

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

Lessons from Kenya for the Global Health Initiative

Author

Janet Fleischman

February 2011



A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

Lessons from Kenya for the Global Health Initiative

Author

Janet Fleischman

February 2011

About CSIS

In an era of ever-changing global opportunities and challenges, the Center for Strategic and International Studies (CSIS) provides strategic insights and practical policy solutions to decisionmakers. CSIS conducts research and analysis and develops policy initiatives that look into the future and anticipate change.

Founded by David M. Abshire and Admiral Arleigh Burke at the height of the Cold War, CSIS was dedicated to the simple but urgent goal of finding ways for America to survive as a nation and prosper as a people. Since 1962, CSIS has grown to become one of the world's preeminent public policy institutions.

Today, CSIS is a bipartisan, nonprofit organization headquartered in Washington, DC. More than 220 full-time staff and a large network of affiliated scholars focus their expertise on defense and security; on the world's regions and the unique challenges inherent to them; and on the issues that know no boundary in an increasingly connected world.

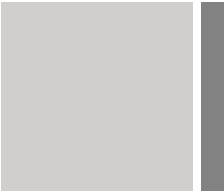
Former U.S. senator Sam Nunn became chairman of the CSIS Board of Trustees in 1999, and John J. Hamre has led CSIS as its president and chief executive officer since 2000.

CSIS does not take specific policy positions; accordingly, all views expressed herein should be understood to be solely those of the author(s).

© 2011 by the Center for Strategic and International Studies. All rights reserved.

Cover image: Alupe District Hospital, Western province, Kenya; photo by Janet Fleischman

Center for Strategic and International Studies
1800 K Street, NW, Washington, DC 20006
Tel: (202) 887-0200
Fax: (202) 775-3199
Web: www.csis.org



LESSONS FROM KENYA FOR THE GLOBAL HEALTH INITIATIVE

*Janet Fleischman*¹

Introduction

The Obama administration's Global Health Initiative (GHI), announced in May 2009 as a six-year, \$63-billion program, has put a strong emphasis on integration of health services, building largely on the work of PEPFAR (the President's Emergency Plan for AIDS Relief). As implementation of GHI is moving ahead and country strategies are being developed, this is an important moment to bring forward lessons learned from the experience of integration in the U.S. government's health and development programs. A key example involves U.S. health programs in Kenya over the past five years, notably the APHIA program (the AIDS, Population and Health Integrated Assistance program), which developed an integrated program based on the PEPFAR platform. This paper finds that the APHIA programs in Kenya hold some important lessons that should help inform GHI implementation. Since Kenya has been designated one of eight GHI-Plus countries,² the emphasis on program integration in those U.S. government programs is especially relevant.

This paper, which is based on interviews conducted in Kenya in November 2010, as well as with policymakers and implementing partners in Washington, D.C., shows that the APHIA experience illustrates that integration across health sectors is feasible and effective, and that more focused evaluation of the impact of integrated programs would help Kenya and other GHI-Plus country teams and national governments as they develop their strategies. The maternal and child health (MCH) model in Kenya's Western province is emerging as an innovative example of the benefits of providing women with a comprehensive set of MCH, family planning, reproductive health, and HIV/AIDS services in an integrated setting. Moving forward, the paper identifies key areas to watch as the GHI program in Kenya is implemented, including: how the GHI principle on

¹ Janet Fleischman is a senior associate with the CSIS Global Health Policy Center. This report was supported by a grant from the David and Lucille Packard Foundation.

² The Obama administration selected eight countries to serve as learning labs for the GHI strategy: Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal, and Rwanda. These countries are supposed to receive additional technical and management resources to implement the GHI approach quickly. See USAID, "Fact Sheet: U.S. Government's Global Health Initiative," <http://www.usaid.gov/ghi/factsheet.html>.

women, girls, and gender equality will be implemented; how the social determinants of health will be addressed, and how linkages will be made beyond the health sector; how integration of services will be prioritized and measured; and how GHI's emphasis on greater U.S. government coordination will be realized.

Background on APHIA and GHI

The APHIA II program, a five-year program of PEPFAR and the U.S. Agency for International Development (USAID) that ended in late 2010, and its successor the *APHIAplus* program, have each emphasized program integration, using innovative ways to bring together the large amount of HIV/AIDS funding with a small amount of family planning funding. In fact, APHIA II was designed to contribute to U.S. and Kenyan goals in HIV/AIDS and TB, and at the same time contribute to reproductive health, family planning, and maternal and child health. This cross-program integration of separate funding streams has been a challenge and an opportunity for APHIA, just as it is likely to be for GHI. In this respect, APHIA is viewed as a model by the officials who are seeking through GHI to change the way the U.S. government conducts its work in global development, away from stove-piped programs and toward integration.³

As a GHI-Plus country, the GHI program in Kenya is expected to build on the APHIA experience with integration, although given the current budget projections, the GHI-Plus countries may not receive any new resources. The new phase of APHIA has been enriched by the GHI approach and principles, notably the principle on advancing a women, girls, and gender equality approach and the new focus on social determinants of health that affect access to health services. The GHI principles fit well with much of the spirit and substance of U.S. government work in Kenya, although these areas will require new levels of commitment and expertise. The GHI strategy in Kenya aims to accelerate high-impact interventions while simultaneously strengthening health systems, with special focus on HIV/AIDS, malaria, family planning, maternal and child health, and TB.

The GHI strategy in Kenya tracks closely with the new *APHIAplus* program, which began in 2011. The GHI team in Kenya is acutely aware of the political imperatives around GHI and the urgency to be able to show results. Some U.S. officials believe that simply getting U.S. agencies to work together will produce a different result and a different product. As one U.S. official put it: "PEPFAR forced us to work together; GHI can build on that."⁴ What precisely these results will look like, and how they will be assessed, remain live issues.

³ The *APHIAplus* projects, which will run from January 2011 to December 2015, were awarded to the following lead organizations: FHI for Rift Valley province; PATH for Western and Nyanza provinces; Pathfinder for Nairobi and Coast provinces; JHPIEGO will lead the health services delivery project.

⁴ Interview in Nairobi, November 1, 2010.

GHI Kenya Focus Areas

The GHI strategy for Kenya has identified two key areas of focus: reducing maternal, neonatal, and child mortality; and reducing morbidity and mortality from neglected tropical diseases (NTDs). Both of these areas will require program integration and health systems strengthening, as well as working with communities to create awareness and demand for services. The GHI Kenya team believes that by more rigorously compiling evidence on the positive health outcomes and cost efficiencies of integrated programming in these areas, these GHI focus areas will be beneficial to the government of Kenya, as well as to the broader global public health community.

GHI provides the opportunity to deliberately and strategically coordinate integrated programming using all existing funding streams, despite the limited maternal newborn and child health (MNCH) resources from the U.S. government in Kenya. In order to accomplish the GHI Kenya goal of reducing maternal mortality, the strategy includes key focus areas:

- *Family planning*—including increasing contraceptive prevalence, increasing demand for services and availability of modern contraceptives, and expanding coverage of integrated family planning (FP), preventing mother-to-child transmission (PMTCT), MNCH, and other HIV services.
- *Pregnancy and childbirth*—improve quality of and access to antenatal care (ANC), improve skills of health providers in PMTCT, HIV, emergency obstetric care (EOC), and essential newborn care; support for breastfeeding and other services for HIV-positive mothers, including identification and follow up with HIV-exposed infants.
- *Infancy, child, and maternal care*—promote improved infant nutrition, including safe breastfeeding for HIV-infected mothers; promote immunization and treatment of malaria; and strengthen household water and sanitation practices to reduce diarrheal diseases.

GHI Proposed Learning Agenda

The GHI-Plus Learning agenda is GHI's research and evaluation strategy to accelerate learning in all GHI countries. The GHI-Plus countries are supposed to receive additional technical and management resources, as well as a small amount of additional financial resources, to accelerate implementation of the GHI. Each GHI-Plus country will develop a learning agenda to support the overall program aims and strengthen country capacity. This learning agenda is geared to changing the way the U.S. government goes about business in global health.

The GHI Kenya strategy has put forward a learning agenda (2011–2014) around reducing MNCH, which will explore the effectiveness and feasibility of integrated services to improve health outcomes for women and children. The project will focus on implementing and evaluating a comprehensive package of services in five geographic areas in Kenya and will focus on integration across health sectors, as opposed to the vertical, disease-specific approach. The GHI

learning agenda will require some additional resources, which were expected to come out of GHI contingency funding but may not now be approved by the new U.S. Congress.

Prompted by GHI's proposed learning agenda, the U.S. government organized a meeting at the end of November 2010 to discuss MCH and integration with the government of Kenya and other donors. This kind of meeting between donors and the government of Kenya on MCH was apparently unprecedented, and the results are expected to inform the strategy for the proposed GHI learning agenda.

One area of discussion for the learning agenda involves an expansion of the Centers for Disease Control (CDC) demographic surveillance system (DSS). As part of the effort to compile evidence and measure the impact of integration on maternal mortality, CDC is planning to expand its surveillance system. For more than 10 years, and in some cases even longer, CDC has been conducting population-based surveys, amounting to a mini-vital registration. In Western province alone, CDC surveys 220,000 people every four months, gathering data on a range of areas including births, deaths, numbers in school, pregnancies, bed nets, HIV testing, access to care, and rotavirus. In the past, CDC did not focus per se on reproductive health, MCH, or orphans and vulnerable children (OVCs), even though many of its programs related to those areas, especially vaccines, malaria services, immunizations, children under five, etc. CDC is now proposing to use the DSS to capture a broader range of health services and to cost it out. The goal is to determine the value of integration and to focus on a few areas where integration might help to improve health outcomes, and then to scale up those interventions. An example of this is to look at changes in maternal mortality from an integrated HIV/AIDS platform.

Using the PEPFAR Platform: Lessons from APHIA for Integration of Services for Women and Children

“HIV is seen as a woman’s disease in our community.” —Member of breast-feeding support group in Teso South, Western Province, Kenya, November 3, 2010

Throughout the history of the APHIA programs in Kenya, the U.S. health team has worked to extend the boundaries of how PEPFAR resources can be leveraged to better address the broader health needs of the population. While many U.S. officials and implementing partners would argue that greater flexibility is still needed, the APHIA programs have shown that allowing in-country programs greater leeway and discretion to pursue integrated programs has been an important element in APHIA's success.

The U.S. government's overall health budget for Kenya is about \$650 million. Although USAID's funding levels for FP and MCH have gone up under the Obama administration, these areas still account for a tiny proportion of the overall U.S. budget in Kenya, with FP at about \$20 million and MCH about \$8.25 million, underscoring, as one U.S. embassy official put it, “the irrational

nature of budget composition.”⁵ Given the high level of unmet need for family planning in Kenya, especially among HIV-infected women, this is an area of significant concern.⁶

These funding imbalances demonstrate why integration of these funding accounts with the PEPFAR program can be so beneficial. Specifically, PEPFAR is positioned to renovate clinics, pay electricity bills, buy vehicles, subsidize some of the operational costs at the health facility level, and invest in health management information systems, human resources for health, procurement systems, and training of health care providers. Based on this platform, the FP/MCH funds can be used for direct services. These PEPFAR investments have made a dramatic, though indirect, impact on broader health outcomes.

Integration of services also makes sense from the patient’s point of view; providing integrated MCH, PMTCT, voluntary counseling and testing (VCT), cervical cancer screening reduces loss to follow up, reduces the time a woman has to spend waiting in queues for different health services, reduces the stigma often associated with HIV services, and improves access to services. These gains are already being recorded in APHIA Western, which is implementing an MCH model of care (see below) and seeing increases in number of patients being tested for HIV and receiving PMTCT services—clear HIV outcomes.

Dr. Ambrose Misore, the director of APHIA Western, noted that the new phase of APHIA (APHIA*plus*) and the new GHI strategy share many common features, focusing on integration. “Gender, education, food security, water and sanitation—it’s a salad of everything,” he explained.⁷ In particular, Dr. Misore noted the importance of linking with networks of community and civil society groups in the areas around the health facilities and establishing effective referral systems. However, referral systems have been hampered by an overall lack of coordination, especially at the provincial and district levels.

The realities in many parts of Kenya support the need for an integrated program. An HIV-positive woman should have access to information and services about family planning and reproductive health, not only to reduce unintended pregnancies and promote spacing of children,

⁵ Interview in Nairobi, November 1, 2010.

⁶ According to the Kenya AIDS Indicator Survey (KAIS), produced by the Kenyan government with technical and financial support from the U.S. government, women are more likely to be HIV infected (8.4 percent) than men (5.4 percent), and young women are four times more likely to be infected than boys their age. Among women of reproductive age (15–49), the report found that 70.5 percent wanted to delay pregnancy for at least two years or did not want a child, but less than half reported using modern contraception. The situation is particularly critical among HIV-infected women: 66.8 percent reported wanting to delay pregnancy for at least two years, yet just over 40 percent of these women used modern contraception. On top of all this, the percentage of Kenyans who know their HIV status remains low throughout the country. See Ministry of Health, *Kenya AIDS Indicator Survey: KAIS 2007* (Nairobi: Government of Kenya, September 2009), http://www.aidskenya.org/public_site/webroot/cache/article/file/Official_KAIS_Report_20091.pdf.

⁷ Interview in Eldoret, November 1, 2010.

but to include screening for cervical cancer, for which HIV-positive women are at high risk, as well as screening for TB, which is a major killer of HIV-positive women. Or an HIV-positive woman may be married to HIV-negative man, who should get information about male circumcision, and they might have a child who has malaria. The idea is to increase the whole family's access to health services.

GHI will try to reverse the vertical nature of all these health programs and use resources more creatively to lead to greater synergies. The idea is that GHI will bring all the U.S. agencies to the table to make plans together. Flexibility in funding will be critical in order to make these programs work, for example, flexibility in using PMTCT funds.

USAID Results Framework for APHIA*plus*

Result 1—strengthen leadership, management, and governance

Result 2—strengthen health systems

Result 3—increase quality health services, products, information

Result 4—address social determinants

MCH Model of Care

APHIA II Western (now APHIA*plus* Western and Nyanza)—a consortium of U.S. nongovernmental partners led by PATH and including the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and World Vision—is using the maternal child health clinic as the entry point for women and their babies to receive a range of health services, including: antenatal and postnatal care; prevention of mother-to-child transmission programs; HIV counseling, testing, and treatment; early infant diagnosis; childhood vaccinations; TB screening; malaria services; cervical cancer screening; and family planning methods.

The APHIA program leverages PEPFAR resources to invest in and develop health systems necessary for HIV care, including standard HIV services and PMTCT. But in order to provide effective PMTCT services, the MCH systems have to be strengthened, so some PEPFAR resources have been used to renovate MCH clinics and improve systems to test and treat pregnant women and their babies. Creating this one-stop shop, which is a more efficient use of a woman's time and enables her to get all her services on one visit, has led to an increase in women seeking services. In Western province, the APHIA program reported a 30 to 40 percent increased uptake in services

in six months,⁸ as well as an 80 to 100 percent increase in the number of HIV-positive mothers enrolled into care, a 15 to 30 percent increase in the number of HIV-positive mothers who accessed a baseline CD4 test, and an increase in access to family planning services and male involvement.⁹

By providing these services within the MCH clinic, as opposed to the HIV/AIDS clinic, the program seeks to create a more conducive and less stigmatizing environment for women to access appropriate HIV, reproductive health, and child health services for themselves and their babies. While the MCH model still faces many challenges, especially regarding adequate training for health care workers, which is further complicated by staff shortages and high turnover, it is showing important results. In some services, this MCH model has led to a 30 to 40 percent increased uptake in services in the past six months. In addition, the increasing opportunities for women to seek integrated services at lower level health facilities has also meant that women can now go elsewhere for health services, often to sites closer to their homes, or participate in health outreach activities in their communities.

The results at a number of the APHIA-supported clinics are noteworthy. At the Matete Health Center in Western Province, a small rural clinic that used to be a community project, the integration of services and the renovation of the facility have corresponded to an increased uptake of services, particularly involved MCH services. A rising number of women are coming for ANC services, and notably, twice as many women are now coming for the recommended four ANC visits, instead of just one, which had been the usual pattern. The MCH consultation room is now set up to provide HIV counseling and testing (100 to 200 patients per month), HIV treatment until their babies are 18 months old,¹⁰ and family planning information and services. Growing numbers of women are returning to deliver at the facility (20 to 25 per month, as opposed to 8 per month before the integration and renovation) and to bring their children to the child welfare clinics (700 to 800 children per month).¹¹

Unfortunately, the level of male involvement in the PMTCT program continues to be quite low, which also translates into low recruitment in pediatric antiretroviral therapy (ART), since male support is usually critical; the women cannot bring the babies' ART drugs home (syrups) without their partners knowing. The clinics and community-based organizations (CBOs) are working to form male clinics and recruit men to participate in support groups. CBOs are also conducting

⁸ Interview with Dr. Maurice Maina, HIV care & support specialist, Office of Population and Health, USAID, Nairobi, November 1, 2010.

⁹ Presentation by Dr. Ambrose Misore, "Integrated Approaches to Improve Maternal, Newborn and Child Health," at the U.S. Congressional Caucus on Women's Issues, Washington, D.C., September 15, 2010.

¹⁰ After 18 months, the women and their babies are transferred to the Comprehensive Care Center (CCC) in a separate building in the same facility. At this writing, about 461 women and 170 men are in care at the CCC, and 169 women and 86 men are on ART.

¹¹ Interviews with health staff at Matete Health Center, Matete District, Western Province, November 2, 2010.

outreach to men in the communities, through VCT outreach clinics and discussions about male involvement.

According to the women who work as peer counselors at the health center, women prefer to avoid the stigma associated with the Comprehensive Care Center (CCC), the AIDS clinic, by getting their HIV services through the MCH clinic. As one of the peer counselors explained: “How do they tell their husband if they test positive? They are scared that their marriage might break, that they’ll be chased away. The men won’t use condoms, so they get reinfected. Because of stigma, the women are shunned in the community. But here [in the MCH clinic], people from the outside don’t know—the women avoid the stigma of the CCC by coming to MCH. They don’t walk over there. The women like it that way—they are more confident here.”¹²

Kakamega Provincial General Hospital, the main referral hospital for Western Province, is implementing one of the most comprehensive and high volume MCH models. For more than a year, the MCH department has been integrating all services under one roof—ANC, postnatal care, child welfare services, immunizations, FP, HIV counseling and testing, antiretrovirals (ARVs), early infant diagnosis, TB screening, malaria, cervical cancer and STD screening and treatment (cervical cancer cases are referred for treatment in the hospital). APHIA support enabled the hospital to improve staff training and development, especially related to PMTCT, family planning, cervical cancer, and integrated management of childhood illness (IMCI). The nurse in charge of the MCH department, Terry Adeka, noted that the integration of services has been extremely helpful to the women, especially those infected with HIV: “It used to be that the women disappeared from the CCC—they didn’t go. With the HIV-MCH care model, we’ve seen a great improvement in enrollment.”¹³ With the start of the integrated program in 2009, the clinic saw a total of 13,326 women for family planning and 10,664 for ANC, of whom 4,015 were counseled and 3,897 were tested, 219 being found to be HIV positive, and 212 infants.

The MCH model also hosts a PMTCT support group, headed by a vibrant HIV-positive woman. She described the difficulties that women face, some who are pregnant and some who already have babies, and the importance of the support and information that the support group provides. Many women are shocked and worried after they receive their HIV diagnosis, and the support group helps them with information about adherence, breast-feeding, nutrition, safe sex, and family problems. The group also helps trace defaulters—those who fail to return for HIV services. One young woman in the support group, holding a little baby wearing a yellow cap, explained that she didn’t know she could have a healthy baby if she was HIV infected, but through the support group she learned about PMTCT, as well as family planning to protect herself and her

¹² Interview with peer counselors at Matete Health Center, November 2, 2010.

¹³ Interview with Terry Adeka, nurse in charge of MCH, Kakamega Provincial General Hospital, Kakamega, November 2, 2010.

husband, since they are a discordant couple, with the husband being negative. As she put it: “The support group helped me learn how to protect my husband and care for my family.”¹⁴

Many support group members commented on the importance of having all their services at one place. As one support group member put it: “It’s easier to get services in the same place—they understand your history better and follow up on your baby. They guide you well here.” And according to another member: “We like it here—when you come, you get offered all the services, you get ARVs, FP methods, immunizations, well baby services, and health talks.”¹⁵

Still, many challenges remain. In particular, women still face serious challenges in disclosing their HIV status to their partners and families. Nurse Adeka explained: “There is still a big issue of disclosure, especially since men are not getting tested... Unless men come on fully, issues of disclosure will be there. Even with the mother-child health booklet, the women often tear out the HIV page. Some mothers don’t want to bring home drug containers—they ask us to put the drugs in an envelope for them to bring home.”¹⁶

Post-Rape Care (PRC)

During the first 10 months of 2010, the PRC Clinic at the Nakuru Provincial General Hospital in Rift Valley Province averaged over 33 cases per month, with as many as 50 cases in some months. Some of the cases were referred to the police; others were referred from the police. At the clinic, the nurse fills out the PRC form, which includes the date, any disabilities, alleged perpetrator(s), complaints, circumstances, type of assault, whether a condom was used, if the incident was reported to police, physical injuries, if the client attended other health facilities, if she is using any form of contraception, and whether she has changed her clothes since the assault. In one case, a 13-year-old girl was raped by a 24-year-old neighbor. The girl reported it to the police and then went to the PRC, where she was found to have bruises and inflammation. She was given a post-exposure prophylaxis (PEP) starter kit, emergency contraception (EC) and sexually transmitted infection (STI) prophylaxis, and referred for trauma counseling. Although some cases are taken up by the Federation of Women Lawyers (FIDA) or the Rift Valley Law Society, for children, most cases go unreported and no investigation or prosecution results.

At Naivasha District Hospital, like most other district hospitals, the rape cases are often referred to the CCC. In one day in early November 2010, the clinic staff attended to five post-rape cases, involving women and girls ranging from 11 to 33 years old, but two were 15 years old. The area is recording a higher rate of reporting sexual violence, due in part to greater community awareness campaigns.

¹⁴ Interview with PMTCT Support Group members, Kakamega Provincial General Hospital, Kakamega, November 2, 2010.

¹⁵ Interviews with support group, Kakamega Provincial General Hospital, November 2, 2010.

¹⁶ Interview with Terry Adeka, nurse in charge of MCH, Kakamega Provincial General Hospital, Kakamega, November 2, 2010.

Key Areas Moving Forward

1. Women, Girls, and Gender Equality

The GHI focus on using a gender lens to better design programs is appropriate for Kenya, which has a wide range of programs addressing gender, as well as public health, and has an active civil society. The GHI focus validates the work on women and girls and emphasizes to the government of Kenya that the U.S. government is serious about making this a priority area. While the United States has supported programs in the area of women, girls, and gender equality, this focus area will need to be strengthened and highlighted under GHI. A key element of this will be involving men and boys, since ensuring their participation and buy-in will help make sustainable progress. There is significant interest with the GHI country team in expanding multisectoral programs to address gender-based violence (GBV), at the national, provincial, and community levels.

The draft GHI guidance on women, girls, and gender equality was distributed to GHI country teams, and their feedback was solicited. However, the sequencing remains problematic, since the guidance has not yet been finalized and the GHI country strategies are already being submitted, so it is not clear how much of the gender guidance will be reflected in country plans. GHI will need to identify gender targets and indicators and go beyond calling for gender mainstreaming or simply making gender a cross-cutting issue. To accomplish this will require building strong gender expertise in all GHI country teams and providing the resources to implement programs addressing women, girls, and gender equality.

2. Social Determinants of Health

The GHI and APHIA*plus* aim to create linkages within and beyond the health sector, including addressing poverty and economic strengthening, education and literacy, nutrition and agriculture, water and sanitation, social protection issues (OVCs, GBV), and sociocultural norms and structures that affect poor and marginalized populations. These areas are generally referred to as “social determinants of health.” (APHIA*plus*—results 3 and 4—which are new for APHIA.) The government of Kenya itself has emphasized the importance of addressing the social determinants of health in its *Kenya Vision 2030* and in the *Kenya Essential Package for Health to the Community*.

Addressing social determinants will involve working with and mobilizing communities—including building the capacity of community health workers—and designing effective program linkages between the community and the health facility. Yet whether this involves programs for OVCs or GBV, community structures are often weak or nonexistent in many parts of Kenya, particularly outside the major urban areas. Some form of mapping of existing resources in different parts of the country will be an important part of any effort to form a referral network and to provide community health workers (CHWs) with the resources they need. Developing appropriate guidance, tools, and indicators will be especially important in this area, since demonstrating progress may be challenging.

3. Prioritization of Integration and Assessing Importance

It will be important for GHI, in collaboration with the host governments, to demonstrate and articulate how integration of health services can work. This includes measuring the uptake in services, the number of clients accessing integrated services, the quality of services, and relevant changes in the policy environment (guidance, strategies, such as Kenya's RH-HIV integration strategy). Based on this documentation, GHI will be better positioned to prioritize integrated interventions and to address the operational aspects of service integration. Cultivating and collaborating with champions for integration within the national governments will also be crucial.

One obvious area for integration involves implementing FP as one of the four pillars of PMTCT. While this has been recognized globally as a key component of PMTCT, the FP piece remains weak and should be strengthened as part of an integrated model. This will involve dedicated support, training, and resources.

4. Measurement and Evaluation

Measurement and evaluation need to be put in place from the start of the new APHIA and GHI programs, in order to document results and outcomes. This includes having the appropriate tools to capture impact. A recent problem in Kenya involved the omission of the FP-HIV integration tool from the summary tool, by which provinces report to the national level. In general, a number of U.S. officials noted that the GHI principles are fine but hard to measure. What will be needed are proxy or interim measures, such as increases in women delivering at a facility and skilled birth attendants (SBAs), that will lead to improvements in the ultimate measurement of outcomes related to maternal and child health.

There are also concerns relating to reporting requirements, indicators, and planning cycles for GHI and the need for alignment/cross-referencing of U.S. government reporting systems. Currently, there is separate reporting for the country operational plan (PEPFAR), the malaria operational plan (PMI), the operating plan (TB), as well as Feed the Future and other areas, such as broader development assistance.

5. Training and Attitude of Health Care Providers: Human Resource Constraints

The training for and attitudes of health care providers remain critical issues, especially due to the stigma among health care workers toward HIV-positive women and their reproductive health needs. The GHI Kenya program will have to go beyond counting health outcomes and look at the issues of training and provider attitudes as they relate to successful integration. In an integrated program, the training component becomes especially important, since one provider will be expected to provide a range of services including reproductive health and HIV.

In *APHIAplus*, the training component has been taken out of the regional programs and put into a central, national mechanism. This is apparently due to problems of replication and inconsistencies associated with training under APHIA II and burdens placed on health centers

when their providers were absent for training, but it remains unclear how this new training system will function effectively and respond to the training needs of different geographical areas and health facilities.

6. Continued Low Funding Levels for FP and MCH

It is becoming increasingly clear that there will be no significant increases for FP or MCH in the near future. However, the Kenya GHI strategy will seek to implement a more balanced program, reflecting the importance of FP and MCH to broader health and development outcomes. To accomplish this, the GHI Kenya program will have to work creatively within different funding accounts by leveraging and linking and working to increase wraparound programming. For example, can GHI in Kenya use PMTCT resources to meet the needs of HIV-infected mothers, but at the same time allow other women to benefit from the system strengthening and health care provider training? Is HIV/PEPFAR the right platform to reach HIV-negative mothers?

7. Need for U.S. Interagency Coordination

For GHI to function effectively working with a “whole-of-government” approach, a new level of coordination between and among U.S. agencies will be required—PEPFAR, USAID, CDC, Department of Defense. This is especially true between USAID and CDC, which often approach programs differently given their perspectives as a development agency and a medical research agency.

8. How to Reach Youth—Especially Adolescent Girls

Effective programs to reach young people with access to health information and services remain critical challenges. Health care provider attitudes toward sexually active young people continue to present barriers for youth to access health services, as do restrictions on how HIV/AIDS, sex, and sexuality can be discussed with young people in school and how to reach out-of-school youth. These issues are particularly acute for adolescent girls, who are more likely to need health information and services and less likely to be able to access them. Many youth projects, including youth-friendly clinics, are still difficult for adolescent girls to access due to stigma and social restrictions. Married adolescent girls are an especially difficult group to reach, although PATH has launched an innovative program targeting this group in the Mt. Elgon area of Western province.

9. GHI Review Process

The GHI strategy review process will focus on how the selection of two to three key areas in each country align with the principles and accelerate the health outcomes of GHI; it does not aim to duplicate the technical and policy review processes for the operational plans of the health programs now included under GHI. The review will be conducted by an interagency review panel, composed of six to eight people who did not participate in the GHI headquarters visit to that country (except for Ethiopia, where all three GHI deputies participated), to include staff from the

Department of Health and Human Services/CDC, USAID, Department of State/Office of the U.S. Global AIDS Coordinator, and one to two GHI-Plus country field staff.

However, U.S. officials in Kenya noted that there are no Kenyans on the review panel. If GHI wants to send an important signal about country-led processes and a new way of doing business, this is an important area for consideration.

10. Flexibility and Allowing Country-led Processes

While there is broad support for GHI and its principles, there is some frustration in Kenya that this is what the U.S. government was doing anyway and that the new GHI process might lead to increased micromanagement from headquarters. There is a strong desire for increased flexibility to allow for country-level decisionmaking.



1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org