ACCESS/ JHPIEGO Kenya

USAID- Quarterly Report

January – March 2006

ACCESS/ JHPIEGO - USAID QUARTERLY MEETING REPORT
JANUARY – MARCH 2006
MEETING DATE- 11 April 2006

A. Summary of Accomplishments

#	Program	Funding	Activity Description	Achievements	Achievements to Date (Cumulative)	Constraints / challenges	Plans for Next Quarter
1.	**IBP**	$250,000	• Advocacy • Baseline	• Buy-in and support from Migori DHMT and provincial leaders. • Project plans mapped out with MoH	•	• Endline postponed.	• Updates for service providers in Migori • Supervision course for PRHT&S and DRHT&S teams including DHMT from 4 districts • Community advocacy, TOT and orientation of CORPS • Follow up support supervision-Migori
2.	**Malaria**	$300,000 $100,000	• Reinvigoration workshop	• **33 participants** from 8 provinces and 3 target districts were sensitized on MIP issues and community RH with malaria	•	• Delay in activities due to MoH schedule	• Community Scale up with PQI • Capacity building (clinical training skills course) for the ministry of health staff will take place between 22nd and 26th May 2006. • Training on focused antenatal care/malaria in pregnancy in urban areas is currently planned for Mombasa.
3.	**CT**	$200,000	• Training	• **149 participants** (health workers) trained this quarter	• **414 service providers** trained to date • **41** trainers trained		Support Supervision to be conducted in the three provinces

4.	**ART**	$270,000	• Training	• **284** nurses, doctors, and pharmacists and clinical officers trained • **24** trainers trained to date	•	• Working in the 8 selected health facilities in Nairobi was difficult since the PHMT insisted that all public sector facilities must be involved. This program ended training health workers from 40 health facilities. • The trainers in Nairobi still needed more support to conduct follow on trainings and this took time to organize. • The timeline was too short and the trainings had to be rushed.	• Support Supervision activity in the two provinces; • Document final program results.

B. Program Reports

Introduction

The ACCESS Program through JHPIEGO continues to strengthen capacity within the Ministry of Health working in 6 provinces and 35 districts. ACCESS/ JHPIEGO technical support targets reproductive health and family planning, safe motherhood and malaria and HIV/AIDS. These comprehensive efforts aim to affect positive change for women and their families. Specifically- affording women and their partners family planning services through international best practices; creating informed demand at the community level around comprehensive RH services targeting malaria in pregnancy; and strengthening capacity to deliver ART and CT services for HIV positive Kenyans.

I. Implementing Best Practices

Background

Implementing Best practices (IBP) is an initiative that began in 1999 to enhance the ability of countries to identify and apply evidence-based and other demonstrated practices that improve the quality and delivery of reproductive health services. The 2003 KDHS study shows that MMR remains high (estimated at 414 per 100,000 live births). Similarly, the data show that fertility levels still remain high in rural areas (5.4 children per woman) and unplanned pregnancies are common with 20% of births being characterized as such. Contraceptive use is estimated at 41% among married women indicating that approximately 59% of women in their reproductive age are not using modern family planning methods. Additionally, 38% of women discontinue use within a twelve-month period after adopting the method. Thus, in order for women to have family planning choices, and thereby address some of the gender imbalances that lead to the unacceptably high maternal mortality ratio, it is essential for FP service providers to have contraceptive counseling skills and ensure that clients receive contraceptive advice and methods that meet their needs. JHPIEGO's current work builds on successes and lessons learned from IBP Phase I; supporting Migori district.

Achievements

1. Support Supervision/Rapid Results Initiative

In support of the MoH's Rapid Results Initiative, JHPIEGO, in collaboration with the MoH, evaluated progress to date for contraceptive demand creation in Nyeri, Nakuru and Homabay districts. This activity was combined with support supervision. Linking these activities resulted in the needed information the MoH required for RRI and to some extent results for support supervision. However, support supervision results were limited due to the scope of work required for the RRI.

A copy of the final RRI report can be found with the MOH/ DRH. Observations:

- Clients' attendance has slightly increased by method.
- Method of choice (by order of preference) - Depo Provera, contraceptive pills, condoms, IUCD and Jadelle.
- Records are not kept for a) new clients and b) revisits for long term, natural and permanent methods
- Most long term and permanent methods are done through mobile clinics.
- Contraceptive stock outs have slightly improved in this quarter.
- Social mobilization had been initiated in the 3 districts.

2. One day advocacy and planning meeting-MIGORI

Approximately 30 participants, drawn from the PRHT&S, DHMT, DRHT&S teams, private sector and NGOs, attended the meeting. A number of issues were deliberated upon:

- IBP in the provincial and district work-plan for Migori.
- Analysis of the district profile
- Challenges in offering FP services
- Ways of improving FP uptake
- Selection of facilities for baseline and trainings.
- Selection criteria of service providers to attend trainings.
- Community involvement

At the end of the meetings, time frames for the proposed activities were agreed upon.

3. Baseline Survey

The DRH and JHPIEGO harmonized and adapted existing tools for data collection. Seven tools were used to capture contraceptive uptake, contraceptive stock levels, provider knowledge and skills, community awareness on FP methods and client FP seeking behavior. This activity was conducted from the 27 Feb – 3 March 2006. Research assistants, drawn from the district, were recruited and orientated to the tools. A total of 14 facilities were visited. Some of the preliminary observations were:-

- **Stock-outs**: Stock-outs affected the district hospital, which has the highest load of family planning clients, as well as other catchment facilities. Since this stock-out had lasted for more than a month in these facilities and women were aware of this, turn out of clients has become low.

- **Staffing**: Apart from the district hospital, all other facilities are experiencing staff shortages. In some cases, as was the case in Luanda and Ongo dispensaries the family planning services were manned by community based

distributors. The qualified staff in some facilities is overworked as was the case in Karungu Sub- District Hospital, where all staff including subordinates offers FP services.

- **Record keeping**: Many facilities did not have bin cards and did not update their registers. The records that were found were incomplete and not well kept. Physical stock counted in the facilities did not correspond with the records.

- **Community based distributors (CBDs):** CBDs have become inactive due to inadequate incentives and low drug stock. CBDs work on a voluntary basis and the team was only able to trace a few.

- **IEC:** Most facilities had **no posters/signposts** indicating the services offered especially for family planning. No facility had materials with family planning information in the waiting rooms. Most facilities didn't have enough space to provide adequate privacy during consultations.

- **Updates:** Most service providers have not received updates in the last three years.

Assessments at the households and client level revealed the following:

- **Attitude:** Most interviewees from the household were women. Men were either in their farms or working elsewhere. Among the men interviewed, many were negative about family planning and contraceptive use saying FP went against traditional beliefs that advocate, for example, for many children.

- **Practice:** Many women go for family planning services secretly, mostly on market days so that their husbands do not find out. Some women left their cards in the facilities they visited, as they could not risk carrying them home. Some didn't even want their names recorded anywhere due to the fear that their husbands would find out.

- **Practice:** The majority of the FP clients prefer Depo. Many were disappointed that they had to be referred to the chemists to buy Depo as facilities had no stocks.

- **Knowledge:** Men continue to hold misconceptions about FP. These were highlighted by one of the CBDs we met in the field:

    - Using injectables will cause a child to be born with defects;
    - Using FP methods will result in multiple births;
    - Women will be unfaithful.

Challenges

1. Endline data collection for Phase I has been postponed until Mid-may to meet the MOH/ DRH's timeline.

Plans for the next quarter

1. Updates for service providers in Migori;
2. Supervision course for PRHT&S and DRHT&S teams including DHMT from 4 districts;
3. Community advocacy, TOT and orientation of CORPS;
4. Follow up support supervision-Migori;
5. Endline for Phase I.

II. MALARIA

Intermediate MAC Result 3: Strengthen national level capacity to improve demand or appropriate prevention and treatment of malaria

Background

In 2004-2005 with USAID support, JHPIEGO/ACCESS supported the Ministry of health (DOMC/DRH) to develop the community reproductive health/ malaria in pregnancy orientation package. JHPIEGO/ACCESS also supported the implementation of the orientation package in three districts (Makueni, Kwale and Bondo). The community component targets existing community resource persons in order to create awareness on safe motherhood and malaria in pregnancy.

The proposed activities for October 2005- September 2006 will focus on: supporting the ministry of health to scale up the implementation of the community RH/MIP package; capacity development in reproductive health/malaria in pregnancy; strengthening MIP interventions in urban areas and re-invigoration of malaria in pregnancy activities.

Achievements

1. The ministry was able to leverage funding from WHO to produce and train in other districts within a period of two months after the completion of the community reproductive health/malaria in pregnancy package.

2. The communities visited appreciated the orientation on malaria in pregnancy and reproductive health broadly.

3. As planned, the re-invigoration meeting was held with the participation of the eight (8) provincial reproductive teams and three (3) districts (Makueni, Kwale and Bondo), which have implemented the community reproductive health/malaria in pregnancy orientation package. In addition to sensitizing the

provincial teams on malaria in pregnancy emerging issues and concerns, the community reproductive health document was also discussed. The meeting had a total of 33 participants.

Challenges/ Constraints

1. One of the key challenges in malaria in pregnancy is the increasing resistance to SP coupled with the fact that the government has changed first line treatment.

2. The team experience some delays in implementing district activities due to the MOH schedule. The scale up in the three districts has been planned in consultation with the districts and the scheduled to take place as follows:

District	Training of Trainers (TOT)	Orientation of COPRs	One day follow up and PQI update meeting for phase I TOTs and CORPs
Makueni	10th -12th May	15th -19th May 12th -16th June	20th May
Bondo	8th -10th May	15th -19th May (two courses running concurrently)	20th May
Kwale	29th -31st May	5th -9th June (two courses running concurrently)	10th June

Plans for Next Quarter

- The capacity building (clinical training skills course) for the ministry of health staff will take place between 22nd and 26th May 2006.

- The training on focused antenatal care/malaria in pregnancy in urban areas is currently planned for Mombasa.

5. Tales from the field

- CORPs trained in Makueni district have been noted for vigor in updating their community. They hold regular update meetings to discuss their progress towards completing their divisional work plans.

- In Kwale, district-members of the community carried out a Maternal Death Review and forwarded the report to the health facility. In this case, the community's review informed the facility level on the maternal death review process.

- In Kwale, during the support supervision one of the village health workers commented, "We are very grateful for the sensitization and we have been referring our people to the health facilities – but better linkages and

sensitization of health workers in hospitals is needed as they do not seem to appreciate the work that we are doing".

- A head teacher in Vigurungani in Kinango division (RH CORP) identified danger signs in a pregnant woman and refereed her to Kinango hospital.

- A chief in Mtaa, Kinango division (RH CORP) mobilized a mother for family planning services.

- An assistant chief in Vanga persuaded his pregnant relative to wait for her delivery at Vanga health center.

- A pastor at Diani in Msambweni division has formed a group of born again Christians to sensitize other Christians on reproductive health issues.

- Minister for Health and Head of DRH used JHPIEGO's Community Package to sensitize the community in Kwale.

III. Counseling and Testing

Background

Background

In order to ensure that there will be **no missed opportunities for HIV testing** in Kenya and to increase awareness on the new guidelines on HIV testing in clinical and medical settings, ACCESS/ JHPIEGO will orientate approximately **450 health workers** in **28 districts** in **3 provinces namely; Eastern, Nairobi & Central** on the new Ministry of Health (MOH) guidelines for HIV testing in Kenya, thereby building their capacity to routinely provide HIV testing and to enable them refer patients for ART. This activity will lead to **2,250** orientated colleagues through the cascade approach *(Ref. FHI evaluation of JHPIEGO cascade approach, August 2001)* during FY05. ACCESS/ JHPIEGO will also strengthen referral systems between CT sites and sites where ARV treatment is available.

Achievements

1. Counseling and Testing courses conducted in the three provinces.
    - Completed DTC training in all 28 remaining facilities for **149** participants. A total of **455 (41 TOT and 414 Service providers)** health workers have been trained to date**.**
    - The CT orientation package was presented to the National CT Technical Group and passed for discussion by the training committee to recommend adoption.

Plans for the next quarter

- Support Supervision activity in the three provinces;
- Document final program results.

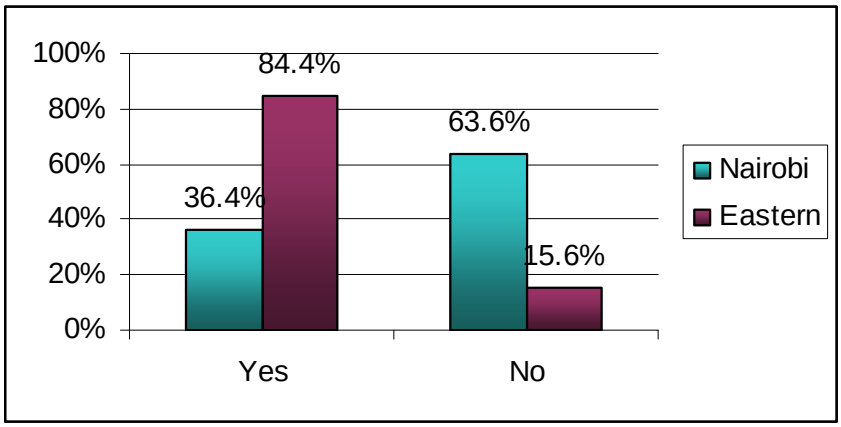
IV. ANTIRETROVIRAL THERAPY (ART) PROGRAM

Background

ACCESS/JHPIEGO in collaboration with NASCOP and selected NGOs in the two provinces (Eastern and Nairobi) will strengthen the capacity and technical skills of health workers (including supervisors) on ART in the provision and support of treatment services. At least **250 health care workers will be trained**. About **21 ART sites in 21 districts** in the eastern half of Kenya will directly benefit. The training program will build on the established materials already prepared by NASCOP and will result in accreditation of the providers in accordance with the national standards that are being developed. ACCESS/JHPIEGO will develop training teams who will have on the ground experience, but also time to train; these services will complement the currently existing activities by NASCOP.

ART Baseline Survey

About 2/3 of Nairobi participants were drawn from facilities without ART services while most target facilities in Eastern province were providing ART.

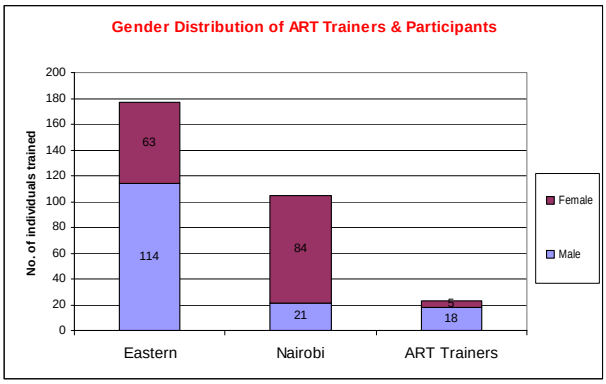


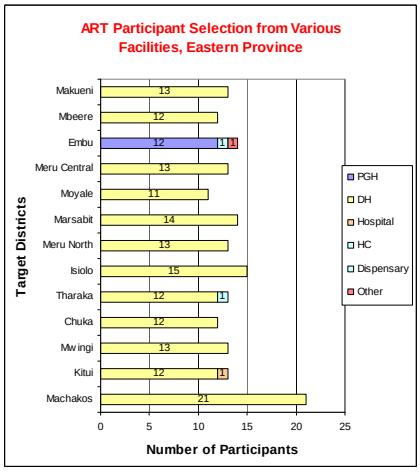
Province	*Type of Patients*	*July*	*August*	*September*	***Total***
Nairobi	New	21	26	15	**62**
	Continuing	44	74	111	**62**
	Referrals	0	2	2	**124**
	Defaulters	0	0	0	**248**
	Total	**65**	**102**	**128**	**496**
Eastern	New	96	103	251	**450**
	Continuing	814	902	939	**2,655**
	Referrals	69	10	35	**114**
	Defaulters	14	20	27	**61**
	Total	**993**	**1,035**	**1,257**	**3,285**

Both Nairobi & Eastern provinces reported steady increase in ART uptake and follow-up for PLWAs.

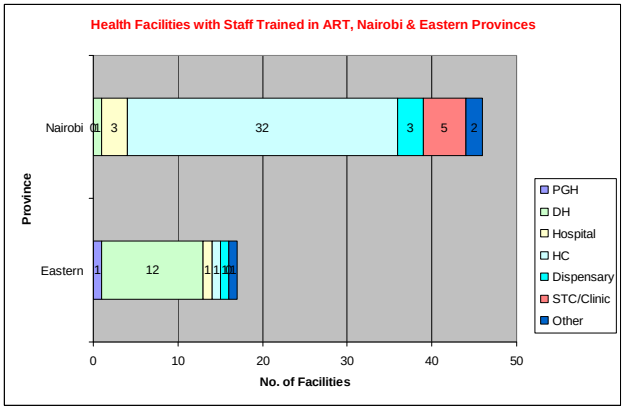
Training Achievements

1. **13** Antiretroviral Therapy (ART) courses conducted in two provinces in Nairobi and Eastern.
   - A total of **308 health workers (includes 24 trainers**) have completed training in ART.

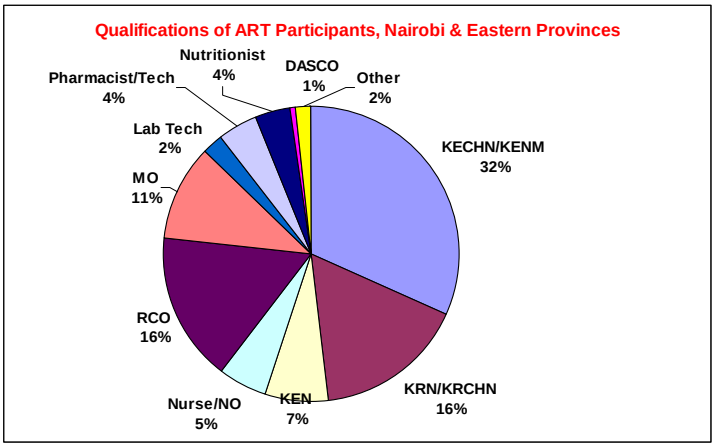




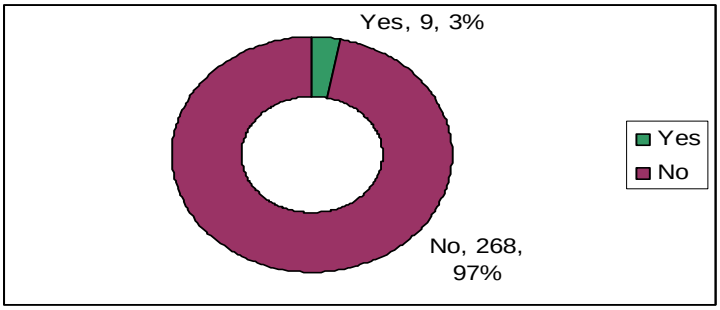
   - More than 60 health facilities now have health workers trained in ART:
     - 17 facilities in Eastern Province (majority (12/17) district hospitals)
     - 44 facilities in Nairobi Province (majority (32/44) are health centres).

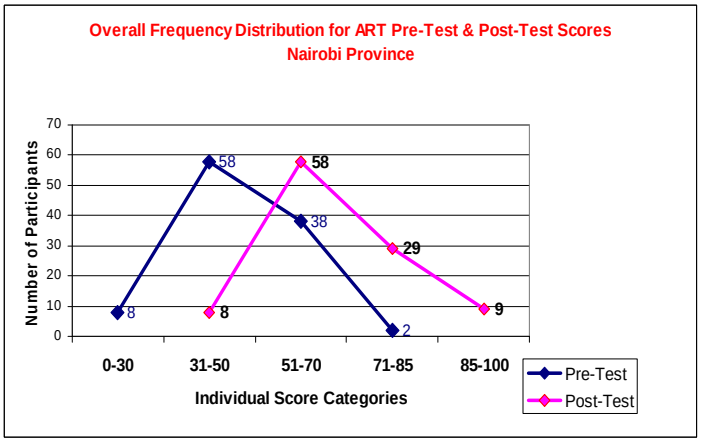


- All cadres of health workers included in the training, majority are nurses



- Only 3% of participants were previously trained on ART by NASCOP, NGOs or other individuals. Using the NASCOP national curriculum the participants gained knowledge on ARV provision and administration.





- External/ practicing physicians are planning to provide technical update on drug administration and drugs logistics as part of ongoing mentoring.

- Courses were conducted in health facilities- e.g. Coptic hospital, which provided a good venue for practical experience especially in the patient support centers and Comprehensive Care Centre's.
- JHPIEGO developed role plays and case studies to complement the national curriculum. These roles & case studies were used in class for demonstration purposes.
- Each participant developed action plans.
- The collaboration & support from NASCOP and the DHMT was tremendous during these trainings.

Challenges / Constraints

- Working in the 8 selected health facilities in Nairobi was difficult as the PHMT insisted that all public sector facilities must be involved. This program ended training health workers from 40 health facilities.
- The trainers in Nairobi required more support to conduct the trainings and this took time to organize.
- The timeline was too short and the trainings had to be rushed.
- Linking JHPIEGO's ART training with initiation of ART services at target facilities.

Plans for the next quarter

- Support Supervision activity in the two provinces;
- Document final program results.

Appendix 1

STORIES FROM THE FIELD.

Reasons for ARVs to be offered in each district hospital.

I. A quote from one of the participants- "My cousin got infected with HIV while in the campus/college. He ignored his status and went ahead and married a beautiful girl from his village and they were blessed with a baby son. After testing and counseling, he was to be initiated on ARVs. There were no drugs in the hospital then and before he was transferred for initiation he succumbed to one of the OIs and he died. Immediately after, her young brother in law inherited her. Within one year, the son of the diseased also died, two years down the line the young man died and the wife followed". This clearly shows that:

- Denial delays initiation of ARTs.
- Wife inheritance has contributed to a great deal to spread of HIV.
- Lack of drugs (ARTs) has caused a lot of death hence the great need to avail ARTs in all district hospitals.

II. My brother died four years ago due to AIDS. Following which his wife started getting frequent attacks of pneumonia, cough and also started to lose weight. I requested her to come and stay in town (Isiolo) with my family so we could take her to Meru for ARVs. Initially she said she had been bewitched, but after discussions, she accepted to come. I then referred her for assessment and consequently was put on ARVs. When she went home she lied to my parents that the drugs she was given were for cold so she never came back. When I visited them after I realized she was not coming, she was too weak and bed ridden, it was too late, she died a week later. Then I realized the need for ARVs at every health facility with competent providers not only to prescribe the ARVs but also to do adherence counseling.