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HEALTH

School for Scaling

A highly focused effort in Kenya to treat worm infections in children delivers lessons on how to expand a proven program.

By [Jessica Harrison](#) | [Spring 2015](#)

In 2009, more than 5 million Kenyan schoolchildren were at risk of parasitic worm infections. Parasitic worms compete for the nutrients that children need to survive and thrive. Worm infections can impair cognitive growth, decrease school attendance, and even affect children's long-term earning potential. The debilitating impact of worm infections can last a lifetime. For many years, worm infections were so common among children in Kenya that people considered them to be a rite of passage. Well-intended organizations delivered deworming treatments, often in an ad-hoc fashion, to people in various parts of the country. But there had been no coordinated effort to solve the worm infection problem nationwide.



(Illustration by Mikey Burton)

Then, six years ago, the government of Kenya took an unprecedented step: It launched the National School-Based Deworming Program, a comprehensive effort to treat all at-risk children in the country. The program leverages the existing infrastructure of the nation's schools and engages teachers in delivering treatment to children in the

areas where soil-transmitted parasites are endemic. In taking that approach, the program built on a strong foundation. Researchers, through the use of studies that included randomized controlled trials, had established a solid evidence base for the benefits of deworming and for the cost-effectiveness of school-based treatment.

Equally important, the launch and implementation of the new program depended on a partnership that included entities from multiple sectors: the Kenyan Ministries of Education and Health; the **Children's Investment Fund Foundation** (CIFF), a London-based philanthropic organization; the **END Fund**, a group that focuses on fighting neglected tropical diseases; and the **Deworm the World Initiative**, a coalition that is now led by **Evidence Action**. (Last year, I joined Evidence Action as associate director of the Deworm the World Initiative.)

Fast-forward to 2014. That year, the school-based deworming program treated more than 6.4 million children for soil transmitted helminths (STH) and more than 890,000 children for schistosomiasis. It did so, moreover, at a cost of just 56 cents per child. The impact of this intervention was equally impressive: Over a two-year period, according to independent monitoring conducted by the Kenya Medical Research Institute, the prevalence of STH declined by 68 percent and the prevalence of schistosomiasis dropped by 77 percent.

“We are very proud of the program in this country,” says Margaret Okemo, acting director of basic education at the Ministry of Education, Science, and Technology. “It has surpassed all the targets we have set.” Rachael Nyamai, head of neonatal child and adolescent health at the Ministry of Health, notes that partnership was the key to success: “None of us can do it alone. In [the Ministry of Health], we have the technical know-how, but the teachers know the children, and neither ministry has the resources, so we need the other partners.”

Many Partners

Multi-sector partnerships are certainly not new in international development. But the story of Kenya's National School-Based Deworming Program demonstrates the potential for using such partnerships to manage evidence-based, results-oriented programs at a large scale. It shows, in particular, that the right form of collaboration can prevent the kinds of turf battles that sometimes arise in complex multi-sector initiatives. “We've benefited from the willingness of our donors to collaborate, not compete,” says Karen Levy, director of global innovation at Evidence Action. (She served as the point person for the Deworm the World Initiative from 2009 to 2013, when it was a project of **Innovations for Poverty Action**.) Interviews with people at each partner organization yield lessons for others who aim to scale up a program that requires coordination among multiple groups.

Take a long-term approach | The deworming program received five-year funding commitments from CIFF and the END Fund. That arrangement allowed program partners to focus on the long game, rather than having to demonstrate quick and potentially superficial wins in order to obtain funding every year. As a consequence, the partners could develop metrics for success that centered not on completing project plans or hitting pre-determined milestones, but on increasing treatment coverage. They could also make course corrections without penalty or fear of losing funding. “We could address challenges as they arose, and [we had] the freedom to adapt,” Okemo explains.

Initially, for example, the program relied on people who work as town announcers to support community mobilization. But monitoring data revealed that the announcers were not effective in that role. So the partners experimented with alternative approaches and eventually decided to engage community health workers in building public awareness. That approach helped scale up treatment and also improved relations between the health and education ministries.

Support government leadership | The National School-Based Deworming Program is a government initiative, and government ownership of it is essential to sustaining its impact over the long term. In fact, people at the highest level of the Ministries of Education and Health are accountable for the success of the program. (The Ministry of Health now has a performance contract that takes the deworming program into account, and the ministry has begun to evaluate staff members on their ability to achieve deworming targets.) But for the program to be successful, other partners must work actively to enable government leadership. These partners’ role, Levy says, is to “help the government overcome structural barriers to implement the program effectively” and to “provide the government with technical inputs.” At the same time, the partners need to allow the government to occupy centerstage. In a multi-sector, government-led initiative of this kind, the most suitable partners are those that combine access to resources with a willingness to remain out of the spotlight.

Use data to inform decision-making | Partners in the deworming program—both on the funding side and on the technical side—share a commitment to data-driven decision-making. “There was a commonality in our DNA from day one,” says Warren Lancaster, senior vice president of programs at the END Fund. Levy, similarly, notes that an important role of Evidence Action today is to help officials in the Ministries of Health and Education base program decisions on solid data. As a group, the partners collect a significant amount of quantitative and qualitative data as part of their effort to improve treatment delivery. Independent monitors, moreover, evaluate both teacher training and deworming efforts in order to assess overall program quality. Their work generates data that give partners a true representation of program performance. With all of these data in hand, partners can engage in collaborative decision-making about training, community mobilization, and other issues.

Invest in governance structures | The crosssector, multi-partner nature of the program raises particular challenges. The Kenyan Ministries of Health and Education, for example, use entirely separate management information systems, have distinct budgets, and follow different planning schedules. For that reason, the partners invested upfront in governance structures that clarify the roles and responsibilities of each ministry and of each participating organization. Representatives of the funding groups, the two government ministries, and the Deworm the World Initiative developed a memorandum of understanding that delineates the efforts that each partner will undertake. To keep communication open and to ensure alignment around priorities, the partners also created two governance bodies: a steering committee that oversees the program, and a management committee that works at an operational level with several technical working groups. “Everything is planned out in committees, so there is transparency and accountability—and no surprises,” Nyamai says.

One Point of Focus

Programs like the one pursued in Kenya have a high potential for replication. Early this year, the government of Ethiopia launched a nationwide school-based deworming program in that country. Similarly, the national and state governments of India recently announced a national program that will target 241 million children who are at risk for parasitic worm infection. As the partners in Kenya have learned, implementing a program on that kind of scale requires careful design and an efficient delivery system. It also requires a commitment to pursuing a single clear objective.

The National School-Based Deworming Program was designed to expand nationally by leveraging existing infrastructure and by breaking traditional barriers between the health and education sectors. One great success of the program is the discovery that schools can be a platform for achieving results at a large scale. Previously, few people had seriously considered the idea of training teachers to distribute a simple treatment to children in their classrooms. Today, teacher training and the distribution of deworming treatments both occur through a cascade process that starts at the national level and continues down to individual schools. Other elements of the program’s scale-oriented design are its highly focused training sessions and its practice of delivering messages to teachers that are clear and direct.

From the outset of the program, the partners worked to pursue a goal that involved a well-defined problem: Simply put, they sought to increase the coverage of deworming treatment to a point where intestinal worm infections would no longer pose a public health threat in Kenya. Early on, the partners avoided the common practice of integrating the deworming treatment with treatments for other neglected tropical diseases. Nor did they try to bundle that treatment with related interventions—delivering micronutrients, for example, or providing health education. Taking that

approach has enabled the program to reach more than 6 million children in nearly 16,000 schools. It also paves the way for scaling up more complex interventions in the future.

Focusing on a single narrow goal, rather than attempting to achieve several goals at once, has created a situation in which all partners clearly understand what success looks like. “We’re not solving every problem. We focus on what’s proven to work,” Levy says.

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