



JULY 2012

APHIAplus NAL (AIDS, Population, and Health Integrated Assistance, Northern Arid Lands) (2007-2012) is a USAID-funded project building health system capacity to deliver quality HIV prevention, care, and treatment; maternal and newborn health (MNH); reproductive health (RH); family planning (FP); and tuberculosis (TB) care and treatment services. Originally called APHIA II North Eastern Province (NEP), the project expanded in 2011 and was renamed APHIAplus NAL.

APHIAplus NAL is led by Pathfinder International, in partnership with IntraHealth International, Management Sciences for Health (MSH), Food for the Hungry, and the International Rescue Committee.

Increasing Access to Quality Health Services in Kenya’s North Eastern Province

Kenya’s northern region is a vast and sparsely populated area where limited resources and persisting stigma related to sexual health and HIV and AIDS create a complex health service delivery scenario. For five years, APHIAplus NAL has implemented a strategy to increase local health system and community capacity for quality health service delivery. This brief discusses the project’s experience in NEP, providing recommendations for future efforts in comparable contexts.

Background

NEP is characterized by recurrent drought, vast distances, and food insecurity.¹ With a population of nearly 2 million and a low overall population density, the province is home primarily to ethnic Somalis—most of whom practice nomadic pastoralism—as well as a sizeable refugee population. Periodic ethnically and politically charged

tensions, combined with persisting security issues along the Kenya-Somalia border, have contributed to the area’s limited access to national services and its disproportionate health and socioeconomic disparities.² In 2008, 75 percent of NEP’s population occupied the lowest wealth quintile of the country.³ NEP’s estimated one percent HIV prevalence rate was the lowest in Kenya,⁴ though supplemental data had led the

* This program brief discusses APHIAplus NAL’s work in NEP, where intervention efforts were consistent over the project’s five years. For discussion of APHIAplus NAL’s efforts related to health information system capacity building, see Pathfinder International’s 2012 technical brief, *Strengthening Strategic Health Information Systems in Kenya’s North Eastern Province*. Other grey literature on APHIA II NEP includes Pathfinder’s 2011 publication, *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*.

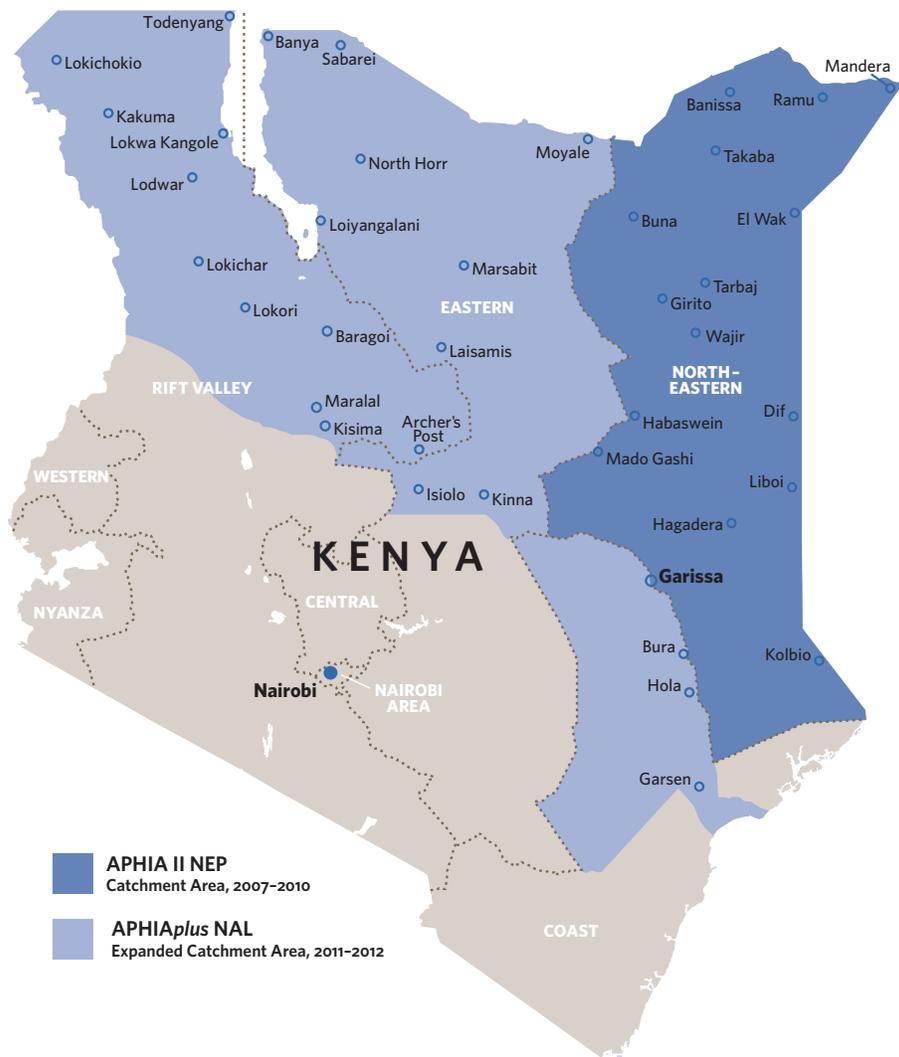


FIGURE 1. PROJECT INTERVENTION AREAS 2007-2012

From 2007 to 2011, under APHIA II NEP, the program was implemented throughout NEP. In 2011, the project’s coverage area expanded to include the northern, arid portions of Rift Valley, Eastern, and Coast Provinces, and was renamed APHIAplus NAL.

government of Kenya (GOK) to believe this rate was rising.⁵ With only 10.5 percent of NEP respondents reporting accepting views toward people living with HIV (PLHIV), stigma and discrimination were likely factors contributing to the province’s testing and counseling rate, which was also the lowest in the country.⁶

In this shifting HIV context, in 2007 the GOK and USAID partnered to prioritize NEP for targeted HIV prevention and health interventions under APHIA II and later APHIAplus programming. Figure 1 illustrates the project’s coverage areas from 2007 through 2012.

† Miraa is a natural stimulant common in the Horn of Africa, found in the leaves of *Catha edulis*. The leaves are chewed.

Project Strategy

ASSESSING THE HIV LANDSCAPE

Because of the dearth of information about HIV in NEP, the project commissioned an assessment of HIV in the province that included a study of HIV risk behaviors among groups perceived to be at risk for infection. Findings revealed that behaviors such as concurrent relationships, commercial sex, and drug and alcohol use were present among populations in the province. Miraa[†] sellers, students, civil servants, uniformed men and women, divorcees, transport drivers, and recently out-of-school youth were found to be among the groups at greatest risk for infection in the province, based on risk behaviors. HIV-related stigma was also confirmed as particularly high, with some community stakeholders advocating for the complete social exclusion of PLHIV.⁷ The assessment also found that Muslim religious leaders play a central role in the formation of community norms related to sexual and reproductive health. Though the assessment found a high level of community distrust toward representatives of HIV services, whether clinical or programmatic, religious leaders offered a potential gateway to positively influencing HIV-related norms in the province.⁸

Assessing health system gaps

To better understand the NEP service delivery context, the project undertook assessments of NEP’s highest volume health facilities, its laboratory services capacity, and its human resources for health needs. Findings from these three reviews confirmed distance and lack of transport, as well as the perceived poor quality of services offered, as key barriers to health service uptake. Lack of equipment and supplies, the poor physical condition of facilities, severe shortages of trained health personnel, and limited availability of services were among the key challenges faced by the health system. NEP’s limited laboratory capacity posed a particularly significant barrier to the quality of HIV care. Because basic diagnostic services were not available at the majority of sites in the province, CD4 testing was only possible at the Provincial General Hospital (PGH) in Garissa, 544 km away from NEP’s northern-most urban center. Without the ability to test CD4 counts, providers relied on WHO

clinical staging to determine when to initiate treatment and were limited in their ability to assess treatment failure. As clients visited facilities for care infrequently, providers were unable to routinely observe signs of HIV progression in their clients and thus faced significant difficulty in timely initiation of treatment or second-line treatment.

PROJECT DESIGN

In light of the range of health needs identified, the project decided to leverage its largely HIV-focused funds to include a broad systems strengthening agenda. Allocating small portions of its budget to RH, FP, MNH, and TB, the project committed itself to making what small achievements it could to strengthen health services, in addition to its HIV-related efforts. At the community level, the project focused on community awareness of and demand for quality services, and fostering the leadership role of PLHIV to create an enabling environment for their improved quality of life and health outcomes. Figure 2 illustrates the project’s logical framework.

Implementation

Per the APHIAplus NAL strategy, the project targeted 100 percent of NEP’s highest volume facilities and their

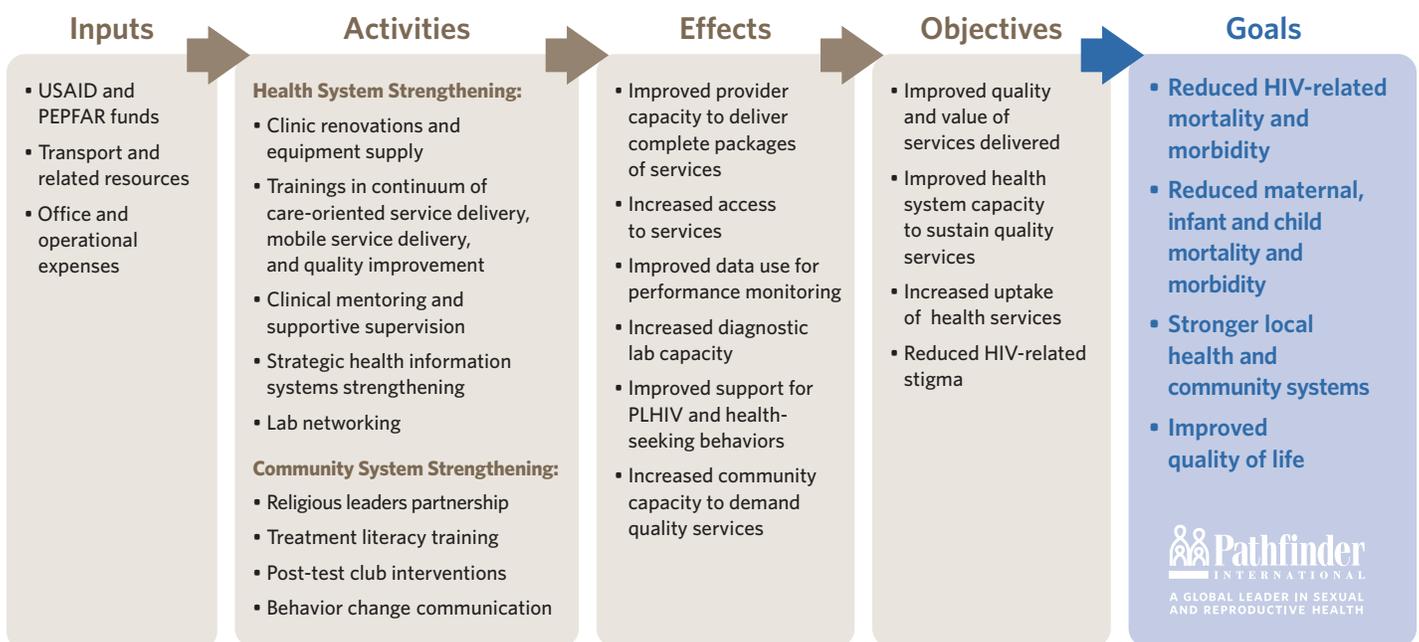
community catchment areas, employing a phased approach to expand to lower level sub-district hospitals and health centers over the course of five years.

HEALTH SYSTEM STRENGTHENING

To begin its capacity building, the project prioritized urgent needs for facility renovations and stocking of essential commodities. To address human resources for health shortages in the province, APHIAplus NAL partnered with the USAID-funded Capacity Project,[‡] which supported the national health workforce in Kenya, to hire 120 clinical officers, nurses, nutritionists, lab technicians, and health records information officers. The project conducted offsite and on-the-job trainings to ensure the local health workforce’s clinical and supervisory capacity for quality improvement.

Building capacity for delivery of a continuum of care

To help facilities maximize the services provided at each client contact, the project focused on assisting providers in delivery of a continuum of care. APHIAplus NAL trainings emphasized an approach to care that grouped relevant services to respond to the widest possible range of client needs at each visit. Trainings emphasized the relationships among provision of HIV prevention, HIV counseling and testing (HCT),



[‡] For more information on IntraHealth’s Capacity Project (now named the CapacityPlus project), visit <http://www.capacityplus.org/>.

FIGURE 2. PROJECT FRAMEWORK

prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART) services, as well as MCH, RH, FP, early infant diagnosis, immunization, nutrition, gender-based violence support services, and general outpatient care. In this way, the project enabled providers to make appropriate linkages based on client need, by thinking of service provision as a continuum of care rather than standalone or discretely paired clinical services. By building the capacity of provincial and district health management teams to conduct targeted supervision and mentoring, the project ensured providers received regular support to apply these skills on an ongoing basis.

Lab networking

With the Garissa PGH offering the only CD4 lab in the province, prior to the project clients had to travel

long distances to learn their CD4 count. As a result, CD4 diagnostics were rarely included in HIV services at facilities outside of Garissa. Recognizing the role that lab capacity played in the province's ability to deliver quality HIV services, APHIAplus NAL supported the GOK to pioneer a lab networking system in NEP. Under the new system, facilities across the province were supported to accurately draw and package blood samples onsite, delivering them to the PGH by placing them on public buses. Appointed PGH staff were responsible for receiving the samples from the bus depots, processing them, and returning the results within three days. The result was a province-wide standard protocol for remote submission of samples, thereby enabling NEP's only functioning CD4 testing site to make full use of its high-volume testing capacity. Lab networking provided a low-cost solution to ensure that PLHIV had routine access to CD4 testing services despite barriers presented by distance. This similarly supported providers to execute timely initiation of correct treatment.

Support for mobile & outreach service delivery

Ministry of Health best practices encouraged paired teams of health center-based nurses and community health workers to conduct outreach to health posts once per month, providing support for immunization, micronutrient supplementation, antenatal care (ANC), and HCT services. During implementation, the project found that facilities were unable to conduct these outreach visits due to expense and challenges posed by the province's rough terrain and poor road infrastructure. To ensure consistent outreach support to health posts, the project aided outreach teams to use available motorbikes to conduct these visits, providing systems for fueling and maintenance. As this costs significantly less than outreach by car or standalone mobile clinics, facilities gained a sustainable means of ensuring remote communities' access to essential health services.

Further supporting access for nomadic communities, APHIAplus NAL collaborated with the GOK to expand services at its existing NEP mobile clinics, which follow pastoralists throughout the province. The project filled critical personnel gaps, provided training and equipment, and enabled supportive supervision by the Ministry of Health.



A laboratory in NEP. Once networked to the Garissa PGH lab, rates of sample acceptance and processing increased.

PHOTO CREDIT: Sarah Day

To support outreach in NEP, APHIAplus NAL introduced local facilities to the “moonlight” HCT model. Offering HCT and risk reduction counseling during late night hours in both mobile and static sites, facilities gained a means of targeted outreach to NEP’s most vulnerable groups through the increased anonymity and convenience of these services.

Institutional support for planning and performance monitoring

At district and provincial levels, APHIAplus NAL focused on management and supervision structures. Working with health management teams, the project bolstered managers’ capacity for strategic planning and implementation, procurement and logistical support for commodities security, and the timely and thorough dissemination of relevant national protocols, guidelines, and tools. To support use of strategic health information systems at all levels, the project conducted data quality audits across facilities, and facilitated the establishment of regular quarterly performance review meetings. This system for routine evidence-based review was later shared at the national level.

COMMUNITY SYSTEM STRENGTHENING

At the community level, the project worked to support PLHIV to advocate for their rights and to access timely, quality care. Beyond HIV needs, the project targeted community leaders capable of shaping positive norms around RH, FP, MNH, and TB.

Targeted interventions for PLHIV

With high levels of stigma against PLHIV and a low HCT rate in the province, an important first step was to ensure community-wide support for HIV-related services. Where orphanages had previously only served male orphans and vulnerable children (OVC), the project supported these important points of service to broaden their outreach to include female OVC. To improve PLHIV’s knowledge of services available and their right to access them, the project also worked with comprehensive care centers⁹ to identify PLHIV for treatment literacy training. These trainings provided information about proper treatment and personal care, and emphasized the difference that

treatment adherence could make in PLHIV’s quality of life. As a result of the trainings, many graduates became “expert patients” at health facilities, assisting HIV-positive clients to navigate services and advocate for care.

The project also broadened the province’s available HIV services to include “post-test clubs.” As a network for PLHIV, these clubs provided a safe space for emotional, informational, and social support. Graduates of treatment literacy trainings formed the clubs’ base membership, later expanding enrollment by conducting personal outreach to other PLHIV in their communities. Many facilities reported a subsequent increase in HCT and initiation of ART.

Finally, recognizing the need of many PLHIV to receive services at home due to distance, confidentiality, and other access barriers, the project initiated community home-based care (CHBC) services in the province. Using a national CHBC curriculum, APHIAplus NAL engaged 172 community health workers, providing them with the technical assistance, equipment, and supervisory support necessary to offer CHBC services in NEP for the first time.

Engaging religious leaders

The project prioritized relationships with religious leaders, as community-based stakeholders capable of influencing NEP’s health-related norms. From the beginning of project design, APHIAplus NAL staff met with local religious leaders to seek their input on proposed project interventions and to build a platform for dialogue. In 2007, APHIAplus NAL supported a three-day Muslim Scholars Conference on Islam and Health for religious leaders to discuss their role in improving health in NEP. Attended by 60 Muslim religious leaders, scholars, and medical professionals, the primary outcome was an endorsed list of resolutions in support of FP; HIV prevention, care, and treatment; adherence to ANC guidelines; and skilled birth attendance for improved MNH outcomes. The leaders’ resolutions also promoted premarital HIV testing, abstinence, and fidelity as a means of HIV prevention. Further, the leaders announced their opposition to harmful community

⁹ These centers are dedicated HIV prevention, care, and treatment service posts located throughout the province in facilities with sufficient staffing and laboratory capacity to support their services.

“Stigmatizing and discriminating against PLHIV is against the teachings of Islam... Muslims should give PLHIV unconditional love, care, and support.”

“Planning pregnancies and spacing of births for the promotion of mothers’ and babies’ health allows the use of all permissible and safe methods of contraceptives.”

— RESOLUTIONS FROM MUSLIM SCHOLARS CONFERENCE ON ISLAM AND HEALTH, 2009

norms such as stigma and discrimination against PLHIV and female genital cutting. The latter was an important development given the wide acceptance and practice of infibulation in the province, where the prevalence was 98 percent.⁹ Over 470 religious leaders were reached with these resolutions. They in turn began disseminating these messages during sermons.

Performance

By 2012, APHIAplus NAL was successfully serving 100 percent of NEP’s 187 facilities, and had reached each facility’s community catchment area with targeted interventions to improve knowledge of and demand for quality health services.

INCREASED ACCESS TO AND DEMAND FOR QUALITY SERVICES

At least 80 percent of health facilities in NEP received training to provide services within a continuum of care, significantly expanding the overall accessibility of services in the province. Between 2007 and 2012, the number of NEP facilities providing ART increased from 6 to 20, the number providing PMTCT services increased from 59 to 90, and the number providing TB and HIV integrated services increased from 37 to 92. Forty facilities were renovated to provide integrated HIV and TB services, and by the end of the project, 113,498 pregnant women had had HCT and received their results, a significant increase from baseline. Of these, 75 percent of those who tested positive received prophylaxis, as did 44 percent of

exposed infants. The number of female OVC receiving services increased from 709 in 2007 to 6,448 in 2012. Overall, more than 16,000 OVC at participating NEP orphanages received services under the project.

With regard to NEP’s diagnostic capacity, the project renovated 14 labs over its five years, enabling each to serve as a sustainable revenue stream for laboratory services at their host facilities. Between 2010 and 2011, the number of samples received per quarter went from less than 100 to nearly 450. Thanks to the project’s technical assistance in proper blood draw and storage, rejection of samples declined from 62 percent at the start of 2010 to as low as 2 percent by the end of 2011. Figure 3 depicts NEP’s change in testing performance in the province between 2010 and 2011.

Through the project’s efforts in mobile outreach via motorbike, uptake of services at participating facilities also increased. During the 2008-2010 pilot, when dedicated data collection was possible, a total of 48 sites were supported to initiate outreach via motorbike. Estimates of clients seen for ANC during this time show that the number doubled and in some instances

CD4 quarterly testing performance NEP laboratories 2010–2011

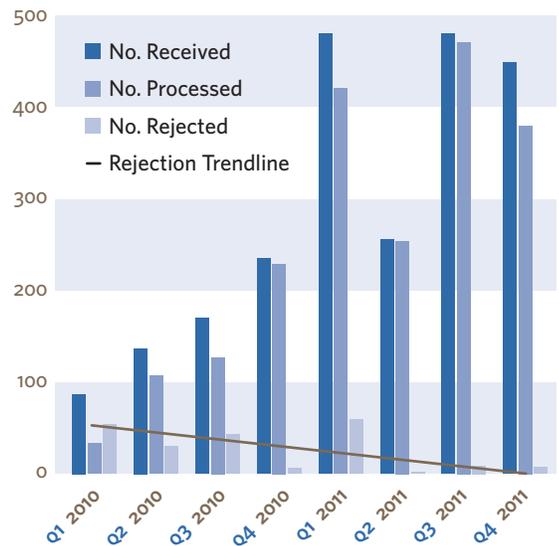


FIGURE 3. QUARTERLY TESTING PERFORMANCE IN NEP LABS, 2010–2011

Submissions and processing of lab samples increased significantly as the number of samples rejected declined.

even tripled. Considering that NEP had among the lowest ANC rates in the country,¹⁹ this finding is particularly promising. Figure 4 demonstrates ANC uptake at the five motorbike outreach pilot sites.

EMPOWERMENT OF PLHIV

Whereas the project found in 2007 that stigma surrounding HIV played a significant part in deterring communities from engaging with HIV services, by end of project the environment was markedly changed. HCT visits increased from below 1,300 in 2007 to more than 180,000 in one quarter alone at the beginning of 2011. All told, 361,000 clients received their test results by project close and, of those who tested positive, 67 percent of all who were eligible initiated care or treatment. CHBC enrollment trends were similarly positive. There were almost no CHBC services offered in the province prior to the project, but over two years of implementation under APHIAplus NAL, 1,559 clients received the home-based service—a significant increase considering the province’s low overall HIV prevalence rate.

As PLHIV’s positive perception of engagement with HIV services grew, so did their community-based engagement. The number of post-test clubs in NEP increased from 1 to 52 over the duration of the project, in large part fueled by PLHIV’s enrollment in and engagement with treatment literacy. While there were no participants in treatment literacy in 2007, 504 had participated by 2012. Of these, 30 went on to become expert patients and nearly all of them became trainers. Many of these PLHIV expert patients now proactively serve as advocates for culturally appropriate HIV services in the region, and are successfully raising funds to continue their work independent of APHIAplus NAL. This shift is particularly striking when considering that there were no known publicly disclosed PLHIV in the province at project start.

Lessons Learned and Recommendations

ACTIVE LEARNING FOR INNOVATION

Understanding that NEP was a new area for the implementing partners, managers fostered a project culture of active learning and innovation to meet the unforeseen challenges that would inevitably arise in

ANC uptake at participating motorbike outreach sites, 2008–2010

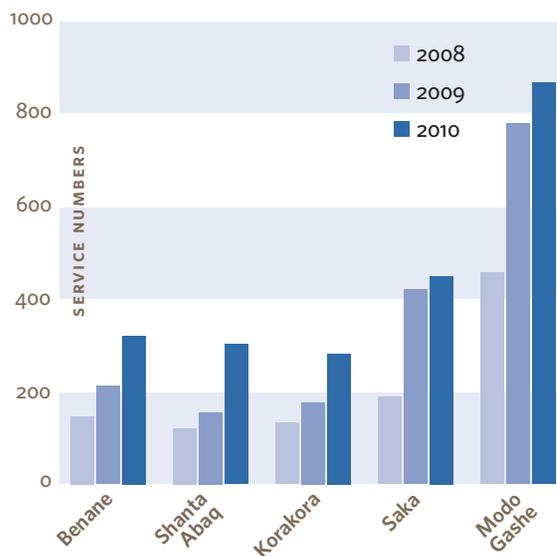


FIGURE 4. ANC SERVICE NUMBERS AT FIVE SITES PARTICIPATING IN THE MOTORBIKE OUTREACH PILOT BETWEEN 2008 AND 2010

the course of implementation. Quarterly review meetings supported this norm, providing a forum for critical assessment of challenges as they emerged, and collaboration to identify possible solutions. This managerial emphasis on solution-oriented thinking resulted in the project’s pioneering of a lab networking system for NEP, motorbike-based outreach to support health posts, and a data systems strengthening strategy to push the use of strategic health information for quality improvement at facility and district levels. Intentional platforms for open learning and inquiry are recommended for projects desiring a widespread staff responsibility for innovation and problem solving.

MANAGING FOR EFFICIENCY

Several early management decisions contributed to efficiency in achievement of project goals. An early investment in personal communications technologies for all staff enabled the project to stay connected despite NEP’s remote setting. Use of M-PESA (Kenya’s mobile phone-based payment and money transfer system) similarly provided staff with a fast and cost-effective financial delivery system, increasing ease of financial accountability and reducing the project’s vulnerability to fraud.

Also contributing to efficiency of operations was the project's emphasis on unity across its implementing partners. By stressing the value of timely and accurate information sharing to promote responsiveness and problem solving, project management discouraged programmatic silos. This unity was so much a part of operations that staff identified primarily with the project rather than parent organizations, resulting in a project team that communicated freely, reduced redundancies in efforts, and was mutually supportive regardless of the task at hand. Such approaches to partner collaboration and operations are recommended in contexts like NAL's.

COMMUNITY ENGAGEMENT FOR POSITIVE SOCIAL NORMS

Given the historical distrust of US-funded development projects in NEP, and especially of efforts related to the sensitive issue of HIV, careful community engagement was crucial to project achievements. The project engaged community gatekeepers—particularly religious leaders—in program planning, strategy development, and implementation. This helped build knowledge, trust, and support between project staff and local communities. Program staff perceived the strong culture and traditions of the ethnic Somali community

as an opportunity rather than a barrier, and actively sought to support community stakeholders to lead sensitive health- and norm-related conversations independent of project staff members' influence. By acknowledging, respecting, and building upon positive norms and values, the project and community members were able to unite around shared goals for improved health outcomes. This partnership enhanced community buy-in to project efforts, and benefited the project with invaluable insights to make interventions culturally relevant and sustainable.

Conclusion

In 2011, the project utilized the strategies and lessons learned from three and a half years of implementation in NEP to expand to the northern arid regions of Rift Valley, Eastern, and Coast Provinces. From 2011 through June 2012, APHIAplus NAL was implemented in 60 percent of northern Kenya, and covered a total of 395 health facilities and surrounding communities. The interventions from the project's first four years have successfully laid the foundation for increasing access to and demand for health services throughout Kenya's north under the next phase of APHIA programming leadership.

WORKS CITED

- ¹ Republic of Kenya, *Vision 2030 Development Strategy for Northern Kenya and Other Arid Lands* (GOK, 2011).
- ² Ministry of State for Development of Northern Kenya and Other Arid Lands, *Interim Strategic Plan 2008–2012* (Nairobi: GOK, 2008).
- ³ Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey 2008–09* (Calverton, MD: KNBS and ICF Macro, 2010).
- ⁴ National AIDS and STI Control Program, *Kenya AIDS Indicator Survey 2007* (Nairobi: National AIDS and STI Control Program, 2007).
- ⁵ National AIDS and STI Control Program, *Annual Health Sector HIV Report 2009* (Nairobi: National AIDS and STI Control Program, 2010).
- ⁶ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008–09*.
- ⁷ K. Macintyre, H. A. Eymoy and I. Hassan, *Assessment of Kenyan Sexual Networks: Collecting Evidence for Interventions to Reduce HIV/STI Risk in Garissa, North Eastern Province, and Eastleigh, Nairobi* (Watertown, MA: Pathfinder International, 2008).
- ⁸ Ibid.
- ⁹ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008–09*.
- ¹⁰ Ibid.



COVER PHOTO: A family seeks services in NEP.

PHOTO CREDIT: Sarah Day

CONTRIBUTORS

David Adriance, MSc

Claire B. Cole, MPH

John Kere

Irene Kitantides, MPH

Alden Nougá, MPH

Pathfinder would like to acknowledge and thank the entire APHIAplus NAL implementation team, partners, and local counterparts, as well as the Kenyan Ministries of Health.

PATHFINDER INTERNATIONAL HEADQUARTERS

9 Galen Street, Suite 217

Watertown, MA 02472, USA

Phone: 1-617-924-7200



A GLOBAL LEADER IN SEXUAL AND REPRODUCTIVE HEALTH