

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

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.²
- **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.

² 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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