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# RAPID ASSESSMENT ON POLICY AND OPERATIONAL BARRIERS TO THE INTEGRATION OF FP/RH/HIV SERVICES IN KENYA

**February 2009**

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**FEBRUARY 2009**

The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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## EXECUTIVE SUMMARY

As part of an overall effort to improve access to family planning and reproductive health (FP/RH) in selected countries, the USAID | Health Policy Initiative, Task Order 1, conducted a literature review and rapid assessment to identify policy and operational barriers to the integration of FP/RH and HIV in Kenya. The project is continuing to support work to eliminate these barriers by facilitating an ongoing and participatory process to develop an integration strategy and operational policy guidelines. The strategy and guidelines will provide a framework for coordination among the agencies and organizations offering integrated services and will cover topics such as the procurement of commodities and supplies, training, supervision, and financing.

The Health Policy Initiative research team worked closely with the Integration Technical Working Group (ITWG), which includes representatives of key Kenyan government agencies, service providers, and international agencies. In collaboration with policymakers, program implementers, service providers, and other key stakeholders, the research team completed the following tasks:

- Reviewed the research literature on FP/RH/HIV integration
- Conducted a rapid assessment of stakeholder views on FP/RH/HIV integration
- Disseminated research findings to the ITWG, government officials, and key stakeholders
- Met with key stakeholders to build consensus on the need for operational policy guidelines
- Established a task force to draft a strategy and operational policy guidelines

The research team conducted the rapid assessment during April–June 2007 in four provinces (Central, Coast, Nairobi, and Western). These provinces were selected because they have been implementing FP/RH/HIV integrated services. The key informants were chosen based on their involvement in integration activities and their role in formulating and implementing policies that affect the provision of health services. The 99 respondents included 15 national-level policymakers from the public and private sectors; 33 program managers at the national, provincial, and district levels in all four provinces; and 51 service providers in 31 public and private health facilities.

## Main Findings

**Policy issues related to FP/RH/HIV integration.** Policymakers, program managers, and service providers support the concept of integration and concur that integrated services add value to service delivery, are efficient, save time, and empower clients to make informed choices about their RH needs. Respondents noted several positive achievements attributed to service integration:

- Increased uptake of services
- Provision of comprehensive, high-quality services
- Development of standardized training materials that reduce service delivery costs
- Reduction of stigma and discrimination in FP sites offering HIV counseling and testing
- Increased acceptance of condoms as a method to prevent HIV, other sexually transmitted infections, and pregnancy

Policymakers appear to have a clear understanding of FP/RH/HIV service integration. However, they reported two major challenges: (1) the lack of a national policy and guidelines and (2) the many operational barriers to implementation, including the lack of a specific government framework and budget to support the process. All respondents noted a lack of clarity on which division of the Ministry of Health (the National AIDS and STD Control Program or the Division of Reproductive Health) should lead integration activities. While there is an integration committee co-chaired by the two divisions, both have

separate systems for program planning, management, and commodity distribution. The vertical funding for these programs from donors contributes to this issue.

**Operational barriers.** Program managers and service providers listed many barriers to the provision of integrated services:

- Absence of service protocols and operational policy guidelines to support integration
- Inadequate funding/budgetary provisions by the government for FP/RH/HIV integration activities
- Shortage of staff, especially in public health facilities
- Limited efforts to enhance the capacity of service providers on integration issues, such as the failure to incorporate integration into the pre-service training of health personnel
- Limited space for integrated services in clinic facilities
- Different reporting formats and the absence of clear monitoring and evaluation indicators to gauge performance
- Existence of parallel HIV and FP/RH supervision and logistics systems
- Irregular supplies of FP and HIV commodities

Some respondents noted that services specifically designed for males and youth are needed to reach these groups. Policymakers noted that community health workers could serve as important links between health facilities and communities.

## **Recommendations**

Based on the literature and assessment findings and with inputs from the ITWG, the Health Policy Initiative provided the following recommendations related to policy and service delivery guidance, management, logistics, supervision, staffing, and infrastructure:

- Develop a clear national policy; strategy; and operational, service, and supervision guidelines to support integration efforts
- Strengthen the ITWG through a small secretariat, giving it authority and a budget to oversee the integration process
- Strengthen the Kenyan Medical Supplies Agency (KEMSA) to provide efficient logistical support and commodities security
- Increase the number of service providers and sensitize and build the capacity of new and existing staff and senior managers and stakeholders
- Renovate and reorganize existing health service structures to create the space needed to deliver integrated services (e.g., drug storage, counseling rooms, examining rooms with medical couches, etc.)
- Conduct public education campaigns to inform community members of the availability of integrated services

The ITWG will consider these recommendations in formulating a draft National RH/HIV Integration Strategy for Kenya.

## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARH	adolescent reproductive health
ARH&D	Adolescent Reproductive Health and Development (Policy)
ART	antiretroviral therapy
ARV	antiretroviral
CBS	Central Bureau of Statistics
CHW	community health worker
CT	counseling and testing
DASCO	District AIDS and Sexually Transmitted Disease Control Coordinator
DHMT	District Health Management Team
DRH	Division of Reproductive Health
FHI	Family Health International
FHOK	Family Health Options Kenya
FP	family planning
HIV	human immunodeficiency virus
HBC	home-based care
IPPF	International Planned Parenthood Federation
ITWG	Integration Technical Working Group
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
M&E	monitoring and evaluation
MCH	maternal and child health
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NCAPD	National Coordinating Agency for Population and Development
NGO	nongovernmental organization
NHSSP	National Health Sector Strategic Plan
PHMT	Provincial Health Management Team
PMTCT	prevention of mother-to-child transmission
RH	reproductive health
STD	sexually transmitted disease
STI	sexually transmitted infection
TFR	total fertility rate
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

## I. INTRODUCTION

National policies provide the vision and framework for government action and set forth the goals and objectives and the involvement of various groups. By explicitly codifying the roles of FP/RH in HIV programs and HIV in FP/RH programs, national policies can increase the chance that integration will take place. In addition to national policies, a country also needs operational policies, defined as “the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services” (Cross et al., 2001, p. v). These operational policies and guidelines tell district management and service providers how the policy will be implemented. For example, who is responsible, what activities are to be carried out, when they are to be done, how they are to be done, the commodities and supplies that will be needed, and the cost/budget for the activities.

In Kenya, integration of FP/RH and HIV services is addressed in numerous policies (see Appendix A for a summary of policies, strategies, and guidelines that include integration). All these policies and guidelines call for integration, but none articulate how services are to be integrated, delivered, funded, and supervised. Thus, not surprisingly, little effective integration has occurred.

The USAID | Health Policy Initiative, Task Order 1, in support of implementing innovative policy approaches to improve access to FP/RH and HIV in selected countries, conducted a literature review and rapid assessment of FP/RH/HIV integration in Kenya. The objective was to identify and document policy, programmatic, or operational barriers to the integration of FP/RH and HIV/AIDS services and determine the achievements surrounding integration to date. A secondary objective was to determine whether FP services were being provided in prevention of mother-to-child transmission (PMTCT) clinics, comprehensive care centers, and youth centers. As follow-up to the assessment, the project is assisting the Ministry of Health (MOH) with an ongoing and participatory process to develop a strategy and operational policy guidelines for eliminating the identified barriers to integration. The strategy and guidelines will provide the vision, goals, objectives, and tactics needed to implement the relevant policies. They will also provide a framework for coordination among the agencies and organizations offering integrated services and cover topics such as the procurement of commodities and supplies, training, supervision, and financing.

The Health Policy Initiative research team worked closely with the Integration Technical Working Group (ITWG), which includes representatives of key Kenyan government agencies and national and international organizations.

This paper presents a brief summary of the literature review and the results and recommendations from the assessment.

## II. LITERATURE REVIEW OF FP/RH/HIV INTEGRATION

The literature review built on the POLICY Project’s previous work to incorporate FP services into HIV prevention, care, and treatment services and vice versa. That work culminated in an overview paper that summarized major guides and resources (Sanders et al., 2004) and a CD-ROM containing these materials. This literature review served to update and expand the 2004 overview paper and to focus on research findings from Africa in general and Kenya specifically.

Foreit and others (2002) provide a basic definition of integrated services:

Any two services can be considered to be integrated when they are offered at the same facility during the same operating hours, and the provider of one service actively encourages clients to consider using the other service *during that visit*. . . . integrated services may or may not be offered

in the same physical location within the facility and may or may not be offered by the same service provider. Where services are not offered in the same facility, strong referral systems are needed to ensure high-quality services (p. 105).

An integration planning and implementation tool, currently being developed by USAID and other ITWG members, adopts and defines integration as the various reproductive health and HIV services or operational programs that can be joined to maximize collective outcomes. For example, integration includes referrals from one service to another and is based on the need to offer comprehensive services.<sup>1</sup>

Integration can improve healthcare services by providing a broader spectrum of services to people in need; it can help to ensure greater responsiveness to client needs and enhance the efficiency and effectiveness of service delivery by reducing costs and making better use of existing staff and resources. However, note that integrated services would not be beneficial in every situation. Factors to consider include the following:

- **Type of HIV epidemic.** In a generalized epidemic (HIV prevalence is more than 1 percent among pregnant women), USAID guidelines call for integrating FP and HIV services for the general population and most-at-risk populations (USAID, 2003). In a concentrated epidemic (HIV prevalence is greater than 5 percent in at least one sub-population but less than 1 percent among pregnant women), USAID guidelines suggest providing FP services for general populations and integrated FP and HIV services for most-at-risk populations. If HIV prevalence is at a low level (less than 5 percent within any most-at-risk population), investments to integrate HIV activities into FP sites for the general population or most-at-risk populations would not make sense (USAID, 2003). The cost effectiveness of integrating FP into HIV in this situation would depend on the country context.
- **Maturity of the FP program.** There may be opportunities for integrating FP counseling or services into HIV activities; however, the significance of unmet need for contraception and where the need is greatest should be considered. Where the total fertility rate is high, use of modern contraception is low and HIV prevalence is low, basic FP services for the general population remains critical. The greatest impact on the spread of the HIV epidemic would be achieved through interventions targeted toward core transmitters and groups who move between core transmitters and the general population, such as married men who visit CSWs. HIV prevention and mitigation activities with these populations may offer opportunities for integration with FP (USAID, 2003).
- **Needs of clients.** Many clients have multiple health needs, and, thus, integrated services are more convenient for them. Also, some clients may not feel comfortable using some vertical health services. For example, FP services may not attract males and youth—just as youth at risk of sexually transmitted infections (STIs) may avoid going to an STI clinic (Foreit et al., 2002; Shears, 2004).
- **Service delivery requirements.** Clinical facilities may not have the trained medical and counseling staff, medical supplies, and equipment to provide a full range of services (Foreit et al., 2002). Other factors such as clinic space, referral systems, client education materials, and service delivery guidelines are also important (Farrell, 2007).

Program managers need to take stock of local needs and resources before adding services that may be used rarely or may not address urgent health problems.

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<sup>1</sup> The Strategic Consideration for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services is currently under development by the ITWG supported by USAID (2008). It is available in draft form.

## The Rationale for FP/RH and HIV Integration

The literature cites many benefits associated with FP/RH/HIV integration compared with stand-alone, vertical programs (Askew and Berer, 2003; Assimwe et al., 2005; Berer, 2003; Preble et al., 2003; Shears, 2004). However, much of this literature is based on anecdotal evidence or research that cannot be generalized to the larger population. That said, there are strong indications that when properly implemented, integrated services have many advantages:

- More comprehensive and convenient care for clients
- More people reached with services, including hard-to-reach groups such as men, youth, people who wish to access HIV services in privacy, and those unaware of their risk of contracting HIV
- More effective prevention of unintended pregnancies and HIV transmission
- Cost savings by avoiding the duplication of services and making more efficient use of staff time, existing facilities, and other resources
- More informed decisions among clients regarding sexual and reproductive behavior, such as the risks of sexual and mother-to-child transmission, and ways to prevent HIV transmission
- PMTCT of HIV, contributing to reduced infant and child mortality
- Improved maternal health, resulting in fewer deaths and fewer orphans
- Support for reproductive choices

Integration not only provides a wider array of services but also benefits clients by encouraging mutually reinforcing behaviors. For example, increased condom use prevents unintended pregnancies as well as HIV. PMTCT programs stress maternal and child nutrition and thus contribute to overall health benefits. Similarly, family planning helps HIV-positive women achieve their childbearing desires and control the timing of future births.

In regard to PMTCT services, preventing unintended pregnancies among HIV-positive women is especially important in protecting their health. Studies in four sub-Saharan countries have found an increased maternal mortality ratio among HIV-positive women (Duerr et al., 2005). Preventing unintended pregnancies also avoids health problems among children born to HIV-positive mothers. Infants born to HIV-positive women are more likely to be affected by stillbirth, low birthweight, and prematurity, according to a 1998 meta-analysis (Duerr et al., 2005). Two studies in Malawi and Uganda found that children born to HIV-positive mothers still had a 2-to-5 fold risk of mortality when compared with children born to uninfected mothers, regardless of the child's HIV status (Duerr et al., 2005). Another concern is that use of antiretroviral (ARV) drugs during pregnancy could cause fetal abnormalities. The World Health Organization (WHO) recommends that pregnant women avoid using the ARV drug efavirenz due to its potential effects on the fetus (Shelton and Peterson, 2004). For HIV-positive women who do not wish to become pregnant, contraceptive use enables them to use a wider array of ARV drugs. In addition, PMTCT services provide the opportunity to counsel pregnant women that they could become pregnant sooner than they expect if they avoid or curtail breastfeeding to protect their newborn from HIV infection. Provision of FP services helps them to avoid unintended pregnancy and to space births.

Computer simulations done by the POLICY Project and Family Health International (FHI) revealed that the cost of preventing HIV infection to a child born to an HIV-positive mother is lower when FP services are added to PMTCT services, compared with PMTCT services alone (Best, 2004; POLICY Project, 2005). The POLICY Project's 2005 analysis found that family planning is more affordable and cost effective than PMTCT in preventing child infections and deaths. It also has the added benefits of averting orphanhood and maternal deaths. For example:

- The FP cost per child infection averted would be \$830, compared with the PMTCT cost of \$2,000.
- The FP cost per child death averted would be \$310, compared with the PMTCT cost of \$4,200.

- The FP cost per orphan averted would be \$280, and the FP cost per maternal death averted would average \$2,200.

Despite evidence from these studies about the efficacy of integrated services, more evidence is needed urgently to provide definitive guidance to program managers to strengthen integration efforts. Without rigorous designs with control sites or analysis of pre-intervention conditions, limited conclusions can be drawn about the efficacy of integrated services.

### **III. REPRODUCTIVE HEALTH AND HIV IN KENYA**

From the 1970s to the 1990s, Kenya achieved significant progress in increasing contraceptive use and reducing fertility. According to national surveys, contraceptive prevalence rose from 10 percent of married women ages 15–49 in 1984 to 27 percent in 1993 and 32 percent in 1998. The total fertility rate (TFR) declined sharply from a high of 8.1 children per woman in the late 1970s to 6.7 in the late 1980s and to 4.7 during the late 1990s. However, in recent years, the TFR has actually increased to 4.9 children per woman, while contraceptive prevalence has increased only slightly to 39 percent of married women in 2003 (CBS/Kenya et al., 2004).

Furthermore, many women are still not able to achieve their reproductive goals. Approximately one in five women have an unmet need for family planning—defined as reproductive-age women in union who wish to limit or space childbearing and yet are not using any method of contraception. Of these women, three in five wish to delay their next birth, while two in five want to limit childbearing. Unmet need is highest among rural women and those from the lowest economic groups. The proportion of women with an unmet need for family planning has not changed since 1998 (CBS/Kenya et al., 2004).

HIV prevalence peaked at approximately 10 percent in the late 1990s and is currently estimated at 7.4 percent. The 2007 Kenya AIDS Indicator Survey 2007 estimated HIV prevalence at 9.2 percent for women ages 15–49 and 5.8 percent for men in this age group; the total prevalence is 7.4 percent (NASCOPI/Kenya, 2008). This HIV prevalence is higher than what was reflected in the 2003 Kenya Demographic and Health Survey, which estimated overall prevalence at 6.7 percent. Females ages 15–24 are four times more likely to be HIV-positive than their male counterparts (6.1 percent compared with 1.5 percent). Approximately 50 percent of HIV-positive women have an unmet need for family planning.

Faced with the dual challenges of unmet need for family planning and the HIV pandemic, the MOH has called for the integration of FP/RH and HIV services. This process began with the integration of PMTCT clinics into maternal and child health clinics. Currently, as pilot activities, PMTCT services are being integrated into other available RH services. According to the Division of Reproductive Health (DRH) and the National AIDS and STI Control Program (NASCOPI), the rationale for integrating RH and HIV services is a high burden of disease, limited resources, targeting of the same population, and activities being implemented by the same personnel. The MOH's National Health Sector Strategic Plan (NHSSP) II supports service integration to provide effective and accessible services to as many people as possible.

#### **Access to HIV/AIDS Services in Kenya**

According to the 2004 HIV/AIDS Kenya Service Provision Assessment Survey, only 37 percent of all health facilities—public or private—have an HIV testing system. Fewer than 30 percent of all facilities have advanced care and support services, including antiretroviral treatment (ART), home-based care, PMTCT, and post-exposure prophylaxis for staff. Antenatal care and delivery services are available in 79 and 38 percent of all facilities, respectively. PMTCT services are available in 24 percent of all facilities.

Youth-friendly services with voluntary counseling and testing (VCT) or PMTCT are available in only 12 percent of those facilities that have an HIV testing system (NCAPD/MOH, 2005).

Most HIV/AIDS services are offered in hospitals. Care and support services are most commonly available, with more than 90 percent of hospitals and maternities and 80 percent of health centers having such services. PMTCT services are provided in three-quarters (74%) of the hospitals, compared with roughly one-third of the health centers (36%) and the maternities (35%). All stand-alone VCT facilities offer HIV testing, but only half (51%) offer any care and support services (NCAPD/MOH, 2005).

HIV testing is most widely available in Nairobi and least available in the North Eastern and Nyanza provinces. Similarly, care and support services are most available in the Coast, Rift Valley, and Nairobi provinces and in nongovernmental organizations (NGOs) and private for-profit facilities. [These data are based on a national sample survey of 440 facilities—of which 56 percent were managed by the government, 25 percent by faith-based organizations, 14 percent by private for-profit providers, and 5 percent by NGOs (NCAPD/MOH, 2005).]

#### **IV. RAPID ASSESSMENT OF BARRIERS TO INTEGRATION**

The objective of the assessment was to identify and document policy, programmatic, or operational barriers to the integration of FP/RH and HIV services and determine the achievements of integration to date. A secondary objective was to find out whether FP services are being provided in PMTCT clinics, comprehensive care centers, and youth centers.

##### **Assessment Planning**

As a first step in information gathering, Health Policy Initiative staff conducted an extensive literature review to understand the issues related to the integration of FP/RH and HIV services globally, regionally, and within Kenya (see Appendix B for Kenya-related research on integration of services). They also reviewed various policy documents to determine the extent to which they support FP/RH/HIV service integration. Project staff then interviewed key NASCOP and DRH stakeholders and key implementing partners.

Health Policy Initiative staff from the Washington, D.C., and Kenya offices used the information gained to design the rapid assessment instruments and determine who would be interviewed. Following additional meetings with the DRH and NASCOP, heads of the two divisions signed an official letter to authorize the assessment, including the visits to health facilities and interviews with the service providers.

##### **Data Collection and Sampling Procedures**

In consultation with the DRH and NASCOP, the Health Policy Initiative research team chose four provinces—the Central, Coast, Nairobi, and Western provinces—for the rapid assessment. Nairobi Province was selected because the national policymakers are based there. The Coast and Western provinces host operations research sites for the integration of FP services into VCT sites, while Central Province hosts pilot activities—of both the testing and referral models—for the integration of counseling and testing (CT) into FP services. The testing model, implemented in Nyeri District, entails having clients tested for HIV in the same room where they receive their FP services. The referral model, implemented in Thika District, involves counseling clients on the need to know their status and, if they desire to know, referring them to testing facilities.

The research team used purposive sampling to select respondents from the three categories of interviewees: (1) national policymakers from the public and private sectors; (2) program managers at the national, provincial, and district levels in all four provinces; and (3) service providers at the facility level in all four provinces. The team interviewed 15 policymakers, 33 program managers, and 51 service providers (99 stakeholders in total).

The policymakers were selected based on their power to influence or determine policies and practices at an international and national level and their involvement in integration activities. The 15 policymakers interviewed were leaders of RH and HIV/AIDS organizations (public and private), including high-level MOH staff representing key divisions dealing with RH and HIV/AIDS and the supplies agency; country representatives of international NGOs working on different aspects of RH and HIV/AIDS; senior staff in donor organizations interested in family planning and HIV/AIDS; and senior representatives from a consortium of faith-based organizations, including the NGO commodity supplies agency, MEDS. Also included were directors of central organizations that directly influence policymaking—such as the National Coordinating Agency for Population and Development and the National AIDS Control Council (NACC). Health Policy Initiative staff conducted the interviews with policymakers.

The selection criterion for program managers required that they be responsible for managing multiple, ongoing interdependent projects by coordinating and prioritizing resources across them. The 33 program managers interviewed included the provincial RH coordinators, provincial AIDS and STD control coordinators, district RH coordinators, district AIDS and STD control coordinators (DASCOS), district medical officers of health, NASCOP and DRH program managers, and program coordinators in NGOs that have RH or HIV concerns as part of their mandate. Program managers were also selected based on their involvement in integration activities, as well as their role in supervising these activities in the public sector.

At the service-provision level, four types of health facilities were considered in sampling: provincial hospitals, district hospitals, health centers, and dispensaries. The facilities visited included both public and private health facilities (see Appendix C). Given the interest in integration at the different service points in health facilities, the research team interviewed both “in-charge” (manager) and “actual” (those who were directly serving the clients) service providers in order to understand the different viewpoints of an administrator and the client contact person. The research team interviewed 51 service providers in 31 health facilities.

Data collection occurred from April–June 2007. Three in-depth interview guides were prepared for the three interview groups. The questions revolved around three main themes:

1. Policy issues—related to political commitment, the extent to which national policies support integration, service delivery protocols and guidelines, level of government funding for integration, and awareness of relevant policies and guidelines.
2. Operational issues—related to the management and administration of integration, planning, staffing, and supervision; and supplies and financing for test kits and FP commodities.
3. Service provision—related to knowledge of the cooperating organizations, achievements, and integration challenges.

## **Data Analysis**

The research team analyzed the data gathered using Nu\*Dist package Version 6, a software tool for analyzing qualitative data. Presentation of the preliminary findings to the ITWG led to further recommendations also highlighted in this report (see Appendix D for a detailed description of the ITWG).

## V. STUDY FINDINGS AND DISCUSSION

### Policy Issues and Barriers to FP/RH/HIV Integration

The interview questions on policy issues and barriers to integration focused on political commitment, national policies and guidelines that support service integration, and the level of government funding for integration activities. Overall, there was significant confusion about the policy environment around integration. Program managers, in particular, lacked information about the policy environment.

**Political goodwill and awareness.** Most of the policymakers (12 out of 15) interviewed generally understand the concept of FP/RH/HIV integration and believe it is beneficial for the health sector in Kenya. They point out that integration adds value to service delivery, increases efficiency, saves time, and helps the health delivery system tap into missed opportunities.

Similarly, most of the program managers (28 out of 33) and service providers (46 out of 51) interviewed also understand the concept of integration and think it has a place in the Kenyan health system. For example, in Nyeri District, where the model (provision of counseling and testing and FP services in the same room) is being pilot-tested, program managers and service providers are passionate about offering integrated services. They stated that integration is cost-effective, saves time for both the client and service provider, and minimizes the duplication of efforts by service providers. The managers think that integrated services help to address the problems experienced in their facilities, including staff shortages, inefficient time management, and heavy workloads.

*It [integration] is important because for one, we have a shortage of resources and it will be [better] quality for a client. Because when a client moves from one place to another, it is a disturbance and a waste of time. It is a waste of their resources. It is better for a client to go back home and do other things. At the moment, we also have a shortage of staff. So instead of a client being seen by two service providers, he/she can be seen by one and finish all the services that the client needs.*

~ Program manager

*I have been involved in [integrating] counseling and testing into family planning for the last one year, and I have seen the success that it has taken up with; and if it is not integration, then there would be a lot of duplication, there would be a lot of confusion. Integration brings everything on board, and it is a one-shop sale or a supermarket, which makes it very easy for the community; and actually, the community has really accepted this integration.* ~ Program manager

Although there is general support for integration, 11 of the 15 policymakers interviewed reported that national leaders, such as the President and Minister for Health, have not made a clear policy statement regarding integration. They noted that national leaders' statements do not directly support integration but often make reference to specific components such as FP or HIV/AIDS independently. Indeed, some state that the concept of integration is much the preserve of technocrats in the field of health.

Program managers and more than half of the service providers interviewed agreed with this and complained that despite all the effort put toward integration, there have been no public advocacy campaigns to support it. Pilot activities have not been focused on informing communities about the integrated services and thus have not created demand for the services.

**National policies and guidelines.** The level of awareness of RH/HIV policies and guidelines varied among the respondents. More than half of the 15 policymakers interviewed reported that FP/RH/HIV integration is not a priority of the government and that no supportive legal environment exists. Most of the 51 service providers reported that a policy is in place to support integration. However, when asked about the

content of the policy, few service providers were able to state it. It is evident that service providers have limited knowledge of the policies and guidelines or protocols that might support integration.

According to most policymakers, the HIV/AIDS policy, RH policy, and others lack proper supportive frameworks or guidelines for FP/RH/HIV integration. About one-third of the policymakers think that national policies and plans are implemented at the service delivery level, and most report that policy implementation is hindered by the lack of both human and financial resources.

*Policies are great to have, but if you don't have an operational framework for the policies, they will remain just policies. Great things to have but you know what I mean when you seek a policy really, one of the things that need to be happening is, you need to be exposing a policy with the end in mind. What is it that you intend to achieve down the road? What is the vision? How do you intend to go about it? And then putting a policy in place, it means that you are also going to back up that policy with the necessary framework, the necessary resources to make the policy actual. And I don't think that we have done that. ~ Policymaker*

At the service delivery level, about half of the providers interviewed noted that the lack of integrated guidelines negatively affects service provision at integrated sites. The existing guidelines are for parallel FP/RH/HIV services and do not focus on provision of integrated services and information. This is especially true in health centers and dispensaries where the service provider has to multi-task in the provision of both curative and preventive services in different rooms. Inclusion of integrated topics in counseling guidelines and client education materials would help to ensure consistent integration of services.

*Not all the counselors with a client will remember to include FP counseling because it is not on the guidelines—like the posters we have, they don't include FP so we just use the knowledge we acquired during training, but it's not easy to remember sometimes—you'll find you have finished the counseling and then you remember you forgot to mention FP afterward. ~ Service provider*

**National management and monitoring of integrated services.** More than half of the 15 policymakers reported a lack of clear guidelines on how integrated activities should be managed—with the exception of Family Health Options Kenya (FHOK), which has established a mechanism to manage its integrated services. At the national level, about half of the policymakers believe that the DRH and NASCOP should manage the integrated services, and the other half is divided among those who think it is the work of the Director of Medical Services or the ITWG. Most of the policymakers believe that territorial issues by both NASCOP and the DRH prevent effective integrated services.

Opinion is divided among policymakers as to whether any monitoring and evaluation (M&E) indicators for policies reflect integrated service delivery. About half of those interviewed reported that indicators are in place, although not in an integrated manner, while the other half reported that no relevant indicators exist and that they must be established for FP/RH/HIV service integration to move forward. Although pilot integration activities are being expanded, respondents noted that without clear related policies, guidelines, and implementation plans, little monitoring can be expected from the program managers.

*We are still far removed from any integration indicators. There are many types of integration, but the one integration that has moved quite ahead is the FP into VCT. The VCT main committee has now agreed to include some three additional indicators or additional questions in the VCT client form, which will be used to respond to some indicators that integration of family planning into VCT is taking place—although that hasn't quite been translated into the actual card. But I would not say that is so for having the registers, having the same indicators, they haven't quite gone that way. So there is still room to be covered to make sure that those indicators are in those registers and in the card, so that they would be able to capture the data, which will show that there is some integration*

*going on. But the other integration activities have not gone to that extent of including indicators that will now capture the integration activity. ~ Policymaker*

## **Operational Support Factors and Barriers to FP/RH/HIV Integration**

The interview questions in this area focused on how integration is working at the service delivery level; what issues the service providers and program managers are facing related to the management and administration of integration; and the issues surrounding planning, supervision, staffing, supplies, and financing.

The operational support factors identified by the respondents included the government provision of staff, facilities, and commodities; the definition of the type of medical staff designated to provide services; the presence of community health workers; and the definition of a reporting format. Policymakers reported the following barriers: staff shortages, lack of capacity-building opportunities for staff, fear of losing donor funds now allocated to vertical programs, lack of appreciation of the concept of integration by national leaders, and few youth-friendly facilities. Program managers and service providers reported the following challenges: no clear supervision guidelines, staff shortages, limited capacity-building opportunities, staff burnout, commodity shortages, and limited space.

**Integrated service delivery.** The majority of the 31 facilities visited offered several integrated services such as FP as part of VCT, CT as part of FP, and FP as part of PMTCT. However, most facilities do not distribute FP commodities at the point of integrated service. Instead, clients are referred elsewhere for contraceptives. This might be in the same facility or at another facility. Providers cited several reasons for this. For example, they believe that reporting on FP commodities is a complicated process and not easily learned. Therefore the VCT rooms in clinics are not supplied with FP commodities. The stand-alone VCT sites do not have service delivery numbers so they cannot obtain their own commodities. Therefore they have to report back to the FP clinic or to the district public health nurse on usage of the commodities and the names of clients who received them. However, VCT services do not require a name in order to protect the client's confidentiality, while FP services do require a client name—creating a fundamental conflict in regulation when the two services are integrated.

Although referral for services and commodities appeared to be the integration mechanism preferred by providers, 40 of the 51 service providers interviewed reported a complete absence of a follow-up or feedback mechanism to monitor how well the referral system was working both for intra-facility and inter-facility referrals. Without such a system in place, it is difficult to know whether those referred actually sought the services or commodities or indeed received them from the referral point.

The differences between FP/RH and HIV services are also reflected in their fees. For RH/HIV services, fees for patients in public health facilities differ depending on the level of facility. Dispensaries charge a standard fee of ksh. 10/=, while health centers charge a standard fee of ksh. 20/=. The fees ensure free access to counseling and testing and FP services. Stand-alone VCT sites charge ksh. 50/= for the testing process, while FP methods are issued for free. Private facilities have a fee attached to every service and commodity offered, in addition to the standard user fee.

**Services for males and youth.** Respondents noted that systems to encourage men to seek HIV testing have not been successful. VCT centers issue vouchers to women to invite their partners to come for CT; however, few men use the vouchers or accompany their partner to the VCT center. The findings are the same in CT/FP integrated centers. When vouchers are provided to women to invite their partners to seek VCT services, only rarely will the man show up with the voucher as recommended. A policy to address FP/RH/HIV integration will need to include special efforts to reach males. Similarly, respondents noted that existing services are not attractive to youth, and there are few youth centers offering integrated FP and VCT

services. Because a high proportion of new HIV infections are among young people, it is important to reach out to them.

**Coordination and supervision.** Fewer than half of policymakers think that NASCOP incorporates FP/RH activities in its annual plans, while more than half think that the DRH includes HIV activities in its annual plans.

*I think it is just the traditional set up, because if you set up a division and you call it reproductive health, now NASCOP is there, you see they will be like two islands. Reproductive health is a republic on its own, and there is another republic called NASCOP; they are like functional zeros; (no interaction between them). ~ Policymaker*

The extent to which FP/RH/HIV program managers coordinate their activities is minimal; and supervision systems are parallel as a result of the vertical systems. For the program managers, 16 of the 33 interviewed acknowledge that supervision of integrated services is not done in an integrated manner. Instead, each program manager and RH and HIV district coordinator are concerned with their parallel roles even in facilities where services are already integrated. For some service providers, this has proved to be discouraging, as the data provided in integrated sites is never considered or included in their quarterly reports.

According to some program managers, there are no clear government policies and guidelines for the supervision of integrated services, but they use guidelines for other vertical services, such as FP and VCT guidelines. For some models of integration, the district health management teams (DHMTs) are supported by partners to enable the supervision of RH/HIV integrated service delivery. Some district managers have developed their own checklists to guide their supervision, especially related to integrating CT into FP services. The DHMTs, in collaboration with partners, have also developed supervision tools to capture some integrated data, which has worked well for the pilot activity. However, the Population Council funded the supervision, so it is unclear if it is sustainable in the long run.

The provincial and facility managers have not been adequately sensitized on the advantages of integration. Service providers who have been trained on integration are sometimes transferred to other departments after a few months, leaving untrained providers to continue with services at the RH/HIV integrated sites. The provincial teams feel left out of many activities implemented in the districts, including integration, and thus have not been able to supervise or ensure implementation.

**Infrastructure.** In most of the smaller facilities, a lack of space limits the extent to which services can be integrated because the equipment needed for effective integration takes up space. In the larger facilities, such as the district and sub-district hospitals, a limited number of rooms are available for providers to offer services concurrently.

**Staffing.** More than half of the 15 policymakers interviewed agreed that the regulations stipulate the cadre of medical staff that can diagnose and treat HIV/STIs and provide FP/RH services. They stated that these services are provided mainly by nurses, clinical officers, and physicians.

Most health facilities lack an adequate number of staff, especially nurses. Twenty of the 33 program managers and 49 of the 51 service providers reported staff shortages as a barrier. Some dispensaries are run and managed by one nurse, who is forced to multi-task. The situation is so severe that when there is a matter that requires the nurse to report to the district headquarters, the facility has to be closed for that day. This situation has been worsened by a government circular that requires nurses to attend a minimum number of trainings before they can renew their registration—to, in effect, stay employed. Many nurses thus seek further education, leaving the facilities understaffed or closed entirely.

Furthermore, the MOH, when hiring nurses, dictates where they are to be posted. The district managers feel that they should be the ones to post the nurses, as they are more aware of which facilities are experiencing the most severe staff shortages.

*The way we are getting staff is not actually what should be done. We should be given the staff, then we know where to take them. Not like now where we are given staff from Nairobi to the big facilities, while we are integrating even in the small facilities where most of the clients go and this makes service provision even more difficult for the small facilities. ~ Program manager*

Indeed some of the smaller facilities encourage group counseling as opposed to individual counseling due to staff shortages and the lack of adequate time to meet all clients individually.

*To start with, it was a bit hard to convince the mothers [to test for HIV] but afterwards, they accepted it and when they did, due to staff shortages, it is very difficult because of the time limit. When counseling a patient, it gets hard and takes up a lot of time so we usually prefer group counseling, which is also not very good because once you counsel them as a group, you still have a client coming to ask more questions and we're also constrained by time. ~ Service provider*

Staff shortages, heavy workloads, and an inability to deal with situations encountered during counseling sessions, especially post-test counseling, have contributed to nursing burnout according to more than half of service providers interviewed. This situation is compounded by the limited opportunities for nurses or, generally, medical cadres to build their capacity. Policymakers recognize that the pre-service training of health personnel, especially nurses, does not incorporate service integration. To date, fewer than 10 percent of service providers have been trained on integration, and yet the services are expected to be scaled up.

According to the program managers and service providers, FP/RH/HIV service integration to a large extent depends on provider motivation at the time of service provision. This motivation is related to whether the particular provider has undergone formal integration training and where he/she was trained. Reasons for poor-quality service often include “I have not been trained” and “There is too much work.” A provider who has gone through the integration training outside the facility is often more motivated to provide integrated services than one who has been trained on the job or has not received any training. This may be due to a perception of inequity when some receive “outside” as opposed to on-the-job or no training.

Most policymakers appreciate the role played by community health workers; they are seen as the bridge to the community. However, with the emphasis on clinical facilities, their role has been de-emphasized. Most policymakers recognize that community health workers need to be trained and retrained to respond to the changing FP/RH/HIV situation. These workers could then serve as the link between the health facilities and the communities, disseminating information and creating demand for the integrated services being offered. This would be in line with the new community strategy being advocated by the government.

*There is a refocus and particularly to the community level of services. It is called level one, and from what we hear is that the whole health sector is being galvanized and rerouted to focus on the community-level kind of health services. And that also includes reproductive health services, because what has been said is that one of the reasons why the impact was not very greatly felt before was that we concentrated so much on the health facility. We started improving the health facility, equipments, and all that, and we waited for the client to come and seek the services, but the client didn't come. ~ Policymaker*

**Logistics and commodity supply.** About half of the policymakers interviewed think that the logistic systems in place do not support effective integration but rather the vertical delivery of services. The DRH manages FP/RH commodities, whereas NASCOP manages HIV commodities; and distribution of these

commodities is done through the Kenya Medical Supplies Agency (KEMSA), the medical supplies arm of the government.

*I think logistics could play a part, just look at how we handle the logistics of the two; the HIV/AIDS commodities and the family planning commodities, the two are totally different. The way we distribute and handle is totally different. Even the logistics of the frequency at which we distribute them, the customers to which we distribute them....Like the ARVs we deliver straight to the customers. Family planning health products we take them to the district stores, so everything is different from a logistics point of view. I think that is the point of departure, because if at that level they are treated totally differently when you talk about integration now, you are just driving the two further and further apart. ~ Policymaker*

At least half of the 15 policymakers interviewed identified the logistics system as a barrier. They agree that antenatal care patients could opt out of HIV testing and agree that the DRH and NASCOP have the responsibility of managing integrated services at the national level. Almost half of the policymakers indicated some disagreement about how the services are or should be structured.

Twelve of the 15 policymakers interviewed think that any new demand for FP and HIV commodities arising from integrated services could not be met due to the lack of commodity security, inaccurate projections, and insufficient funds. They note that the number of test kits needed is based on forecasted demand and projected use, while the number of FP commodities needed is based on census population projections.

As reported by most of the district and provincial health management team members interviewed during the assessment, health facilities have experienced shortages in HIV and FP commodities. The same problem was acknowledged by 26 of the 51 service providers interviewed. Recently, the HIV commodity supply has been more reliable, although logistical issues are still a challenge. For example, Western Province faced shortages for two weeks because the kits in stock had expired. FP commodity stockouts are still frequent, especially the commodities most preferred by clients such as injectables, followed by pills. In fact, during the assessment period, all the areas the research team visited were experiencing injectable and pill stockouts, thereby affecting CT/FP integration, as the FP clinics were the entry points for obtaining contraceptives. As expressed by some program managers, much more needs to be done to ensure timely commodity supplies.

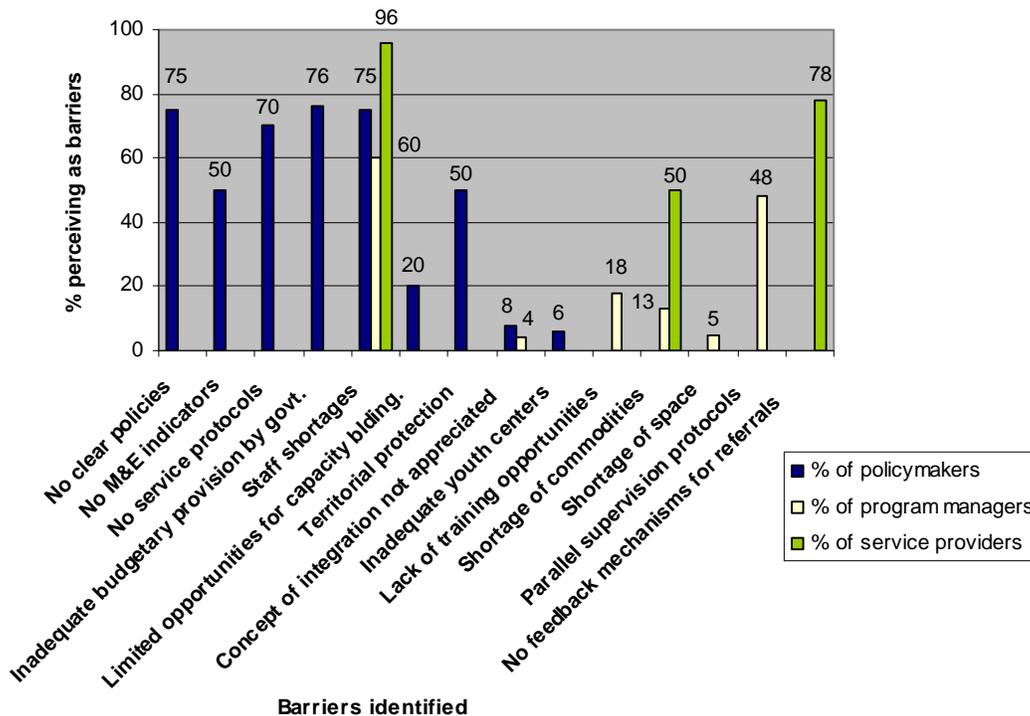
**Reporting format and supply collection.** The MOH has a reporting format for the supply of FP and HIV commodities used in all facilities. Reporting on HIV commodities use is done monthly, while reporting on FP commodities is done quarterly. The FP commodities are collected from the district stores after approval by the District Public Health Nurse, while the HIV commodities are collected from the laboratory technician after approval by the DASCO. Orders from facilities are based on current usage and projected demand; although the facilities often do not receive the amounts ordered because supplies are in short supply.

**Financing.** About half of the policymakers agree that the majority of funding for FP/RH/HIV services comes from the government, while the other half is either not sure whether there is a budget line or any funds at all allocated for integrated services. Some program managers believe that the government is the largest financier of the services in the public facilities in addition to the Facility Improvement Fund, which is money generated by the facilities through a cost-sharing approach. In fact, the government receives funding for HIV test kits from donors such as the United Kingdom Department for International Development, USAID, the President's Emergency Plan for AIDS Relief, and the Global Fund; and funding for FP commodities from donors such as the United Nations Population Fund, USAID, and the German Technical Cooperation. The government provides 53 percent of the total budget for FP commodities and the

human resources and infrastructure needed for integration—including service providers, space, and supplies. The respondents agree that there is no budget line for integrated services.

Figure 1 summarizes both the policy and operational barriers to FP/RH/HIV integration, as perceived by policymakers (n=15), program managers (n=33), and service providers (n=51). Note the diversity of issues cited as barriers to FP/RH/HIV integration by the three groups interviewed. Similarities are observed in relation to staff shortages, opportunities for capacity building, and understanding of the concept of integration. All the other barriers are viewed differently, depending on the source of information. This shows the diversity of opinion in integration as a concept and its feasibility.

**Figure 1: Barriers to FP/RH/HIV Integration Identified by Policymakers, Program Managers, and Service Providers**



Note: The data presented are not representative of the larger group of policymakers, program managers, and service providers, as the sample was not randomly drawn.

## Achievements of Integrated FP/RH/HIV Services

Policymakers agree that the integration of services has resulted in some achievements, including the increased uptake of services by clients, the creation of standardized training materials, more trainers, and increased staff motivation due to capacity building and the establishment of the ITWG. Services provided in parallel RH and HIV systems can limit clients’ access because of increased costs, stigma and discrimination by providers, and lost opportunities to address all their needs in one place.

Table 1 presents the benefits of integration to the client and service provider. When the services are integrated, the client is able to access more than one service at the same time; there is no need to decide which service to seek first. Greater access can lead to better quality services, more efficient time management, and an empowered client who can make informed choices based on the information given at

the clinics. With integration, especially in the VCT sites and youth centers, more young people are able to access RH/HIV services and information.

**Table I. Operational Achievements of FP/RH/HIV Integration**

Benefits to clients	Benefits to service providers
<ul style="list-style-type: none"> <li>• Greater access to services</li> <li>• Improved quality of services</li> <li>• More convenience and less time needed</li> <li>• More privacy</li> <li>• Empowerment to make informed choices</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive service delivery</li> <li>• More efficient time management</li> <li>• Standardized training materials</li> <li>• Training-of-trainers conducted for all provinces</li> </ul>

The MOH uses standardized training materials to train service providers on integration. The uniformity of materials ensures that all staff can work anywhere in the country without thinking that the training they received was different. Training has been decentralized. Thirty-eight provincial trainers have been trained on integration so that service providers can receive training at the provincial level, thereby lowering training costs.

According to the service providers interviewed, integration has allowed them to manage their time more efficiently and provide services to more people at one location. Integration has increased the number of clients accepting the condom as a method to prevent HIV/STIs as well as unintended pregnancies. It has also helped reduce the level of stigma among clients accessing HIV services, as no one knows which services the clients are accessing (FP or HIV).

*It [CT/FP integration] is welcomed even by the patient. It is something that they really welcome. Because the issue of queuing in different areas comes with stigma...going to the VCT is stigmatized and for some, even going for FP is stigmatizing. But with integration, one is left guessing what service you are out to receive. Therefore with integration, nobody will know what business that woman is going to do there in the first place because they are all in one place. ~ Program manager DHMT*

Client satisfaction is an important reason in and of itself to integrate FP/RH/HIV services.

## VI. CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

The assessment findings show that integration is indeed feasible in the Kenyan public health sector. Most of the policymakers, program managers, and service providers interviewed support the concept of integration and all concur that integrated services add value to service delivery, are efficient, save time, empower clients to make informed choices on their RH needs, and increase the uptake of services by clients. Substantiating these views are some achievements reported in the Population Council study, *Feasibility, Acceptability, Effect, and Cost of Integrating Counseling and Testing for HIV within Family Planning Services in Kenya* (FRONTIERS and the MOH, 2008):

- More efficient time management
- Increased uptake of FP/RH/HIV services by clients
- Greater satisfaction exhibited by clients
- An empowered clientele capable of making informed choices
- Development of standardized training materials and trained trainers for all provinces ready for roll out

- Greater acceptance of condoms as a method to prevent HIV/STIs and unintended pregnancy
- Reduced stigma for clients accessing integrated services

These achievements form the basis and justification for scaling up integrated FP and HIV services. Nevertheless, the three groups of respondents cited many barriers to the provision of integrated services and agreed that two major challenges are (1) the lack of a national policy/strategy and guidelines on integration and (2) the operational barriers to implementation at the facility level. While some government documents—the National Health Sector Strategic Plan II, National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission, Family Planning Guidelines for Service Providers, and Adolescent Reproductive Health and Development Policy—support the provision of integrated services, program managers and service providers stated that implementation is poor. Some of the operational barriers cited included the following:

- Minimal national-level supervision for integrated services
- Lack of M&E indicators to measure the progress of FP/RH/HIV service integration
- No government budget line item for integrated services
- Lack of pre-service and in-service training of health personnel on components of service integration, contributing to the negative attitudes exhibited by some service providers, especially nurses
- Frequent rotation of service providers, especially nurses, trained in integration makes it difficult to maintain the services
- Lack of public advocacy campaigns for integration
- Failure to include and train community health workers in service integration
- Commodity stockouts across service delivery points
- Frequent referrals for FP commodities because of confidentiality issues in VCT clinics
- Weak or nonexistent follow-up and feedback systems for referrals
- Limited space, which also compromises confidentiality (both audio and visual)
- Lack of FP and HIV services targeted to youth, which contributes to increased stigma and discrimination in this high-risk group
- Staff shortages and burnout
- No other FP method at VCT sites, except for condoms
- Absence of service delivery point numbers at VCT sites, which prevents access to contraceptive commodities
- FP clinics not included on the approved test kit distribution lists at KEMSA
- Requirements for FP clinics not included in the forecasting and procurement of HIV test kits
- Inadequate reporting on number of people tested and number of women accepting an FP method due to the vertical nature of HIV and FP programs
- Stigma and discrimination by some FP providers against positive women when they seek services
- Failure to sensitize the facility managers and provincial health management teams (PHMTs) on the need to integrate RH/HIV services

## Recommendations

Based on the literature review, assessment findings, and stakeholder input, the ITWG approved the following recommendations related to policy and service delivery guidance, management, logistics, supervision, staffing, and infrastructure:

- **Develop a clear national strategy, operational guidelines, service delivery guidelines, supervision guidelines, and yearly implementation plans/budgets** to support integration efforts. At present, integration is called for in multiple national policies, but nowhere has it been operationalized. Policy development tends to be a process run largely by policymakers, while

policy implementation tends to be carried out by technical staff. The devolution of responsibility for implementation is weak or non-existent for the national policies. However, for a policy to be implemented effectively, it must be disseminated widely to those responsible for its implementation and to those it was designed to reach. This has not yet happened. Kenya should develop a national strategy that is inclusive of all areas where integration is desired. Based on the strategy, the ITWG should develop operational guidelines that answer the following questions:

- What needs to happen at the operational level for this strategy to be implemented?
- Who is responsible for making it happen?
- How much will it cost?
- What is the benefit of spending this money?
- When should it be done (timeline)?

A one-year implementation plan should then be developed and costed. This can be presented at the budget meeting and can also be used as the basis for advocacy targeted to the MOH and the Ministry of Finance for approval and to obtain funding.

- **Improve dissemination of policies, strategies, and implementation plans** to address lack of knowledge. The academic community could be engaged to build the capacity of its students by distributing policies and holding roundtable discussions on how best to implement policies and how to advocate for funding. This could be done either bi-annually or annually and will help ensure that students are better able to implement integrated services. Pre-service students should also be made aware of existing policies that guide the provision of health services in the country. Currently, the pre-service curricula make no mention of existing policies. Another tactic would be to develop brochures or leaflets that summarize the policy documents that can be distributed widely. PHMT and DHMT members can also conduct meetings at the health facilities to disseminate new and amended policies as they become available.
- **Strengthen the ITWG** by clearly articulating its role and responsibilities, providing it with the appropriate level of authority, permanent staff, and the budget required to oversee and implement the integration strategy. This could be achieved by creating a small secretariat made up of DRH and NASCOP staff that manages the integration process with technical assistance provided by cooperating agencies and donors working on integration. The larger ITWG would then serve as an advisory body. It would be necessary to build the capacity of the secretariat staff to enable them to develop and estimate costs for yearly implementation or action plans and to advocate to the heads of NASCOP and DRH to include integration activities in the departmental annual operating plans.
- **Strengthen KEMSA** to provide efficient logistical support and commodities security. One of KEMSA's strategic objectives is to develop and evolve a world class integrated medical supply chain encompassing selection, forecasting, quality assurance, procurement planning, warehousing, logistics, and customer service. Parallel programs, such as RH commodity and ARV provision, should be integrated into the overall distribution process, as this will ensure savings in distribution costs. Also, a single supply chain will result in greater reach and efficiency while conserving resources. Lastly, it will solve the problem of vertical reporting and forecasting systems.
- **Increase the number of service providers and sensitize and build the capacity of new and existing staff, senior managers, and stakeholders.** For example, provincial teams could serve as trainers in scale-up efforts by providing training on counseling and testing, related HIV/AIDS skills, FP counseling, contraceptive methods, and technical updates when they arise. Pre-service training of all medical cadres and especially nurses should include the purpose and importance of service integration. In addition, cost-effective, on-the-job training (with clear guidelines on who can conduct the training) could ensure that nurses feel more competent in handling clients seeking FP/RH/HIV integrated services. Job aids developed in line with policy guidelines could help to remind service providers about what is expected from them at every

service delivery point. New staff posted to the districts would be utilized better if it is left to the district managers to determine where they can best provide services given the prevailing shortages.

- **Renovate and reorganize existing health service structures and build new structures** where appropriate to ensure enough space for integrated services.
- **Conduct public education campaigns** to inform community members of the availability of integrated services. This would be in line with the community strategy launched by the MOH in addressing community-level involvement.

## VII. NEXT STEPS

The ITWG plans to undertake the following actions to finalize and implement a strategy and operational plan for integrating FP/RH and HIV services in Kenya:

- **Finalize the National RH/HIV Integration Strategy.** The draft National RH/HIV Integration Strategy for Kenya is currently under review. Final changes will be incorporated and it will be submitted to the full ITWG, the Minister of Public Health and Sanitation, and the Minister of Medical Services for approval.<sup>2</sup>
- **Draft operational policy guidelines.** Once the ITWG, the Minister of Public Health and Sanitation, and the Minister of Medical Services approve the strategy, the drafting subcommittee will develop operational policy guidelines that address the barriers identified in this study. The guidelines will explicitly articulate how integration will occur for both the DRH and NASCOP.
- **Identify integration indicators and an M&E plan.** Based on the above, a subcommittee will ascertain the information needed on integration to effectively manage the program. The subcommittee will identify indicators that can be easily captured and incorporate them into an M&E plan that includes yearly objectives.
- **Develop and cost a one-year action plan for implementing the guidelines.** Once the strategy and guidelines are approved, a subcommittee will draft a one-year action plan that includes cost estimates. The plan will articulate what will be done in the following year, how it will be done, the benefits that will be achieved, and the cost. This will form the basis of the submission to the DRH and NASCOP annual action plans.

The integration strategy covers many services that can potentially be implemented. However, funding, manpower, and infrastructure preclude implementing everything at once. It is therefore necessary to choose those services that will be implemented first and that will have the most impact. Others will be added in as appropriate given the environment.

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<sup>2</sup> In March 2008, the government of Kenya created two ministries responsible for health. The Ministry of Public Health and Sanitation (MOPHS) includes the Division of Reproductive Health, which is responsible for coordinating RH activities. The MOPHS is also responsible for HIV prevention programs. The Ministry of Medical Services (MOMS) oversees health services at the district, national, and referral health facilities. The MOMS also covers HIV treatment and care. Because both ministries are involved in RH and HIV/AIDS work and will need to work closely to facilitate coordination and implementation of integrated services, both ministers need to approve the National RH/HIV Integration Strategy.

## **APPENDIX A: KENYA'S POLICIES AND GUIDELINES ON FP/RH/HIV INTEGRATION**

ITWG members identified the lack of national and operational policies and/or guidelines at the national level as a key barrier to scaling up FP/RH/HIV service integration. Accordingly, the Health Policy Initiative conducted a review of national and operational policies and service delivery guidelines to identify the areas needing clarification. The following is a summary of the relevant strategies, policies, and service delivery guidelines.

The **National Health Sector Strategic Plan (NHSSP) II (2005–2010)** aims to ensure that health service delivery is effective and accessible to as many people as possible (Republic of Kenya MOH, 2005b). Under the NHSSP-II, the Kenya Essential Package for Health (KEPH) represents the integration of all health programs into a single package that will serve to improve health at all phases of the human development cycle. Among the objectives of the KEPH is to integrate the different programs toward the clients' full needs. The KEPH includes services specifically targeted at adolescents such as RH counseling and contraceptives, VCT for HIV, and youth-friendly services within existing health facilities.

The **Kenya National Reproductive Health Strategy (1997–2010)** explicitly recognizes the need to provide integrated services. However, it does not call for the implementation of integration but rather aims to remove all barriers to the provision of these services. Under its objectives related to integration, the strategy calls for training health personnel at all levels for the integration of RH services, developing and disseminating policy guidelines and service standards, and enhancing the quality of care at all service delivery outlets.

The **National Reproductive Health Policy**, issued in 2006, and launched in 2008 identifies inadequate integration as a challenge. It mentions the integration of VCT, ART, and PMTCT into RH services, specifically in relation to services for HIV-positive women. The policy designates the Division of Reproductive Health as the MOH unit responsible for coordination and implementation of RH services. It lists other ministries as having supportive functions but does not mention the NACC.

The Kenyan **Family Planning Guidelines for Service Providers** (Republic of Kenya MOH, 2005c) advise service providers that clients coming for FP services also have HIV/AIDS service needs and vice versa—hence the need for both FP and VCT counselors to be equipped with basic counseling skills appropriate to both service needs. The guidelines include a chapter on why it is important to link FP and HIV/AIDS/STI services and also discuss linkages between FP and VCT services and the key role of family planning in PMTCT. However, nowhere does it discuss how to operationalize the guidelines. Issues such as procuring and reporting on contraceptives for HIV prevention, care, and treatment sites and HIV test kits for FP and RH clinics; changing commodity forecasts to include the new service delivery points; obtaining service delivery point numbers for VCT sites; and training of staff are not addressed.

Kenya's **National HIV/AIDS Strategic Plan (KNASP) 2005/6–2009/2010** (Republic of Kenya NACC, 2005) does not specifically mention family planning, but it recognizes the special needs of women and youth. Among the services recommended is youth-friendly access to HIV and RH information and other services. In addition to the prevention of new infections, it gives priority to the improvement of the quality of life of people infected and affected by HIV/AIDS. A key initiative in this area is ensuring that counseling on human rights, including legal and treatment rights and RH, is included in the comprehensive care services package offered to HIV-positive people.

The **Health Sector HIV/AIDS Strategic Plan 2005–2010** (Republic of Kenya MOH, 2005d) acknowledges the need for integration of HIV/AIDS services within reproductive and other health services.

The plan further recognizes the need for NASCOP to develop integration plans for all the key HIV/AIDS components. However, in addressing the overall quality of health for HIV-positive people, the plan is not explicit on which services should be integrated; it merely states that “every attempt should be made to ensure that HIV/AIDS programs are integrated within the relevant health services (MOH 2005d, p.49).”

Various sections of Kenya’s **VCT Policy** detail the integration of FP services into VCT programs (Republic of Kenya MOH, 2001a). The policy stresses the need “to incorporate family planning counseling in all VCT counseling sessions, for both HIV-positive and HIV-negative clients,” (MOH 2001a, p.15) and also presents clear guidelines for doing so. In the case of pre-test or test-decision counseling, the guidelines recommend having a discussion on family planning in light of clients’ reproductive intentions. During post-test counseling, in addition to delivering information on FP methods and services, counselors are encouraged to reinforce the client’s current use of contraception and to stress the need for condom use for dual protection. Under the section pertaining to couples counseling, counselors are encouraged to assist couples with identifying appropriate contraceptive methods and to help them explore the implications of test results for their current sexual practices. Finally, the guidelines instruct counselors to discuss the practicality of behavior change to reduce risk.

Kenya’s VCT Policy also discusses the promotion of dual protection and the importance of providing both men and women with FP services at the VCT center. It recommends providing referrals to facilities where clients can access the full range of FP methods, including long-term or permanent methods. The policy clearly emphasizes FP counseling as a major component of VCT.

The **Strategy for the Integration of HIV Voluntary Counseling and Testing and Family Planning Services**, drafted in 2004 and adopted in 2008, specifies FP/VCT integration at four levels of intensity and sets minimum requirements for training, staff time, clinic space, contraceptives, counseling materials, and referral lists. At level 1, VCT counselors provide basic FP information and the VCT center offers condoms and pills. At level 2, injectables are added to the contraceptives available. Intrauterine contraceptive devices are added at level 3. At level 4, all contraceptive methods are provided at the VCT center, although availability of voluntary sterilization is limited to those sites with physicians. The VCT/FP Integration Strategy includes a sample implementation plan and is therefore a useful model for an operational plan covering all aspects of FP/RH/HIV integration.

The **Guidelines to Antiretroviral Drug Therapy in Kenya** state that “ideally, adequate and timely counseling regarding contraception and breastfeeding should have been part of the care all through pregnancy and continued during the postpartum and postnatal periods” (Republic of Kenya MOH, 2001b, p. 40).

The Kenya **National PMTCT Guidelines** recommend making contraceptive information available as part of postpartum care to help reduce the number of HIV-positive births. The guidelines specifically recommend that HIV-positive women begin using a reliable contraceptive method by 2–4 weeks postpartum and note that these women can use all modern contraception methods (Republic of Kenya MOH, 2002).

Kenya’s **National Home-Based Care Program and Service Guidelines** acknowledge that home-based care (HBC) is a collaborative effort among the hospital, family, and community. Its components include offering physical, psychological, and spiritual support. According to the guidelines, HBC is a holistic system of care, including provisions for, among other things, addressing the FP/RH needs of people living with HIV. As a policy goal, the guidelines aim to ensure that HBC is thoroughly integrated into existing health services (Republic of Kenya MOH and NACC, 2002).

According to the action plan drafted to guide the implementation of Kenya's **Adolescent Reproductive Health and Development (ARH&D) Policy**, increased availability, accessibility, and use of integrated, high-quality ARH services are key outcomes. A primary activity is providing essential ARH commodities and services that include counseling, family planning, STI management, pre- and post-natal care, comprehensive HIV/AIDS care, and PMTCT (Republic of Kenya MOH and NCAPD, 2005).

The ARH&D policy itself includes strategic actions in support of adolescent and youth health, such as providing appropriate RH information and services at all levels, including family planning. The policy further seeks action on establishing and promoting adolescent-friendly VCT sites and linking them to appropriate services.

## APPENDIX B: RESEARCH ON FP/RH/HIV INTEGRATION IN KENYA

Following is a summary of the research studies that specifically examine the issues related to FP/RH/HIV integration and report on results of pilot studies in Kenya:

- **Provider and client attitudes.** In 2005, the POLICY Project conducted focus group discussions with FP service providers, FP/antenatal (ANC) clients, and HIV-positive women in three districts of Kenya (Kisumu, Nairobi, and Nyeri). The 24 service providers working in FP/ANC departments in health facilities stated that the integration of FP/RH and HIV services was long overdue. An important facet of integrated services was clients' ability to access them privately. They also recommended that health providers find innovative ways to reach men and youth with FP services. Providers said that their workload had increased due to AIDS patients and they were worried about being exposed to HIV through their clinical work. The 23 FP/ANC clients and 24 HIV-positive women participating in the discussions recognized the benefits of condoms. However, many had negative views of condoms, and married women did not think they could ask their spouse to use them because this suggested a lack of trust. The women wanted service providers to reach men directly with messages about condoms. HIV-positive women wanted more information on the best FP methods for them to use. Some FP/ANC clients complained about the quality of care, citing long delays, unclean facilities, stigma and discrimination, and uncaring and insensitive providers at government health clinics (Gichuhi et al., 2004).
- **FP added to VCT sites.** During 2002–2005, FHI introduced family planning into 14 VCT sites. Working closely with NASCOP, FHI conducted a feasibility study at 20 VCT sites in the Coast and Western provinces in 2002. The study found that VCT clients wanted FP services; the VCT staff thought that adding family planning would benefit their clients but would also add to the length of counseling sessions and their workload; some counselors lacked adequate knowledge about contraceptive methods (Fischer, 2006). Next the Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO) and AMKENI Project developed training manuals for clinical and nonclinical providers. The MOH trained two sets of trainers in 2004. By 2005, 38 trainers and 101 service providers from all eight regions of Kenya were trained in FP/VCT integration. FHI then assessed provider knowledge and attitudes, the provision of FP services, and referrals and demand for contraception in the 14 VCT sites. It found that providers' knowledge of family planning had increased and more VCT clients had received FP information than previously—although providers were less likely to discuss family planning with men rather than women and with couples being counseled together. Nevertheless, the intervention did not appear to increase contraceptive use among VCT clients because many providers had not received training or did not implement their training. The researchers concluded that “VCT providers need to strengthen their skills on pregnancy risk screening” (Fischer, 2006, p. 14), and training and supervision needed to be provided to all VCT providers in a site.
- **FP added to PMTCT.** During 2000–2002, Population Council's HORIZONS Program conducted operations research on the use of family planning by PMTCT clients at a hospital and NGO clinic. In both sites, FP services and PMTCT were offered in the same building. The study found that more than one in five clients discussed family planning during their antenatal visit, but less than 4 percent of the postpartum clients received any FP counseling. At PMTCT sites, among the clients at six months postpartum, contraceptive use was similar for HIV-positive and HIV-negative clients. However, in one site (Karatina), condom use was significantly higher among HIV-positive clients; 40 percent of HIV-positive clients reported regular condom use with a regular partner or spouse, compared with 2 percent of HIV-negative women. At the second site (Homa Bay), condom use among PMTCT clients was less than 3 percent for both HIV-positive and HIV-negative women. These findings suggest that FP counseling can be effective in influencing condom use among HIV-positive PMTCT clients (Baek and Rutenberg, 2005).

- **STI identification among FP and ANC clients.** In 1998, the Population Council conducted a study to assess the accuracy of syndromic management to identify STIs. To improve the effectiveness of syndromic management, the researchers added assessment of the client's risk of contracting an STI to the clinical protocol. Conducted in five Nakuru clinics, the study found that 14 percent of the FP clients and 21 percent of the ANC clients had an STI. However, providers correctly diagnosed less than 16 percent of the women who later tested positive in laboratory tests (Solo et al., 1999).
- **VCT, PMTCT, and ART added to FP services.** In 2005, the Family Planning Association of Kenya (FPAK, now Family Health Options Kenya) incorporated VCT, PMTCT, and ART services into four of its nine clinics (IPPF, 2005; Osur, 2005). Two clinics were already providing PMTCT services, and seven had VCT services. To provide integrated services, FPAK trained a core service delivery team, which then trained other FPAK staff. Service delivery systems were expanded to include more integrated counseling and psychosocial support and better client monitoring. FPAK also set up treatment support groups. In the first nine months of operation, the project provided PMTCT treatment to 20 HIV-positive women and ART to 25 other HIV-positive clients. A key lesson learned from this project is the following:

Comprehensive HIV/AIDS care is very expensive—it demands careful planning to address all elements, time to adapt facilities and services as necessary, and significant resource investment to start and maintain all services required. It calls for referral partnerships, expanded resource mobilization, and participation of all stakeholders in the process of care and support (IPPF, 2005, p. 17).

A related issue is having access to laboratory services or obtaining the necessary equipment. Using external services can be difficult if the machines are frequently broken, but purchasing a CD4 counting machine and a hematology analyzer is costly (IPPF, 2005).

- **Community-based FP/RH linked with HIV/AIDS care and support.** Since 1999, Pathfinder International has supported community-based programs integrating FP/RH and HIV services. Under a two-way referral system, trained community health workers (CHWs) refer women to clinical facilities for antenatal care, counseling and testing, delivery, and other services; while the clinic refers clients to the CHWs for follow-up and support. The CHWs also make home visits to provide basic care for HIV-positive people, FP information, and condom and pill supplies (Kane and Colton, 2005). They also follow up on clients' adherence to ART regimens; link clients to food, income-generating activities, and other community services; educate community members; and organize women's support groups. Challenges facing the program are lack of space for counseling and testing in clinics; lack of nurses and trained HIV/AIDS counselors; stockouts of HIV testing kits, ARVs, and oral contraceptives; inadequate follow-up of mothers and babies; difficulties ensuring appropriate infant feeding; stigma, fear of disclosure, and traditional beliefs that discourage women from being tested; poverty; and insufficient monitoring and supervision (Kane and Colton, 2005).
- **CT added to FP services using two models.** FRONTIERS supported the DRH and NASCOP to design, implement, and compare two models (testing and referral) of integrating CT for HIV within FP services in 23 health facilities in the Nyeri and Thika districts in terms of their feasibility, acceptability, cost, and effect on the voluntary use of CT, as well as the quality of FP services (FRONTIERS and MOH, 2008). The study used a pre-post intervention design to obtain information from FP providers and their clients in 2006 and 2007. The study demonstrated that both models were feasible and acceptable to providers and clients as a means of integrating and linking HIV prevention counseling, condom promotion, and counseling and testing with FP services; and were effective in increasing the quality of care and service use. Overall, 50–72 percent of FP clients who were offered HIV testing had the test. On average, the additional time required during an FP

consultation to provide the CT service was 3.03 minutes for the testing model (increasing from 12.4 to 15.4 minutes) and 4.18 minutes in the referral model (increasing from 13.2 to 17.4 minutes); and the additional costs per FP client for this time were affordable at US\$0.41 for the testing model and US\$0.24 for the referral model. For planning the scale-up of the testing model, the estimated incremental cost per FP client who is also counseled and tested for HIV ranged from US\$5.60 (hospital) to US\$9.53 (dispensary). This compares favorably with an estimated cost per client at stand-alone VCT sites of US\$27.

## **APPENDIX C: SAMPLED HEALTH FACILITIES BY PROVINCE**

### **Nairobi Province**

1. Eastleigh youth center (FHOK)
2. Nairobi West clinic (FHOK)

### **Western Province**

3. Kakamega PGH
4. Chwele Health Center
5. Khunyangu Sub-District Hospital
6. Bungoma District Hospital
7. Friends Lugulu Mission Hospital
8. Kakamega VCT Stand Alone
9. Tigoi Health Center – Vihiga
10. Likuyani Hospital – Lugari

### **Coast Province**

11. Mombasa Youth Centre (FHOK)
12. Coast Provincial General Hospital
13. Magongo Health Center – Mombasa
14. Port Reitz Hospital – Mombasa
15. Better Off Knowing Liverpool VCT Center (Stand-Alone) – Malindi
16. Kilifi District Hospital – Kilifi
17. Malindi District Hospital – Malindi
18. Jocham Hospital – Mombasa

### **Central Province**

19. Tigoni Health Center – Kiambu District

### **Thika District health facilities (CT/FP referral model)**

20. Thika Youth Center (FHOK)
21. Thika District Hospital
22. Gatundu Sub District Hospital
23. Ngorongo Health Center (VCT closed; In-charge away on training)
24. Kirwara Health Center
25. Gakoe Dispensary
26. Mukurwe Dispensary (Closed since January 2007)

### **Nyeri District health facilities (CT/FP testing model)**

27. Nyeri Provincial General Hospital
28. Gichira Health Center
29. Warazo Health Center
30. Mweru Dispensary
31. Kiaguthu Dispensary

## APPENDIX D: THE INTEGRATION TECHNICAL WORKING GROUP

A leading force in supporting FP/RH/HIV integration is the ITWG, formerly the Integration Working Group. The original group drew from the VCT Committee of NASCOP and was formally established in 2002 to support a pilot study for integrating FP and VCT services. Other stakeholders included FHI, JHPIEGO, the AMKENI Project, and later the Population Council.

With assistance from FHI, the Integration Working Group devised a strategy for the integration of FP into VCT services. This strategy was finalized in 2007 and formally issued in July 2008. Its approach will contribute to the overall integration strategy, covering the range of HIV, FP, RH, and MH services.

When the Health Policy Initiative began working with the group on identifying barriers to FP/RH/HIV integration, members recognized the need to incorporate other RH services besides FP with HIV services. Accordingly, the group was expanded and is now called the ITWG (see Box 1). The group, co-chaired by NASCOP and the DRH, is responsible for establishing mechanisms to make the integration of FP/RH/HIV services a reality—both at the policy and operational levels. The members represent the Kenyan interests of their organizations and are champions of integration. The ITWG’s specific objectives are to bring integration work to scale by ensuring policies and guidelines that support integration are in place, harmonizing planning, and ensuring that stockouts and reporting needs will not derail integration. The group is also expected to advocate and ensure commitment and resources for integration. The ITWG meets only when there is an agenda or a document that needs consensus from stakeholders.

### Box 1. Current ITWG Members

Division of Reproductive Health  
National AIDS and STI Control Program  
National AIDS Control Council  
National Coordinating Agency for Population and Development  
MOH planning and finance departments  
Kenya Medical Supplies Agency  
Kenyan medical training colleges  
Nursing Council  
Kibera Community Self Help Program  
Women Fighting AIDS in Kenya  
University of Nairobi  
Mission for Essential Drugs & Supplies  
Liverpool Voluntary Counseling and Testing  
Christian Health Association of Kenya  
Family Health Options Kenya  
Futures Group International  
Management Sciences for Health  
JHPIEGO  
Population Council  
Family Health International  
University of Nairobi  
Kenya Obstetrics and Gynecology Society  
Engender Health  
Pathfinder International  
PATH  
Centers for Disease Control and Prevention  
U.S. Agency for International Development  
United Nations Children’s Fund  
United Nations Population Fund  
World Health Organization

From the ITWG, a smaller group known as the RH/HIV Integration Committee was formed to steer the integration process, carry out day-to-day management, and conduct the work. Its authority is derived from its co-chairs, the heads of NASCOP and DRH. Members include the DRH, NASCOP, and a small group of cooperating agencies and donors supporting integration and PLHIV groups. The committee meets at least once every quarter or as needed, which is dictated by matters arising from integrated activities taking place in the country. It submits documents, training materials, and so on to the broader ITWG for comments and discussion. Feedback is then incorporated into the document being reviewed.

The committee was tasked with developing a National RH/HIV Integration Strategy and operational policy guidelines. The ITWG has reviewed the draft strategy, and the committee is now finalizing it for MOH approval.

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