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Mapping for better healthcare in Nairobi's slums

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Mapping for better healthcare in Nairobi's slums

By Mwangi Chege, Carol Wainaina and Caroline Kabaria

A citizen mapper at work during the mapathon hosted at the APHRC campus

> Maps and geographic data can be used to tell stories from communities as well as address development challenges.

Slum areas are not just defined by the presence of poverty; they are also characterized by the near absence of public services. Residents of these areas often cannot access quality health and education services while infrastructure for water, sanitation and energy is usually woefully inadequate. This has impacts on the health and well being of people who live in slums.

APHRC research has shown that slum dwellers have similar if not worse health outcomes than rural poor populations. High rates of infant mortality and deaths from infectious diseases as well as diarrheal diseases reflect the hard reality of life in slums.

This is striking because many slum residents are people who left rural areas for urban centers, seeking to improve their quality of life.

In cases where public services such as clinics and hospitals within slums are provided, barriers to access still remain. Lack of financial resources can make it difficult for slum residents to utilize the few available facilities. Sometimes they simply cannot afford to take time off from work to seek the care they need. Poor political will on the part of municipal authorities may also result in the needs of slum residents being neglected.

APHRC staff also participated in the mapathon to map health facilities in Korogocho and Viwandani

APHRC has partnered with the University of Warwick to study healthcare-seeking practices among people living in the Nairobi slums of Korogocho and Viwandani. The study will also explore factors that influence these practices such as cost of healthcare, accessibility of facilities and quality of care. Other study cities include Ibadan, Nigeria; Karachi, Pakistan; and, Dhaka, Bangladesh. Evidence from these diverse sites will improve understanding of what it takes to achieve effective and efficient delivery of healthcare for the urban poor.

A mapping marathon

One of the study activities is a mapping exercise to identify where healthcare facilities are located in Korogocho and Viwandani, to support further analysis on accessibility and costs. The first phase of this mapping was conducted in a mapathon held at the APHRC campus in January 2018. The mapathon involved university students, professional mappers, representatives from Korogocho and Viwandani, as well as staff from the center. Their mapping skills ranged from novice to master-cartographer.

These 'citizen mappers' used satellite images, existing maps and geographic information systems (GIS) software to add missing features and modify existing ones so that the maps are a more accurate representation of reality. Specific features that they were identifying included roads, health facilities, water sources and sanitation points in the two slum areas.

Professional mapper Zachariah Muindi, who has participated in a number of mapathons noted the importance of mapping slum areas. "Maps and geographic data can be used to tell stories from communities as well as address development challenges. Different organizations can use the data to provide solutions to needs that are highlighted by the maps. For instance, humanitarian organizations use these data when they are planning for provision of aid to areas affected by natural disasters."

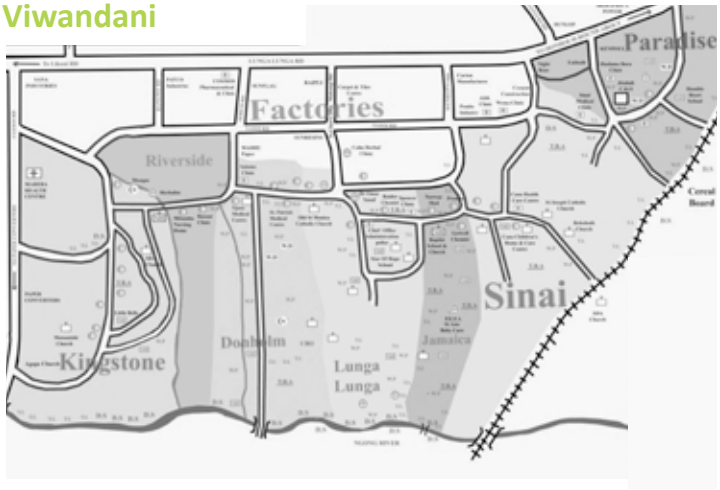
Participation by community members at the event was critical, because of their intimate familiarity with the areas being mapped. It also provided an

opportunity for empowerment, as the skills they learned during the mapathon can be adapted and used for other community-building activities.

"The mapathon was a totally new experience for me! I only ever really use maps to get directions," one of the participating APHRC staff members said. "By the end of it all I was impressed at what I had accomplished despite having no knowledge or experience in mapping."

Speaking on his overall experience at the mapathon, Muindi said: "My experience at the mapathon was fantastic. I was able to map several buildings in Viwandani and to also assist in modifying buildings that had been mapped in an earlier exercise. Data accumulated through the mapping exercise will go a long way in assisting APHRC to provide lasting solutions for the people of Korogocho and Viwandani."

Viwandani



Korogocho

The mapathon was just the first step in understanding patterns of health service delivery within the two Nairobi slums; the resultant maps will feed into the long-term project goal to develop viable models for delivery of health services in slums worldwide. While slums will continue to be part of our urban reality, poor healthcare service provision in these areas should not.

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DR. JOSEPH GICHURU

Spotlight on
APHRC's newly appointed deputy executive director

Joseph Gichuru is one of APHRC's longest-serving staff members. He joined the Center in 2003 as a finance and administration manager and steadily rose through the ranks to become director of Operations. In January 2018, Joseph was appointed as the Center's deputy executive director.

Carol Gatura sat down with Joseph to find out more about how he sees his new role as a steward of the Center's achievement of the 2017-2021 Strategic Plan.

Congratulations on your appointment! How does it feel to be the second in command of the Center?

I feel a great weight and responsibility on my shoulders. Not in a bad way, but the title carries great responsibility. I know more is expected of me and I am honored. At APHRC, we pride ourselves in promoting people to the jobs they are already doing, so I feel up to the task because I know what is expected of me. It's about doing the same thing but with a more defined mandate and requisite authority.

> "The title carries great responsibility. I know more is expected of me and I am honored"

What are the key responsibilities of your new role?

Mainly to support the executive director in leading the institution and effectively implementing the strategic plan. I will act in the ED's absence and lead on corporate matters that have legal, regulatory and commercial implications: opening new offices, contract reviews and negotiations, as well as corporate governance, for example.

What do you hope to achieve?

Some of the special projects I plan to handle include the opening of our West African office as well as opening a fundraising office in the United States. I will also oversee fundraising for and commencement of APHRC's Phase II development, which will see the extension of our current campus to include a training center. We plan to source and implement an Enterprise Resource Planning system that will link most of the processes at the Center, thereby enhancing efficiency and output.

You've always been passionate about APHRC and its work, stating that the Center is built on integrity. What are you most proud of over your tenure at the Center?

I appreciate the professionalism at APHRC and the freedom that is given to all staff to air their views. I was recruited by one of the big four audit firms to go and streamline processes at APHRC after the previous person in the role was found wanting. I took over at a time when there were compliance issues that needed to be sorted out in Kenya and in the US. Within one year, we had sorted them all out. Next was the process of developing numerous policy documents and strengthening internal controls. I am happy that I have contributed to strengthening the systems and processes at APHRC from the time it had a budget of US$1 million when I joined, to now, when our operating budget is US$15 million.

How are you going to spend your even more limited spare time now that you are wearing two hats?

I like jogging a couple of times every week and try to participate in one or two half-marathons every year. I also like to play table tennis. The rest of my spare time is taken by social events with family and friends as well as church activities.

What is one thing about you that might come as a surprise to your APHRC colleagues?

I am an open book. Most people don't know that I am the last born in my family, as I do not exhibit any of the typical characteristics of a last-born. In a family of eight children, born to parents who never saw the inside of a classroom, life was a hustle and there were no luxuries for anybody.

Any last thoughts?

The Center has grown immensely in the last two years and more issues continue to land in the deputy ED's office, as staff use this office as first point of call on top-level decisions. In future, there may be need for more support for the division to ensure that specific deliverables are not affected. We will review as we continue to define what this support will be.

Congratulations Joseph, we wish you well in your new position!

Education and incarceration: Perspectives on the pathways from prison program

By Susan Dewey

I was fortunate to spend three weeks at APHRC in February 2018, and deeply appreciated the warm welcome and collegial support I received during my short visit. I especially enjoyed speaking with APHRC colleagues about the origin, evolution, successes, and impacts of Wyoming Pathways from Prison (WPfP), a college-in-prison program I founded and co-coordinate alongside three other colleagues in the United States.

Susan Dewey, co-founder of Wyoming Pathways from Prison

Wyoming Pathways from Prison is a nationally recognized and award-winning collaborative initiative that provides high-quality college courses to incarcerated women and men through generous volunteer support from University of Wyoming (UW) faculty, staff, and students. In 2017, the Correctional Education Association -- the primary professional organization in the US for educators working in jails and prisons -- recognized WPfP as a leader in developing best practices that can be implemented nationwide.

Incarceration impacts all members of our human community, as the vast majority of people who go to prison will eventually be released back into society. This reality makes incarceration a potentially transformative time to make significant changes for the better, both for prisoners and for members of the communities to which they will be returning following their release. At WPfP, we believe in the power of education to transform lives, both inside and outside prison, by creating opportunities for skill-building, personal growth, and self-reflection. WPfP does this work as part of its mission to provide a no-cost college education to incarcerated people, engage in service to the state of Wyoming, and mentor University of Wyoming students through real-world teaching and leadership experience.

In just two years since its founding, WPfP has provided direct benefits to the university and state of Wyoming, as well as incarcerated people through numerous professional development and community engagement opportunities.

Yet WPfP's impacts on incarcerated people's lives are best-expressed in their own words. As some of the women in our classes have said:

We do this by providing:

- Dozens of university students with supervised practical teaching experience in Wyoming prisons. Many of these students receive internship or study credit and later go on to successful careers in teaching, law, social work, and related fields
- Nearly 200 inmates with hundreds of college credits thanks to an agreement with community colleges. Inmates receive instruction through in-person and distance-learning courses focused on skill-building through the study of philosophy, writing, literature, and social work
- International recognition for UW through the publication of *Telling My Story: Voices from the Wyoming Women's Prison.* This collection of incarcerated women's memoirs was co-edited by UW faculty and students and is available online.

> "We're not lepers. Some of these girls have no education, and they can't get access to education because of why they're here. If they could get educated, have housing, and be able to go out there and be productive in society, things would be different. They wouldn't come back."

Some of the men have shared the following regarding a recent class on financial literacy WPfP offered:

> "Real practical skills like the ones we learned in this class help keep guys out of trouble. I don't think any of us had ever gone through the steps of what's involved in doing taxes before this class … A lot of guys are afraid to ask questions about money because it makes them feel stupid. Classes like this are a real necessity."

I accompanied APHRC colleagues Sheru Muuo and Dr. Boniface Ushie to meet with the officer-in-charge at the Machakos Women's Prison, where we spoke at length about WPfP's work and the possibility of pursuing similar work in Kenya. Sheru and I were inspired by the possibility of doing work that's similar to WPfP's in Kenya.

We learned from our visit that incarcerated women in the United States and Kenya face many similar issues including intergenerational poverty, compromised mental and physical health, significant stress caused by caregiving responsibilities for small children, and other forms of marginalization. These similarities provide the opportunity for APHRC and WPfP to work together, as incarcerated individuals all over the world deserve a second chance.

Go with the flow:

Lessons in policy engagement from tracing the flow of Nairobi's fecal waste

By Emilly Okello-Juma, policy and communications officer

Participants drawn from national, Nairobi and Nakuru county governments, civil society, development agencies, informal settlements, and private sector at the Nairobi SFD Validation Workshop on February 15, 2018 at APHRC Campus, Kitisuru.

Prof. Barbara Evans and her engineering faculty colleagues at the University of Leeds stared at a satellite image of the coastal city of Accra, Ghana. They were trying to figure out why the seawater around Accra's Lavender Hill neighborhood looked so brown instead of the typical ocean blue. Further investigation revealed that trucks were dumping untreated human waste into the sea. Yet there was a fecal sludge treatment plant a short distance away from the dumping spot at Lavender Hill.

This graphic image led to the birth of the idea for a tool that could quantify and visually depict the flows of fecal waste within a city, in order to help municipal authorities understand how much fecal waste from the city is safely treated (or not), and also to identify intervention areas along the sanitation value chain from defecation to disposal. The tool, called the Shit Flow Diagram (SFD), has now been used in close to 50 cities worldwide, among them East African cities such as Dar es Salaam, Kampala and Nakuru and Kisumu in Kenya.

As part of our engagement in a multi-country initiative to understand the gaps and opportunities in implementing national sanitation policies in Kenya, Tanzania and Uganda, we saw an SFD for Nairobi as a critical tool for advocacy and smarter, more effective application of the mandates outlined in the 2016 Kenya Environmental Sanitation and Hygiene policy.

A good SFD has its roots in community collaboration, engaging city authorities, utility companies, researchers and civil society. For the development of the Nairobi SFD, APHRC partnered with social enterprise firm Sanergy and the Nairobi County government to ensure shared ownership from the outset. We also worked closely with the Nairobi Water and Sewerage Company to ensure that the final product would be embraced and, most importantly, actionable by key players in the nascent sanitation sector in Nairobi.

Learning and unlearning from experience

Knowing the players was critical to the process of developing the SFD. Our engagement with the Nairobi County Department of Public Health's Deputy Director Jairus Musumba, and Department of Water Director Dr. Mario Kainga opened a number of doors, as did our early consultations with the Ministry of Health's Acting Director, Dr. Kepha Ombacho. We had a list, long as a toilet plunger, of urban sanitation stakeholders from both community level and government, and set out to find out what they thought they knew, what they knew for sure, and what they knew that they were missing. Prof. Evans and her team were critical in helping us think through our approach, and worked with us to make sure our tools were the right ones to validate conventional wisdom.

An early obstacle was the murkiness of responsibility for sanitation service delivery: it was about as clear as a pit latrine who was responsible for what at what level, be it municipal, county or national. A lot of this can be attributed to the relative novelty of sanitation as a standalone sector requiring its own governance and leadership. So we took our questions to the county departments of Environment, Water and Public Health, meeting officials in corridors and conferences and joining the TWG (urban sanitation working group) where the questions we were asking were often the basis for long and passionate discussions among Nairobi's most expert sanitation stakeholders.

What we learned was that the solutions to Nairobi's growing sanitation crisis were self-evident to officials within the sector – and a mystery to everyone else. Sanitation experts were able to articulate the iterative process needed to provide safely managed sanitation to the city's four million people, even those in informal settlements, from improved infrastructure to linking effective sanitation solutions to improved public health. But they were also equally aware of the challenges they faced, from inadequate resources, unwieldy bureaucratic processes and institutional inertia that has hobbled their ability to deliver services effectively and efficiently.

We also learned that the research process can be equally opaque, and that we have a responsibility as policy-oriented researchers to explain the value of the process – everything from how we formulate a research question, to why we need ethical approvals, to what the validation of research findings entails and the value of peer review. Engaging government as co-conveners in a process that they do not fully understand, or treating them simply as respondents during the data collection or dissemination stages, misses the opportunity for the process to be truly collaborative and for the outcome to compel action.

"What we learned was that the solutions to Nairobi's growing sanitation crisis were self-evident to officials within the sector – and a mystery to everyone else."

This is where a hard lesson was learned; we did not seize on the opportunity to bring finance, treasury or planning officials into the process. Other government agencies charged with charting the country's development course, for example the Vision 2030 Secretariat, also need to weigh in during the research process, as well as in the crafting of policy recommendations.

Resource allocation is a key concern for policymakers, as the gap between existing problems and available solutions in public service delivery can only be fully addressed when finance and planning officials are part of the process from the outset; more than that, they need to understand where the needs are coming from!

Kenya could do well to take its cues from our neighbor to the west, Uganda, where a representative from the Ministry of Finance is embedded in the Ministry of Sanitation; not only does it give the sanitation teams more insight into financial processes and how budgeting is done, but it also provides a window into the infrastructure needs for improved and safely managed sanitation that would otherwise be a mystery to the people who hold the national purse-strings.

A final lesson was that every policymaker has a story that is worth hearing. How to honor these stories, of personal challenge or of personal triumph, is a critical tool for advocacy to humanize and provide context to the indignities of not having a safe and accessible place to do one's daily business.

The Nairobi SFD was validated during a rousing and inspiring session at the APHRC campus in February 2018, bringing together policymakers and community leaders who pored over maps, argued over approaches and laughed at the inevitable scatological puns that emerged during our conversations.

As one of the county's leading voices in the sector, Jairus Musumba, deputy director, Department of Public Health at the Nairobi City County Government, noted: "we now have the tool we need to advocate for safer, better sanitation solutions for Nairobi. It's time to dig deep and get it done."

The resilience of **South Sudanese mothers** and babies in the face of conflict

By Lynette Kamau, policy and communications officer

Living in a conflict zone means that women are often prevented from being able to see their caregivers even during the most challenging parts of their pregnancies. For women in South Sudan, the constant risk of fighting requires them to be in flight mode – a panic that can have dangerous consequences for themselves and their unborn children. Being able to see a caregiver can often mean the difference between life and death for these women, which makes South Sudan one of the most risky places in the world to be a pregnant woman.

World Health Organization statistics about maternal death are a sober reminder of the consequences of conflict. The most recent estimates, drawn from incomplete data in 2015, suggest that the number of maternal deaths in the world's newest country are 789 per 100,000 live births: the world's fifth highest maternal mortality rate.

How to make it easier to keep women alive while bringing life is the goal of new implementation research being conducted jointly between the Torit State Hospital, South Sudan Ministry of Health and Université de Montréal, as part of the seven-year, $36-million initiative of Innovating for Maternal and Child Health in Africa funded by the International Development Research Center. The team is investigating community-centered approaches to make sure that even in times of crisis, women are linked to health facilities and able to use maternal health services.

In December 2017, APHRC had the opportunity to visit this team in Torit, Imotong State in South Sudan. These photos only begin to tell the story.

1

Pregnant women patiently wait at the antenatal clinic in Torit Hospital in Imotong State, South Sudan. Only 17% of women in South Sudan make at least four antenatal visits as recommended by the World Health Organization. Access to maternal health services is a challenge for many pregnant women due to insecurity caused by periodic outbreaks of conflict.

2

A pregnant mother undergoes screening at the Nyong Health Facility in Torit, South Sudan as part of antenatal care. For many mothers in South Sudan, a visit to a health facility or access to caregivers is only made at a critical stage in their pregnancies. This means that some mothers do not carry their babies to term as they did not access lifesaving services on time. Aside from insecurity, other reasons that delay or prevent pregnant women from accessing caregivers are long distances between homesteads and health facilities, lack of transport, flooding and poor road terrain. It is for these reasons, researchers supported by the IMCHA initiative are investigating community-centered approaches to make sure that even in times of crisis, women are linked to health facilities and are able to use maternal health services.

3

A woman holds her child as they wait patiently for the doctor during a postnatal visit. The postnatal period is a critical phase in the lives of mothers and newborn babies as most maternal and infant deaths occur during this time. But according to the WHO, it is also the most neglected period for the provision of quality care. In South Sudan, it is especially difficult for women to follow through with postnatal visits as sporadic situations of violence make it difficult for health caregivers to work. Doctors, nurses and midwives are sometimes also forced to flee from their work stations as they cannot guarantee their security. Women therefore are unable to travel to health facilities and are also not guaranteed they will find caregivers to attend them when fighting erupts. The IMCHA-supported project is implementing and assessing community-centered approaches to facilitate access and utilization of maternal health services during labor, birth and the immediate postnatal period to improve newborn and maternal survival.

4

A child being immunized during a postnatal visit at the Torit Hospital in Imotong State, South Sudan. Torit Hospital is one of the main facilities that provides immunization services in Imotong State. Immunization is one of the most effective interventions to prevent disease and early child death. Despite widespread conflict and insecurity, South Sudan witnessed a remarkable improvement in routine vaccination coverage in 2017. With the introduction of the pentavalent or five-in-one vaccine to guard infants against diphtheria, pertussis, tetanus, hepatitis B and Haemophilus influenza type B, South Sudan raised its pentavalent vaccine coverage from 45 percent in 2016 to 57 percent in 2017. Due to population displacements coupled with disrupted health service delivery as a result of fighting, the IMCHA-supported research project is implementing and assessing community-centered approaches to facilitate access to lifesaving services such as immunization so as to reduce risk of consequences of vaccine-preventable diseases among children under five years.

A woman joyfully holds her baby after a postnatal visit at the Torit Hospital in Imotong State, South Sudan. The baby has been given a clean bill of health. This is the desire for every mother in the world. In South Sudan, this happy ending is not a guarantee for many women and children who face life and death on a daily basis due to the constant risk of conflict. Access to caregivers and lifesaving maternal health services even in such unpredictable circumstances, go a long way in preventing women's deaths while giving life. The IMCHA-supported project is implementing and assessing community-centered approaches to ensure that more children get the healthiest possible start to generate productive human capital for their country's growth and development.

Violence affects both recipients and providers of services: Evidence from Dadaab

By Sheru Muuo, research officer

Refugee settings can be a difficult environment for those fleeing conflict in their home countries. Kenya's Dadaab is home to one of the largest refugee camps in the world. More than 235,000 refugees, mostly from Somalia, call it home. Daadab has been open for 27 years, meaning some young adults have spent their entire lives there, and know no other home.

Violence against women and girls directly touches one in three worldwide, making it a global health issue. Worse still, one in three Refugee Community Workers (RCWs), who are refugees trained to provide gender-based violence (GBV) services to fellow refugees in Dadaab complex, reported experiencing threats or physical violence in the last 12 months. Despite this, the RCWs, overwhelmingly continue in the role because they believe their work makes a difference.

Insufficient funding and low prioritization means that GBV is inadequately addressed, leaving many women and girls vulnerable to ongoing physical, sexual and emotional harm. Existing interventions are infrequently evidence-based, poorly designed, rarely scrutinized, and seldom evaluated.

APHRC in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) conducted research on an individualized case management model with a task-sharing approach of assisting GBV survivors in the Dadaab. Task-sharing in this context means that humanitarian aid workers deliver GBV services alongside RCWs.

During the 2014-2017 research period, the model was implemented by the International Rescue Committee (IRC) and CARE in two camps within the complex, called Dagahaley and Hagadera. Due

to funding limitations, the model is only being implemented by IRC in Hagadera at this time. The project is part of the What Works to Prevent Violence against Women and Girls program, funded by the UK Department for International Development (DFID). The aim is to understand how a GBV response model of comprehensive case management with task sharing works to influence access to care, wellbeing, and health and safety among GBV survivors living in the Dadaab refugee camps.

Women accessing GBV services completed multiple interviews while receiving care, and RCWs completed a survey on their work and personal histories of violence. Qualitative interviews were also conducted with women accessing services, RCWs and with other staff working on GBV (Kenyan GBV case managers and counsellors with educational and professional backgrounds in counseling or social work skilled in delivering GBV response services). These helped to provide insight into the context of GBV in Dadaab, the working relationship between staff and survivors, as well as the unique challenges RCWs face.

In February, the research team shared its findings in the report "Violence, Uncertainty, and Resilience among Refugee Women and Community Workers: An Evaluation of Gender-Based Violence Case Management Services in the Dadaab Refugee Camps". The launch event in Nairobi included participants from local and international organizations including the United Nations High Commission for Refugees, Save the Children, Population Council, LVCT Health and DFID Kenya. IRC Country Director, Mohamed El Montassir El Safi and his DFID counterpart, Peter Vowles, provided opening remarks. This was followed by a joint research presentation by Mazeda Hossain of the London School of Tropical Medicine and Chimaraoke Izugbara of APHRC. Later in a panel discussion, two refugee community workers and representatives from IRC and CARE shared their experiences in implementing the case-management model as well as what stood out for them from the research findings. Finally, there was an engaging question and answer session before closing remarks by Joyce Muchena, a representative from CARE Kenya.

The research project showed that the case-management model was working well in this setting, especially with respect to mental health outcomes such as depression, anxiety and post-traumatic stress disorder (PTSD). And the women who were surveyed agreed: 82% reported that their interactions with RCWs had a positive effect.

Even though RCWs provide vital services to the community and especially survivors of GBV, they themselves face challenges including violence from family and community members as a result of their work. Yet, they remain convinced of the value of their work. The study showed that additional support could improve what they are able to do. These might include capacity-building, a reduced workload, counseling and other work-related benefits such as transport to different parts of the camp, mobile phones with air time, and salary increments.

Overall, the study confirmed that the GBV case -management model using task sharing with RCWs in Dadaab is feasible and acceptable. However, further research is needed to determine whether the model is applicable to other settings. The resounding refrain from both the discussions and the research is that, at a minimum, increased funding is needed to plug the service gaps for violence survivors and to support prevention efforts.

A **breastfeeding initiative** that is saving children's lives

In December 2017, the National Academy of Sciences, Partnership for Enhanced Engagement in Research selected this essay as the third-best overall submission in its global story contest. The story on the Baby Friendly Community Initiative (BFCI) was narrated by Betty Samburu from Kenya's Ministry of Health to APHRC's Peterrock Muriuki and Lynette Kamau.

Tabutany Ledana, 70, displays a bottle containing the herbal mixture she used to prepare for infants during a community sensitization session at the Esageri Health Center in Baringo County, Kenya. /Amunga Eshuchi, APHRC.

My experience with the Baby Friendly Community Initiative (BFCI) project in Koibatek sub-county, Baringo County, a rural area in Kenya, was remarkable. The project promoted optimal breastfeeding and child feeding practices by working with community health volunteers to support mothers at the community level. This bridged the lack of support gap for women after delivery.

One memorable thing is how the project changed the narrative around exclusive breastfeeding in the community. The counseling provided to mothers helped to demystify myths and misconceptions on breastfeeding. Mothers in this community have overcome barriers related to exclusive breastfeeding. The experiences of two women in particular linger in my heart.

Immaculate Kosgei was 28 when she had her first child at home in September 2006, assisted by a retired midwife who had only basic supplies. A hospital birth was too expensive for her family, which survives only on money they earn from casual labor.

Soon after she was born, Immaculate's daughter fell ill. She was breastfed but the family advised her to use a local mixture of herbs, which they said would help 'improve the baby's immune system'. With each passing day, her daughter's health deteriorated despite the breastfeeding and herbal mixtures.

Unsettled, Immaculate took her now ailing daughter to a nearby hospital for treatment one morning, in February 2007. A battery of tests later, she was shocked to learn that both she and her child were HIV-positive. This was the last thing she had expected to hear. However, after receiving counseling from healthcare workers and her local community health volunteer, she determined to live positively and bring up her daughter in the best possible way.

Purity Wangeci who was part of the BFCI initiative, breastfeeds her child as her husband John Cheboi at the Solian Health Center in Baringo County, Kenya. /Amunga Eshuchi, APHRC.

Fast forward to eight years later, and Immaculate was pregnant again. Her joy was tempered by anxiety, as she worried whether her new baby would also be HIV-positive. This time, though, things were different.

The BFCI project started in 2014, as a collaboration between APHRC, Kenyatta University and Kenya's Ministry of Health Nutrition and Dietetics Unit. For two years, we provided 351 mothers with breastfeeding support where they were counseled at home by trained community health volunteers on exclusive breastfeeding for the first six months and appropriate complementary feeding after six months, as part of the global initiative to promote optimal feeding practices for infants and young children.

It was an uphill battle at first in Kenya, where just 61% of children were exclusively breastfed for their first six months of life, according to the 2014 Demographic and Health Survey -- a far cry from our national target of 80%. We used the global momentum to try and reach our target, with mothers like Immaculate enrolled into the project.

Support for participants included antenatal care and information on how to prevent HIV transmission to her baby, the importance of good nutrition and how to optimally breastfeed her child.

Seven months after enrolling in the project, Immaculate delivered in a health facility. Thereafter, she was linked to a community health volunteer (CHV) for follow-up. The CHV visited her home regularly and counseled her on exclusive breastfeeding and how to introduce complementary foods after six months. Immaculate is now empowered and knows what actions to take to ensure her children remain healthy. She also encourages other mothers in her community to attend antenatal clinics, deliver in health facilities and exclusively breastfeed their children for six months.

The project's impacts extended beyond mothers. It improved knowledge and transformed attitudes and practices about breastfeeding among community members and leaders, among them 70- year-old traditional herbalist, Tabutany Ledana. Ledana was skeptical that breastmilk would be enough for an infant; like many of her generation, she was a firm believer in the value of the herbal supplements that had been used for her children and the children before them.

But the advocacy and education component of the BFCI turned Ledana into a champion of breastfeeding, a powerful voice urging mothers that breast is best.

"Since the project started, we have seen many changes in the community. We were giving our babies herbs which are harmful to their stomachs. Now we have stopped," Ledana explained.

Such is the power of education and empowerment, and the value of the BFCI to communities like Koibatek. In training CHVs, we made sure that the learning was passed on, not just to pregnant women and their families, but to entire communities. Our CHVs were taught how to monitor growth, how to ensure that breastfeeding was done right and done exclusively, and that mothers were supported with the right information to silence the doubters around them.

CHVs kept a counseling checklist with the mothers' contacts and used key messages on each of the eight steps of BFCI during home visits. They also shared this information with community members during chief barazas and other public forums.

The project has led to a significant improvement in breastfeeding practices in the community. For instance, 88% of children who benefited from the BFCI intervention were exclusively breastfed for six months.

> The project has led to a significant improvement in breastfeeding practices in the community

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This was higher than the **56%** recorded among children whose mothers **did not benefit from the intervention**.

This is significantly higher than the 56% recorded among children whose mothers did not benefit from the intervention.

The project demonstrates the effectiveness of BFCI in promoting optimal infant feeding practices and health outcomes. There are now 22 counties in Kenya implementing BFCI, drawing on lessons learned from this project. Other organizations including UNICEF and World Vision are using the BFCI model in their community-based work.

For myself, my years of breastfeeding are long past, but my advocacy as a policymaker is only just beginning. I have learned the value of participatory policy-making, and the importance of working with communities, not just on their behalf. Like my new friend Ledana, I have also learned that no matter how old you are, you can learn something new.

Tracking **financial flows** in the sanitation sector

By Lauren Gelfand, director of policy engagement and communications

As part of our work to identify gaps and opportunities to improve implementation of sanitation policies in Kenya, Tanzania and Uganda, APHRC was invited in February 2018 to participate in a training of trainers on the WHO-developed tool, Trackfin. The tool seeks to identify the scope and breadth of expenditure on water, sanitation and hygiene (WASH) services.

The goal of Trackfin is to help close the financing gaps to achieve universal access to water and safely managed sanitation services. This goal has eluded more than four billion people worldwide, the vast majority of whom live in sub-Saharan Africa.

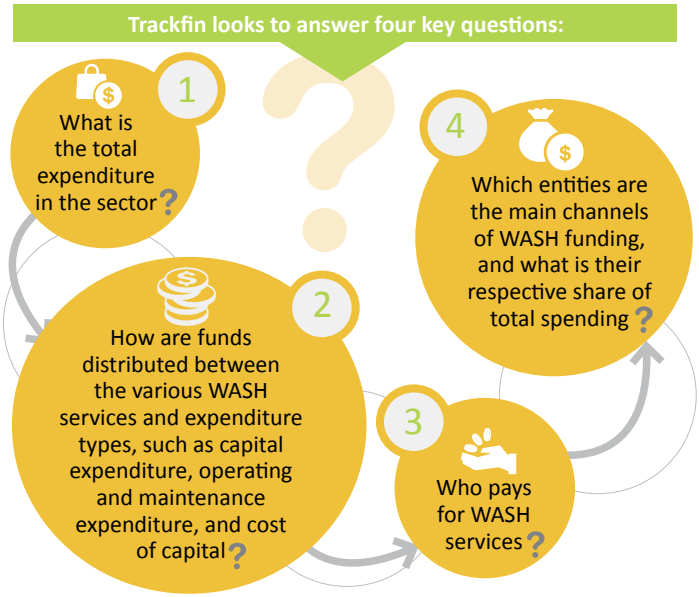
Trackfin marks a significant evolution in the way the water and sanitation sector understands and tracks financial flows at national level, because it requires full participation of all actors beyond the public sector in contributing to financial reporting. It draws extensively on tracking tools developed for the health sector, particularly for countries seeking to attain universal health coverage for their populations.

For many countries, this has been particularly challenging, as the absence of data – or reluctance of actors to contribute their financial data – has meant that financing decisions are made in the absence of sufficient information.

The tool, which is its own self-contained platform is easy-to-use,

Trackfin will enable the tracking of financial flows towards water, sanitation and hygiene services. /Amunga Eschushi, APHRC.

accessible in multiple languages and provides for customization based on national contexts.



Through a partnership between WHO and USAID, Kenya is a pilot country for use of the tool. Going forward, APHRC intends to be part of a regional community of practice to support the wider use of Trackfin as an advocacy tool to both understand and increase spending on sanitation, in line with the 2016 Ngor Declaration which commits African governments to spend at least 0.5% of GDP on safely managed sanitation services for their people.

APHRC recognized among the **top think tanks** worldwide for its work in health policy and advocacy

For the second year in a row, the African Population and Health Research Center (APHRC) has been ranked among the top think tanks worldwide by the Think Tanks and Civil Societies Program of the Lauder Institute at the University of Pennsylvania.

APHRC is the only African institution to be ranked among the top 20 influential think tanks providing superior research and analyses on domestic health issues. The Kenyan-based think tank was also recognized for its work in global health policy as well as in advocacy, earning a ranking among the top 30 worldwide in both categories.

The rankings were released in the 2017 Global Go To Think Tank Index Report, developed by the Lauder Institute's Think Tank and Civil Society Program (TTCSP) based at the University of Pennsylvania. This 11th edition of the annual report highlighted the top think tanks from a database of more than 7,000 institutions globally. The rankings were drawn from a survey of policymakers, media representatives and donor organizations. Expert panels consisting of individuals from a wide range of countries and disciplines then helped to refine and validate the rankings. The result is a comprehensive and authoritative list of think tanks that are at the top of their game.

"APHRC is delighted to be featured in the Global Go To Think Tank report for the second consecutive year," said APHRC Executive Director Dr. Catherine Kyobutungi. "We are proud to be in the company of the illustrious institutions listed in the report. It demonstrates that we are a Center that lives our values, including excellence. We will continue to work closely with our partners to generate evidence for the transformative changes that Africa needs."

> "We are proud to be in the company of the illustrious institutions listed in the report"

This year's report highlighted the challenges faced by African think tanks, many of which are facing a sustainability crisis due to inadequate resources and workforce limitations. In a foreword to the report, Dr. James McGann from the Lauder Institute notes that, "Africa's think tanks have few staff and limited budgets due to insufficient and irregular funding, high staff turnover due to low salaries, and financial instability. Taken together, they create widespread institutional fragility and an acute sustainability crisis in the region."

Dr. McGann's comments make APHRC's accomplishments even more remarkable as the Center has existed as an independent research entity for over 15 years and continues to grow from strength to strength. Since 2001, APHRC has been able to generate a large body of evidence and knowledge that has shaped policy discourse across sub-Saharan Africa. The Center conducts research in a range of inter-related fields including urban health, sexual and reproductive health, maternal and child wellbeing, and education. In a continent with a mostly youthful profile, APHRC is one of the few institutions in Africa to actively engage in research on older people and the contribution they can make to help the continent realize its development potential, including harnessing the benefits of the demographic dividend.

The Center is also committed to raising the next generation of researchers and research leaders in Africa by offering fellowships and facilitating training for scholars in institutions of higher learning within the continent.

"Since its inception, APHRC has been driven by the firm belief that the people of Africa and their institutions are capable of developing solutions to many of the vexing challenges facing us," Dr. Kyobutungi said. "I am proud of the contribution we are making to understand the nuances of these challenges and reaffirm the Center's commitment to generating and sharing the vital research evidence that this continent needs."

APHRC celebrates **women in science**

The International Day of Women and Girls in Science (IDWGS) is celebrated every year in recognition of the role that women and girls play in science and technology communities.

This year's IDWGS was held on February 11, 2017. APHRC and the Consortium for Advanced Research Training in Africa (CARTA) joined other scientific institutions to celebrate the achievement of female scientists and to inspire the next generation of women in research. Nearly half of APHRC scientists are women, which makes us an exception in an industry where typically only one in three scientists are women, according to UNESCO. APHRC remains committed to gender parity and equal opportunities for all, in order to advance women in science and to ensure that scientific discovery is open to everyone with a yearning for knowledge.

APHRC honored its female scientists by running a social media campaign in the week leading up to February 11. Here are some of the posts that were shared on Twitter by APHRC and CARTA.

Pauline Bakibinga
Associate Research Scientist

To ensure gender parity in sciences, we need to keep girls in school; offer career guidance on STEM for girls; and both men and women scientists need to mentor one girl per year.

#APHRCWOMENINSCIENCE

Marylene Wamukoya
Data Analyst

"Being a woman in science means maximizing your inherent feminine characteristics in order to excel. It means using your intution to pose the right scientific questions as well as mentor future male and female scientists."

#APHRCWOMENINSCIENCE

"Africa's success in development is dependent on the untapped potential of women in the continent as scientists and leaders. It is time for gender policies to be put into action."

#APHRCWOMENINSCIENCE

Tizta Tilahun
Post-Doctoral Fellow

Eniola Cadmus
CARTA Cohort Seven Fellow

"Encouraging funding bodies to ensure that opportunities for application and participation is favourably disposed to female participant. The CARTA scholarship platform does this so well and should be emulated."

#CARTAWOMENINSCIENCE

> Empowerment of women with high quality education is the surest and easiest way to ensure their full and effective participation at every level of decision making. This will open women to limitless opportunities and all inequalities will be erased.
>
> #CARTAWOMENINSCIENCE

Folusho M. Balogun
CARTA Cohort
Five Fellow

Evelyn Gitau
Director of Research
Capacity
Strengthening

> Men need to be champions for the inclusivity of women in all areas of science. We also need to ensure we include men in adopting and implementing gender mainstreaming frameworks.
>
> #APHRCWOMENINSCIENCE

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