

Development and Operationalization of the Minimum Package for Reproductive Health (RH) and HIV Integrated Services

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Executive Summary

The minimum package (MP) for Reproductive Health and HIV integrated services seeks to provide guidance to implementers and service providers on requirements for infrastructure, human resource, skills set and training materials, equipment, commodities and supplies, and M&E services necessary for effective service provision at any level of care. Background is provided in Section 1.

Section 2 of this report describes the process of developing the minimum package. The content of the package was informed by feedback from the regional dissemination meeting for the National Reproductive Health and HIV and AIDS Integration Strategy and information collected during validation visits across Kenya. The MP was developed through a participatory, interactive process, involving several stakeholders and led by NASCOP and (now RMHSU).

Section 3 summarizes the process of selecting model sites. The following criteria were used:

- Facilities in high HIV prevalence area
- Supportive administration and leadership
- Facilities with motivated staff
- The 5 facilities per region included:
 - 2 at the primary level, tier 2 (1 dispensary and 1 health center), 1 should have demonstrated a strong community linkage
 - 3 at the county level, tier 3- sub-county hospital level
- 3 facilities have demonstrated some integration and 2 new sites with minimal integration

This section provides details of pilot sites' baseline assessments prior to MP implementation and describes the step-by-step implementation process utilized in two pilot facilities.

Section 4 describes evaluation of the MP six-months following implementation roll-out. It summarizes the facilitators, staff perceptions and challenges to the implementation. The evaluation demonstrates that both pilot facilities are now implementing the minimum package in most departments.

The final section describes the process of estimating resource requirements to support implementation of the minimum package and provides the resource requirements by facility level.

List of Abbreviations and Acronyms

ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral
CaCx	Cervical cancer
CCC	Comprehensive Care Clinic
CHEW	Community health extension worker
CHW	Community health worker
DRH	Division of Reproductive Health
EC	Emergency contraceptive
EID	Early infant diagnosis
FANC	Focused antenatal care
FP	Family planning
HMIS	Health Management Information System
HTC	HIV testing and counseling
IEC	Information, education and communication
IUCD	Intrauterine contraceptive device
KEPH	Kenya Essential Package for Health
KHSSP	Kenya National Health Sector Strategic & Investment Plan
LARC	Long Acting and Reversible Contraceptives
MCH	Maternal and Child Health
MGDs	Millennium Development Goals
MP	Minimum Package
MARPs	Most at risk populations
MVA	Manual vacuum aspiration
NASCOP	National AIDS/STI Control Programme
OPD	Outpatient Department
PAC	Post-abortion care
PMTCT	Prevention of mother to child transmission
PNC	Post-natal care
RMHSU	Reproductive and Maternal Health Service Unit
TB	Tuberculosis
USAID	United States Agency for International Development
VIA/VILI	Visual inspection with acetic acid/Lycol's Iodine
YFS	Youth Friendly Services

Section 1: Background

The Kenya National Health Sector Strategic & Investment Plan 2012-2017 (KNHSSIP) seeks to ensure that health service delivery is both more effective and accessible. The Kenya Essential Package for Health (KEPH) recommends the integration of health programs into a single package that focuses interventions toward the improvement of health at different levels of human development cycle. The integration of Reproductive Health (RH) and HIV and AIDS services involves restructuring and reorienting health systems to ensure the delivery of HIV and AIDS services within sexual and reproductive health services (SRH) or the delivery of SRH services within HIV and AIDS services

To achieve this goal, the National Reproductive Health and HIV and AIDS Integration Strategy was developed and launched in 2010 and disseminated to all the regions between October 2010 and June 2011. The National Reproductive Health and HIV and AIDS Integration Strategy aims to provide a coherent framework to ensure improved coordination and collaboration among key agencies and organizations offering integrated RH and HIV and AIDS services. The strategy describes potential services that can be integrated at various service delivery levels such as Family Planning counselling and condom provision in the community with referrals for other methods, HTC in antenatal care clinic and provision of ART for prophylaxis at KEPH level 2 to 6.(dispensary, health centre, district hospital, provincial hospital and national or tertiary level)

In order to operationalize the strategy, there was a need to develop a Minimum Package for Reproductive Health and HIV integrated services. Integration would also support the Ministry of Health to address the Millennium Development Goals (MGDs) 4-reduce child mortality rates, 5-improve maternal health, and 6-combat HIV AIDS, Malaria and other diseases. The MP was developed and launched in 2012 by the RH-HIV Integration Committee under the leadership of both NASCOP and DRH (now referred to as the Reproductive Health & Maternal Health Services Unit (RHMSU)) with technical support from FHI360 and other partners and funding from USAID. It is a set of recommendations for different types of RH-HIV integration services that are feasible for integrating RH and HIV by level of care.

Section 2: The Process

The RH-HIV Integration Committee oversaw the development of the Minimum Package (MP) for RH-HIV integration. The aim of the minimum package was to: 1) operationalize the national RH-HIV integration strategy, 2) standardize the provision of integrated RH-HIV services, 3) identify key types of integration that may be offered by level of care, 4) improve access to and uptake of key RH and HIV services, 5) give a baseline entry point for the provision of RH and HIV services, and 6) guide on basic service provision requirements for RH and HIV services.

In preparation for the development of the MP, members of the RH-HIV integration committee conducted validation visits to 10 different facilities including four provincial hospitals, three

district hospitals, one Non-Governmental Organization (NGO) facility, a dispensary and a community unit. (See list in appendix). These facilities offered guidance on the basic requirements for integrated services given that they were already offering different types of integrated services within their health care facility. Using a checklist integration committee members interviewed health providers at these facilities about the types of integrated services being offered. The purpose of the validation visit was to:

- Assess the current status of RH-HIV services at facility and community levels,
- Document steps or innovative approaches or strategies that the facilities had used to integrate services,
- Validate factors that have made particular models/types of integration effective and/or acceptable in the facility,
- Identify the challenges encountered during the integration process.

Findings from the validation visits

Information collected during both the dissemination of the National Reproductive Health and HIV and AIDS Integration Strategy and the validation visits provided details about various facilities needs in order to operationalize the strategy. The teams were able to observe the feasibility of and ease in providing different types of integrated services across various levels of care. They were also able to identify the minimum requirements necessary in order to offer integrated services. Below are key findings observed during the validation visits:

- In all facilities most integration was centered around the ANC where the following services were offered: Family Planning (FP)/HIV Testing and Counselling (HTC)/Focused Antenatal Care (FANC)/Post Natal Care (PNC)/Post Rape Care (PRC)/Visual Inspection with Acetic Acid/ Lygol's Iodine (VIA-VILLI).
- Integration at the Comprehensive Care Centre (CCC) involved mainly FP and all the facilities gave oral contraceptive pills and Depo-Provera (DMPA) injections. Clients were referred to MCH clinic for contraceptive implants and intrauterine contraceptive device (IUCD) insertions.
- Most facilities were offering either onsite, offsite and mixed models of integration.
- A majority of facilities reported receiving very little administrative support for integrating services. The administration was reluctant to have RH services integrated in CCC since already HIV services did not generate income.
- Shortages of certain FP methods made integration of RH-HIV services challenging.
- Appropriate registers were not available at all service delivery points, for example, the FP register is only available in the FP clinic.
- There were no integrated registers for recording integrated services resulted in multiple registers per client. This added both to increased workload and a loss of data.
- Several facilities had inadequate space and staff shortages.
- Staff lacked adequate skills to integrate services in some departments, such as staff in CCC lacking skills to insert implants and IUCDs

- Supervision was not integrated therefore posing a challenge
- Clients refused family planning services, especially in CCC.
- There was a lack of male involvement among clients.

A series of meetings and one workshop were conducted during which the RH-HIV committee developed the minimum package based on the information gathered during the dissemination of the national RH-HIV integration strategy and validation visits. The objectives of the workshop were to:

- Update stakeholders on the progress made since the launch of the National RH and HIV and AIDS Integration Strategy
- Share feedback on regional dissemination and validation visits
- Build consensus on the content of the minimum package

The RH-HIV committee received input from this workshop in order to finalize the minimum package for reproductive health and HIV services. FHI 360 printed 10,000 copies of the final document which was launched nationally in October 2012. FHI360 provided technical assistance for the development of a dissemination plan and supported dissemination of the document to 10 regions, reaching approximately 600 service providers.

Following the dissemination of the minimum package, the committee started the process of creating 50 model sites throughout the country. The RH-HIV integration committee developed criteria which was used by the regional team to select the sites

Section 3: Selection and Implementation of the MP

Selection criteria for model sites

The following criteria were used to select the 50 model sites (five sites per region in each of the 10 regions):

1. Facilities in high HIV incidence areas;
2. Administration or leadership who were supportive of integration based on previous records;
3. Facilities with staff who were motivated to offer integrated services;
4. Five facilities per region needed to include:
 - Two at the primary level, tier 2 (one dispensary and one health center), one with demonstrated strong community linkages
 - Three at the county level, tier 3 (District hospital level)
 - Three historically demonstrating integration and two new sites with minimal integration

The RH-HIV integration committee, under the leadership of both NASCOP and RMHSU and with funding from CDC held planning meetings during June and July of 2013 with five facilities per region (in each of the 10 regions) and representation from County Directors across all 10 regions.

Pilot sites

Two of the 50 facilities were identified as pilot integration sites to receive targeted support and cost-analysis from FHI360. The two facilities identified were: Eldama- Ravine Sub-County Hospital, in Baringo County which was already offering integrated services and Makunga Rural Demonstration Health Center, in Kakamega County, which had minimal integrated services.

FHI360 partnered with NASCOP, RMHSU and APHIAplus Rift and Western /Nyanza to implement the pilot project.

Strategic information collected during the regional dissemination of the MP and input from the RH-HIV integration committee informed the pilot implementation process. The main focus of the pilot project was to identify how best to roll out the MP to all facilities in the country and assess the associated cost to implement the package across the country.

Steps for implementing the MP at the pilot sites

The following are the steps to implement the MP in the two facilities: sensitization of model sites staff, sensitization of all facility staff, facility assessment, and implementation of the minimum package.

1. Sensitization of model sites

The process began with a meeting held in Nakuru for the South Rift region and in Kakamega for Western region. This was a one-day meeting for the five facilities in each of the regions selected to be model sites for the implementation of the minimum package. The meetings were organized by NASCOP and RMHSU. There were five participants from Makunga in the Kakamega meeting and four participants from Koibatek in Nakuru.

During the meetings, the contents of the MP were discussed, led by a team comprised of MOH officials and FHI360 staff. Participants had group work which was guided by the following questions:

1. How would you go about implementing the Minimum Package?
2. What are some of the things you need to take into consideration?
3. What systems would you need to put in place - administrative role, service provision role, community role?
4. What do you foresee as challenges or gaps?
5. How would you overcome these challenges?
6. Assuming there are no extra resources, how would you go about ensuring the services are integrated?

The groups presented a step-by-step approach for implementing the MP. Below is an example:

Step 1

- Sensitization of key stake holders
- Site assessment and recommendations
- Commodity, supplies and equipment acquisition and distribution/redistribution
- Distribution of guidelines and IEC materials
- Community sensitization

Step 2

- Review site work plans based on the assessment
- Avail RH commodities at: CCC, OPD, In-patient department, MCH/FP.
- Initiate CMEs, OJT, Mentorship on RH-HIV integration and service provision OPD, MCHFP, IPD Drop in centers for MARPs, Youth friendly services
- Integrate RH/HIV services according to the Minimum Package

Step 3

- Monitoring and evaluation
- Support supervision
- Stake holders performance review meetings

The different facilities then developed work plans for the implementation of the minimum package.

2. Sensitization of all facility staff, including administrative staff in the selected facilities

The staff from the two facilities who had been sensitized during the model sites meeting conducted a series of continuing medical education (CMEs) to sensitize all their staff including Community Health Extension Workers (CHEWs) on the implementation of the MP. CHEWs oriented Community Health Workers (CHWs) during their monthly meetings. CHWs then sensitized the community. CMEs have been ongoing on different topics related to RH-HIV integration.

3. Facility assessment

The implementation of the MP was initiated by a facility-level assessment of the two targeted facilities by NASCOP, RMHSU and FHI 360 to determine what had been done in the year since the minimum package was launched.

The objectives of the assessment were:

1. To assess the extent to which the MP was being implemented at the facility
2. To document steps or innovative approaches or strategies that the facility had used to implement the MP
3. To determine facility-based MP implementation challenges
4. To determine enabling factors that promoted MP implementation

4. Assessment results

4.1 Services offered

Both facilities were offering integrated services though they were at different levels of implementation of the package.

Table 1. Integrated Services Provided at Two Pilot Sites Prior to Implementation of MP

Service provision area	Possible services to integrate (as indicated in the MP)	Integrated services Makunga H/C	Integrated services Eldama ravine Sub-county Hospital
Out-patient (OP)	FP, TB screening, HTC,STI, CaCx and prostate cancer screening	General OP services, HTC, TB screening	General OP services HTC, TB screening
In-patient	HTC, FP, PAC,FP,STI/RTI, TB, CaCx, Breast cancer, Prostate cancer screening,	None	HTC, ART, MVA
Maternal and Child Health & Family Planning (MCH/FP)	PMTCT, HTC,TB, CaCx, Breast cancer, Prostate cancer screening, EID,	HTC, PMTCT	FANC, PNC, CaCx, EID, HTC, PMTCT
Maternity/Labour ward	PMTCT, HTC,FP	None	HTC, PMTCT, ART
Comprehensive Care Clinic (CCC)	FP, STI, CaCx, Breast Cancer, Prostate cancer, TB screening, EID	TB screening	TB screening, FP-OC, DMPA
Tuberculosis (TB)	HTC, FP	HTC	HTC
Youth Friendly Services (YFS)	FP, HTC, STI, CaCx, Breast cancer, prostate cancer, TB screening	None	No YFS

In Makunga Rural Demonstration Health Centre, RH-HIV integrated services were only offered in MCH/FP clinic. In outpatient services, other than the general outpatient services, HTC and TB screening were offered, but no FP services. Likewise in CCC, only TB screening was offered and in TB clinic HTC was offered, but no FP services (See table 1)

In Eldama-Ravine sub-County Hospital, RH-HIV integrated services were offered in MCH/FP, maternity/labour ward and CCC. In outpatient, just like in Makunga, FP was not offered, though they offered HTC and TB screening. The facility did not offer FP services in the TB clinic and did not have youth friendly services (YFS). (See table 1)

4.2 Common challenges across facilities:

- Staff had gaps in MP-specific knowledge, especially among newly posted staff.
- Staff were rotated to other units without adequate work-experience.
- The integrating of new services such as FP and cervical cancer screening into HIV services at CCC requiring staff training.
- There was inadequate equipment such as IUCD and implant insertion kits.
- There was inadequate IEC materials and job guidelines.
- In some departments there was inadequate space for introducing new services.

4.3 Enabling factors across facilities:

- There was supportive administration in both facilities.
- Both facilities identified the staff trained on FP and conducted OJT for those who are not trained.
- The facilities started implementing the MP with a few selected services (e.g., providing short term FP methods at CCC such as oral contraceptives, condoms and DMPA).

5. Actual Implementation

Once the assessments were completed, the team from MOH and the facility Health Management Team (HMT) held discussions to identify ways of handling challenges and service gaps. The key topics discussed included: formation of a multidisciplinary team and identifying a champion to spearhead integration activities, reorganizing services to create more space, partitioning existing rooms to provide privacy, strengthening OJT to minimize knowledge gaps, and availing the necessary protocols and guidelines across service units.

5.1 Operationalizing the MP

To operationalize the Minimum Package, the following steps were taken in both facilities:

- Feedback was provided to facility staff and health facility management committees (HFMC) following dissemination.
- Consensual work plans were developed with the health facility management committee.
- Both facilities held a general staff meeting which included the facility HMT, which included a self-assessment. The teams identified available space for re-organizing services to accommodate integrated services.
- The facility staff identified an integration champion. The HMT held discussions with partners about plans to operationalize the MP and support requested.

- The HMT formed an implementation committee.
- The facilities organized CME sessions for all staff and CHEWs, on integration-related topics.
- Facilities organized OJT services to support operationalization of the MP.
- CHWs were oriented in the facilities during their monthly meetings.
- Hospital matrons assigned departmental in-charge staff the responsibility of MP implementation by departments with continued supervision by the matron.
- Departmental in-charge staff ensured commodities, registers, guidelines and IEC materials were available within their units. In cases where registers were not available, a black book was used to capture integrated services.
- A meeting was held with HFMC, which resulted in submission of request for funds needed for room partitioning.
- CHEWs supported the CHWs to sensitize the community on availability of integrated services in the facility.

5.2 Capacity building

To support operationalization of the MP both facilities received updates on different topics. No staff members had any formal training during the implementation of the MP. With the support of FHI360 and other partners, the facility staff organized updates and CMEs to build capacity for implementing the MP. Most of the updates were given by the county TOTs and CMEs given by staff in the respective departments. Topics covered included: Basic Emergency Obstetric Care and Comprehensive Post abortion Care (BEOC/ PAC), New Born Care, Paediatric ARVs, PMTCT, CaCx screening, IUCD and implant insertions, emergency Obstetric and Neonatal Care (EmONC), Malaria In Pregnancy (MIP), HIV Exposed Infant (HEI) and use of ANC register.

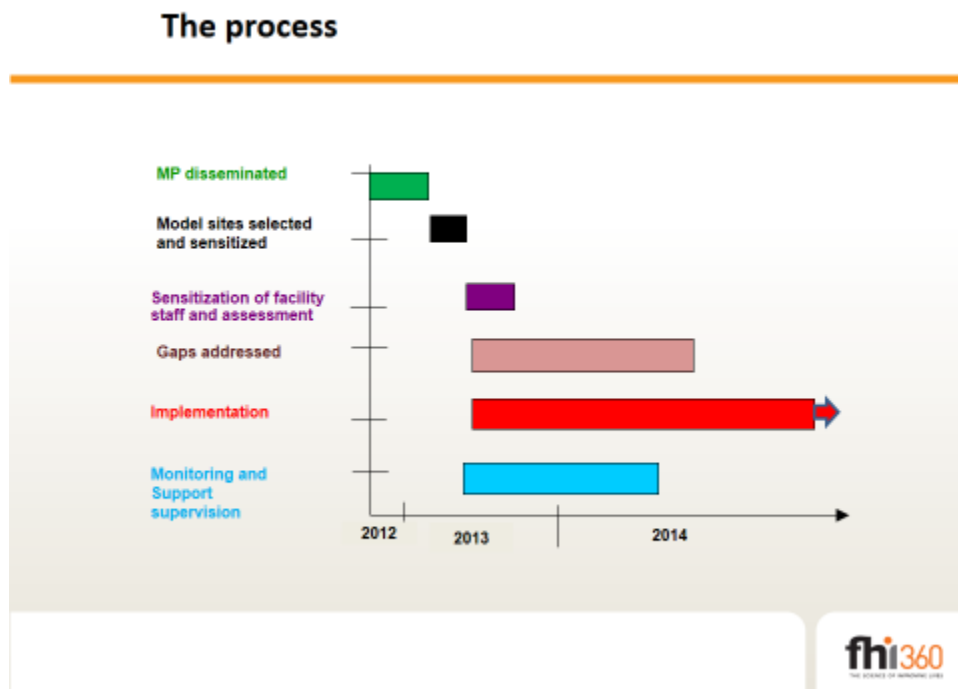
After receiving updates, both facilities reported positive changes in staff performance and attitudes towards integration, despite initial hesitance. Staff members who were initially not involved in the MP scale up, later asked to be involved. For example in Eldama Ravine where the paediatrics ward was not integrating services, the ward in-charge later introduced an FP register, stocked FP commodities and all parents and visitors are now offered HTC and FP services.

She says - “we have realised that many mothers have been missing a chance to get FP and even HIV test while in the ward with sick babies so we decided to bring the services to them. We only used to refer those who asked, but we never told others.”

5.3 Involvement of other facilities and the community

Pilot facilities have involved other non-pilot facilities within their catchment areas in integration activities. Eldama-Ravine involved Mercy Mission Hospital by sending their staff to sensitize them on the Minimum Package including topics specifically related to RH-HIV integration. Eldama-Ravine found this broader facility involvement necessary since many of their patients use Mercy Mission Hospital. Makunga also sensitized nearby dispensaries, which have since begun to refer clients to Makunga for relevant services like screening for cervical cancer.

This chart summarizes the implementation steps



Section 4: The Evaluation

FHI360 conducted a six-month process evaluation of the two pilot sites using an indicator monitoring tool and a checklist. The monitoring tool was used six months prior to and six months following MP implementation. Evaluators interviewed two champions from each facility using the checklist. The evaluation team identified the following key areas of interest based on the process evaluation: facilitating factors, staff perceptions, use of integrated services, client feedback, challenges, and solutions.

1. Facilitating Factors

Factors that facilitated implementation of integrated services included:

- Supportive administration
- Availability of skills within the facility
- Availability of commodities
- Motivated and flexible staff

Example: Staff members were very interested in making things better. A few who do not have the required skills made requests for OJT in order to offer the services.

- Support from neighbouring facilities.
 - Example: Facilities shared copies of registers and redistributed commodities.
- Presence of active community units that followed-up and referred patients for the relevant services
- Support from technical partners

2. Staff Perceptions

Staff felt that implementing the minimum package was essential in order to offer reproductive health and HIV services in an organized way.

“We now know how best to offer integrated services. We tried before but with no proper plan and sometimes gave up. Integration makes work much easier, my patients are happier because I give them more than one service, though I get tired. There is also less loss to follow up since the community is fully involved and helps the facility to trace those who are not following treatment well” – Staff member

“Integration has made work much easier, we no longer have crowds in MCH since clients receive FP as they receive other services.” For example, “Previously after MVA we would tell mothers- “Mama enda MCH uambiwe mambo ya family planning” (Go to MCH where you will be told about family planning). Now because of integration these clients are counselled and methods offered in the female ward.” – Hospital Matron

3. Services offered six months following the operationalization of the MP

Both facilities offer mixed integration, largely within the facility with occasional external referrals and they receive referrals from the community. Since the operationalization, facilities have been able to introduce additional integrated services in various departments.

RH-HIV integrated services offered during the pilot

Service provision area	Possible integrated services (as recommended in the MP)	Additional services, 6mths later (Makunga)	Additional services, 6mths later (Eldama-Ravine)
Out-patient	FP, TB screening, HTC,STI, CaCx and prostate cancer screening	FP counseling with referral, CaCx screening	FP counseling with referral, CaCx screening
In-patient	HTC, FP, PAC,FP,STI/RTI, TB, CaCx, Breast cancer, Prostate cancer screening,	FP counseling, with referral	FP counseling in all the wards, provision of short term methods, with referral for LARC, comprehensive PAC
MCH/FP	PMTCT, HTC,TB, CaCx, Breast cancer, Prostate cancer screening, EID,	CaCx screening	Fully integrated
Maternity	PMTCT, HTC,FP	HTC, PMTCT	Fully integrated
CCC	FP, STI, CaCx, Breast Cancer, Prostate cancer, TB screening, EID	FP-All methods, CaCx screening	All FP methods, CaCx screening
TB	HTC, FP	None	FP counseling, provision of OCs, DMPA
YFS	FP, HTC, STI, CaCx, Breast cancer, prostate cancer, TB screening	None	HTC, FP,STI screening

4. Reaction/feedback from clients

Clients appreciated the change in service delivery. They report spending less time in the hospital since they are getting most of their services in one department rather than multiple departments.

“These days I come to the clinic only once and get both my ARVs and my injection for family planning. I do not have to spend fare twice like before, yet I do not even spend a lot of time in the hospital” - CCC client in Makunga

“I can now tell the doctor all my problems and not fear that others are hearing” (in response to room partitioning) – hospital patient

5. Challenges

Facilities reported several challenges to the implementation processes which included:

- Lack of staff knowledge about integrated services particularly among recent hires
- Staff were rotated to other units without adequate work-experience
- Staff owning certain procedures such as IUCD insertion. Others will always say-“ let Nurse so and so ... insert since she has always done all the insertions”
- Staff ownership of space/certain areas
- Integration of new services such as FP and cervical cancer screening into HIV services at CCC), requires staff training
- Inadequate IEC materials and job guidelines
- Inadequate equipment such as IUCD and implant insertion kits. Other departments willing to insert these methods have to borrow the kits from MCH which also does not have enough
- Inadequate space for newly introduced services
- Erratic supply of data collection tools
- Lack of staff training on documentation
- Lack of a summary sheet for integrated services. This demoralizes providers since the efforts do not seem to be reported anywhere
- Commodity stock-outs
- Inadequate collaboration among implementing partners
- Lack of incentives for CHWs

6. Solutions to challenges and continued needs

During the assessments, facilities highlighted the following solutions and continued needs.

a. Partners

The facilities were able to address their challenges with very minimal external support. They have not received any support from their county governments. Specifically, they received support from facility leadership to partition rooms and purchase of curtains.

Partners offered support; AMREF trained CHWs, APHIAplus in collaboration with FHI360 trained service providers and Peer Educators, provided items for infection control, paint for windows and screens for more privacy. In Eldama-Ravine, APHIA plus renovated the CCC to provide more space in order to more effectively offer integrated services.

b. Commodities

Facilities receive commodities (excluding ARVs) quarterly from KEMSA. County laboratory technicians and APHIA plus provided HIV test kits. In the last 3 months facilities stocked out of implants, ECP and female condoms. Supplies were provided to facilities based on reported use. As a result, facilities had to account for what was previously supplied by providing reports. During stock outs, clients were referred to the nearest facility or asked to purchase out of stock

commodities. Occasionally facilities borrowed from one another, however during shortage supplies were only provided to one unit, therefore limiting provision of integrated services.

When there were nationwide shortages of commodities, clients were not referred but other relevant services are offered.

c. Equipment

KEMSA supplied most equipment. Facilities also purchased equipment using facility improvement funds and through support from partners. Both facilities had not received facility improvement funds since the advent of the county governments, resulting in inadequate levels of basic equipment like IUCD and implant insertion kits so these services can only be offered in one department even when the commodities are available.

d. Referrals

Both facilities referred clients to other facilities mostly for emergency cases and also received referred clients. For non-emergency cases, for example for FP services, or continuum of care for HIV patients, the referral mechanisms included:

- Verbal referral
- Issue referral note
- Make telephone referral and give client a referral note
- Escort clients physically. This is done particularly for referrals within the facility from one unit to another

Facility staff followed-up with referred clients via phone calls and in-person. For example a facility referred a client with positive CaCx screening results. They called the facility before referral and later called to confirm that the facility had received the client. Eldama-Ravine referred clients to Nakuru Provincial General Hospital and also received referrals from Mercy Mission Hospital and health centres and dispensaries in their catchment area. Makunga referred patients to Kakamega Provincial General Hospital. They received referrals from nearby dispensaries.

e. Data

Data collection on the minimum package services was done at all integrated service delivery points. Health record information officers (HRIO) consolidated and forwarded data to DHIS in order to inform the District (County) AOP. The data was later forwarded to the national HMIS to assess the Principal Secretary's performance.

At the national level, data also informed national workplans, operational plans, strategies and guidelines. A summary sheet to document integrate services was lacking.

The data tools available in both facilities were:

- Integrated FP register
- ART Blue card
- Note book
- HTC register

- ANC, Maternity, PNC, CWC, Pre-ART, ART, Lab, VCT, Inpatient and outpatient registers
- CaCx screening register

Neither facility had enough copies of data tools for all the departments. As a result black books were introduced in some departments to record services offered. The health management team discussed month data and deviations from monthly targets before forwarding to the national HMIS.

IEC materials available to support implementation of the MP included:

- Tiahrt chart for FP
- STI syndromic management chart
- PMTCT guidelines
- Immunization card/mother baby booklet
- Criteria for starting ARVs
- Nutritional guidelines

f. Infrastructure/space

Services were reorganized to accommodate privacy in FP/HIV counselling and method provision. Both facilities identified spaces for use of integrated services. They re-arranged rooms to provide more space, introduced curtains and screens, painted windows to provide privacy, and utilized low-traffic corridors. Additional step in reorganization included:

- Integrating FP into CCC at the same room after moving records to records office
- Creating space for cervical cancer screening
- Availing commodities in the different departments
- Using corridors after partitioning using curtains

Identifying appropriate integration service space was initially challenging. Facility matrons served as integration champions and were involved the HMT. Matrons toured the facilities together before conducting a staff meeting to discuss the implementation of the MP and to ensure there was consensus prior to MP implementation. Matrons found it difficult convincing some members to give away rooms they regarded as theirs. Some rooms in the facilities belong to partners e.g. CCC.

g. Support supervision

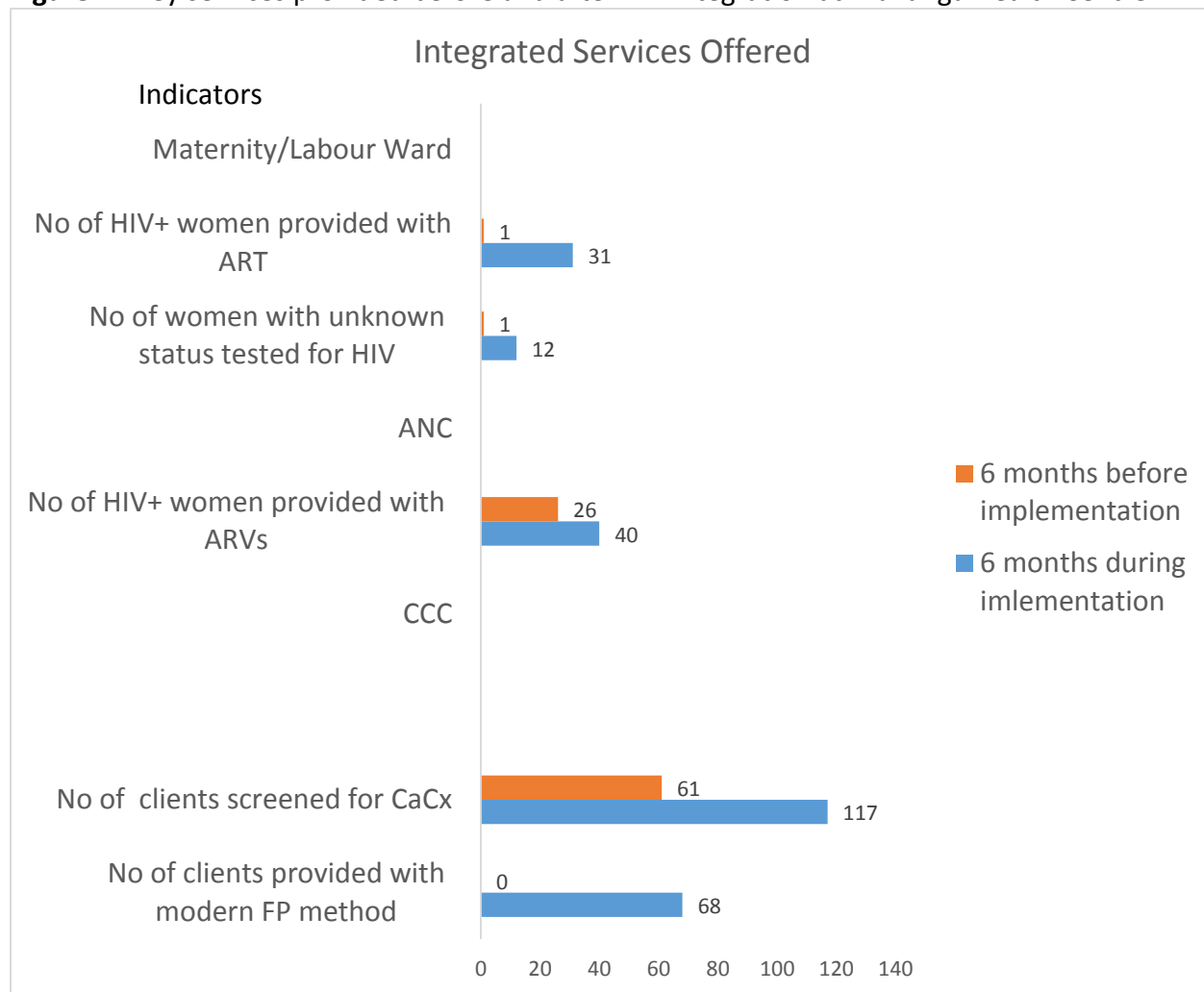
A national MOH team conducted four support supervision visits over the course of six months to assess the MP implementation across facilities. During these visits MOH teams and facility staff discussed any gaps hindering the implementation process and following up on the progress of the work plan. The team provided the different guidelines that the facilities needed for them to implement the minimum package. The departments offering integrated services received regular support supervision from the implementation committee and integration champion, critical to success.

7. Indicator Results

Service delivery statistics were collected from departments offering integrated services, both six months prior to MP implementation and over the six months during implementation with the purpose of evaluating the effect of the MP on the provision of integrated services. It is important to note that the short implementation period was unable to impact the number of patients seen. However, both facilities have since introduced integrated services in new departments.

Makunga Health Centre only offered integrated services in the ANC where HIV testing was done and positive mothers were offered ART prophylaxis. Prior to the MP implementation CCC did not offer FP services and the FP clinic did not offer HTC. Six months later, CCC offered various modern FP methods to 68 clients and the number of clients screened for CaCx doubled. Following the implementation of the MP, the facility started testing women admitted in the maternity and labour ward with unknown status for HIV and offering ART prophylaxis to the HIV positive women. Details of integrated services from baseline to endline are provided in Figure 1.

Figure 1. Key services provided before and after MP integration at Makunga Health Centre

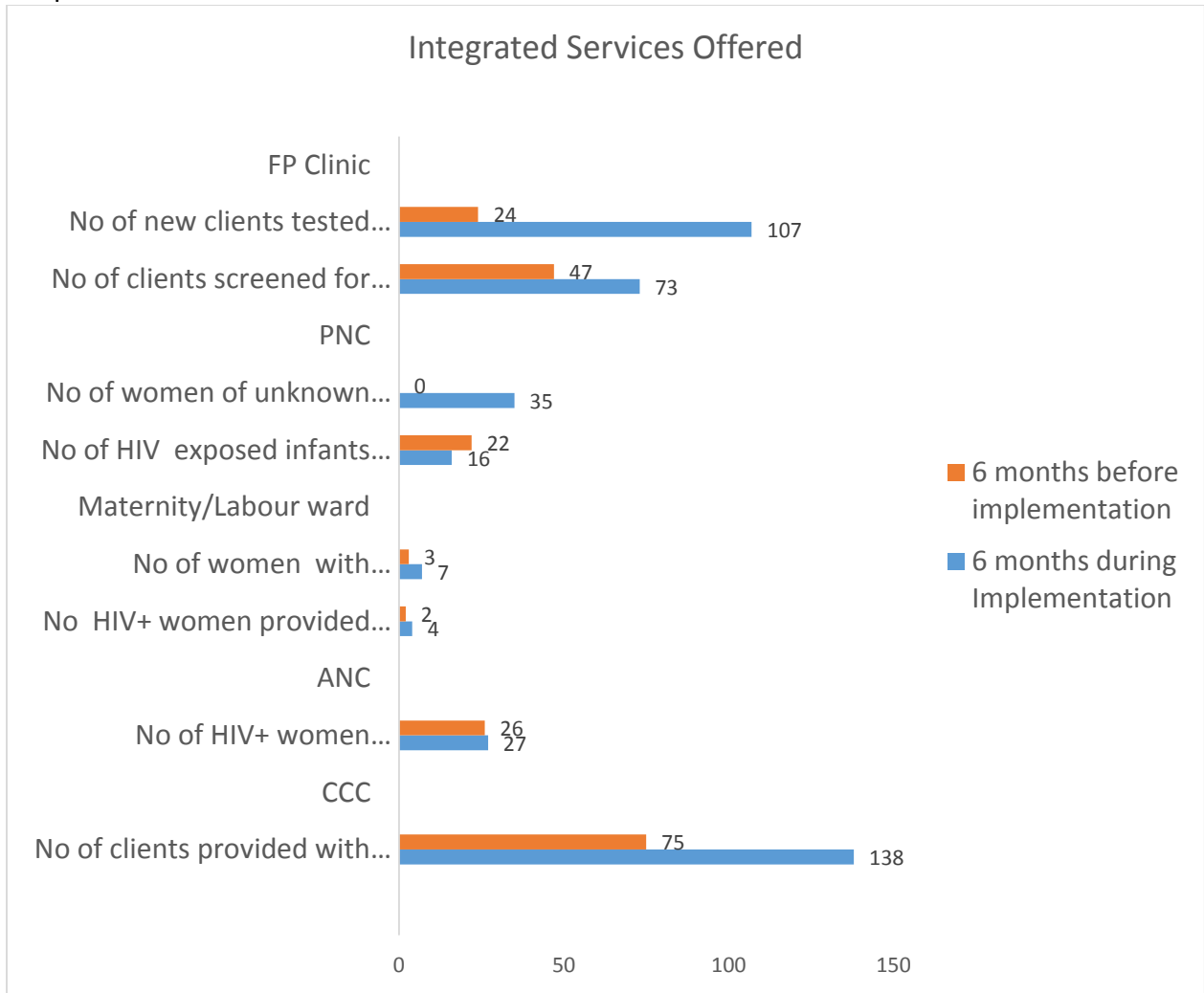


Eldama-Ravine sub-County Hospital was already integrating services in several departments, with substantial improvements since the implementation of the MP.

Six months following the MP implementation, the number of clients receiving modern FP methods and CaCx in CCC both doubled. Furthermore as a result of the integration PNC clients are now receiving HTC. HIV testing in ANC and maternity ward is nearly 100 percent. In the FP clinic the number of clients receiving HTC has more than tripled. Those receiving CaCx screening have doubled. All HIV positive mother infant pairs are followed up in MCH for 18 months. Details of integrated services from baseline to endline are provided in Figure 2.

As a result of the MP, the facility initiated both FP counselling and HTC in all the wards, with provision of short-term methods and referrals for LARC. The chest clinic also offers FP counselling with provision of short-term contraceptive methods. With the support of APHIAplus nuru ya bonde, the hospital also now has a youth-friendly centre where among other services, HTC and FP services are provided.

Figure 2. Key services provided before and after MP integration at Eldama-Ravine sub-County Hospital



Section 5:

Estimating Resource Requirements to Support Implementation of the Minimum Package

While implementing the MP in the two facilities, staff from FHI360 collected information for cost analysis in order to estimate the facility resources needed to implement the minimum package for reproductive health and HIV integrated services.

Methods:

Identification and Quantification of Resources Required: FHI360 led a retrospective process review of the activities used to support the implementation of the minimum package at two facilities (Eldama Ravine Sub-County Hospital and Makunga Health Demonstration Centre). They focused on the activities that would need to be repeated if this intervention were to be replicated in other facilities. The key activities included: site assessment of existing integrated services; infrastructure; human resource, skill sets, and staff sensitization; community sensitization; development of site-specific work plan for implementation; provider capacity building to support integrated service delivery; and additional implementation supervision. For each activity, FHI360 and facility staff collectively estimated the specific resources needed to undertake each implementation activity.

Assigning a Value to Resources: Once the resources were identified and quantified, the next step was to assign an appropriate unit cost to each resource. Because our objective was to provide estimates from the perspective of the Kenyan MOH, resources from international NGOs and per diems rates for the international NGO staff were assigned corresponding values from the Government of Kenya to be consistent with their policies for per diems and allowances¹. By multiplying the quantity of a resource required by its corresponding unit cost, we are able to estimate the cost of that resource for an activity. Costs were then aggregated by type (labor, supplies, travel/transportation, or other) for each activity. A distinction was made between financial labor costs (where an additional payment is made to a person for work performed such as an allowance or facilitation fee) and opportunity labor costs (where the time spent by an individual supporting the intervention would be considered part of their regular responsibilities). It is useful to include this latter category when thinking about the full resource envelope required to support the intervention despite not having specific budgetary implications assuming adequate staff is already in place.

Financial Costs: Additional resources will be required in order to cover the expenses related to the training of the service providers and supporting them with additional supervisory visits. The costs of the trainings are based upon the additional costs for allowances, per diems, food, transportation, and training supplies. Subsequent supervision visits will require additional travel, transportation costs, as well as supplies (fuel).

Opportunity Costs: In addition to the financial costs described above, there are non-financial opportunity costs associated with the time that MOH personnel would need to spend supporting this intervention as opposed to taking care of other responsibilities. While this does not result in additional demands from the treasury, it is important to assess whether or not there is sufficient capacity to undertake this intervention and understand the value of those human resources that are being redeployed to support this intervention. The salary structure for the 2012/2013 financial year was used² to assign time values of MOH staff. Personnel were assigned to the midpoint of their salary scale for estimates.

Results: The total value of resources required to support the implementation of the minimum package ranged from 630,000 Kshs at the sub-county hospital level to 300,000 Kshs at the health centre level (see Table 1). This two-fold difference is due primarily to the larger number of providers at the sub-county hospital level that need to be trained in integrated service provision, resulting in longer on-site supervision post implementation. Approximately 40 - 45% of the costs are financial costs which will require additional budget outlays. Over half (59%) of the financial costs at the sub-county hospital level correspond to the cost of provider training (35% at the health centre level). At both levels the additional supervision support constitutes 20% of the additional financial costs. In both sites, the financial cost of the site assessment is approximately 37,000 Kshs. The breakdown of financial and opportunity costs by activity can be seen in see Figure 1.

Summary of Resource Requirements by Activity and Type (Ksh.)

Table 1. Resources Required at Sub-District Hospital

Activity	Total Value of Resources-Ksh (USD)	Financial Costs (Ksh)	Financial costs (USD)	Opportunity Costs (Ksh)	Opportunity cost (USD)
Site Assessment of: current level of integration, infrastructure, human resource skill sets & sensitization of staff	69,931(821)	36,759	432	33,172	390
Sensitization of the community	4,696(55)	970	11	3,726	44
Development of site work plan	59,798(702)	23,459	275	36,339	427
Provider capacity building	330,663(3,883)	169,740	1,993	160,923	1,890
Supervision of implementation (additional to regular supervision)	161,561(1,897)	55,746	655	105,814	1,243
Total -KSh(USD)	626,649(7,359)	286,674	3,366	339,975	3,992
% of total	100.0%	45.7%	45.7%	54.3%	54.3%

Table 2. Resources Required at Health Centre

Activity	Total Value of Resources-Ksh(USD)	Financial Costs (Ksh)	Financial cost (USD)	Opportunity Costs (Ksh)	Opportunity cost(USD)
Site Assessment of: current level of integration, infrastructure, human resource skill sets & sensitization of staff	65,879(774)	37,160	436	28,719	337
Sensitization of the community	2,124(25)	220	3	1,904	22
Development of site work plan	57,285(673)	14,060	165	43,225	508
Provider capacity building	94,930(1,115)	41,477	487	53,453	628
Supervision of implementation (additional to regular supervision)	73,243(860)	24,240	285	49,003	575
Total KSh(USD)	293,461(3,446)	117,157	1,376	176,304	2,070
% of total	100.0%	39.9%	39.9%	60.1%	60.1%

Kshs.-USD exchange rate: 85.1596 Kshs. /USD

Figure 1a: Additional Activity Specific Resources Required by Type and Facility Level (Ksh)

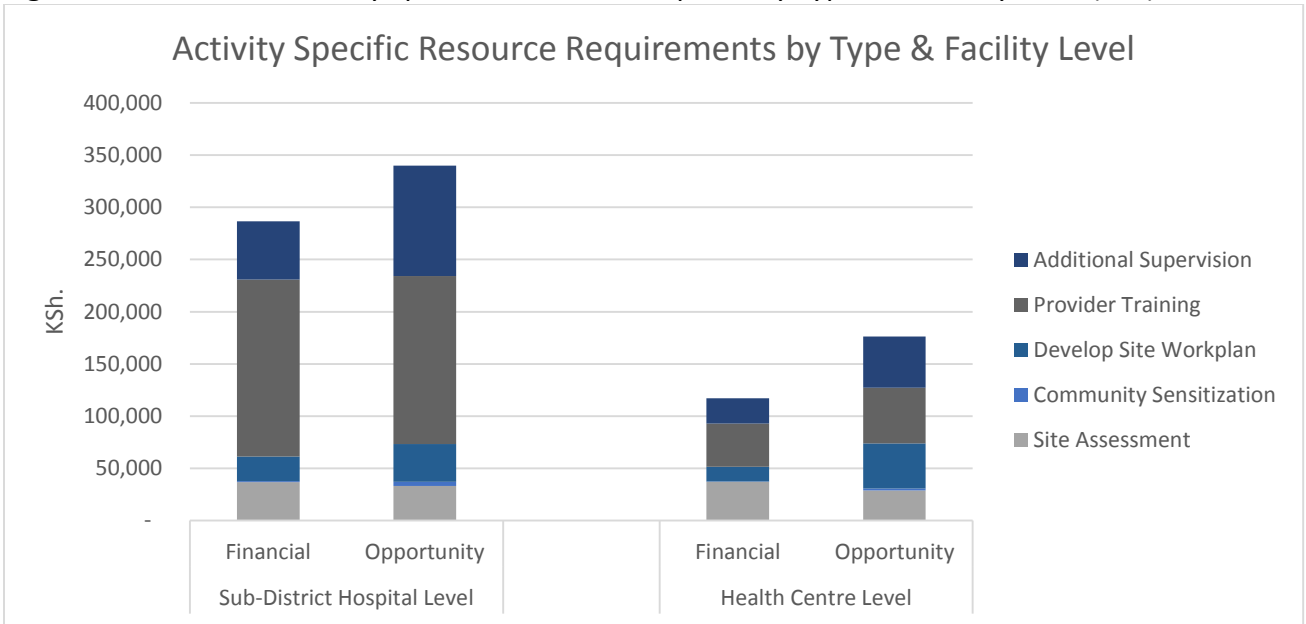
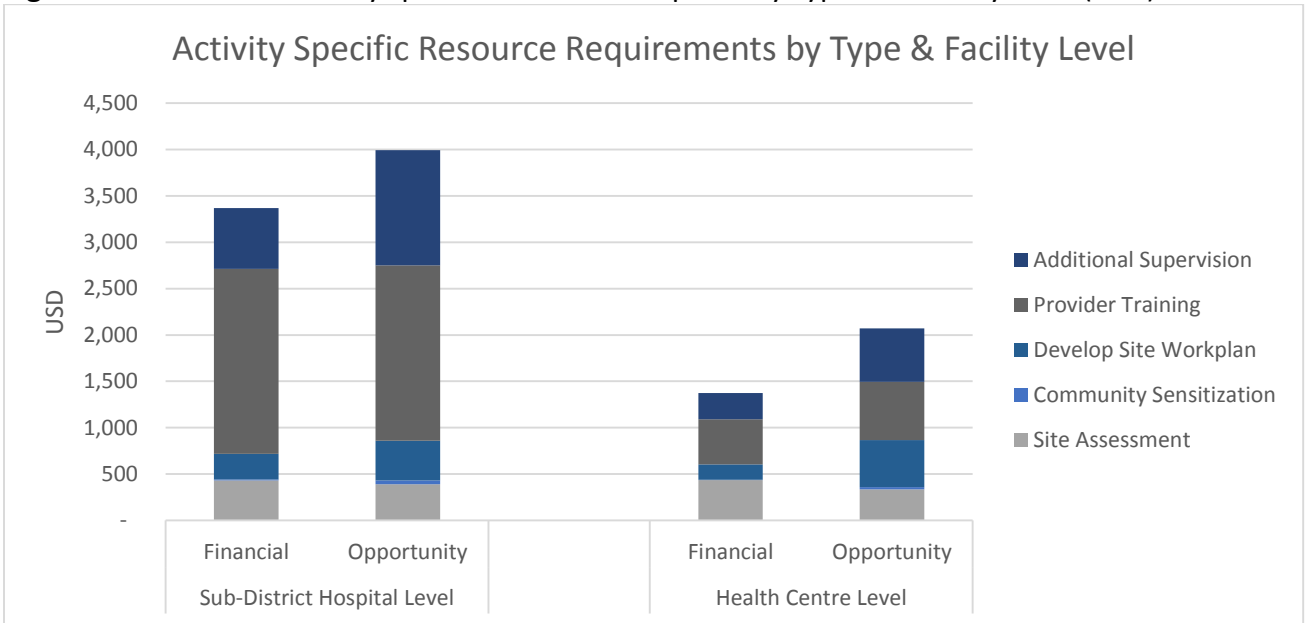


Figure 1b: Additional Activity Specific Resources Required by Type and Facility Level (USD)



Lessons learned

The following is a list of key lessons learned during the implementation of the MP in the two facilities:

- It is critical to identify a hands-on champion to ensure implementation.
- Orientation of all staff including service providers, administrators, the CHMT and stakeholders in the facility is crucial to implementation success
- A smart/realistic work-plan is vital and assists staff in adherence to the roll-out activities
- Support supervision provides invaluable feedback, encourages team performance and provides a platform to discuss delivery challenges
- Pooling resources supports staff performance
- Changing staff mind set encourages ownership of the process which is critical during the implementation process
- Even minor changes, (e.g., painting a window for privacy) can result in advances in RH-/HIV integration

Recommendations

Following the implementation of the minimum package, the following recommendations were made:

1. The MOH and CHMT need to ensure that:
 - all staff are oriented on data collection tools
 - support supervision of staff documentation is strengthened
 - required equipment and commodities are availed to the facilities
2. The CHMT and the HFMT need to:
 - roll-out the implementation slowly into facilities through selected departments with the intention of expansion
 - encourage facility teams to start implementing the MP with fewer services, gradually expanding
 - identify staff who can serve as mentors for staff who lack skills or newly employed
 - regulate internal deployment of staff based on skills
 - partition available rooms or use screens to provide privacy for clients receiving FP, cervical cancer screening, and HT
 - identify and implement various forms of staff motivation including appraisals, support supervision, and certification
 - strengthen reporting system to ensure timely availability of commodities
3. HFMT needs to work closely with partners in their regions to leverage resources.

Conclusion

In conclusion, this report gives a detailed step-by-step process of implementing the minimum package. The two pilot facilities were able to implement the package with very minimal external financial support. For the successful implementation of the minimum package, the planning process needs to be very participatory in order to get appropriate buy-in and successful collaboration. Sensitization meetings proved helpful in this collaboration whereby administrators and staff collectively identified both facility-specific challenges and solutions. Regular support supervision by the integration committee was also valuable in successful implementation. The supervision team was able to ensure staff members were on track with implementation. The main implementation activities included: formation of a multidisciplinary team and identifying a champion to spearhead integration activities, reorganizing services to create more space, partitioning existing rooms to provide privacy, strengthening OJT where knowledge gaps were identified, and availing the necessary protocols and guidelines in the various service units.

The cost of implementing the package was Ksh 626,649 (USD 7,359) in the Sub-County Hospital and Ksh 293,461 (USD 3,446) in the Health Centre. As with most interventions introducing a new skill or service, there are high up-front costs associated with training a cadre of service providers to deliver the service at an acceptable level of quality. The training and subsequent supervision of the providers account for the majority of additional financial costs. While there was a reliance on OJT, the periodic continuing medical education sessions and supervisor visits will eventually add up to require additional resource mobilization.

The advantage of the minimum package approach is that with the available guidelines and supporting documents, once this process of site assessment, sensitization, planning, training and supervision is completed, the facility should be well-positioned to keep these services integrated going forward. Therefore it is a one-time investment of minimal additional resources that will be required per facility to bring this goal of integrated services to a success.

It is our hope that this report will inform implementation of the minimum package in all the other facilities

Endnotes:

¹ Republic of Kenya, Office of the Prime Minister, Ministry of State for Public Service Circular MSPS 18/2A/(89) (2009) "Accommodation and Subsistence Allowance for Officers Travelling on Duty Within and Outside Kenya".

² Republic of Kenya, Office of the Prime Minister, Ministry of State for Public Service Circular MSPS 2/6/4A Vol. X/(2) (2012). "Re-alignment of the Salary Structure for Civil Servants".

³ The Kenya National Health Sector Strategic and Investment Plan 2012-2017

⁴ The Essential Package for Health

⁵ National Reproductive Health and HIV and AIDS Integration Strategy

APPENDIX

A-validation checklist

MINISTRY OF PUBLIC HEALTH & SANITATION AND MINISTRY OF MEDICAL SERVICES

Telephone: Nairobi 725105/6/7/8
All correspondence should be addressed
to the Head.
When replying please quote



DIVISION OF PRIMARY HEALTH CARE
MBAGATHI ROAD (OLD)
P.O. Box 43319
NAIROBI

RH/HIV INTEGRATED SERVICES CHECKLIST

Objectives of the site visits on RH/HIV Integration Services-Validation checklist

5. Assess the current status of RH HIV services at the facility or community level
6. Document steps or innovative approaches or strategies that the facility has used to integrate
7. Find out the challenges encountered during the integration process
8. Validate factors that have made this model/type effective or acceptable in the facility

(Please note that this form will be filled for every type of integration implemented)

Date of visit:.....Province.....District.....

Facility Name:.....Facility Level.....

Contact Person:.....

Names of persons interviewed.....
.....

1. What is your definition of integration of services? OR How do you define integration of services in this facility?

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2. What is it that makes a facility start integration of service?

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3. What type/s of RH/HIV integrated services is your facility implementing?

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3. What factors have assisted you to implement these types of integration of services?
Please list all

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4. What challenges/constraints did you have in implementing the specific type/s of integration?

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5. How did you deal with these challenges?

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6. If you are to advise another facility wishing to integrate, what would you regard as the basic requirements for implementation of integration of services?

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Commodity

- 7. i) Where do you obtain your commodities from?
 - Contraceptive methods?.....
 - Test kits?.....
 - ARVs?.....
 - Others?.....

8) Please explain your distribution patterns for the various commodities i.e. from one service area to the other. How do you track movement from one area to another?

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.....
.....

9) Have you had any contraceptive stock outs in the past three months?

- 0 No
- 1 Yes

iii) Which contraceptive methods were out of stock?

.....
.....
.....

10) Have you had any stock out of test kits in the last three months?

- 0 No
- 1 Yes

v) Which HTC commodities were out of stock?

.....
.....
.....

- VCT register
- Integrated FP register
- Other
(Specify).....

Data capture tools. *Please list all that are available*

.....

14. Which IEC materials do you have to support your integration activities?

- a)
- b)
- c)
- d)
- e)
- f)
- g)
- h)

15. i) How has the facility created awareness for RH/HIV integrated services within the facility?

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16). How have you involved the community within your catchment area in your integration activities?

.....

17). How have you involved other facilities within your catchment area in your integration activities?

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18. What measures have you put in place to sustain the provision of integrated activities?

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19. In your view, how does the facility staff view the integration activities/efforts?

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How have they demonstrated ownership of the process?

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20. What approaches have you used to build the capacity of service providers to offer integrated services?

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21. In your view, how can this type of integration be replicated

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22. Do you have any suggestions for improvement?

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23. What broad recommendations do you have for integration efforts?

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B- Evaluation checklist

**MINISTRY OF HEALTH
AFYA HOUSE, CATHEDRAL ROAD, P.O. BOX 30016,
NAIROBI. TEL: 2717077**

RH/HIV INTEGRATED SERVICES CHECKLIST

Date of visit: County:

Facility Name:

Contact Person:

Objectives of the site visits on RH/HIV Integration Services

9. To assess the extent to which the minimum package has been operationalized at the facility.
 10. To document steps or innovative approaches or strategies that the facility has used to operationalize MP
 11. To find out the challenges encountered during the operationalization of the MP
 12. To find out enabling factors that have made this operationalization possible in the facility
-
1. What services are provided at this facility?
 2. What are the service hours for this facility?
 3. What RH/HIV integrated services are provided at this facility?
 - (i) List them
 - (ii) Specify the types of integration implemented
For each type –indicate the model of integration
 4. How has the Minimum Package been operationalized in the:
 - (i) Facility
 - (ii) Community
-
13. What challenges/constraints have you faced in operationalizing the MP?

14. How did you deal with these challenges/constraints?
- 14.2 Received any support from the county government in dealing with the challenges?
 - 14.3 Any support from the Facility leadership? if Yes, which one/s
 - 14.4 Support from other partners?
 - 14.5 Community??Support/involvement?
15. Have you had any training/updates for staff to support operationalization of the MP?
16. What cadre of staff received trainings/updates on RH/HIV integration services? What were the updates on?
17. How many of each cadre of staff were involved?
18. Has there been any change in performance/attitude of the staff since the trainings/updates
19. How have you involved other facilities within your catchment area in your integration activities since the operationalization of the MP?
20. How have you involved the community within your catchment area in your integration activities since you started implementing the MP?
21. In your view, how does the facility staff view/perceive the operationalization of the MP?
22. What recommendations do you have on how the Minimum Package could be most optimally operationalized? What lessons have you learnt that you can share with facilities planning to operationalize the MP?

COMMODITIES AND SUPPLIES

15. Have you had any contraceptive stock outs in the past three months?

0 No 1 Yes

(i) Which contraceptive methods were out of stock?

15. Have you had any stock out of test kits in the last three months?

0 No 1 Yes

i) Which HTC commodities were out of stock?

ii). How do you deal with your clients when you experience stock out of any of the commodities?

REFERRALS

16. Do you refer clients to other facilities/units?

0 No 1 Yes

If yes, please explain how referrals are made to other facilities/units. Indicate for which specific services referrals are made.

Referral mechanism used

17. Do you have a way of establishing whether clients go to referral points?

0 No 1 Yes

If yes,

(i) How do you find out whether they have visited the referral points?

(ii) If they received the services they were referred for?

(iii) How is documentation for the referred services done?

(iv) How is the client followed up?

18. Do you have any feedback system from where you refer your patients?

DATA

19. Availability of data tools

Yes

No

If yes, please specify:

20. Which IEC materials do you have to support implementation of the MP?

INFRASTRUCTURE/SPACE:

21. How were services reorganized to accommodate private FP/HIV counselling or method provision?

22. Was identifying this type of space a challenge and if so how was it handled?

23. What feedback have you received from service providers/community about the changes?

MALE INVOLVEMENT:

24. Have any specific measures been taken to improve male engagement with regard to integrated services?

Has there been any difference in uptake by male clients - male numbers?

Which service units have reported increased uptake of services by male clients?

C-List of facilities validated

1. Kakamega Provincial Hospital
2. Nakuru Provincial Hospital
3. Garissa Provincial Hospital
4. Embu provincial Hospital
5. Migori District Hospital
6. Maragua District Hospital
7. Kitui Provincial Hospital
8. Kauwi District Hospital
9. Family Health Options of Kenya (FHOK)
10. Kakeani Dispensary and a community unit attached to the dispensary

