employment opportunities.

RESULTS

Through the youth buffer strategy, Nilinde successfully transitioned 9,889 out-of-school youth above the age of 18 from the project. The project trained 5,136 of these youth on the Plan International/Making Cents Enterprise Your Life curriculum, as well as on life skills, employability, and SRH.

"I wanted to study hairdressing and beauty upon graduation, and Nilinde supported me with a startup kit [a blow dryer, shampoo, conditioner, and hair braids] to start a salon business. The income I make every day goes into my savings. I save about Ksh. 200 [US $2] per day. I want to start a wholesale shop selling hair and beauty products."
- Esther Nyambura,
22 years, Nairobi County.

"Back in 2016, Nilinde supported me, and I was trained in hospitality and catering. I was hired at Naivas supermarket and started as an assistant in the bakery section. I was promoted and am currently assisting the Head Baker at the Naivas Headquarters."
- Benson Otieno,
25 years old, Nairobi County.

"In 2018, Nilinde linked 50 youth, through Generation Kenya and the Kenya Commercial Bank Foundation, for vocational training on hairdressing, plumbing, mechanics, and carpentry. Some initiated businesses, and others got employment opportunities."
- Joseph Gitu, Programs Manager,
St. John's Community Centre, Nairobi County.

Figure 11. Nilinde youth buffer strategy.

Step 1: Identify youth who are over age 18 and out of school. Conduct a needs assessment to identify their career preferences, and prepare for career development.

Step 2: Support the formation of YSLAs, using the Community-based youth training model.

Step 3: Using the YSLA platform, provide demand-driven trainings (including Enterprise Your Life, life skills, and employability skills) to the youth groups.

Step 4: Exit the target youth out of the project after a six-month period in the YSLA.

Step 5: Using the YSLA platform, link youth to emerging opportunities in technical and vocational education and training, apprenticeships, job attachments, sports and talent schools, etc.

World Bicycle Relief in partnership with Nilinde distribute bicycles to CHVs.

Nilinde linked 849 youth to other youth-serving projects implemented by Kenya Commercial Bank Foundation, DREAMS partners, German Development Agency, and Research Triangle Institute. Youth were taught general life skills and skills in the areas of motor vehicle mechanics, electrical wiring and installation, hairdressing and beauty, hospitality, welding, plumbing, and employability.

Nilinde also partnered with World Bicycle Relief, a nonprofit organization mobilizing people through the power of bicycles. The partnership saw 448 CHVs receive bicycles to offer care and support to OVC in hard-to-reach areas.

By empowering these youth, Nilinde helped them gain a sense of belonging, improving their self-esteem, and reduce their risk of drug abuse and other anti-social behaviors. Nilinde provided a safe space for youth to openly discuss issues important to their survival. Through partnerships, the project leveraged resources, skills, and opportunities to extend essential services to caregivers and OVC. Strengthening the public-private partnership portfolio in planning and programming remains an opportunity to be explored.

BIDIRECTIONAL REFERRAL

Bidirectional referral refers to the process of recognizing a risk or concern about an OVC or a household, deciding that action needs to be taken, providing information, referring them for services within or across sectors, and then tracking the referral and getting feedback on whether the service was received on time and the need was met.

STRATEGIC APPROACH

Nilinde strategically strengthened several bidirectional referral mechanisms and partnerships to increase OVC access to required services in a timely manner.

- **Supporting community-facility link desks.** A community link desk provides a community workforce member with a designated workspace at a government health facility. This helps community members feel comfortable when accessing services at the health facility, given that they meet a familiar face upon arrival. Nilinde supported CHVs at 82 community link desks in high-volume health facilities across the project coverage area. Nilinde trained the community workforce to effectively link individuals to services through these desks.
- **Mapping service providers.** Nilinde collaborated with different SDPs, such as the MOH, child protection services and other NGOs and faith-based organizations, to map the services provided by various partners that could benefit OVC. This enabled Nilinde and its partners to strengthen and track the quality and effectiveness of services provided through referrals.
- **Supporting county referral mechanisms.** Nilinde collaborated with the USAID-funded 4Children project and the DCS to form county-level TWGs, who were tasked with harmonizing referral tools for all services relevant to OVC.

RESULTS

By using its QITs to expand the network of service delivery and support the diverse needs of the OVC under its care, Nilinde saw an increase in the number of OVC receiving age-appropriate services. Nilinde's treatment outcomes for OVC and CLHIV increased achievement of the UNAIDS 90-90-90 targets: 11,532 OVC were re-integrated into school through linkages for school fee support, and a total of 75,030 OVC households were able to access a wide range of services. Nilinde also created a strong referral network to address unanticipated problems.

Over time, OVC households became more confident in seeking and demanding services from different service providers, based on their needs. Through mapping service delivery points, Nilinde was able to minimize duplication of services and improve the quality of service delivery. Enhanced collaboration and linkages with county line ministries and other stakeholders facilitated innovative support mechanisms, such as community link desks and stronger referral coordination frameworks. Furthermore, through strengthening referral pathways, Nilinde has contributed to the sustainability of OVC service provision after the project's lifetime.

"My name is Peninah, and I am 14 years old. Last year I sat for my primary school final examinations and attained 395 out of 500 marks, allowing me to join secondary school. I was worried that my grandmother could not afford to pay for my secondary education. With Nilinde's support, I was linked to the Kilifi County Women Representative Bursary Fund and received a full scholarship to take me through my entire four years of secondary education at Alliance Girls High School. I thank the Nilinde project for guiding me through the application process. I want to become a surgeon in the future so that I can help my family and community."

- Peninah, Student, Kilifi County

QUALITY IMPROVEMENT TEAMS

Many children lack access to basic needs and are vulnerable to abuse and exploitation. Nilinde established QITs to enhance the provision of quality care to OVC.[10]

A QIT is a community-level structure comprising multi-sectoral representatives. QITs empower community members and local leadership to address key community challenges, using locally available resources. QITs monitored and evaluated the impact of interventions through a community child status index. They raised awareness, built capacity in child protection and welfare, mobilized resources, and facilitated linkages with community-level service providers to address priority OVC issues. Nilinde coached and mentored QITs to provide technical capacity and motivational support.

Composition of a QIT

- Community workforce
- Local implementing organization representative
- OVC representative
- GOK representative
- NGO representative
- Private-sector representative
- Religious representative

RESULTS

Nilinde established 37 functional QITs who contributed to local ownership of OVC support and worked to verify that quality improvement standards for service delivery were adhered to during implementation. The QITs:

- Encouraged fair distribution of interventions to the most vulnerable households;
- Created lasting strategic partnerships in both the private and the public sectors, allowing them to lobby for additional resources to support OVC needs.
- Embraced the use of data in service delivery for decision-making, and enhanced community participation in Nilinde activities. This enabled communities to hold meaningful conversations to determine gaps in implementation and to prioritize OVC needs based on data.
- Leveraged on their positions to mobilize resources to improve service delivery for OVC. Through these efforts, a greater number of OVC received services.

Key QI Outcomes

- 452 OVC received education bursaries worth Kes. 2 million (USD 20,000) from public and private sector actors.
- 500 OVC received shoes worth Kes. 150,000 (USD 15,000)
- 30 OVC households received NHIF sponsorships

GENDER AND DISABILITY INCLUSION

Nilinde strove to build the knowledge, attitudes, and behavior of its staff and community workforce in the areas of gender and disability. Mainstreaming approaches included:

- **Building the capacity of SDPs.** Nilinde established a gender task force with representatives from eight SDPs to lead and infuse gender mainstreaming in project operations and activities. The SDPs joined the sub-county Sexual and Gender-Based Violence TWGs to network and strengthen bidirectional referrals for these cases.
- **Eliminating gender disparity in school progression.** Nilinde supported community engagement forums to address gaps in girls' education. The project provided a package of services specifically for adolescent girls, including distribution of dignity kits, mentorship clubs, and life skills workshops. Girls were also given priority when disbursing school bursaries and scholarships. Community forums fostered increased awareness of the importance of education, and resulted in improved enrollment of OVC, from 139,428 (68,143 male, 71,285 female) in 2017 to 145,428 OVC (71,030 male, 74,398 female) in 2018, with more girls (51 percent) enrolled in and attending school.
- **Engaging males.** To address the low engagement of male caregivers in economic-strengthening and caregiving activities, Nilinde sensitized men and boys on the importance of sharing financial responsibilities and decision-making with their spouse, caring for young children, and eliminating gender-based violence in their community. By the end of the project, 2,854 men were engaged in VSLAs and positive parenting activities, thus contributing to reducing the harmful gender norms that perpetuate inequality in communities. Forty-seven men formed a men's-only VSLA that aimed to improve male involvement in HES and reduce violence over control of income.
- **Providing support groups for children living with a disability.** Nilinde facilitated PSS groups for 423 children living with disability (197 male, 226 female) and mentorship sessions for caregivers to improve their ability to perform home therapy and practice proper nutrition. In partnership with the Kenya Institute of Special Education, Nilinde offered occupational therapy services to 252 OVC (130 male, 122 female). The project supported 490 OVC (245 male, 245 female) living with a disability across five counties.

"One day, I received a strange call pointing me to a child living with HIV and a physical disability. He was locked in a dark room inside a house, gagged, with his hands tied up. He could only stare and wait for days to pass. With help from community members, we rescued the boy from the abusive environment. He was taken to the Lea Toto Health Facility for treatment. The matter was reported to the local authorities and the children's office, who linked him to Nyumbani Children's Home, where he is currently accessing basic preventative, curative, and palliative care."

- Alice, Nilinde CMM

Transformation of gender roles, attitudes, and social and cultural practices requires patience and persistence. By mainstreaming gender and disability in its programming, Nilinde is raising community awareness of these issues, which is the first step toward equality, equity, and inclusion.

INSTITUTIONALIZING DATA FOR DECISION-MAKING

Data and digital technologies are changing the way that international development programs are implemented. Nilinde contributed to system-strengthening through information-mapping, data validation, and development and decentralization of the SDPs' management information systems, thus increasing efficiency in data output and tracking. The project trained the SDP and LIP workforce on management information systems and tools and the effective analysis, presentation, and use of data.

RESULTS

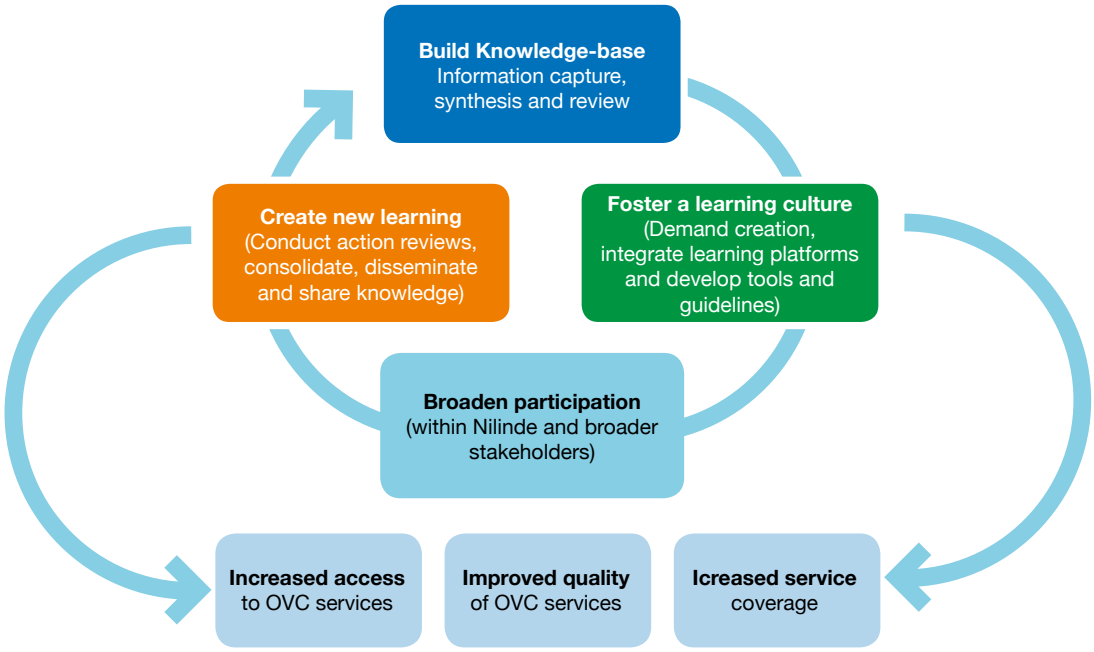
Nilinde championed the need for quality data at all levels to spur the use of data for decision-making. This led to effective and evidence-informed planning, resource use, performance tracking, and targeted service delivery. Using data for informed decision-making significantly contributed to the following:

- **Improved outcome indicators.** Adherence to timeliness improved quality of the data. With confidence, Plan International could report that 98 percent of OVC were served at the end of Year 3, as compared to 82 percent of the caseload served in Year 2, the first year in which data quality measures and systems were fully in place.
- **Rationalization of CHV case load.** By using CPIMS to accurately identify OVC, the project was able to use the SDP caseload to determine the number of workforce members needed to serve beneficiaries and allocate resources effectively. By the end of Year 3, the project had 3,776 CHVs, who each monitored an average of 42 OVC, a target that was routinely used by LIP managers to inform the performance of individual CHV, using monthly reporting rates.
- **Improved service delivery.** High demand for quality data ultimately led to the development of other customized management information systems, such as Nilinde's HES Management Information System, the national CPIMS, and a Web-based Routine Data Quality Assessment system. Community cadres and SDPs now embrace the use of data to inform service provision and to advocate for resources from the county government and other partners to support OVC. Increased capacity to collect and analyze data at the community level has improved the timeliness of service provision, and has influenced prioritization of services by QITs.

Through deliberate participatory engagement between data users and producers at the community level, more attention is being given to the use of quality data to inform decision-making. The communities became more aware of the benefits of generating quality data and using them to make decisions.

Community Health Volunteers in a data review meeting.

Figure 12: Nilinde's learning and knowledge management framework



ADAPTIVE LEARNING AND KNOWLEDGE MANAGEMENT

Nilinde established a communication, learning, and knowledge management unit to foster intentional learning and to anchor the project implementation environment in the principles of learning and knowledge management. Nilinde used USAID's collaboration, learning, and adapting approach to progressively assess the causal pathway to desired outcomes and adjust activities as needed to achieve better results. Using this approach, Nilinde established both internal and external learnings that promoted dialogue among all stakeholders, including government and other development partners and the beneficiary community.

Nilinde then developed a framework to guide the operationalization of learning throughout the project. The learning and knowledge management framework led to the development of key learning questions, the creation of a TWG, and an annual learning agenda.

KEY RESULTS

- To guide service delivery, Nilinde initiated standards of practice across all OVC technical areas, which promoted harmony in service provision, data capture, and reporting across the 164 LIPs and 32 SDPs, and led to better aggregation of results and targeted interventions.
- The project organized capacity development and learning forums with DCS, SDPs, and LIPs on a range of topics, including gender mainstreaming, HES (in particular, changing the poverty mindset, and using the GRI), quality improvement, case management, sustainability, and, in collaboration with the 4Children project, investment case planning. These forums provided a foundation for sustaining OVC programming at the county and lower levels.
- The project promoted documentation of emerging and promising practices to support learning at different levels, and developed five technical and program briefs, technical posters, abstracts, and information, education, and communication materials aligned to its learning questions and agenda. Nilinde's abstracts were shared in national and international conferences (International AIDS Society 2019, Africa Health Agenda International Conference 2019 and National Organization of Peer Educators 2018) and with communities of practice, such as TWGs. The content was also simplified and then shared with communities.

The learning and knowledge management approach has advanced and expanded the outlook of OVC service implementation by encouraging dialogue at different levels regarding OVC. Nilinde has developed a number of publications (including this document) to present project implementation processes and results and to provide a lens for policy imperatives in OVC programming.

SECTION 5

LESSONS TOWARD SUSTAINABLE SELF-RELIANCE

1. **The program's responsiveness to community needs was important in delivering the desired project results and in fostering community structures that would sustain the gains made in the life of the project.** The services rendered were guided by assessments that informed the prioritization of needs. These exercises were carried out by CHVs together with family members at the household level—a departure from how OVC programs were previously implemented. Use of unique innovations—such as the community-led HVA, which grouped households by vulnerability type (high, moderate, and low)—guided the delivery of targeted interventions and helped households graduate from the program, thus creating space for lateral program expansion to include additional deserving households. Working with community-based volunteer cadres to regularly implement activities (e.g., PSS groups, peer-to-peer support groups, VSLAs, and YSLAs) and monitor and assess their progress created honesty, trust, and a sense of ownership and contributed to a resilient community able to sustain support for OVC to grow and thrive. When community members drive the agenda and collaborate with the government and other partners, the needs of OVC, including CLIHV, will be better and more sustainably addressed.

2. **Multi-sectoral and multi-stakeholder engagement is an essential ingredient for long-term success in OVC program implementation.** No project can meet the needs of OVC without relying on the expertise and resources of other stakeholders. Service providers assessed and responded to OVC needs, both directly and indirectly through referrals to other partners. Strong coordination of partners at various levels led to increased coverage of the OVC programs, including diversification of services, synergies, and reduced duplication of resources. This has built a sustainable stakeholder environment that allows for seamless transition of children from one project to another, and helps services to be sustained during and even after transitions. A strong stakeholder coordination mechanism, anchored within the government infrastructure, promotes equitable distribution of resources, collective planning and priority setting, and accountability in resource use.

3. **The use of technology in data management and information-sharing enhanced efficiency in program implementation and monitoring, improved data availability and analyses, and enabled quality decision-making.** Digitization of OVC data in both the OVC Longitudinal Management Information System and CPIMS solved many of the project's data management challenges, including analysis, exportation, sharing, extraction, and visualization for use by project staff. Use of social media platforms such as WhatsApp to share key messages regarding health and HES enabled direct communication within groups. For example, sharing information on SRH among adolescent peer support groups provided a forum for discussing confidential information that may be difficult for this age group to discuss with parents or other adults. It also enhanced mobilization efforts for program meetings at different levels and promoted the use of pictorial evidence of activities. Using a SMS platform and having direct access to the National AIDS & STI Control Programme VL website to access VL data enabled an efficient and targeted response toward viral suppression. Use of technology reduced the cost of doing business, enabled affordability, and promoted self-reliance in timely data access, analyses, and use, hence empowering the community.

4. **Working within and strengthening existing community and government policies and structures facilitated project entry and implementation, thus building the impetus for sustained child protection and service delivery.** Maximizing existing structures led to increased allocations for OVC in the county budgets. For example, Nilinde anchored its work around the government's Community Health Strategy and existing CHVs, who had a certain level of capacity, thus saving resources and time that would have been spent on capacity-building and creating efficiencies. CHVs were key implementers of the project: leading the enrollment of OVC, assessing needs, developing case plans, delivering services, and monitoring the effectiveness of some project strategies at the household level, always with the goal of fostering self-reliance. Integrating the project into existing child protection government structures, such as Area Advisory Councils and TWGs at the county and sub-county levels, enabled Nilinde to easily leverage the efforts of other partners and support these structures in promoting an OVC agenda. Participating in other structures at the ward level—village health committees, social assistance committees, beneficiary welfare committees, and economic-strengthening committees—enhanced working relationships and promoted collective responsibility. The program supported county governments in developing sustainability plans, investment cases, and advocacy plans to lobby the national government for additional funding for OVC programs.

5. **VSLAs are very popular with women, and most members are women; male engagement can counteract negative reactions to this dynamic and enhance sustainability**. As women became empowered and started thriving through participation in VSLAs, some spouses felt threatened by their wives' economic empowerment. This destabilized the power dynamics in the household, leading to hostility. The project, through CBTs, trained and mentored VSLA members on how to manage their emerging economic power and mitigate the potential conflict at their households.

Equiping adolescents with information and knowledge on SRH, and HIV prevention.

KEY CHALLENGES TO ATTAINING SELF-RELIANCE AND SUSTAINABILITY

Nilinde has contributed substantively to the self-reliance of its community partners and households and the sustainability of project efforts throughout its implementation. However, certain elements slowed the pace of progression toward sustainability:

- Downward reclassification of counties within the donor strategy based on a revised lower HIV burden resulted in Lamu exiting the project much earlier than expected, which impacted a wide range of program activities and sustainability planning. While Nilinde worked successfully with a highly effective set of Lamu counterparts to plan the transition, the rapid scale-down meant that little time was available to fine-tune solutions for linking beneficiaries to care and to support and build the capacity of institutions to sustain the gains of the project.

- The budget cuts that eventually led to early project closure led to the reduction and eventual termination of sub-grantees. The short transition time and uncertainty regarding possible successor projects created anxiety among beneficiaries, especially CLHIV and the supported OVC in schools. The project used linkages to sustain support; however, this will require follow-up to ensure longer-term transition to self-reliance among the affected community partners and households.

- Many OVC in urban informal settlements were not able to access public schools because the schools were full beyond capacity. These OVC resorted to Alternative Provision to Basic Education and Training schools, which were affordable and closer to them but do not comply with government standards. Although the OVC attending these schools technically had access to education, they could not be supported, due to organizational policies restricting engagement with these institutions.

- The security situation in the Coast region, particularly Lamu County, was a key constraint in Year 2. Threat levels remained fluid, with restrictions on staff travel and project activities. This eventually contributed to the program's exit, as advised by USAID.

- With the mandate to intensify selected activities in Year 2 under the PEPFAR "plus up" framework, a quick turnaround time for implementation was required. This short timeframe made modifications to sub-grantees nonviable, and therefore Plan International implemented activities directly in order to meet targets, thereby shifting the workload from SDPs to Plan and to some extent disenfranchising the SDP model.

- Programs should be prepared to react to unintended consequences. For example, after HES interventions, some households diversified their businesses and started thriving, leading to caregivers spending more time at their businesses than at home. Their children, especially the older ones, had to step in to undertake household chores that were initially performed by the parents, while others started helping in the family businesses. This was an unintended outcome. Through positive parenting skills trainings, caregivers were guided on finding alternative help for their businesses and household chores, thus freeing the children from tasks that were not age-appropriate for them

RECOMMENDATIONS AND POLICY IMPERATIVES

Donors and Government

- Using a community workforce in OVC programming helped bring about timely linkages to HIV treatment and adherence to care and treatment. Capacity-building improved the quality of services and the sustainability of gains. A government-led policy dialogue toward institutionalizing

the community workforce in the continuum of care for long-term HIV treatment would be beneficial.

- Vulnerable communities struggle to meet the minimum requirements for active NHIF subscription and thus do not benefit from universal health coverage. Nilinde recommends that the NHIF systems consider frequent payments at lower rates for vulnerable groups, and enhanced collaboration with VSLA groups to support increased uptake of NHIF. This would likely lead to increased coverage of universal health care, thus promoting a healthy society that contributes to gainful economic development.

- Establishment of digitization data hubs at the community level has the potential to catalyze real-time data use by communities that have for a long time simply been suppliers of information. This will help programs identify areas of greater need and hence lead to more targeted service provision, contribute to ownership of data and resultant analyses, and promote evidence-based advocacy and resource mobilization for OVC services.

Program Designers

- Peer-to-peer support is crucial in HIV management. When families with a member living with HIV are supported by an HIV-positive CMM, they easily open up on the issues affecting them and share freely. In such a context, it is easier to offer treatment support to individuals, since peers are able to relate to the shared issues they are facing and can offer well-informed support. Nilinde recommends that OVC programs adopt CMMs as a cost resource during project budgeting.

- Future OVC programs should enroll HIV-positive OVC directly from the health facilities and then enroll their siblings at the community level. This will minimize false HIV-positive enrollments and will help the project enroll the correct beneficiaries from the start.

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10 Quality care is defined as the provision of the correct mix of services for each child, family, and community based on current best practices and expert knowledge.

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Adventist Centre for Care and Support (ACCS)
Association of Volunteers in International Service (AVSI)
CARITAS
Carolina for Kibera
Global Communities (formerly Cooperative Housing Foundation International)
Community-Based Health Care (CBHC)
Council of Imams and Preachers of Kenya (CIPK)
Deaf Empowerment Kenya (DEK)
For the Children's Sake Foundation
Deutsche Stiftung Weltbevoelkerung (DSW)
HAKI (Humanity, Activism, Knowledge, Integrity) Africa
Hope Worldwide Kenya
Integrated Education for Community Empowerment
Kibera Community Self Help Program (KICOSHEP)
KWETU
Movement of Men Against AIDS in Kenya (MMAK)
Mukuru Child Wellness Centre (MCWC)
Nairobi Integrated Program (NIP)
Njukini Community Organization
Redeemed Integrated Development Agency
Ruben Centre
Strategic Community Development Network (SACODEN)
Strengthening Community Partnership & Empowerment (SCOPE)
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