



Integrating other health services with HIV programs can protect young people and save lives.

photo: Sarah Day

The USAID-funded AIDS, Population and Health Integrated Assistance Project: North Eastern Province (APHIA II NEP) brings together Pathfinder International, IntraHealth International, and Management Sciences for Health under the umbrella of the Extending Service Delivery project to implement an integrated program of assistance through government, private, nongovernmental, and faith-based partners in NEP. APHIA II NEP focuses on HIV and AIDS, tuberculosis, reproductive health, and healthy timing and spacing of pregnancy and supports a wide range of activities addressing prevention, care, treatment, and support for people living with HIV, their families, and communities.

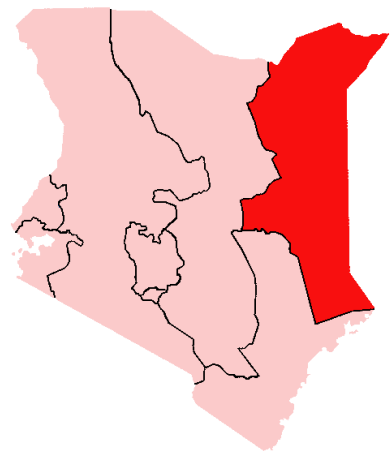
Integration of HIV and Other Health Services in APHIA II:

Leveraging an HIV Project to Support Broad Health Service Access in Kenya’s North Eastern Province

This report describes the implementation of integration approaches that enhanced health service access and quality improvement under the AIDS, Population, and Health Integrated Assistance Project: North Eastern Province (APHIA II NEP) in the areas of HIV prevention, care, and treatment; tuberculosis (TB); maternal, newborn, and child health (MNCH), including preventing mother to child transmission (PMTCT); and reproductive health/family planning (RH/FP).

Integration is a key priority of the United States Government’s (USG) Global Health Initiative and the current focus of attention among policy makers and implementing partners alike, as the field of global health seeks to identify approaches that promote sustainability, efficiency, and results. For the purposes of this document, “integration” refers to the WHO HIV/MNCH Technical Working Group’s interpretation: “the organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use.” This report details APHIA II NEP approaches to integration for increased access and utilization of essential services. Prepared from interviews, focus group discussions, and field reports, it covers successes, challenges, and opportunities in integrating HIV and other health services in NEP; the report also offers conclusions and next steps, which have relevance to project activities in other parts of Kenya and the world with similar health, socio-cultural, and geographic characteristics.

North Eastern Province, Kenya



the people are nomadic pastoralists who herd livestock, moving seasonally for fresh water and pasture. From 2001 to 2005, between 60-75 percent of all livestock – the main source of income and nutrition in NEP – perished due to drought, leading to high levels of extreme poverty and malnutrition (31 percent of under-fives are underweight). Infant mortality (57/1,000 live births), and under-five mortality (80/100,000 live births) are high while literacy rates remain the lowest in the country (63.6 percent of men and 21.2 percent of women). The average ages at first marriage and first birth are 17.9 and 19.4, respectively, and modern FP method use is 0.3 percent. Consequently, NEP

Background

Population – NEP is an isolated, culturally conservative Muslim region of Kenya with a population of 2.3 million. Over 70 percent of



NEP's nomadic pastoralists regularly move for water and pasture availability, a challenging obstacle for the standard static model of healthcare service delivery.

photo: Sarah Day

has a high fertility rate of 5.9. Female genital cutting (FGC) is nearly universal, and only 12 percent of children have an immunization card. Clan rivalries, limited higher education opportunities, and historical exclusion from Kenyan national systems have left NEP one of the most underserved regions in Africa.¹

Geography – Spanning the length of the Somali and Ethiopian borders, NEP covers an expansive 123,000 km² area of arid terrain. Its size and remote location pose a formidable challenge for health delivery given the distances involved to reach communities. During the rainy season, NEP's poor road network effectively isolates approximately 75 percent of the province from the rest of the country. When there is drought, NEP's nomadic population disperses in search of pasture,

often crossing the province's international borders into Somalia and Ethiopia. The low population density, high population mobility, and poor roads result in limited physical access to static health facilities and significant problems for referral services. These conditions, along with the harsh climate, create problems in attracting and retaining health personnel.

HIV/AIDS - NEP's remoteness has provided natural protection against HIV (0.9 percent in 2008). But connections with the rest of Kenya, particularly Nairobi and Central Kenya, are growing more complex. Mounting pressure to access more distant markets, seasonal work (e.g., tourism or casual labor), infrastructure improvements, and the desire to maintain connections with relatives and friends outside

¹ Kenya Demographic and Health Survey 2008, MACRO and GOK, Nairobi.

NEP has translated into a rapid and significant increase in contact between the “remote” north and the rest of the country. Buses now run daily between all the towns in this zone and Nairobi. The surge in the numbers traveling between Garissa, NEP’s provincial capital, and Nairobi has been dramatic.² While these shifts will bring development and access to markets, they also create an environment conducive to risky behaviors with respect to HIV. These effects have emerged in several sub-regions, particularly in urban Garissa.

Health Services Coverage – Only 42 percent of NEP’s population currently has access to any health services. A significant part of the problem is geographical; the average distance to a health facility is 52 km, compared to the national target of 5 km. Additionally, health infrastructure in NEP is poor, with scattered health facilities suffering from severe understaffing that leave many areas without service for months, even years. In 2008, 47 of the province’s 153 facilities (32 percent) were closed due to lack of personnel.³ The inconvenient distances and irregular service have greatly reduced NEP residents’ use of health services. Only 19.5 percent of women have demand for contraception, compared to 48.3 percent nationally. While 70 percent of pregnant women make at least one antenatal care (ANC) visit, only 3 percent go four times, as recommended. In NEP, the ratio of doctors to population is 1:120,823 compared to Central Province where it is 1:20,715.⁴

Project Description

The APHIA II Project was part of a national program funded by USAID to contribute substantially to USG and Government of Kenya (GOK) goals in the areas of HIV, AIDS, TB, RH, FP, and MNCH. From 2007-2010, Pathfinder International led APHIA II activities in NEP with a focus on provincial-level strategy and local service delivery. The project objectives included:

- Strengthening access, quality, and integration of facility-level HIV/AIDS, TB, MNCH, and RH/FP services;

- Improving and supporting community capacity to respond to HIV/AIDS, TB, MNCH, RH/FP, and orphans and vulnerable children (OVC)
- Building multi-sectoral collaboration to upgrade, coordinate, and sustain an HIV/AIDS response

APHIA II NEP faced the unique challenge of designing a health service project in a geographic area with significant limitations to health service access and quality. Few development partners had ever implemented projects of this magnitude in the region. Furthermore, project resources were primarily intended for HIV-related activities in an area where HIV prevalence was relatively low and stakeholder interest in HIV activities was limited. Under APHIA II NEP, 90 percent of funds were earmarked for HIV and AIDS-related activities.

Pathfinder recognized that linking RH/FP, TB, and MNCH services with project activities offered a meaningful use of resources, addressing the most pressing needs of the population and engaging local stakeholders who regarded MNCH and TB as greater priorities than HIV.

Implementation Approaches that Fostered Integration

Building Community Demand for Health Services

Religious Leader Engagement - Facing significant challenges to health access, the project identified key opportunities in NEP: near uniformity Muslim faith and Somali language and culture; well-organized clan and religious structures; and respected religious and opinion leaders. Religious leader engagement became a priority early on given the recognition that as key stakeholders, religious leaders could guide public opinion and behavior. Local religious leaders were already involved in orphan care projects and became supportive of APHIA II activities when the project made tangible improvements in orphan living conditions. The project also collaborated with local groups to support meetings where religious leaders developed “resolutions” (formal recommendations) across multiple

² The Sexual Networks Study: Secondary Bachelors and Sexual Pensions. Macintyre and Eymoy, 2008. USAID and APHIA II NEP.

³ Report of Human Resources for Health Rapid Assessment in North Eastern Province Kenya by APHIA II NEP and Capacity Project. USAID, 2008.

⁴ Kenya Demographic and Health Survey 2008, MACRO and GOK, Nairobi.





APHIA II supported three conferences where religious leaders discussed changing community attitudes around HIV, family planning, and birth spacing.

health topics to promote utilization of RH, FP, and HIV prevention and care services. The first conference of Muslim scholars in NEP was held in April of 2008 and yielded actionable, locally acceptable health-related resolutions. It proved so successful that a subsequent conference was held in February of 2010. Two additional conferences were also held for female Muslim scholars, the first in October of 2009 and the second in February of 2010. Overall, 134 male and 71 female religious leaders attended the conferences.

Through the information presented and the ensuing discussions, the scholars' awareness of HIV/AIDS and their attitudes toward persons living with HIV (PLHIV) changed dramatically. Religious leaders developed a commitment to decrease HIV stigma and increase mother and child access to healthcare, while resolving to enlighten their followers at mosques, schools, and *madrassas* (Islamic religious schools). Conference attendees expressed similar attitude shifts on issues like birth spacing and FGC. Religious resolutions included the following:

- Couples should undergo HIV testing before marriage
- Expectant mothers should attend MNCH clinics
- Health services should deploy female midwives in health facilities
- Communities should abandon harmful practices

such as FGC

- Facilitate the marriage process by lowering the amount of money required for wedding ceremonies, thus allowing more couples to wed and avoid pre-marital sex
- Show love for those affected by HIV and AIDS since stigma and discrimination is against Islamic teaching.
- Islam allows child spacing and planning of pregnancies and recommends any form of permissible methods of contraception including, but not limited to, the Standard Days Method (SDM).

These resolutions promoted healthy practices that addressed a variety of health topics. They also allowed the project to introduce sensitive HIV topics in the context of broader health and social issues while influencing social determinants of health.

Integrated Prevention Behavior Change – APHIA II NEP developed a health communication strategy based on a baseline “Sexual Networks Survey” that targeted key populations at risk and ensured that a variety of health behaviors were addressed at each point of client contact (community health promotion, facility-level counseling, and information, education, and communication [IEC] materials). This allowed the project to address the root causes of HIV risk through behavior change, while also acknowledging related health and social behaviors. For example, the project supported a local PLHIV group to conduct health talks for students and sex workers. These talks addressed appropriate HIV risk reduction strategies for each target group based on the baseline survey, but also included related key topics including RH/FP and hygiene. Another example is TB ambassadors, who worked with facilities to share information with clients and follow up cases of non-adherence to TB medicines. They also visited primary, secondary, and tertiary level schools to discuss HIV, TB and proper hygiene (bathing, hand-washing, house-cleaning, and use of Waterguard). Finally, the project developed IEC materials promoting behaviors identified in the baseline survey as alleviators of risky behavior, such as keeping girls in school, limiting divorce, and avoiding substance abuse.



Nurse Wilson Kurgat uses an APHIA-supported motorcycle to deliver immunizations and medical supplies to the furthest outposts in Shantaabaq.

Integrated Technical Training and Supervision Systems

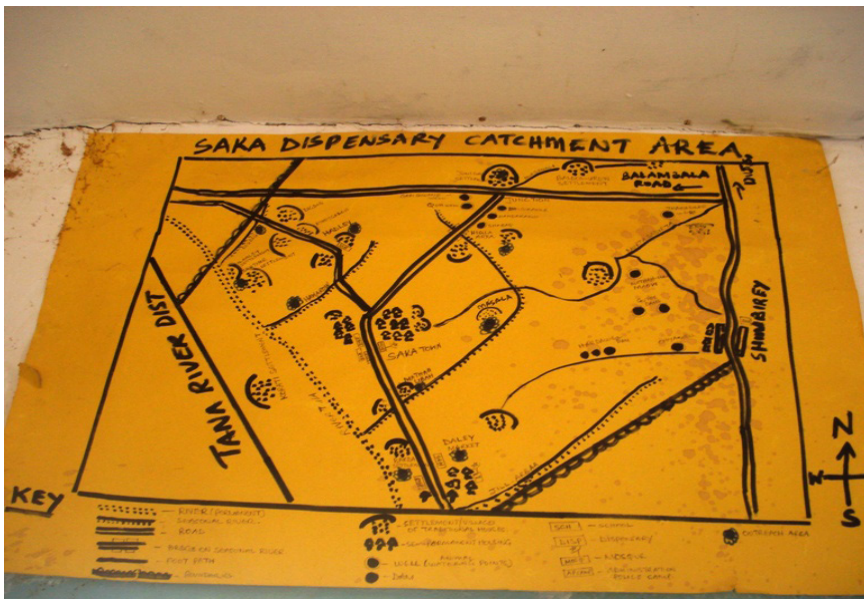
Skills Building through Training - By September 2010, APHIA II NEP had trained 1,988 health facility providers in a range of health services that enabled them to offer multiple services. At least 80 percent of health facilities in the province received training that allowed them to provide several HIV/FP health services during each client visit, including HIV prevention, voluntary counseling and testing (VCT), PMTCT of HIV, anti-retroviral therapy (ART), MNCH, early infant diagnosis, immunization, nutrition counseling, lab services, RH/FP, post-rape management services, and general outpatient care. Specific trainings on the technical considerations of integrated care were offered for HIV/FP and for HIV/TB integration.

Integrated Supervision Support - APHIA II NEP supported Provincial Health Management Team (PHMT) quarterly technical supervision visits of health facilities

with Provincial Reproductive Health Coordinators (PRHC). As part of its integrated supervision, the project provided financial assistance to ensure timely visits, training, and tools. While this support had the primary intention of bolstering HIV services using HIV funds, it helped health systems in all areas. On these visits, PRHCs comprehensively reviewed facility services to ensure providers offered integrated services to their clients. Given the long distances travelled and the value of training in quality supervision, the project ensured PRHCs reviewed progress in all relevant health areas, not just in any one vertical program area. APHIA II NEP also led district-level quarterly feedback meetings with facility in-charges, District Health Management Teams (DHMTs), project staff, and other stakeholders. During these sessions, meeting members discussed problems they encountered and developed action plans with facility staff and management to address them. In total, project staff made 27 supervision visits in all districts of NEP.



Nomadic clinics trail pastoralists across NEP, visiting markets and schools to treat illnesses, offer immunizations, and provide counseling on RH and HIV.



A hand-drawn catchment map for the Saka dispensary helps health providers develop strategies for reaching clients with services.

Addressing Access through Integrated Outreach, Transport Mechanisms, and Community Providers

Since NEP's population lives in widely dispersed areas with small settlements and poor roads, the standard model of static healthcare provision is large ineffective. APHIA II NEP developed several outreach strategies that brought integrated – and efficient – health services to the people.

Motorcycle Outreach – APHIA II initiated and supported a motorcycle outreach service, which emerged as an ideal method to access the hardest to reach areas since motorcycles are cheaper to run and maintain than cars and have the added benefit of reaching terrain that cars simply cannot access. Motorcycles were used for community mobilization, immunizations, and transport of staff and medical supplies to distant outposts, essentially serving as a rallying point for all intervention programs, especially MNCH/FP and HIV/TB. APHIA II NEP trained staff in integrated service delivery, provided fuel for the motorcycles (facilities already had Ministry of Health [MOH] motorcycles), and offered lunch allowances for drivers; overall, the project supported 48 facility-based motorcycles throughout NEP. Motorcycle outreach proved extremely cost-efficient, costing only 9,800 Kenyan shillings per month compared to 150,000 Kenyan shillings for normal vehicle outreach services. It was also effective at changing access to key services. Communities in Benane, Shanta abaq, Korakora, and Modogashe all saw increases in ANC uptake ranging from 100 to 300 percent motorcycle outreach was active in these areas. Over 93,000 clients were seen by outreach services from 2008 to 2010.

Nomadic Clinics – To serve the migratory lifestyles of pastoralists, the MOH created nine nomadic clinics to trail pastoralists as they followed water and pasture across NEP. Nomadic clinics also provided outreach to schools and markets and assisted with emergency transport. The Danish International Development Agency outfitted vehicles with two tents (one for consultations/examinations and another for housing the health provider), solar energy panels, a trailer to store and transport medical supplies, and a motorbike. APHIA II NEP assisted nomadic clinics with health provider training, ongoing technical assistance, fuel, equipment, and supportive supervision, all of which enhanced the integration of the services provided. Nomadic clinics visited market centers and primary schools on a weekly basis to treat fungal infections, carry out immunizations and de-worming, administer vitamin A to under-5 children, and provide information on HIV prevention, hand-washing, and hygiene. Most clients were reproductive age women, allowing providers to offer RH and HIV services when these clients

arrived for general outpatient services. Over 41,000 clients were seen by nomadic clinics between 2008 and 2010.

Facility Transport Mechanisms – As part of a small-scale activity in APHIA II NEP called “Care for the Mother,” the project provided donkey carts to four womens’ livelihood groups to act as emergency ambulances for pregnancy, laboring, and postpartum women. Local craftsmen built the carts to the specifications of the livelihood groups, who provided their own donkeys. In addition to increasing facility deliveries, the donkey carts brought women in contact with project-trained providers who taught them the benefits of ANC, RH/FP, PMTCT, and healthy timing and spacing of pregnancy. In one year, referrals to facilities in Sankuri and Balambala increased from 38 to 200 and facility deliveries increased from 14 percent to 31 percent of all deliveries.

Providing Infrastructure and Laboratory Support

APHIA II NEP invested \$300,000 in health infrastructure (renovation, furniture, and equipment), collaborating closely with DHMTs and Facility Management Committees (FMCs) to make investments to meet the population’s needs. While infrastructure funding was primarily aimed to improve HIV services, this work built foundations for the institutionalization of all integrated services. Laboratory services and maternity wards were strengthened, increasing access and utilization of health services beyond HIV. Eight VCT centers were established, providing an entry point for comprehensive and integrated care. Consulting rooms, labs, delivery rooms, MNCH rooms, and outpatient departments received renovations, along with new furniture and equipment like BP machines, stethoscopes, scales, examination couches, autoclaves, microscopes, dry baths, computers and modems. Facility staff reported significant improvements in morale when given an appropriate environment to perform their duties, a notable achievement when human resource shortages continue to be an endemic problem.

In addition to supporting renovations and equipment for laboratory services, APHIA II NEP established a laboratory networking system that linked 20 laboratories for the transport of samples. This system primarily



For the “Care for the Mother” activity, local craftsmen built donkey carts for women’s livelihood groups to use as emergency transport to health facilities.

transported samples for HIV clients, but also facilitated disease surveillance, particularly measles, malaria, and TB. It was carefully developed with local health authorities to ensure a cost-efficient and sustainable system using existing personnel and local transport. The improved laboratory capacity also helped to increase facility revenues, as some tests involve a minor fee; this proved to be a valuable contribution of the project to fiscal stability among facilities.

Strengthening Health Systems

Monitoring and Evaluation Capacity Building and Data for Decision-Making – APHIA II NEP strengthened health facilities’ ability to collect and analyze data across multiple health disciplines, including HIV, RH/FP, ANC, and immunizations. By 2011, the project had trained over 74 individuals in monitoring and evaluation, surveillance, and health management information systems, surpassing their targets by 148 percent. The project provided ongoing support to data collection and

review. In all eleven districts of NEP, facility in-charges, District Facility Coordinators, DHMTs, implementing partners, and APHIA II staff met quarterly for data feedback meetings at the district level. While health services were recorded in separate logbooks by health topic area (e.g. MNCH, FP, HIV), these meetings reviewed achievements in all health areas and fostered discussion of integrated services.

To further enhance analysis of integrated services, interdepartmental forums on TB/HIV, MNCH/FP, maternity and HIV clinics were held, with departments

sharing information to improve linkages and internal referral mechanisms. APHIA II NEP assisted with the MOH monitoring system of

integrated services by using introducing patient cards that noted linkages for integrated services.

Planning and Leadership Support – APHIA II NEP helped Provincial and District Medical Officers, PHMTs/DHMTs, facility level managers, and community groups with planning and leadership support that supported multiple health areas. This work was paid for by HIV funds, but impacted all health areas directly. For example, training in commodity management, community group engagement, and human resources for health (HRH) management strengthened broad sections of the overall health system.

APHIA II NEP trained facility staff in stock management of essential medicines and commodities for all health areas, and provided data tools, on-the-job trainings, and follow-up of commodity consumption data. The project has also filled commodity gaps by procuring essential commodities including HIV test kits, CycleBeads for SDM, and reporting tools. During

the life of the project, APHIA II NEP witnessed greatly reduced stock-outs.

APHIA II NEP worked with 115 FMCs as part of its community group engagement. This work included clarifying the roles and responsibilities of committee members as well as collaborating with FMC chairpersons on data review and feedback. This work promoted engagement of FMCs in demand creation for facilities services, especially ANC.

To support HRH, the project collaborated with the Capacity Project to cover the salaries of 65 staff persons, including laboratory and pharmacy technologists, VCT counselors, data clerks, and nutrition officers. In close collaboration with the PHMT and other key stakeholders, the project also conducted a HRH assessment and developed an action plan.

Conclusions and Next Steps

Conclusions

APHIA II NEP introduced several implementation approaches that augmented the availability and quality of a range of preventative and curative health services at both the community and facility level.

Community Stakeholder Engagement – APHIA II NEP faced a significant challenge at the beginning of the project given that HIV was not identified as a priority by community stakeholders; rather, HIV was regarded as a serious taboo. Through careful engagement of FMC and religious leaders, along with clear contributions to health systems and orphan care, the project gained support for its work. Given the significant influence of religion in NEP, the project's broad engagement of religious leaders proved an appropriate approach, and a key factor contributing to the project's successes. Assisting FMCs in data analysis and encouraging their involvement in promoting health seeking behavior also proved to be a sustainable and meaningful project achievement.

Integrated Outreach – In the context of vast distances and poor transport infrastructure, integrated outreach services allowed providers to offer multiple services at each health visit, which broadened access and coordi-

ANC/HIV Integration through Community and Facility Efforts

As of September 2010, the number of pregnant women who received HIV counseling and testing for PMTCT and received their test results was 34,527, and the number of pregnant women who were provided with a complete course of antiretroviral prophylaxis in a PMTCT setting was 120. This achievement is attributed to a combination of community demand creation, laboratory capacity, and staff training.



Women in the NEP capital city of Garissa have easier access to health facilities and providers than those living in its more remote regions.

nation across health sectors.

Data Collection, Management, and Use – Through support in filling human resource gaps in health records, engaging FMCs, and training health providers, the project improved record keeping, data management, and data analysis. This contributed to improved planning, coordination, and community partnership – core elements that benefited all health areas.

Equipment, Renovations, Furniture Supply – APHIA II NEP’s investment in health equipment and renovations supported HIV activities and other health areas, including testing, PMTCT, and treatment. This work improved laboratory functionality and added services, which led to increased facility revenue and higher job satisfaction among staff.

Next Steps

The next phase of the project, called APHIAplus Northern Arid Lands (NAL), began in 2011 and is led by Pathfinder International. With an extended geographic coverage and a mandate to apply best practices and locally-relevant lessons learned, this project supports the enhancement of health systems and quality services for the following goals: to increase use of quality health services, products and information; and to address social determinants of health to improve the well-being of targeted communities and populations. The geographic coverage now covers a total population of 2.85 million in three sub-regions: Turkana County; upper Eastern province (plus Samburu County); and North Eastern province (plus Tana River County). This covers approximately 60 percent of the total geographic terrain of Kenya. Under APHIAplus NAL, Pathfinder has the opportunity to reflect on the approaches applied under APHIA II NEP and strategically scale-up successful implementation approaches that fostered integration.

Expand data collection to analyze impact on MNCH and RH/FP - APHIA II NEP met or exceeded its service delivery targets in HIV, but did not track indicators like malaria treatment or vaccination to determine the effect its approaches may have had for these services. The project focused its reporting on HIV indicators

because of the source of its funding, but its approaches clearly had a significant impact in other health areas. APHIAplus NAL has more balanced funding from HIV, MNCH, and RH/FP sources, so going forward the project will track health service data in more areas to observe the true effect of integrated services from both a cost and an efficacy perspective.

Address health facility provider support more broadly than training alone – The project operated in an environment of severe HRH shortages and weaknesses. A significant lesson learned that will inform APHIAplus's next steps is the importance of work conditions for health provider performance and motivation. While the technical training the project offered improved skills, providers reported that renovations, equipment, community demand creation, and coordination of outreach greatly increased their job satisfaction and morale.

Expand innovations to address geographic distances – APHIA II NEP piloted and scaled-up new approaches to address substantial geographic access challenges, such as the motorcycle outreach and lab networking activities. These innovations were introduced at small scale in NEP, were refined and scaled-up over time, and will be further expanded under APHIAplus NAL.

The ESD Project (ESD), funded by USAID's Bureau for Global Health, is designed to address unmet need for family planning and increase the use of reproductive health and family planning services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Pathfinder International is a global leader in sexual and reproductive health. For more than 50 years, Pathfinder has delivered critical sexual and reproductive health care in the developing world that expands opportunities for women, men, and young people. Pathfinder provides a range of services—from contraception and maternal care to HIV prevention and AIDS care and treatment. Through innovative approaches and community participation, Pathfinder strengthens access to family planning, works to ensure the availability of safe abortion services, advocates for sound reproductive health policies, and, through all of our work, supports the rights and lives of the people we serve.



Project staff tackle the dusty roads and arid terrain of NEP en route to a health outpost.

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