Delivering Health Services to Key and Vulnerable Populations at Cross-Border Sites in the East African Region

Summary of Research Findings from Kenya

INTRODUCTION AND STUDY OBJECTIVES

In 2017, the Cross-Border Health Integrated Partnership Project (CB-HIPP) conducted a study in Kenya to determine the unique health needs of key, vulnerable, and mobile populations along the transport corridors and cross-border towns, and to assess the readiness of health facilities in the sites to meet those needs. The study's specific objectives were:

- To describe the readiness (i.e., attitudes, perceptions, training) of health care workers to provide high-quality and friendly health and HIV and AIDS services to the target population
- To determine access to health services by key, vulnerable, and migrant populations in the selected study areas and their health-seeking behaviors
- To assess barriers and facilitators affecting access to health and HIV and AIDS services among members of the target population

The study was conducted in Busia, Malaba, Taveta, Muhuru Bay, and Sio Port and Port Victoria. It focused on female sex workers (FSWs), vulnerable women and girls (VWG), people living with HIV (PLHIV), fisherfolk (FF), long-distance truck drivers (LDTDs) and their assistants, clearing and forwarding agents (CFAs), and health care workers and stakeholders in the study sites. This brief provides the study approach and a summary of the key findings.

Overview of CB-HIPP

The Cross-Border Health Integrated Partnership Project (CB-HIPP) (September 2014–August 2019) is supported by the U.S. Agency for International Development with funding through the U.S. President's Emergency Plan for AIDS Relief. The project is designed to extend quality integrated health care services in strategic border areas and other transport corridor sites in Eastern, Central, and Southern Africa.

In addition to expanding service delivery for key and vulnerable populations, the project recognizes the need for alternative health-financing models to increase uptake and sustainability of services within an enabling policy environment. In this regard, the region's intergovernmental bodies (i.e., East African Community, Intergovernmental Development Authority, Southern African Development Community) are expected to play a key leadership and partnership role in the project's implementation.

The goal of CB-HIPP is to catalyze and support sustainable and African-led regional health development partnerships to improve health outcomes among mobile populations and vulnerable communities residing along Eastern, Central, and Southern African transport corridors and cross-border sites. This is expected to be achieved through three result areas:

- Increased access to and uptake of integrated health and HIV and AIDS services at strategic cross-border sites and regionally recognized HIV transmission "hot spots" along Eastern, Central, and Southern African transport corridors
- Alternative health-financing models identified, implemented, and tested to strengthen the long-term sustainability of networked health and HIV and AIDS service delivery
- Strengthened leadership and governance by intergovernmental institutions to improve the health of mobile and vulnerable populations

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RESEARCH METHODS

The study had two components: a quantitative cross-sectional survey of key and vulnerable populations across the five cross-border sites, and a qualitative formative assessment. The formative assessment included 68 focus group discussions (FGDs) with the study population, community health volunteers, and peer educators. Seventy-eight key informant interviews and 148 in-depth interviews were also conducted. The quantitative survey involved a sample of 4,567 respondents from the study population and 140 health care staff (Table 1).

Table 1. Summary of study population in the quantitative survey

Population	Number in Sample	Study Sites
Female sex workers	1,099	All sites
People who inject drugs	203	Busia, Malaba, and Taveta
Men who have sex with men	137	Busia and Malaba
Long-distance truck drivers	445	Busia and Taveta
Vulnerable women and girls	1027	Busia, Malaba, and Taveta
Clearing and forwarding agents	288	Busia, Malaba, and Taveta
Fisherfolk	613	Sio Port and Port Victoria, and Muhuru Bay
People living with HIV	755	All sites
Staff in charge of health facility	39	All sites
Health care providers	101	All sites

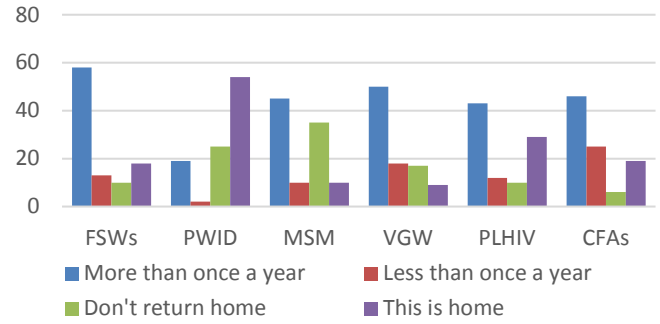
The health facility assessment covered all facilities within 10 km of the transport corridor in each study site. Fifty-two facilities were included in the survey, and all staff in charge of the facilities and health care providers from family planning, HIV, tuberculosis (TB), and outpatient clinics were interviewed. A checklist was also used to take an inventory of the equipment and supplies in all facilities as part of a functional quality assessment.

KEY FINDINGS

The majority of those interviewed in the quantitative survey were Kenyans with at least a primary school education: Nearly all the participants in this study were Kenyan nationals. FSWs and VWG had the lowest levels of formal education, with nearly 40 percent having only completed some primary school or none at all. CFAs and MSM had higher educational attainment than other groups; more than 70 percent of CFAs had completed secondary school or college, and more than half of MSM had at least some secondary school education. Marital status varied widely by group, from marriage rates as low as 1 percent among FSWs to as high as 83 percent among LDTDs.

The study population had a high level of mobility: Considerable portions of all key populations and most priority populations were neither born in nor lived in the study sites, indicating a high degree of mobility (33 percent of FSWs, 51 percent of PWID, 45 percent of MSM, 63 percent of PLHIV, 93 percent of LDTDs, and 64 percent of CFAs). In contrast, a much higher proportion of VWG were born in or lived in the study area (96 percent); however, the VWG appeared to be very mobile as well, as only 9 percent called their current location "home," and 50 stated that they returned "home" more than once a year. Many of the other groups also reported considerable mobility, with more than half of FSWs and about 45 percent of MSM, CFAs, and PLHIV reporting that they travel back to their home districts more than once a year (Figure 1).

Figure 1. Percentage with different frequencies of returning home



Drivers of mobility included income-generating activities such as fishing and sex work. In the formative study, FF reported that they travel to neighboring islands in search of fish and may stay away for up to a month. Women fish mongers/traders also reported spending time on the landing sites away from home, extending into months, in order to secure fish.

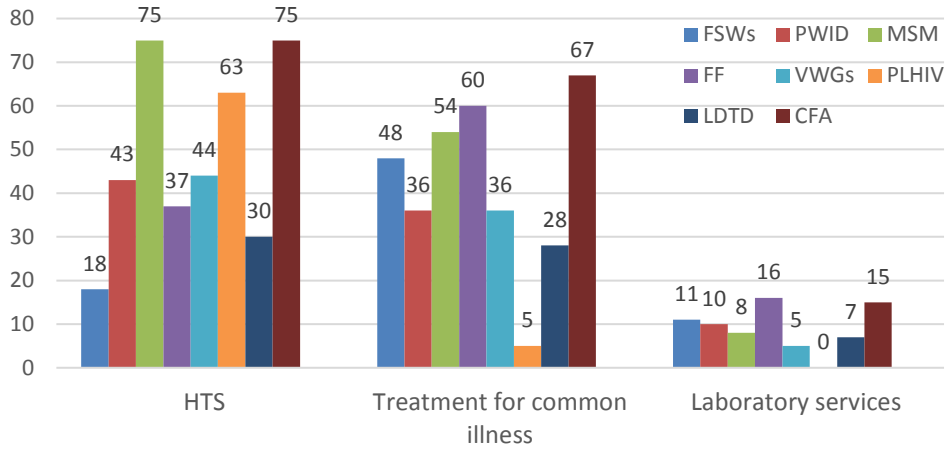
> *"The Marenga beach is a place that pulls populations from all counties in Kenya as well as from Uganda who have come in search of work—fishing."*
>
> – FGD, FF, Port Victoria

FSWs (78 percent) and MSM (25 percent) reported sex work as a main reason for travelling to other districts. In qualitative interviews, MSM reported that they often crossed the border at Malaba to the neighboring country to search for clients, while LDTDs revealed that they had regular sexual partners along their transit routes and were also regular clients of the FSWs found along the transport corridor.

The most common reasons for seeking health care services were treatment of common illnesses and HIV testing services (HTS): More than 90 percent of respondents who had ever sought services in the local health facilities said they received all the services they wanted. The top two reasons they sought care were treatment of common illnesses and HTS, with laboratory services as a distant third (Figure 2). Very few participants sought sexually transmitted infection (STI) or TB services. Demand for family planning and antenatal care was generally low, but it was high among some groups (59 percent among PLHIV and 11 percent among VWG for family planning, and 32 percent among VWG for antenatal care). The majority of respondents were satisfied with the services they had received and thought that the services were "good" or "excellent." Across nearly all population groups, participants were divided on the issue of waiting times at the facility—more than 30 percent felt they were too long, while the others felt they were reasonable. LDTDs were the only group with more favorable experiences, as only 12 percent felt the waits were too long.

Study participants were concerned about a range of health issues: In the formative study, participants were asked about the health issues they were most worried about and for which they felt at risk. FSWs reported that they were concerned about being able to prevent pregnancy and about sexual and gender-based violence. Most said they had experienced sexual and gender-based violence, especially physical and verbal abuse, discrimination, and rape. PLHIV, on the other hand, were more concerned about contracting STIs, TB, pneumonia, and other opportunistic infections, as well as poor nutrition, which affected treatment adherence. FF cited pneumonia, typhoid,

Figure 2. Percentage who sought the most frequently cited services at last visit



malaria, HIV, and STIs as their general health concerns; however, they were most worried about waterborne diseases. CFAs and LDTDs were concerned about HIV infection and other STIs (i.e., gonorrhoea and syphilis), as they often engage in casual sex with women at the border. They described how their work provides them with economic access and opportunity that leads them to act upon temptation. VWG also raised concerns about family planning, contraceptive methods, and method side effects; sought more information about cancer; and expressed challenges related to menstruation.

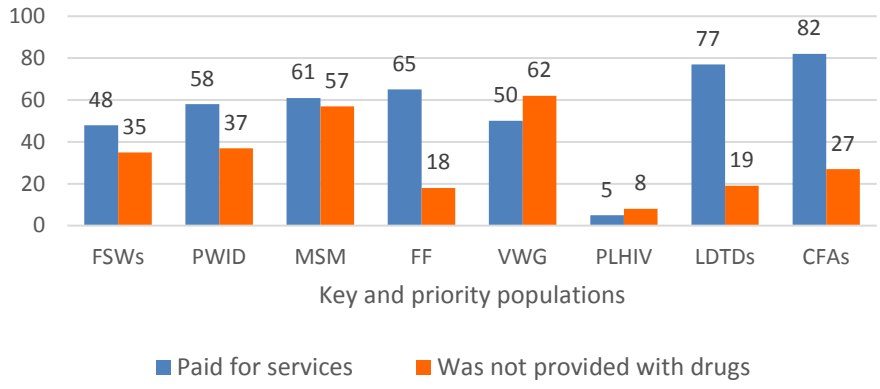
Rates of screening for some noncommunicable diseases were low in some of the study population, but rates of HIV testing were generally high: Across all groups, less than 2 percent of participants had gone for hypertension, diabetes, or cervical cancer (for female participants) screening at their last facility visit. On the other hand, the proportions of respondents who had ever been screened for noncommunicable diseases were relatively high. For instance, 53 percent of FSWs, 61 percent of VWG, and 52 percent of PLHIV had ever been screened for hypertension. There were much lower rates of having ever been tested for diabetes, with the highest being 25 percent among LDTDs. Thirty percent of FSWs and 22 percent of female PWID had ever been screened for cervical cancer, as well as 29 percent of female PLHIV and 14 percent of female FF. Nearly all FSWs and VWG, as well as 90 percent of MSM, 91 percent of FF, and 90 percent of CFAs, had ever been tested for HIV. PWID had the lowest proportion who had ever been tested for HIV, at 56 percent. Among LDTDs, 83 percent had ever taken an HIV test. Among those who reported they were HIV-positive, the majority were already enrolled in a care and treatment regimen and were on treatment for other infections.

Some respondents in all groups travelled for health care services across the border in a neighboring country. Across all the groups, some respondents reported having crossed the border into a neighboring country for health care services. However, the proportions were small, around 17 percent for LDTDs; 10 percent for VWG, CFAs, and FSWs; and even lower for FF (9 percent), PLHIV (8 percent), and MSM and PWID (7 percent). Most sought HTS and treatment of common illnesses, with VWG and LDTDs also seeking provider-initiated testing and counseling and condom services.

More than half of respondents paid for health care services, and a notable proportion were not provided with drugs: The quantitative survey results showed that except for PLHIV, most of the respondents paid for the services received at their last visit to a health facility (Figure 3), and a considerable portion had to pay for drugs separately. Among those who paid for services, the majority paid cash directly out of pocket.

Many providers had been trained to provide services needed: The assessment results showed that most of the staff in study sites had received pre-service training in a range of essential skills required for providing services for key and vulnerable populations. For instance, nearly all providers reported that their basic training included education on

Figure 3. Percentage who paid for services and were not provided with drugs at last visit



prevention of STIs, and 61 percent had been trained on HTS or provider-initiated testing and counseling. A further 84 percent had been trained to demonstrate condom use, but only 43 percent had been trained to provide lubricants. A greater proportion of the providers had received refresher training in these service areas. Service providers were also asked if they thought their facility was supportive of service provision for key and vulnerable populations. Across the five sites, the majority thought their facility was either very (61 percent) or somewhat (26 percent) supportive.

Provider attitudes, location of facilities, and short waiting times were important factors in deciding where to seek health care services: In the qualitative interviews, participants identified a range of factors that influenced their choice of a facility for health care. These factors included availability of the required services, short waiting times, location of the facilities, and the availability of drugs and equipment. Friendly open hours and friendly service providers were also considered.

> *"[…] is a good hospital. They treat us just like ordinary people. I take children who are HIV positive to that facility, and they treat them positively. The children do not feel discriminated against when they go there."*
>
> – FGD, FSW, Busia

On the other hand, the main barriers to seeking care were attitudes of health care providers, long waiting times, lack of drugs and equipment, inconvenient facility locations, and unavailable services. Respondents felt that sometimes they waited for long hours to receive services, that some providers were harsh or neglected them, and that they often had to buy their own drugs due to unavailability.

> *"Sometimes the health care services are poor…for example, at times we are told there are no drugs so you are given drugs for only two weeks. Like now there are no multivitamins….so you get told to go and buy, and you do not have money to buy."*
>
> – FGD, PLHIV, Malaba

The majority of the mix of health care facilities in the study sites were public facilities: The formative research found that each of the study sites had a mix of health facilities managed by different agencies, with more public than private facilities. At the time of the study, 97 percent of the 97 health facilities in Busia and Malaba were public, and 3 percent were private. There was one referral hospital and six sub-county hospitals. In Taveta, the proportion of public to private health facilities was reported to be 70:30. Sio Port and Port Victoria had only two facilities (both public), while the Muhuru Bay site had 230 facilities (2.6 percent private and 96.4 percent public), including 195 dispensaries. Most participants reported that they used Level 2 (dispensary) and Level 3 (health center) facilities.

County-level support appeared to be increasing: County-level policies on the delivery of health services did not exist in the study counties at the time of the study but were reported to be under development. The three counties were relying on national guidance on health and HIV services, and none had specific policies, guidelines, or other tools on key and vulnerable populations. However, the study established that in some of the counties, the government and stakeholders had made efforts to accommodate key populations and provide them with dedicated services. It was also reported that the National AIDS Control Council had deployed staff to the counties to coordinate HIV programs.

CONCLUSIONS

These findings provide important insights into the characteristics of key and vulnerable populations with regards to mobility and health care needs, access, and quality, which are essential in informing improvements to services targeting these groups. The results showed that the study population is highly mobile, with a large portion returning to their home districts more than once a year. The results also showed that the health services in the transport corridor zones, as constituted at the time of the study, included a mix of health facility types staffed by providers with varying degrees of training across service areas.

The study identified factors that are amenable to change to improve access, including waiting times at facilities (which were seen as too long by many of the respondents) and availability of drugs (which many of the facilities did not have). The fact that study participants pay upfront in cash for services suggests that there is room for a health care financing system to alleviate direct payments. In addition, the observed high level of mobility across borders points to the need to harmonize standards and policies on health care and HIV services to ensure that groups at high risk of HIV infection and those on treatment for HIV, TB, and other diseases can access the same quality of services, and can continue treatment as they move across borders.

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